BOARD OF DIRECTORS' AGENDA

MEETING HELD IN PUBLIC

To be held at 1pm on Thursday 26 March
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref Nº.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB021/26	**Chair's welcome and note of apologies** ***Purpose:*** *To record apologies for absence and confirm the meeting is quorate.*	*Verbal*	Chair	
TB022/26	**Patient and Staff Story** ***Purpose:*** *To **receive** the patient and staff story*	*Presentation*	Chair	
TB023/26	**Declaration of Interests concerning agenda items** ***Purpose:*** *To record any interests relating to agenda items*	*Verbal*	Chair	**13:00** (20 mins)
TB024/26	**Minutes of the previous meeting held on 29 January 2026** ***Purpose:*** *To **approve** the minutes of the previous meetings.*	*Report*	Chair	
TB025/26	**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				
TB026/26	**Chair's Update** ***Purpose:*** *To **receive** the Chair's Update*	*Verbal*	*Chair*	**13:20** (10 mins)
TB027/26	**Consent Agenda** • ***Committee Terms of Reference*** ***Purpose:*** *To approve the Committee Terms of Reference*	*Report*		**13:30**
TB028/26	**Chief Executive's Report** ***Purpose:*** *To **receive** the Chief Executive's Report.*	*Report*	*CEO*	**13:30** (10 mins)
TB029/26	**Board Assurance Framework** ***Purpose:*** *To **approve** the Board Assurance Framework*	*Report*	*DCG*	**13:40** (10 mins)

IMPROVING CARE, TRANSFORMING LIVES

TB030/26	**Integrated Performance Report** ***Purpose:*** *To* ***receive*** *the Integrated Performance Report.*	*Report*	*Exec Directors*	**13:50** (20 mins)
TB031/26	**Quality Assurance Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on the work delegated to the Committee.*	*Report*	*QAC Chair*	**14:10** (05 mins)
TB032/26	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Report** ***Purpose:*** *To* ***receive*** *the CNST Maternity Incentive Scheme Report.*	*Report*	*CNO + Director of Midwifery*	**14:15** (10 mins)
	COMFORT BREAK (10 mins)			**14:25**
TB033/26	**Antimicrobial Stewardship Update** ***Purpose:*** *To* ***receive*** *the Antimicrobial Stewardship Update.*	Report	CNO	**14:35** (10 mins)
TB034/26	**2026/27 Quality Account Improvement Priorities** ***Purpose:*** *To* ***approve*** *the 2026/27 Quality Account Improvement Priorities.*	*Report*	*CNO/MD*	**14:45** (10 mins)

A GREAT PLACE TO WORK

TB035/26	**People Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.*	*Report*	*PC Chair*	**14:55** (05 mins)

A HIGH PERFORMING PRODUCTIVE ORGANISATION

TB036/26	**Finance and Investment Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.*	*Report*	*F&I Chair*	**15:00** (05 mins)
TB037/26	**Audit and Risk Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.*	*Report*	*ARC Chair*	**15:05** (05 mins)
TB038/26	**Charitable funds Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.*	*Report*	*CFC Chair*	**15:10** (05 mins)

A POSITIVE PARTNER

TB039/26	**Questions to the Board** ***Purpose:*** *To discuss and respond to any questions received from the members of the public.*	*Verbal*	*Chair*	**15:15** (05 mins)
TB040/26	**Feedback from Board Walkabouts** ***Purpose:*** *To* ***receive*** *feedback following walkabouts.*	*Verbal*	*Members*	**15:20** (05 mins)

CONCLUDING BUSINESS

TB041/26	**Messages from the Board** ***Purpose****: To agree messages to be shared with all staff.*	*Verbal*	*Chair*	**15:25** (02 mins)
TB042/26	**Any Other Business** ***Purpose:*** *To* ***receive*** *any urgent business not included on the agenda*	*Report*	*Chair*	**15:27** (03 mins)
	Date and time of next meeting: • Thursday 28 May 2026			***15:30*** ***Close***

Chair: Dr Niruban Ratnarajah

NHS Bolton NHS Foundation Trust

Board of Directors Register of Interests – Updated March 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
		Kirklees 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	

NHS
Bolton
NHS Foundation Trust

Board of Directors Register of Interests – Updated March 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

NHS Bolton NHS Foundation Trust

Board of Directors Register of Interests – Updated March 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 29 January 2026

Subject to the approval of the Board of Directors Meeting on Thursday 26 March 2026

Present

Name		Initials	Title
Ratnarajah	Niruban	NR	Chair
Allen	Tony	TA	Non-Executive Director
Bhutani	Gita	GB	Associate Non-Executive Director
Crofts	Seth	SC	Non-Executive Director
Harriss	Sean	SH	Non-Executive Director
Hulston	Janat	JH	Non-Executive Director
Katema	Sharon	SK	Director of Corporate Governance
Mawrey	James	JM	Chief of People/Deputy Chief Executive
Munshi	Rauf	RM	Interim Medical Director
Mutambasere	Tiri	TM	Associate Non-Executive Director
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
Williamson	Ian	IW	Non-Executive Director

In Attendance

Ali Ross	Nadia	NAR	Consultant (for item 012)
Carter	Rachel	RC	Associate Director of Communications and Engagement
Crompton	Victoria	VC	Corporate Governance Manager
Emmison	Charlotte	CE	Access, Booking and Choice Manager
Toms	Michaela	MT	Divisional Nurse Director Surgery Division
Wildman	Mel	MW	Assistant Divisional Midwifery & Nursing Director (Neonatal) (for item 012)

Apologies

Andrews	Francis	FA	Medical Director

There was one observer in attendance

AGENDA ITEM	DESCRIPTION	Action Lead
TB001/26	**Chair's Welcome and Note of Apologies**	
	The Chair welcomed everyone to the meeting and apologies for absence were as noted above.	
TB002/26	**Patient and Staff Story**	
	The Board of Directors received a patient story from the Surgery Division relating to a patient named Barbara who shared her experience of having attended several pre-operative appointments had believed her procedure was imminent. Barbara had cancelled personal plans and holidays, only to later learn that the actual wait time was 65 weeks. The initial surgery had not proceeded as planned, and Barbara was advised that corrective surgery would take place by the end of the year. However, further assessments were also postponed these included missed calls, rescheduled appointments, and being informed upon arrival that the appointment had been cancelled. Barbara expressed concern following inconsistent advice from staff regarding expected waiting times and the poor discharge communication during her hospital stay. Barbara stated that the repeated delays, conflicting information, and lack of communication had a significant impact on her daily life and dignity. Adding that experiences such as hers were not isolated and that she was sharing her story so other patients would not have the experience. **Staff Story** Board members heard the staff story from Charlotte Emmison, Booking, Access and Choice Manager who advised that Barabara's experience had been raised to her by the Patient Advice and Liaison Service (PALS) who highlighted how Barbara faced several pre-assessment appointment cancellations. CE advised that on one occasion, Barbara attended hospital because the team were unable to contact her in time to communicate that her appointment had been cancelled. However, the pre-assessment team managed to see her as an extra patient on the day, but the situation underscored the need for stronger processes. CE advised the story also highlighted the impact of insufficient staffing in the booking team, emphasised the need for quick and clear communication using multiple channels to inform patients about cancellations as soon as possible. It had	

AGENDA ITEM	DESCRIPTION	Action Lead
	also been suggested to have a backup plan for early appointments that could not be cancelled in time and to keep the reception teams informed to support and manage patient expectations upon arrival. MT reported that the patient story reflected wider challenges throughout the pathway from booking to theatre, with communication emerging as the predominant theme. She advised whilst there was a new leadership team in place in the department, a Divisional project was underway to improve theatre utilisation to 85%, with full engagement from all staff groups, including administrative and clerical teams. MN asked CE how empowered she felt to implement process improvements within the department. CE confirmed that under the new leadership, her wider team felt supported and were encouraged to contribute ideas for service improvement. In response to a query around whether clearer waiting time information could be provided to patients during Outpatient appointments and if clinicians were routinely made aware of waiting times, FN responded that waiting lists were managed by clinicians, so information should be communicated directly to patients by them. With regards to mechanisms in place to ensure effective communication and the sharing of learning arising from the patient's experience, MT confirmed that the patient had already received a response and would be contacted again following the Board meeting to provide further feedback. She also confirmed that all patients who submitted a PALS concern or complaint received appropriate feedback. RW noted that this was a difficult and important story, which highlighted the essential contribution that administrative staff make to patient care. She acknowledged the booking team had been affected by the financial constraints but confirmed that Executive Directors had supported additional recruitment into the team. In thanking CE for sharing her experience to the Board, NR asked how CE would redesign the pathway if given the opportunity. CE suggested that ideally, patients would receive a provisional date at their first clinical visit following referral by their GP. However, the current theatre scheduling only allowed dates to be set a for a limited period in advance, which restricted the ability to allocate dates earlier in the process.	

AGENDA ITEM	DESCRIPTION	Action Lead
	RESOLVED: The Board of Directors ***received*** the Patient and Staff Story.	
TB003/26	**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.	
TB004/26	**Minutes of the previous meetings**	
	The Board received and approved the minutes of the meeting held on 27 November 2025, as a correct and accurate record of proceedings.	
	RESOLVED: The Board of Directors ***approved*** the minutes from the meeting held on 27 November 2025.	
TB005/26	**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.	
TB006/26	**Chair's Update**	
	The Chair advised that this meeting marked the inaugural Board meeting for the newly appointed Medical Director, Rauf Munshi, as well as Non-Executive Directors Tony Allen, Ian Williamson, and Janat Hulston. Additionally, the Trust welcomed Associate Non-Executive Directors Tiri Mutambasere and Gita Bhutani. The Trust extended gratitude to outgoing Non-Executive Directors, Alan Stuttard and Becks Ganz, for their invaluable support and guidance, particularly in navigating the financial challenges currently faced by the Trust.	

AGENDA ITEM	DESCRIPTION	Action Lead
	NR acknowledged the challenges which were impacting both patients and staff but also highlighted areas of positive progress. Specifically, the Chair highlighted the consistently good waiting times for cancer treatments and the effective collaboration with partners to expedite patient discharge and enable them to return home more quickly. However, NR highlighted that the ongoing challenges in the Emergency Department (ED) and the Trust finances were posing additional pressure and required additional attention. The Chair also acknowledged the impact on staff and members of the public when incidents occurred in the ED, and the need to address these concerns. **RESOLVED:** The Board of Directors ***received*** the Chair's Update.	
TB007/26	**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: • Staff made the festive period special for patients and their loved ones. Lydia Hill, a Play Specialist, supported children on Christmas Day at Royal Bolton Hospital, ensuring only those needing hospital care were on the ward. • The Trust continued to lead in equality, diversity, and inclusion through initiatives like the 'We Belong' module in the Our Leaders training programme, focusing on WRES awareness, anti-racism, inclusive recruitment, unconscious bias, and active bystander approaches. • The Trust launched digital check-in kiosks in Outpatient departments to modernise services, reduce congestion, and give patients more control over their appointments. • The University of Greater Manchester officially opened its state-of-the-art medical training building at Royal Bolton Hospital, marking a pivotal chapter in Bolton's healthcare journey. **RESOLVED:** The Board of Directors ***received*** the Chief Executive's Report.	
TB008/26	**Board of Directors Effectiveness Survey**	

AGENDA ITEM	DESCRIPTION	Action Lead
	The Director of Corporate Governance presented the Board of Directors Effectiveness Survey, advising that there was an overall score of 92% with respondents expressing strong confidence in the Board's governance, culture, and strategic focus. While the evaluation praised the cohesive Board culture and clear strategic agenda, it also highlighted the need to shift agenda time from routine reporting to more in-depth strategic discussions. The high effectiveness score and positive feedback confirmed the Board's solid foundation for leadership and decision-making. However, addressing the identified areas for improvement was crucial to fully realise the Board's strategic ambitions and ensure the Trust's long-term success. To this end, a review of the agenda structure would be undertaken to allocate more time to strategic matters, and ongoing investment in Board development would be maintained. **RESOLVED:** The Board of Directors ***received*** the Board of Directors Effectiveness Survey	
TB009/26	**Corporate Governance Report** The Director of Corporate Governance presented the Corporate Governance Report, summarising the 2026 arrangements and the 2025 Committee Effectiveness Reviews. The report sought to provide assurance to the Board that all five committees were functioning effectively, meeting their Terms of Reference, and contributing significantly to the Trust's governance framework. Overall effectiveness scores ranged from 92% to 96%, which reflected sustained high performance and improvement. Strengths included effective chairing, disciplined meeting management, high quality papers, timely information, and well-established assurance processes. Each committee was aligned with its Terms of Reference, ensuring robust scrutiny and support for the Trust's strategic ambitions. Development themes included strengthening triangulation between committees, balancing operational and strategic agenda items, and improving assurance flow across the governance system. The results confirmed a mature and continuously improving governance environment, with opportunities to further refine strategic oversight and inter-committee connectivity.	

AGENDA ITEM	DESCRIPTION	Action Lead
	SH inquired about the scheduling of another external review. SK responded that it was under consideration and may be scheduled for next year rather than this year.	
	RESOLVED: The Board of Directors ***approved*** the Corporate Governance Report	
TB010/26	**Integrated Performance Report**	
	The Chief Operating Officer presented an update on community and urgent care performance. • Month 9 performance for two-hour Urgent Care Response (UCR) performance was 90.2%. Referrals increased to 371, up from 324, with further improvement expected as pathways embed and engagement continued. • December Emergency Department (ED) attendances were 11,894, which was a reduction from November. January forecasted attendance was 11,888, which represented 329 more attendances compared to January 2025. • Ambulance performance remained challenging with handovers within 15 minutes slightly improved, handovers within 30 minutes increased to 74.1%, whilst those completed within 60 minutes remained relatively stable at 90.32%. • Referral to Treatment (RTT) overall waiting list size was 37,532 which was an increase of 54 patients compared to the previous month. 18-Week RTT performance was 57.42% which was a slight decrease compared with the previous month. • 52-week waits: there were 910 patients, which was an improvement from 1,103 in November. After adjusting for potential industrial action, the likely position would be around 966 patients, an improved position than the 56 in the previous update to GM, though 271 above the operational plan. • 65-Week Performance; there were two patients, both involving complex Plastic Surgery cases. This represented a substantial improvement from 32 patients in November. • The cancer 62-day standard for November was not met due to capacity issues in Breast and complex pathways in Gynaecology and Lung. Despite this, November's performance improved, however, a slight deterioration was expected in December due to capacity challenges. • DM01 performance for the month was 4.98%, with 164 breaches, a 0.68% decline from the previous month, primarily due to reduced performance in cystoscopy and urodynamics.	

AGENDA ITEM	DESCRIPTION	Action Lead

Quality and Safety

The Chief Nurse provided an update on quality and safety metrics, emphasising the importance of maintaining high standards of patient care and safety. He outlined initiatives to ensure harm-free care, which focussed on strategies to reduce patient harm and improve care quality.

An overview of infection rates and control measures was provided, highlighting new protocols to prevent infections and enhance patient safety. An update on maternity services and performance metrics was given, which focussed on improving maternal and neonatal outcomes through targeted interventions. Patient feedback and satisfaction scores were reviewed, with initiatives to enhance patient experience and address areas of concern in place.

The Medical Director advised that:

- Clinical correspondence compliance for inpatient and outpatient performance was being monitored and although national targets were not being met, an audit confirmed there were no patient harms due to delays.
- Outpatient correspondence remained a challenge, achieving 58.3% against the 95% national target, this was impacted by reduced administrative support and digital dictation issues.
- SHMI was 108.19, which was in the expected range. There continued to be a downward trend in this metric. Improved compliance with defining "well babies" and palliative care episodes should also continue to support this trend.
- HSMR was now in the expected range, with crude mortality being in line with the national average.
- The Trust was working to the national 14-hour standard for prophylactic VTE compliance with compliance now organisationally at 94.9% against 95% achievement criteria. This continued to be monitored closely by the Trust VTE leads, BI and through the IPM dashboards.

Finance

The Chief Finance Officer presented the Month 9 status finance report advising:

- Revenue year to date showed a deficit of £17.3m, which was averse to plan by £10.4m. The revenue forecast indicated a break-even, but the mid-case scenario projected a deficit of £14.4m and required a surplus of £2.9m in the remaining months. This improvement was expected through Cost Improvement Programmes (CIP), additional controls, and non-recurrent benefits from CNST and technical items, whilst mitigating most known risks.

AGENDA ITEM	DESCRIPTION	Action Lead

- Cost improvement year to date delivery was £10.5m, behind plan by £10.1m.
- Agency spending was £4.9m compared to the NHSE target of £4.1m, and bank spending was £13.0m compared to the NHSE target of £18.8m.
- The capital year-to-date spend was £13.3m, compared to a plan of £27.9m.
- The balance sheet showed a reduction in total assets employed of £2.7m, with £17.4m due to the deficit and £13.8m due to Public Dividend Capital (PDC) cash received. The cash position was £6.4m, compared to a plan of £3.7m, due to timing issues. The Trust had received £13.8m cash support to date, with £3.9m approved for January. However, the February application of £3.3m had not been supported by NHSE, and mitigations were being worked on.

Workforce

The Chief People Officer provided an update on the current sickness rates, appraisals, and agency spending. The importance of managing sickness rates effectively to ensure a healthy and productive workforce was emphasised, with various initiatives and support mechanisms in place to assist staff and reduce sickness absence. The status of appraisals within the Trust was discussed, noting completion rates and areas for improvement, and stressing the importance of regular appraisals in supporting staff development and performance. Efforts were being made to ensure that all staff received timely and meaningful appraisals.

An update on the current levels of agency spend was provided, comparing them to the targets set by NHSE. The need to manage agency spend effectively to ensure financial sustainability was highlighted, with various strategies and controls implemented to reduce reliance on agency staff and manage costs.

SH expressed concern regarding ED performance and questioned whether there was enough support and challenge being applied, as well as what further actions might be required. RW advised that sustainability remained the key issue across Urgent Care and that the improvement plan was being strengthened with a renewed focus on leadership, culture, grip and control, applying this approach across the full patient pathway rather than solely within ED. FLT noted that the Quality Assurance Committee had been assured that a review of the pathway was underway, with staff engagement and leadership and culture included within its scope and confirmed that the findings would be reported through the QAC Chair's Report.

AGENDA ITEM	DESCRIPTION	Action Lead
	SC queried the rise in ambulance attendances over recent years. RW reported that the Trust continued to work closely with the Northwest Ambulance Service (NWAS) to understand the trend. **RESOLVED:** The Board of Directors ***received*** the Integrated Performance Report.	
TB011/26	**Quality Assurance Committee Chair's Report** Fiona Taylor presented the Chair's Reports from the Quality Assurance Committee meeting held on 28 January 2026 which provided an overview of key items discussed at the meeting, including updates on the Quality Account priorities and QI activity, Mortality performance, Audiology service pressures, the Medium Term Operational Plan, thematic review findings relating to Total Laparoscopic Hysterectomy injuries, and progress on Community Business Case benefits realisation. The Committee noted continued improvement in mortality indicators, and progress across multiple quality initiatives. Areas of operational and workforce pressure were reviewed, including Audiology capacity, clinical correspondence timeliness, and ongoing coding challenges. The Committee also received the Chair's Reports from the Clinical Governance and Quality Committee and the Performance and Transformation Group. **RESOLVED:** The Board of Directors ***received*** the Quality Assurance Committee Chair's Report.	
TB012/26	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Report** Dr Nadia Ali Ross, Consultant and Mel Wildman, Assistant Divisional Midwifery & Nursing Director (Neonatal) delivered a presentation updating on the Trust's compliance with the Year 7 Clinical Negligence Scheme for Trusts (CNST). The Trust had achieved all 10 maternity safety actions, as required under the scheme. The presentation outlined performance for each action, confirming that evidence had been reviewed and verified by the Division and externally through the Local Maternity and Neonatal System (LMNS) checkpoints. The key highlights reported to the Board were:	

AGENDA ITEM	DESCRIPTION	Action Lead
	• Strong Board and Executive oversight enabled timely escalation of issues and provision of support throughout the declaration period. • Improvements to reporting processes, reflected national changes following the publication of the Perinatal Quality Oversight Model. • Enhanced training compliance oversight, supported by dedicated administrative input and multidisciplinary leadership engagement. • Ongoing Local Maternity and Neonatal Systems (LMNS) support, with data reviewed by the LMNS panel to assure accuracy and completeness. The Board also received assurance regarding the next steps in the declaration process, which included the approval of the CNST Year 7 submission by the Board, followed by final Chief Executive sign-off and formal submission to the LMNS. The LMNS would then submit the declaration to the Integrated Care Board Accountable Officer before returning it to the Trust, after which the final signed declaration would be submitted to NHS Resolution by 03 March 2026. MN asked for a view on expectations going into Year 8 of the scheme. MW advised that some changes were anticipated, including potential updates related to home births and training requirements. She confirmed the Trust had introduced quarterly checkpoints for the coming year to ensure progress against the training trajectory. The Board formally endorsed the CNST Year 7 declaration and noted the progress made across maternity and neonatal safety actions. The Board thanked the team for their continued work and commitment to service improvement and patient safety. **RESOLVED:** The Board of Directors ***received*** the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme.	
TB013/26	**Mortality Report** The Medical Director presented the Mortality Report, noting continued positive progress in mortality indicators, with SHMI reduced to 108.19 and HSMR improving to 105.95, both within the expected range, and crude mortality remained low. Improvements in clinical coding, supported by enhanced Electronic Patient Record (EPR) documentation and staff training, were narrowing the gap with national comparators, though some data quality issues remained, including uncoded Virtual Ward activity and an ongoing alert relating to “Other perinatal conditions,” expected to be resolved following national guidance on “well babies.”	

AGENDA ITEM	DESCRIPTION	Action Lead
	Work continued to strengthen data accuracy through updated EPR forms and targeted training, with Type 5 attendances anticipated to affect future metrics. The report also highlighted improved Structured Judgement Review (SJR) completion rates following the recruitment of additional reviewers, with a new quality assurance process in place and actions taken in response to recent case reviews. TA sought clarification the timeliness of the data prompting RM to explain that mortality data runs approximately six months in arrears, requiring the use of alternative mechanisms to identify any current concerns. NR added that Bolton's figures had been adversely affected by the Covid-19 pandemic in previous years, and this had taken time to stabilise affecting the trend and interpretation of data. **RESOLVED:** The Board of Directors ***received*** the Learning from Deaths/Mortality Report.	
TB014/26	**Thematic Review: Total Laparoscopic Hysterectomy Injuries Report**	
	The Medical Director presented the Thematic Review into Total Laparoscopic Hysterectomy (TLH) Injuries from August to November 2024, noting there were four complications during this period, which all required further surgical intervention. Incident rates were higher than national benchmarks, which prompted the thematic review to identify key improvements. TLH procedures were paused in August 2025 to ensure patient safety, and an external review was commissioned to provide additional independent assurance. The external review is due to be reported separately and resumption of TLH surgery would not occur until both the internal thematic and external reviews were reported and triangulated to address clear safety steps. Themes identified in the thematic review included the judicious use of electrosurgery, attention to ureteric identification intraoperatively, patient selection and clear Multi-Disciplinary Team (MDT) planning for high-risk cases, maintenance of competency and laparoscopic Continuous Professional Development (CPD) and the requirement of robust governance oversight especially around consultant personal training and the training other colleagues. NR thanked FA and the clinicians involved in the review, noting that this exemplified the principles of duty of candour in identifying issues and undertaking thorough investigation.	

AGENDA ITEM	DESCRIPTION	Action Lead
	RESOLVED: The Board of Directors ***received*** the Thematic Review: Total Laparoscopic Hysterectomy Injuries Report.	
TB015/26	**People Committee Chair's Report**	
	Martin North presented the Chair's Report from the People Committee held on 20 January 2026 advising that the Committee received an update on key workforce developments, including current operational pressures, recent periods of industrial action and the organisation's escalation to OPEL 4. The Chief People Officer had expressed appreciation for staff resilience during the challenging period and confirmed that national negotiations on industrial action remained ongoing. The Committee had noted the update and agreed to remain sighted on any emerging impacts on workforce capacity and morale. The Committee discussed workforce planning performance, acknowledging that sickness absence, appraisal completion and staff engagement indicators had deteriorated, partly due to seasonal factors but also reflecting wider pressures across the Trust. It was noted that planned reductions in Worked Whole Time Equivalents (WTE) for 2025/26 remained insufficient to meet financial requirements. A Health and Wellbeing Report was expected to be presented to the Committee in March. Assurance was received across several areas of workforce activity. The 2025 workplans were reviewed and aligned with workforce priorities, and updates were provided on organisational culture, leadership development programmes, and the Our Future Programme. The Committee also noted the Trust's position on the Gender Pay Gap, the continued effectiveness of the Freedom to Speak Up service, the Guardian of Safe Working Q3 findings, updates to the national Job Evaluation Scheme, progress on the national 10-Point Plan for Resident Doctors, and development of the HR Chatbot. The Committee reviewed the latest iFM People and Culture Report, and noted a deterioration in sickness absence, mandatory training compliance and appraisal rates, alongside efforts to improve data quality and workforce reporting.	

AGENDA ITEM	DESCRIPTION	Action Lead

NR asked how many members of the medical workforce had completed the *Our Leaders* programme. RF advised the numbers were likely to be low but held the expectation that Clinical Leaders should undertake the programme, with consideration given to ensuring all new recruits completed it within their first few months.

RESOLVED:
The Board of Directors ***received*** the People Committee Chairs Report.

TB016/26 **Finance and Investment Committee Chair's Report**

Sean Harriss presented a verbal update from the Finance and Investment Committee held on 28 January 2026 and highlighted several significant matters for escalation to the Board:

- The Committee reviewed the Month 9 financial position and noted an adjusted deficit of £17.4m, which was £10.4m adverse to plan, alongside continued risks relating to under delivery of the CIP and pressure on planned income. Concerns were also raised regarding the Trust's deteriorating cash position.
- The Committee discussed the Medium-Term Financial Plan, and the Chief Finance Officer outlined the requirement for a 5% run-rate improvement in Year one and the continued slippage in the development of CIP plans.
- The Committee additionally received assurance on the management of finance related risks and considered the high-level findings from the 2024/25 National Cost Collection Index, noting Bolton's overall position and planned deep-dive reviews.
- The Maternity EPR programme was currently rated red, with significant redesign work underway and a revised user-testing approach planned. An update was expected in March.
- Community Services Business Case updated were received, where benefits realisation work remained premature during the implementation phase.
- The Managed Equipment Service Contract Retender was reviewed, with the Committee recommending that the Board approve progression of the retender process following pre-market engagement.

SW advised that a lesson learned review would be undertaken in relation to the Maternity EPR, with the findings to be reported back through the Finance and Investment Committee and included in future Chair's Reports to the Board.

RESOLVED:

AGENDA ITEM	DESCRIPTION	Action Lead
	The Board of Directors ***received*** the Finance and Investment Committee Chair's Report	
TB017/26	**Questions to the Board**	
	There were no questions received from members of the public to the Board of Directors.	
TB018/26	**Feedback from Walkabouts**	
	FLT reported that during her visit to J Block the lifts were working intermittently and the automatic doors were now functioning. At Radiology reception, staff raised concerns regarding the new check-in desks. She also visited Maternity Triage, where she noted that some rooms were very cold; an emergency occurred whilst she was present, which staff managed effectively.	
	SC reported that the environment and staff within the Coronary Care Unit were very good. In the Pacing Suite, he noted a high level of activity that was not always fully recognised within wider Trust reporting, and that the environment required improvement. He also visited the ED and the new build area, describing the new facilities as impressive and noting that the Mental Health Assessment area was close to opening.	
	NR reported visiting the surgical departments, noting that one ward demonstrated strong engagement and a positive approach to change, while another ward expressed significant dissatisfaction.	
	RESOLVED: The Board of Directors ***received*** the Feedback from Walkabouts.	
TB019/26	**Messages from the Board**	
	There were no questions received from members of the public to the Board of Directors.	
TB020/26	**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 26 March 2026 at 1pm in the Boardroom.	

Meeting Attendance 2026						
Members	**Jan**	**March**	**May**	**July**	**Sept**	**Nov**
Niruban Ratnarajah	✓					
Annette Walker	✓					
Fiona Noden	✓					
Fiona Taylor	✓					
Gita Bhutani	✓					
Ian Williamson	✓					
James Mawrey	✓					
Janat Hulston	✓					
Martin North	✓					
Rae Wheatcroft	✓					
Rauf Munshi	✓					
Sean Harriss	✓					
Seth Crofts	✓					
Sharon Katema	✓					
Sharon White	✓					
Tiri Mutambasere	✓					
Tony Allen	✓					
Tyrone Roberts	✓					
✓ = 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 January 2026

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

Report Title:	Committee Terms of Reference (ToR)			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	26 March 2026		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	✓

Purpose of the report	To present the updated ToR for the Finance and Investment, People, and Quality Assurance Committees for ratification, following their scheduled periodic review.

Previously considered by:	All Committee ToR have been presented for approval at respective committees.

Executive Summary	All committee ToR have been reviewed to maintain compliance with governance standards and regulations. The revisions clarify purpose, define delegated authority, and align each committee's remit with the Trust's strategy and operations. The updated ToR support ongoing statutory and regulatory compliance, reflect current requirements, and incorporate best practice in governance. The review has resulted in: • Clear and consistent purpose statements, improving transparency and assurance on compliance, quality, workforce and financial stewardship. • Streamlined principal duties, with removal of duplication, improved alignment and oversight of the Board Assurance Framework (BAF) • Updated membership structures to strengthen independence, refresh Executive Director representation, and clarify attendance expectations. • Stronger reporting and governance requirements including annual effectiveness reviews, enhanced minuting and cross-committee referral and clearer administrative responsibilities. • Revised meeting frequencies, enabling capacity planning and alignment with the Trust-wide governance cycle.

Proposed Resolution	The Board of Directors are asked to **ratify** the revised Committee Terms of Reference.

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**	
Legal/ Regulatory	**Yes**	
Impact on Health Inequalities	Yes (QAC only)	Expanded scope to assure improvement in access, experience and outcomes
Impact on Equality, Diversity and Inclusion	Yes (People Committee)	Strengthened oversight of statutory reporting and EDI assurance.
Is a Quality Impact Assessment required	No	No changes to clinical pathways or services.

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

1. Introduction

1.1. The Terms of Reference (ToR) set out the formal framework within which a committee operates, defining its purpose, scope and authority. They clarify why the committee exists, the areas it is responsible for, and the extent of the powers delegated to it by the Board.

1.2. Clear ToR enhance effective governance by ensuring committees operate within a defined framework, making their responsibilities obvious and easy to understand. ToR clarify expectations for managing meeting cycles and conduct during meetings while also mandating regular reviews to maintain committee effectiveness. This method supports strong accountability, dependable assurance, and consistent governance practices throughout the Trust.

1.3. These Committee ToR have been reviewed and updated to ensure continued alignment with the Trust's Corporate Governance Framework which includes the Constitution, Standing Orders, Standing Financial Instructions, and the Scheme of Delegation. They clarify the Committee's purpose, authority, membership, quorum, reporting arrangements, and responsibilities, ensuring they remain consistent with the NHS Code of Governance and reflect current statutory, regulatory, and operational requirements.

2. Summary of changes across all Committee Terms of Reference

2.1. The Committee Terms of Reference (ToR) have undergone a comprehensive annual and periodic review in line with the Trust's governance framework and the FT Code of Governance, which requires committees to operate with clearly defined remits, current delegated authority, and regular evaluation. This cycle has resulted in an update of the Finance & Investment, People, and Quality Assurance Committees' ToR, strengthening governance, assurance, and alignment to Trust priorities.

2.2. Across all Committees, updates have sought to:

a) **Strengthen clarity of purpose and strategic alignment**
Purpose statements have been rewritten to be clearer and more concise, improving transparency about delegated authority and reinforcing alignment to the Trust's strategic ambitions, regulatory requirements, and assurance responsibilities.

b) **Streamline principal duties**
Outdated or duplicative duties have been removed. Responsibilities now focus more sharply on assurance, compliance, risk management, and delivery of strategic objectives. New themes including digital transformation, health inequalities, workforce culture, estates, and procurement have been integrated to reflect current NHS priorities.

c) **Strengthen membership and independence**
Membership structures have been refreshed, increasing Non-Executive Director representation and rebalancing executive roles. Expectations around attendance and representation have been clarified, enhancing the independence and robustness of oversight in line with the FT Code of Governance.

d) **Enhance alignment with internal frameworks and regulatory standards**
All ToR now include strengthened references to the Trust Constitution, Standing Orders, Standing Financial Instructions, Scheme of Delegation, Board Assurance Framework, and the AAA reporting framework, providing clarity and consistency in governance routes and escalation.

e) **Improve consistency and quality of governance processes**
All Committees now include:

- Annual effectiveness reviews
- Clearer minuting and action-tracking requirements
- Enhanced cross-committee referral mechanisms
- consistency in administrative practice and assurance to the Board.
- Update meeting frequency and operational expectations

3. Recommendations

The Board is asked to **ratify** the Terms of Reference for the Finance and Investment, Quality Assurance and People Committees.

Finance and Investment Committee

Terms of Reference Document Control Sheet

MEETING	**Finance and Investment Committee**
ESTABLISHED BY/REPORTING TO:	Board of Directors
REVIEWER:	Director of Corporate Governance
EXECUTIVE LEAD:	Chief Finance Officer
REVIEW:	March 2026
ASSOCIATED DOCUMENTS:	Trust Constitution Board Standing Orders Finance Scheme of Delegation Standing Financial Instructions
REPORTING GROUPS AND FORA	Capital Revenue and Investment Group Digital Performance and Transformation Group

Document Control	
Document Name:	Terms of Reference Finance and Investment Committee
File Name:	F I Terms of Reference
Version/Revision Number:	4.0

Terms of Reference of the Finance and Investment Committee

1. Authority

1.1 The Finance and Investment Committee is established to act as a decision-making committee to the Board of Bolton NHS FT and is authorised to investigate any activity within its terms of reference.

1.2 The Finance and Investment Committee operates within the Trust's Constitution, Scheme of Delegation and Standing Financial Instructions.

1.3 The Finance & Investment Committee is authorised by the Board to investigate any issues within its terms of reference or seek any information it requires from any employee. All employees are directed to co-operate with any request made by the Committee in the pursuit of its business.

1.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any decision taken by the committee to obtain outside legal or other independent professional advice will always be highlighted in the Chair's report.

1.5 The Chair of the Committee will provide a summary of meeting proceedings and escalate items requiring the Board's attention through the Chair's Report.

2. Purpose

The purpose of the Finance and Investment Committee is to provide assurance to the Board on matters relating to finance, digital, estates, procurement and the Green agenda; approve decisions within the Financial Scheme of Delegation; oversee financial plans and performance for the Trust and its subsidiary IFM; and monitor the impact of system partnerships on financial governance and resource use.

3. Principal Duties

In order to achieve its purpose, the Finance & Investment Committee will:

a) Operational

- Review group revenue, income and expenditure plans of the Group and the capital programme for recommendation to the Board.
- Review and/or approve invoices and contracts in accordance with the limits set out in the Financial Scheme of delegation.

- Monitor income and expenditure against planned levels seeking explanations from for any significant adverse variances.
- Monitor performance against savings plans seeking explanations for any significant adverse variances.
- Monitor expenditure against capital budgets on behalf of the Board and approve cost increases where required under the Scheme of Delegation and appropriate corrective action in respect of significant variances from plan.
- Review cash flows and balances ensuring that significant variances from plan are explained and action taken where appropriate.
- Approve arrangements for borrowing/loans following approval of the loan by the Board.
- Review of high value supplier payments.
- Approve the use of Measured Term Contracts for capital schemes.
- Approve any ex gratia payments as per the Financial Scheme of Delegation.
- Monitor productivity & efficiency metrics that support financial improvement.
- Oversee financial risk assessment and financial risk management.
- Approve and oversee the Treasury Management Policy and banking arrangements making decisions on significant investments of cash balances.
- Review and/or approve comparative cost statements or other benchmarked information to assess the relative efficiency of the Trust and to be assured that actions are being taken to make improvements.

b) **Strategic**

- Approve trust business cases in accordance with the financial scheme of delegation.
- Ensure that the business case process is followed and embedded throughout the Trust. Monitor progress against developments in service and major capital schemes.
- Consider the implications of longer-term strategy (including financial medium term plan) for the Group given the resources available and the locality, GM position.
- Ensure the development of the Trust's Digital Plan.
- Approve tenders for major external service contracts where the financial values require Board approval.
- Approve progress to tender for schemes in accordance with the Financial Scheme of Delegation.
- To receive updates on System/GM/National Financial position.

c) Digital Transformation

The Committee shall provide oversight, scrutiny and assurance in relation to the organisation's digital investment, transformation activities, and associated financial and operational impacts. In particular, the Committee will:

- Monitor the implementation and delivery of the Trust's Digital Plan.
- Review digital transformation programmes and technology investments to ensure they align with the Trust's objectives, finances, and risk profile.
- Confirm digital investment priorities are coordinated with corporate, clinical, and operational plans.
- Examine financial appraisals of digital business cases, ensuring clear costs, benefits, ROI, affordability, and value.
- Track digital budgets, cost pressures, and spending versus plans, escalating major variances as needed.

- Oversee investment in core digital infrastructure, ensuring secure, resilient, interoperable, and sustainable systems.
- Receive assurances on system lifecycle planning, including replacement, optimisation, and long-term revenue impacts.
- Monitor key digital, data, and cybersecurity risks, including financial exposure, mitigation, and regulatory compliance.
- Ensure digital processes meet statutory and regulatory requirements.
- Track and report realised benefits from digital business cases through proper governance.
- Oversee procurement strategies for digital systems, ensuring regulation compliance and value.
- Assess proposals for emerging digital tech based on operational, clinical, or financial benefits.
- Guide prioritisation of digital innovation in capital and revenue planning.

d) Risks and Assurance

- Review the Board Assurance Framework and any associated Strategic risks to achieving the Trust's Ambitions and evaluate the effectiveness of controls and the adequacy of assurance for each risk. The Committee will review current and target risk scores, ensuring alignment with the Trust's risk appetite and monitor progress on actions to address gaps in control or assurance.
- Identify where additional assurance is required and escalate concerns or recommendations to the Board of Directors as appropriate.
- Receiving and considering issues from other Committees when appropriate and taking any necessary action

On behalf of the Board the committee shall:

- Approve the Trust's procurement medium term plan.
- Monitor the implementation and delivery of the procurement medium term plan through regular updates from the Procurement Steering Group
- Obtain external assurance that the procurement medium term plan remains fit for purpose as required.

4. Reporting

4.1. The F&I Committee is accountable to the Board of Directors.

4.2. The minutes of the F&I Committee meetings shall be formally recorded and presented to the next meeting for approval.

4.3. The Chair of the Committee shall produce an Advise Assure Alert (AAA) Key Issues Highlight Report to draw the attention of the Board of Directors any issues that require disclosure to the full Board or require executive action.

4.4. The Committee will refer to other Committees of the Board, matters deemed relevant for their attention. The Committee will consider matters referred to it by other committees.

4.5. The annual work plan of the Committee may be reviewed by the Group Audit and Risk Committee at any given time.

4.6. The Committee may request Deep Dives or establish ‘task and finish’ groups to deliver specific actions

5. Membership

5.1. The Finance and Investment Committee membership will be appointed by the Board to ensure representation by Non-Executive and Executive Directors. Membership will consist of:

- Four Non-Executive Directors
- Chief Finance Officer
- Chief Operating Officer
- Chief of Strategy & Partnerships
- Chief People Officer

5.2. The following members are generally expected to be in attendance at meetings; however, their attendance may vary depending on the agenda:

- Commercial Director of Finance
- Operational Director of Finance
- iFM Managing Director
- Deputy Director of Finance
- Deputy Director of Strategy

5.3. The Director of Corporate Governance will attend all Committee meetings in an advisory capacity, providing governance guidance and, through their team, supporting the Chair in ensuring the effective operation of the Committee.

5.4. The Trust Chair and Chief Executive, as ex-officio members, have a standing right of attendance at all meetings.

5.5. Other key individuals will be co-opted to the F&I Committee dependent on key work streams to be initiated. All attendees are responsible for providing feedback to their Divisions/ Teams and any agreed actions or recommendations as required.

5.6. From time to time the committee may wish to invite individuals to attend the meeting to aid in the understanding of particular items. The meeting secretary will issue such invitations on behalf of the Chair of the Committee.

6. Chair

6.1. The F&I Committee shall be chaired by a Non-Executive Director of the Board *as appointed by the Group Chair*.

6.2. In the Chair’s absence another Non-Executive Director, who is a member of the Committee, will assume the authority of the Chair.

7. Quorum

7.1. A quorum will be no less than four members of which two must be Non-Executive Directors and two Executive Directors of whom one must be Chief Finance Officer or the Chief of Strategy and Partnerships.

8. Meeting Attendance and Frequency

8.1. The F&I Committee will meet no less than 10 times a year unless a meeting is operationally necessary.

8.2. It is highly important that members attend the F&I Committee on a regular basis. No more than two meetings should be missed in any year unless due to extenuating circumstances. Executive members are expected to nominate a deputy to attend in their absence.

8.3. If a committee member is unable to attend the meeting or send a deputy then a formal summary report of progress made against their areas of responsibility should be given, in advance of the meeting, identifying the key issues that should be raised.

8.4. If a member fails to attend two consecutive meetings the Chair of the Committee will speak to the individual. The Chair of the Committee will also be required to bring to the attention of the Chair of the Trust if they feel that lack of attendance has not enabled adequate discussion or decision making.

9. Organisation

9.1. The agenda and papers for the meeting shall be distributed 4 days in advance of the meeting.

9.2. The Committee will be supported by a member of the Corporate Governance Team, whose responsibilities will include*:*

- Agreeing the meeting agenda with the Chair and Chief People Officer
- Coordinating the collation of meeting papers and circulation these to all members in a timely manner
- Preparing the minutes of the meeting and maintaining an action log to track matters and issues to be progressed.

10. Review and Assessment of Performance and Effectiveness

10.1. These Terms of Reference shall be reviewed annually or in light of changes in practice or legislation. Changes to these Terms of Reference must be approved by the Board of Directors.

10.2. The F&I Committee will conduct an annual assessment of its performance and effectiveness, reviewing its activities from the previous year to ensure consistency with its Terms of Reference, Standing Orders, and Scheme of Delegation. The resulting report will be submitted to the Board of Directors

Approved by: Finance & Investment Committee

Submitted to: Finance & Investment Committee

Date of approval: **[planned for 25 March 2026]**

Date for review: March 2026

Version Control Document			
Version Ref	**Amendments**	**Committee Approval**	**Ratified by Board**
1.0	Transfer of previous version to new template	Mar 2023	Mar 2023
2.0	Review and amended	Jul 2024	Jul 2024
3.0	Review and amended	Jun 2025	
4.0	Full review to ensure consistency with other committees. Changes include • Para 2 - Updated purpose statement • Para 3c - added Digital Transformation section • para 3 - streamlined and clarified principal duties • para 5 - updated membership and attendance • para 10 - strengthened reporting and governance requirements • para 10 - removed duplication (including “Decisions” section) • para 10.2 - added annual effectiveness review	Mar 2026	

People Committee

Terms of Reference Document Control Sheet

MEETING	**People Committee**
ESTABLISHED BY/REPORTING TO:	Board of Directors
REVIEWER:	Director of Corporate Governance
EXECUTIVE LEAD:	Chief People Officer
REVIEW:	March 2026
ASSOCIATED DOCUMENTS:	• Trust Constitution • Board Standing Orders • Scheme of Delegation
REPORTING GROUPS AND FORA	• Staff Experience Group • Medical Education Board • EDI Assurance Group

Document Control	
Document Name:	People Committee Terms of Reference
File Name:	People Committee ToR
Version/Revision Number:	Version 5.0

Terms of Reference of the People Committee

1. Authority

1.1 The People Committee (Committee) is established as a committee of the Board of Bolton NHS FT.

1.2 The People Committee operates within the Trust's Constitution, Scheme of Delegation and Standing Financial Instructions.

1.3 The People Committee is authorised by the Board to investigate any issues within its terms of reference, or seek any information it requires from any employee. All employees are directed to co-operate with any request made by the Committee in the pursuit of its business

1.4 The Committee has the delegated authority to obtain, within the limits set out in the Trust Scheme of Delegation, outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any decision taken by the committee to obtain outside legal or other independent professional advice will always be highlighted in the Chair's Advise Assure Alert (AAA) Report to the Board.

1.5 The Chair of the People Committee will provide a summary of meeting proceedings and escalates items requiring the Board's attention through the Chair's AAA Report.

2. Purpose

The purpose of the People Committee is to provide strategic oversight and assurance on all workforce, culture, leadership, and organisational development matters. It oversees the development and implementation of the Trust's People Strategy, monitors workforce performance and risks, ensures effective arrangements for education and staff development, reviews workforce-related policies and reward frameworks, and assures delivery of Equality, Diversity and Inclusion plans and statutory reporting for the Trust and its wholly owned subsidiary Integrated Facilies Management (iFM)**.**

3. Principal Duties

In order to achieve its purpose, the People Committee will be responsible for:

- Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors.
- Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues.
- Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys.
- Reviewing and approving partnership agreements with Staff Side.
- Seeking assurance to ensure that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues, including but not limited to equality and diversity.

- Monitoring cases of Whistleblowing and escalate as appropriate to the Board.
- Overseeing the development of strategic relationships with further and higher education institutions to ensure the Trust is able to influence the supply of practitioners and professionals with the skills and competencies required by the organisation.
- Receiving assurance on the effectiveness of staff health and wellbeing programmes, including the delivery of Occupational Health services.
- Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings.
- Review the Board Assurance Framework and any associated Strategic risks to achieving the Trust's Ambition and evaluate the effectiveness of controls and the adequacy of assurance for each risk. The Committee will review current and target risk scores, ensuring alignment with the Trust's risk appetite and monitor progress on actions to address gaps in control or assurance.
- Identify where additional assurance is required and escalate concerns or recommendations to the Board of Directors as appropriate.
- Receiving and considering issues from other Committees when appropriate and taking any necessary action

4. Reporting

4.1. The People Committee will be accountable to the Board of Directors.

4.2. The minutes of People Committee meetings shall be formally recorded and presented to the next meeting for approval.

4.3. The Chair of the Committee shall produce an Advise Assure Alert (AAA) Key Issues highlight report to draw the attention of the Board of Directors any issues that require disclosure to the full Board or require executive action.

4.4. The Committee will refer to other Committes of the Board, matters deemed relevant for their attention. The Committee will consider matters referred to it by other committees.

4.5. The People Committee may request Deep Dives or establish 'task and finish' groups to deliver specific actions

5. Membership

5.1. The People Committee membership will be appointed by the Board to ensure representation by Non-Executive and Executive Directors. Membership will consist of:

- Four Non-Executive Directors (one of whom will be the Chair of the Committee)
- Chief Nurse
- Chief People Officer
- Medical Director
- Chief Finance Officer

5.2. The following members are generally expected to be in attendance at meetings; however, their attendance may vary depending on the agenda:

- Deputy Director of People
- Deputy Director of Organisational Development
- Head of Resourcing
- Director of Operations
- iFM Managing Director
- Associate Director of Communications

5.3. The Director of Corporate Governance will attend all Committee meetings in an advisory capacity, providing governance guidance and, through their team, supporting the Chair in ensuring the effective operation of the Committee.

5.4. The Trust Chair and Chief Executive, as ex-officio members of the Committee, have a standing right of attendance at all meeting.

5.5. Other key individuals will be co-opted to the People Committee dependent on key work streams to be initiated. All attendees are responsible for providing feedback to their Divisions/ Teams and any agreed actions or recommendations as required.

5.6. From time to time the committee may wish to invite individuals to attend the meeting to aid in the understanding of particular items. The meeting secretary will issue such invitations on behalf of the Chair of the Committee.

6. Chair

6.1. The People Committee shall be chaired by a Non-Executive Director of the Board as appointed by the Trust Chair.

6.2. In their absence another NED, who is a member of the Committee, will automatically assume the authority of the Chair.

7. Quorum

7.1. A quorum will be no less than four members of which two must be Non-Executive Directors, and two Executive Directors one of whom must be the Chief People Officer or their nominated deputy.

8. Meeting Attendance and Frequency

8.1. The People Committee will meet bi-monthly and no less than 5 times a year.

8.2. It is highly important that members attend the People Committee on a regular basis. No more than two meetings should be missed in any one year unless due to extenuating circumstances. Executive members are expected to nominate a deputy to attend in their absence.

8.3. If a committee member is unable to attend the meeting or send a deputy then a formal summary report of progress made against their areas of responsibility should be given, in advance of the meeting, identifying the key issues that should be raised.

8.4. If a member fails to attend two consecutive meetings the Chair of the Committee will speak to the individual. The Chair of the Committee will also be required to bring to the attention of the Chair of the Trust if they feel that lack of attendance has not enabled adequate discussion or decision making.

9. Organisation

9.1. The agenda and papers for the meeting shall be distributed 4 days in advance of the meeting.

9.2. The Committee will be supported by a member of the Corporate Governance Team, whose responsibilities will include*:*

- Agreeing the meeting agenda with the Chair and Chief People Officer
- Coordinating the collation of meeting papers and circulation these to all members in a timely manner
- Preparing the minutes of the meeting and maintaining an action log to track matters and issues to be progressed.

10. Review and Assessment of Performance and Effectiveness

10.1. These Terms of Reference shall be reviewed annually or in light of changes in practice or legislation.

10.2. The People Committee will conduct an annual assessment of its performance and effectiveness, reviewing its activities from the previous year to ensure consistency with its Terms of Reference, Standing Orders, and Scheme of Delegation. The resulting report will be submitted to the Board of Directors.

Approved by: **People Committee**

Submitted to: People Committee

Date of approval: **17 March 2026**

Date for review: March 2026

Version Control Document			
Version Ref	**Amendments**	**Committee Approval**	**Ratified by Board**
Version 4	Amendment to membership and frequency.	20.2.24	March 2024
Version 5.0	Annual revision including template refresh to ensure consistency with other committees. the following changes: • Para 2 - Updated purpose statement • para 3 - streamlined and clarified principal duties • para 5 - updated membership and attendance • para 10 - strengthened reporting and governance requirements • para 10.2 - added annual effectiveness review	18.3.2026	Mar 2026

Quality Assurance Committee

Terms of Reference Document Control Sheet

MEETING	Quality Assurance Committee
ESTABLISHED BY/REPORTING TO:	Board of Directors
REVIEWER:	Director of Corporate Governance
EXECUTIVE LEAD:	Medical Director
REVIEW:	March 2026
ASSOCIATED DOCUMENTS:	Trust Constitution Board Standing Orders Scheme of Delegation
REPORTING GROUPS AND FORA	Patient Safety and Experience Group Clinical Effectiveness Group Performance and Transformation Group Professional Forum Risk Management Group Safeguarding Group Mortality Group Health and Safety Group

Document Control	
Document Name:	Terms of Reference Quality Assurance Committee
File Name:	QAC Terms of Reference
Version/Revision Number:	4.0

Terms of Reference of the Quality Assurance Committee

1. Authority

1.1 The Quality Assurance Committee is established to act as a committee of the Board of Bolton NHS FT and is authorised to investigate any activity within its terms of reference

1.2 The Quality Assurance Committee operates within the Trust's Constitution, Scheme of Delegation and Standing Financial Instructions.

1.3 The Committee is authorised by the Board to investigate any issues within its terms of reference, or seek any information it requires from any employee. All employees are directed to co-operate with any request made by the Committee in the pursuit of its business

1.4 The Committee is authorised by the Board to obtain, within the limits set out in the Trust Scheme of Delegation, outside legal or other independent professional advice on any matter within its terms of reference. Any decision taken by the Committee to obtain outside legal or other independent professional advice will always be highlighted in the Chair's report

1.5 The Chair of the Committee will provide a summary of meeting proceedings and escalate items requiring the Board's attention through the Chair's Report.

2. Purpose

The purpose of the Quality Assurance Committee is to provide assurance to the Board that the Trust is complying with its policies and all relevant external regulations and standards of governance and risk management. The Committee reviews and approves matters within its delegated authority, oversees external quality reports including those from the CQC, and ensures that robust, monitored action plans are in place to address any deficiencies in clinical governance. It also assures the Board that the structures, processes, and responsibilities for identifying and managing key risks to patients, staff, and the organisation are effective and fit for purpose.

3. Principal Duties

In order to achieve its purpose, the Quality Assurance Committee will:

a) Patient Safety, Experience and Effectiveness

- Promote systems which provide assurance and improve the quality of care, safety and experience of patients, carers, staff and visitors to the Trust
- To oversee the effective management of risks as appropriate to the purpose of the committee
- The Committee will seek assurances that the Trust complies with its own policies and all relevant external regulations and standards of governance and risk management.
- Review quality governance and require action to address any non-compliance with key regulatory frameworks and policies

- Review and have oversight of any relevant external reports including those from the CQC and ensure that robust action plans are devised and performance managed to address any identified deficiencies in clinical governance.

- To have an overview of the process to investigate and learn from serious incidents.

- Satisfy itself and the Board that the structures, processes and responsibilities for identifying and managing key risks to patients, staff and the organisation are adequate.

- To ensure that standards and procedures relating to risk are embedded throughout the Trust, with mechanisms through the Committee for detailed scrutiny of high and significant areas, including consultation with appropriate Trust staff.

- Such other relevant matters which the Board may delegate to the Committee

- Such other relevant matters which are referred to the Committee by its sub-committees or the other committees of the Board

- Such other relevant matters as the Committee takes upon itself in line with the broad scope of its main duties and responsibilities.

- Provide oversight and assurance on the Trust's approach to reducing health inequalities.
    - Review data on access, experience and outcomes across different population groups to identify unwarranted variation.
    - Monitor delivery of actions and improvement plans, including priorities aligned to Core20PLUS5 and national NHS requirements.

b) Operational Performance

- Review the monthly Integrated Performance Report and provide assurance to the Board on the operational Performance of the Trust.

- Understand organisational pressures, priorities and opportunities and oversee the development and delivery of plans and programmes that support optimal operational performance.

- Provide assurance to the Board on progress towards delivery of annual operational planning targets.

- Provide assurance to the Board on organisational resilience.

c) Risks and Assurance

- Review the Board Assurance Framework and any associated Strategic risks to achieving the Trust's Ambitions and evaluate the effectiveness of controls and the adequacy of assurance for

each risk. The Committee will review current and target risk scores, ensuring alignment with the Trust's risk appetite and monitor progress on actions to address gaps in control or assurance.

- Identify where additional assurance is required and escalate concerns or recommendations to the Board of Directors as appropriate.
- Receiving and considering issues from other Committees when appropriate and taking any necessary action

4. Reporting

4.1. The Quality Assurance Committee is accountable to the Board of Directors.

4.2. The minutes of the Committee meetings shall be formally recorded and presented to the next meeting for approval..

4.3. The Chair of the Committee shall produce an Advise Assure Alert (AAA) Key Issues Highlight Report to draw the attention of the Board of Directors any issues that require disclosure to the full Board or require executive action.

4.4. The Committee will refer to other Committes of the Board, matters deemed relevant for their attention. The Committee will consider matters referred to it by other committees.

4.5. The Committee may request Deep Dives or establish 'task and finish' groups to deliver specific actions

5. Membership

5.1. The Quality Assurance Committee membership will be appointed by the Board to ensure representation by Non-Executive and Executive Directors. Membership and will consist of:

- Four non-executive directors (one of whom will be the Chair of the Committee)
- Chief Nurse
- Executive Medical Director
- Chief Operating Officer
- Chief of Strategy and Partnership

Each member will have one vote with the Chair having the casting vote, if required. Should a vote be necessary, a decision will be determined by a simple majority.

5.2. The following members are generally expected to be in attendance at meetings; however, their attendance may vary depending on the agenda:

- Director of Quality Governance

5.3. The Director of Corporate Governance will attend all Committee meetings in an advisory capacity, providing governance guidance and, through their team, supporting the Chair in ensuring the effective operation of the Committee.

5.4. The Trust Chair and Chief Executive, as ex-officio members of the Committee, have a standing right of attendance at all meeting.

5.5. Other key individuals will be co-opted to the Committee dependent on key work streams to be initiated. All attendees are responsible for providing feedback to their Divisions/ Teams and any agreed actions or recommendations as required.

5.6. From time to time the committee may wish to invite individuals to attend the meeting to aid in the understanding of particular items. The Secretary will issue such invitations on behalf of the Chair of the Committee.

6. Chair

6.1. The Quality Assurance Committee shall be chaired by a Non-Executive Director of the Board as appointed by the Trust Chair.

6.2. In the Chair's absence another Non-Executive Director, who is a member of the Committee, will assume the authority of the Chair.

7. Quorum

7.1. A quorum will be no less than four members one of whom should be the Chair or their deputy and at least one other non-executive director and two executive directors including either the Medical Director or Chief Nursing Officer.

7.2. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised by the Committee.

8. Meeting Attendance and Frequency

8.1. The Quality Assurance Committee will meet bi-monthly and no less than 5 times a year.

8.2. It is highly important that members attend the Quality Assurance Committee on a regular basis. No more than two meetings should be missed in any one year unless due to extenuating circumstances. Executive members are expected to nominate a deputy to attend in their absence.

8.3. If a committee member is unable to attend the meeting or send a deputy then a formal summary report of progress made against their areas of responsibility should be given, in advance of the meeting, identifying the key issues that should be raised.

8.4. If a member fails to attend two consecutive meetings the Chair of the Committee will speak to the individual. The Chair of the Committee will also be required to bring to the attention of the Chair of the Trust if they feel that lack of attendance has not enabled adequate discussion or decision making.

9. Organisation

9.1. The agenda and papers for the meeting shall be distributed 4 days in advance of the meeting.

9.2. The Committee will be supported by a member of the Corporate Governance Team, whose responsibilities will include*:*

- Agreeing the meeting agenda with the Chair, Medical Director and Chief Nursing Officer
- Coordinating the collation of meeting papers and circulation these to all members in a timely manner
- Preparing the minutes of the meeting and maintaining an action log to track matters and issues to be progressed.

10. Review and Assessment of Performance and Effectiveness

10.1. These Terms of Reference shall be reviewed annually or in light of changes in practice or legislation. Changes to these Terms of Reference must be approved by the Board of Directors

10.2. The Committee shall undertake an annual evaluation of its performance and effectiveness, reviewing its activities from the preceding year to ensure alignment with its Terms of Reference, Standing Orders, and Scheme of Delegation. The report will be presented to the Board of Directors

10.3. The Committee will conduct an annual assessment of its performance and effectiveness, reviewing its activities from the previous year to ensure consistency with its Terms of Reference, Standing Orders, and Scheme of Delegation. The resulting report will be submitted to the Board of Directors.

Approved by: **Quality Assurance Committee**

Submitted to: Quality Assurance Committee

Date of approval: [planned for 25 March 2026]

Date for review: March 2026

Version Control Document			
Version Ref	**Amendments**	**Committee Approval**	**Ratified by Board**
V.2.0	Full review of ToR document including template. Notable amendments include: • s.6.1 quorum to exclude representation from each Division • s.8.1 amendment to 5 days (removing working days) • s.8.2 Revision of reporting groups	Oct 2022	Nov 2022
V.3.0	Review and refresh of Tor. • S.6 amended to reflect chairing arrangement • S.7.1 quorum amended so it is … at least one NED instead of 2 • s.8.1 amendment to 4 days from to ensure consistency with all committees • s.9 Removed reference to agenda items as included on Work plan.Merged s.9 & S.10 Administration & frequency of meetings. • S.4 Main Responsibilities - The Committee will exercise oversight of the systems of governance and risk management and seek assurance that they are fit-for-purpose, adequately resourced and effectively deployed to concentrate on matters of concern. • S.5.3 removed from membership - Divisional Representation and GM ICS Bolton Locality representative	Jan 24	Jan 24
V.3.1	Transferred to new template and updated due to Strategy and Operations Committee being disbanded Reviewed ToR and amended reference to Risk as this now sits with Audit Committee.	Dec 2024	
V.4.0	Regular review with no change to Committee remit. Amendments include: • Updates to template • Para 2 - Revision and clearer purpose • Para 3 - Removal of duplicate duties and addition of committee role in reviewing the BAF and Health Inequalities • Para 5 - membership increase to 4 NEDs from 3 • Para 8 - Updated meeting frequency from monthly to bi-monthly • Para 10 – tightenting of governance arrangements including meeting admin and addition of annual self- assessment	Mar 26	Mar 26

NHS Bolton NHS Foundation Trust

Report Title:	Chief Executive's Report			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	26 March 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 is asked to note 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

Our new Surgical Triage Unit is reducing the amount of time patients wait in our Emergency Department (ED) when they potentially require emergency surgery. In its first few months, the unit has had a significant impact, halving the length of stay for patients from an average of 1.5 days to 0.7 days. The unit has enabled clinicians to regularly review patients who were waiting in ED, and fast-track suitable individuals directly to the unit, enabling earlier assessment and treatment. This approach streamlines the patient journey, supports faster admissions, improves continuity of care, and increases capacity for both emergency and day-case surgery.

Open visiting has now been reinstated at Royal Bolton Hospital following a period of temporary visiting restrictions, which had been introduced to help prevent the spread of winter illnesses. The decision to ease restrictions came after a significant reduction in confirmed cases of winter illnesses, including flu and norovirus, following the protective measures put in place across the hospital to keep patients, staff and visitors safe.

Parents and families who have sadly experienced the loss of a baby were invited to attend Bolton's annual Baby Remembrance Service this month. The event took place at its new venue in Little Lever, and provided a meaningful opportunity for people to come together, reflect, and honor the memories of their babies who are no longer with us. The service included multi-faith prayers and readings, along with poems and music chosen to offer comfort and support.

Research plays a crucial role in healthcare by generating the evidence needed to improve clinical practice and treatment for the future. Our research team has recruited a milestone 200 patients in a major research trial looking to find new treatments for critical illnesses. The GenOMICC trial is using the DNA of people with severe infections or injuries to understand what causes some people to be more unwell than others.

Researchers hope this vital information will help develop better treatments for patients who have critical illnesses, such as sepsis, influenza and Group A Strep, in the future. The global study is taking place across 13 countries with more than 41,000 patients recruited to date. A new treatment for critically ill patients with COVID-19, known as baricitinib, has already been discovered through the trial, making GenOMICC the only critical care or infectious disease genetics study to ever directly lead to a new effective drug.

Ambition 2:
A great place to work

The results of the 2025 NHS Staff Survey have now been published, with more than 43% of our workforce taking the time to complete the survey. Our commitment now is to listen and use the information that our colleagues have shared with us to make meaningful improvements that ensure Bolton is a great place to work for everyone. The information will be analysed over the coming weeks to

help shape the organisation's people and culture priorities which are likely to range from improving wellbeing at work and strengthening learning and development opportunities for staff at all levels.

As part of our commitment to making our services and workplaces welcoming, inclusive and safe for everyone, we have taken further steps to strengthen how we challenge and prevent all forms of hatred and discrimination, including antisemitism. In line with many other NHS organisations, we will be using the International Holocaust Remembrance Alliance (IHRA) Working Definition of Antisemitism. This will support greater awareness, education and a consistent approach to identifying and responding to antisemitic behaviour. If anyone using or working in our services experiences or witnesses discriminatory behaviour, we encourage them to speak up so that we can take the relevant action, in line with our policies.

Our apprentices shared their passion for the work they do to mark National Apprenticeship Week. We have a wide range of apprentice roles at both our hospital and community sites, from medical engineers to administrative support and pharmacy technicians to student nursing associates. The celebrations helped us to shine the spotlight on how apprenticeships can help people reach their full potential by breaking down the barriers to opportunity.

Three of our nurses are finalists at the prestigious Student Nursing Times Awards. Kizzy David has been shortlisted in the Practice Supervisor of the Year award and Ashleigh Jones is a finalist in the Learner of the Year: Post-registration category. Nurse, Oluchi Okoroafor who provides care on Ward D3, has been shortlisted for five awards: Mary Seacole Award for Outstanding Contribution to Diversity and Inclusion, Most Inspirational Student Nurse of the Year, Outstanding Contribution to Student Affairs, Student Innovation in Practice, and Student Nurse of the Year. Winners and finalists will be celebrated on Friday 24th April at a ceremony in London, bringing together the nursing community to recognise their contributions.

One of our nurses who changes careers from the corporate sales world to provide life-changing care for patients shared her journey to mark International Women's Day. After experiencing the care and compassion from NHS staff following a breast cancer diagnosis, Lindsay took the opportunity to start something new. Having enjoyed her own learning and upskilling experience through training to become a nurse, Lindsay is passionate about supporting other women who are looking to kick start their career in the NHS.

Ambition 3:
A high performing, productive organisation

We have submitted a further iteration of our medium-term plan, aligned to NHS England's Medium Term Planning Framework which 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.

We have made some changes to our Adolescent Health Service, The Parallel, to increase nursing capacity at our drop-in clinics, where the demand for support is greatest. The changes mean that telephone support will no longer be provided over the weekend, but patients will still be able to make

contact with a nurse if needed for advice or to arrange appointments outside of clinic hours by calling 01204 462444, between 9am and 6pm, throughout the week.

The NHS recently experienced a temporary global shortage of bone cement, a specialist material used in joint replacement procedures such as hip and knee replacements. The disruption follows a fault at the factory of Heraeus Medical, one of the NHS's main suppliers, which paused production for a short period. This has resulted in reduced supplies across the country. We had to take the difficult decision to postpone all non-emergency joint replacement procedures for a short time, to ensure we could continue to provide safe care for patients requiring emergency surgery while supplies were limited. An interim measure has now been put in place nationally with another supplier, and all procedures have resumed.

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

Our Proactive Care Team was formed in September 2025 in response to the Government's 10 Year Health Plan for England, and the focus on moving services from hospital to community. The team works with people over the age of 65 with moderate to severe frailty, their families and healthcare providers to identify health conditions and needs at the earliest possible opportunity, before they worsen and risk needing hospital treatment. The team took over the Trust's Instagram and Facebook channels for a day, to offer a glimpse into their new ways of working.

We have joined a world-leading study that is screening newborn babies for more than 200 rare genetic conditions. The pioneering study aims to identify a range of conditions, including metachromatic leukodystrophy (MLD) in babies sooner, and could enable hundreds to benefit from earlier diagnosis and treatment that could help slow the progression of disease and improve or even extend lives. The Generation Study, led by Genomics England in partnership with NHS England, sees newborn babies offered whole genome sequencing using blood samples, which are usually taken from their umbilical cord shortly after birth. The sequencing identifies treatable, rare conditions shortly after a baby is born rather than when symptoms might appear later in childhood. This means families can access the right support, monitoring, and treatment from NHS services much earlier.

We are one of 14 NHS trusts across the North West that will receive a share of £11.1 million to adopt clean energy technologies and improve their energy efficiency - helping bring down bills and create savings to be reinvested into local frontline services. This includes £1 million delivered in partnership with Great British Energy (GBE) for new batteries and solar panels, building on the publicly owned energy company's £255 million investment in solar power for hospitals, schools and military sites last year. The funding is part of £74 million worth of Government support for public buildings across the country to generate their own electricity and save tens of millions on their bills. These measures will save over 190 NHS sites almost £30 million a year on their energy bills.

Ambition 5: A positive partner

We recently welcomed visitors and representatives from the Royal College of Surgeons, to our surgical and diagnostic sites to understand our challenges, and many successes. It was a great opportunity to demonstrate how we are managing increasing surgical lists with a backdrop of ongoing estates issues,

and how our training facilities and the new Medical School's co-location is having a positive difference to patient experience.

We are working in partnership with people who have lived experience of NHS services to improve the quality and safety of care across our services. Members of our lived experience panel ensure that the voices of patients, carers and families are heard and reflected in the Trust's work. Panel members also have opportunities to get involved in wider group activities, such as participating in recruitment processes and joining key meetings to share insights and represent the patient perspective.

Our Bolton NHS Charity is proud to fund the things that make a lasting and meaningful difference to the people of Bolton, and beyond. Over recent weeks, our charity supporters have continued to make a huge difference to our patients and their families.

Dozens of children's books have been generously donated to Royal Bolton Hospital's Neonatal Unit in celebration of World Book Day. Jess Hobson, an Usborne Community Partner, delivered a wonderful selection of books for families to read to their newborn babies during their stay in hospital. The hospital holds a special place in Jess' heart following the birth of her son, and both her mum and nan have dedicated many years' service there as employees.

Our generous communities, are choosing to make a Sadaqah (Lillah) donation in support of Our Bolton NHS Charity, throughout the holy month of Ramadan and directly supporting patients, families and staff at Royal Bolton Hospital and in the community. Ramadan is a time of reflection, compassion and generous giving, with many people supporting charitable causes during this special month.

Lancashire based charity Merciful Giving has generously donated Eid gifts to children on our E5 ward at Royal Bolton Hospital. This thoughtful gesture is part of a wider initiative, with Our Bolton NHS Charity and Royal Bolton Hospital being one of seven hospitals in the North West to benefit from their kindness and support.

NHS
Bolton
NHS Foundation Trust

Report Title:	Board Assurance Framework Q4 Update			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	26 March 2026		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	✓

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

Previously considered by:	The BAF was reviewed by the relevant Executive Director Leads and discussed in committees before being presented to the Board.

Executive Summary	The Board Assurance Framework (BAF) provides a systematic and structured mechanism for the Board to monitor delivery of the Trust's Ambitions. It enables the Trust to assess the robustness of controls for managing strategic risks and the effectiveness of the assurance mechanisms that underpin those controls. Ahead of submission to the committees, this iteration of the BAF was reviewed by Executive Director leads. Following this, each lead committee was invited to evaluate both the adequacy of the controls in place and the strength of the assurances supporting those controls. This approach ensures the BAF remains a reliable and up-to-date source of strategic oversight and supports risk-informed decision-making. Since the BAF was last received by the Board, all actions have been reviewed and updated. Actions that remain in progress will continue to be refined following finalisation of the Trust's strategic priorities for 2026–27. A Board Development session on Risk Appetite is scheduled for April and will include a review of current appetite levels and the Trust's wider approach to strategic risk. Due to the timing of the Quality Assurance Committee (QAC) and Finance and Investment Committee meetings, a verbal update will be provided to the Board.

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

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

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

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

Board Assurance Framework Explanatory Notes

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

1. Introduction

1.1. In an ever-evolving healthcare landscape, robust risk management and assurance are essential to safeguarding the achievement of the Trust's strategic ambitions and ensuring the highest standards of governance.

1.2. This iteration of the Board Assurance Framework (BAF) has been reviewed and updated to ensure that it continues to provide a comprehensive overview of the principal risks facing Bolton NHSFT, detailing the controls and assurance mechanisms in place to support effective decision-making. The report offers clear insight into how strategic risks are identified, managed, and monitored, reinforcing the Trust's Strategic Ambitions.

2. Strategic Alignment

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

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

2.3. This alignment strengthens the Trust's ability to make informed decisions, allocate resources effectively, and provide robust assurance to stakeholders. Each Strategic Risk is supported by:

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

3. Executive Oversight

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

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

4. Risk Management

To maintain a standardised approach across the organisation, all identified risks are evaluated in accordance with the established Risk Management Policy. This ensures that risk assessments are both robust and comparable, supporting effective risk oversight and decision-making across the Trust.

Each risk is systematically graded using a clearly defined scoring system. The risk score is calculated by multiplying the severity (or consequence) of a risk event by the likelihood of its occurrence. This method provides a quantifiable means of evaluating different risks and helps to identify those requiring immediate attention or intervention.

Severity (Consequence) x Likelihood = Risk Score.

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

Risk Categorisation Matrix

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

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

4.1. Principal Risks

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

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

5. **Risk Appetite**

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

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

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

Each Risk Appetite Statement is categorised as follows:

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

6. **Recommendation:**

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

Q4 2026 - Board Assurance Framework Dashboard

Corporate Objective		Strategic Risk	Risk Appetite	Risk Rating (S x L)	Exec Lead	Lead Commitee	
Ambition 1: Improving care, transforming lives							
CO1	Deliver high quality, safe care to everyone who uses our services and make sure that everyone has a positive experience of our care	**SR1 -** If the Trust does not provide safe, high-quality, and effective patient care, then overall experience of care may be adversely affected resulting in poor clinical outcomes, an inability to meet patients' evolving needs, increased health inequalities and unsustainable services	Avoid	**12** 4 x 3	CNO	Quality Assurance Committee	↔
CO2	Create a culture where staff can innovate and collaborate to improve care	**SR2 -** If the Trust does not create a culture where staff can innovate and collaborate to improve care, then it will be unable to support or take an innovative approach to healthcare research to adapt to the changing needs of our patients resulting in sub-optimal response to the needs of its patients and staff	Cautious	**12** 4 x 3	MD	Quality Assurance Committee	↔
CO3	Play our part in improving health and preventing illness, so that people live healthier lives	**SR3 -** If the Trust does not play its part in improving health and preventing illness, then the Trust will be unable to plan and respond to the needs of its community leading to an increase in health inequalities, unsustainable services and poor clinical outcomes	Cautious	**12** 4 x 3	CSP	Quality Assurance Committee	↔
Ambition 2: A great place to work							
CO4	Improve the experience of our staff and make our organisation a great place to work.	**SR4 -** If the Trust does not achieve its Ambition (To be a great place to work) then it will be unable to recruit, retain and support staff to maximise their potential	Cautious	**16** 4 x 4	CPO	People Committee	↔
CO5	Help all staff to unlock their potential	**SR5 -** If staff are not supported to unlock their full potential, then we risk reduced performance, lower morale, and missed opportunities for innovation and improvement	Cautious	**16** 4 x 4	CPO	People Committee	↔
CO6	Ensure that our workforce reflects the population we serve	**SR6 -** If our workforce does not reflect the diversity of the population we serve, then we risk reduced public trust, diminished service effectiveness and potential reputational harm.	Cautious	**16** 4 x 4	CPO	People Committee	↔
Ambition 3: A high performing productive organisation							
CO7	Improving access to our services	**SR7 -** If the Trust does not deliver reliable compliance of the operational standards, then this may result in regulatory action.	Minimal	**20** 4 x 5	COO	Finance & Investment Committee	↑
CO8	Being Efficient and Productive	**SR8 -** If the Trust does not optimise its processes, this could negatively impact productivity and efficiency, resulting in unsustainable services	Minimal	**16** 4 x 4	COO CFO	Finance & Investment Committee	↔
CO9	Delivering Financial Sustainability	**SR9 -** If the Trust does not deliver its Financial Plan, then it will fail to meet its financial objectives, which could negatively affect the Trust's long-term financial sustainability	Minimal	**20** 4 x 5	CFO	Finance & Investment Committee	↔
Ambition 4: An organisation that's fit for the future							
CO10a	Being digitally enabled and inclusive Corporate Objective	**SR10 -** If the Trust is not digitally enabled and inclusive, then it can face significant challenges, including barriers to essential services, widening health inequalities, missed economic and educational opportunities	Minimal	**12** 4x3	CSP	Finance & Investment Committee	↔
CO10b	Cyber Security	**SR10b -** If the Trust experiences a cyber-attack and lacks effective defences and recovery plans, Then it may face serious disruption to patient care, data security, and regulatory compliance, with prolonged downtime and delayed recovery**.**	Avoid	**20** 4 x 5	CSP	Finance & Investment Committee	↔
CO11	Improving our estate	**SR11 -** If the Trust does not provide compliant and reliable premises and supporting infrastructure then personal safety and business effectiveness will be compromised resulting in potential harm, service disruption and potential statutory breach.	Avoid	**20** 4 x 5	CFO	Finance & Investment Committee	↔
CO12	Proactively planning for the future	**SR12 -** If the Trust fails to proactively plan for the future, it will negatively affect service provision and hinder the overall achievement of the Strategy	Minimal	**12** **4 x 3**	CFO	Finance & Investment Committee	↔
Ambition 5 : A positive partner							
CO13	Developing our neighbourhoods	**SR13 -** If the Trust fails to integrate care, opportunities to improve the health and wellbeing of the population of Bolton will be missed	Open	**12** 4 x 3	CSP	Executive Committee + Board	↔
CO14	Working as one team	**SR14 -** If the Trust does not promote a collaborative environment, it could result in fragmented efforts, misaligned objectives, and inefficiencies.	Open	**12** 4 x 3	CSP	Executive Committee + Board	↔
CO15	Partnership for local benefit	**SR15 -** If the Trust fails to integrate care, opportunities to improve the health and wellbeing of the population of Bolton will be missed	Open	**12** 4 x 3	CSP	Executive Committee + Board	↔

Ambition 1: Improving care, transforming lives

PRINCIPAL RISK: IF the Trust does not provide safe, high-quality, and effective patient care, then overall experience of care may be adversely affected resulting in poor clinical outcomes, an inability to meet patients' evolving needs, increased health inequalities, and unsustainable services.

CO.1: Improving access to our services — EXECUTIVE LEAD: CHIEF NURSING OFFICER

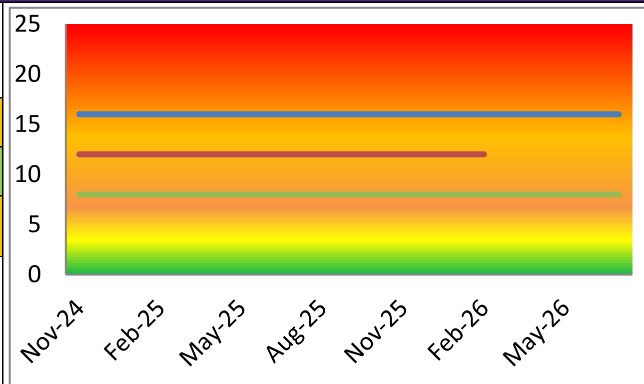
26/27 Improvement Priority: We communicate in ways people understand, and we will find better ways of working that releases more time to care.

Risk Appetite: **OPEN**

Risk Appetite Statement: In relation to this area of work, Bolton NHS FT is willing to accept risks that are likely to occur and would then lead to some degree of damage to its reputation, or possible financial loss, exposure or short term disruption to one or more service area

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

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



Link to Risks on Corporate Risk Register

- 1595 (15) Critical care delayed discharges & mixed sex accommodation breaches
- 1869 (15) lack of ENT outpatient capacity
- 3330 (15) Waiting time for Glaucoma new patient appointments and follow-up
- 5425 (16) Delivery of Urgent Care Performance Standards
- 6491 (15) Failure of ambulatory cardiac monitoring analysis software
- 2836 (16) CYP with mental health and behavioural difficulties being cared for within the acute setting

Catastrophic for Impact

- 6145 (15) Maternity Theatres ventilation failure
- 2937 (15) Orthopaedic Interface Service (OIS) waiting times
- 6344 (16) Unavailability of Abatacept

Issues impacting achievements of our objective

- Service demand in excess of capacity that creates challenged environments
- Inconsistent application of quality improvement methodologies compromise standards and outcomes.
- Leadership inconsistency with application of required standards and delivery of accountability frameworks
- Non-compliance with prescribed quality governance systems and processes which then lack reliability in delivering impactful learning from adverse events/near misses
- Inadequate access to inclusive and representative patient experience / outcome data, along with missed opportunities to implement evidence-based interventions, restrict learning and innovation.

KPIs / Measures

- Year-on-year improvement in patients who report that they were treated with dignity and respect
- Year on year improvement in patients who reported that they were involved in decision making
- Year-on-year reduction in avoidable harm ~~and mortality~~
- Year-on-year improvement in the % of staff reporting they would recommend BFT as a place to receive care
- Year-on-year improvement/increase in the number of patients responding to national survey
- A minimum of 60% of our wards and departments score a silver or higher by 2029 as measured through our BOSCA accreditation programme
- Communication; we will identify themes for communication improvements across all areas that undertake friends and family test (FFT) and we will have completed at least two forms of feedback for all areas not covered by FFT
- We will have removed all agreed un-necessary documentation from the electronic patient record (EPR) for phase 1 areas

Controls

- Quality Account Priorities
- Quality Improvement Plan
- Patient Safety Incident Response Plan
- Being Open Policy (includes duty of candour)
- Enabling professional priorities established for Nursing, Midwifery, AHPs and Health-care scientists (NMAHP&HCS),
- Accreditation (BoSCA) escalation framework
- Safeguarding Assurance Framework
- Quality and Equality Impact Assessments
- NHSE workforce safeguards
- Learning from experience 6 monthly report
- Annual Leadership conference
- Talent management programmes in place for all NMAHP & Health Care Scientists (HCS)
- Clinical Audit Work -Plan
- National patient safety alerts NICE guidance and other safety related guidance reviewed, audited and implemented where relevant and appropriate
- Policies/procedures to support safe care delivery, i.e. falls, pressure ulcers, safeguarding
- Fundamentals of care internal development programme for non-registered clinical staff
- Quality governance prescribed systems and processes (mirroring Quality & Clinical Governance and 'AAA' template)
- Community Safer Nursing Acuity Tool
- AQuA Quality Management System diagnostic with road map to follow.
- ACP Workforce Strategy
- National research and development gap analysis tool (SORT);

Assurances

1st line of Defence (Operational management)

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

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

Reports to Quality Assurance Committee and Board, namely:

- Integrated Performance Report with monthly heatmap
- Safe staffing report to Board in line with NQB recommendations within heatmap
- Quality Account Priorities
- Mandatory training compliance
- Bi-annual Nurse & Midwifery establishment reviews
- CNST & other Maternity related specific reports
- Risk Management Group chairs report to Audit and Risk Committee
- Monitoring of NMAHP clinical outcomes for stratification by ethnicity and deprivation included as part of Midwifery, Complaints and Patient Safety Incident Reports to Patient Safety and Experience Group (previously CQQG)

3rd Line of Defence (Independent or external assurance)

- GMICB Bolton Locality Quality Spot Checks
- Internal audit reviews
- CQC inspection reports, visits, Insight reports, and engagement meetings
- Peer reviews and accreditation.
- Quality governance review via Good Governance institute 2023
- National patient surveys
- CQC Improvement Plan reporting/oversight to QAC. Well led recommendations reported through to appropriate committees of the Board
- Maternity specific outcomes benchmarked against peers using available data (and new national datasets). Introduction of MOSS – Maternity national dashboard quality performance.
- National Oversight Framework quality dashboard / league table.

Actions (Chief Nursing Officer)

1. Scoping procurement of a digital solution to support with provision of aggregated data / thematic analysis**.** Expected (business case) presentation March 2025). ~~July 25 Update: Revised Target Date Q3 2025~~ ~~**Update Nov 25: Target Date of Q3 25/26 remains.**~~
   Procurement completed – business case to CRIG Dec 2025 (agreed in principle as linked to CIP)
   Update Feb 2026: Genome procured and implementation and roll out underway. **Revised Target date: Sep 26**
2. Roll out and embedding of community safer nursing acuity tool – **Target Completion Date 30.03.**-Relaunched following national pause and next safer nursing care tool scheduled for Sep 2025**.**.
   Mar 26 Update: CSNT now available, validators trained and first census collection occurred in February 2026. **Action completed**
3. Development of Risk Management Framework with stakeholder engagement **Target Completion Date ~~30.12.2023.~~**
   Risk Management Framework has been drafted with wider discussions with Executive Team to discuss new approach planned.
   Mar 26 Update 26: To be presented at Board Development Day in April 2026 and then for wider engagement/roll out.
4. Introduction of shared decision-making councils. TOR developed, further engagement planned in April with Divisional teams, first leadership council meeting in June **Target Completion Date** – revised date to **Q2 25/26** Divisional restructure necessitated changes in Divisional Governance.
   Target Completion date 30 June 2026
5. Improvement plan to attain full compliance with NHSE workforce safeguards: **Target Completion Date 31.3.2026**
   March 26 Update – On track and expected to be completed in line with target date.
6. Completion of National research and development gap analysis tool (SORT); **Target Completion Date 31.3.26**
   March 26 Update: Action Completed and moved to controls
7. Provision of inclusive patient experience / service user feedback that represents all users; **Target Completion Date 31.3.26**
   Mar 26 Update: All FFT areas are set to deliver at least 30 returns per team in March 2026; activity likely to continue after April.
   Revised Target Date: Sep 26
8. Agreement of initial NMAHP clinical outcomes for stratification by ethnicity and deprivation; **Target Completion Date 31.3.26**
   March 26 Update: **Action completed** and is routinely reflected through (Midwifery, Complaints and Patient safety incident investigation PSII REports)

		9. ACP workforce strategy completed – for discussion and review at 'People committee Nov/Dec 2025. **March 26 Update**: The ACP Strategy has now been submitted to the People Committee . The Divisions are now working through the strategy's objectives. Progress updates will be shared at future People Committee meetings. **Action Completed** 10. Very Important Person (VIP) group established and initial overview of compliance with various standards and key performance indicators presented to Quality and Clinical Governance October 2025. Action plan agreed. Review progress 6 monthly. **Update Feb 26:** Initial meeting held. ToR agreed. For review 31.03.2026. **Revised Target Date: July 26** 11. Completed self-assessment against NHSE Experience of Care standards. **Target Completion Date**: 31.08.2026 12. Procure new FFT provider with increased ability to generate questions and ability to translate responses from other languages other than English. **Target Completion Date:** 31.08.2026
Gaps in Control	**Gaps in Assurance**	**Committee Feedback**
• Development of a Risk management framework/strategy • Lack of robust non-medical research plan • Lack of an ACP Workforce Strategy • Community Safer Nursing acuity tool • Establishment of Shared decision making councils • Quality Management Service Roadmap	• Lack of robust, co-ordinated & consistent intelligence on patient experience / service user feedback from those without / with limited, mental capacity and / or those for whom English is not first language • Lack of robust process for inclusion of NMAHP&HCS outcome data stratified according to ethnicity and deprivation • Real-time access to Quality KPIs and access to automated triangulation (to be addressed by roll out o genome) • Ability to benchmark predominantly patient experience data in real time	**March 26:** This section of the BAF was reviewed by the Chief Nursing Officer who has requested a change in Risk Appetite from Avoid to Open. The amended statement is as follows: *We are not willing to accept any risks that could lead to damage to its reputation, financial loss or exposure, major breakdown in services, information systems or integrity, failings in significant aspects of regulatory and/or legislative compliance, potential risk of injury to staff, service users or public*. There is no proposed change to risk score at this moment. All controls, assurances and actions to support any gaps have been reviewed and updated.

Ambition 1: Improving care, transforming lives

CO.2 - Create a culture where staff can innovate and collaborate to improve care and reduce harm

EXECUTIVE LEAD: MEDICAL DIRECTOR

26/27 Improvement Priorities: To find better ways of working that releases more time for care, guided by what matters most to our patients

Risk Appetite: CAUTIOUS

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

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

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

20
10
0
Nov-24 Feb-25 May-25 Aug-25 Nov-25 Feb-26 May-26

Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

- Inadequate job planned time due to service commitments
- Lack of support/resource within the organisation to be able to deliver change including the absence of a structured research and innovation strategy
- Inadequate clinical data in EPR systems and inadequate integration and development of digital systems restricts innovation, learning, and evidence-based decision making due to immaturity/capacity of business intelligence.
- Lack of alignment of objectives and priorities of system partners due to varied work practices, clinical commitments, and lack of shared values hinder effective collaboration across teams and with primary care.
- Absence of a structured innovation pathway and insufficient funding for pilot schemes to enable innovation.
- Lack of infrastructure undermines the development of a robust research programme.
- Missed opportunities for improvement or implementation of evidence-based interventions.

KPIs / Measures

- Through developing our approach to quality improvement, embedding QI methodologies and nurturing a culture of improvement and innovation and will ensure that a minimum of 75% percentage of our staff have the skills and knowledge to do this
- Increase in the number of changes and innovations implemented annually aligned to the priorities in our clinical and organisational strategy
- We will embed QI methodologies and foster a culture of improvement, ensuring at least 75% of medical and multiprofessional staff participate annually in QI, research or innovation through job plan objectives, with year-on-year improvements benchmarked against peers.
- QI capability - >75% of staff formally trained in QI methodology
- Enhanced corporate and clinical decision-making accuracy and efficiency through the effective utilisation of technologies such as AI, predictive analytics and decision-support
- Expanded research collaboration and provision, providing service users with increased access to clinical trials and supporting our workforce to take part in research in line with the organisational research plan and the priorities within health inequity reduction group for the alignment to research ready communities
- Improvement in NHS IMPACT self-assessment Maturity Matrix level
- Compliance with NICE guidelines and Clinical Audit Annual plan
- Compliance and achieving top quartile against National and local quality recommendations such as GIRFT

Controls

- Quality Improvement collaboratives for recognising and responding to deteriorating patients incorporating Martha's Rule (NHSE pilot) –
- A strengthened Quality, Control, Improvement and Assurance framework
- NHSE Improving Patient Care Together (IMPACT) self-assessment Maturity Matrix level
- Advanced Care Planning (ACP) to support Admission Avoidance with monitoring at End of Life Steering Group
- QI strategy
- QMS
- Bolton locality plan
- Borough wide Patient engagement and collaboration strategy
- Clinical strategy
- Job planning policy
- Benchmarking through Model Health Systems
- Increased attendance at the OUR LEADERS programme

Assurance

1st line of Defence (Operational management)

- Quarterly Quality Account updates to CG&QA committee
- Quarterly mortality reports, including Learning from Deaths, neonatal, stillbirth and child deaths, to CGQA
- Clinical audits
- Alignment and monitoring of actions within the Research Plan
- Reports to Research Committee, Clinical Effectiveness Group, CG&QC, AI Steering Group
- Delivery and progress of Transformation Plans reviewed at Performance and Transformation Group

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

- Integrated Performance Reports to QAC and Board
- Reports on IPC, transfusion, Medicines Safety, Safeguarding
- Quarterly Mortality Steering Group and LfD reports to QAC
- Mortality reports to QAC and Board

3rd Line of Defence (Independent or external assurance)

- NIHR and GM research benchmarking and strategic alignment to the university
- National reporting and benchmarking including Model Hospital Systems
- AQuA audits of care
- GIRFT reviews into care provision
- External assessments and accreditation
- Report to Bolton University Joint Delivery Board?
- NHS mid-term and long term plans
- Performance against the GM ICB and Strategic Commissioning system

Actions

1. Implementing artificial intelligence (AI) and robotic process automation to ~~enhance efficiency and aid in decision-making~~ deliver trust wide clinical data and decision support programme that improves the improves timeliness and reliability of data for decision making aligned to patient safety, flow and productivity. Target Completion Date: Q4 2025/26. **Revised Target Date: Q4 2027**

2. Expanding research trial access to benefit more people with innovative therapies. Deliver the trust research plan, increasing patient access to research and integrating research delivery with clinical improvement priorities. Target Completion Date: Q4 2025/26
Revised Target Date: Q3 2026/27

3. Rolling out of Quality Improvement training to Medical staff. Establish QI faculty with job planned time ensuring > 75% of medical staff are QI-capable and actively contributing to priority improvement programmes aligned to trust priorities addressed through objective setting within job plans.
Target Completion Date: Q4 2026

4. Development of Research Plan. **Target Completion Date: Q3 2025. Update Mar 26**: Revised and now included in Action 2 above.

5. Implement a system-wide quality improvement programme covering admission avoidance, virtual wards and hospital at home with

		measurable improvements in access, experience and outcomes for patients. initiative for Advanced Care Planning (ACP) to support Admission Avoidance Completion Date Q.4 2025. **Revised Target Date: Q2 2026** 6. Outcomes based focus with greater oversight of data. Improve outcomes for non-elective patients through better responses to deteriorating patients, cancer pathways, elective list and complications related to procedures and surgery with board level visibility of data disaggregated to allow oversight of impact on different population groups**.** Improve tracking and compliance with NEWS policy and appropriate response to patient deterioration**. Target Completion date ~~Q.1 2025/26~~ Q.4 2025-26** 7. Recruitment to the role of Chief Clinical Information Officer (CCIO**). Target Completion Date of August 26** 8. Ambition and action plan relating to University Hospital Status**. Target Completion Date: Q2 2027**
Gaps in Control	**Gaps in Assurance**	**Notable Changes since last iteration of the BAF**
• Development of a Research Plan • Capacity in consultant job planning to support delivery of Ambitions. • Protected job planning and structured support for medical staff to lead and participate in Quality Improvement (QI) • Lack of Quality Improvement education for medical staff. • Central oversight of innovation, research and QI • Resident Doctor listening events • Lack of consistent EPR solution • Development of medic specific blended learning bundles and Action Learning Sets • Lack of strategic alignment between system partners • Lack of resource/know how and support for transformation • Lack of bi support for data • Borough wide patient engagement and collaboration strategy • Research and innovation committee • Vacant CCIO to deliver • Authorisation as a University Hospital	Reporting and oversight of innovation and collaboration Regular reporting and oversight through QAC to provides assurance of staff participation, impact of QI programmes, and learning from QI collaboratives, demonstrating sustained improvement and alignment with organisational priorities.	The BAF has been reviewed by the Medical Director and is due to be reviewed at Quality Assurance Committee at the meeting scheduled for 26 March 2026. All actions are progressing as planned, with new target dates requested and specified alongside each action. There is no proposed change to the Risk Score or Risk Appetite.

Ambition 1: Improving care, transforming lives

CO.3: Play our part in improving health and preventing illness, so that people live healthier lives

EXECUTIVE LEAD: MEDICAL DIRECTORS

26/27 Improvement Priorities: Develop high quality demographic and outcome/effectiveness metrics that help us understand how care is delivered and identify opportunities to improve

Risk Appetite: CAUTIOUS

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

STRATEGIC RISK 3: If the Trust does not play its part in improving health and preventing illness, then the Trust will be unable to plan and respond to the needs of its community leading to an increase in health inequities, unsustainable services and poor clinical outcomes.

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

20
10
0
Nov-24 Feb-25 May-25 Aug-25 Nov-25 Feb-26 May-26

Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

- ~~Widening health inequalities if health disparities are not equitably implemented~~
- ~~Reduced Life expectancy~~
- ~~Increased chronic health diseases leading to long-term health implications and quality of life~~
- Higher healthcare costs resulting in diverting resources from other clinical areas
- Inability to systematically identify and act on health inequities within the Trust services due to incomplete or inconsistent disaggregated data.
- Insufficient integration with neighbourhood, PCN and community partners, reducing the Trust's contribution to population health improvement.
- Clinical priorities and operational pressures under financial constraints reduce focus on prevention leading to widening health inequalities if health disparities are not equitably implemented
- Increased morbidity and reduced Life expectancy leading to additional pressures on services.
- Limited feedback loop between outcomes data and service redesign, slowing improvement.

KPIs / Measures

- Contribute to Smoke Free targets for Bolton locality to support delivery of a reduction in the % of people who smoke
- Contribute to reduction in obesity targets for Bolton Locality to support delivery of a reduction in the % of people who are overweight or obese through implementation of Making Every Contact Count
- Continued optimisation of health outcomes for cancer and chronic conditions through earlier diagnosis and specific interventions, including playing our part in diagnosing 75% of cancers at Stage I/II by 2028
- Working towards decreased acute demand, as a result of proactive and preventive approaches i.e. reduced avoidable admissions, re-admissions and extended hospital stays for priority conditions.
- By 31/03/27, every clinical specialty to have a suite of disaggregated clinical outcome metrics to track quality of care and identify areas of inequity for targeted improvement plans
- Reduce admissions related to COPD by 20% by 31/03/27

Controls

- Bolton Locality Plan
- NHS Greater Manchester Sustainability Plan
- Clinical Strategy
- Bolton Public Health Annual Report 2023
- Bolton Joint Strategic Needs Assessment (JSNA)
- Benchmarking through Model Hospital
- Revised Bolton Carers' Strategy
- Health Inequalities Group
- Quality Improvement Plan
- Bolton Outcomes Framework
- Educational programme to improve communication with patients, families and carers
- Making Every Contact Count (MECC) Health Programme
- Health Inequalities Action Plan reviewed and refreshed.
- Mandatory inclusion of health inequalities impact in business cases and service redesign

Assurances

1st line of Defence (Operational management)

- Reports from Neighbourhood teams and weekly programme of community visits
- Neighbourhood maturity measured through the maturity matrix
- MECC embedded into appraisal, induction and clinical governance processes.

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

- Health Inequalities enabling group
- Neighbourhood Steering Group reporting to Locality Board
- Health inequality metrics to be added to the Integrated Performance Report presented to Committees and Board~~.~~

3rd Line of Defence (Independent or external assurance)

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

Actions

1. ~~Enhancing links between primary, community, secondary, and social care to ensure people get the services and advice they need promptly. **July 25 Update:** Plan for provider collaborative developed (**Review March 2026)** Plan for provider collaborative~~
   ~~**Update Nov 25 Plan for provider collaborative being developed linked to Locality Board**~~
   Update Mar 26: Action reviewed and will now be included in Ambition 5. **Action Completed.**

2. Making Every Contact Count implemented and reviewed in Community Division Target Completion Date: March 2026.
   Update Mar 26: Action progressing as Community Division piloting MECC. To be monitored through HI steering Group. **Revised Completion Date: Sep 26**

3. ~~Identifying and involving carers in care planning, decision making and discharge so that we improve experience. **Target Completion Date: March** 2026~~
   Update Mar 26: This now forms part of the Carers Strategy. **Action Completed**

4. Board level discussion on our Socio-Economic Duty and Action Plan. Target Completion Date: March 2026
   Update Mar 26: Date provisionally planned for Feb 26 and deferred to April 2026
   Revised Completion Date: May 26

5. Ensuring continuity of care in our Maternity Services for those at most risk and from most deprived areas. **Target Completion Date: March 2026**. Ongoing with oversight from CGQG
   Update Mar 26: The current focus of this action is the ongoing maternity work within the neighbourhood aimed at reducing stillbirths. This initiative has been reviewed by the QAC and will remain a key priority going forward.

6. ~~Ensure Health Inequalities Framework is embedded into the organisation **– Ongoing into 2026**~~
   ~~Ongoing with oversight through HIE~~

		Update Mar 26: The integration of health inequalities indicators into the Integrated Performance Report (IPR) has now been confirmed. **Action completed.** ~~7. Board approved health inequity dashboard. Target Completion Date: May 2026~~ **Update Mar 26:** The HI indicators are now included in the IPR. **Action Completed** ~~8. Embed neighbourhood and PCN alignment into at least 2 priority pathways. Target Completion Date: July 2026~~ **Update Mar 26**: Action reviewed and will now be included in Ambition 5. **Action Completed**
Gaps in Control	**Gaps in Assurance**	**Notable changes since last iteration of the BAF**
• Establishing new models of care in the community and through neighbourhoods • Using technology to support people with long-term conditions to live well at home. • Carer Plan Review • Availability of disaggregated data and visibility at board level	• ~~PCN and Neighbourhood alignment~~ • Increasing focus on prevention and equitable access, experience and outcomes through community engagement and neighbourhood groups. • ~~Health inequality metrics to be added to the Integrated Performance Report presented to Committees and Board.~~	This element of the BAF has been reviewed by the Chief of Strategy and Partnerships (who was previously the Executive Lead) and by the Medical Director, who has assumed the role of Exec Lead. Some actions will move to Ambition as indicated and others are expected to progress. All controls, assurances and actions to support any gaps have been reviewed and updated. All actions are progressing as planned, with new target dates requested and specified alongside each action. There is no proposed change to the Risk Score or Risk Appetite.

Ambition 2: A great place to work

PRINCIPAL RISK: If the Trust does not achieve its Ambition (To be a great place to work) then it will be unable to recruit, retain and support staff to maximise their potential.

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

26/27 Improvement Priority: Improve staff wellbeing and attendance so that All staff feel supported, healthy, and able to deliver great care

Risk Appetite: CAUTIOUS

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

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

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

20
10
0
Nov-24 Feb-25 May-25 Aug-25 Nov-25 Feb-26

Link to Risks on Corporate Risk Register

6418 (16) Resident Doctor staffing levels
6422 (16) General Surgery CT on call rota
6438 (15)Insufficient staffing within the pharmacy team leading to reduced service provision
6498 (16) Changes to Additional Clinical Activity Pay (Locum bank rates) for Resident and SAS Doctors.

Issues impacting achievements of our objective

- Worked Whole Time Equivalents not reducing in line with our plan due to the operational / quality pressures impacting our organisation.
- Poor management and provision of health and wellbeing support to staff, leading to an increase in sickness absence rates.
- Low staff engagement and satisfaction experienced due to the high number organisational change.
- ~~A slowing down in recruitment may reduce our aspiration to increase the % of staff with protected characteristics, reflecting the population that we serve~~ (moved to CO6)

KPIs / Measures

- Reduction in Worked Whole Time Equivalents in line with our operational plan
- Year-on-year improvement in % staff reporting that they would recommend BFT as a place to work and receive care
- An achieved sickness rate of 4.8% or lower
- Sickness absence no greater than 4.8% by 31/03/27 (baseline Jan 26 6.5%)
- Significant Improvement against comparators in NHS Staff Survey for recommend as a place work / care by 31/03/27
- ~~Year-on-year improvement in % staff with protective characteristics reflective of the population we serve~~ (moved to CO6)

Controls

Experience

- Operational Plan
- Executive Vacancy Panel (monthly)
- Executive Variable Pay Panels (daily/weekly)
- Refreshed Flexible Working Policy
- Our People Plan
  - People
    - Resourcing Plan
    - Staff Health and Wellbeing Plan
    - Occupational Health Provision
    - Job Planning
    - Rostering
  - Culture
    - Equality, Diversity and Inclusion Plan ~~2022-26~~
    - Great Place to Work Plan
    - Our VOICE ~~Change~~ Reset Programme
    - Our Leaders Programme
    - Staff Networks
    - FTSU
    - Appraisal

Assurances

1st line of Defence (Operational management)

- Attendance KPI
- Friends and Family Tests
- Pulse Survey Staff Survey
- Divisional People Committees reports to People Committee
- IPM meetings with Divisions
- Reports to Vacancy Control Panel IPM meetings with Divisions aligned to operational plans
- Worked Whole Time Equivalents
  - Medical Variable Pay (daily)
  - Nursing/Midwifery/AHP Variable Pay (daily)
  - Administration and Clerical Variable Pay (twice weekly)

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

- Integrated Performance Report to People Committee and Board.
- Staff Story included as a standing item in Board
- People Plan actions overseen by People Committee (People and Culture)

3rd Line of Defence (Independent or external assurance)

- NHS Staff Survey
- WRES/WDES/Gender Pay Gap
- Local, Regional & national Benchmarking
- Internal Audit reviews
- Report and attendance at Bolton Locality Workforce Group

Actions

1. Agile Working Action plan in place overseen by the agile working group including review of the Policy, roll out plan for equipment and risk assessments. **Target Completion Date**: March 2026. **Update Mar 26**: Revision and refresh of Flexible Working policy completed. **Action Completed. [CPO]**
2. Review of Trust Well Being offer and financial well-being in light of cost of living pressures and national issues on pay. **Target Completion Date: March 2026** **Update Mar 26**: The wellbeing offer has been expanded and now includes focussed on psychological and mental wellbeing offers. **Action Completed [CPO]**
3. EDI Plan to be revised and complement the existing People Plan. Initial Target Completion Date March 2025. **Update Mar 26**: EDI plan updated and reviewed at People Committee. **Action Completed [CPO]**
4. Refreshed Vacancy Control Process from 1 September 2025 (meets monthly). **Update Mar 26**: The Executive Pay Panel (EPP) has been reviewed, and governance arrangements have been strengthened and realigned with Improvement plan to ensure decisions and actions are recorded. Monthly meetings will continue, supported by a glass-break process for urgent issues. **Action Completed [CPO]**
5. Executive Variable Pay Panels have all been set up from 1 September, 2025. **Update Mar 26**: Separate panels have been established led by respective executive directors with continued collective oversight provided by the full Executive Director team. **Action Completed [CPO]**
6. Reset Programme launches end of September / early October 2025 to support high levels of organisational change. **Update Mar 26**: Action **Completed [CPO]**
7. Medical E Rostering roll out plan to commence in Oct 2025 **Update Mar 26**: Expected to progress into 2026 with a new project plan. Timescale extended to allow for MD to review with support from CPO. **Revised Action Date: July 2026**
8. Establishment Controls to be put in place with a view to align the Ledger and information on Electronic Staff Record (ESR) **Target Completion Date Q3 2026.**

Gaps in Control

Establishment Controls to be put in place with a view to align the Ledger and information on Electronic Staff Record (ESR) timescale Q3 target for completion.

Gaps in Assurance

Assurance is assessed as complete at this time, with no gaps currently identified. Routine monitoring will continue to ensure emerging gaps are detected promptly.

Notable changes since previous iteration

The BAF was reviewed at People Committee. There is no proposed change in risk score or Appetite and all actions have been updated.

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

26/27 Improvement Priorities: Ensure the right people are in the right place at the right time

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

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

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

Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

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

KPIs / Measures

- Continue to achieve and sustain an appraisal rate of 85% and deliver a year-on-year improvement in the % reporting that their appraisal helps them to perform their role
- ~~To achieve compulsory training rates of 95% or greater~~
- Year-on-year improvement in % staff reporting that they would recommend BFT as a place to work and receive care
- An achieved sickness rate of 4.8% or lower
- WWTE reduction by 300 by 31/03/27
- Achieve >85% appraisal compliance by 31/03/27
- Achieve >92% mandatory and statutory training by 31/03/27

Controls

Our People Plan

- People
  - Staff Health and Wellbeing Plan
  - Occupational Health Provision
- Culture
  - Equality, Diversity and Inclusion Plan 2022-26
  - Great Place to Work Plan
  - Our VOICE Reset ~~Change~~ Programme
  - Our Leaders Programme
  - Staff Networks
  - FTSU
  - Appraisal

Assurances

1st line of Defence (Operational management)

- IPM meetings with Divisions aligned to operational plans Attendance KPI
- Staff Survey (quarterly and annually)
- Reports from Staff Network Groups into the Equality Diversity and Inclusion Group
- Regularly monitoring and oversight of actions relating to Equality Diversity and Inclusion Plan at EDI Group

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

- Integrated Performance Report to People Committee and Board.
- Staff Story included as a standing item in Board
- People Plan actions overseen by People Committee (People and Culture)
- Reports to People Committee from the EDI Assurance Group

3rd Line of Defence (Independent or external assurance)

- NHS Staff Survey
- WRES/WDES/Gender Pay Gap
- Local, Regional & national Benchmarking
- Internal Audit reviews
- Report and attendance at Bolton Locality Workforce Group

Actions (CPO)

1. Agile Working Action plan in place overseen by the agile working group including review of the Policy, roll out plan for equipment and risk assessments. **Target Completion Date: March 2026**
   Update Mar 26: Revision and refresh of Flexible Working policy completed. **Action Completed.**
2. Review of Trust Well Being offer and financial well-being in light of cost of living pressures and national issues on pay. **Target Completion Date: March 2026**
   Update Mar 26: The wellbeing offer has been expanded and now includes focussed on psychological and mental wellbeing offers. **Action Completed.**
3. Our Voice Programme commenced with regular reports to People Committee and Executive Directors Group on a bi-monthly basis. **Target Completion Date: March 2026**
   Update Mar 26: Action completed; quarterly reporting to PC is now in place and aligned with the Improvement Plan.
4. ~~Regular meeting and expansion of Community voices group. **Target Completion Date: March 2026**~~ Moved to CO6
5. Reset Programme launches end of September / early October to support high levels of organisational change
   Update Mar 26: **Action Completed**
6. Refreshed EDI Assurance Group established in Quarter 1. Ongoing review
   Update Mar 26: Group is now chaired by CPO with reporting lines into the People Committee. **Action Completed.**
7. Refreshed presentation of EDI to People Committee to provide more helicopter position in Quarter 1, Ongoing review
   Update Mar 26: Action completed now with a full report going to EDI Assurance Group and People Committee (including WRES/WDES, Gender Pay Gap reporting metrics)

Gaps in Control

Existing controls are supported by sufficient assurance, and no gaps have been identified through current reporting and oversight mechanisms.

Gaps in Assurance

Assurance is assessed as complete at this time, with no gaps currently identified. Routine monitoring will continue to ensure emerging gaps are detected promptly.

Notable changes since previous iteration

The BAF was reviewed at People Committee. There is no proposed change in risk score or Appetite and all actions have been updated.

CO.6: Ensure that our workforce reflects the population we serve | **EXECUTIVE LEAD: CHIEF PEOPLE OFFICER (CPO)**

26/27 Improvement Priority: Build a representative and inclusive workforce where "we all belong"

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

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

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

20
10
0
Nov-24 Feb-25 May-25 Aug-25 Nov-25

Link to Risks on Corporate Risk Register

6418 (16) Resident Doctor staffing levels
6422 (16) General Surgery CT on call rota
6438 (15) Insufficient staffing within the pharmacy team is leading to reduced service provision
6498 (16) Changes to Additional Clinical Activity Pay (Locum bank rates) for Resident and SAS Doctors

Issues impacting achievements of our objective

- Failure to have an inclusive and diverse workforce representative of the population.
- Widening health inequalities impacting care provision, reputation, recruitment and retention
- ~~A slowing down in recruitment may reduce our aspiration to increase the % of staff with protected characteristics, reflecting the population that we serve~~

26/27 Trust Level Outcome Aims

- To have a workforce representative of population served as measured by WRES/ WDES
- Year-on-year improvement in % staff with protective characteristics reflective of the population we serve.
- Staff disability declaration rates in line with the NHS national average (baseline 5.2%)
- >80% of staff with a declared disability receiving adequate workplace adjustments (baseline of 73.2%)
- Improvement in staff declaration rates for: religion 85% and sexual orientation 87%
- Reduction in any disparity in appointment rates between White / non-disabled and BME / disabled applicants by 50% within 12 months
- Reduction in any disparity of BME/disabled staff experiencing bullying, harassment or discrimination from any source by 50% within 12 months
- Achievement of 90% Oliver McGowan (LD & autism) e-learning by 30/09/26
- With Tier 1 and Tier 2 delivery programme approved by 30/06/26

Controls

- Our People Plan
  - People
  - Resourcing Plan
- Culture
  - Equality, Diversity and Inclusion Plan 2022-26
- Attendance and membership of Bolton wide People and culture group.
- Equality Diversity and Inclusion Strategy
- Equality Impact Assessments / Equality analysis
- Health Inequalities Enabling group
- Staff networks and forums representing diverse groups

Assurances

1st line of Defence (Operational management)

- Staff Survey (quarterly and annually)
- WRES and WDES (quarterly and annually)
- EDI Assurance Committee
- Staff Experience Inclusion Steering Group

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

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

3rd Line of Defence (Independent or external assurance)

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

Actions (CPO)

1) Regular meeting and expansion of Community voices group. **Target Completion Date: March 2026** **Mar 26 Update**: Ongoing with regular reviews. **Revised Target Date: Q2 2026**

2) EDI Plan to be revised and complement the existing People Plan. **Revised Target Completion Date March 2026** **Mar 26 Update**: Ongoing with regular reviews **Revised Target Date: Q2 2026**

3) Refreshed EDI Assurance Committee established in Quarter 1. Ongoing review **Mar 26 Update**: Ongoing with regular reviews **Revised Target Date: Q2 2026**

4) Refreshed presentation of EDI to People Committee to provide more helicopter position in Quarter 1, Ongoing review **Update Mar 26**: **Action completed** now with a full report going to EDI Assurance Group and People Committee (including WRES/WDES, Gender Pay Gap reporting metrics) **Revised Target Date: Q2 2026**

Gaps in Control

Existing controls are supported by sufficient assurance, and no gaps have been identified through current reporting and oversight mechanisms.

Gaps in Assurance

Assurance is assessed as complete at this time, with no gaps currently identified. Routine monitoring will continue to ensure emerging gaps are detected promptly.

Notable changes since previous iteration

The BAF was reviewed at People Committee. There is no proposed change in risk score or Appetite and all actions have been updated.

AMBITION 3: A HIGH PERFORMING, PRODUCTIVE ORGANISATION

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

CO7: Improving access to our services — EXECUTIVE LEAD: CHIEF OPERATING OFFICER

26/27 Trust Priority: People have improved timely access to care and are seen, in the right place at the right time by right person.

Risk Appetite: MINIMAL

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

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

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

20
10
0
Nov-24 Feb-25 May-25 Aug-25 Nov-25 Feb-26 May-26

Link to Risks on Corporate Risk Register

5425(16) *Delivery of Urgent Care Performance Standards*
695 (5) *Emergency Planning Risks (Catastrophic for Impact)*
6193 (16) Reduced bed capacity DUE TO RAAC within the Maternity
6145(15) Maternity Theatres ventilation failures
5424 *- Elective Care Delivery*

Issues impacting achievements of our objective

- Increased waiting list size and cancer backlog size since 19/20 baseline
- Insufficient capacity within the Emergency Department to deal with the demand
- Failure to timely discharge plan & apply SAFER ward standards
- Discharge capacity frequently does not meet demand
- Failure to deliver against nationally mandated performance standards

KPIs / Measures

- Annual improvement in timeliness of care – including:
  - reduced wait times for appointments and treatment
  - response to requests
  - and length of stay
- Deliver annual operating plan standards
- Delivery of medium term submitted plan for 26/27
- Achievement of 82% - 4 hour ED in March 2027
- Achieve 2% DM01
- 7% improvement in RTT

Controls

- Trust policies including (Escalation, Access, Discharge)
- Joint system working with NWAS, Council and ICS to admission avoidance, streaming from ED and discharge
- System Co-ordination Centre Meetings previously (SCC)
- Joint working with GM on cancer pathways to ensure equality of access across GM
- Regular validation of waiting lists strengthened by Internal audit review and completion of recommendations
- Escalation Policy, Revised Access Policy and Discharge Policy now refreshed and implemented
- Urgent and Elective care assurance meeting with GM
- ~~Tier 2 meetings with the regional team about elective care delivery.~~
- ~~Support from the Elective Care Improvement Team (ECIST)~~
- Support from the Emergency Care Intensive Support Team (ECIST) when requested
- Capacity & Demand planning cycle
- Sustainability Plan 26-29

Assurances

1st line of Defence (Operational management)

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

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

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

3rd Line of Defence (Independent or external assurance)

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

Actions

1. Refreshed Capacity & Demand cycle **Revised target completion date December 2025)**
   Update Nov 25: Capacity and demand have been completed for all Divisions using the Intensive Support Team (IST)model. More bespoke reviews will be completed where needed. Check and Challenge sessions have also taken place with each Division to ensure that the assumptions made are used in the next operational planning round.
   Update Mar 26: This is now incorporated into our annual planning process. **Action Completed**.

2. Development of a workplan following conclusion of the Internal Audit review of waiting list management. **(Target Completion Date December 2025)**
   Update Nov 25: All actions from the waiting list audit are complete
   Update Mar 26: The recommendations from the internal audit review are now completed. Further monitoring of compliance to be presented to QAC. **Action Completed.**

3. Full Implementation of actions following the ECIST review for both Emergency and Elective Care. **(Target Completion Date March 2026)**
   Update Nov 25: Phase one actions for Emergency Care have been completed and Phase 2 actions are now underway. Elective actions are captured in the Elective Improvement Programme and are underway.
   Update Mar 26: The improvement plans continue to be implemented with refreshed plans being developed for 2026/27. Action progressing
   Revised Target Date: Sep 26

Gaps in Control

~~Lack of monitoring of the effectiveness of Access policies~~

Weak monitoring of the implementation of ward SAFER principles

~~Lack of a robust Capacity & Demand planning cycle~~

Refreshed ED Improvement Plan

Gaps in Assurance

Notable change from previous iteration of the BAF

This Strategic Risk of the BAF has been reviewed by the Chief Operating Officer.

All actions are progressing as planned, with two actions now completed and moved into Controls. A new target date has been requested against Action 3.

There is no proposed change in Risk Appetite. However, the QAC is asked to consider the proposed increase in score from 16 to 20.

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

26/27 Improvement Priorities: Our services are committed to being efficient, productive and making the most of the Bolton pound

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

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

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

Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

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

KPIs / Measures

- Deliver year on year improvements in productivity and efficiency
- Achieve our annual plan targets
- Processes, workflows and pathways are streamlined resulting in minimised waste and optimised recourse allocation and reduced duplication
- Improved service performance to the highest benchmarking quartiles in Model Hospital and GIRFT, enhancing overall quality of care and productivity
- Improve outpatient clinic utilisation to 90% by 31/03/27
- Increase theatre utilisation (capped) 85% by 31/03/27
- Increased day case rates 80% by 31/03/27
- Minimum 2% productivity target across all specialities by 31/03/27

Controls

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

Assurances

1st line of Defence (Operational management)

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

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

- Integrated Performance Reports to F&I and Board
- Operational Update to Board
- Monthly Finance Report to F&I
- Monthly report to F&I detailing activity levels and performance along with regular updates on service profitability
- Finance Report to Board from CFO

3rd Line of Defence (Independent or external assurance)

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

Actions

1. Use of patient-level costing and income reporting at Divisional level benchmarking. **Target Completion Date: Q2 2025/26** Action Progressing with monitoring through Performance Transformation Board. Information is now produced and shared quarterly and will be included in Division Improvement Plan.
   Update Mar 26: A new Income Improvement Group has been established to optimise income and review PLICs and SLR information as parr of BAU process to drive transformation and cost improvement. **Revised Target Date: Q3 26**

2. Understand impact of contract reconciliation work and implications of the 10 year plan. **Target Completion Date: Q3 2025/26**
   Action Progressing and will become clearer as part of the national workstream and planning round. Expected to progress into Q4 as part of Medium-Term Planning
   Update Mar 26: This will become part of BAU processes now as the national work has completed and will be updated routinely to F&I and as part of annual planning. **Revised Target Date: Q3 26**

3. Improved activity and income reporting **Target Completion Date: Q3 2025/26**
   Action Progressing and will continue to be monitored through Performance Transformation Board.
   Update Mar 26: The new income improvement group will receive and oversee improved reporting and drive associated actions **Revised Target Date: Q3 26**

4. Expanded use of Model Hospital benchmarking reporting. **Target Completion Q.4 2025**
   Action Progressing **(moved from CO9)**
   Update Mar 26: Model hospital and other benchmarking is being used to drive transformation and CIP. This is now ongoing and BAU. **Revised Target Date: Q3 26**

Gaps in Control

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

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

Long term financial model

Gaps in Assurance

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

Notable change from previous iteration of the BAF

Strategic Risk 9 *Being efficient and productive* of the BAF has been reviewed by the Chief Finance Officer. The framework continues to reflect the organisation's current risk posture and mitigation efforts.

All actions are progressing as planned, with new target dates requested and specified alongside each action.

There is no proposed change to the Risk Score or Risk Appetite.

CO.9: Delivering Financial Sustainability	EXECUTIVE LEAD: CHIEF FINANCE OFFICER

26/27 Improvement Priorities: Provide the right care, in the right place, at the right time, while using our resources efficiently and effectively so everyone can stay within budget and income is maximised

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

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

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

20
10
0
Nov-24 Feb-25 May-25 Aug-25 Nov-25 Feb-26 May-26

Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

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

KPIs / Measures

- WTE Headcount reductions
- Deliver financial break-even and achieve financial sustainability
- A measurable increase in income/revenue growth (measured through recording gains, contract review, commercial opportunities)
- ~~Annual achievement of our Cost Improvement Programme~~
- Annual bank / agency spend
- Ensuring return on investment through regular review and evaluation of business cases and investments as agreed through Investment Assurance Group and CRIG
- Delivery of Cost improvement programme 5% by 31/03/27

Controls

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

Assurances

1st line of Defence (Operational management)

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

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

Reports to F&I including

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

3rd Line of Defence (Independent or external assurance)

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

Actions

1. Understand cost and income at budget level **Target Completion Q3 2025** **revised to Q1 2026**
   Update Nov 25: Action Progressing with Trust working at getting income at Divisional level. Due to restructure, new ledger work expected to progress into Q1 .2026
   Revised Target Date: Q3 2026

2. Clarity on GM Financial Strategy **Ongoing to be reviewed.** Action Progressing and is subject to latest guidance that has come through. Expected completion in Q4 which will support with our development of our own plan in line with national plans.
   Update Mar 26: This is ongoing and superseded by the national planning process and payment rules. **Action Completed.**

3. Implement the outcome of the Drivers of Deficit Financial improvement work and resulting Action Plan. **Target Completion Q3 2025**
   Action expected to carry on into Q4.
   Update Mar 26: Implementation is ongoing. MIAA undertaking a review of actions. **Revised Target Date: Q3 2026**

Gaps in Control

- ~~GM ICB overarching strategy~~

Gaps in Assurance

- Model Hospital benchmarking reporting to F&I Committee

Notable change from previous iteration of the BAF

Strategic Risk 9 *Delivering Financial Sustainability* of the BAF has been reviewed by the Chief Finance Officer. The framework continues to reflect the organisation's current risk posture and mitigation efforts.

All actions are progressing as planned, with new target dates requested and specified alongside each action.

There is no proposed change to the Risk Score or Risk Appetite.

AMBITION 4: AN ORGANISATION THAT IS FIT FOR THE FUTURE

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

CO.10a - Being digitally enabled and inclusive — EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS

26/27 Improvement Priorities: Improving care and experience by strengthening our digital foundations and using innovation to support and empower staff and patients

Risk Appetite: MINIMAL

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

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

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

Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

- Availability of investment for Digital programmes against need and expectations
- Digital exclusion within Bolton which can lead to health inequalities
- Availability of digital staff to support growing demand
- Increased demand for data and information
- Investment for the right technology to allow an effective recovery time

KPIs / Measures

- ~~Year on Year~~ Improvement in the Digital maturity matrix level score by 30/06/26
- Regular updated capacity and demand data
- Full EPR rollout 2026
- Increasing the number of specialties in which Patients will have digital access to Self Help Information & Information about procedures
- ~~Sub-KPI: Publication of a clear plan for agile working 2025~~
- 8 Pyxis cabinets deployed across the Maternity new build 31/03/27
- Rebuild EPR med catalogue to facilitate Community prescribing 31/03/27
- Implementing Electronic Blood Transfusion workflows to improve clinical safety of blood administration. 30/09/26
- Patient Knows Best (PKB) in applicable services by 30/06/26
- Implementation of Maternity into the Trust wide EPR 31/03/27

Controls

- Board approved Digital Plan
- Lead Bolton Borough wider Partnership
- Digital Performance and Transformation Board
- Digital Maturity Matrix
- Data Protection Toolkit Annual assessment
- External and Internal Audit reports
- Digital Teams manage delivery of programme based on good practice project methodology
- Divisions included in the Digital Performance and Transformation Board to ensure they have oversight of the Digital program
- Community and OPD rollout of the Electronic Patient Record (EPR)
- Laboratory Information Management System software system used to manage and track laboratory samples, associated data, and laboratory workflows

Assurances

1st line of Defence (Operational management)

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

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

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

3rd Line of Defence (Independent or external assurance)

- NHS Digital Toolkit
- Internal Audit Reviews
- Use of resources benchmarking
- Cyber Security national assessments
- Digital and Data capacity and demand assessment by internal audit

Actions (Chief of Strategy and Partnerships)

1. Refresh Digital Strategy – **Target Update Date: July 2026** Action progressing
   Update Mar 26: Strategy development in progress and in line with completion date.
2. System for staff feedback – **Target Completion Date: March 2025**
   July 25 update: Complete
   Update Nov 25: Quarterly survey in place. Action plan and *you said we did* to be put in place
   Update Mar 26: Continue to obtain quarterly feedback and action plan in place to resolve staff feedback.
3. Maternity EPR Rollout – **Target Completion Date: March 2026**
   Action progressing risk to the February implementation due to complexities of configuration. Working with Clinical and Digital Teams to understand this risk
   Update Mar 26: February 2026 go-live was deferred in agreement with F&I. Programme replanning has been undertaken and revised go live date to be presented to F&I committee in March 2026.

Gaps in Control

- Require system to understand and respond to staff feedback on Digital support
- Digital Strategy to be refreshed 2026
- Implementation and ongoing optimisation of the Electronic Patient Record (EPR) in Maternity (supports safer, more efficient, and more reliable patient care by improving data accuracy, accessibility, and security).
-

Gaps in Assurance

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

Notable changes from previous iteration of the BAF

Strategic Risk 10a Being *digitally enabled and inclusive* of the BAF has been reviewed by the Chief of Strategy and Partnerships. The framework continues to reflect the organisation's current risk posture and mitigation efforts.

All actions are progressing as planned, with new target dates requested and specified alongside each action.

There is no proposed change to the Risk Score or Risk Appetite.

CO.10b - Being resilient against Cyber Threats | **EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS**

26/27 Improvement Priority: Improving care and experience by strengthening our digital foundations and using innovation to support and empower staff and patients

Risk Appetite: AVOID

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

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

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

Link to Risks on Corporate Risk Register

5869 (20) – Cyber attack

Issues impacting achievements of our objective

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

KPIs / Measures

- Meeting "Standards Met" of the Data Security and Protection Toolkit year on year
- Achieving Informatics certifications, such as:
  - ISO 27001 and
  - Secure Email Standards (DCB1596)
  - .
- Monthly reports to Digital Performance Transformation Board
- Incidents with lessons learnt reports
- Improvement log from ISO 27001
- Digital literacy and competence training needs analysis and associated training plan complete by 30/06/26

Controls

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

Emergency planning

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

Assurances

1st line of Defence (Operational management)

- Reports to the Digital performance and transformation Group
- A report on unsupported systems and data protection implications presented IG Group
- Informatics, Cyber and IG Risks presented to Risk Mgt Group
- All at risk systems have support in place, or the cyber risk is assessed and appropriately mitigated
- Reports to Cyber Steering Group
- Digital updates to Finance & Investment Group
- Bi-monthly report to the Information Governance Group with cyber security KPIs, including:
  - Unsupported systems and hardware
  - Patching stats
  - Cyber security alerts from NHSE (old CareCerts), e

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

- Yearly submission of the DSPT to the board
- Bi-annual review of DSPT at Audit and Risk Committee
- 6 monthly digital updates to board
- Monthly review of DPTB risks at F&I

3rd Line of Defence (Independent or external assurance)

- Independent assurance reports from Internal and external audit reviews
- ISO 27001 certification and surveillance audit reports
- Secure Email Standards (DCB1596)
- Yearly penetration test
- DSPT external audit to Audit & Risk committee

Actions (Chief of Strategy and Partnerships)

1. Review of digital team responsibilities to put a dedicated Cyber security role in place. **Target Completion Dec 2025**
   Mar 26 Update: Role continues to be undertaken by the level three technical team. Job description and business case is under developments to be submitted to CRIG April 2026.
   Revised Target Date: July 2026
2. Cyber Subgroup to be established with the needed representation from divisions **Target Completion Dec 2025.** **Update Nov 25:** Action progressing Terms of Reference has been created but we are looking for an external chair to assess the work that IT does as part of cyber.
   Mar 26 Update: 1st meeting is taking place March 2026, with the new chair and stakeholders. **Action Completed**
3. Complete the recommendations from the Toolkit submission and MIAA report **Target Completion Dec 2025** Action progressing. Some progress has been made; however, we are currently dependent on the divisions to provide key information, including details about contracts and business continuity plans, etc. due to this the deadline has been extended to December. 13/42 recommendations have been closed.
   Mar 26 Update: The Improvement Plan was completed and submitted to NHSE in December 2025, and the Trust achieved full DSPT compliance for 2024–25. **Action Completed**
4. Penetration test recommendation to be prioritised and actioned by Digital Services. Target Completion March 2026. For the recommendations provided by the external company there has been a progress of 59% of completed task as part of the report.
   Update Mar 26: Penetration testing completed action in place being reported through DPTB and via the new Cyber Group. Development of Business continuity plans for all Essential Functions on track. **Revised Completion Date: July 2026**

Gaps in Control

- Completion of the recommendations from the cyber security review
- Completion and implementation of the recommendations from the IT Disaster Recovery Review
- Completion of business continuity plan for essential functions, covering all critical systems used across the Trust

Gaps in Assurance

- Performance Monitoring should be reviewed to included cyber KPIs measures to be consider for a holistic assessment.
- The Trust should reinstate the Cyber Security Group across the Trust with the representation from essential functions, for example LabMed, Radiology, Pharmacy, EBME. This will report into IG Committee
- Status of BCP must be reviewed by EPRR BC Group

Notable changes since previous iteration of the BAF.

Strategic Risk 10b Being *resilient against Cyber Threats* of the BAF has been reviewed by the Chief of Strategy and Partnerships. The framework continues to reflect the organisation's current risk posture and mitigation efforts.

All actions are progressing as planned, with new target dates requested and specified alongside each action.

There is no proposed change to the Risk Score or Risk Appetite.

CO.11 – Improving our estate and deliver against Net Zero targets and infrastructure compliance | **EXECUTIVE LEAD: CHIEF FINANCE OFFICER**

26/27 Trust Priorities: Consolidation of buildings and maximising the use of Bolton health economy spaces to help us work more efficiently, reduce costs, and ensure our facilities meet the needs of patients and staff

Risk Appetite: AVOID

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

STRATEGIC RISK 11: If the Trust fails to provide compliant and reliable premises and infrastructure, then it may compromise safety and operational effectiveness, lead to service disruption and statutory breaches, and significantly hinder progress towards NHS net zero and environmental goals.

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

Link to Risks on Corporate Risk Register

5747 (15) Substation 10 Air circuit breaker replacements
~~3194 (16) Outdated ventilation systems within ophthalmology~~
6145 (15) Maternity Theatres ventilation failures
5929 (15) Site wide roofing repairs

Issues impacting achievements of our objective

- Shortage of capital and revenue funding
- Changes to capital regime
- High levels of backlog maintenance
- Planning, traffic constraints to the site
- Controllability of community estates not owned by BFT
- PDC bids/funding not linked to Strategy
- Shortage of cash
- Inability to meet national sustainability objectives and potential breach of regulatory non-compliance

KPIs / Outcome measures

- Achievement of our Green Plan targets with a focus on annual improvement towards net zero,
- Year on Year improvement in estates utilisation
- Improved safety and compliance through a year-on-year reduction in backlog maintenance
- IMC (N Block) – delivered 30/06/26
- Ophthalmology Theatres – delivered by 30/09/26
- Labs – delivered by 31/03/27
- Electrical Substations – delivered by 31/03/27
- Phase 2 - Ward refurbishment, 4 wards complete 31/03/27

Controls

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

Assurances

1st line of Defence (Operational management)

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

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

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

3rd Line of Defence (Independent or external assurance)

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

Actions

1. Production of a shared vision for the site and neighbouring land.
   Support the Partners of Health Innovation Board to develop a shared vision via monthly delivery board meetings. **Target Completion Date**: ~~**December 2025**~~ **Revised to Q3 26**
   Update Mar 26: Vision document has been reviewed by Strategic Estates Group and work is ongoing. Business cases will come to Board as needed for approval.
2. Monitor and manage the aging estate and escalate urgent issues with the estates. - Additional PDC bids submitted to support critical infrastructure works.
   Target Completion Date: ~~**Dec 2025**~~ **Revised to Q3 26**
   Update Mar 26: This is an ongoing action with a three-year rolling capital programme aimed at reducing backlog maintenance.
3. Review and formalisation of Strategic Estates Group to F&I. Continue to meet monthly to track progress with business cases and updates to the Executive and Board.
   Target Completion Date: ~~**Q3 2025**~~ **revised to Q2 2026**
   Update Mar 26: A review of the ToR for the Strategic Estates Group and Our Green Group is underway with a view to prepare a AAA Report the Executive Committee for escalations.

Gaps in Control

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

Gaps in Assurance

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

Notable changes since previous iteration of the BAF

Strategic Risk 11 *Improving our estate and deliver against Net Zero targets and infrastructure compliance* of the BAF has been reviewed by the Chief Finance Officer. The framework continues to reflect the organisation's current risk posture and mitigation efforts.

All actions are progressing as planned, with new target dates requested and specified alongside each action.

There is no proposed change to the Risk Score or Risk Appetite.

CO.12 – PROACTIVELY PLANNING FOR THE FUTURE | EXECUTIVE LEAD: CHIEF FINANCE OFFICER

26/27 Trust Priorities: Establish an Improvement Board that oversees a joined-up approach to strategy, planning and transformation, ensuring priorities are aligned and progress is delivered consistently across the organisation

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

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

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

20
10
0
Nov-24 Feb-25 May-25 Aug-25 Nov-25 Feb-26 May-26

Link to Risks on Corporate Risk Register

6245 (16) Elective Care microscope obsolescence issued

Issues impacting achievements of our objective

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

KPIs / Measures

- Improved accuracy and timeliness in forecasting service demand, leading to optimised resource allocation, strategic planning and enhanced decision making
- Comprehensive understanding of long-term healthcare trends, their impact on our services and plans in place to address
- Estates and capital planning based on data and intelligence on demographic and demand changes
- % of clinical services that have access to demographic data and disease prevalence and use this to inform planning
- Sub-KPI: Approach to workforce planning and service design informed by population health changes
- Sub-KPI: Succession planning effectiveness measured by the percentage of key positions with identified successors
- Improvement Board established and operational by 30/06/26
- Transformation and Improvement Programme in place by 30/06/26
- Delivery of 2026/7 CIP Programme with £26m value of schemes identified and green by 30/06/26
- Improvement of Trust position through the NOF framework specifically urgent care and finance
- 100% compliance of NHS EPRR Core standards by 31/03/27

Controls

- PMO coordination of CIP
- Annual budget setting and planning processes
- Finance department annual business planning process
- Finance and Intelligence Group reviews of productivity and actions to improve
- Financial Improvement Group
- Executive Pay Panel
- Discretionary Non-Pay Panel
- Variable / agency pay panel
- Training panel

Assurances

1st line of Defence (Operational management)

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

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

Reports to F&I Board

3rd Line of Defence (Independent or external assurance)

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

Actions

1. Understand cost and income at Divisional and specialty level through at budget level. Profitability by service is produced quarterly with oversight from the Executive. Divisions to develop improvement plans using this information to drive profitability. Target Completion Date Q3 2025/26.
   Update Mar 26: Work is ongoing through the Income Improvement Group. Expected to be ongoing through to Q2 2026. **Revised Target Date Q3 26**.

2. *Closer / joint local working in Bolton System.* Ongoing through Locality Board meetings.
   Update Mar 26: Board meetings are becoming less frequent and changes due to the ICB reorganisation are affecting this trend. **Revised Target Date Q3 26**.

3. Clarity on GM Financial Strategy which would inform local Strategic Planning. Awaiting national planning guidance.
   Update Mar 26: This document has been superseded by the national planning guidance.

4. Ongoing revision of the three-year Financial Outlook. Long Term Financial Plan under development to inform the improvement plan Target Completion Date: Mar 26
   Update Mar 26: Completed and incorporated into the Medium-Term Plan (MTP). **Revised Target Date Q3 26.**

5. Enhanced workforce controls and reporting triangulated with activity and finance Medical, variable pay panels in place. Additional controls for bank and agency. Long term financial model with drive triangulation. **Target Completion Date Q2 25/26. Update Mar 26**: Work has progressed to triangulate monthly workforce numbers with financial run rates and included in the F&I report. People and F&I committees review in detail **Revised Target Date Q3 26**.

Gaps in Control

Pay and non-pay controls require further enhancement

Gaps in Assurance

- Model Hospital benchmarking reporting to F&I Committee

Notable changes since previous iteration of the BAF

Strategic Risk 12 *Proactively planning for the future* of the BAF has been reviewed by the Chief Finance Officer. The framework continues to reflect the organisation's current risk posture and mitigation efforts.

All actions are progressing as planned, with new target dates requested and specified alongside each action.

There is no proposed change to the Risk Score or Risk Appetite.

AMBITION 5: A POSITIVE PARTNER

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

CO13: Developing our neighbourhoods — EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS

26/27 Trust Priorities: Provide care to as many people as possible in the community

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

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

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

Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

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

Outcome Measures

- Staff report that neighbourhood working is improving the care, experience and outcomes of the people we serve
- Patient, service user and carer feedback demonstrates that neighbourhood working has improved their care, experience and outcomes
- Increase in the number of services that are provided in the neighbourhood footprint
- Neighbourhood leaders report that they are able to use data and intelligence to inform the health and care priorities for their neighbourhood
- Percentage reduction in preventable hospital admissions as our neighbourhoods mature
- Delivering the measures set out in the community business case by 31 March 2027

Controls

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

Assurances

1st line of Defence (Operational management)

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

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

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

3rd Line of Defence (Independent or external assurance)

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

Actions

1. Refresh and embed the Locality Plan and ensure delivery. **Target Completion Date: March 2026**
   Update Mar 26: Delivery of the Locality Plan continues and the Neighbourhood Plan has been refreshed. **Revised Target Date: Q3 2026**

2. Implement regular stakeholder engagement forums. Target Completion Date: March 2026. Completed through the neighbourhoods including the use of patient stories.
   Update Mar 26: Action now completed.

3. Ensure timely and clear communication of decisions and developments. **Target Completion Date: March 2026**
   Update Mar 26: Ongoing with regular reviews. **Revised Target Date: Q3 2026**

4. Monitor stakeholder feedback and adjust communication strategies accordingly. **Target Completion Date: March 2026** Ongoing reviews at Voice and Influence Group.
   Update Mar 26: Live Well project Breightmet piloting different ways of engaging with and communicating with communities with good outcomes. **Revised Target Date: Q3 2026**

5. Develop Provider Collaborative Board to further develop the Neighbourhood offer and support the roll out of the Proactive Care model. Workshops in place with partners to scope Provider Collaborative
   Update Mar 26: Neighbourhood Plan has been refreshed work continues with the ICB to develop provider collaborative. BFT continue to roll out the Business Cases for Proactive Care. **Revised Target Date: Q3 2026**

6. Deliver against the Bolton Outcomes Framework
   November 25 Update: Quarterly monitoring through the Locality Board
   Update Mar 26: Ongoing with Quarterly monitoring through the Locality Board

Gaps in Control

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

Gaps in Assurance

Assurance is assessed as complete at this time, with no gaps currently identified. Routine monitoring will continue to ensure emerging gaps are detected promptly.

Notable changes from previous iteration of the BAF

Strategic Risk *13: Developing our neighbourhoods* of the BAF has been reviewed by the Chief of Strategy and Partnerships. The framework continues to reflect the organisation's current risk posture and mitigation efforts.

All actions are progressing as planned, with new target dates requested and specified alongside each action.

There is no proposed change to the Risk Score or Risk Appetite.

CO.14 - Working as one team | EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS

26/27 Trust Priorities: We use every opportunity we can to improve the health of our patients

Risk Appetite: SEEK — We are willing to accept risks that may occur and would then lead to some degree of damage to its reputation, possible financial loss, exposure, or short term disruption to no more than one service area.

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

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

Chart axis: 20, 0; Nov-24, Feb-25, May-25, Aug-25, Nov-25, Feb-26, May-26

Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

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

Outcome Measures

- Working with partner organisations to agree integration priorities (i.e. shared systems) and delivering on these priorities
- Percentage increase in shared electronic health records linked to partner organisations
- Improvement in patient and service user satisfaction and feedback/decreased complaints
- Sub-KPI: Staff report an improvement in their ability to work across teams and with partner organisations to achieve organisational priorities
- Integration of Bolton Locality Outcomes Framework into FT governance by 01/04/26
- Realisation of improvement against KPIs measurable link to LOF 31/03/27

Controls

- Bolton Joint Strategic Needs Assessment (JSNA)
- Membership of Bolton Strategic Development and Partnership Meetings
- Bolton Locality Governance Structure
- Bolton Partner Communication Update
- Community engagement plan and meetings with partners at Locality
- Bolton Alliance Agreement to support the governance of the partnership
- Governors Monthly Update
- Membership Newsletter
- Quarterly update to Locality following BFT Board meetings
- Active Connected and Prosperous (ACP)
- Local pathology, radiology and pharmacy clinical service strategies.
- GM network agreements

Assurances

1st line of Defence (Operational management)

Deputy Place Based Lead attendance monthly at Executive Directors

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

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

3rd Line of Defence (Independent or external assurance)

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

Actions

1. Continued participation in GM working group to shape and influence the developing programme. **Target Completion Date: March 2026**
   Update Mar 26: GM work program in place with TPC priorities developed - ongoing progress updates, with regular reviews in place **Revised Target Date: Q3 26**
2. Implementation of GM PACs and LIMS procurements. **Target Completion Date: March 2026**
   Update Mar 26: **Complete** – LIMs and PACS now implemented as part of GM program. **Action Complete**
3. Finalisation of GM network agreements
   Update Mar 26: **Network arrangements Action complete.**
4. Development of Local pathology, radiology and pharmacy clinical service strategies. Target Completion Date: March 2026 workshops in place with partners to scope Provider Collaborative
   Update Mar 26: Complete GM work programmes in place. **Action Complete**
5. Develop Provider Collaborative Board. workshops in place with partners to scope Provider Collaborative
   Update Mar 26: development of Provider Collaborative still a priority but progress delayed due to the NHS reforms. **Revised Target Date: Q4 26**
6. Work with the ICB on developing the Place Based Partnership Team. ICB led workshops in place with partners to scope structure of the team
   Update Mar 26: work on the structure of the partnership team continues within the ICBs consultation. **Revised Target Date: Q3 26**

Gaps in Control

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

Gaps in Assurance

Assurance is assessed as complete at this time, with no gaps currently identified. Routine monitoring will continue to ensure emerging gaps are detected promptly.

Notable changes from previous iteration of the BAF

Strategic Risk 14: *Working as one team* of the BAF has been reviewed by the Chief of Strategy and Partnerships. The framework continues to reflect the organisation's current risk posture and mitigation efforts.

All actions are progressing as planned, with new target dates requested and specified alongside each action.

There is no proposed change to the Risk Score or Risk Appetite.

CO.15: Partnering for local benefit	EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS

26/27 Improvement Priorities: Increase services delivered in partnership with other providers and system partners to reduce costs, hand offs and duplication

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

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

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

20
10
0
Nov-24 Feb-25 May-25 Aug-25 Nov-25 Feb-26 May-26

Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

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

Outcome Measures

- ~~Readiness to be lead partner for Bolton Medical School in 2024/25~~
- 100% tenders published by BFT include a social value section
- % of total spend on goods and services from local suppliers
- Establish Provider Collaborative aligned to Bolton Locality Outcomes Framework and Locality Board assurance processes by 31/12/26
- A minimum of 3 priority services (e.g., UEC, frailty, out-of-hospital pathways) operating through integrated delivery models across providers by 31/03/27
- Each neighbourhood will have a robust plan that demonstrates targeted improvement against LOF indicators and CORE20PLUS 5 priorities (e.g., preventable admissions, experience measures, CORE20PLUS5 priorities), by 31/03/27 (Q2 baseline)

Controls

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

Assurances

1st line of Defence (Operational management)

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

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

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

3rd Line of Defence (Independent or external assurance)

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

Actions

1. Development of a stronger partnerships with local academic providers to develop a workforce pipeline – **Target Completion Date: March 2026**
   Mar 26 Update: expected to be ongoing with regular review. Library has moved into the Bolton Medical School Building, and first cohort of medical students start September 2025. Revised Target Date: Q3 2026.
2. Expansion of clinical courses and programmes mapped to workforce demand–**Target Completion Date: March 2026**
   Mar 26 Update: Action ongoing and expected to progress into Q3 2026. **Revised Target Date: Q3 2026**
3. Development of new programmes to fulfil recruitment issues e.g. health informatics. **Target Completion Date: March 2026**
   Mar 26 Update: Action ongoing and expected to progress into Q3 2026. **Revised Target Date: Q3 2026**
4. Production of a shared vision for the site and neighbouring land. **Target Completion Date: March 2026.**
   Mar 26 Update: Action ongoing and expected to progress into Q3 2026. **Revised Target Date: Q3 2026**

Gaps in Control

Substantive membership and participation in service transformation programmes within GM.

Development of Local pathology, radiology and pharmacy clinical service strategies

Gaps in Assurance

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

Notable changes from previous iteration of the BAF

Strategic Risk 15: Partnering *for local benefit* of the BAF has been reviewed by the Chief of Strategy and Partnerships. The framework continues to reflect the organisation’s current risk posture and mitigation efforts.

All actions are progressing as planned, with new target dates requested and specified alongside each action.

There is no proposed change to the Risk Score or Risk Appetite.

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Report Title:	Integrated Performance Report			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	26 March 2026		Discussion	✓
Executive Sponsor	Deputy Chief Executive/Chief People Officer		Decision	

Purpose of the report	To present the Month 11 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 February 2026. 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**

NHS

Bolton NHS Foundation Trust

Integrated Performance Report

February 2026

Guide to Statistical Process Control

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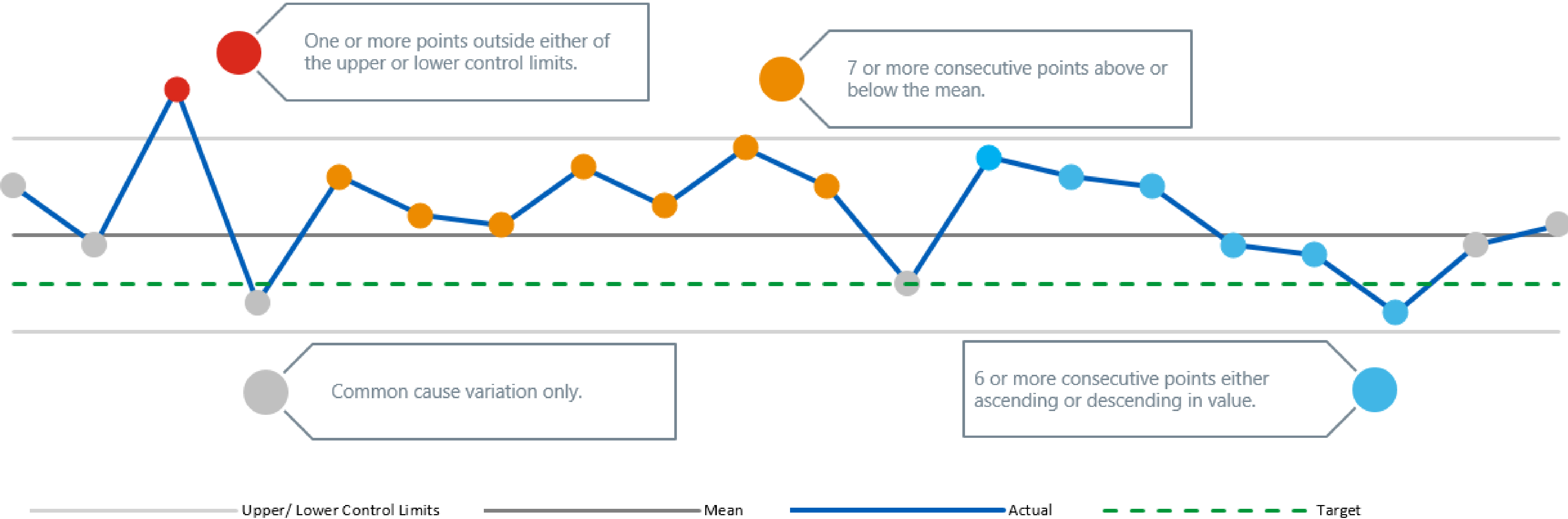
Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. Understanding how to react to data is the most important thing, not the detail of the statistical rules that underpin 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

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Trust Objective	Variation: Common cause	Variation: Improvement (High)	Variation: Improvement (Low)	Variation: Concern (High)	Variation: Concern (Low)	Assurance: Pass (P)	Assurance: Fail (F)	Assurance: ?
Quality and Safety								
Harm Free Care	11	2	4	0	2	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	13	0	0	0	3	2	0	14
Maternity	9	1	1	0	0	1	0	8
Operational Performance								
Urgent Care	10	1	1	0	1	2	7	4
Elective Care	7	1	5	1	1	1	7	4
Cancer	3	0	0	0	0	1	0	2
Community Care	6	2	0	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	2	0	0	0	1	1	0	2
Appendices								
Heat Maps								

Variation

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

Assurance

Icon	Description
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

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

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Quality and Safety - Harm Free Care

Pressure Ulcers

During the reporting period, Category 2 and Category 3 pressure ulcers across inpatient and community services remained within common cause variation, with community acquired Category 4 pressure ulcers also now in common cause variation. Hospital acquired Category 4 pressure ulcers continue to show sustained special cause improvement, with no cases reported since January 2025. Recent panel reviews reflect that most incidents occurred in the context of patients who were extremely unwell, approaching end of life, or presenting with significant frailty and complex clinical needs. Where opportunities for improvement were identified—such as clearer documentation of skin assessments, timeliness of repositioning records, or confirmation of equipment use—targeted education and local support have been provided, and equipment pathways have been reinforced. Oversight from the senior leadership teams remains in place to ensure learning is acted on and sustained.

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

Falls

Falls per 1,000 bed days remained within common cause variation with some expected seasonal fluctuation, and one fall resulted in harm during the reporting period. This incident has been reviewed by the Patient Safety Review Panel to ensure a full understanding of the circumstances and any opportunities for improvement. The review identified the need to strengthen staff awareness and consistent use of the enhanced care risk assessment within one ward area. In response, focused education, direct support from the senior leadership team, and enhanced monitoring have been put in place to ensure the assessment is used reliably and that appropriate care plans are implemented. These actions provide assurance that learning has been acted upon promptly and that oversight remains in place to support safe practice across the inpatient areas.

	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%	93.5%	Feb-26		>= 95%	94.8%	Jan-26	>= 95%	95.1%	
9 - Never Events	= 0	0	Feb-26		= 0	0	Jan-26	= 0	1	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	5.38	Feb-26		<= 5.30	5.68	Jan-26	<= 5.30	7.73	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	1	Feb-26		<= 1.6	3	Jan-26	<= 17.6	25	
15 - Number of Acute Inpatient incidences - pressure damage (category 2)	<= 6.0	8.0	Feb-26		<= 6.0	20.0	Jan-26	<= 66.0	133.0	
620 - Number of Acute Inpatient incidences - pressure damage (category 3 plus unstageables)	<= 1	3	Feb-26		<= 1	9	Jan-26	<= 6	46	
17 - Number of Acute Inpatient incidences - pressure damage (category 4)	= 0.0	0.0	Feb-26		= 0.0	0.0	Jan-26	= 0.0	0.0	

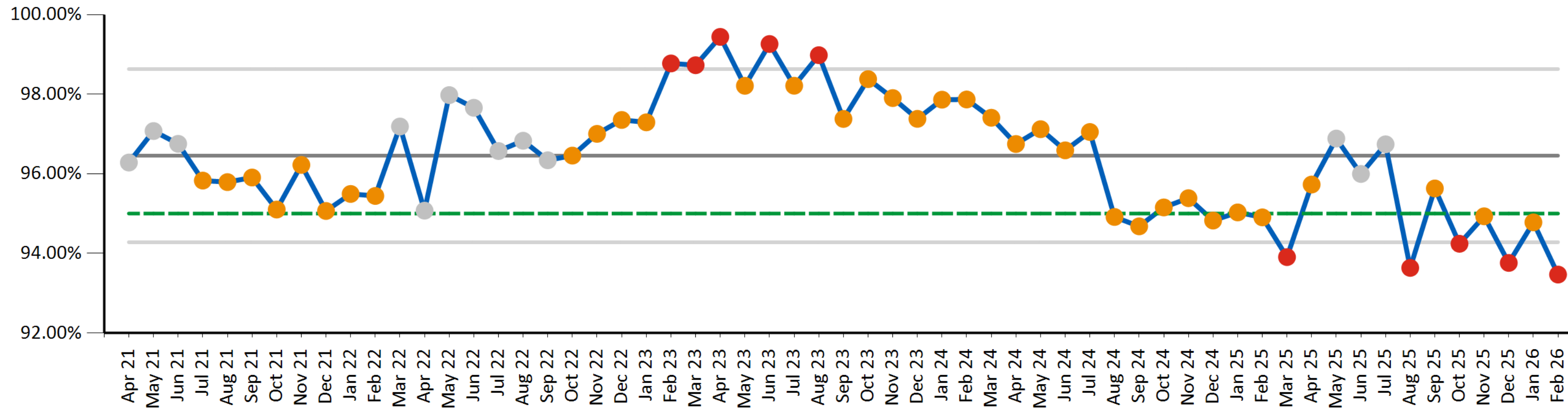
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
18 - Number of Community incidences - pressure damage (category 2)	<= 7.0	11.0	Feb-26		<= 7.0	14.0	Jan-26	<= 77.0	127.0	
621 - Number of Community incidences - pressure damage (category 3 plus unstageables)	<= 4	11	Feb-26		<= 4	7	Jan-26	<= 44	78	
20 - Number of Community incidences - pressure damage (category 4)	<= 1.0	1.0	Feb-26		<= 1.0	0.0	Jan-26	<= 11.0	11.0	
535 - Community patients acquiring pressure damage - significant learning category 2		0	Feb-26			0	Jan-26		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Feb-26			0	Jan-26		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Feb-26			0	Jan-26		0	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	77.1%	Feb-26		>= 95%	78.9%	Jan-26	>= 95%	77.9%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	59.1%	Feb-26		>= 95.0%	61.6%	Jan-26	>= 95.0%	60.4%	
86 - Patient Safety Alerts - Trust position	= 100%	100.0%	Feb-26		= 100%	100.0%	Jan-26	= 100%	77.3%	
88 - Nursing KPI Audits	>= 85%	95.1%	Feb-26		>= 85%	95.1%	Jan-26	>= 85%	96.0%	
91 - Patient Safety Incident Investigation turnaround performance by agreed deadline	= 100%	100.0%	Feb-26		= 100%	100.0%	Jan-26	= 100%		
8 - Same sex accommodation breaches	= 0	12	Feb-26		= 0	14	Jan-26	= 0	147	

6 - Compliance with preventative measure for VTE

Special cause variation with deteriorating performance

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

1/6



Latest

Plan	Actual	Period
>= 95%	93.5%	Feb-26

Previous

Plan	Actual	Period
>= 95%	94.8%	Jan-26

Year to Date

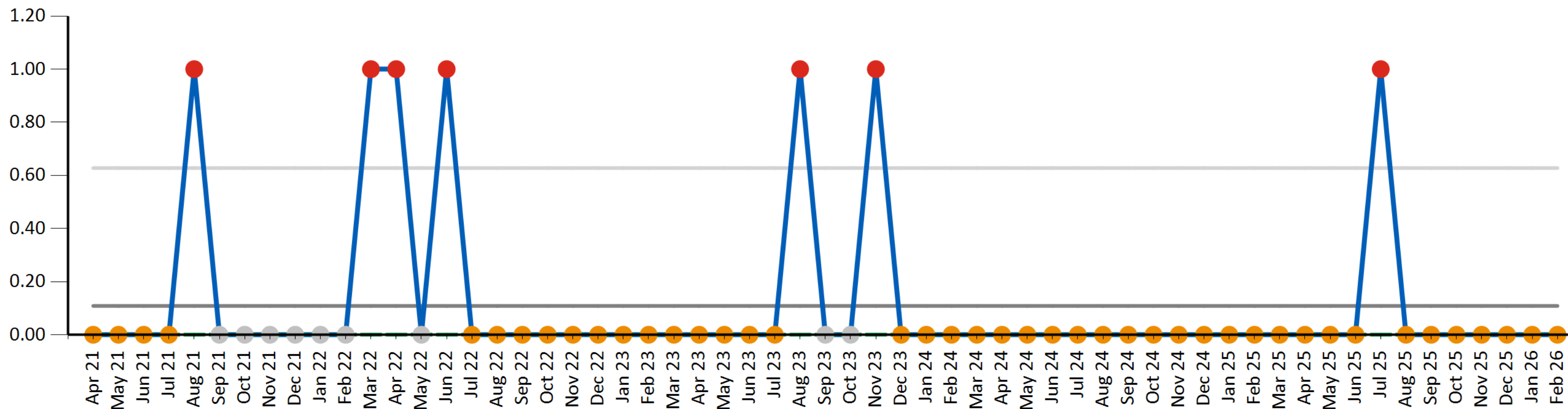
Plan	Actual
>= 95%	95.1%

9 - Never Events

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
= 0	0	Feb-26

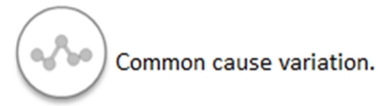
Previous

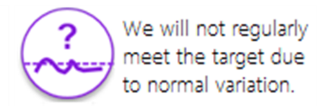
Plan	Actual	Period
= 0	0	Jan-26

Year to Date

Plan	Actual
= 0	1

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





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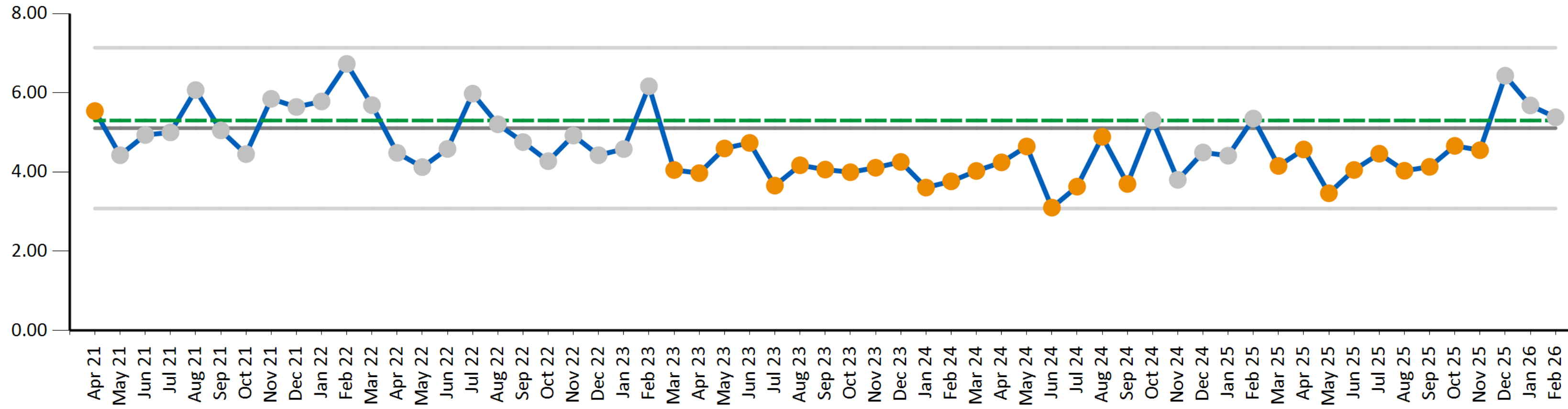


Latest

Plan	Actual	Period
<= 5.30	5.38	Feb-26

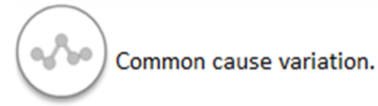
Previous

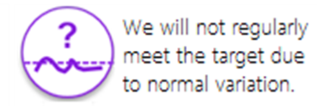
Plan	Actual	Period
<= 5.30	5.68	Jan-26

Year to Date

Plan	Actual
<= 5.30	7.73

14 - Inpatient falls resulting in Harm (Moderate +)





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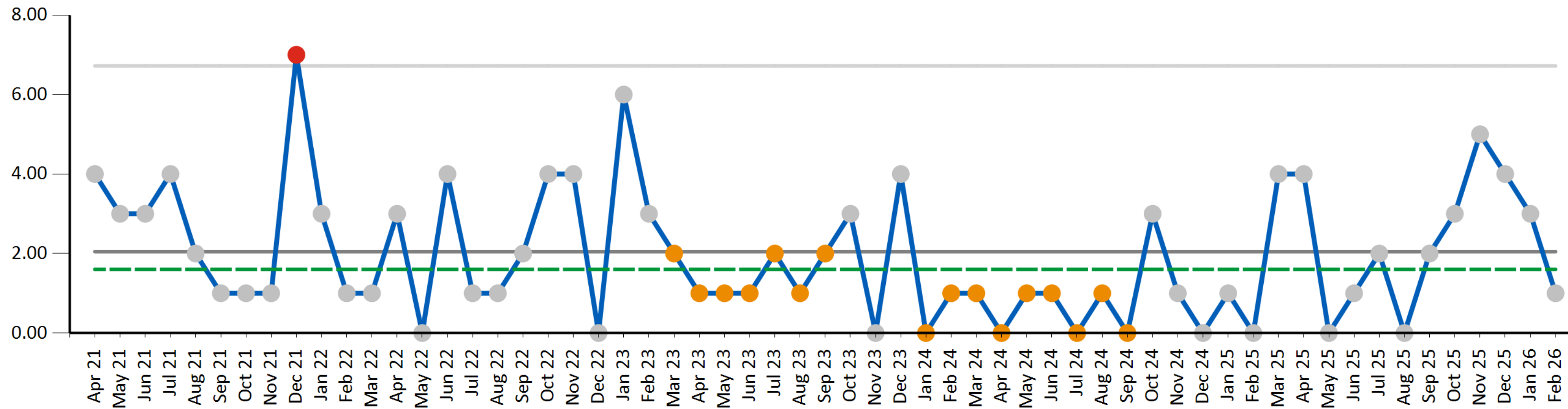


Latest

Plan	Actual	Period
<= 1.6	1	Feb-26

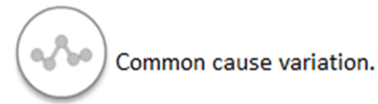
Previous

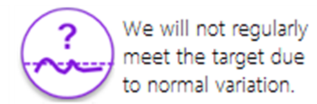
Plan	Actual	Period
<= 1.6	3	Jan-26

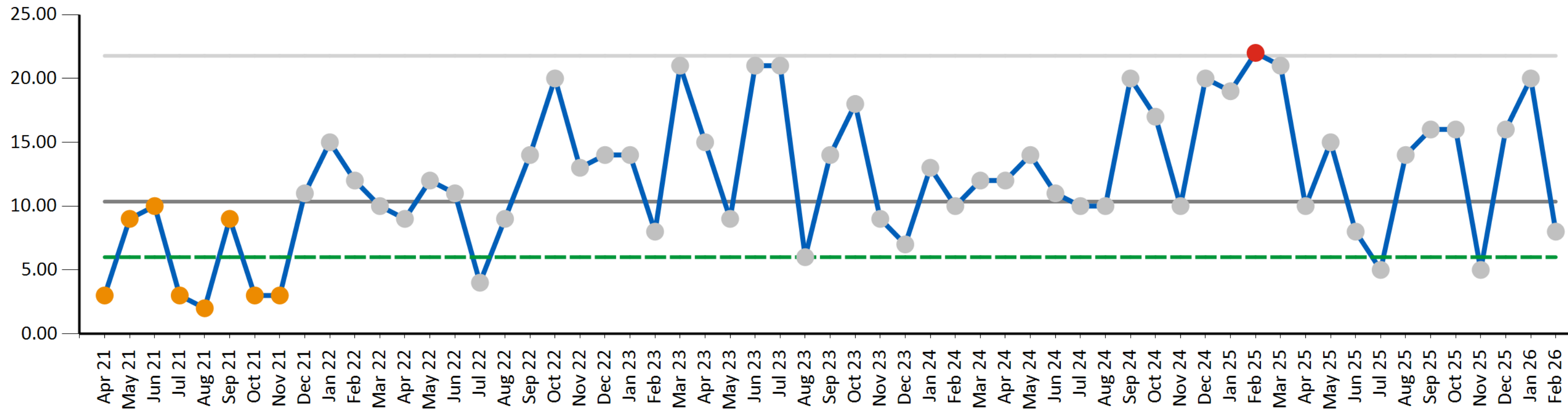
Year to Date

Plan	Actual
<= 17.6	25

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







Latest

Plan	Actual	Period
<= 6.0	8.0	Feb-26

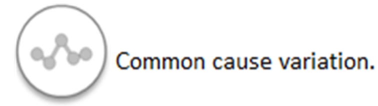
Previous

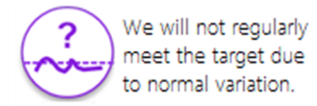
Plan	Actual	Period
<= 6.0	20.0	Jan-26

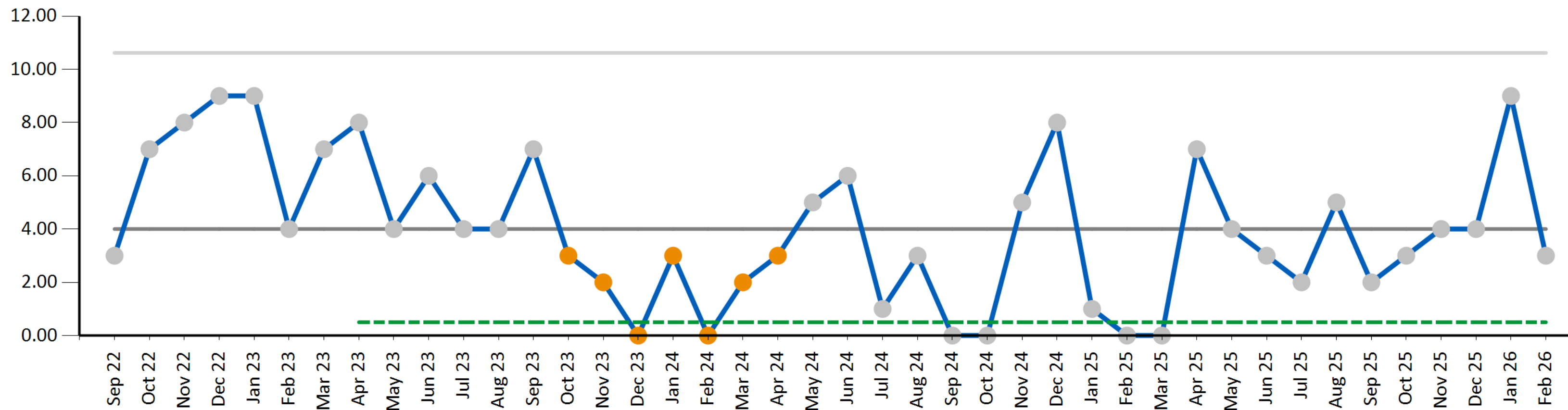
Year to Date

Plan	Actual
<= 66.0	133.0

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







Latest

Plan	Actual	Period
<= 1	3	Feb-26

Previous

Plan	Actual	Period
<= 1	9	Jan-26

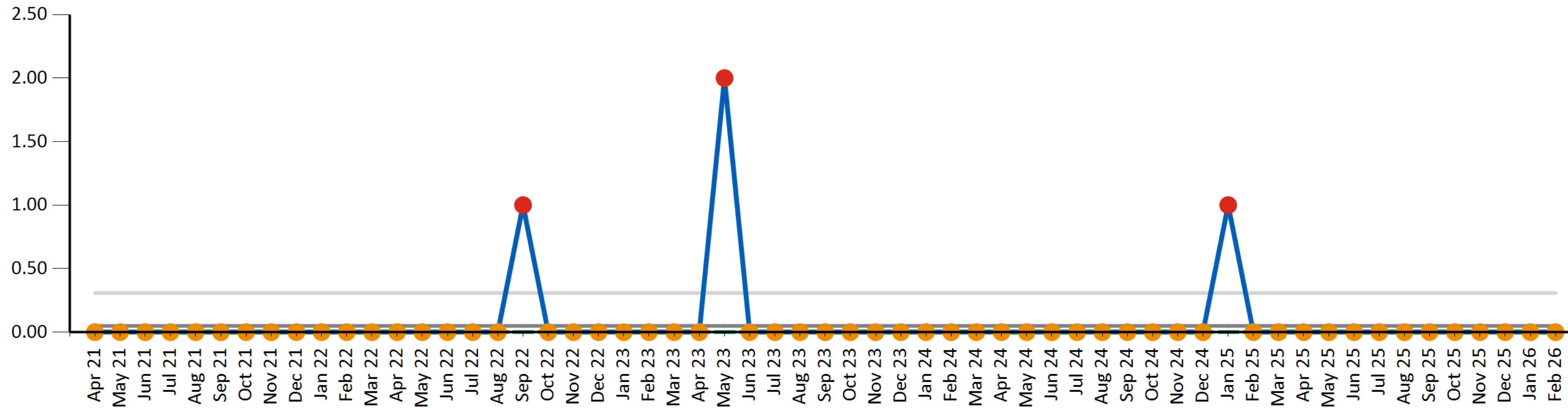
Year to Date

Plan	Actual
<= 6	46

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.



Latest

Plan	Actual	Period
= 0.0	0.0	Feb-26

Previous

Plan	Actual	Period
= 0.0	0.0	Jan-26

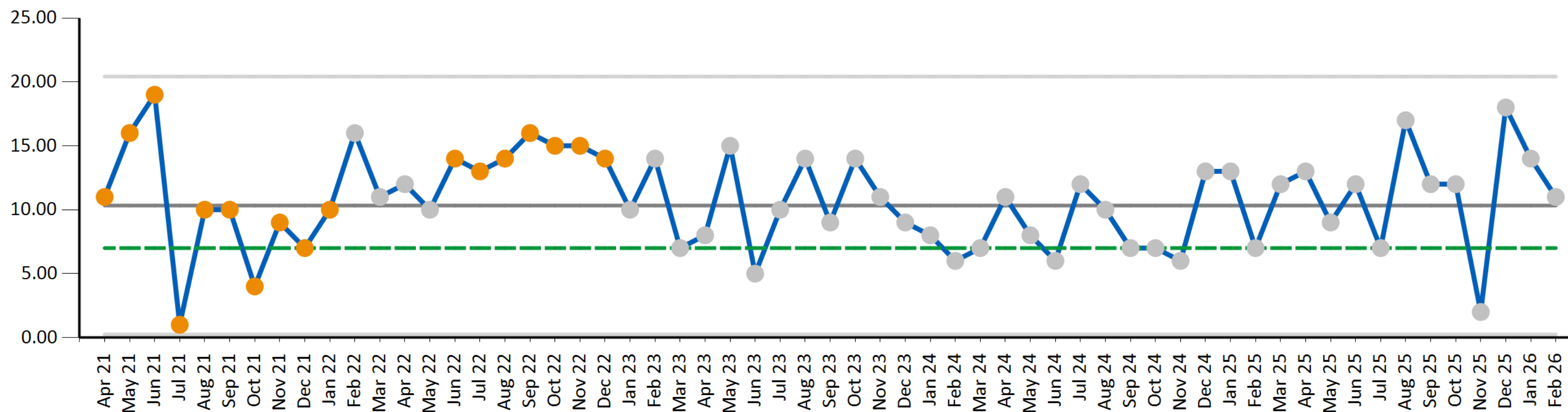
Year to Date

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.



Latest

Plan	Actual	Period
<= 7.0	11.0	Feb-26

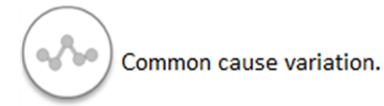
Previous

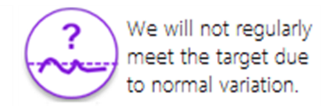
Plan	Actual	Period
<= 7.0	14.0	Jan-26

Year to Date

Plan	Actual
<= 77.0	127.0

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





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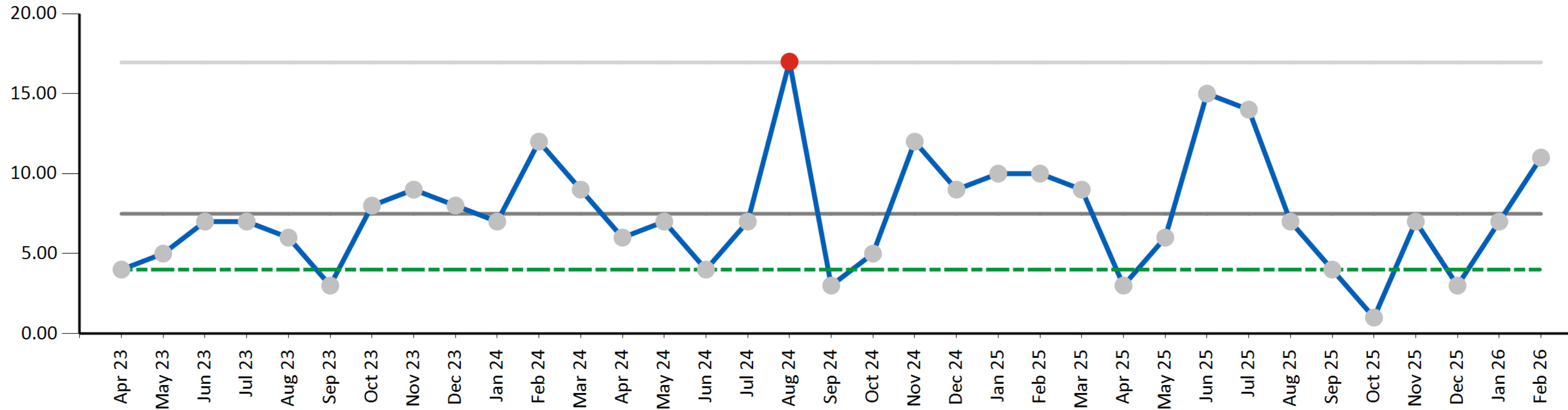


Latest

Plan	Actual	Period
<= 4	11	Feb-26

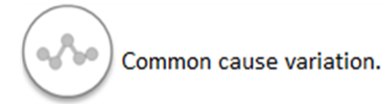
Previous

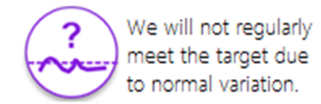
Plan	Actual	Period
<= 4	7	Jan-26

Year to Date

Plan	Actual
<= 44	78

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





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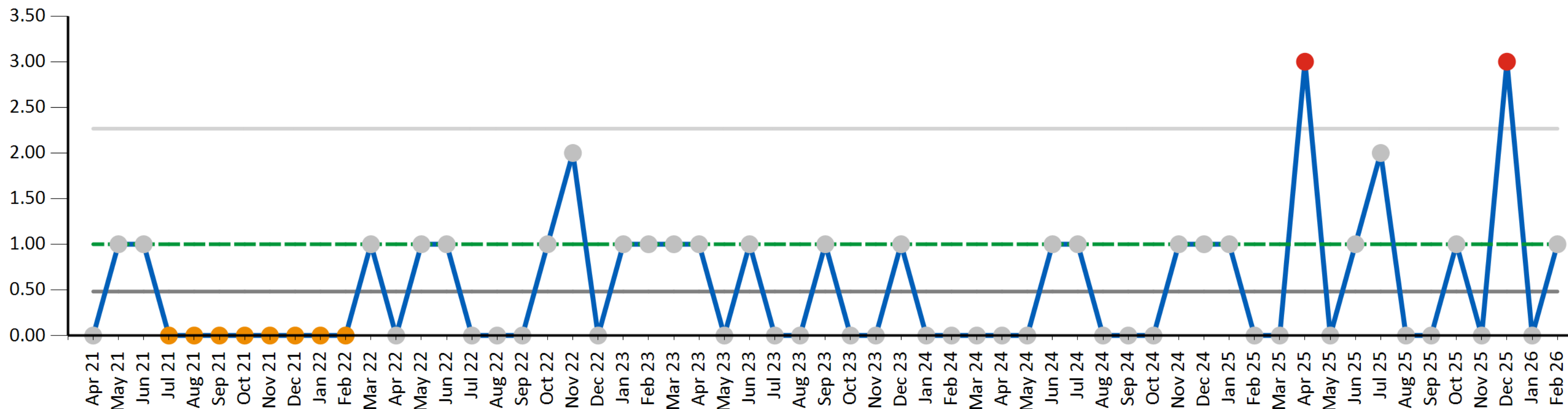


Latest

Plan	Actual	Period
<= 1.0	1.0	Feb-26

Previous

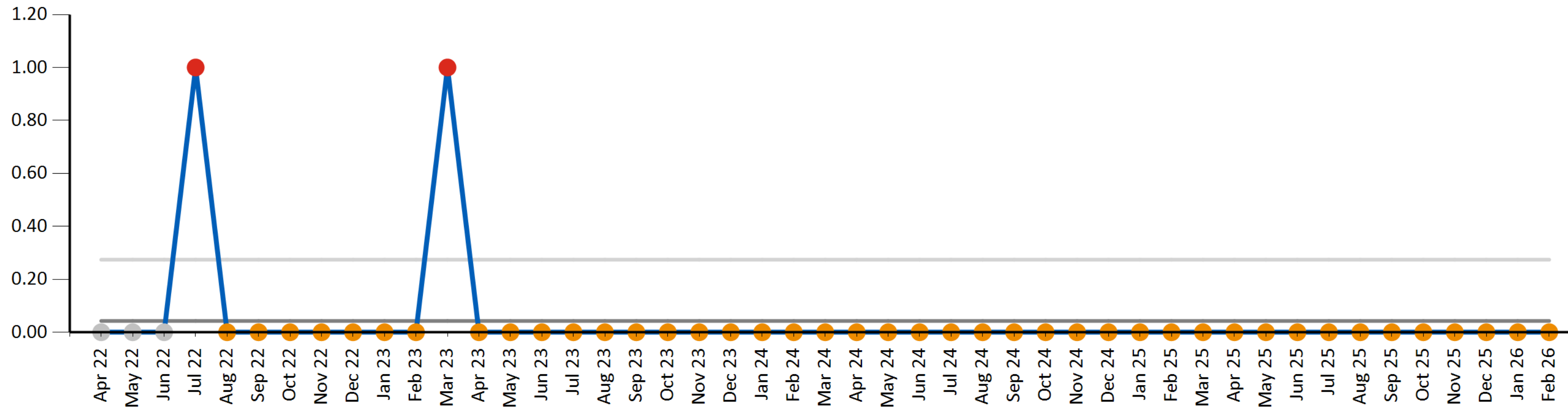
Plan	Actual	Period
<= 1.0	0.0	Jan-26

Year to Date

Plan	Actual
<= 11.0	11.0

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Feb-26

Previous

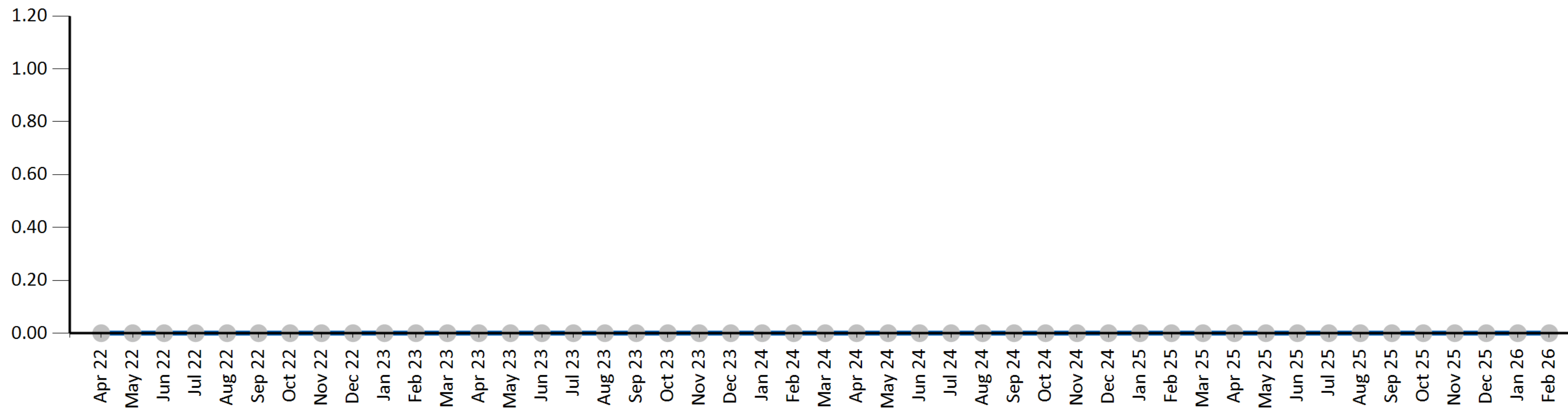
Plan	Actual	Period
	0	Jan-26

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Feb-26

Previous

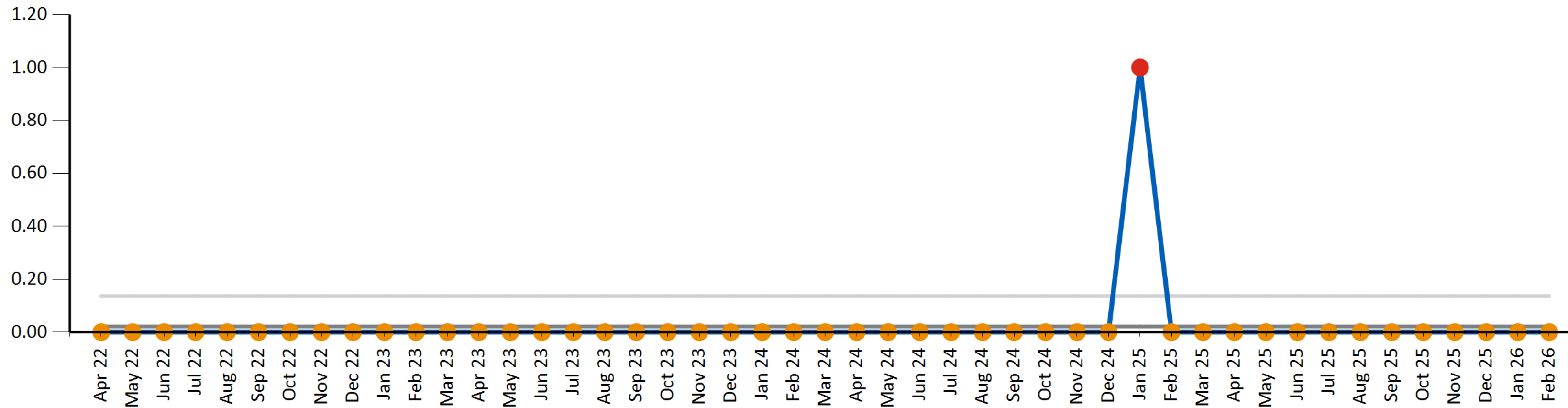
Plan	Actual	Period
	0	Jan-26

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	Feb-26

Previous

Plan	Actual	Period
	0	Jan-26

Year to Date

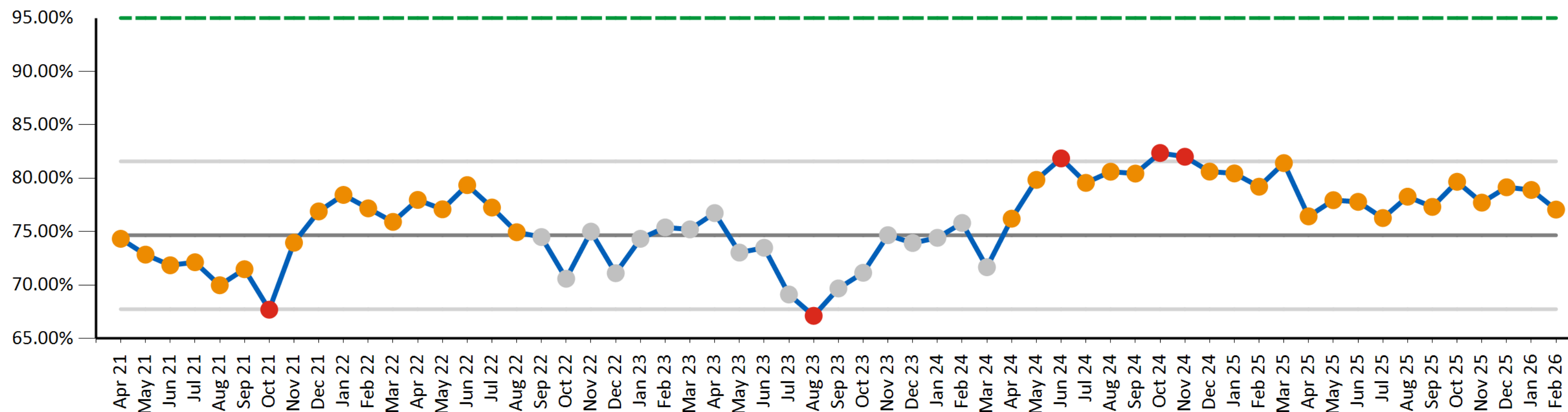
Plan	Actual
	0

30 - Clinical Correspondence - Inpatients %<1 working day

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	77.1%	Feb-26

Previous

Plan	Actual	Period
>= 95%	78.9%	Jan-26

Year to Date

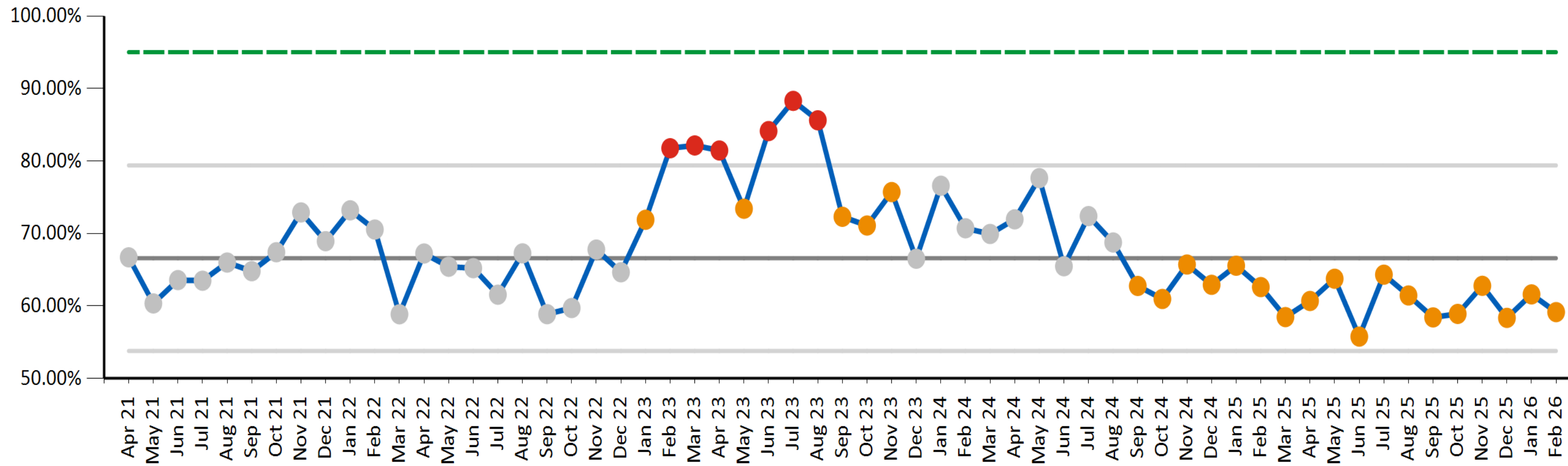
Plan	Actual
>= 95%	77.9%

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%	59.1%	Feb-26

Previous

Plan	Actual	Period
> = 95.0%	61.6%	Jan-26

Year to Date

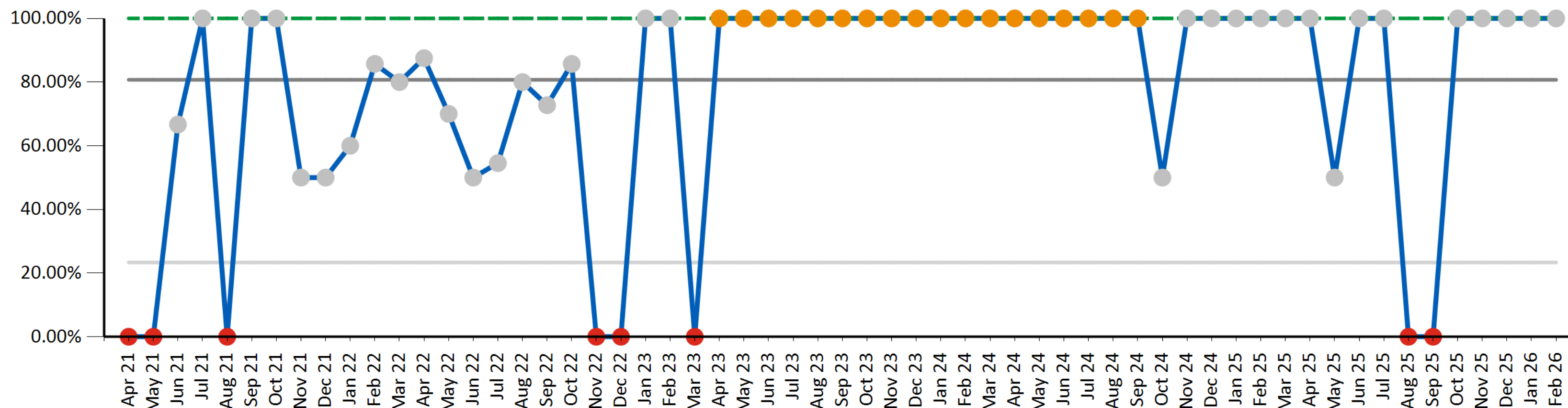
Plan	Actual
> = 95.0%	60.4%

86 - Patient Safety Alerts - Trust position

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
= 100%	100.0%	Feb-26

Previous

Plan	Actual	Period
= 100%	100.0%	Jan-26

Year to Date

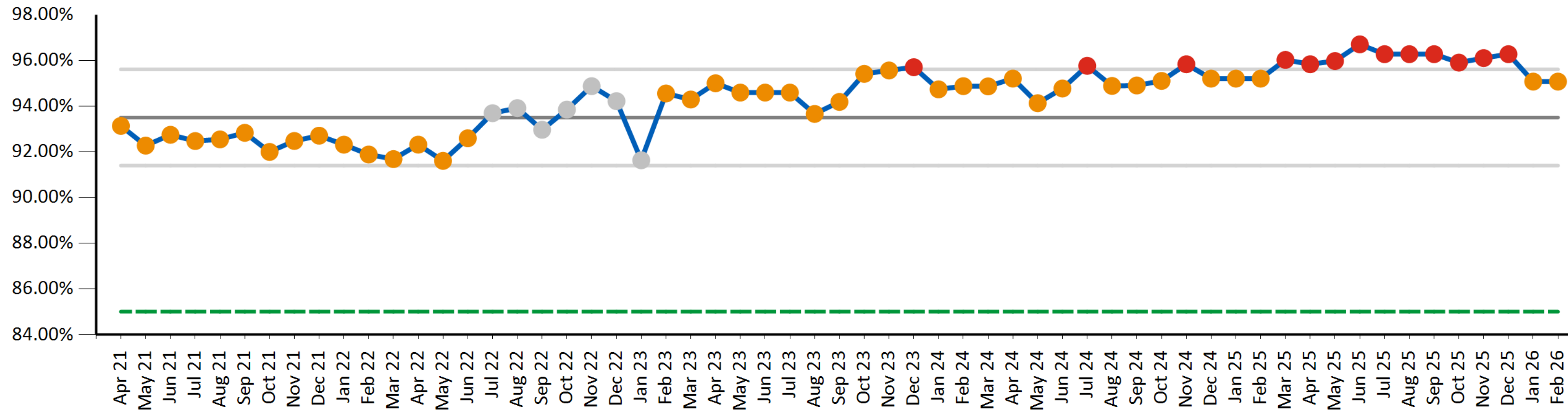
Plan	Actual
= 100%	77.3%

88 - Nursing KPI Audits

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	95.1%	Feb-26

Previous

Plan	Actual	Period
>= 85%	95.1%	Jan-26

Year to Date

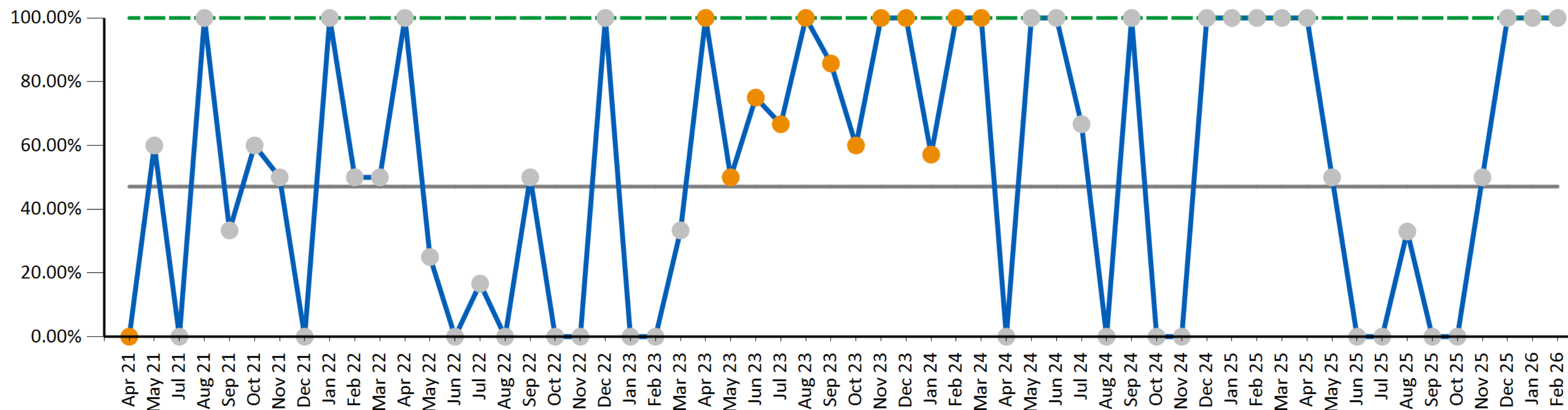
Plan	Actual
>= 85%	96.0%

91 - Patient Safety Incident Investigation turnaround performance by agreed deadline

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
= 100%	100.0%	Feb-26

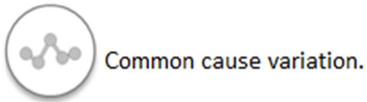
Previous

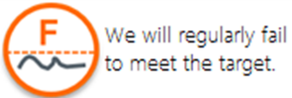
Plan	Actual	Period
= 100%	100.0%	Jan-26

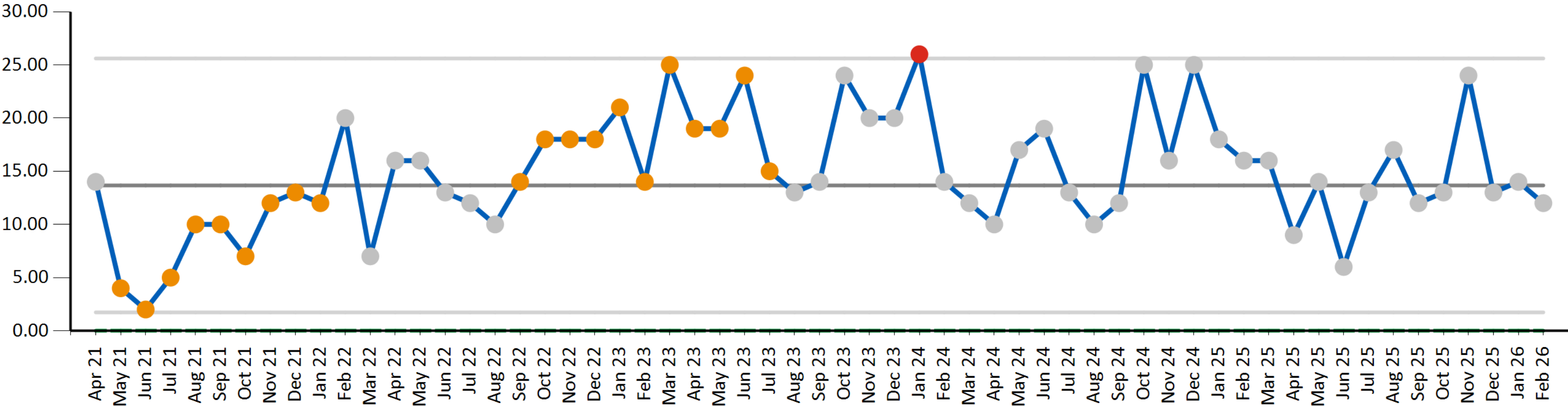
Year to Date

Plan	Actual
= 100%	

8 - Same sex accommodation breaches







Latest

Plan	Actual	Period
= 0	12	Feb-26

Previous

Plan	Actual	Period
= 0	14	Jan-26

Year to Date

Plan	Actual
= 0	147

Quality and Safety - Infection Prevention and Control

NHS Bolton NHS Foundation Trust

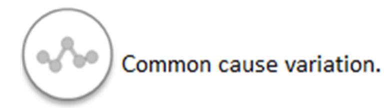
There have been seven healthcare associated CDT cases in February, over two cases under the monthly target; the Trust is more than 14 cases under target with 87 cases against a target of no more than 102 cases for this point in the year. There have been 25 fewer cases in 2025/26 compared to the same point in 2024/25. The monthly average for 2025/26 is 7.9 cases/month compared to an average of 10.5 cases/month for 2024/25. The healthcare case rate has reduced from 55.4 for 2024/24 to 37.9 in 2025/26 and the Trust is currently the 4th of 6 providers in GM.

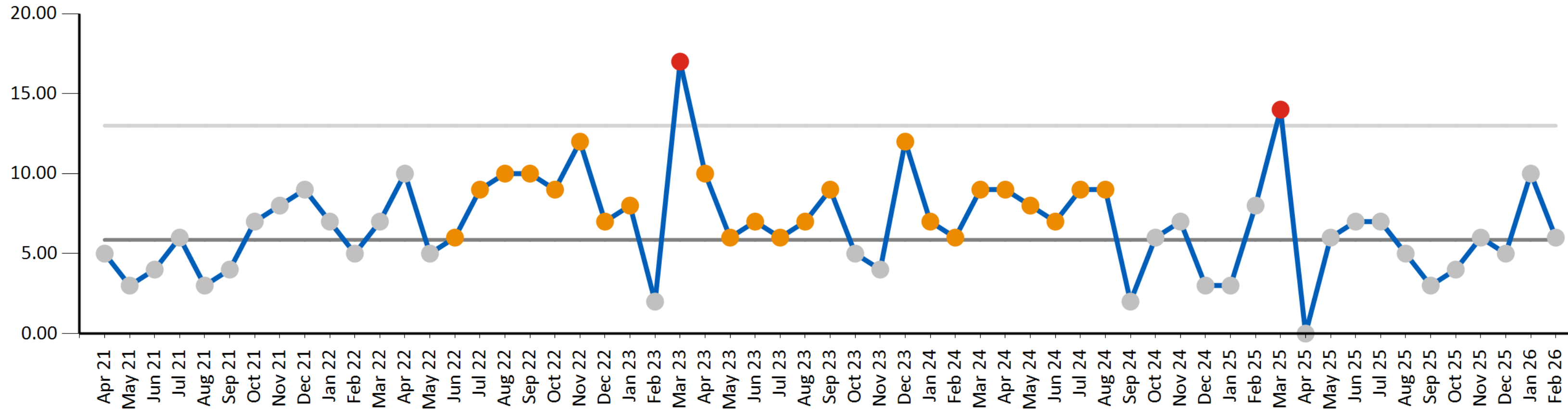
There has been one Pseudomonas aeruginosa bacteraemia in February. This is the first case in 259 days – the second longest period since 2018 (409 days). There have now been four cases in 2025/26, two fewer than at the same point in 2024/25. The Trust is the provider in GM with the fewest case by rate December.

For E. coli and MRSA Bolton is the best provider in GM by rate and for Klebsiella spp. Bolton is the second best provider by rate.

	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		6	Feb-26			10	Jan-26		59	
346 - Total Community Onset Hospital Associated C.diff infections		1	Feb-26			1	Jan-26		28	
347 - Total C.diff infections contributing to objective	<= 10	7	Feb-26		<= 10	11	Jan-26	<= 109	87	
217 - Total Hospital-Onset MRSA BSIs (days between cases)	= 0	0	Feb-26		= 0	0	Jan-26	= 0		
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 5	3	Feb-26		<= 5	1	Jan-26	<= 58	49	
219 - Blood Culture Contaminants (rate)	<= 3%	3.8%	Feb-26		<= 3%	4.0%	Jan-26	<= 3%		
304 - Total Trust apportioned MSSA BSIs	<= 1.0	1.0	Feb-26		<= 1.0	1.0	Jan-26	<= 11.0	20.0	
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	1	Feb-26		<= 1	3	Jan-26	<= 6	18	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	1	Feb-26		= 0	1	Jan-26	= 0		
637 - Healthcare Associated Pseudomonas Aeruginosa Cases (12 month rolling average)										

215 - Total Hospital Onset C.diff infections





Latest

Plan	Actual	Period
	6	Feb-26

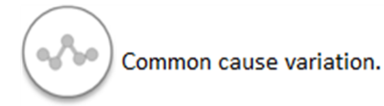
Previous

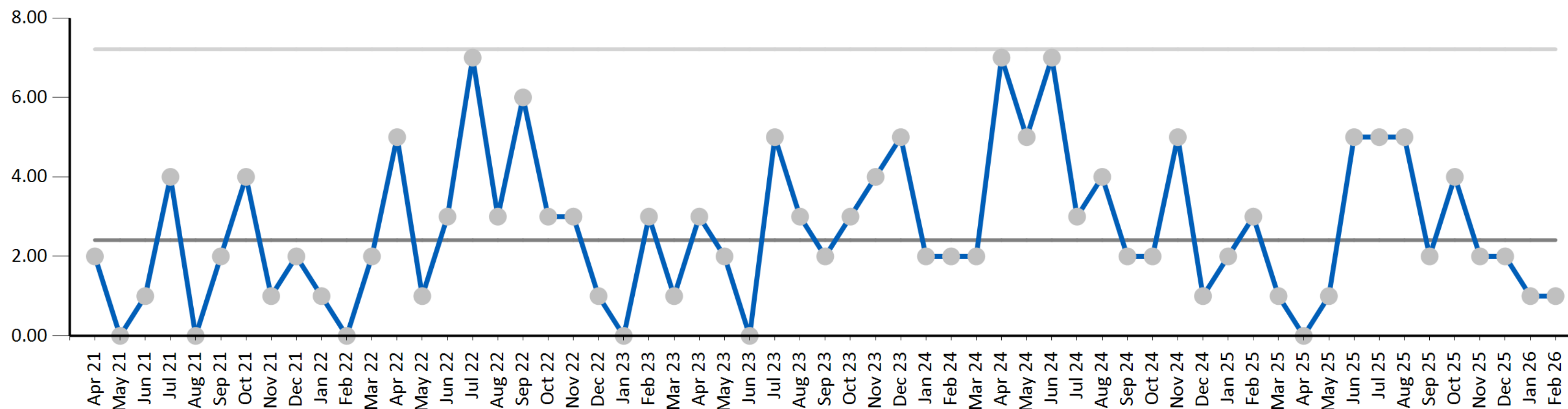
Plan	Actual	Period
	10	Jan-26

Year to Date

Plan	Actual
	59

346 - Total Community Onset Hospital Associated C.diff infections





Latest

Plan	Actual	Period
	1	Feb-26

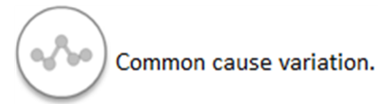
Previous

Plan	Actual	Period
	1	Jan-26

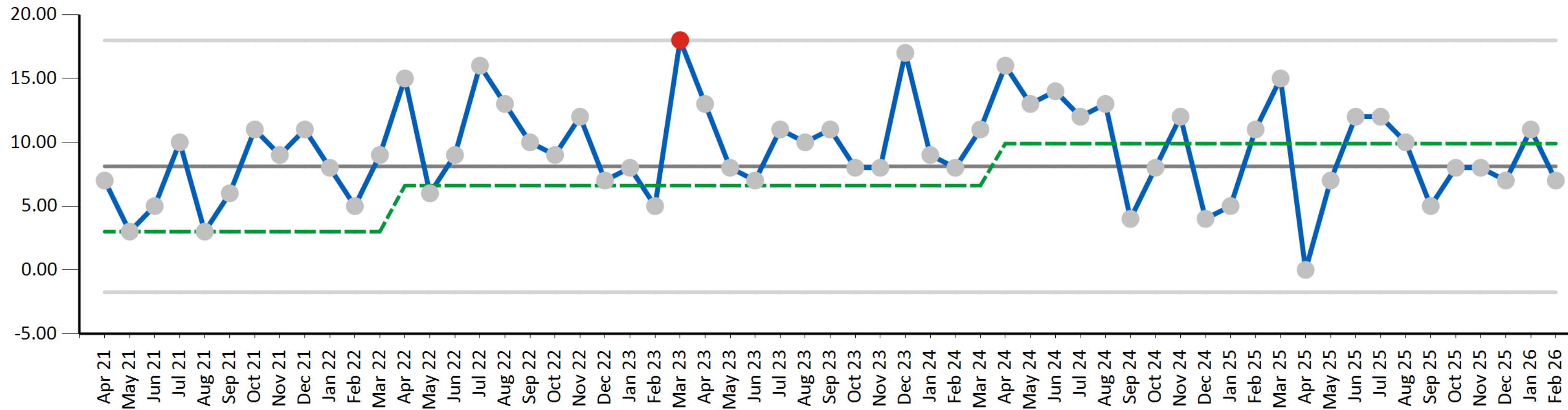
Year to Date

Plan	Actual
	28

347 - Total C.diff infections contributing to objective



5/6



Latest

Plan	Actual	Period
<= 10	7	Feb-26

Previous

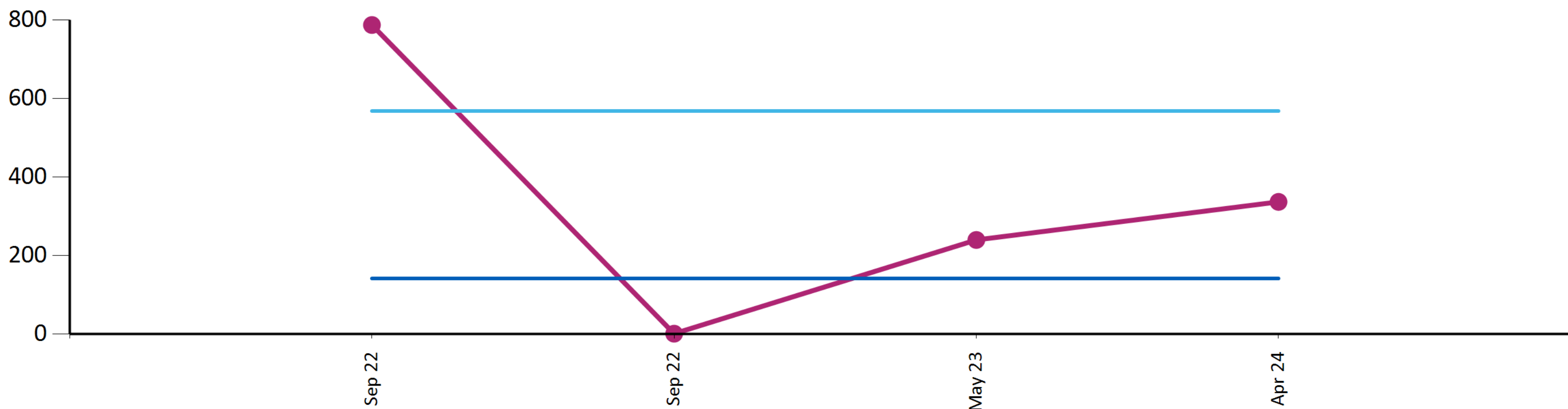
Plan	Actual	Period
<= 10	11	Jan-26

Year to Date

Plan	Actual
<= 109	87

217 - Total Hospital-Onset MRSA BSIs (days between cases)

0/6



Latest

Plan	Actual	Period
	0	Feb-26

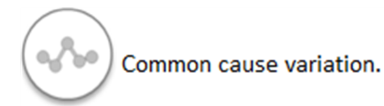
Previous

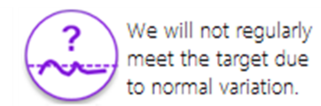
Plan	Actual	Period
	0	Jan-26

Year to Date

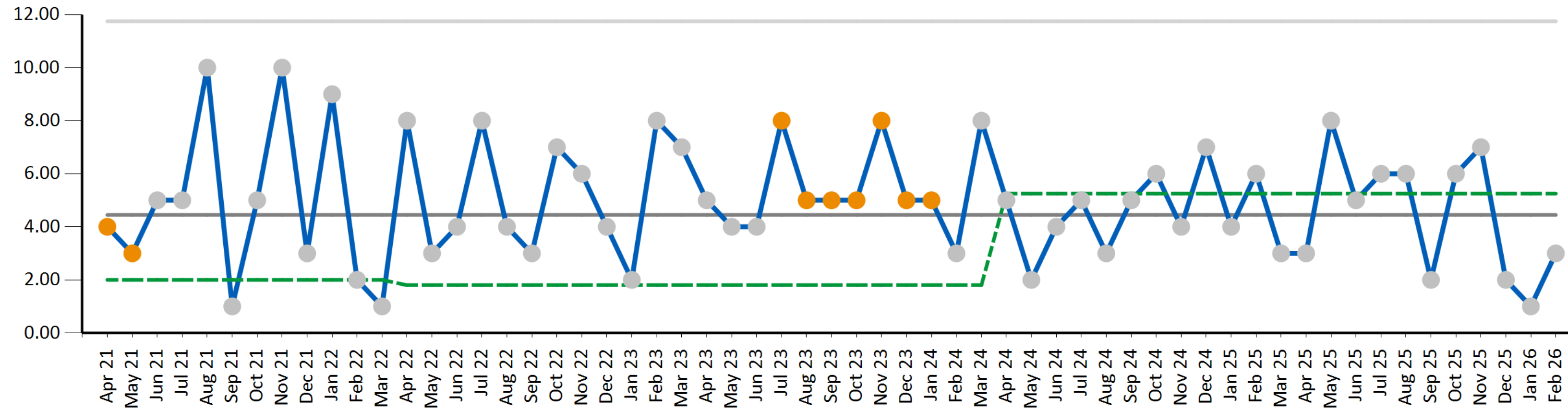
Plan	Actual

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





4/6



Latest

Plan	Actual	Period
<= 5	3	Feb-26

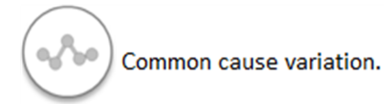
Previous

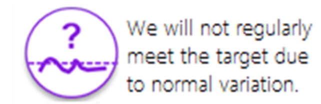
Plan	Actual	Period
<= 5	1	Jan-26

Year to Date

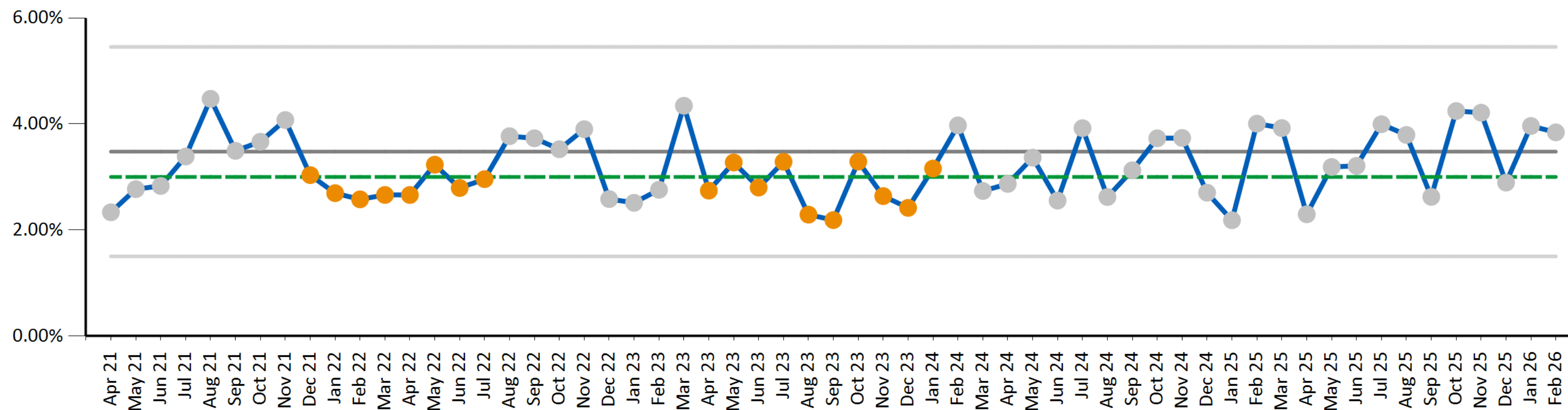
Plan	Actual
<= 58	49

219 - Blood Culture Contaminants (rate)





2/6



Latest

Plan	Actual	Period
<= 3%	3.8%	Feb-26

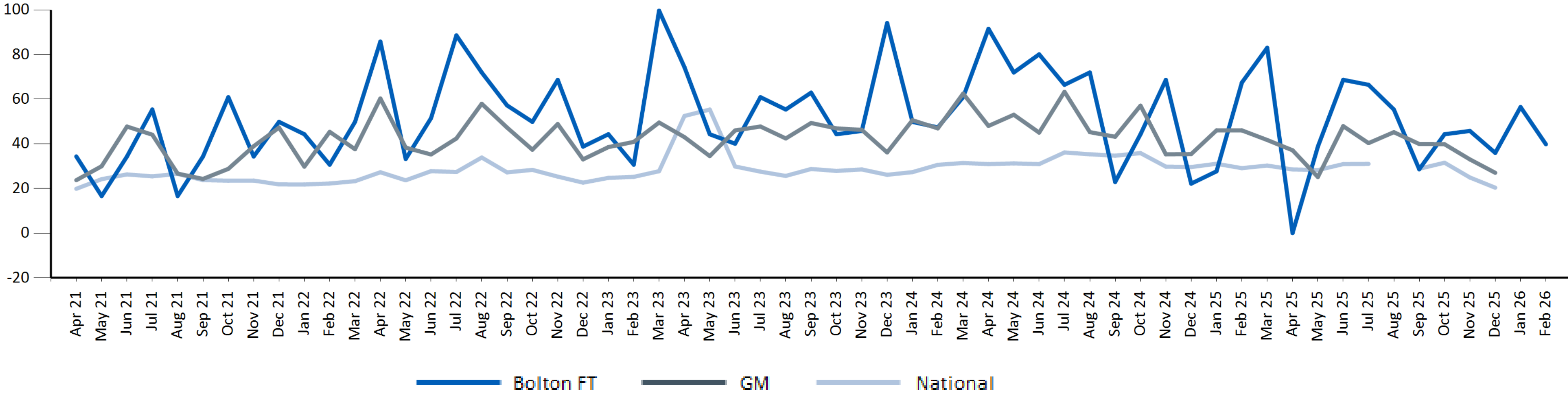
Previous

Plan	Actual	Period
<= 3%	4.0%	Jan-26

Year to Date

Plan	Actual
<= 3%	

549 - C Diff Rate Comparison

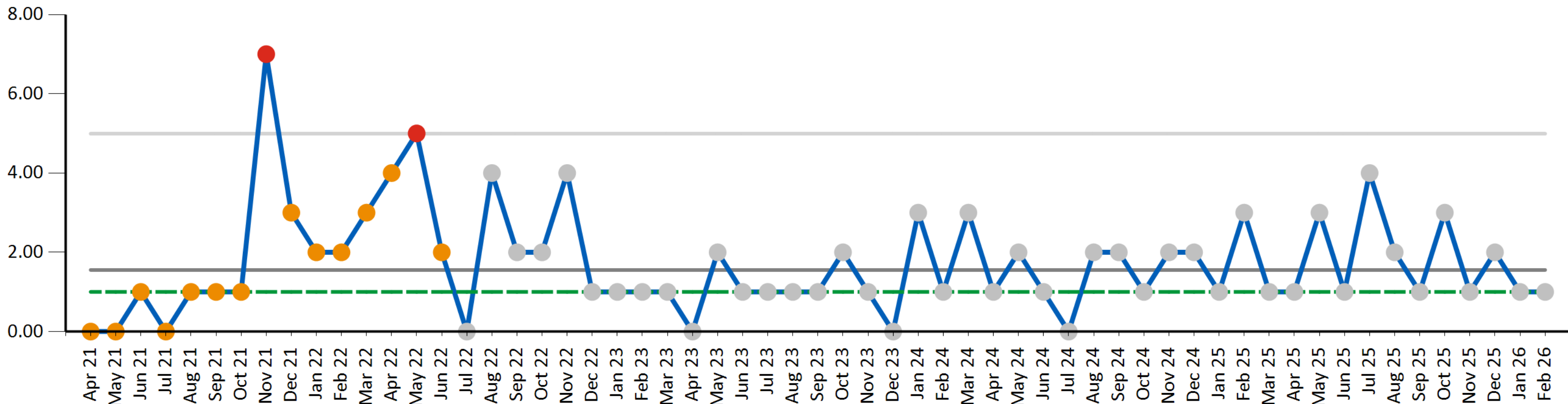


304 - Total Trust apportioned MSSA BSIs

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 1.0	1.0	Feb-26

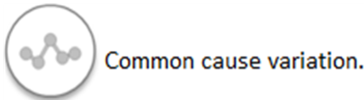
Previous

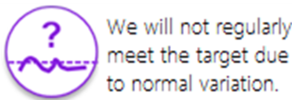
Plan	Actual	Period
<= 1.0	1.0	Jan-26

Year to Date

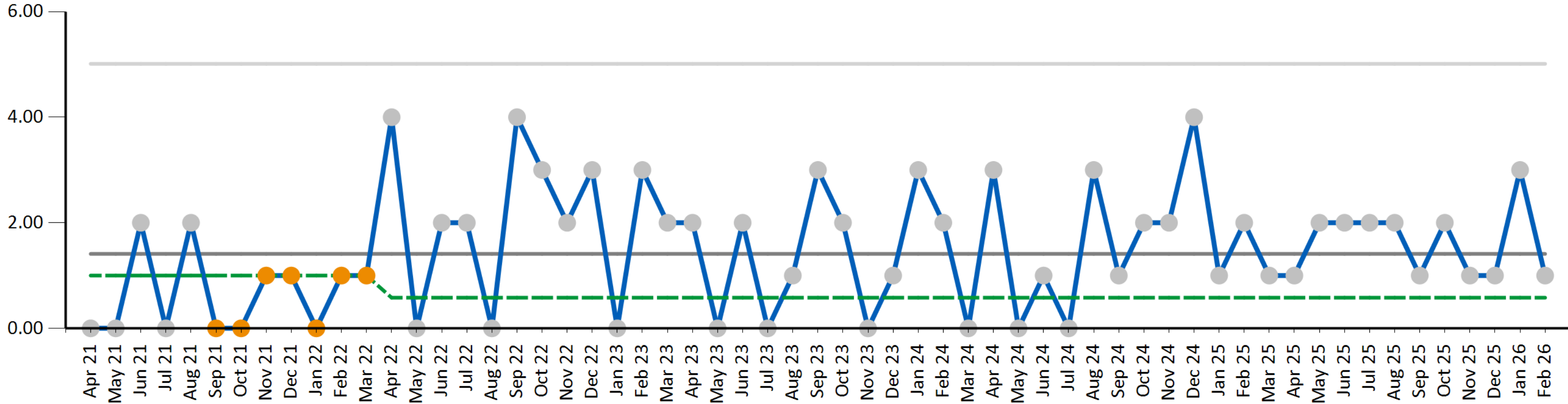
Plan	Actual
<= 11.0	20.0

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





0/6



Latest

Plan	Actual	Period
<= 1	1	Feb-26

Previous

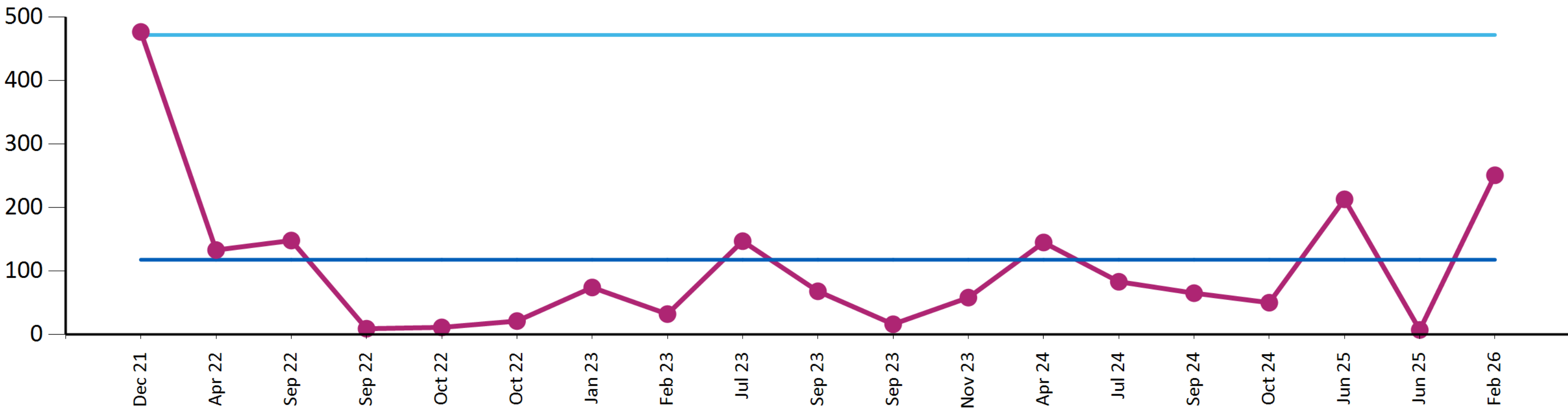
Plan	Actual	Period
<= 1	3	Jan-26

Year to Date

Plan	Actual
<= 6	18

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

0/6



Latest

Plan	Actual	Period
	1	Feb-26

Previous

Plan	Actual	Period
	0	Jan-26

Year to Date

Plan	Actual

Quality and Safety - Mortality

Crude – in month rate is below Trust target and average for the timeframe and is showing 21 points below the mean showing improved special cause. It has now remained in control for more than three years.

HSMR – in month figure is slightly above average for the period and remains in control. The 12 month rolling average to November 2025 is 107.38, this is an 'Amber' alert when compared to other Trusts.

SHMI – in month figure is below the average for the time period and remains in control. The published rolling average for the period November 2024 to October 2025 is 108.5 which is 'as expected'.

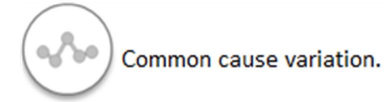
The proportion of Charlson comorbidities is above average for the time frame and the current month is part of a run of improved special cause. The depth of recording remains in control and is below the average. Both indictors are still lower when benchmarked against the England average of all Acute Trusts.

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.

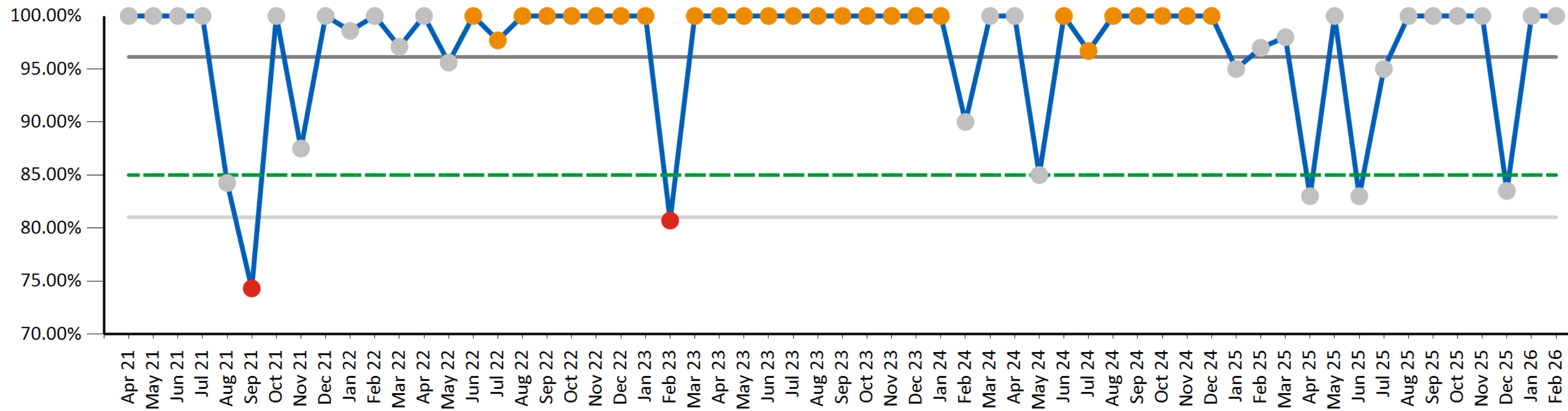
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Feb-26		>= 85%	100.0%	Jan-26	>= 85%	95.0%	
495 - HSMR		118.30	Nov-25			109.24	Oct-25		118.30	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	101.99	Sep-25		<= 100.00	114.96	Aug-25	<= 100.00	101.99	
12 - Crude Mortality %	<= 2.9%	2.1%	Feb-26	L	<= 2.9%	2.4%	Jan-26	<= 2.9%	1.9%	
519 - Average Charlson comorbidity Score (First episode of care)		4	Oct-25	H		5	Sep-25		30	
520 - Depth of recording (First episode of care)		6	Oct-25			6	Sep-25		43	
521 - Proportion of fully coded records (Inpatients)		99.8%	Nov-25	H		99.6%	Oct-25		98.7%	
604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS)		2.00	Feb-26			0.00	Jan-26			

3 - National Early Warning Scores to Gold standard



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

5/6



Latest

Plan	Actual	Period
>= 85%	100.0%	Feb-26

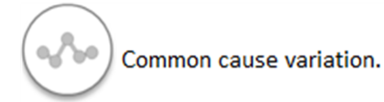
Previous

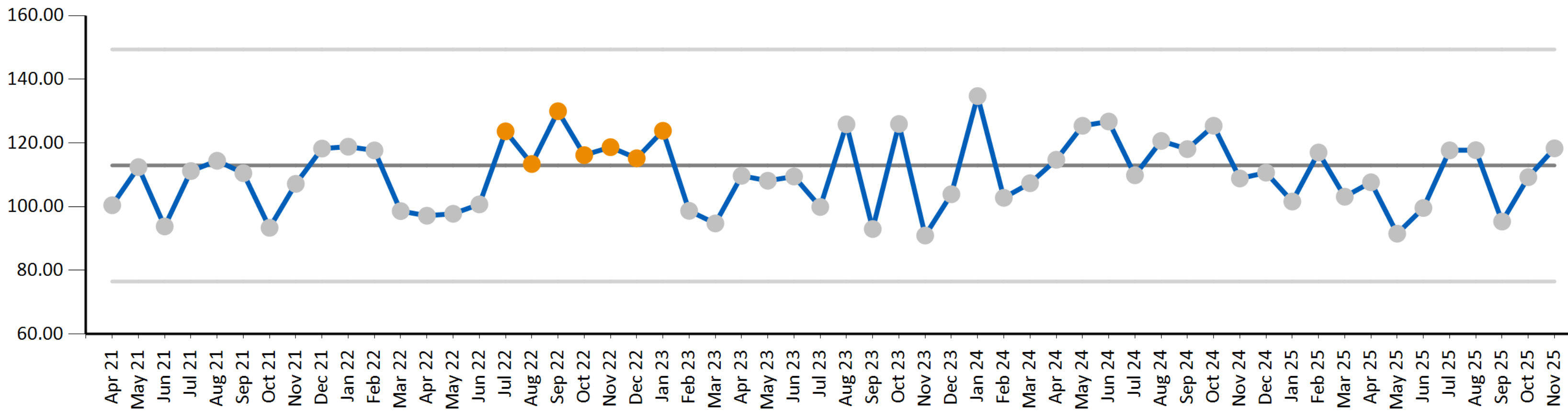
Plan	Actual	Period
>= 85%	100.0%	Jan-26

Year to Date

Plan	Actual
>= 85%	95.0%

495 - HSMR





Latest

Plan	Actual	Period
	118.30	Nov-25

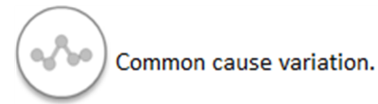
Previous

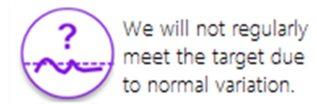
Plan	Actual	Period
	109.24	Oct-25

Year to Date

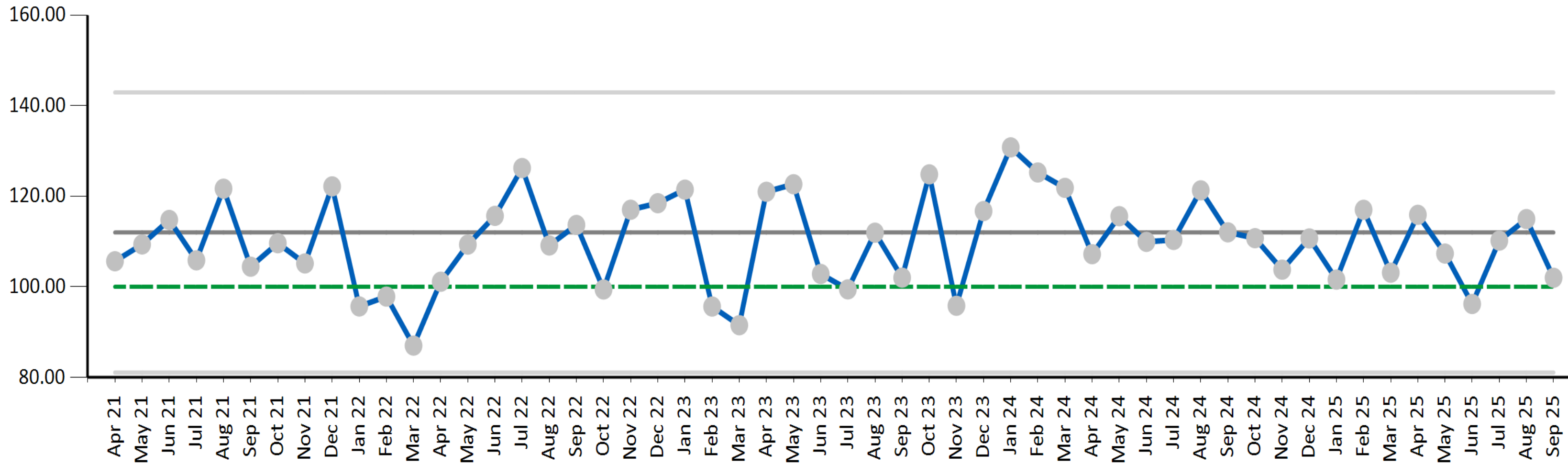
Plan	Actual
	118.30

11 - Summary Hospital-level Mortality Indicator (SHMI)





1/6



Latest

Plan	Actual	Period
<= 100.00	101.99	Sep-25

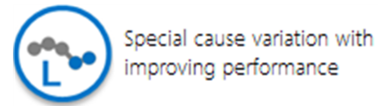
Previous

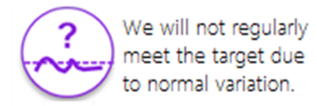
Plan	Actual	Period
<= 100.00	114.96	Aug-25

Year to Date

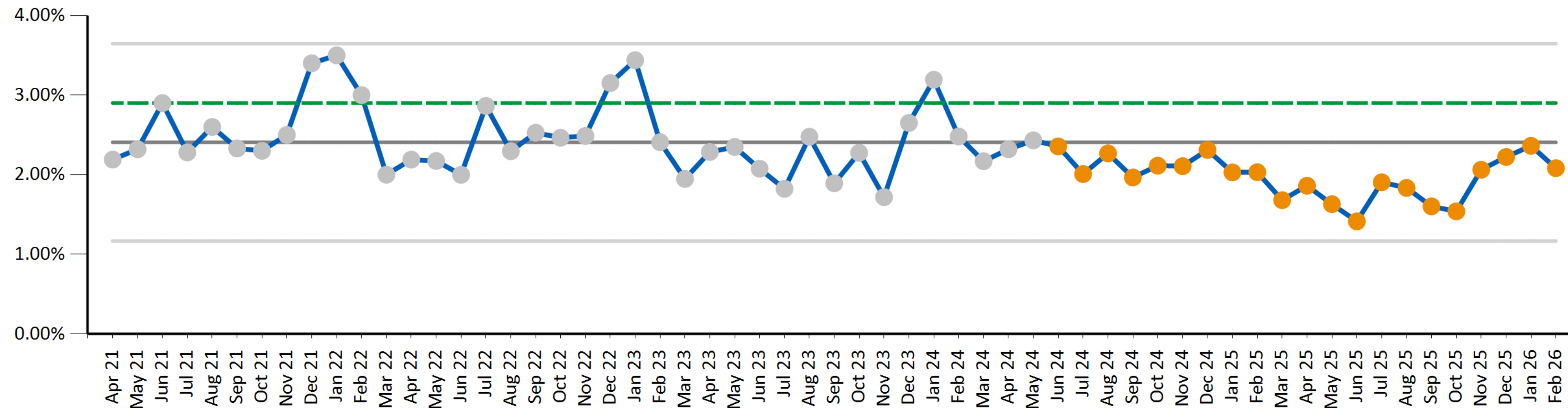
Plan	Actual
<= 100.00	101.99

12 - Crude Mortality %





6/6



Latest

Plan	Actual	Period
<= 2.9%	2.1%	Feb-26

Previous

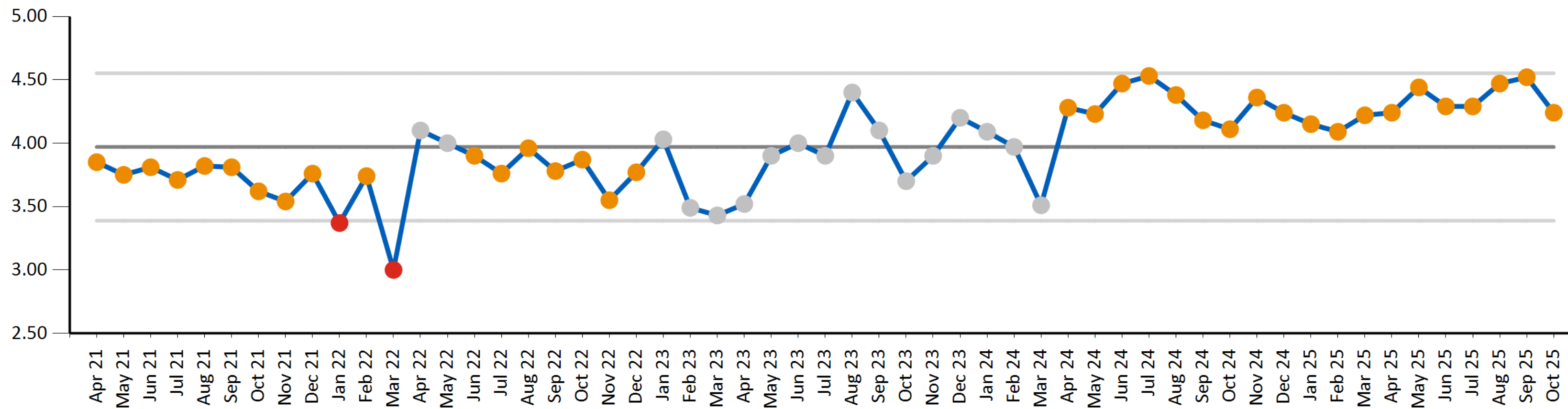
Plan	Actual	Period
<= 2.9%	2.4%	Jan-26

Year to Date

Plan	Actual
<= 2.9%	1.9%

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	4	Oct-25

Previous

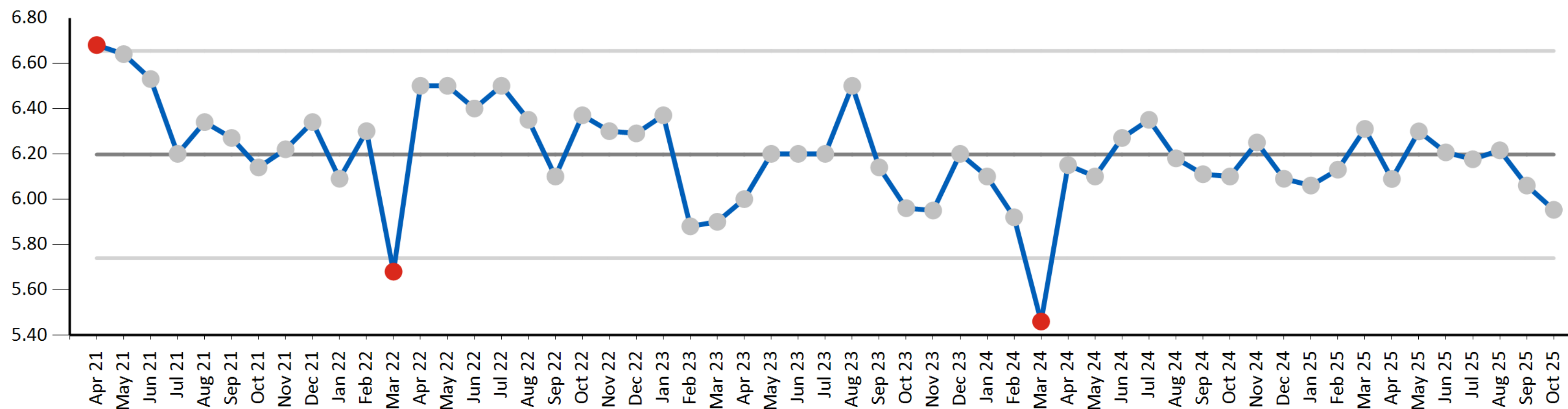
Plan	Actual	Period
	5	Sep-25

Year to Date

Plan	Actual
	30

520 - Depth of recording (First episode of care)

Common cause variation.



Latest

Plan	Actual	Period
	6	Oct-25

Previous

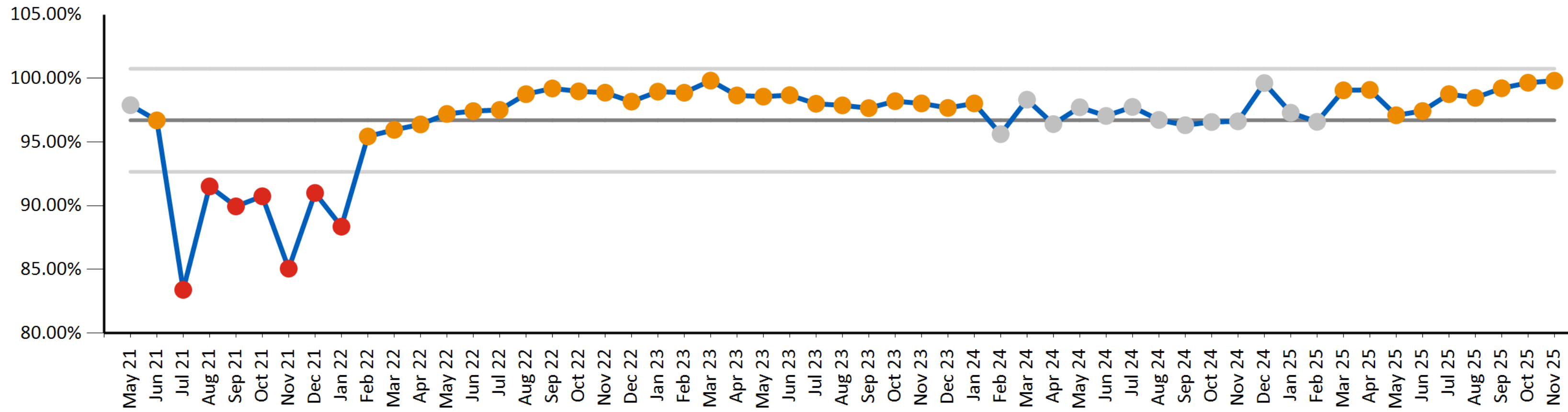
Plan	Actual	Period
	6	Sep-25

Year to Date

Plan	Actual
	43

521 - Proportion of fully coded records (Inpatients)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	99.8%	Nov-25

Previous

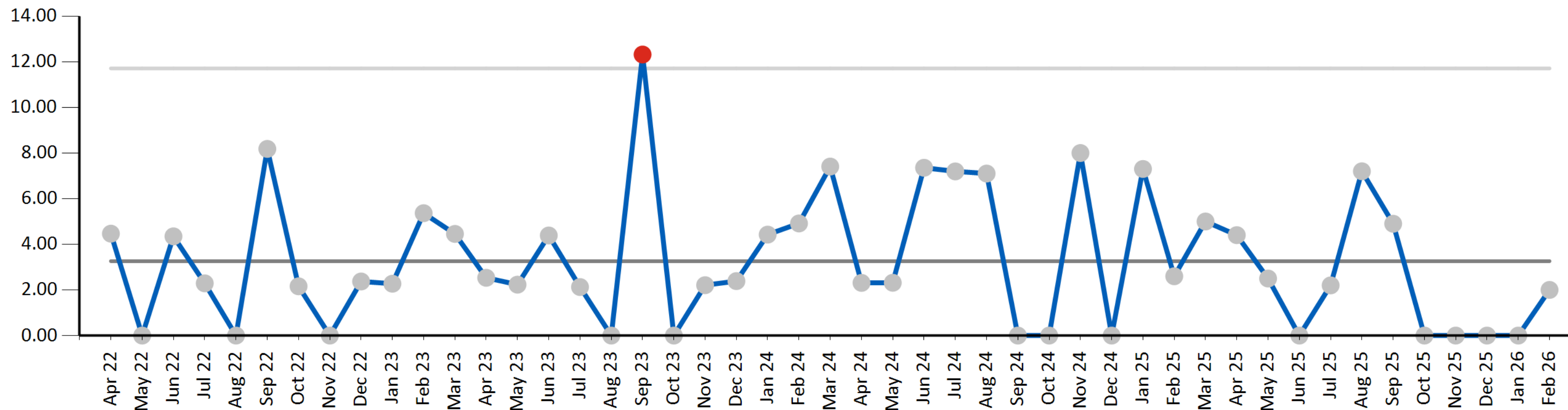
Plan	Actual	Period
	99.6%	Oct-25

Year to Date

Plan	Actual
	98.7%

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

Common cause variation.



Latest

Plan	Actual	Period
	2.00	Feb-26

Previous

Plan	Actual	Period
	0.00	Jan-26

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 20% local target rate. ED satisfaction rates remain below the target of 90% but are within 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 above the target rate of 90%.

Complaints
Formal complaints acknowledged within 3 working days was 96% (24/25).
One complaint was acknowledged one day over the target date due to operational constraints of reducing staffing within the team.
Complaints responded to were below the planned 95% however remained in common cause variation.
Across four divisions there were a total of two overdue responses one in Medicine Division, one in Surgery Division. Both complaint responses have since been sent.

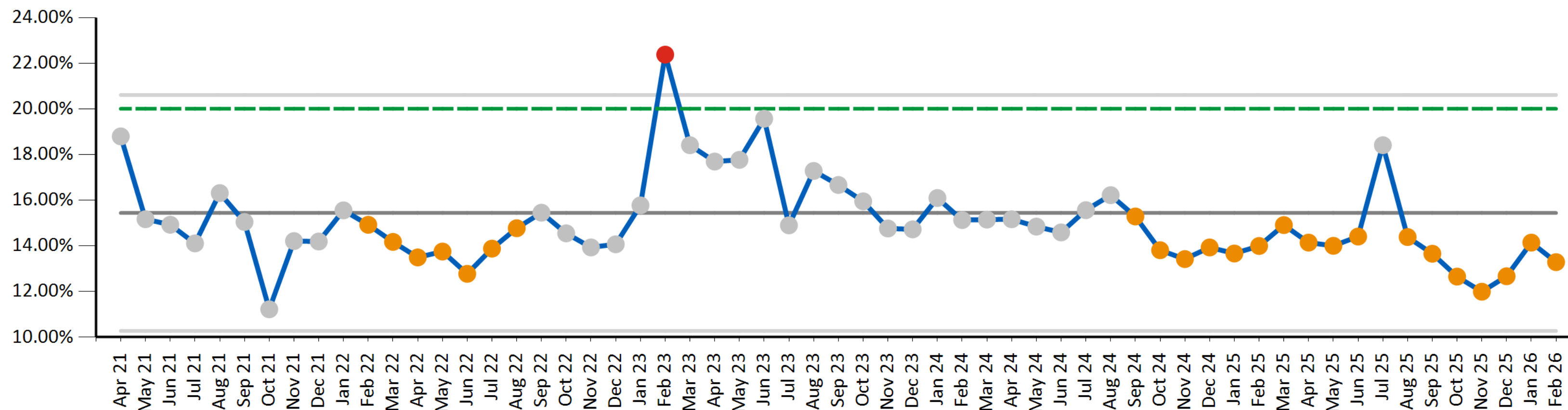
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	13.3%	Feb-26		>= 20%	14.1%	Jan-26	>= 20%	13.9%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	81.3%	Feb-26		>= 90%	83.3%	Jan-26	>= 90%	83.0%	
80 - Inpatient Friends and Family Response Rate	>= 30%	21.7%	Feb-26		>= 30%	21.7%	Jan-26	>= 30%	22.8%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	96.5%	Feb-26		>= 90%	95.8%	Jan-26	>= 90%	97.1%	
81 - Maternity Friends and Family Response Rate	>= 15%	14.0%	Feb-26		>= 15%	18.6%	Jan-26	>= 15%	22.0%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	89.4%	Feb-26		>= 90%	89.9%	Jan-26	>= 90%	92.1%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	3.6%	Feb-26		>= 15%	17.7%	Jan-26	>= 15%	14.1%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	96.5%	Feb-26		>= 90%	96.5%	Jan-26	>= 90%	96.8%	
83 - Birth - Friends and Family Response Rate	>= 15%	27.2%	Feb-26		>= 15%	33.3%	Jan-26	>= 15%	36.6%	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	89.6%	Feb-26		>= 90%	87.1%	Jan-26	>= 90%	89.9%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	16.6%	Feb-26		>= 15%	11.5%	Jan-26	>= 15%	18.6%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	82.9%	Feb-26		>= 90%	83.9%	Jan-26	>= 90%	88.2%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	11.6%	Feb-26		>= 15%	9.9%	Jan-26	>= 15%	18.7%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	92.9%	Feb-26		>= 90%	89.7%	Jan-26	>= 90%	94.9%	
89 - Formal complaints acknowledged within 3 working days	= 100%	96.0%	Feb-26		= 100%	90.0%	Jan-26	= 100%	93.2%	
90 - Complaints responded to within the period	>= 95%	75.0%	Feb-26		>= 95%	100.0%	Jan-26	>= 95%	76.5%	

200 - A&E Friends and Family Response Rate

Special cause variation with deteriorating performance

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



Latest

Plan	Actual	Period
>= 20%	13.3%	Feb-26

Previous

Plan	Actual	Period
>= 20%	14.1%	Jan-26

Year to Date

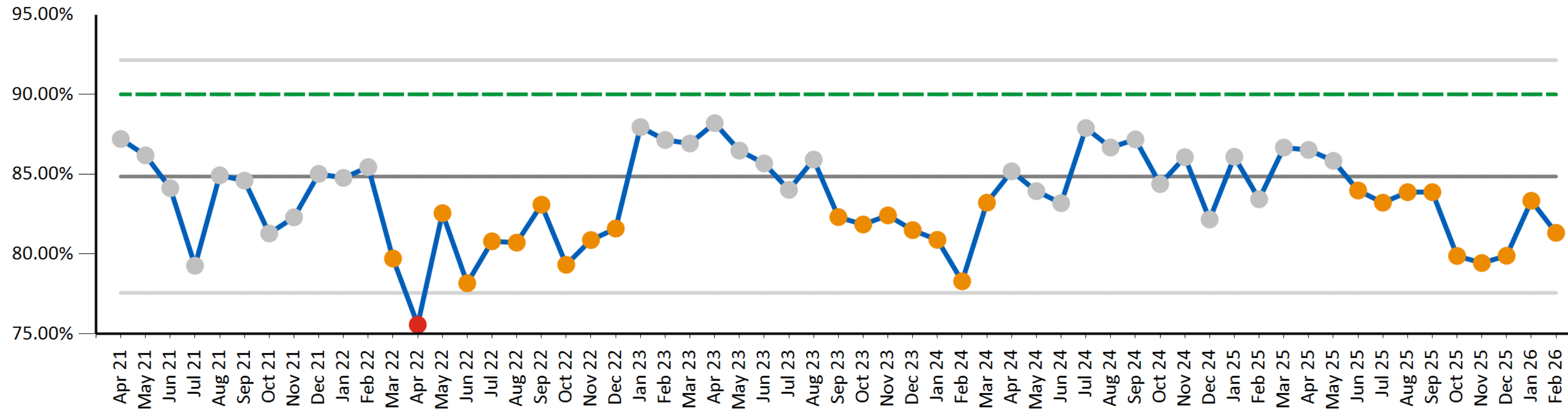
Plan	Actual
>= 20%	13.9%

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%	81.3%	Feb-26

Previous

Plan	Actual	Period
>= 90%	83.3%	Jan-26

Year to Date

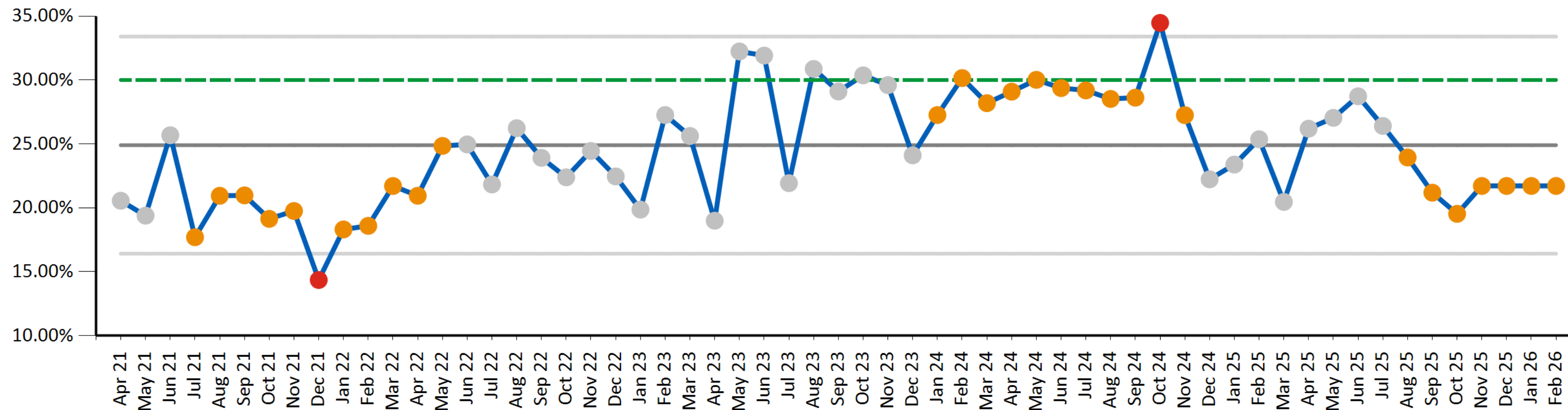
Plan	Actual
>= 90%	83.0%

80 - Inpatient Friends and Family Response Rate

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 30%	21.7%	Feb-26

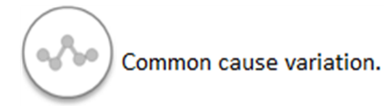
Previous

Plan	Actual	Period
>= 30%	21.7%	Jan-26

Year to Date

Plan	Actual
>= 30%	22.8%

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



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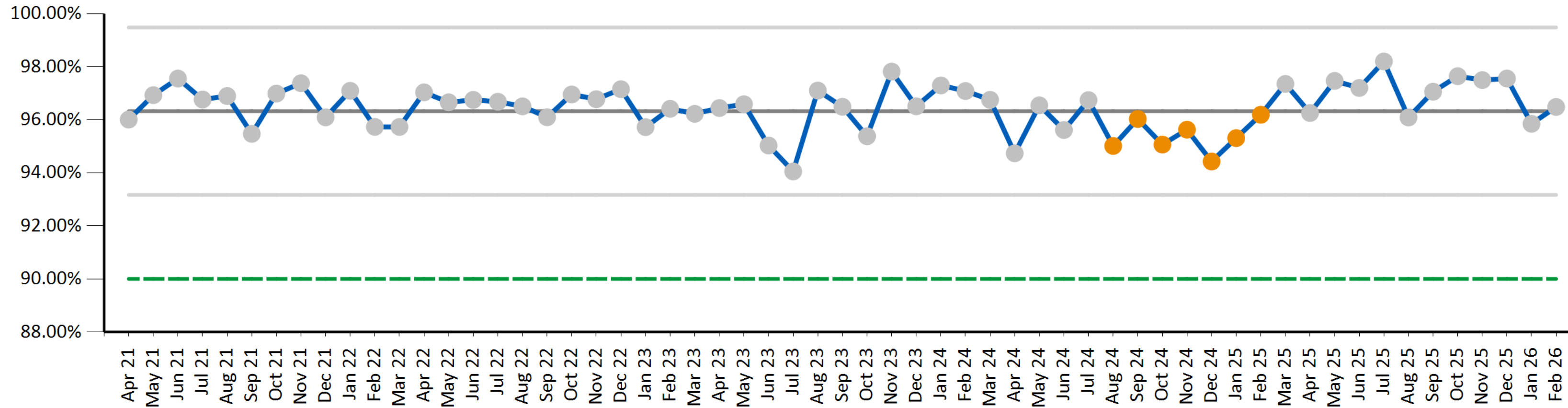


Latest

Plan	Actual	Period
>= 90%	96.5%	Feb-26

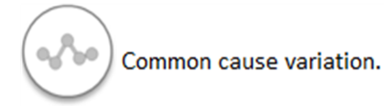
Previous

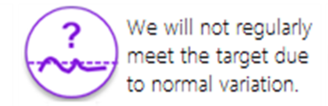
Plan	Actual	Period
>= 90%	95.8%	Jan-26

Year to Date

Plan	Actual
>= 90%	97.1%

81 - Maternity Friends and Family Response Rate





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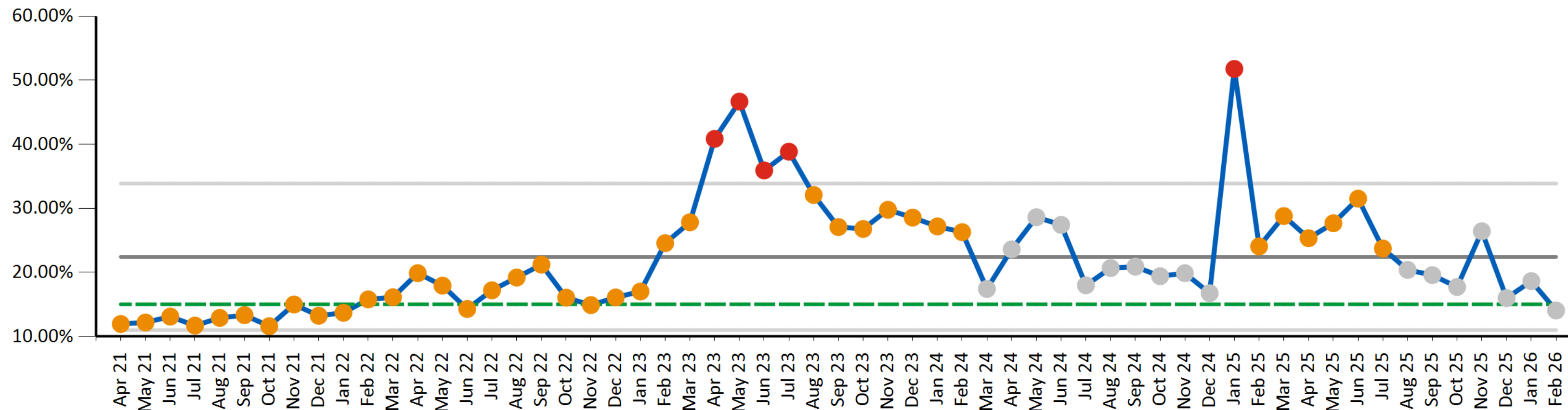


Latest

Plan	Actual	Period
>= 15%	14.0%	Feb-26

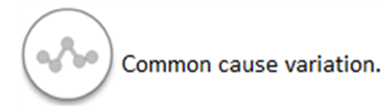
Previous

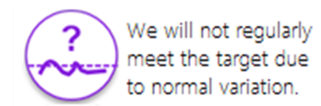
Plan	Actual	Period
>= 15%	18.6%	Jan-26

Year to Date

Plan	Actual
>= 15%	22.0%

241 - Maternity Friends and Family Test - Satisfaction %





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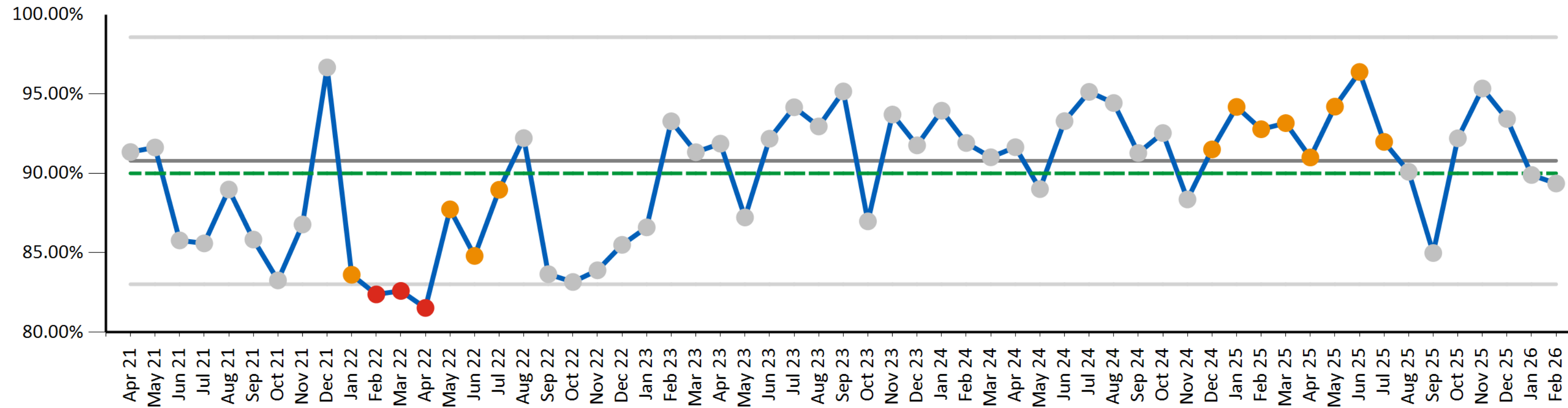


Latest

Plan	Actual	Period
>= 90%	89.4%	Feb-26

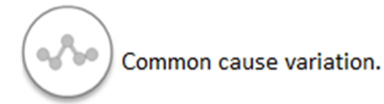
Previous

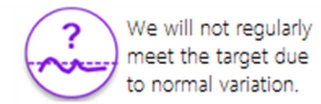
Plan	Actual	Period
>= 90%	89.9%	Jan-26

Year to Date

Plan	Actual
>= 90%	92.1%

82 - Antenatal - Friends and Family Response Rate





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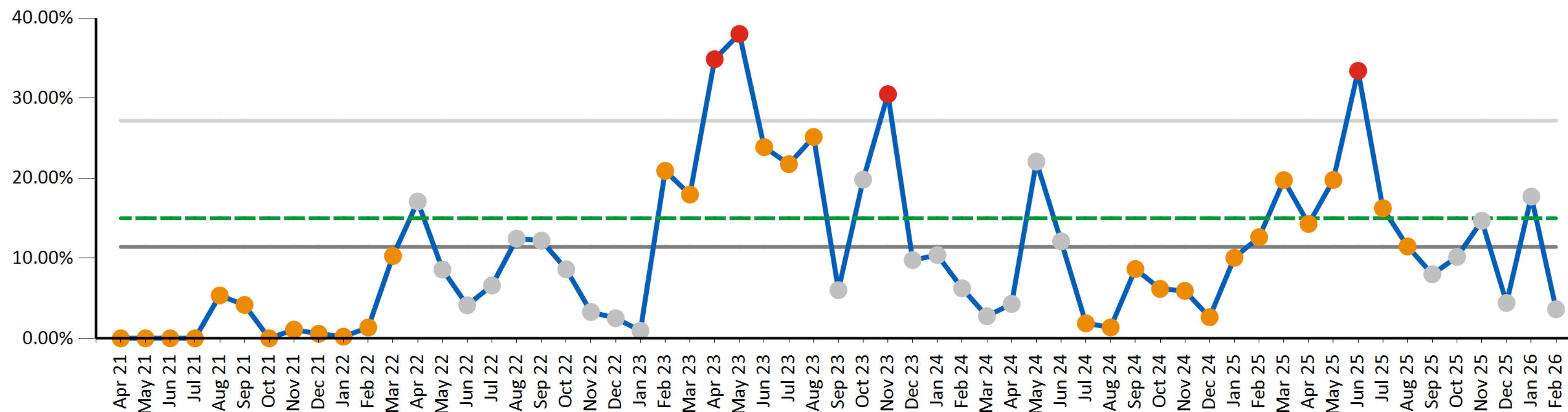


Latest

Plan	Actual	Period
>= 15%	3.6%	Feb-26

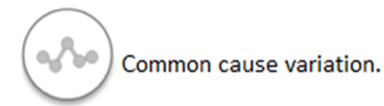
Previous

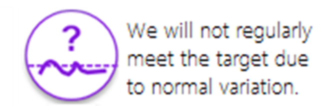
Plan	Actual	Period
>= 15%	17.7%	Jan-26

Year to Date

Plan	Actual
>= 15%	14.1%

242 - Antenatal Friends and Family Test - Satisfaction %





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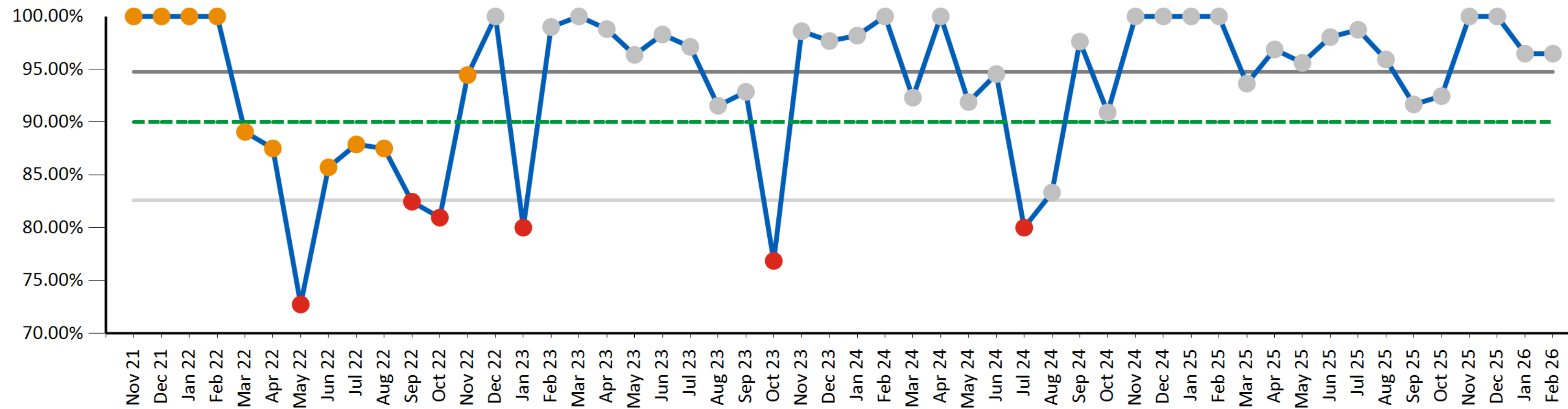


Latest

Plan	Actual	Period
>= 90%	96.5%	Feb-26

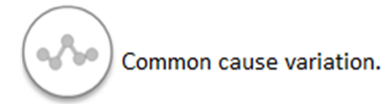
Previous

Plan	Actual	Period
>= 90%	96.5%	Jan-26

Year to Date

Plan	Actual
>= 90%	96.8%

83 - Birth - Friends and Family Response Rate



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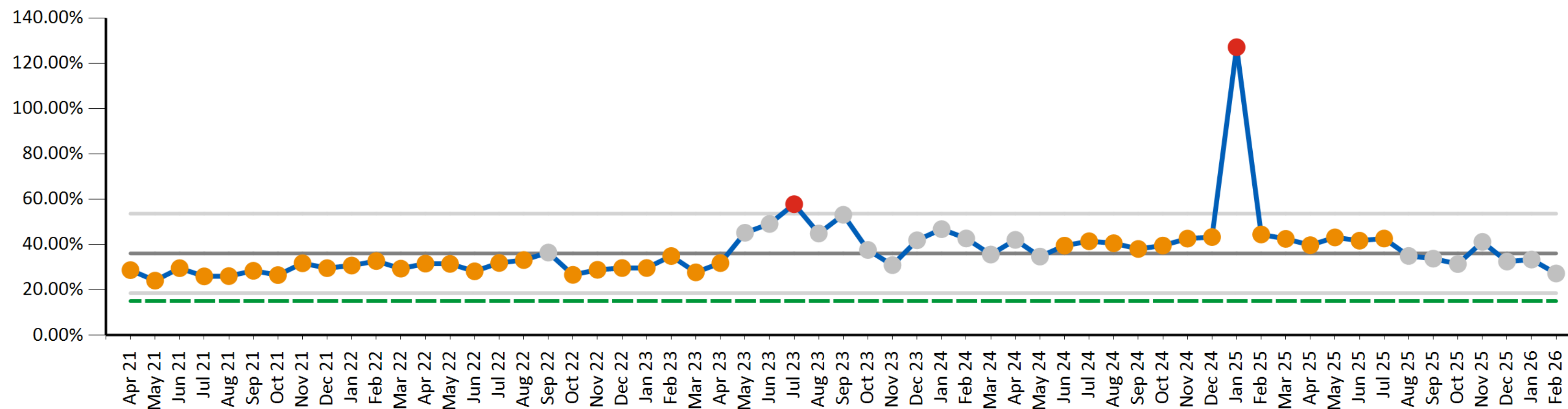


Latest

Plan	Actual	Period
>= 15%	27.2%	Feb-26

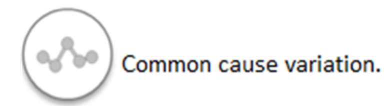
Previous

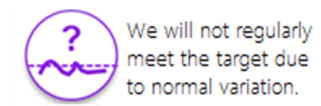
Plan	Actual	Period
>= 15%	33.3%	Jan-26

Year to Date

Plan	Actual
>= 15%	36.6%

243 - Birth Friends and Family Test - Satisfaction %





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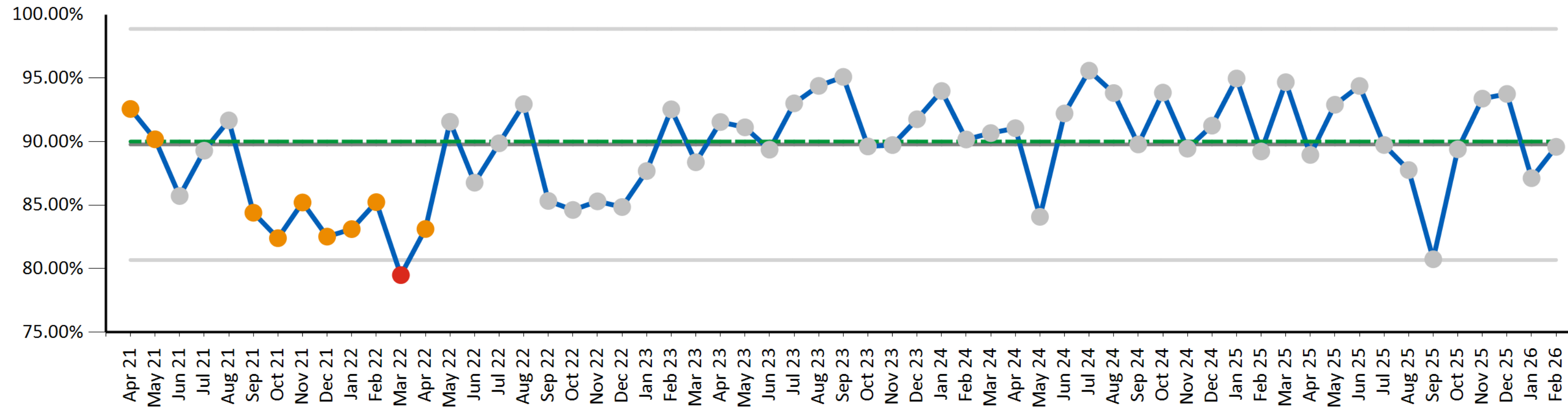


Latest

Plan	Actual	Period
>= 90%	89.6%	Feb-26

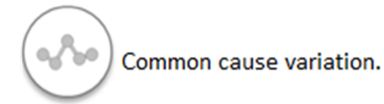
Previous

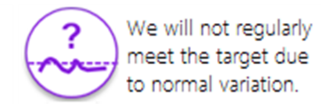
Plan	Actual	Period
>= 90%	87.1%	Jan-26

Year to Date

Plan	Actual
>= 90%	89.9%

84 - Hospital Postnatal - Friends and Family Response Rate





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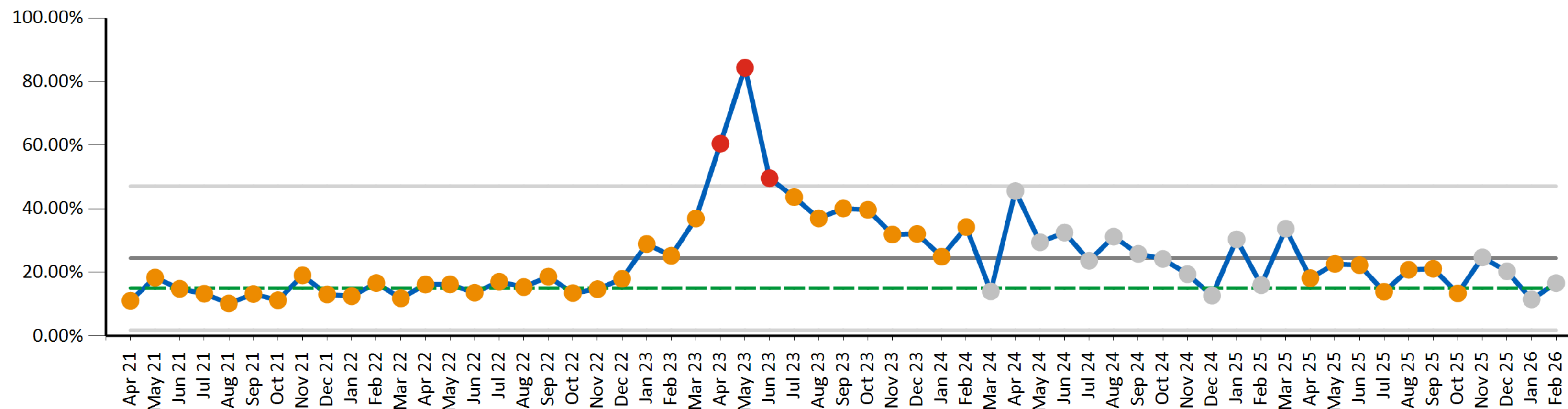


Latest

Plan	Actual	Period
>= 15%	16.6%	Feb-26

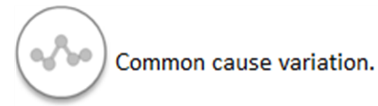
Previous

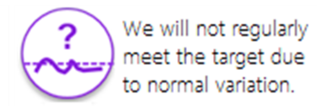
Plan	Actual	Period
>= 15%	11.5%	Jan-26

Year to Date

Plan	Actual
>= 15%	18.6%

244 - Hospital Postnatal Friends and Family Test - Satisfaction %





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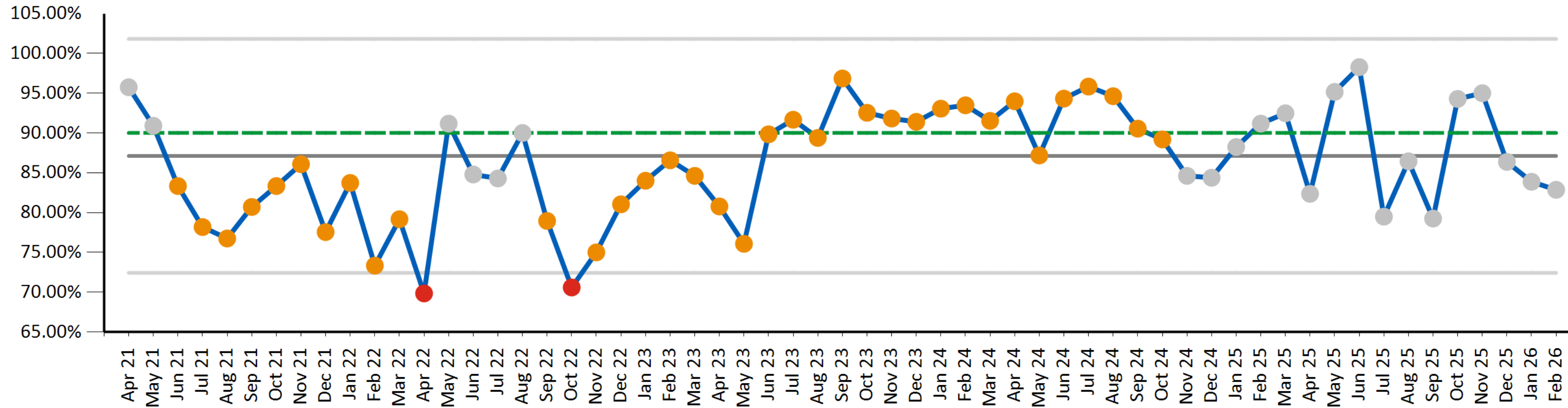


Latest

Plan	Actual	Period
>= 90%	82.9%	Feb-26

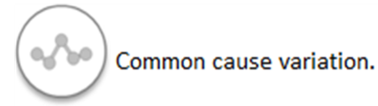
Previous

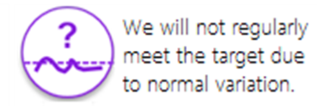
Plan	Actual	Period
>= 90%	83.9%	Jan-26

Year to Date

Plan	Actual
>= 90%	88.2%

85 - Community Postnatal - Friend and Family Response Rate





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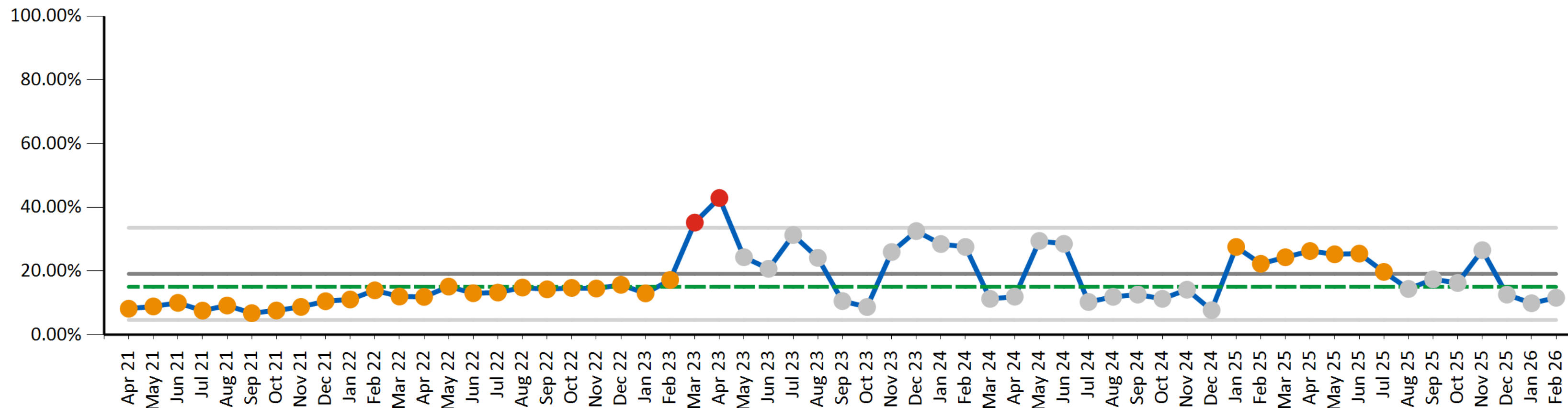


Latest

Plan	Actual	Period
>= 15%	11.6%	Feb-26

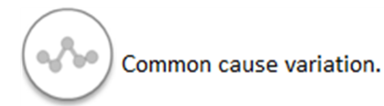
Previous

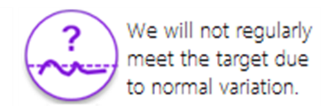
Plan	Actual	Period
>= 15%	9.9%	Jan-26

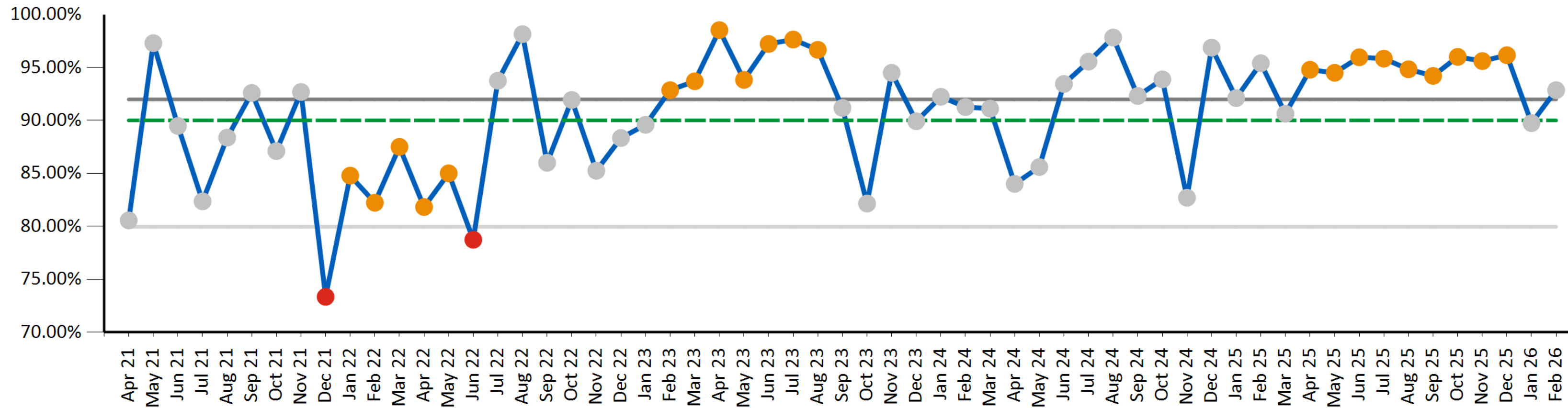
Year to Date

Plan	Actual
>= 15%	18.7%

245 - Community Postnatal Friends and Family Test - Satisfaction %







Latest

Plan	Actual	Period
>= 90%	92.9%	Feb-26

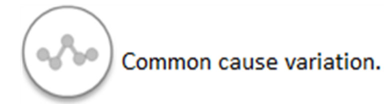
Previous

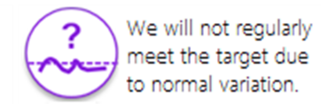
Plan	Actual	Period
>= 90%	89.7%	Jan-26

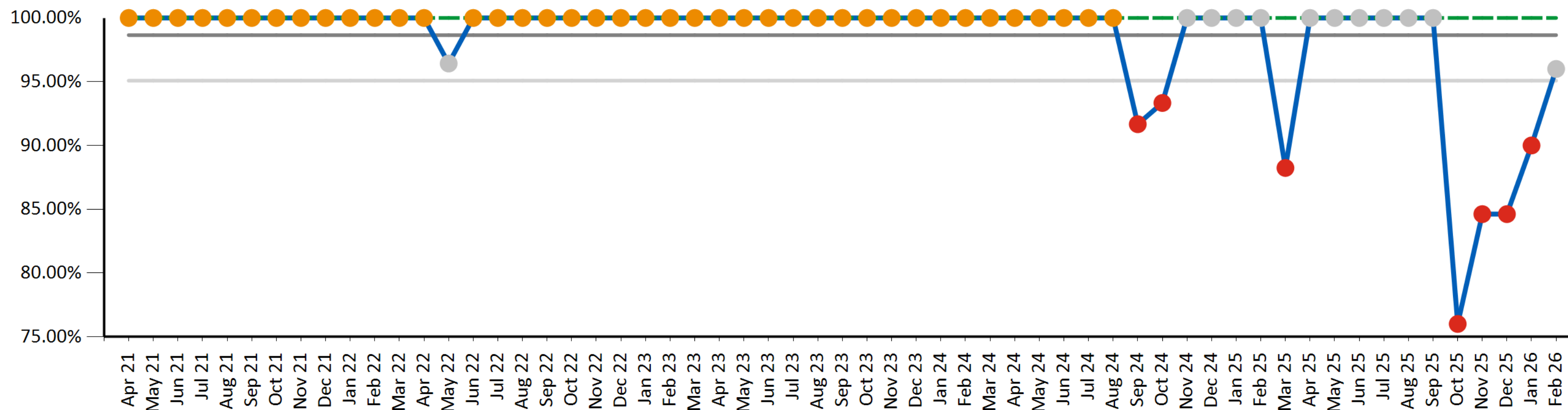
Year to Date

Plan	Actual
>= 90%	94.9%

89 - Formal complaints acknowledged within 3 working days







Latest

Plan	Actual	Period
= 100%	96.0%	Feb-26

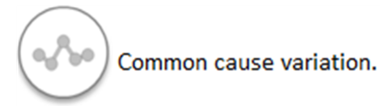
Previous

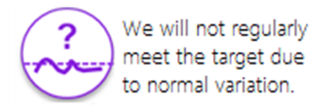
Plan	Actual	Period
= 100%	90.0%	Jan-26

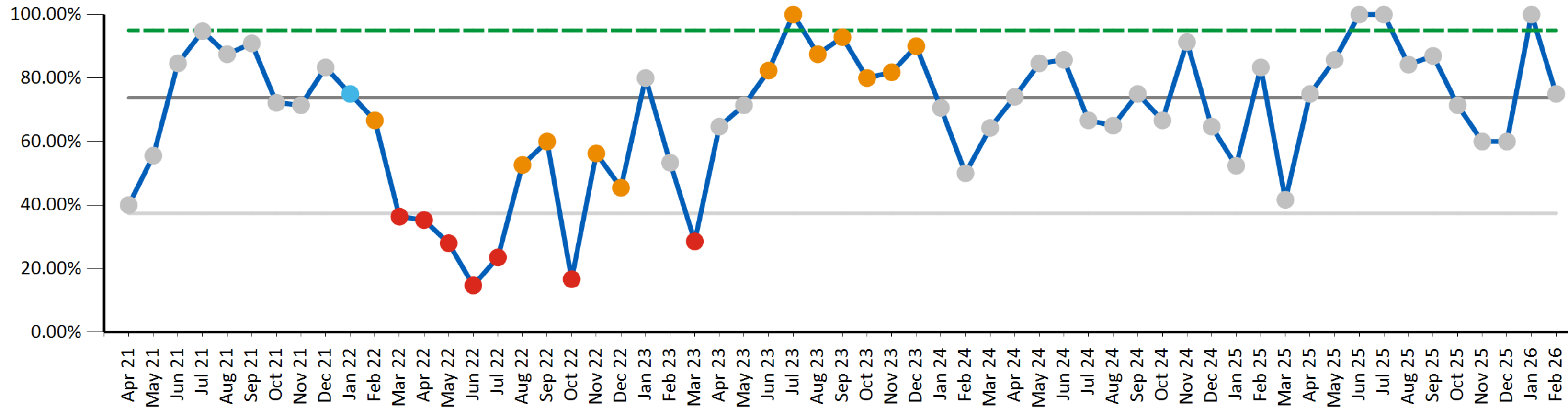
Year to Date

Plan	Actual
= 100%	93.2%

90 - Complaints responded to within the period







Latest

Plan	Actual	Period
>= 95%	75.0%	Feb-26

Previous

Plan	Actual	Period
>= 95%	100.0%	Jan-26

Year to Date

Plan	Actual
>= 95%	76.5%

Quality and Safety - Maternity

Friends and Family Response Rate - The Friends and Family Test response rate has decreased to 14.0% this month (from 18.6%), with a small reduction in birth related satisfaction to 89.4%.
The reduced response rate is primarily linked to limited administrative capacity to upload paper forms into the Envoy system and incomplete QR code submissions.
Targeted actions are in place to improve compliance. Support for FFT completion has been added into the Maternity Care Assistant role . Inputting of paper FFTs has been reassigned to the out of hours Ward Clerk, ensuring timely data entry. These measures are expected to stabilise and improve response rates over the coming months.

Maternity Stillbirth Rate (excluding termination of pregnancy (TOPS)
There were no stillbirths recorded this month. Work is underway to expand the availability of REACH pregnancy circles across the full geographical footprint. This model increases overall contact time with a community midwife from an average of 4.5 hours to around 8 hours through group-based teaching.
The REACH circles replace routine antenatal appointments with facilitated group sessions, offering women more consistent time with their midwives. While currently delivered from two family hubs, plans are progressing to roll the model out across all family hubs to ensure equity of access and further strengthen antenatal support.

¾ degree tears- The rate of 3rd/4th degree tears shows common cause variation, with a decrease this month to 2.2%. Implementation of the Perinatal Pelvic Health Service continues at pace, aligned with MPOP requirements, with women now receiving enhanced pelvic health support delivered jointly by midwifery and physiotherapy teams. Ongoing education ensures midwifery and medical staff remain competent in providing pelvic health advice across both the antenatal and postnatal periods. These training sessions form a continuous programme and are included within mandatory training, offering assurance of sustained workforce capability.

1:1 care in labour – Common cause variation continues, with 98.9% 1:1 care in labour achieved this month. Recruitment remains extremely positive, with an anticipated 4.28 WTE Registered Midwife deficit by March 2026.
While this vacancy can present a potential risk to maintaining consistent 1:1 care, mitigation is in place. Delivery of 1:1 care is prioritised, and staff are redeployed across the unit in real time to ensure coverage.

Booked by 12+6- Common cause variation was noted in February 2026, with 90.0% of women booked by 12+6. Work continues to expand the Early Bird offer into more areas of Bolton, supported by education to ensure accurate data entry at the point of booking.
The Early Bird offer is a group information session provided before the formal booking appointment. It includes early pregnancy public health and screening information and offers women the opportunity to have their booking bloods taken early. This enables prompt interpretation of results and timely referral or action if required, improving early access to antenatal care.

Percentage of women induced remains within common cause variation at 33.6% compared with 34.3% in January 2026.

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). The date remains within common cause variation with 56.9% compliance reported in following the introduction of the early bird antenatal session.

Inductions of labour- common cause variation was noted with 24 induction cases delayed by more than 24 hours in 10. A new Maternity Escalation Tool is now in place to alert the senior team to any delays, supported by the introduction of a Matron of the Day and twice daily MDT safety huddles.
Delays were due to acuity and activity pressures on central delivery suit. Women awaiting transfer remain under medical review, and all delays are reported via Safeguard. No adverse outcomes have resulted from these delays.

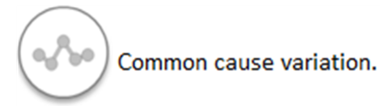
Breastfeeding initiation- common cause variation was recorded on M11, with breastfeeding initiation decreasing to 72.26% from 75.26%. The service is preparing to request the external Stage 2 Baby Friendly assessment later this year. Fluctuation is anticipated month to month based on women's feeding choices. The Infant Feeding Team continues to audit antenatal feeding information delivery.

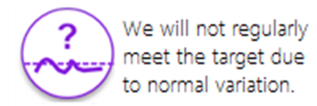
Preterm birth (less than 37 weeks gestation) with an increase to 11.0% reported in February 2026. Introduction of the partner trial and decision-making tool in progress that will assist in the screening to detect high risk pre term cases and enable the early allocation to appropriate pathways with ongoing monitoring.

MEWS compliance –a decrease in compliance in month which relates to the completion of the sepsis screening tool when patients are well and scoring 0. Education opportunities have been increased across the unit to raise awareness that the field is mandatory even in well patients.

	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	0.00	Feb-26		<= 3.50	7.43	Jan-26	<= 3.50	2.72	
23 - Maternity -3rd/4th degree tears	<= 3.5%	2.2%	Feb-26		<= 3.5%	3.5%	Jan-26	<= 3.5%	2.5%	
202 - 1:1 Midwifery care in labour	>= 95.0%	98.9%	Feb-26		>= 95.0%	99.5%	Jan-26	>= 95.0%	99.0%	
203 - Booked 12+6	>= 90.0%	90.0%	Feb-26		>= 90.0%	87.8%	Jan-26	>= 90.0%	91.0%	
586 - Booked 10+0		56.9%	Feb-26			56.0%	Jan-26		65.6%	
204 - Percentage of women induced	<= 40%	33.6%	Feb-26		<= 40%	34.3%	Jan-26	<= 40%	35.1%	
210 - Initiation breast feeding	>= 65%	71.26%	Feb-26		>= 65%	75.26%	Jan-26	>= 65%	71.16%	
213 - Maternity complaints	<= 5	0	Feb-26		<= 5	8	Jan-26	<= 55	24	
319 - Maternal deaths (direct)	= 0	0	Feb-26		= 0	0	Jan-26	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	11.0%	Feb-26		<= 6%	6.9%	Jan-26	<= 6%	8.3%	
631 - Number of Neonates with suspected HIE Grade 2 and 3, = 37 Weeks (Bolton Babies only)		1	Feb-26			1	Jan-26		2	
575 - Delay in transfer to Central Delivery Suite during the Induction Of Labour process over 24 hours		24	Jan-26			3	Dec-25		232	

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





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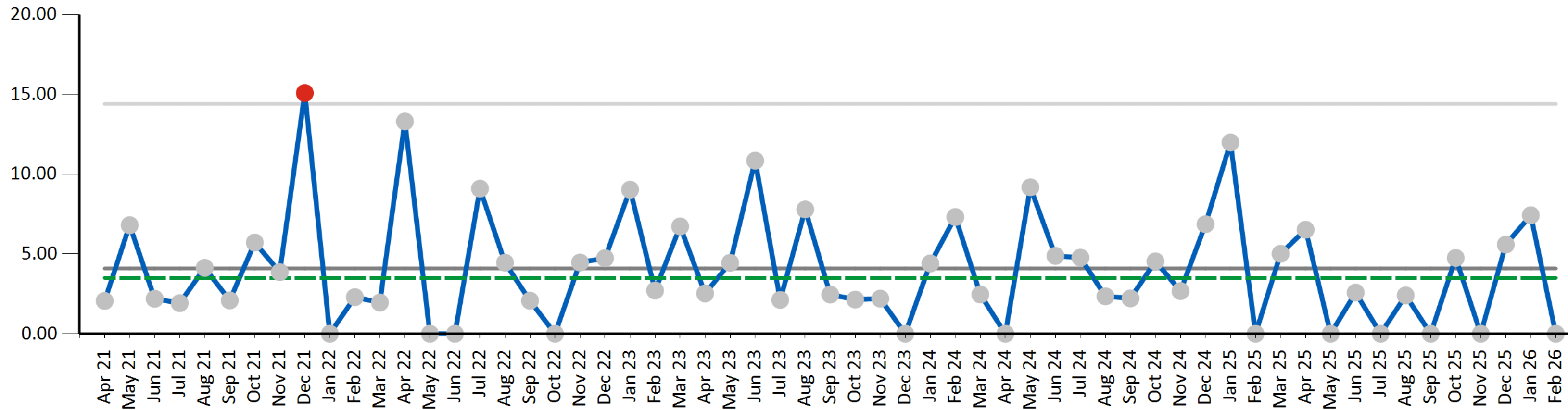


Latest

Plan	Actual	Period
<= 3.50	0.00	Feb-26

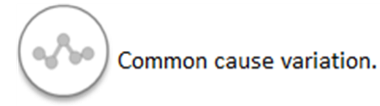
Previous

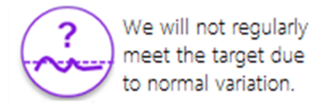
Plan	Actual	Period
<= 3.50	7.43	Jan-26

Year to Date

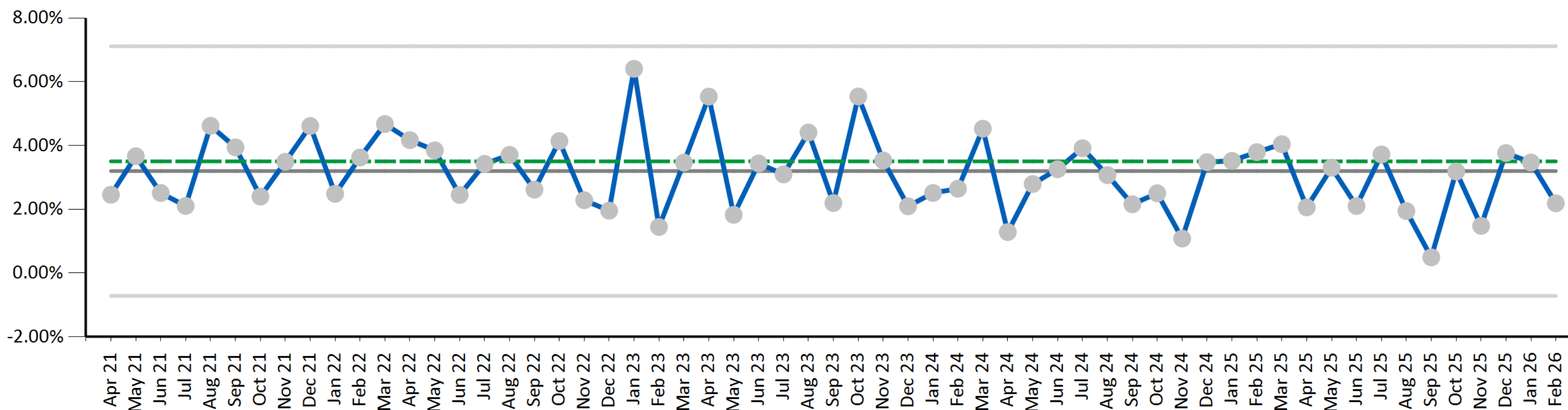
Plan	Actual
<= 3.50	2.72

23 - Maternity -3rd/4th degree tears





5/6



Latest

Plan	Actual	Period
<= 3.5%	2.2%	Feb-26

Previous

Plan	Actual	Period
<= 3.5%	3.5%	Jan-26

Year to Date

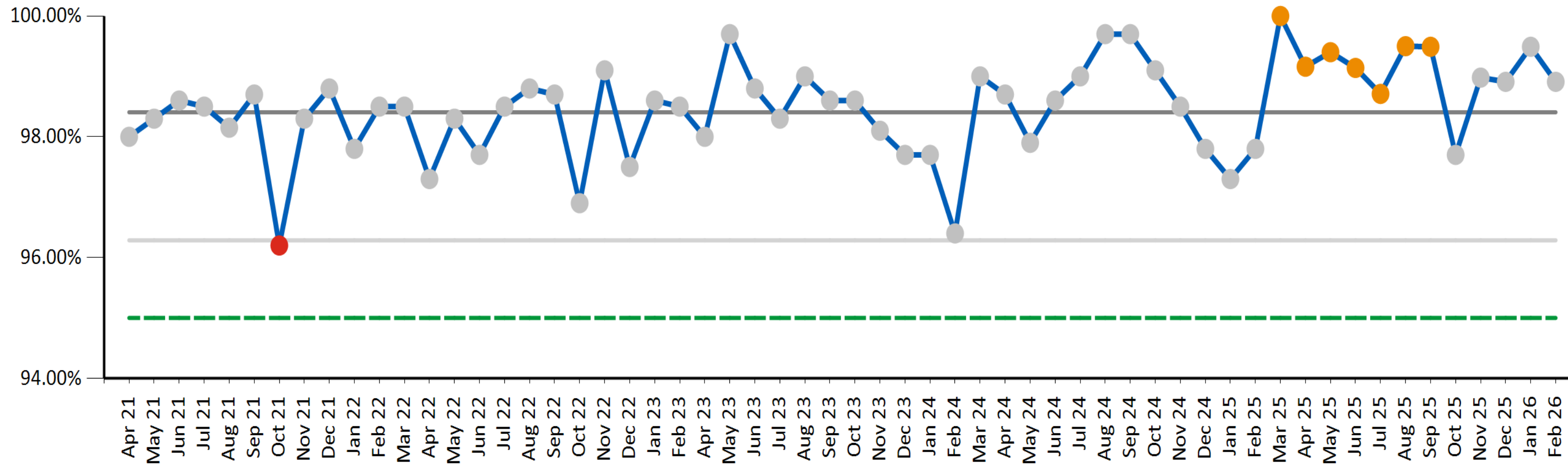
Plan	Actual
<= 3.5%	2.5%

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%	Feb-26

Previous

Plan	Actual	Period
>= 95.0%	99.5%	Jan-26

Year to Date

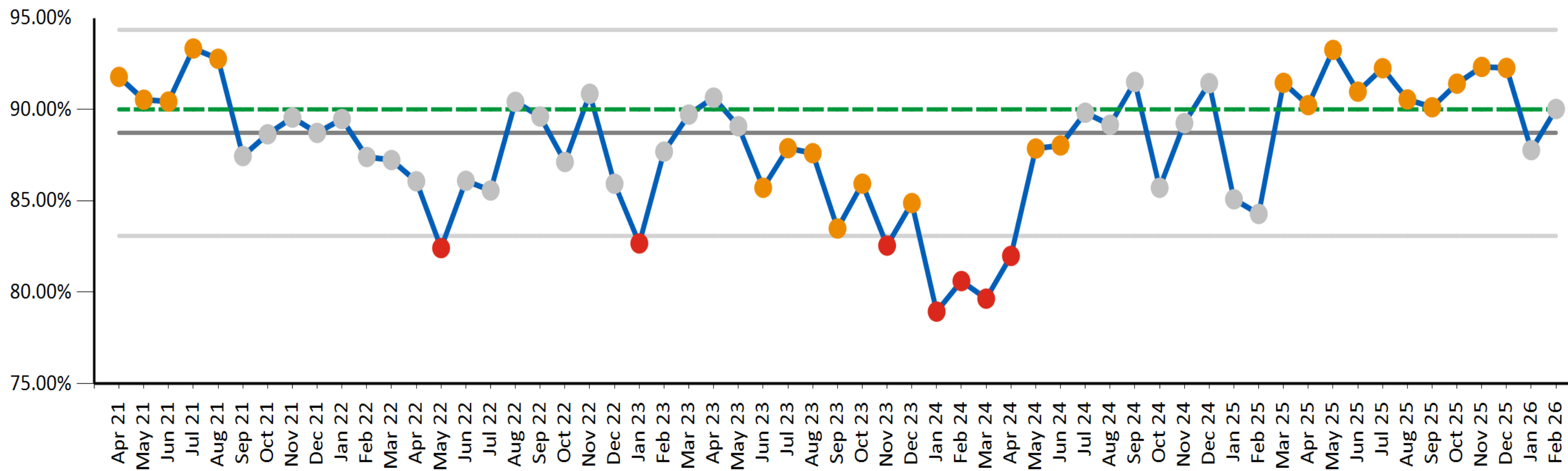
Plan	Actual
>= 95.0%	99.0%

203 - Booked 12+6

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 90.0%	90.0%	Feb-26

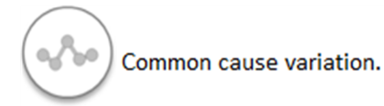
Previous

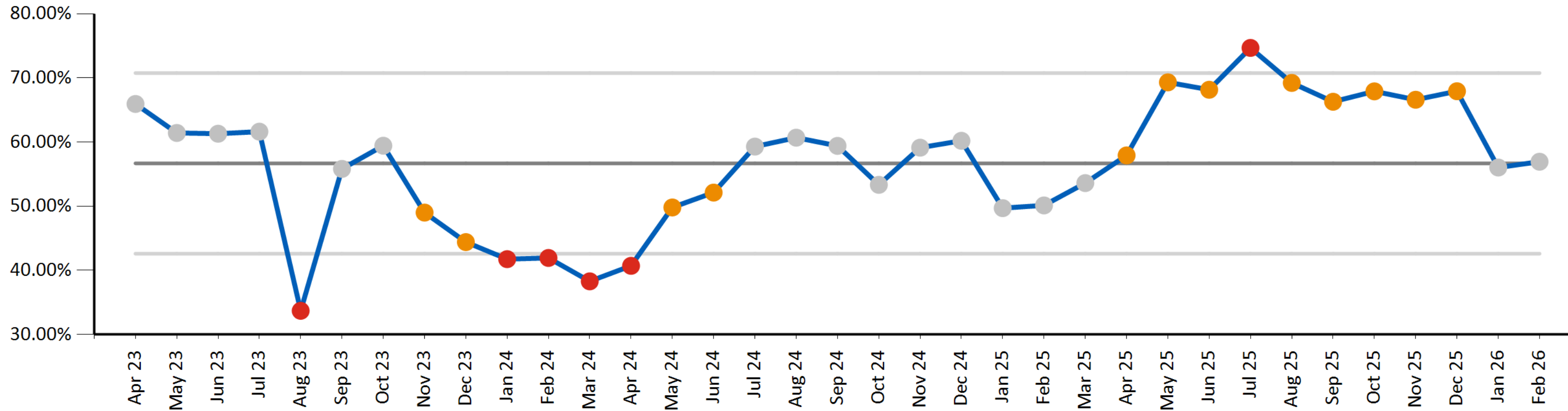
Plan	Actual	Period
>= 90.0%	87.8%	Jan-26

Year to Date

Plan	Actual
>= 90.0%	91.0%

586 - Booked 10+0





Latest

Plan	Actual	Period
	56.9%	Feb-26

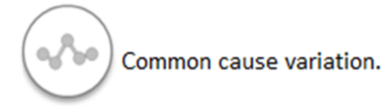
Previous

Plan	Actual	Period
	56.0%	Jan-26

Year to Date

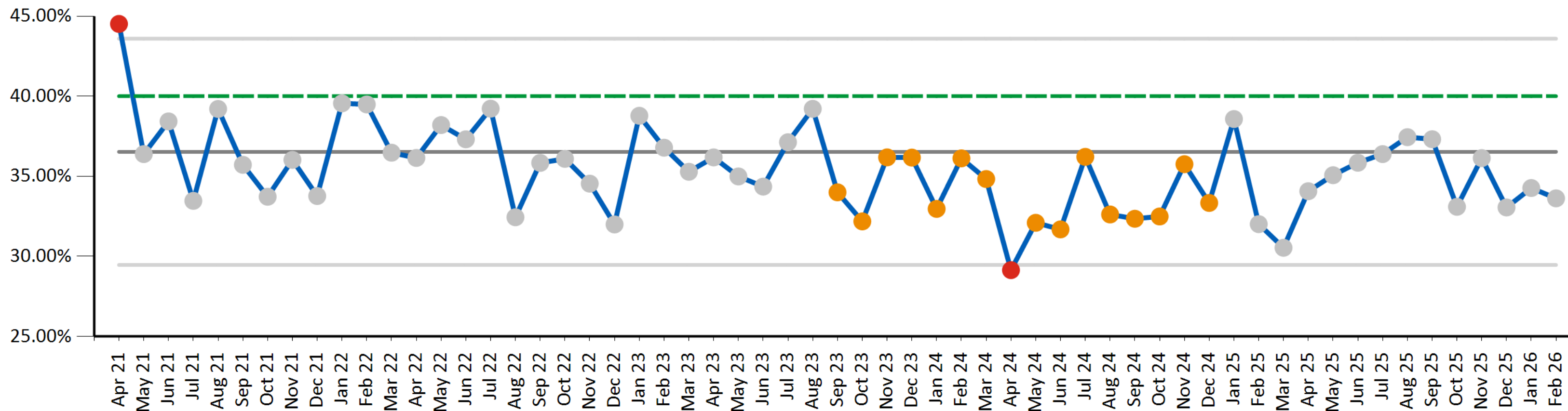
Plan	Actual
	65.6%

204 - Percentage of women induced



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

6/6



Latest

Plan	Actual	Period
<= 40%	33.6%	Feb-26

Previous

Plan	Actual	Period
<= 40%	34.3%	Jan-26

Year to Date

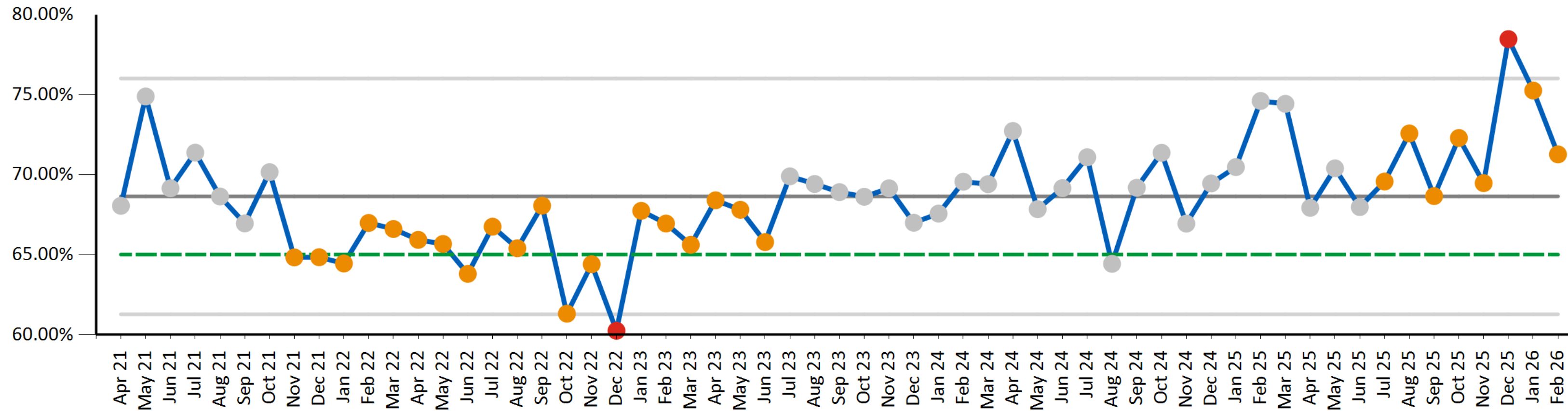
Plan	Actual
<= 40%	35.1%

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%	71.26%	Feb-26

Previous

Plan	Actual	Period
>= 65%	75.26%	Jan-26

Year to Date

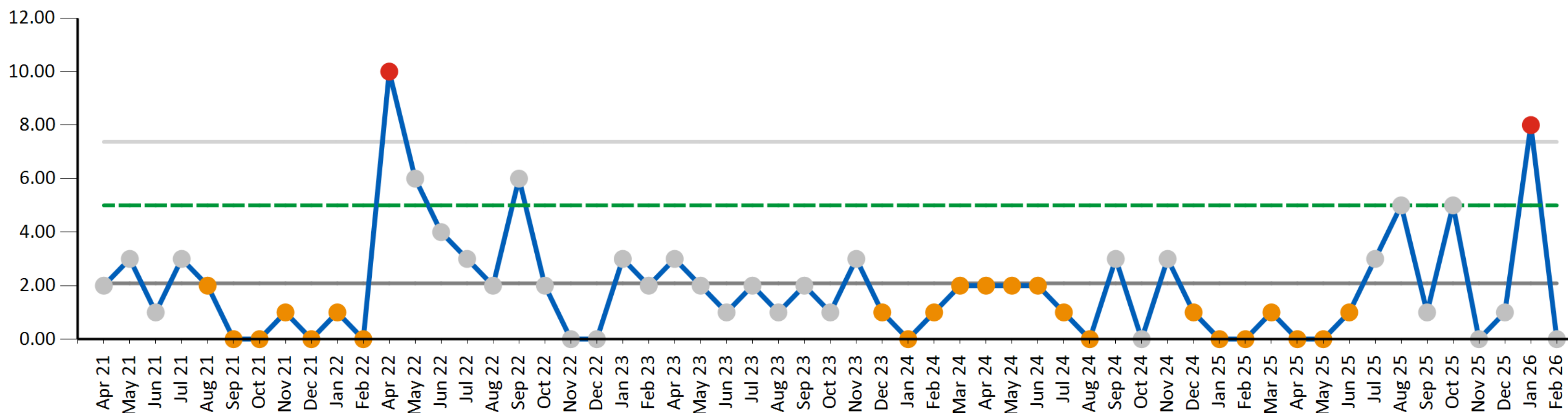
Plan	Actual
>= 65%	71.16%

213 - Maternity complaints

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 5	0	Feb-26

Previous

Plan	Actual	Period
<= 5	8	Jan-26

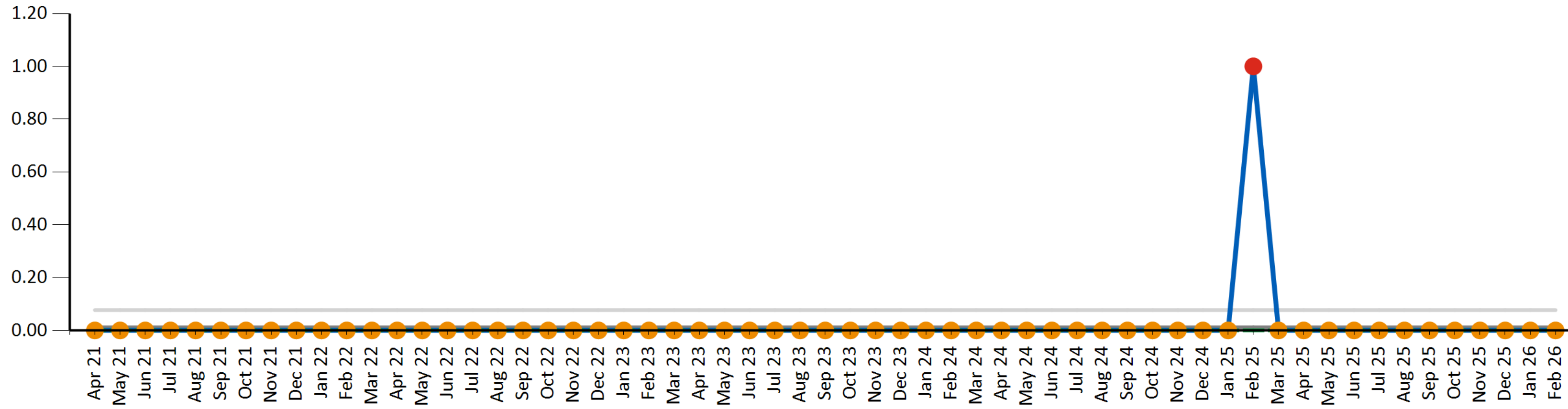
Year to Date

Plan	Actual
<= 55	24

319 - Maternal deaths (direct)

Special cause variation with improving performance

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



Latest

Plan	Actual	Period
= 0	0	Feb-26

Previous

Plan	Actual	Period
= 0	0	Jan-26

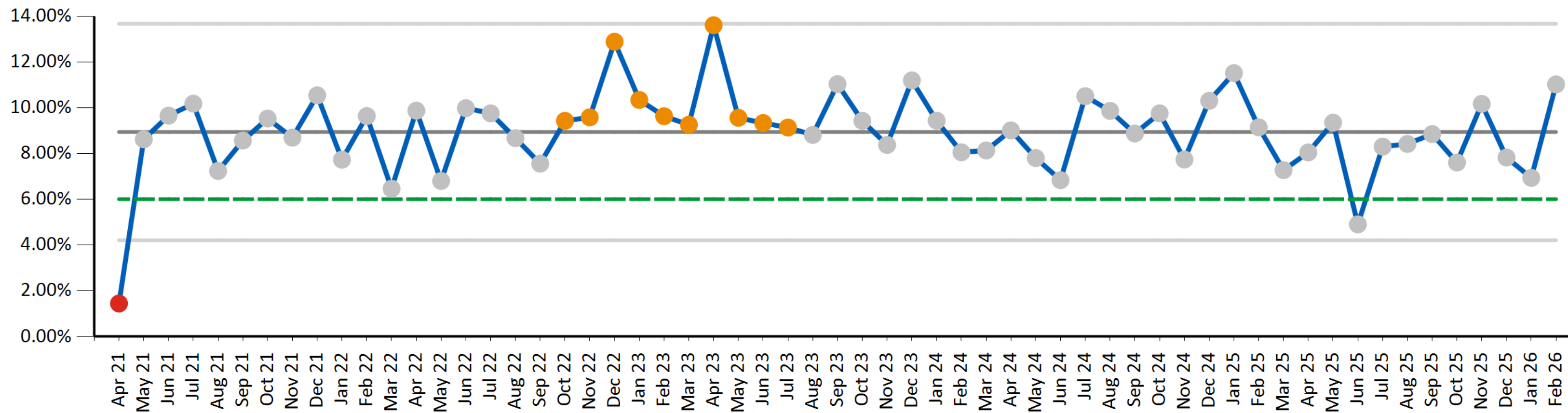
Year to Date

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.



Latest

Plan	Actual	Period
<= 6%	11.0%	Feb-26

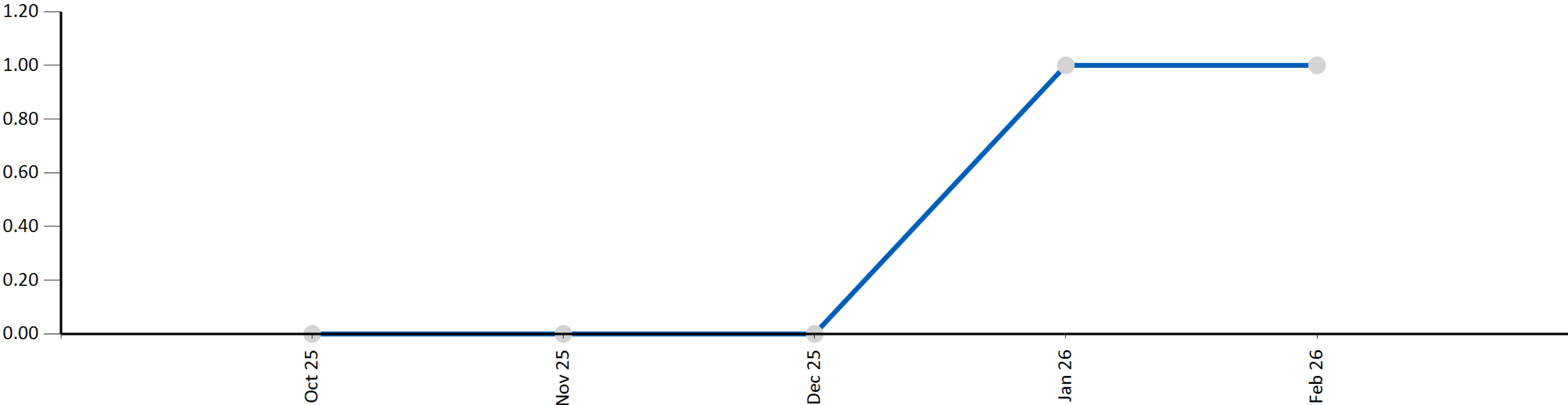
Previous

Plan	Actual	Period
<= 6%	6.9%	Jan-26

Year to Date

Plan	Actual
<= 6%	8.3%

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
	1	Feb-26

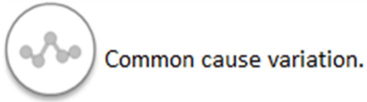
Previous

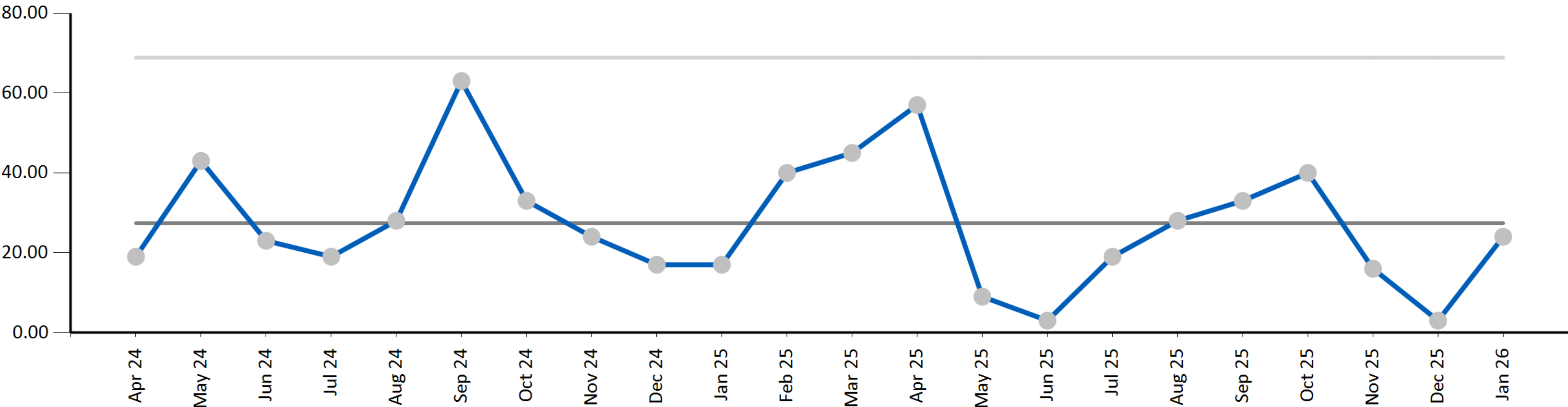
Plan	Actual	Period
	1	Jan-26

Year to Date

Plan	Actual
	2

575 - Delay in transfer to Central Delivery Suite during the Induction Of Labour process over 24 hours





Latest

Plan	Actual	Period
	24	Jan-26

Previous

Plan	Actual	Period
	3	Dec-25

Year to Date

Plan	Actual
	232

Operational Performance - Urgent Care

Urgent Care
In February 2026, performance against the all types 4 hour standard was 63.81%, representing a 1.6% improvement compared to January 2026 (62.19%). Ambulance handovers within 15 minutes worsened to 41.99% (44.47% in January), handovers above 30 minutes worsened to 26.97% (up from 23.17%), while those completed above 60 minutes also worsened at 11.06% (8.38% in January).
The percentage number of over 12 hour waits improved to 9.55% in February compared to 10.16% in January. Non elective length of stay also improved slightly, reducing to 4.91 days in February from 5.08 days in January.

NOF
For February, our fractured neck of femur performance improved to 60.9%, with 14 of 23 eligible patients getting to theatre within the 36 hour window.
Of the 9x patients who breached the target, 1x patient was delayed due to a complex fracture requiring a specific surgeon to assist, 4x were delayed due to an influx of 4x fractures in the same evening, and 4x were delayed due to higher than normal levels of weekend admissions for fractures. Mortality remains under the national average when adjusted for casemix, and our average number of hours to operation has fallen for the tenth successive month on an annual rolling average.
It is expected that due to an increase in demand so far in March, that performance will deteriorate ahead of improvement in April.

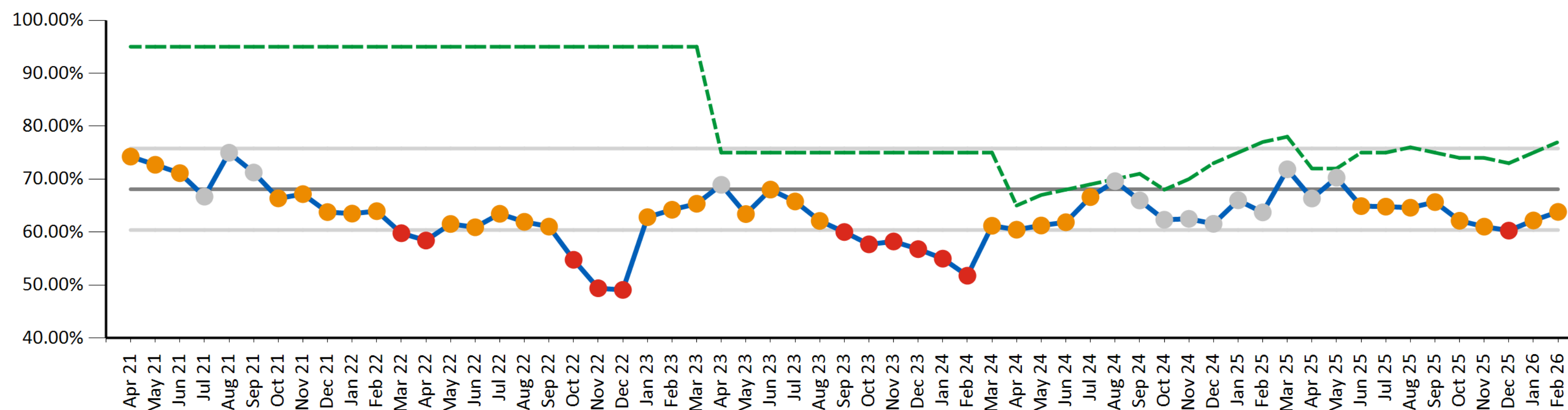
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
53 - A&E 4 hour target	>= 77%	63.8%	Feb-26		>= 75%	62.2%	Jan-26	>= 77%	64.2%	
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	42.0%	Feb-26		>= 65.0%	44.5%	Jan-26	>= 65.0%	50.8%	
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	73.0%	Feb-26		>= 95.0%	76.6%	Jan-26	>= 95.0%	80.6%	
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100%	88.94%	Feb-26		= 100%	91.44%	Jan-26	= 100%	93.56%	
539 - A&E 12 hour waits	= 0	1,001	Feb-26		= 0	1,191	Jan-26	= 0	9,918	
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	60.9%	Feb-26		>= 75%	54.1%	Jan-26	>= 75%	49.3%	
56 - Stranded patients - over 7 days	<= 200	269	Feb-26		<= 200	239	Jan-26	<= 200	269	
307 - Stranded Patients - LOS 21 days and over	<= 69	109	Feb-26		<= 69	83	Jan-26	<= 69	109	

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
541 - Adult G&A bed occupancy	<= 92.0%	86.4%	Feb-26		<= 92.0%	87.6%	Jan-26	<= 92.0%	86.8%	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.91	Feb-26		<= 3.70	5.08	Jan-26	<= 3.70	4.89	
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	11.4%	Jan-26		<= 13.5%	11.3%	Dec-25	<= 13.5%	11.0%	
554 - 2 Hour Urgent Community Response %	<= 70.0%	84.7%	Feb-26		<= 70.0%	89.3%	Jan-26	<= 70.0%	84.6%	
555 - 2 Hour Urgent Community Response Referrals	>= 358	300	Feb-26		>= 358	346	Jan-26	>= 3,938	3,230	

53 - A&E 4 hour target

Special cause variation with deteriorating performance

We will regularly fail to meet the target.



Latest

Plan	Actual	Period
>= 77%	63.8%	Feb-26

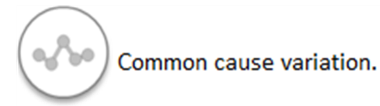
Previous

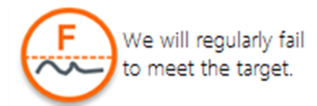
Plan	Actual	Period
>= 75%	62.2%	Jan-26

Year to Date

Plan	Actual
>= 77%	64.2%

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





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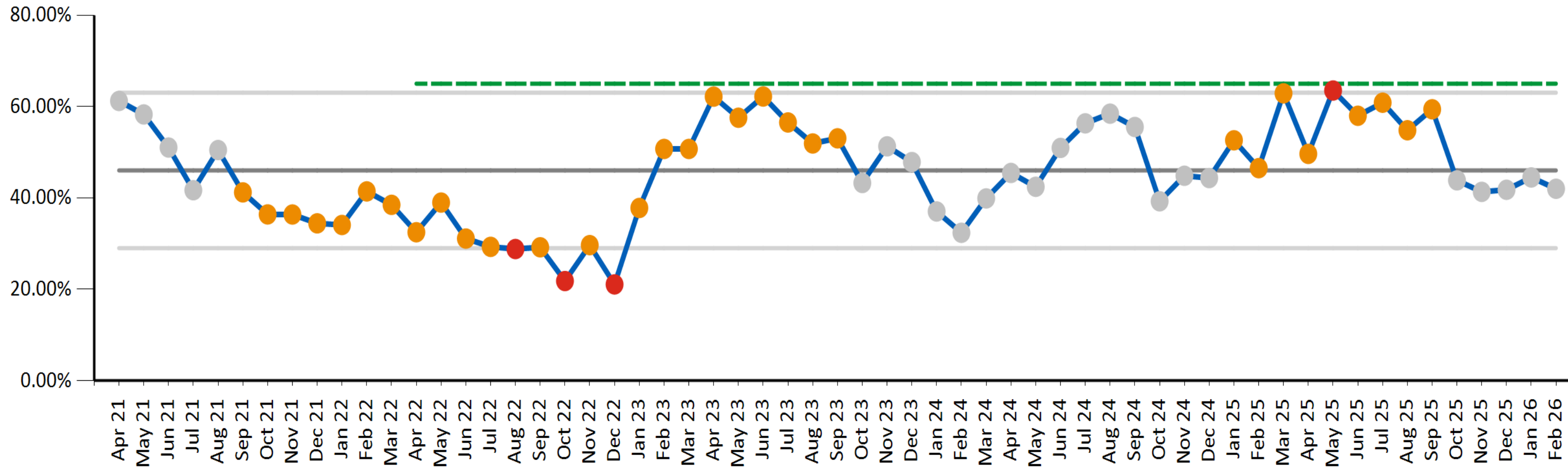


Latest

Plan	Actual	Period
>= 65.0%	42.0%	Feb-26

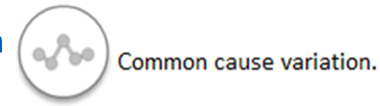
Previous

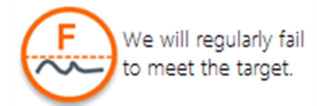
Plan	Actual	Period
>= 65.0%	44.5%	Jan-26

Year to Date

Plan	Actual
>= 65.0%	50.8%

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





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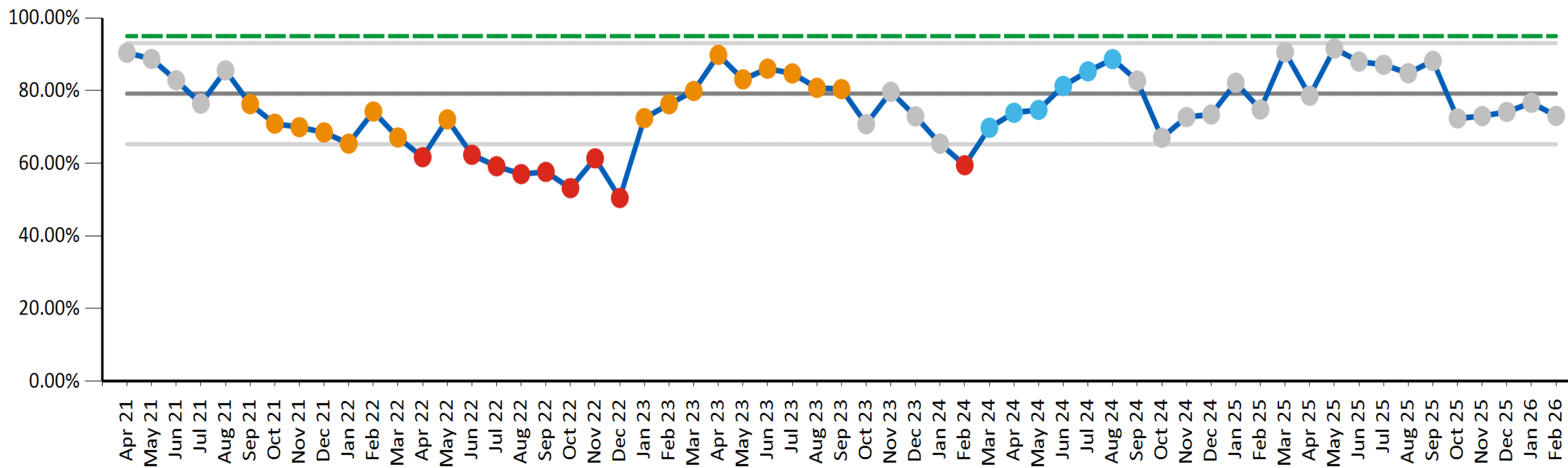


Latest

Plan	Actual	Period
>= 95.0%	73.0%	Feb-26

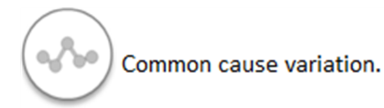
Previous

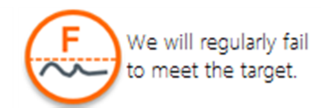
Plan	Actual	Period
>= 95.0%	76.6%	Jan-26

Year to Date

Plan	Actual
>= 95.0%	80.6%

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





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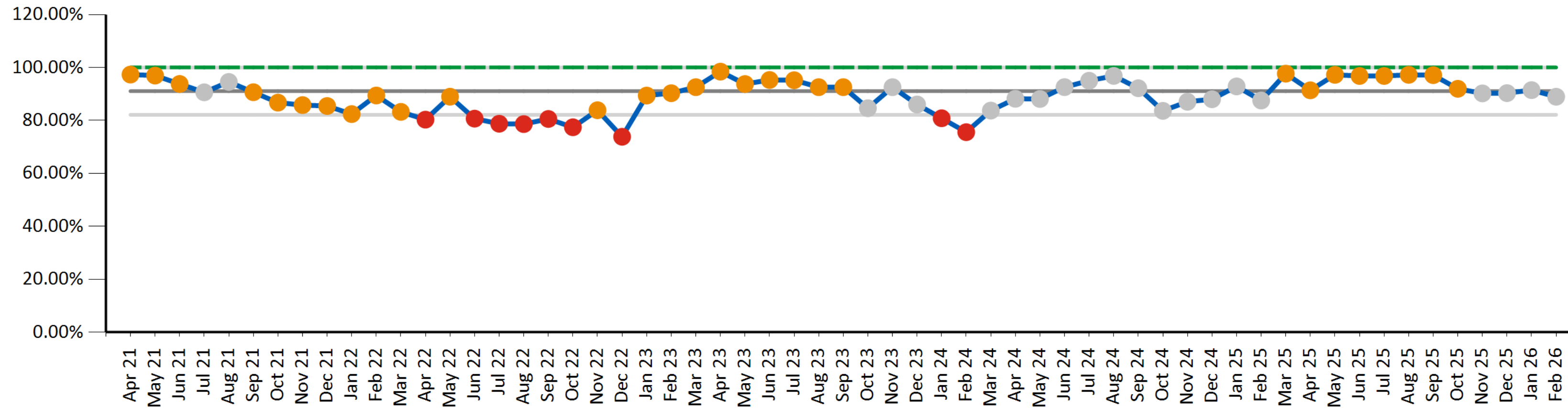


Latest

Plan	Actual	Period
= 100%	88.94%	Feb-26

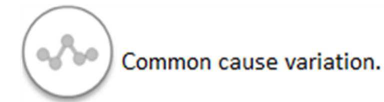
Previous

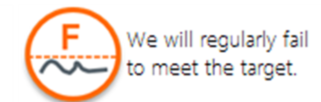
Plan	Actual	Period
= 100%	91.44%	Jan-26

Year to Date

Plan	Actual
= 100%	93.56%

539 - A&E 12 hour waits





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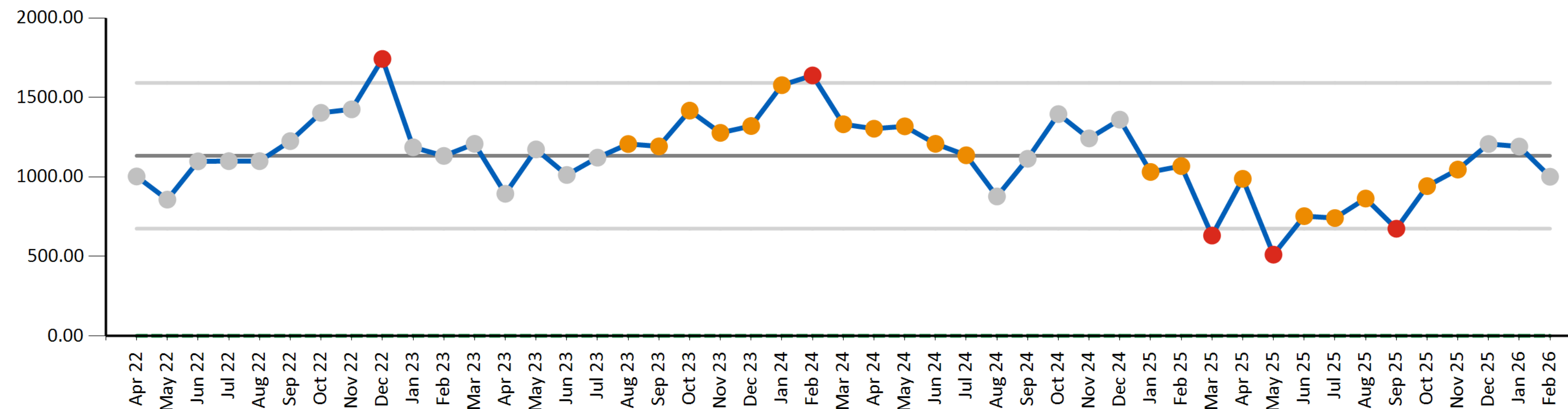


Latest

Plan	Actual	Period
= 0	1,001	Feb-26

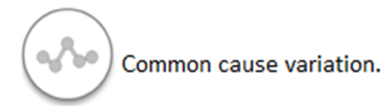
Previous

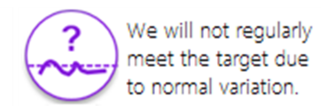
Plan	Actual	Period
= 0	1,191	Jan-26

Year to Date

Plan	Actual
= 0	9,918

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





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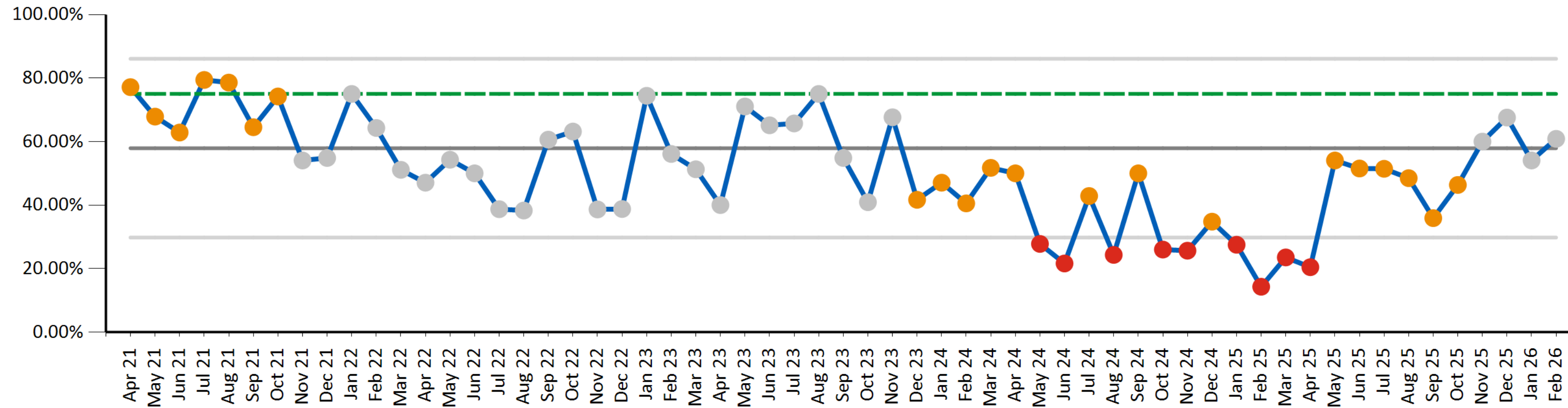


Latest

Plan	Actual	Period
>= 75%	60.9%	Feb-26

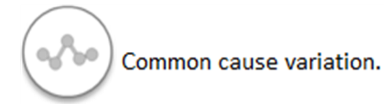
Previous

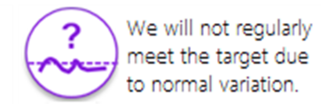
Plan	Actual	Period
>= 75%	54.1%	Jan-26

Year to Date

Plan	Actual
>= 75%	49.3%

56 - Stranded patients - over 7 days





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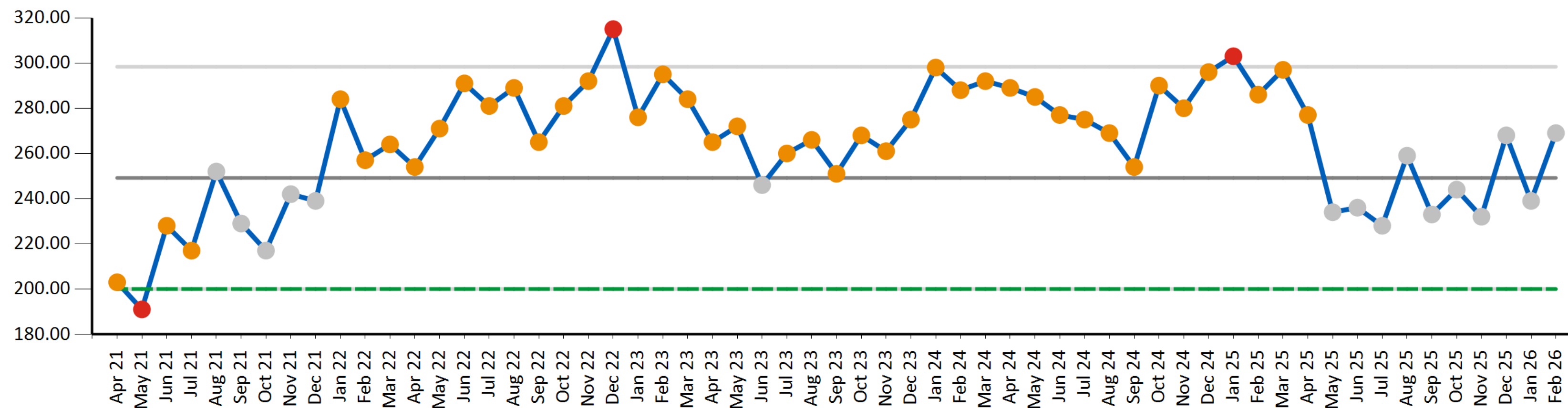


Latest

Plan	Actual	Period
<= 200	269	Feb-26

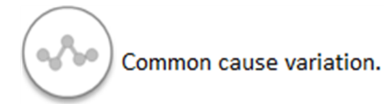
Previous

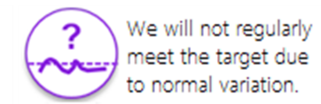
Plan	Actual	Period
<= 200	239	Jan-26

Year to Date

Plan	Actual
<= 200	269

307 - Stranded Patients - LOS 21 days and over





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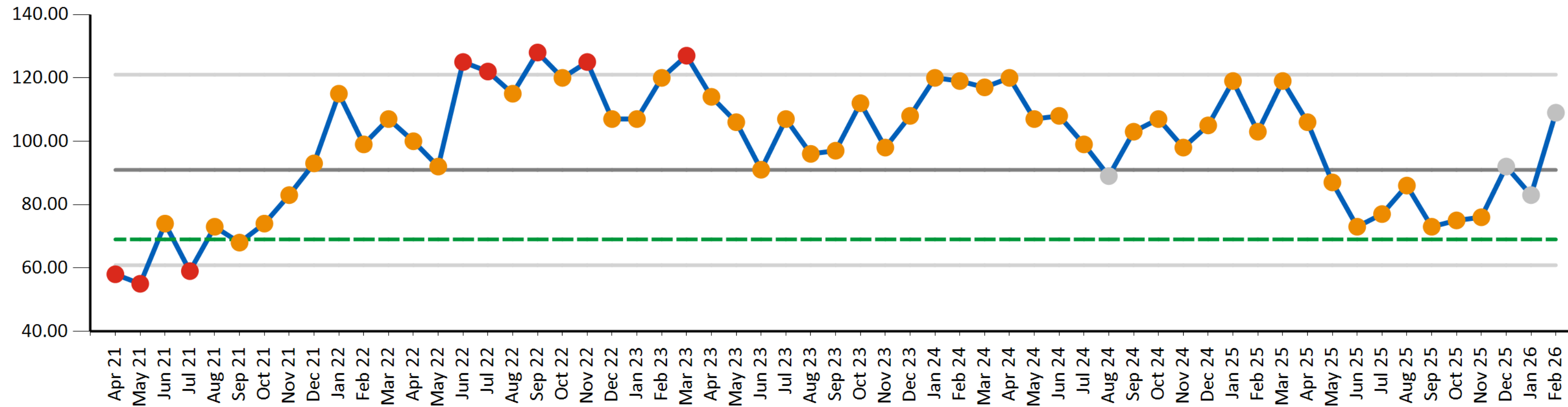


Latest

Plan	Actual	Period
<= 69	109	Feb-26

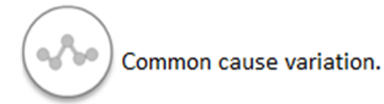
Previous

Plan	Actual	Period
<= 69	83	Jan-26

Year to Date

Plan	Actual
<= 69	109

541 - Adult G&A bed occupancy



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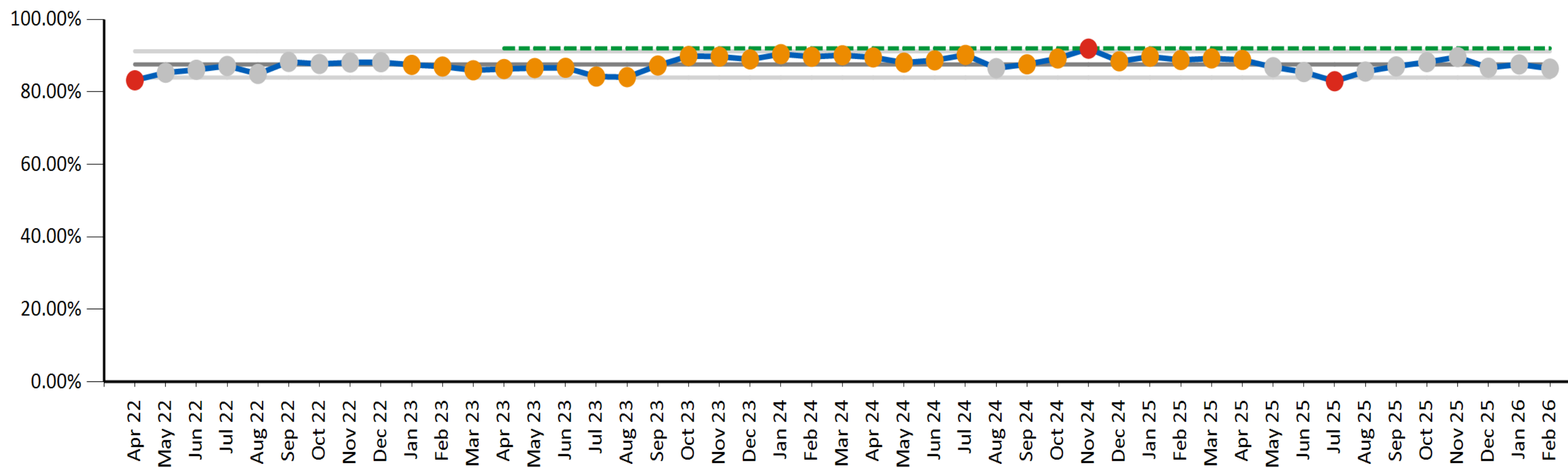


Latest

Plan	Actual	Period
<= 92.0%	86.4%	Feb-26

Previous

Plan	Actual	Period
<= 92.0%	87.6%	Jan-26

Year to Date

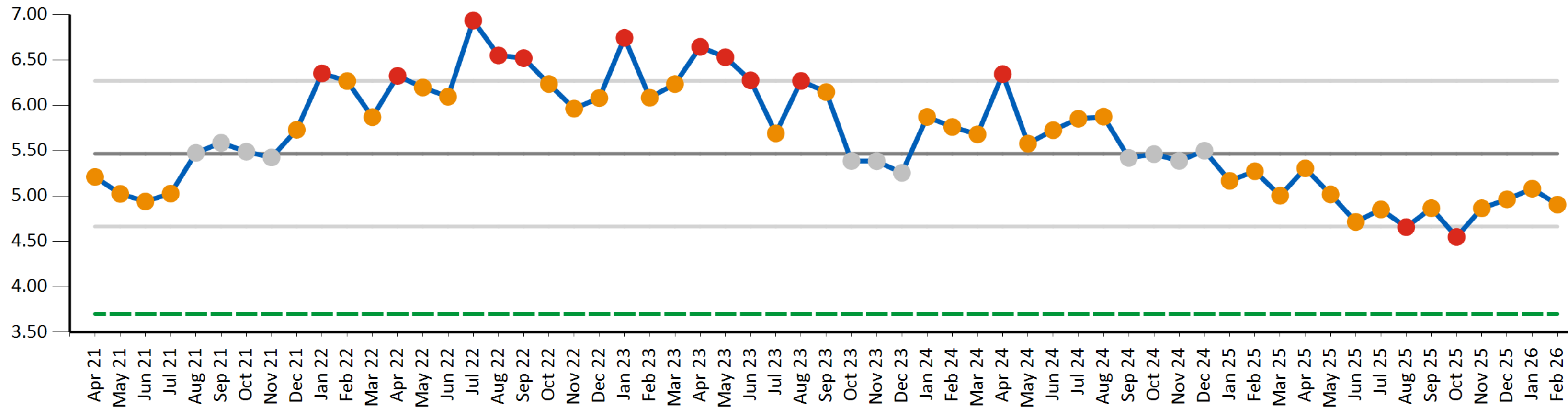
Plan	Actual
<= 92.0%	86.8%

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	4.91	Feb-26

Previous

Plan	Actual	Period
<= 3.70	5.08	Jan-26

Year to Date

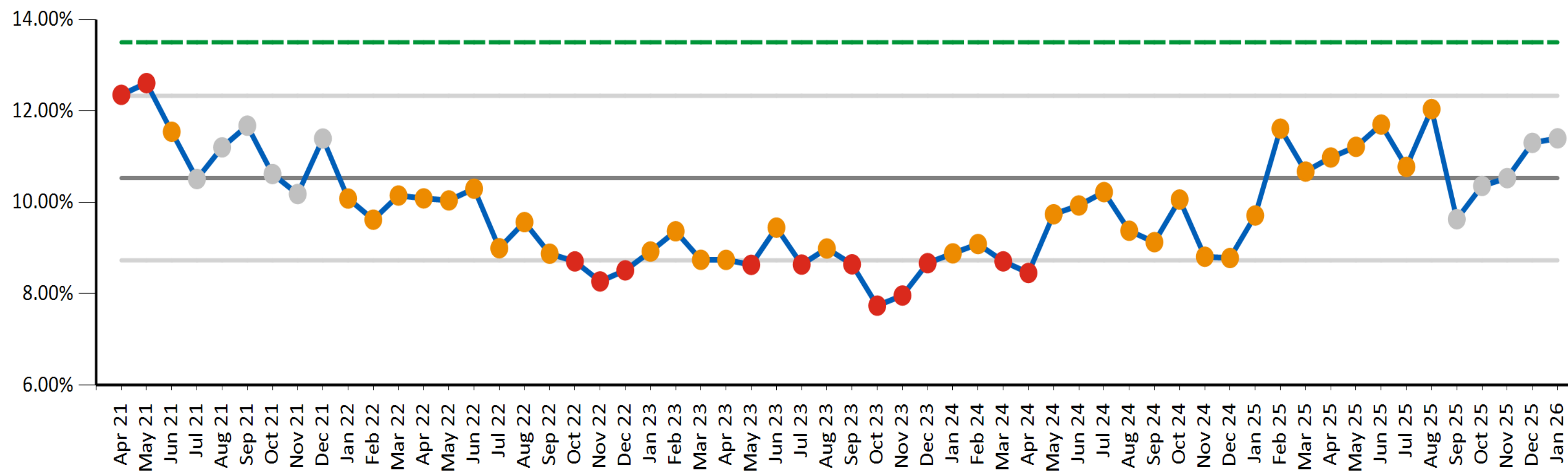
Plan	Actual
<= 3.70	4.89

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

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 13.5%	11.4%	Jan-26

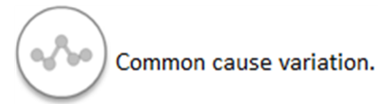
Previous

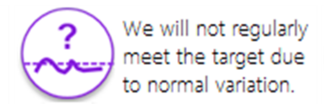
Plan	Actual	Period
<= 13.5%	11.3%	Dec-25

Year to Date

Plan	Actual
<= 13.5%	11.0%

554 - 2 Hour Urgent Community Response %





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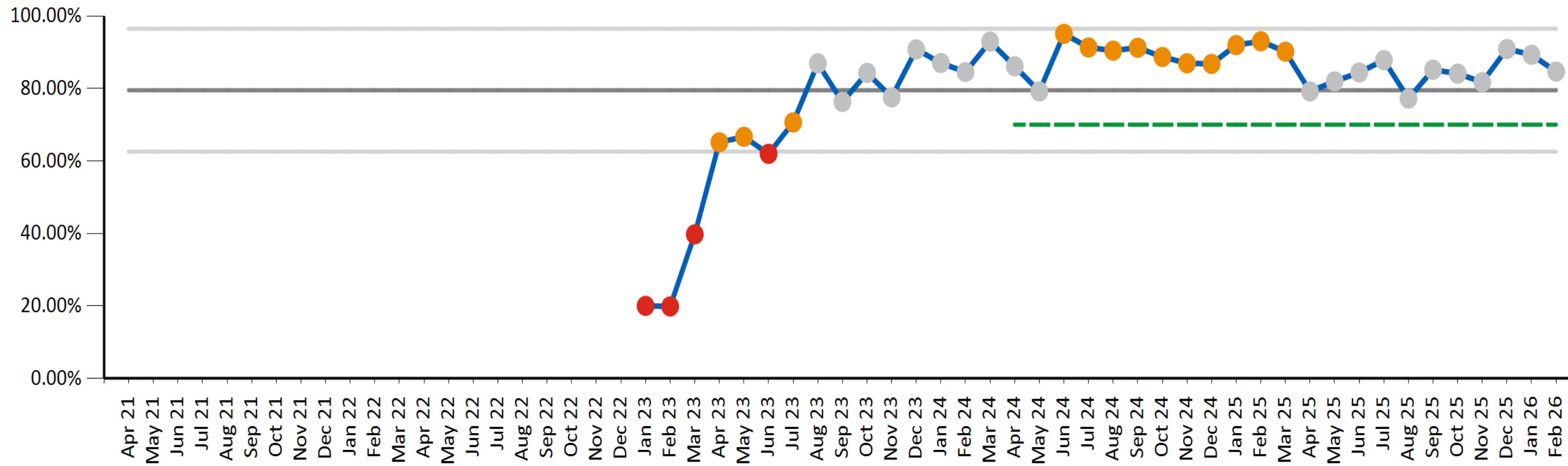


Latest

Plan	Actual	Period
<= 70.0%	84.7%	Feb-26

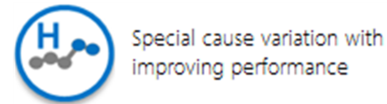
Previous

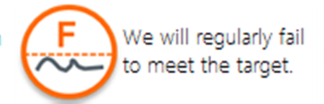
Plan	Actual	Period
<= 70.0%	89.3%	Jan-26

Year to Date

Plan	Actual
<= 70.0%	84.6%

555 - 2 Hour Urgent Community Response Referrals





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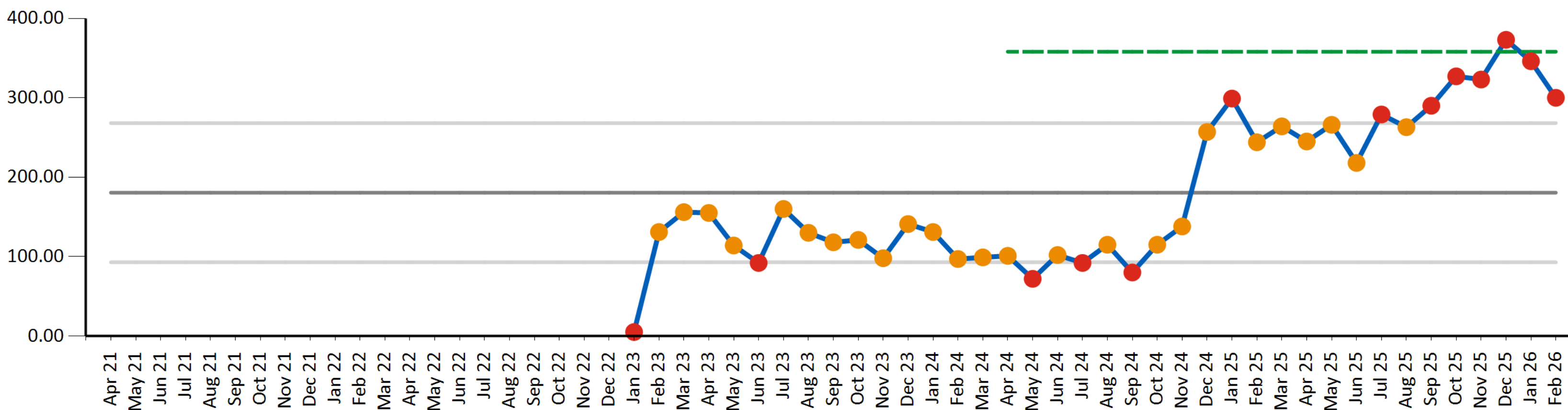


Latest

Plan	Actual	Period
>= 358	300	Feb-26

Previous

Plan	Actual	Period
>= 358	346	Jan-26

Year to Date

Plan	Actual
>= 3,938	3,230

Operational Performance - Elective Care

NHS Bolton NHS Foundation Trust

RTT

We finished February with 0x 78-week breaches, or 65-week breaches.

We finished February with 543x 52-week breaches. This is a reduction of 153x patients from last month. We remain off-track against our plan due to challenges in a few key specialties, however we are on track against our reprofiled trajectory to still achieve the national elective targets for the end of March.

Our overall waiting list size decreased by over 1,500 patients following significant growth in January, to 37,369. We still remain adrift of our plan waiting list size due to factors relating to incorrect outcomes within EPR. This is expected to be resolved by the end of Q1 26/27.

Our RTT overall performance improved by over 1.3% in-month, largely due to the additional activity which is being delivered through the Q4 elective sprint. Confidence remains high of returning to the projected end of year RTT position of 61.5%.

DM01

The February 2026 month end position for DM01 was validated at 2.6%, representing 107 breaches. This reflects an improvement of 0.9% compared the previous month with 15 fewer breaches. While performance remains below the current year standard of <5%, it is above the 1% standard applicable from 2026/27. However, with the introduction of reviews from April 2026, performance will deteriorate, and this risk will continue to be closely monitored.

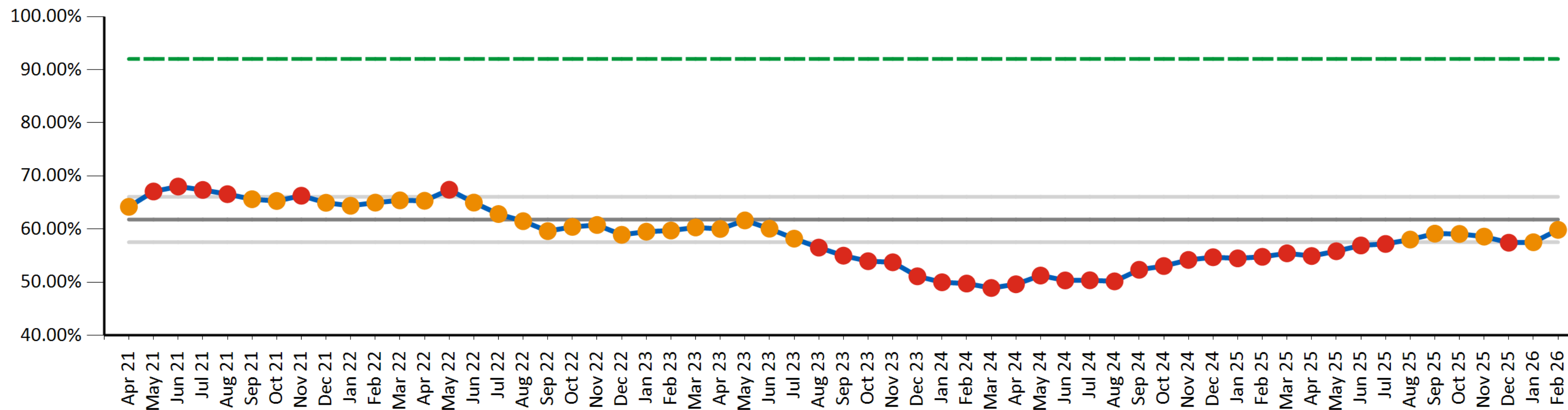
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	59.8%	Feb-26	L	>= 92%	57.5%	Jan-26	>= 92%	57.7%	F
314 - RTT 18 week waiting list	<= 36,405	37,369	Feb-26	H	<= 36,686	38,836	Jan-26	<= 36,405	37,369	P
42 - RTT 52 week waits (incomplete pathways)		543	Feb-26	L		696	Jan-26		11,491	
540 - RTT 65 week waits (incomplete pathways)	= 0	0	Feb-26	L	= 0	0	Jan-26	<= 4,613	209	F
526 - RTT 78 week waits (incomplete pathways)	= 0	0	Feb-26	L	= 0	0	Jan-26	= 0	5	F
527 - RTT 104 week waits (incomplete pathways)	= 0	0	Feb-26	L	= 0	0	Jan-26	= 0	0	F
72 - Diagnostic Waits >6 weeks %	<= 5%	2.6%	Feb-26	L	<= 5%	3.5%	Jan-26	<= 5%	9.9%	F
489 - Daycase Rates	>= 85%	81.9%	Feb-26		>= 85%	82.8%	Jan-26	>= 85%	82.0%	?

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
582 - Theatre Utilisation - Capped		80.8%	Feb-26			75.9%	Jan-26		76.6%	
583 - Theatre Utilisation - Uncapped		84.2%	Feb-26			78.9%	Jan-26		80.1%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.4%	Jan-26		<= 1%	1.4%	Dec-25	<= 1%	1.6%	
62 - Cancelled operations re-booked within 28 days	= 100%	57.6%	Dec-25		= 100%	83.3%	Nov-25	= 100%	30.1%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.95	Feb-26		<= 2.00	3.33	Jan-26	<= 2.00	2.99	
309 - DNA Rate - New	<= 6.3%	9.5%	Feb-26		<= 6.3%	9.8%	Jan-26	<= 6.3%	9.5%	
310 - DNA Rate - Follow up	<= 5.0%	8.8%	Feb-26		<= 5.0%	9.0%	Jan-26	<= 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.



Latest

Plan	Actual	Period
>= 92%	59.8%	Feb-26

Previous

Plan	Actual	Period
>= 92%	57.5%	Jan-26

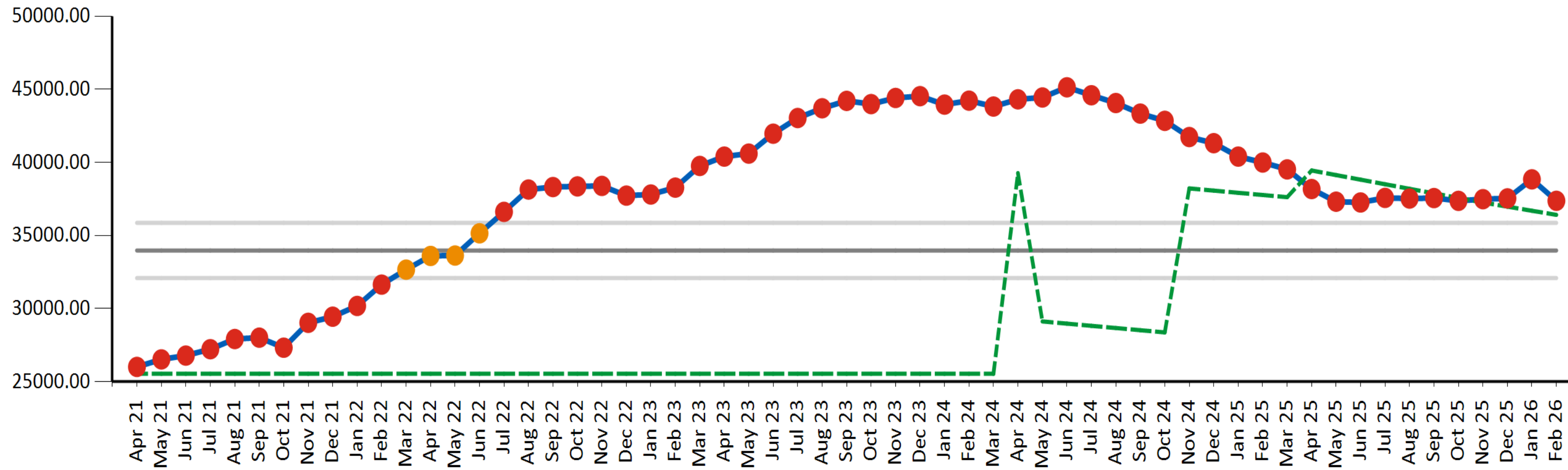
Year to Date

Plan	Actual
>= 92%	57.7%

314 - RTT 18 week waiting list

Special cause variation with deteriorating performance

Target will be regularly met.



Latest

Plan	Actual	Period
<= 36,405	37,369	Feb-26

Previous

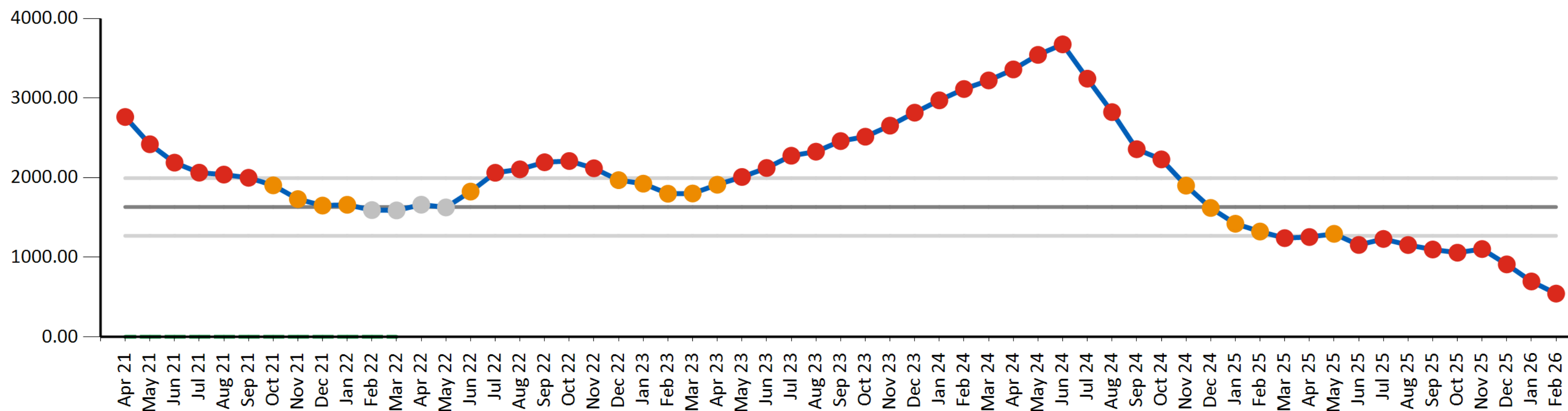
Plan	Actual	Period
<= 36,686	38,836	Jan-26

Year to Date

Plan	Actual
<= 36,405	37,369

42 - RTT 52 week waits (incomplete pathways)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	543	Feb-26

Previous

Plan	Actual	Period
	696	Jan-26

Year to Date

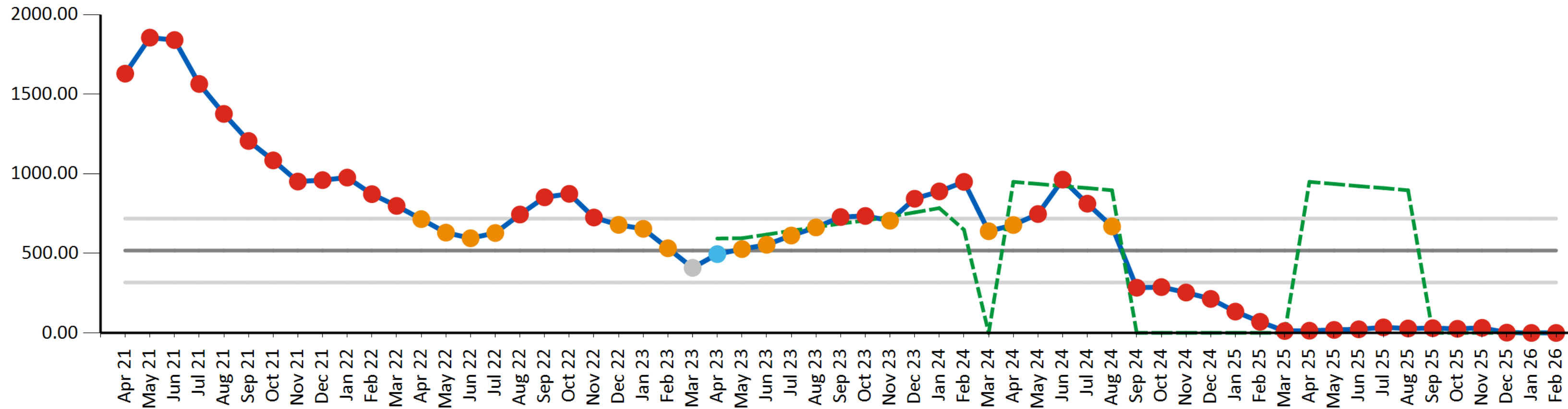
Plan	Actual
	11,491

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	0	Feb-26

Previous

Plan	Actual	Period
= 0	0	Jan-26

Year to Date

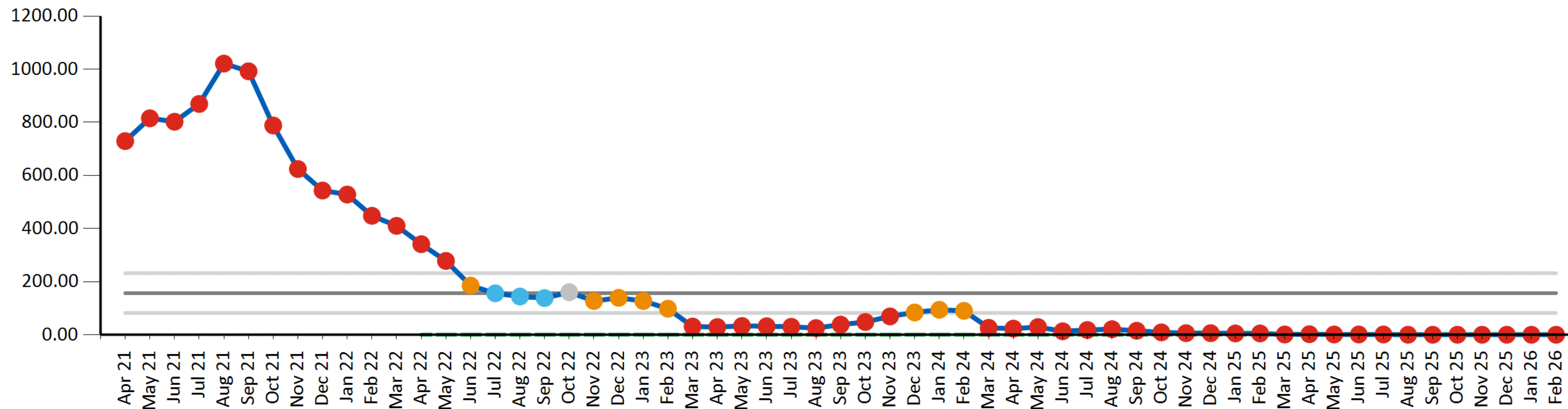
Plan	Actual
<= 4,613	209

526 - RTT 78 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

6/6



Latest

Plan	Actual	Period
= 0	0	Feb-26

Previous

Plan	Actual	Period
= 0	0	Jan-26

Year to Date

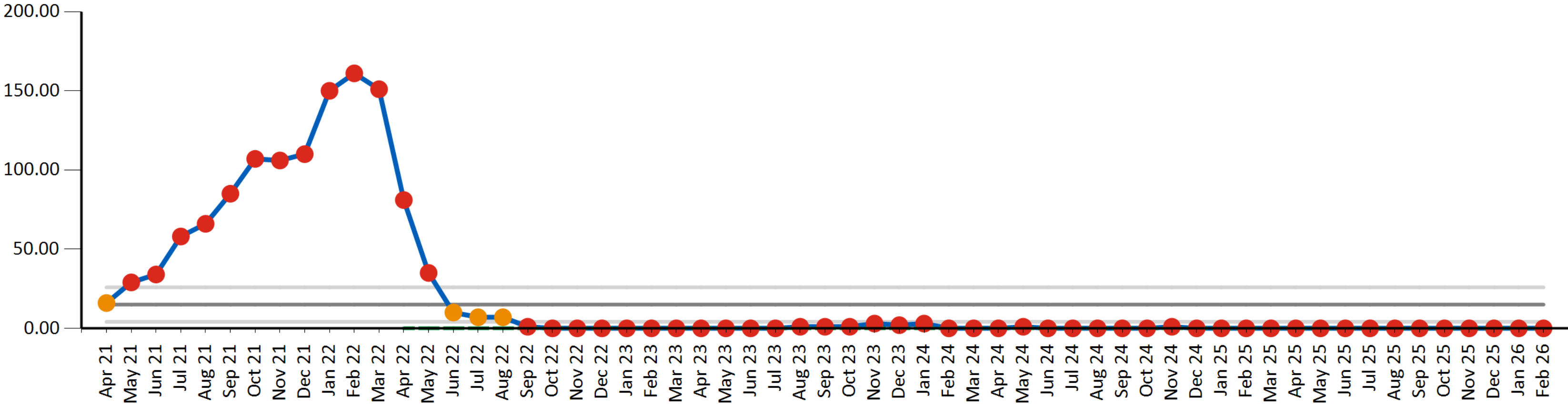
Plan	Actual
= 0	5

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	Feb-26

Previous

Plan	Actual	Period
= 0	0	Jan-26

Year to Date

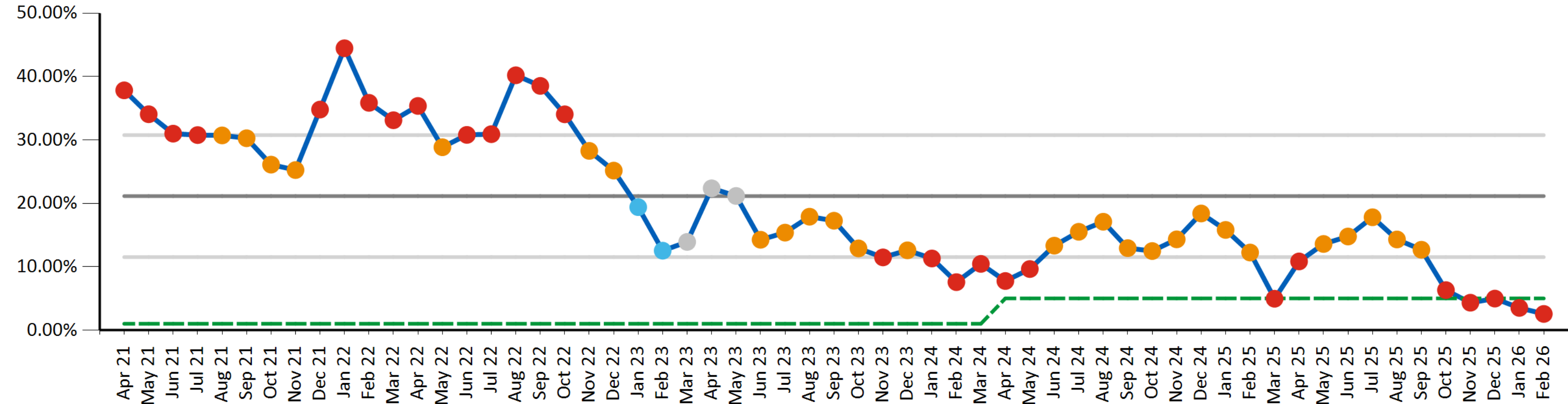
Plan	Actual
= 0	0

72 - Diagnostic Waits >6 weeks %

Special cause variation with improving performance

We will regularly fail to meet the target.

4/6



Latest

Plan	Actual	Period
<= 5%	2.6%	Feb-26

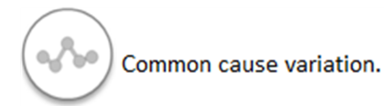
Previous

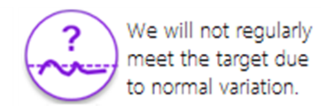
Plan	Actual	Period
<= 5%	3.5%	Jan-26

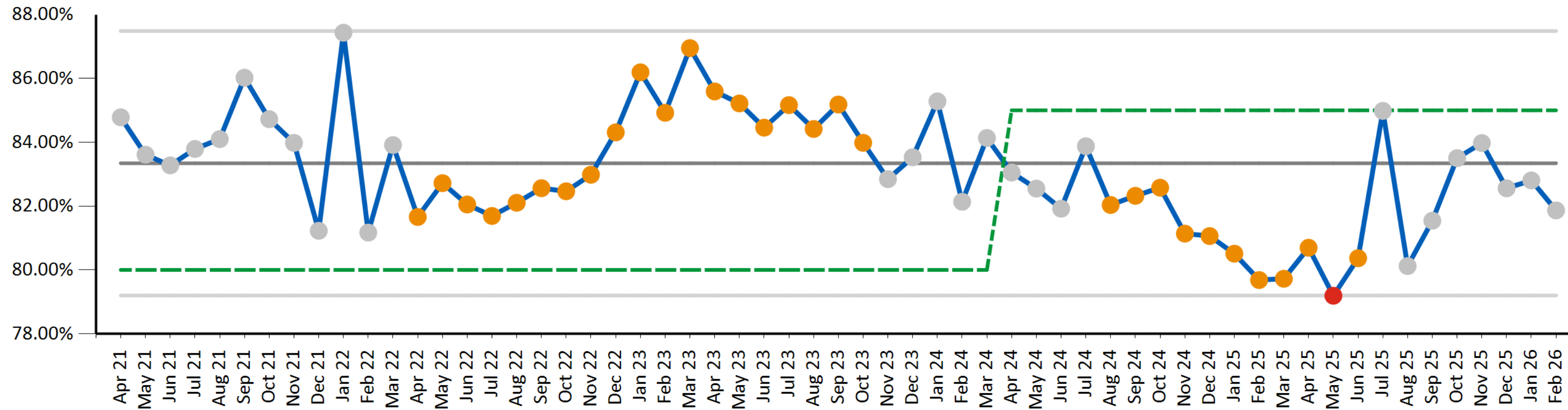
Year to Date

Plan	Actual
<= 5%	9.9%

489 - Daycase Rates







Latest

Plan	Actual	Period
>= 85%	81.9%	Feb-26

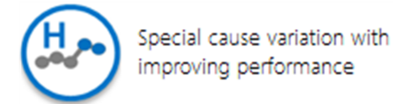
Previous

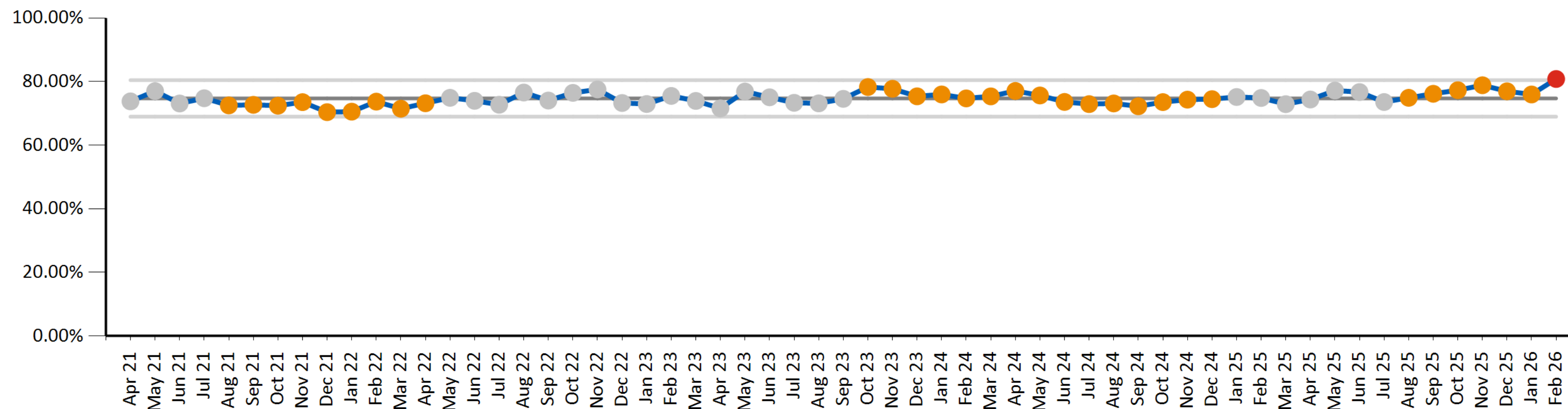
Plan	Actual	Period
>= 85%	82.8%	Jan-26

Year to Date

Plan	Actual
>= 85%	82.0%

582 - Theatre Utilisation - Capped





Latest

Plan	Actual	Period
	80.8%	Feb-26

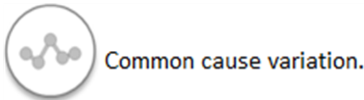
Previous

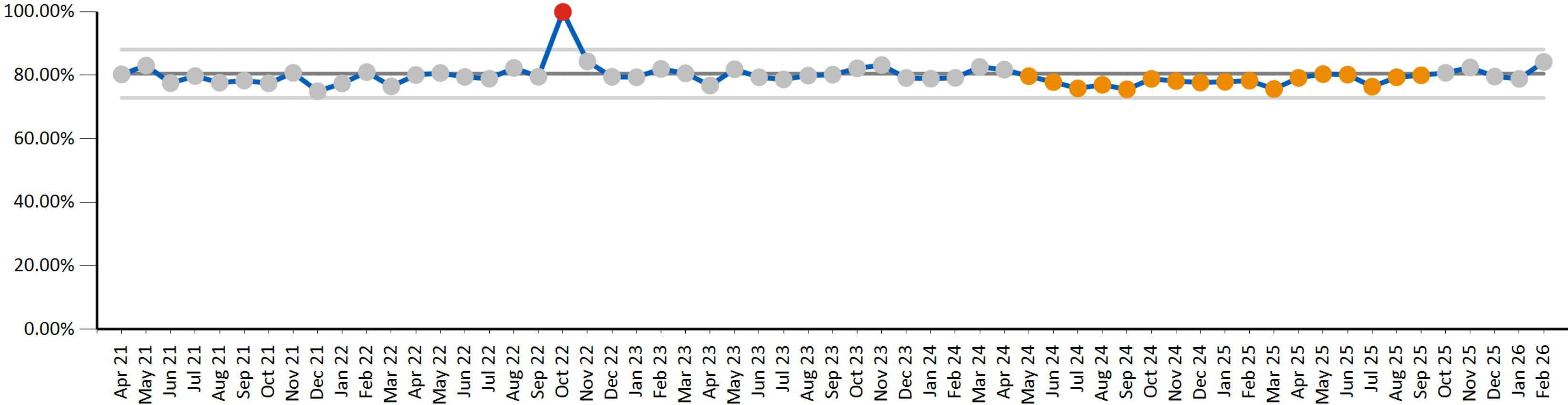
Plan	Actual	Period
	75.9%	Jan-26

Year to Date

Plan	Actual
	76.6%

583 - Theatre Utilisation - Uncapped





Latest

Plan	Actual	Period
	84.2%	Feb-26

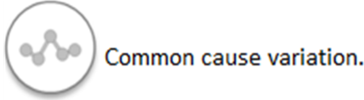
Previous

Plan	Actual	Period
	78.9%	Jan-26

Year to Date

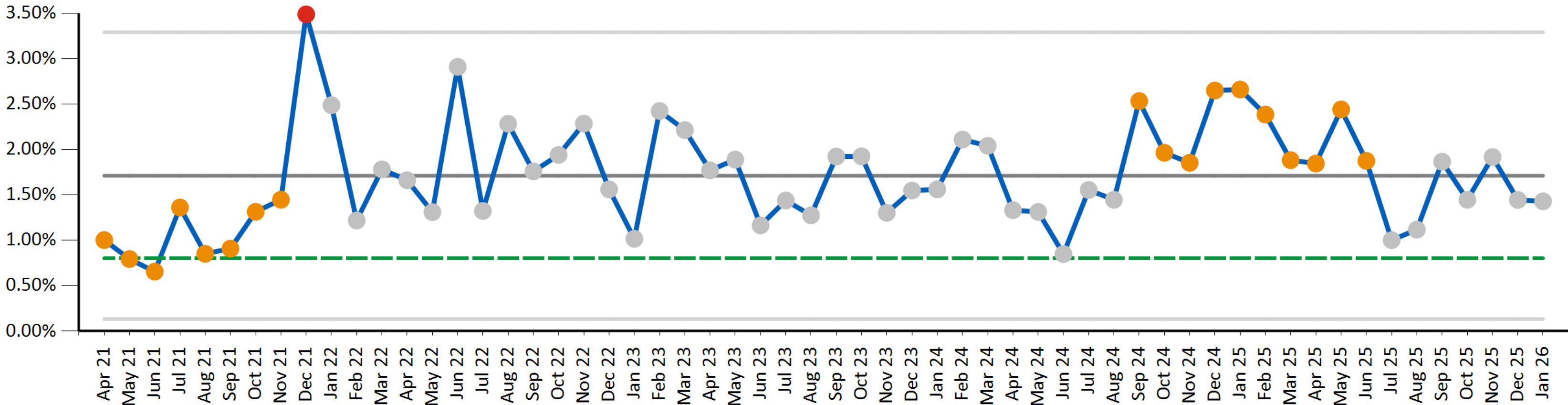
Plan	Actual
	80.1%

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



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

0/6



Latest

Plan	Actual	Period
<= 1%	1.4%	Jan-26

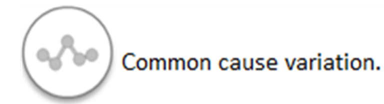
Previous

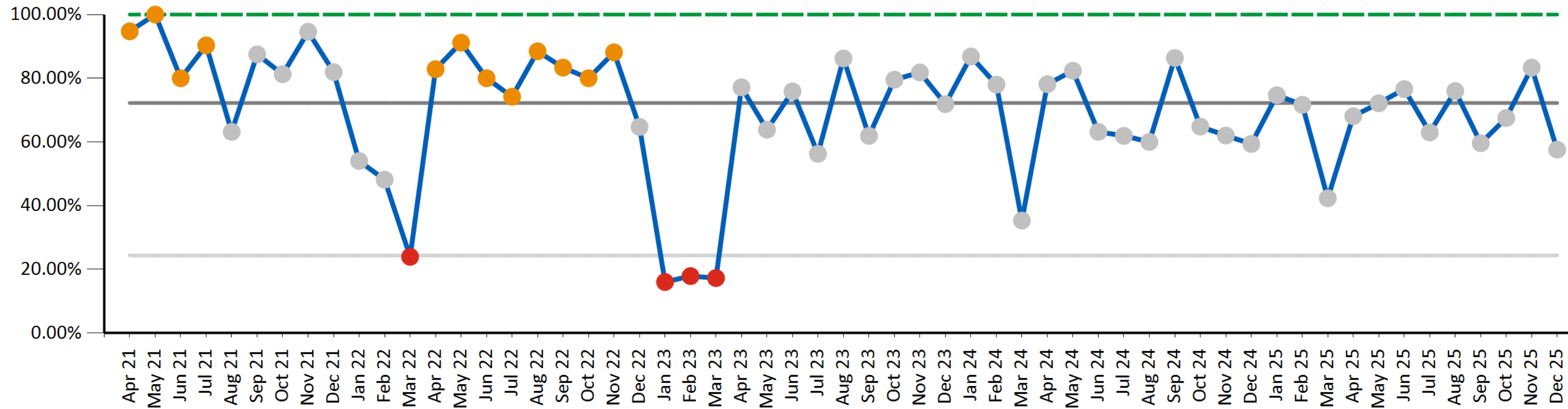
Plan	Actual	Period
<= 1%	1.4%	Dec-25

Year to Date

Plan	Actual
<= 1%	1.6%

62 - Cancelled operations re-booked within 28 days





Latest

Plan	Actual	Period
= 100%	57.6%	Dec-25

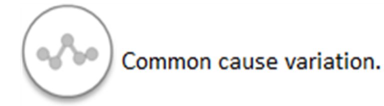
Previous

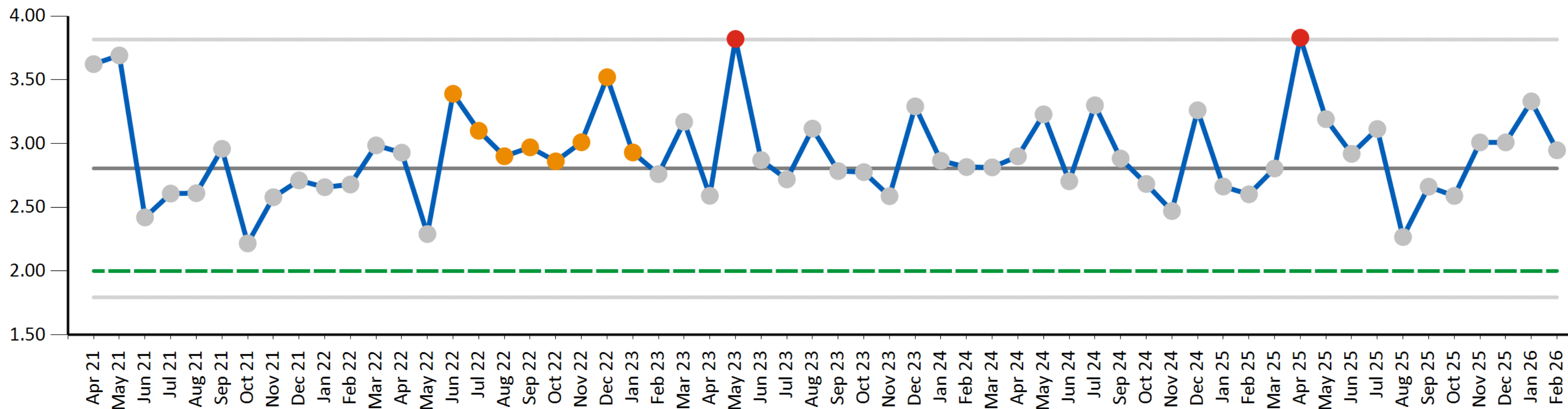
Plan	Actual	Period
= 100%	83.3%	Nov-25

Year to Date

Plan	Actual
= 100%	30.1%

65 - Elective Length of Stay (Discharges in month)





Latest

Plan	Actual	Period
<= 2.00	2.95	Feb-26

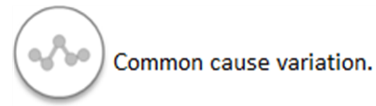
Previous

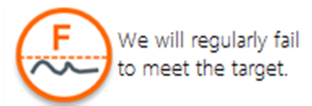
Plan	Actual	Period
<= 2.00	3.33	Jan-26

Year to Date

Plan	Actual
<= 2.00	2.99

309 - DNA Rate - New





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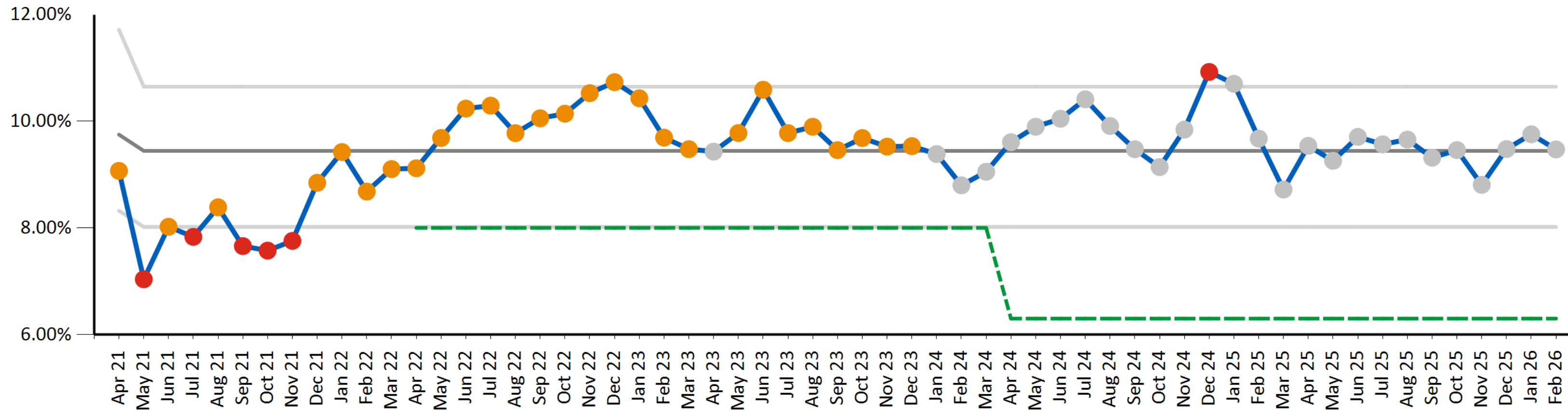


Latest

Plan	Actual	Period
<= 6.3%	9.5%	Feb-26

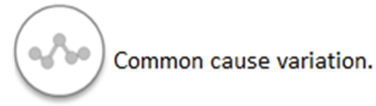
Previous

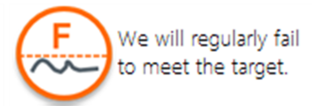
Plan	Actual	Period
<= 6.3%	9.8%	Jan-26

Year to Date

Plan	Actual
<= 6.3%	9.5%

310 - DNA Rate - Follow up





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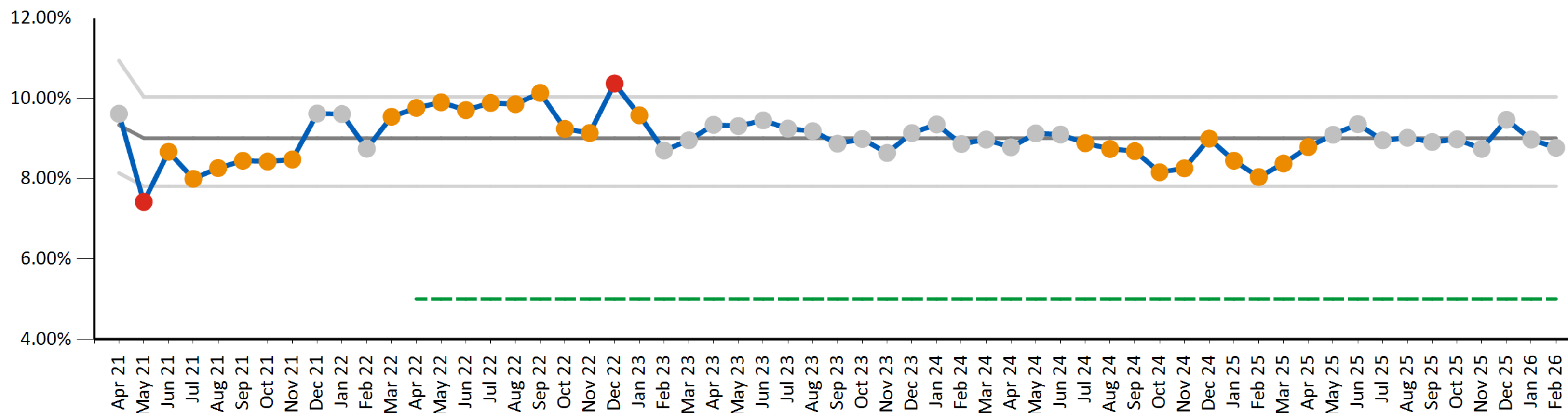


Latest

Plan	Actual	Period
<= 5.0%	8.8%	Feb-26

Previous

Plan	Actual	Period
<= 5.0%	9.0%	Jan-26

Year to Date

Plan	Actual
<= 5.0%	9.0%

Operational Performance - Cancer

Bolton
NHS Foundation Trust

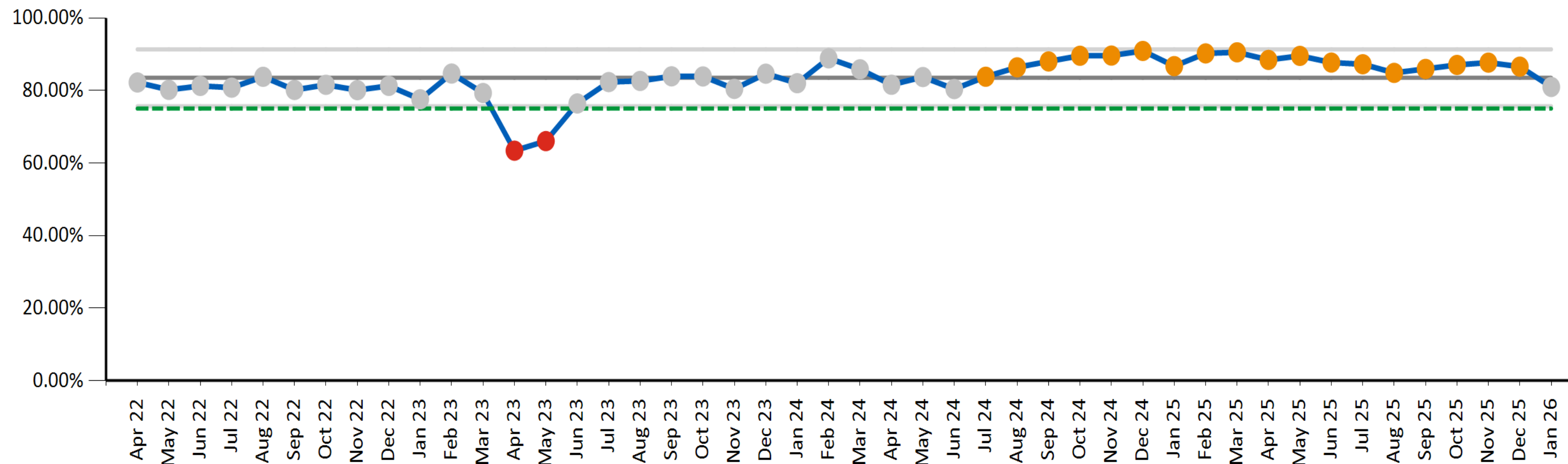
For January, we achieved the faster diagnosis standard, and the 31-day treatment standard.
We failed to achieve the 62-day standard for January; this is driven by performance linked to capacity within Breast, and complex multi-stage patient pathways in Gynaecology, Urology, Bowel Screening, and Lung.
It is unfortunately expected that performance will deteriorate in February due to ongoing capacity challenges within Breast, and due to early pathways delays for Urology, Skin, and Gynaecology. Recovery for 62-day performance is expected partially in March and further in April.

	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%	81.0%	Jan-26		>= 75.0%	86.6%	Dec-25	>= 75.0%	86.6%	
584 - 31 Day General Treatment Standard	>= 96%	98.7%	Jan-26		>= 96%	97.1%	Dec-25	>= 96%	98.0%	
585 - 62 Day General Standard	>= 85%	79.1%	Jan-26		>= 85%	85.4%	Dec-25	>= 85%	83.1%	

542 - Cancer: 28 day faster diagnosis

Common cause variation.

Target will be regularly met.



Latest

Plan	Actual	Period
>= 75.0%	81.0%	Jan-26

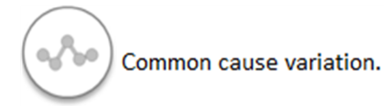
Previous

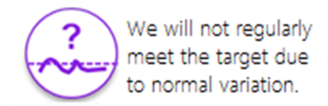
Plan	Actual	Period
>= 75.0%	86.6%	Dec-25

Year to Date

Plan	Actual
>= 75.0%	86.6%

584 - 31 Day General Treatment Standard





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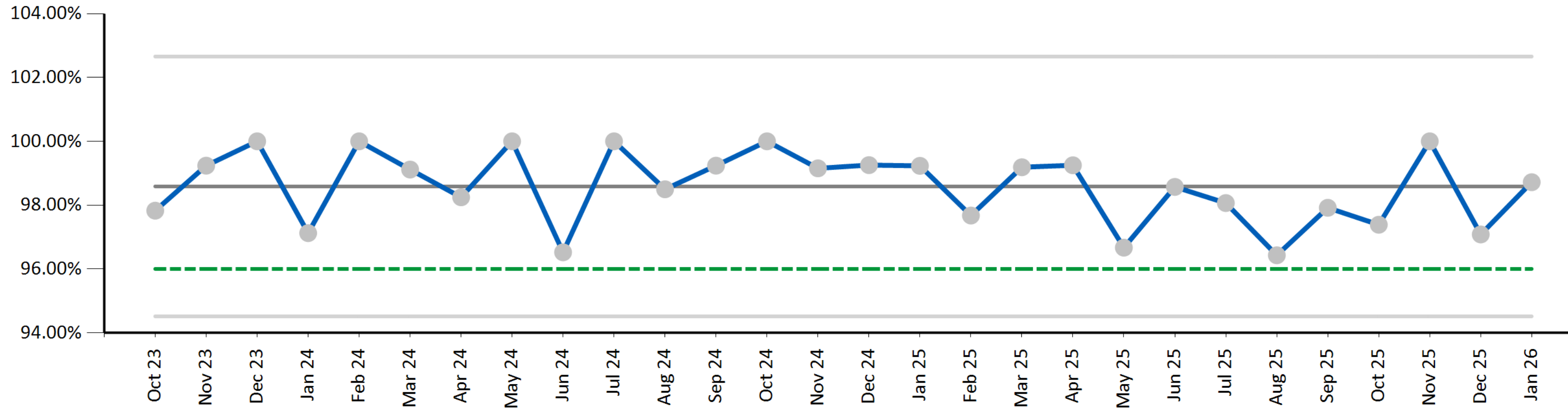


Latest

Plan	Actual	Period
>= 96%	98.7%	Jan-26

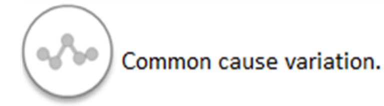
Previous

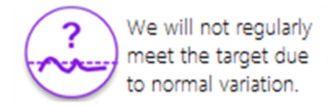
Plan	Actual	Period
>= 96%	97.1%	Dec-25

Year to Date

Plan	Actual
>= 96%	98.0%

585 - 62 Day General Standard





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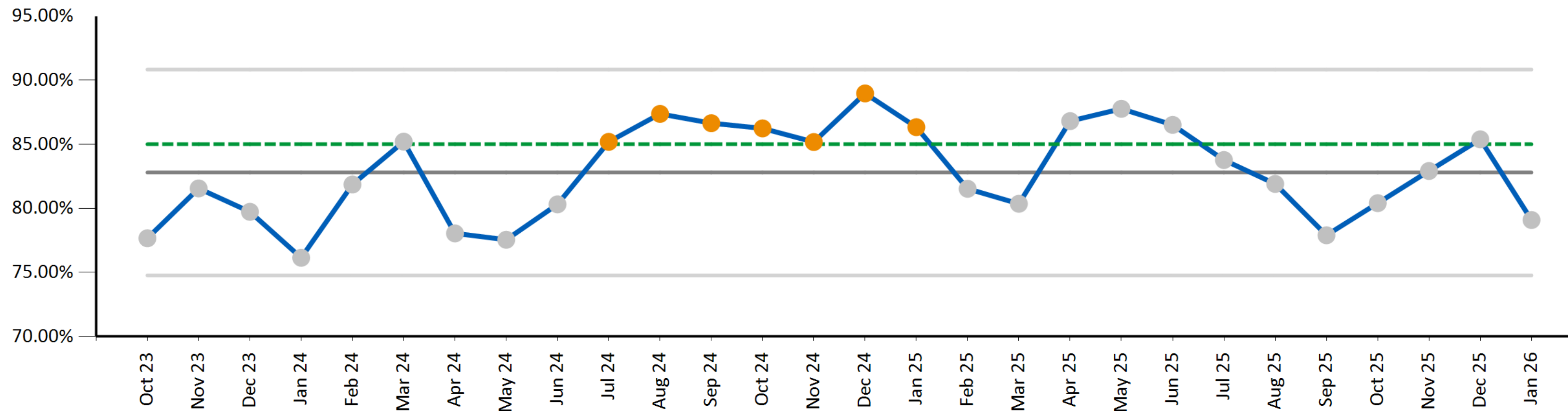


Latest

Plan	Actual	Period
>= 85%	79.1%	Jan-26

Previous

Plan	Actual	Period
>= 85%	85.4%	Dec-25

Year to Date

Plan	Actual
>= 85%	83.1%

Operational Performance - Community Care

NHS Bolton NHS Foundation Trust

NCTR
Month 11 NCTR numbers increase slightly from 91 to 99, meeting the plan of 99, however remaining above the target of 90. Lost bed days equated to 650, increasing from 605 the previous month. This remains above the target of 400 and is, mainly due to Pathway 2/3 delays linked to IPC closures and complex placement needs. Additional pressures resulted in requiring SPOT purchase beds/ reduced DTAH capacity impacting on P1 flow. System escalation continues to unblock delays, however capacity within the system over the festive and new year period have resulted in additional delays and lost bed days. Longer term improvement work continues across community services (N block IMC, Hospital at Home expansion, ITOCH), and we are expected to recover in M12/M1 with the final rollout of all Discharge Facilitators in March. Bolton remains in the top 2 performing trusts in GM in relation to average length of stay.

Emergency Department Deflections & 2 Hour UCR
AAT/Home First ED deflections were 583, down from 646 but well above plan (400) due to proactive screening and early identification. This also included a shorter working month (being February) however achieved the same average per day. AAT continue to promote 2 hour UCR pathways, presenting recently to GP Clinical Board. 2 hour UCR performance remained high at 84.4% (target 70%), however it is 5% lower on the previous month. Referral numbers also reduced slightly in month to 301 (from 347), however this was expected and in line with February 2025. Expansion of clinic pathways continues including acute urinary retention pathway, (up to 30 referrals/month expected). A BARDOC case holding pathway has been developed and awaiting test for change start date, this will enable out of hours GP's to refer in to UCR to reduce conveyance to ED.

0-5 Years Mandated Contacts
Performance remains below target (86.66% vs 95%). Following a period of sustained improvement. This is linked to high levels of sickness and subsequent vacancy within the service with posts actively being recruited into. Despite this, the 86.6% performance is a significant improvement based on the previous year, and represents a continued trend of M10/11 dips for this metric evidencing some season variation.

EHCP compliance
Compliance was 91.3% in M11 versus the 95% target. This is the first month under target since May 2025 and is significantly linked to staff sickness and vacancies – particularly within the consultant cohort (2 vacancies + 1LTS) recruitment is ongoing and reviews of workload to support have been completed. Robust processes are in place to monitor and escalate delays.

Looked after Children
Has achieved 94% against the of 90%, initial Health Assessments increased to 93% (from 84%) Capacity early in the month owing to sickness, DNAs and short notice cancellations specifically impacted this metric and is in line with historically trends around Dec-Feb data that aligns with school holidays.

Review Health Assessments in Special Schools remained 100%, continuing to exceed target.

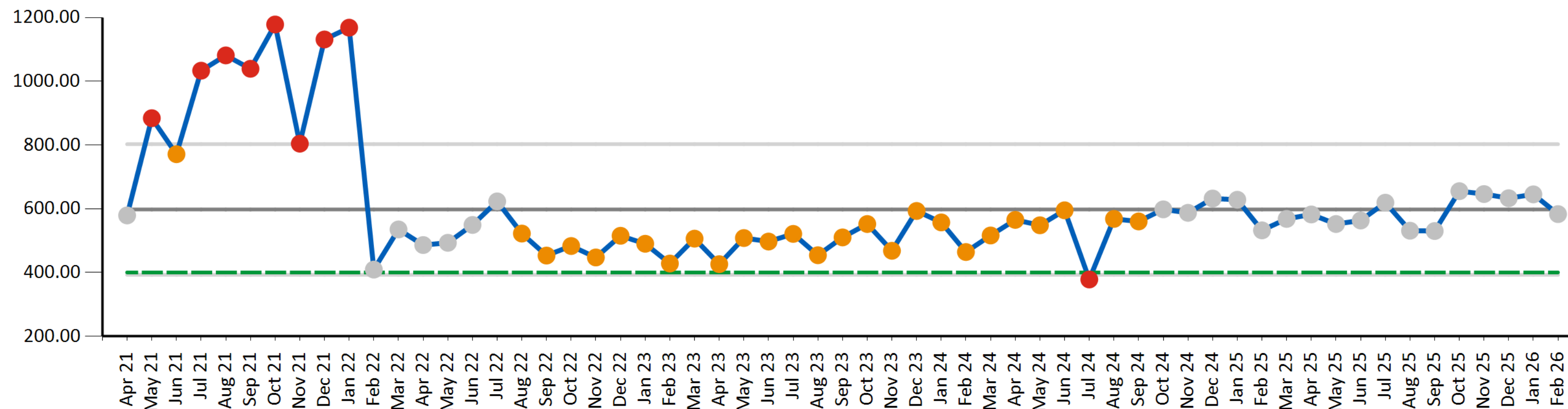
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	583	Feb-26		>= 400	645	Jan-26	>= 4,400	6,539	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
493 - Average Number of Patients: with no Criteria to Reside	<= 99	99	Feb-26		<= 98	91	Jan-26	<= 99	99	
494 - Average Occupied Days - for no Criteria to Reside	<= 360	650	Feb-26		<= 360	605	Jan-26	<= 3,960	6,609	
267 - 0-5 Health Visitor mandated contacts	>= 95%	87%	Feb-26		>= 95%	84%	Jan-26	>= 95%	87%	
269 - Education, health and care plan (EHC) compliance	>= 95%	91%	Feb-26		>= 95%	100%	Jan-26	>= 95%	97%	
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse	>= 90.0%	94.0%	Feb-26		>= 90.0%	92.0%	Jan-26	>= 90.0%		
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales	>= 90.0%	93.0%	Feb-26		>= 90.0%	89.0%	Jan-26	>= 90.0%		
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools	>= 90.0%	100.0%	Feb-26		>= 90.0%	100.0%	Jan-26	>= 90.0%		

334 - Total Deflections from ED

Common cause variation.

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



Latest

Plan	Actual	Period
>= 400	583	Feb-26

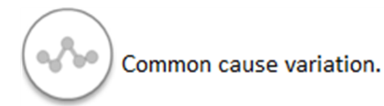
Previous

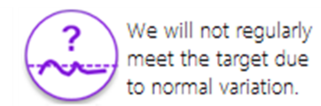
Plan	Actual	Period
>= 400	645	Jan-26

Year to Date

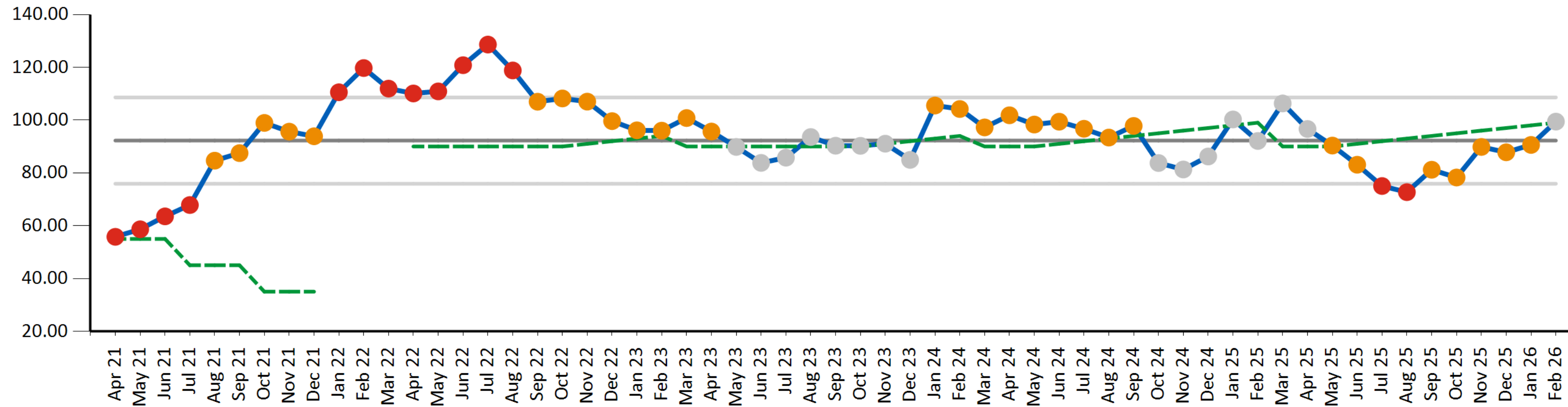
Plan	Actual
>= 4,400	6,539

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





5/6



Latest

Plan	Actual	Period
<= 99	99	Feb-26

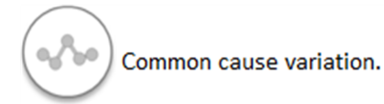
Previous

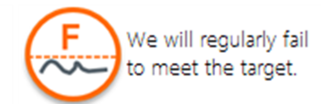
Plan	Actual	Period
<= 98	91	Jan-26

Year to Date

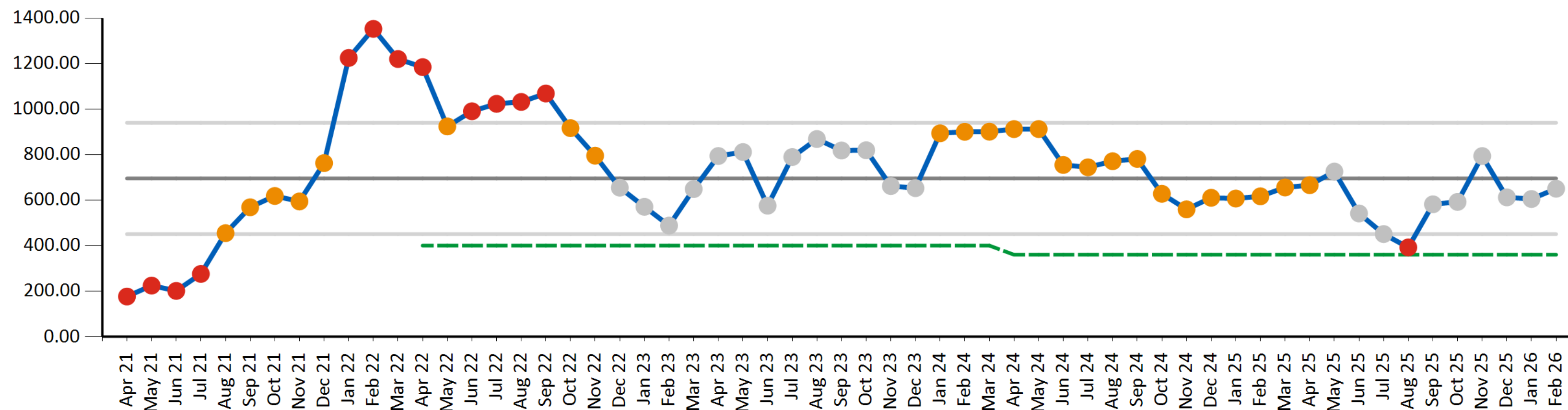
Plan	Actual
<= 99	99

494 - Average Occupied Days - for no Criteria to Reside





0/6



Latest

Plan	Actual	Period
<= 360	650	Feb-26

Previous

Plan	Actual	Period
<= 360	605	Jan-26

Year to Date

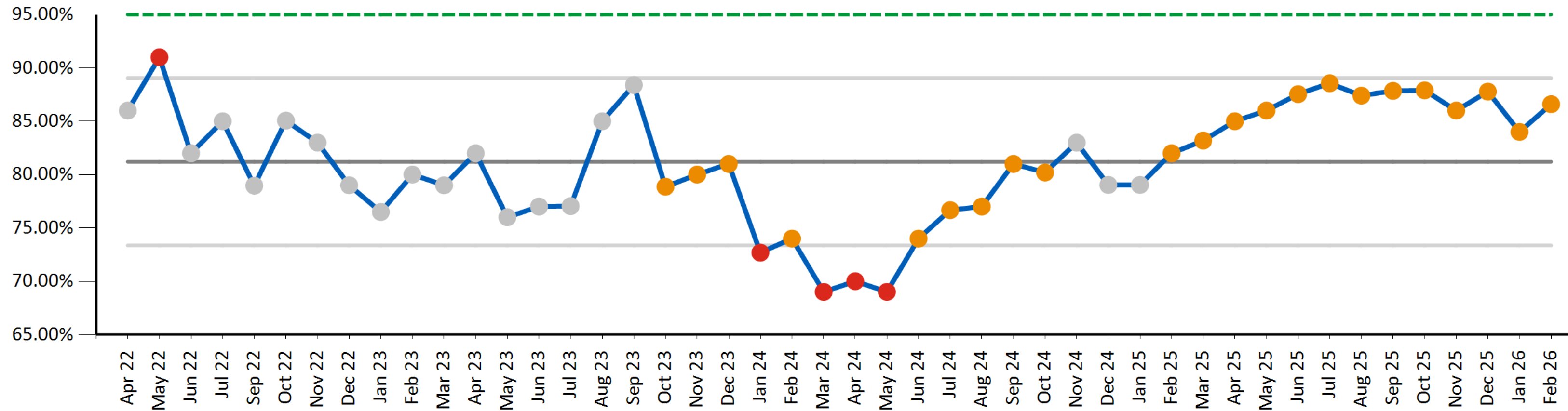
Plan	Actual
<= 3,960	6,609

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%	87%	Feb-26

Previous

Plan	Actual	Period
>= 95%	84%	Jan-26

Year to Date

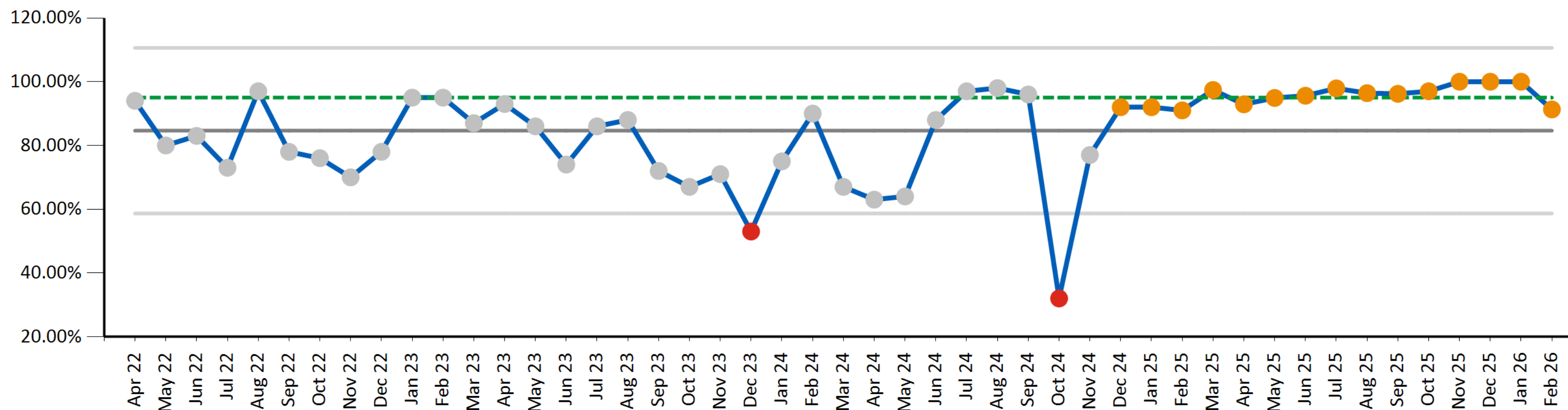
Plan	Actual
>= 95%	87%

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.

5/6



Latest

Plan	Actual	Period
>= 95%	91%	Feb-26

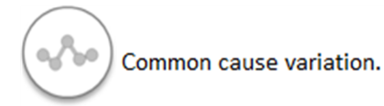
Previous

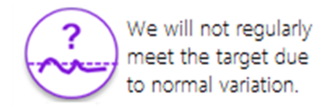
Plan	Actual	Period
>= 95%	100%	Jan-26

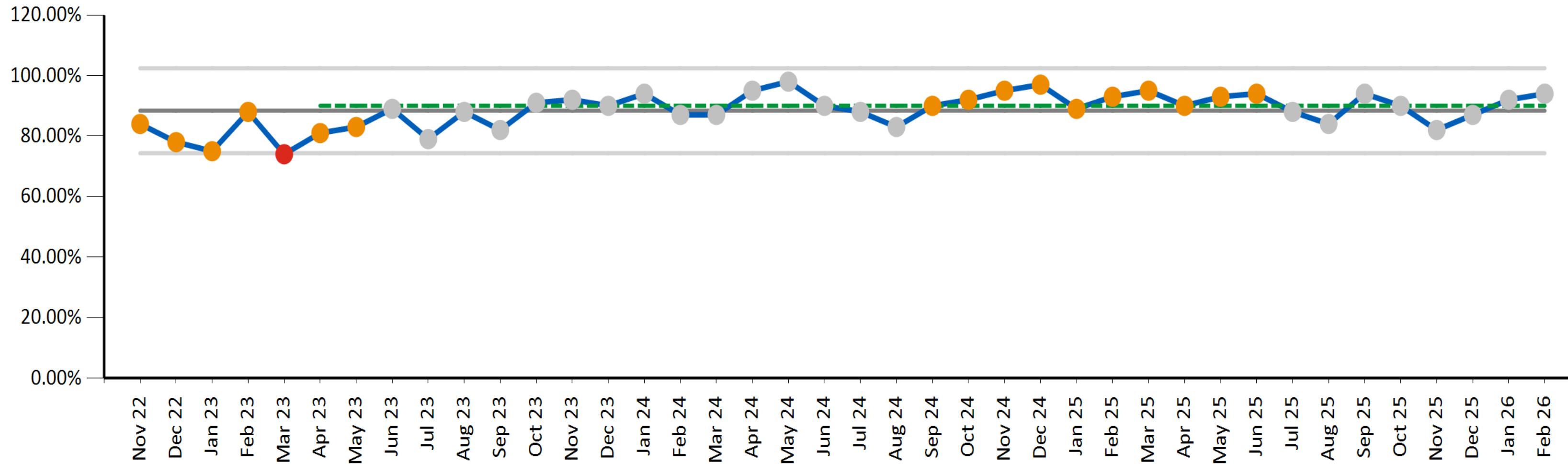
Year to Date

Plan	Actual
>= 95%	97%

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







Latest

Plan	Actual	Period
> = 90.0%	94.0%	Feb-26

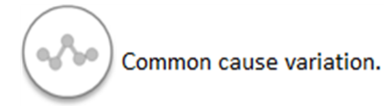
Previous

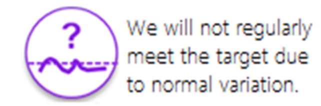
Plan	Actual	Period
> = 90.0%	92.0%	Jan-26

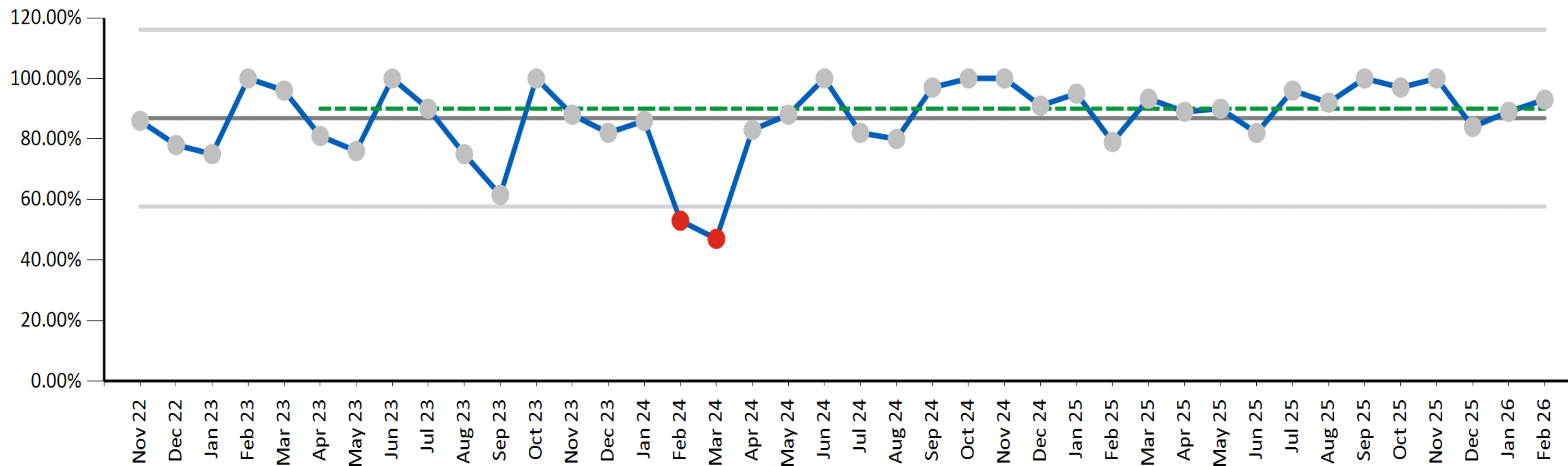
Year to Date

Plan	Actual
> = 90.0%	

551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales







Latest

Plan	Actual	Period
> = 90.0%	93.0%	Feb-26

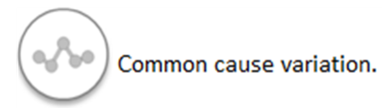
Previous

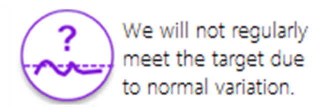
Plan	Actual	Period
> = 90.0%	89.0%	Jan-26

Year to Date

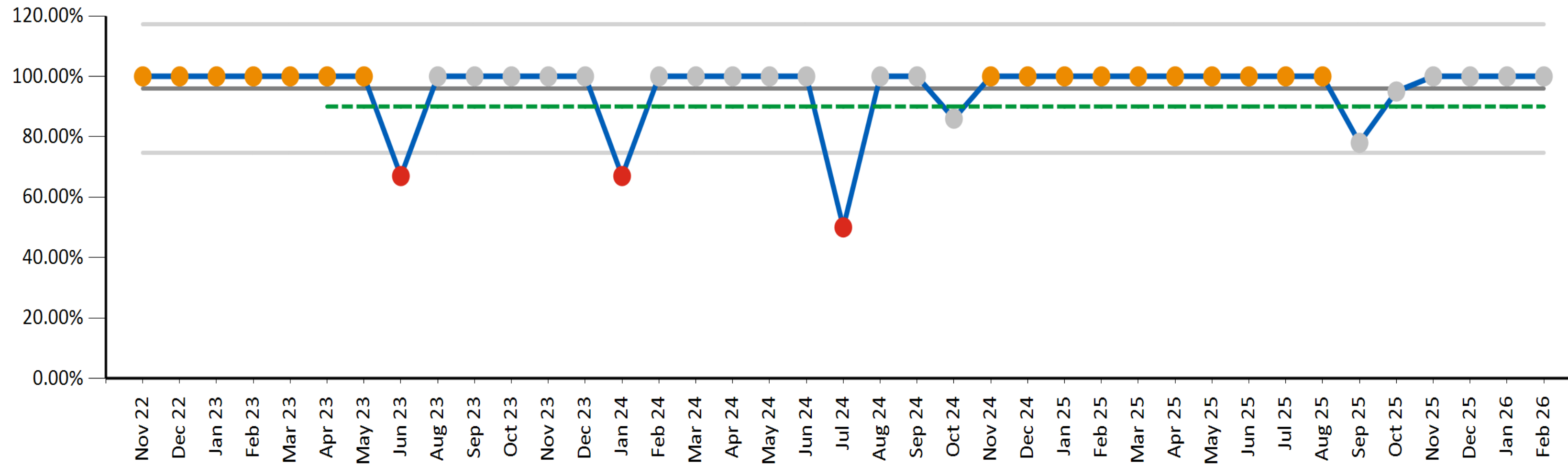
Plan	Actual
> = 90.0%	

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





5/6



Latest

Plan	Actual	Period
> = 90.0%	100.0%	Feb-26

Previous

Plan	Actual	Period
> = 90.0%	100.0%	Jan-26

Year to Date

Plan	Actual
> = 90.0%	

Workforce - Sickness, Vacancy and Turnover

NHS Bolton NHS Foundation Trust

Sickness:
Sickness has remained high in February 26 at 6.43% compared to 6.50% in January 2026. Sickness remains high across the clinical divisions, there has been some reductions in corporate functions. There continues to be a significant increase in seasonal absence (cold, Flu and D&V) with an increase in stress / anxiety related absences. The Trust continues to provide additional support through the Trust's Employee Assistance Programme (EAP) and early intervention support through Occupational Health.

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. Additional oversight meetings have been established to review Divisional absence and identify any further actions and support.

Turnover:
Trust turnover remains stable and within expectation at 11.97% (highest turnover in Additional Clinical Services, Nursing & Midwifery, and Admin & Clerical, staff groups).

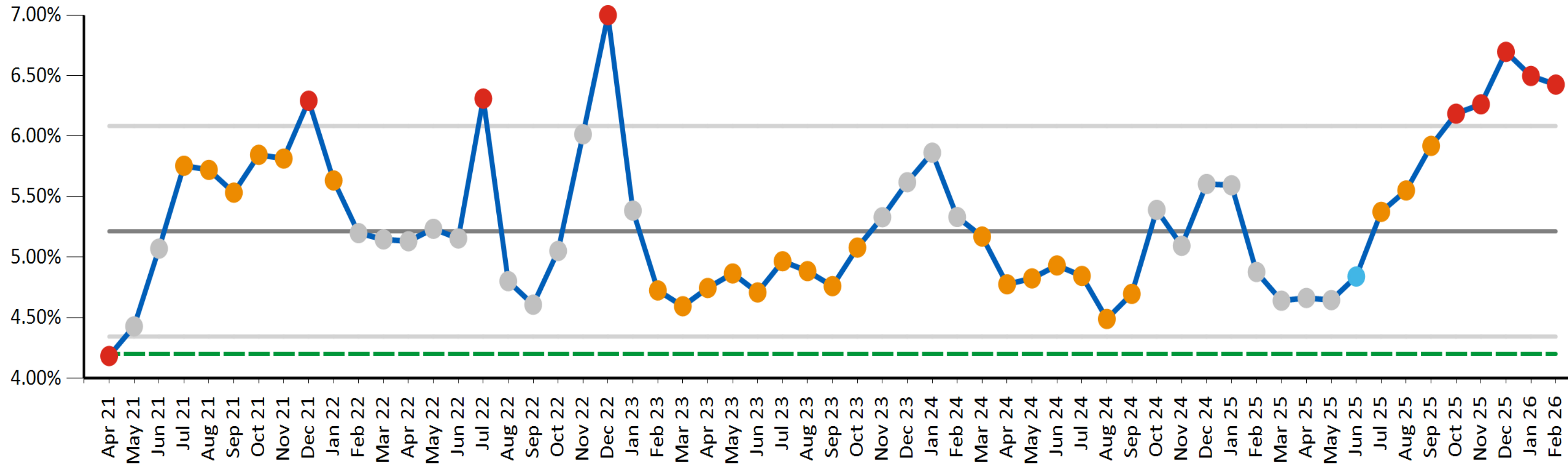
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	6.43%	Feb-26	H	<= 4.20%	6.50%	Jan-26	<= 4.20%	5.73%	F
120 - Vacancy level - Trust	<= 6%	4.62%	Mar-25		<= 6%	5.08%	Feb-25	<= 6%		?
121 - Turnover	<= 9.90%	11.97%	Feb-26	L	<= 9.90%	11.70%	Jan-26	<= 9.90%	11.52%	F
366 - Ongoing formal investigation cases over 8 weeks		1	Jan-26	L		0	Dec-25		3	

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%	6.43%	Feb-26

Previous

Plan	Actual	Period
<= 4.20%	6.50%	Jan-26

Year to Date

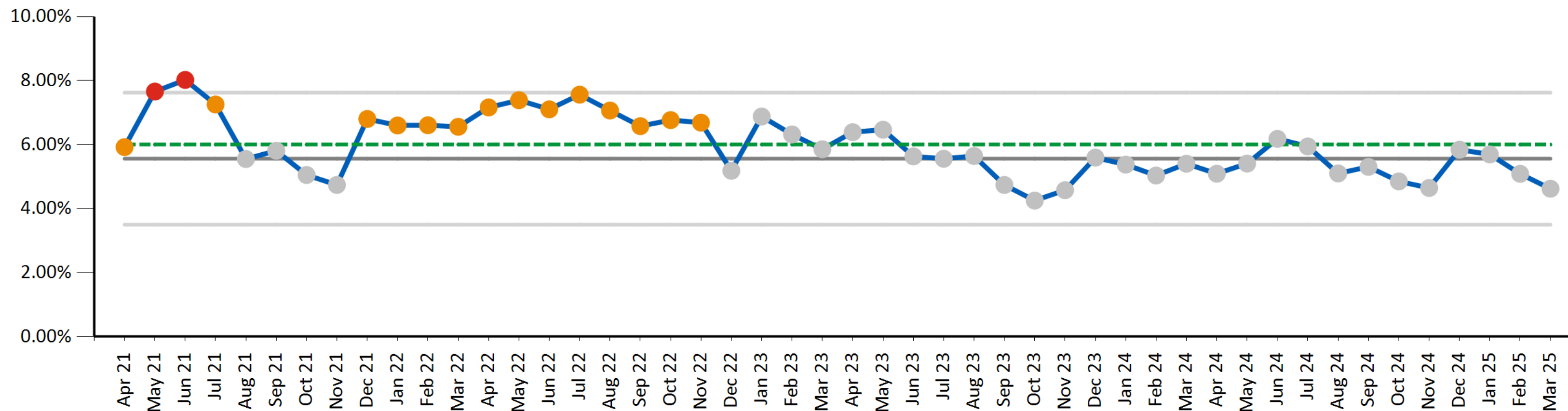
Plan	Actual
<= 4.20%	5.73%

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

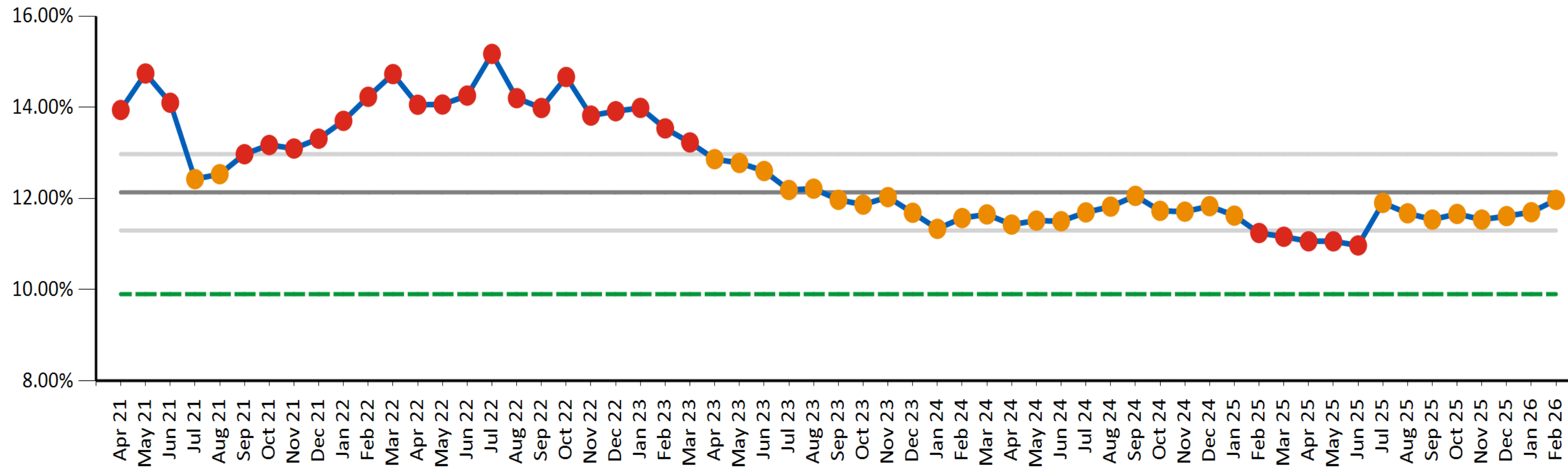
Plan	Actual
<= 6%	5.31%

121 - Turnover

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 9.90%	11.97%	Feb-26

Previous

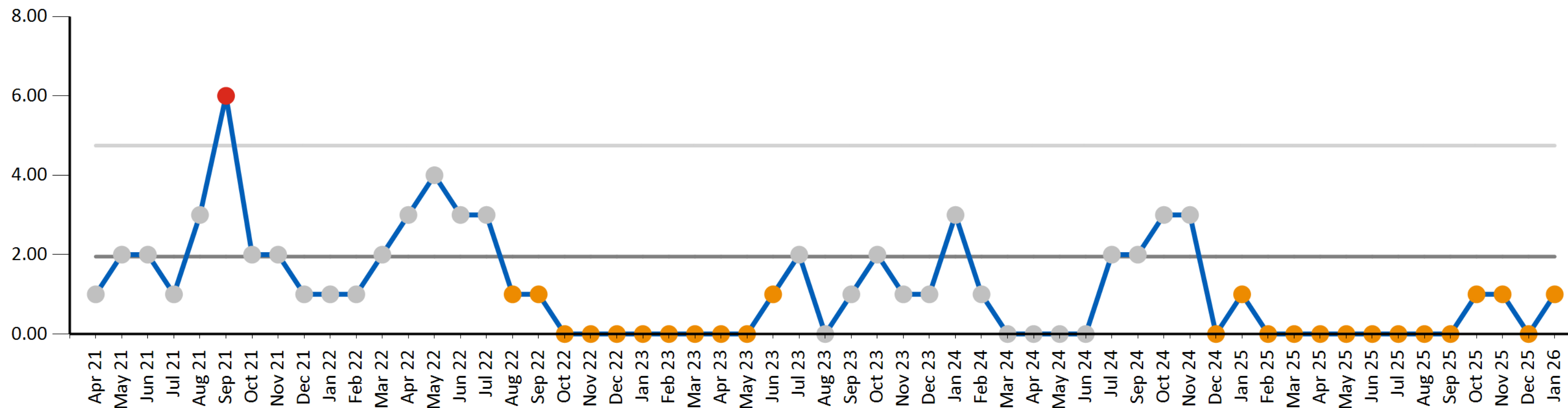
Plan	Actual	Period
<= 9.90%	11.70%	Jan-26

Year to Date

Plan	Actual
<= 9.90%	11.52%

366 - Ongoing formal investigation cases over 8 weeks

Special cause variation with improving performance



Latest

Plan	Actual	Period
	1	Jan-26

Previous

Plan	Actual	Period
	0	Dec-25

Year to Date

Plan	Actual
	3

Workforce - Organisational Development

NHS Bolton NHS Foundation Trust

Compulsory Training
Overall compliance has declined by 0.3% in month to 93.4%. All subjects with the exception of safeguarding level 3, M&H and BLS (which require face to face training) are reporting above 90% compliance rates.

Trust Mandated Training
A very slight decline in performance in month by just less than 0.4%.

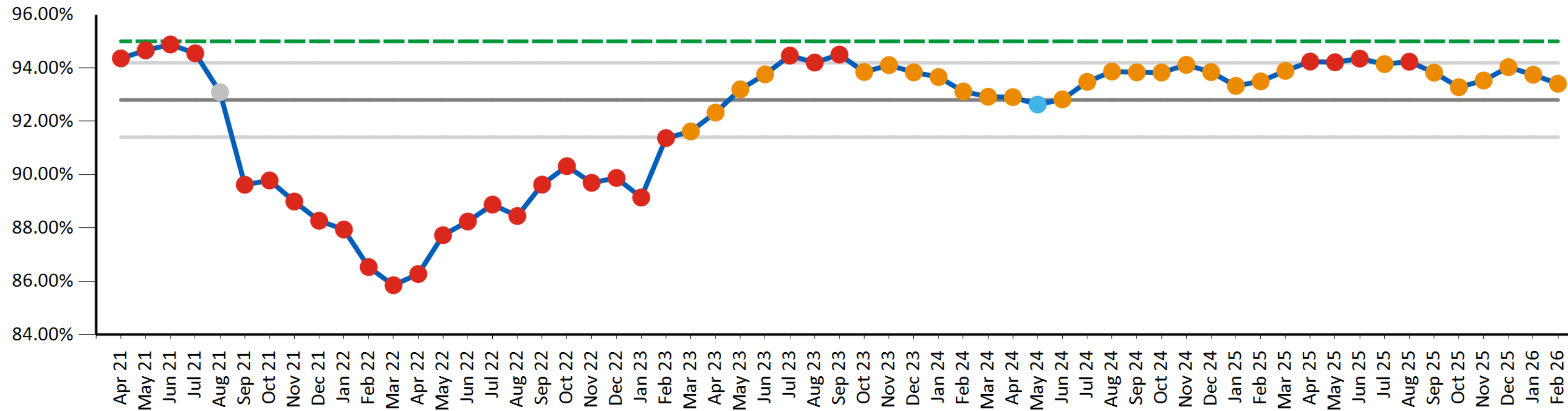
Appraisal
There has been a very slight improvement in the number of overall appraisals recorded as completed at the end of February 2026 (exact figure pre round up 82.57% to 82.59%). Although the figure remains below 85% compliance figure it is encouraging to see there has not been a further deterioration.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Compulsory Training	>= 95%	93.4%	Feb-26	H	>= 95%	93.7%	Jan-26	>= 95%	93.9%	F
38 - Staff completing Trust Mandated Training	>= 85%	89.4%	Feb-26		>= 85%	89.7%	Jan-26	>= 85%	91.0%	P
39 - Staff completing Safeguarding Training	>= 95%	92.73%	Feb-26		>= 95%	92.89%	Jan-26	>= 95%	93.43%	?
101 - Increased numbers of staff undertaking an appraisal	>= 85%	82.6%	Feb-26		>= 85%	82.6%	Jan-26	>= 85%	83.9%	?
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.



Latest

Plan	Actual	Period
>= 95%	93.4%	Feb-26

Previous

Plan	Actual	Period
>= 95%	93.7%	Jan-26

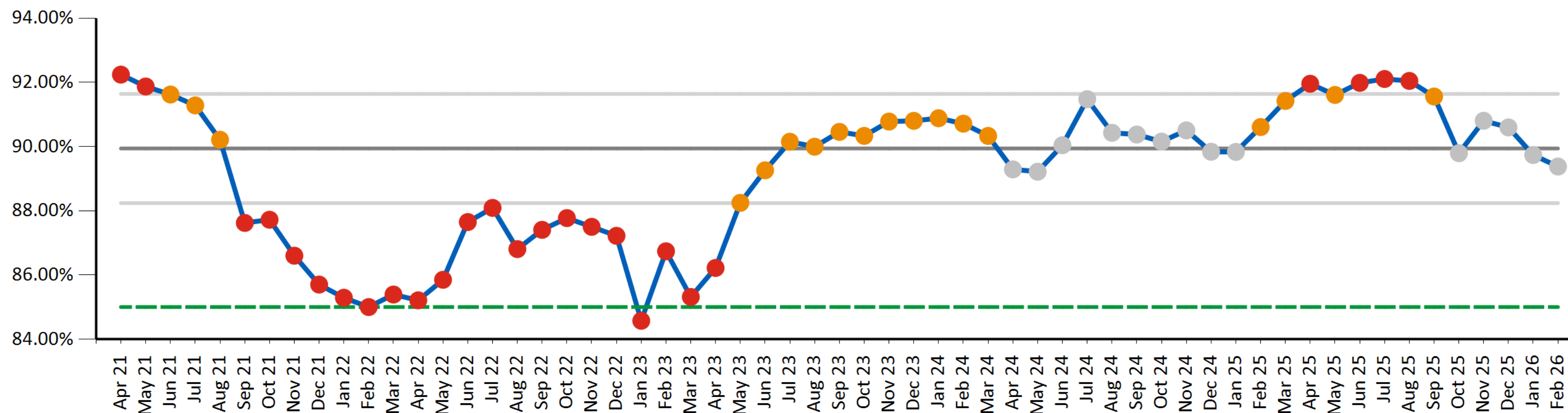
Year to Date

Plan	Actual
>= 95%	93.9%

38 - Staff completing Trust Mandated Training

Common cause variation.

Target will be regularly met.



Latest

Plan	Actual	Period
>= 85%	89.4%	Feb-26

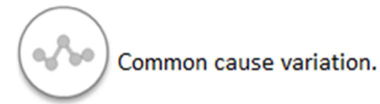
Previous

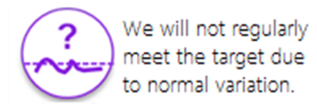
Plan	Actual	Period
>= 85%	89.7%	Jan-26

Year to Date

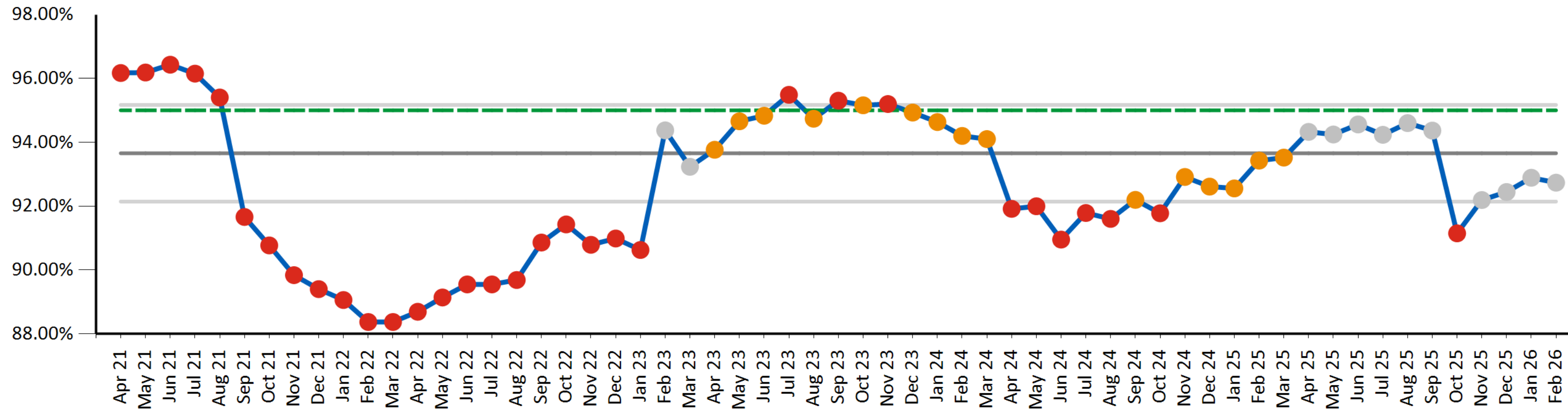
Plan	Actual
>= 85%	91.0%

39 - Staff completing Safeguarding Training





0/6



Latest

Plan	Actual	Period
>= 95%	92.73%	Feb-26

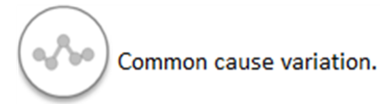
Previous

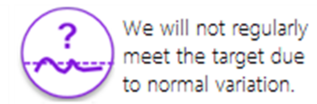
Plan	Actual	Period
>= 95%	92.89%	Jan-26

Year to Date

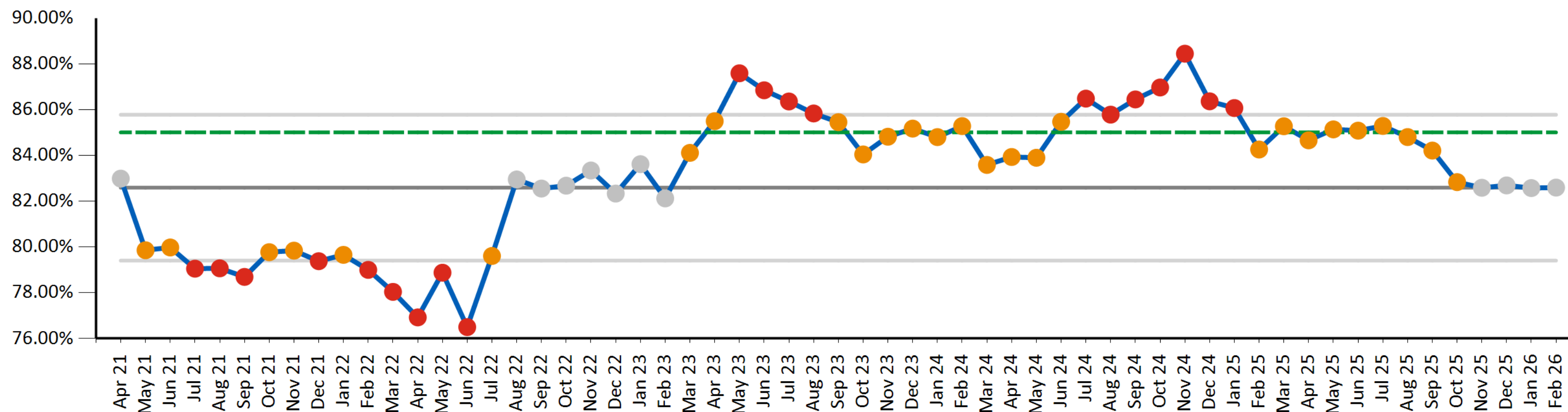
Plan	Actual
>= 95%	93.43%

101 - Increased numbers of staff undertaking an appraisal





0/6



Latest

Plan	Actual	Period
>= 85%	82.6%	Feb-26

Previous

Plan	Actual	Period
>= 85%	82.6%	Jan-26

Year to Date

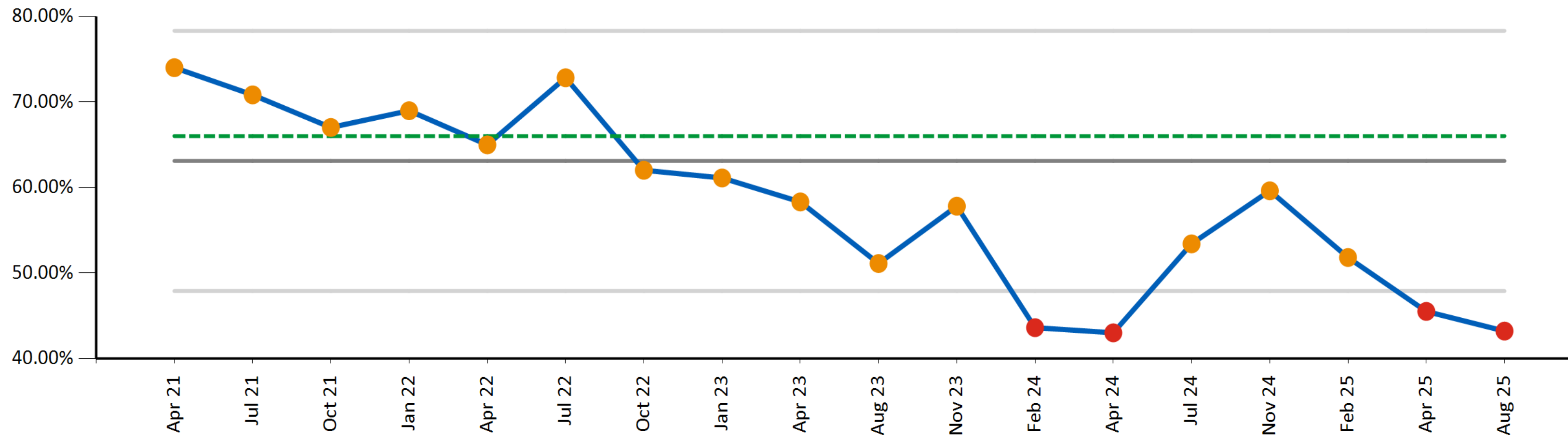
Plan	Actual
>= 85%	83.9%

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

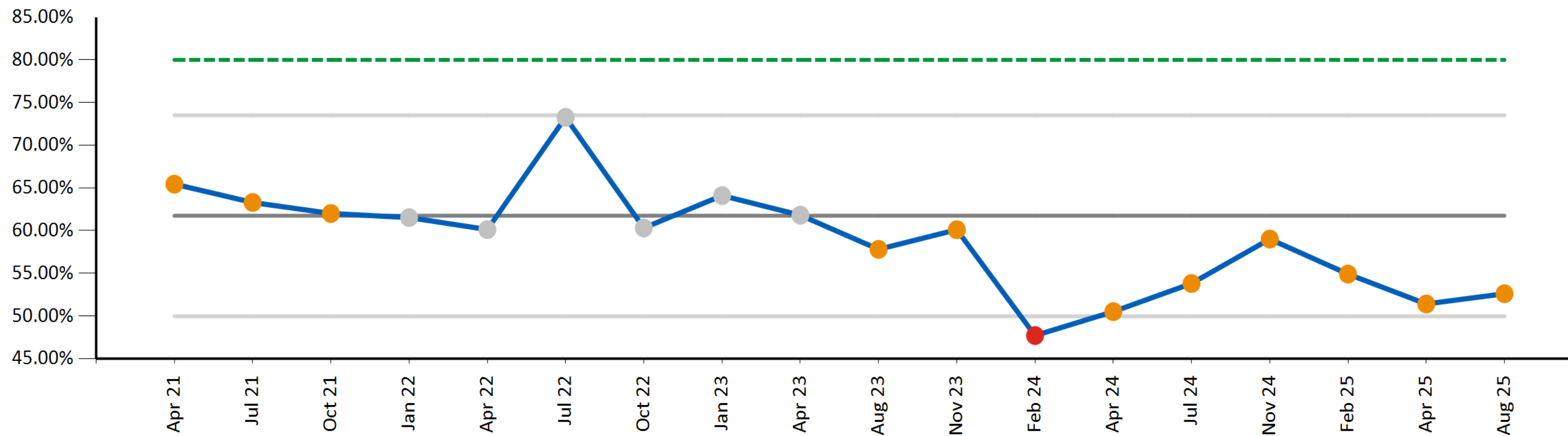
Plan	Actual
>= 66%	

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%	

NHS Bolton
NHS Foundation Trust

Workforce - Agency

Agency usage remains low and most of that usage relates to nationally identified hard-to-recruit roles: the Trust has made appointments into some of those roles, and we expect further reductions as a result in the coming months. We have been under the NHSE agency spend target since M8 of this financial year.

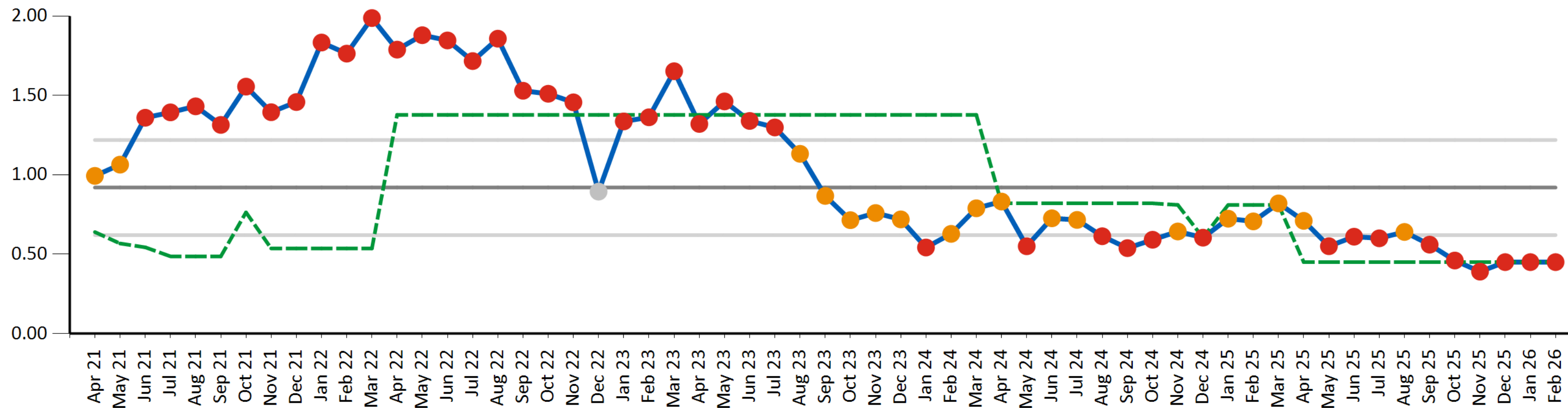
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.45	0.45	Feb-26		<= 0.45	0.45	Jan-26	<= 4.95	5.87	
111 - Annual ceiling for Nursing Staff agency spend (£m)	= 0.00	0.00	Feb-26		= 0.00	0.00	Jan-26	<= 0.12	0.13	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.37	0.31	Feb-26		<= 0.37	0.31	Jan-26	<= 4.93	4.81	

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

Special cause variation with improving performance

We will regularly fail to meet the target.

4/6



Latest

Plan	Actual	Period
<= 0.45	0.45	Feb-26

Previous

Plan	Actual	Period
<= 0.45	0.45	Jan-26

Year to Date

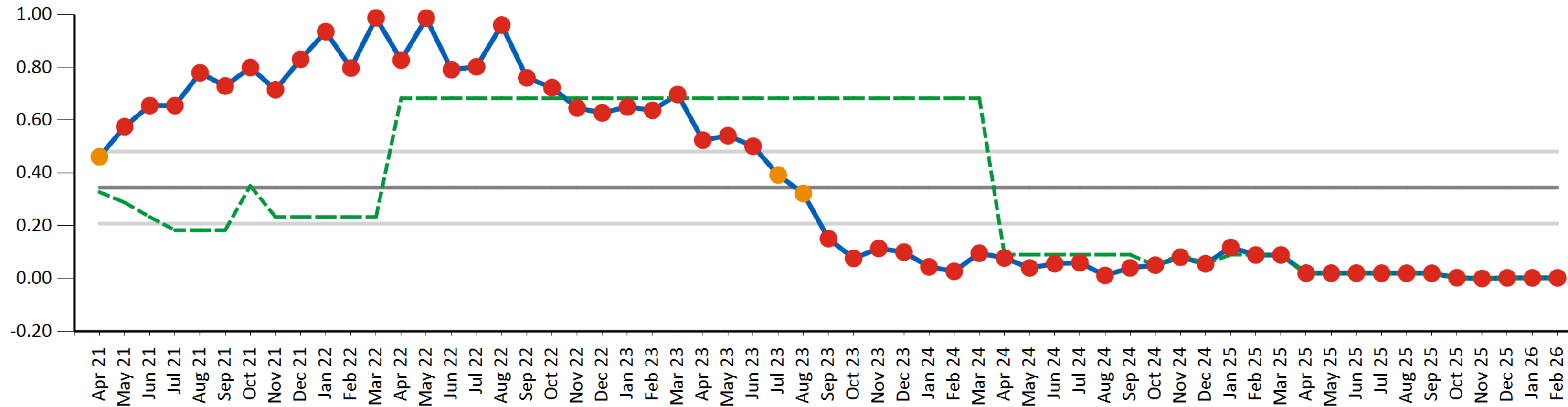
Plan	Actual
<= 4.95	5.87

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

Special cause variation with improving performance

We will regularly fail to meet the target.

2/6



Latest

Plan	Actual	Period
= 0.00	0.00	Feb-26

Previous

Plan	Actual	Period
= 0.00	0.00	Jan-26

Year to Date

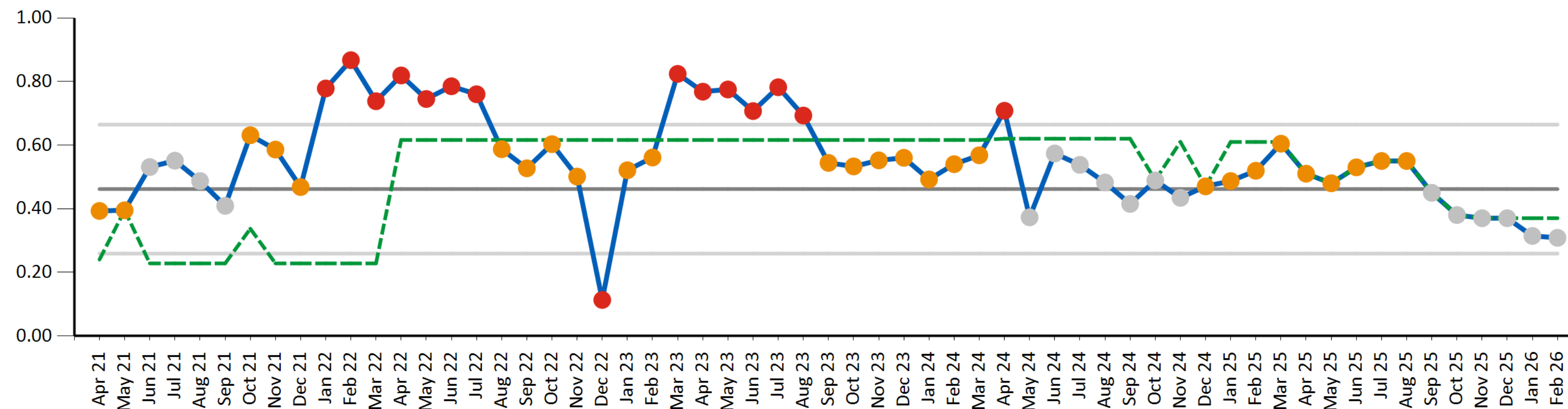
Plan	Actual
<= 0.12	0.13

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

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 0.37	0.31	Feb-26

Previous

Plan	Actual	Period
<= 0.37	0.31	Jan-26

Year to Date

Plan	Actual
<= 4.93	4.81

Finance - Finance

Surplus / (Deficit)
The Trust is reporting a cumulative deficit of £18.2m largely due to CIP under-delivery. The in-month position is a deficit of £0.3m, which is in line with the trajectory to hit £14.4m deficit for the full year.

Adjusted Surplus / (Deficit)
Adjusting for allowable deductions/adjustments, including technical adjustments relating to donated capital equipment, the Trust is reporting a deficit of £18.0m YTD.

Forecast
The external forecast has been reported as meeting plan based on receiving additional funding from the ICB. There are some significant risks to achieving this, with mitigations needed for existing issues and a residual gap needing to be addressed. The worst-case forecast is a deficit of £24.6m, the realistic case is a deficit of £22.9m, realistic best-case is a deficit of £14.4m. Revenue funding of £13.8m from the ICB would improve the position and is the basis of reporting a break-even forecast externally.

Income
Commissioner income is based on contractual and budget values, Planned Care Variable Income performance has now dropped below plan YTD by £1.7m, although it is assumed that activity lost due to Industrial Action and EPR Implementation will not be clawed back. Injury Cost Recovery Scheme income of £3.4m, 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. Q1-4 Deficit Support funding is now secured at £6.5m. It is assumed that there will be no clawback of CDC income, although this presents a further risk of £2m.

Pay
WTEs and underlying pay costs have reduced slightly in month, although these remain raised due to the impact of winter pressures, which has driven an increase in Bank spend. Pay controls remain in place, with substantive WTEs continuing to reduce. 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 £0.5m since M10, mainly due to the recognition of a £1.3m CNST rebate in M10. 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.

Cash
The Trust was above plan by £8.8m in Month 11. PDC funding cash has provided a temporary benefit of £11.6m and some other cash has been received in advance of being paid out. The underlying cash is an overdrawn position of £16.1m although this will improve significantly in Month 12 when additional revenue funding is received from the ICB. The Trust has received cash support from NHSE of £8.3m in November, £5.5m in December and £3.9m in January, a total of £17.7m. The February application for £3.3m was rejected on the basis that we will receive £1.4m of Industrial Action funding. Additional cash support of £13.8m was received from the ICB at the start of March, hence no further cash applications have been made to NHSE at this stage, although further cash will be required in early 2026/27.

CIP Delivery
Reduction in in-month delivery from M10 to M11 due to the non-recurrent benefit of a CNST rebate at M10, 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 £36.4m, reduction of £12.4m. 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.

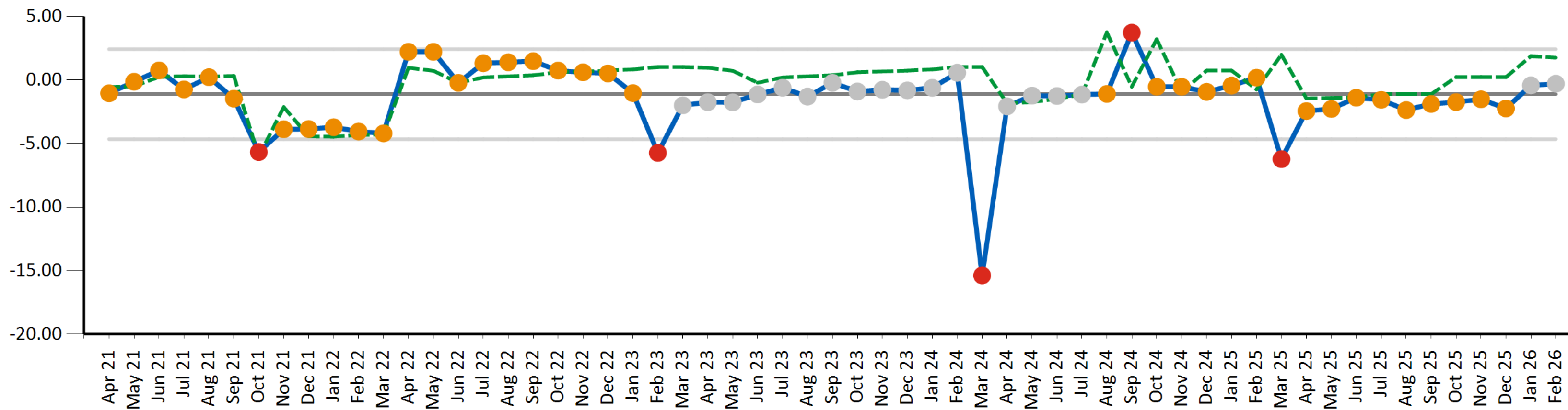
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= 1.8	-0.3	Feb-26		>= 1.9	-0.4	Jan-26	>= -3.3	-18.2	
222 - Capital (£ millions)	>= 5.3	4.8	Feb-26		>= 5.8	4.7	Jan-26	>= 39.7	22.8	
223 - Cash (£ millions)	>= -0.4	18.5	Feb-26		>= -3.5	6.0	Jan-26	>= -0.4	18.5	

220 - Control Total (£ millions)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 1.8	-0.3	Feb-26

Previous

Plan	Actual	Period
>= 1.9	-0.4	Jan-26

Year to Date

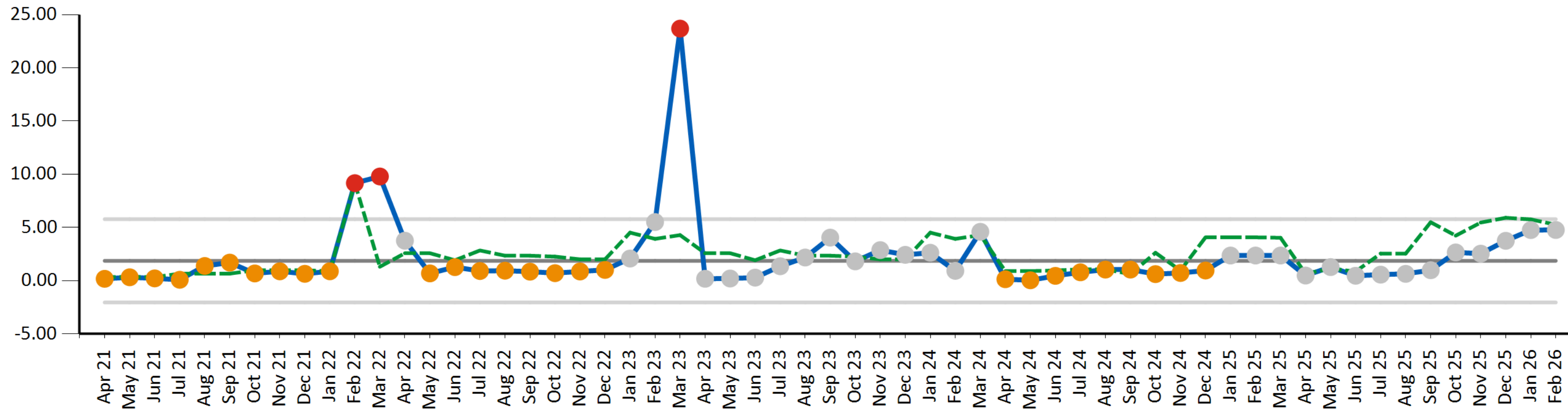
Plan	Actual
>= -3.3	-18.2

222 - Capital (£ millions)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 5.3	4.8	Feb-26

Previous

Plan	Actual	Period
>= 5.8	4.7	Jan-26

Year to Date

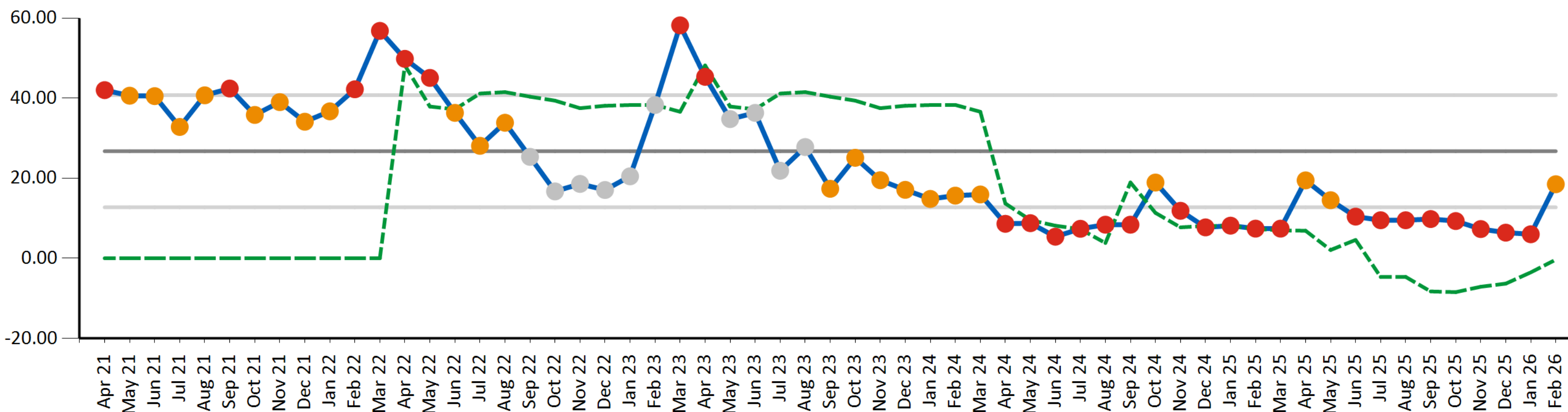
Plan	Actual
>= 39.7	22.8

223 - Cash (£ millions)

Special cause variation with deteriorating performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= -0.4	18.5	Feb-26

Previous

Plan	Actual	Period
>= -3.5	6.0	Jan-26

Year to Date

Plan	Actual
>= -0.4	18.5

Report Title:	Quality Assurance Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 March 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 25 March 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 March 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

ALERT | ADVISE | ASSURE (AAA)
Key Issues Highlight Report

Name of Committee /Group:	Quality Assurance Committee	Reports to:	Board of Directors
Date of Meeting:	25 March 2026	Date of next meeting:	27 May 2026
Chair	Fiona Taylor	Meeting Quoracy	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING: (report written prior to the meeting)

- Board Assurance Framework (BAF)
- Trust Heatmap
- IPC and Antimicrobial Update
- Maternity Incentive Scheme Year 7 Progress Update (CNST Update)
- Quality Account Priorties/QI Plan Update (2024/2025)
- Medium Term Plan
- A & E Attendance Report
- Serious Incident Reports x 3
- Clinical Governance and Quality Group Chair's Report
- Performance and Transformation Group Chair's Report

ALERT

Agenda items	Action Required
Any alerts following from discussions held at the meeting will be provided verbally by the Committee Chair.	

ADVISE

Maternity Incentive Scheme Year 7 Progress Update (CNST Update)
Assurance is provided that the CNST Year 7 maternity declaration was submitted on 17 February 2026, with receipt confirmed, and that CNST Year 8 will launch on 23 April 2026. Q3 2025/2026 perinatal oversight data confirms ongoing progress with the national maternity care bundle, participation in neonatal stakeholder events, and continued data submission to the MOSS dashboard

IPC and Antimicrobial Stewardship (AMS) Update
The Trust continues to perform well on Antimicrobial Resistance (AMR) metrics, with antibiotic use better than national averages and strong reductions from the 2019/20 baseline. Three AMS priorities are proposed: increasing Access antibiotic use, improving intravenous (IV)-to-oral switching, and introducing mandatory AMS training. These align with national targets and will support safer prescribing. Overall, the Trust shows strong stewardship and clear plans for further improvement

Quality Account Priorities/ QI Plan Update (2024 /2025 Quality Account)
The Quality Assurance Committee noted the requirement to agree three Quality Account Improvement Priorities for 2026/27. Following an options appraisal, the proposed priorities are; improving patient communication and shared decision-making (Years 2–3), releasing time to care (Year 2) and understanding health inequalities.

Quality and Equality Impact Assessment (QEIA): Medium Term Plan
The QEIA provides an overview of the key risks, schemes and mitigations linked to delivering the Trust's Medium-Term Plan and its associated performance, workforce and finance standards and targets. It outlines how quality, safety, workforce and equity impacts will be monitored and managed through established governance and assurance processes.

A&E Attendances Report
Demand has risen significantly from 2023–2025. Analysis highlights increased attendances among 20–29-year-olds, children, and patients from more affluent areas. Key drivers remain unclear, and further work with system partners is needed. This aligns with ongoing development of the Neighbourhood Health Model

Serious Incident Investigation Reports
There are three serious Investigation Reports submitted for information and awareness at the Quality Assurance Committee

ASSURE

Board Assurance Framework (BAF)
The Committee received the updated BAF, confirming oversight of strategic risks, controls, and assurance mechanisms. All actions have been reviewed, with remaining updates pending finalisation of the 2026/27 strategic priorities. A Board development session on Risk Appetite will be held in April. QAC was asked to approve the revised risk score for CO7, the updated risk appetite for CO1, and to consider the adequacy of current controls and assurance arrangements

Trust Heatmap
The Month 11 (February 2026) heatmap highlights key workforce and staffing metrics. All elements are reviewed in detail within the six-monthly Safe Staffing reports to the Board of Directors and in individual performance reports.

Clinical Governance and Quality Group Chair's Report
The Chair's Report was received from the Clinical Governance and Quality Group meeting which was held on the 04 March 2026. Across all divisions, only partial assurance could be provided on procedural document compliance, with ongoing gaps in availability, accuracy and timely updates. Divisions were reminded of the need for robust tracking and timely submission, and that strengthened oversight and accountability will remain in place until compliance improves. All divisions were asked to provide their current position and improvement trajectory directly to the Chief Nurse outside the meeting

Performance and Transformation Group Chair's Report
The Chair's Report from the Performance and Transformation Group meetings held on the 03 February 2026 and the 03 March 2026 were received. Alerts noted on reports:-

- 03 February - The Committee noted significant capacity issues impacting the Breast Recovery Plan, with extended waits and cancer pathway risks; mitigation actions and a further update were in progress. Ongoing UTC challenges were also highlighted, with improvement supported by additional clinical staffing, pathway development, and strengthened senior oversight
- 03 March - Cancer performance was expected to decline due to radiology capacity constraints, with no additional funding secured. Urgent Care performance improved but remained below target, with

continued operational pressures despite strengthened staffing, pathways, and oversight. March work focused on further pathway improvements, diagnostic review, and mental health collaboration, with the escalation-ward decision pending
New Risks identified at the meeting: None
Review of the Risk Register: N/A

Report Title:	Clinical Negligence Scheme for Trusts (CNST) year 7 update			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	26 March 2026		Discussion	
Executive Sponsor	Tyrone Roberts - Chief Nurse		Decision	✓

Purpose of the report	The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services and ongoing work with regard to the NHS Resolution Clinical Negligence Scheme for Trusts year 7 (CNST) Maternity Incentive Scheme (MIS).

Previously considered by:	Clinical Governance and Quality Committee - 04 March 2026 Quality Assurance Committee – 25 March 2026

Executive Summary	Assurance can be provided that the formal CNST year 7 maternity scheme declaration was submitted to NHS Resolution on the 17 February 2026 and safe receipt acknowledged. The Trust has since been notified of the launch of the CNST year 8 maternity scheme as from 23 April 2026. This report includes the data relating to the Q3 2025/2026 perinatal quality oversight model implementation and provides assurance that the Trust is working towards implementation of the national maternity care bundle, participating in the neonatal critical care stakeholder engagement events and submitting data to the new Maternity Outcomes Signal System (MOSS) dashboard.

Proposed Resolution	The Board of Directors are asked to: 1. Receive the contents of the report. 2. Approve the action plans detailed within this report.

	3. 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

Summary of additional detail requested by Clinical Governance and Quality Committee meeting following presentation of the paper on 4 March 2026.

1. **Maternity and Neonatal Service Metrics –** request made for additional detail to be added to the stillbirth narrative within the paper. In response narrative updated to include any learning identified from the initial review of the cases.
2. **Neonatal Service Review –** Assurance requested that the Trust will be updated as the neonatal service case for change progresses. Committee assured of engagement in the current stakeholder engagement process and advised any further updates will be included in subsequent reports.
3. **Maternity Patient Safety Incident Response Framework: Thematic learning –** Assurance requested regarding the governance oversight of the safety improvement plan collated in response to the thematic review and hypoxic ischaemic encephalopathy status within the service. Committee advised that the action plan will be presented in the paper to Quality Assurance Committee in May 2026 and at quarterly intervals thereafter.
4. **Neonatal Nurse Staffing –** Assurance was requested regarding the staffing levels in the neonatal unit as it was noted the service is currently not staffed to 100% occupancy levels. Assurance provided that safe neonatal nursing cover was provided during the Q3 2025/2026 period with an average BAPM compliance of 93.96% overall achieved. Bank staff usage is approved to address the acknowledged circa 15wte Registered Nurse staffing deficit subject to ongoing recruitment with daily oversight of the BAPM compliance was undertaken.
5. **Maternity CNST training compliance** – Table 1 updated to reflect position as of 4 March 2026.

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 updates

Assurance can be provided that the completed CNST year 7 declaration form was submitted to NHS Resolution on the 17 February 2026 and safe receipt acknowledged.

The Trust has since been notified of the launch of the CNST year 8 maternity scheme as from 23 April 2026.

3. Mandatory updates

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 1 December 2024 to 30 November 2025 to the required standard?

The maternity service has previously been advised that all activities to meet the standards should continue, prior to commencement of the subsequent CNST scheme.

The maternity service will therefore continue to submit a report each quarter that includes details of all deaths reviewed from 1 December 2024 and continue to monitor the required indicators in future board reports namely:

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.

All cases within the CNST year 7 monitoring period have been reviewed to the required standard as detailed in Appendix 1. Ongoing monitoring of all cases will continue until commencement of the CNST year 8 scheme.

The thematic learning and ongoing actions from all cases completed to date is detailed within Appendix 1a.

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

A revised Birth Rate Plus staffing review of the maternity service is currently in progress and is due to be published in March 2026. The initial data has highlighted an increase in the acuity of women, and a noticeable change is the % in category V (highest category) at 51.4% from 29.3%, which will have an impact upon the future staffing ratio requirements. A detailed update will be provided following publication of the formal report.

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

The service continues to monitor all required profession specific CNST training elements as detailed in table 1. All elements have maintained compliance with the exception of the neonatal medical staff for which a detailed plan is in place.

Table 1 – Training compliance as of 4 March 2026

Course	Total	Advanced Neonatal Practitioners	Consultant Obstetricians	Obstetric Medical Doctors	MSW	HCA	Midwives	Neonatal Consultants	Neonatal Doctors	Neonatal Nurses	Obstetric Anaesthetic Consultant	Obstetric Anaesthetist
Total	62.54%	100.00%	72.62%	62.71%	91.00%	100.00%	59.54%	100.00%	78.57%	95.00%	95.24%	96.15%
PROMPT	97.51%	NA	100.00%	100.00%	97.92%	100.00%	97.15%	NA	NA	NA	95.24%	96.15%
Fetal Monitoring GMEC	93.19%	NA	NA	NA	NA	NA	93.19%	NA	NA	NA	NA	NA
Fetal Monitoring Core Competency Stds.	96.72%	NA	100.00%	100.00%	NA	NA	96.09%	NA	NA	NA	NA	NA
Neonatal Life Support	97.04%	100.00%	NA	NA	91.67%	NA	97.16%	100.00%	91.67%	99.12%	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 15 January 2026.

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 2). 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.

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 Q3 data from October - December 2025.

4.1 Maternity and Neonatal Service Metrics

The maternity and neonatal safety champions dashboard (Table 2) was introduced in 2022 to evidence ongoing monitoring of key outcomes and service trends relating to perinatal safety intelligence.

Table 2 – Maternity and Neonatal safety champions dashboard

5 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	July 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
CNST attainment	Information only								
Critical Safety Indicators									
Births	Information only		446	415	407	419	364	356	401
Maternal deaths direct	0	1	0	0	0	0	0	0	0
Still Births			0	1	0	2	0	2	3
Still Birth rate per thousand	3.5	≥4.3	0	2.4	0	4.75	0	5.59%	7.43%
HIE Grades 2&3 (Bolton Babies only)	0	1	3	2	0	0	0	0	1
Early Neonatal Deaths (Bolton Births only)	Information only		1	3	2	0	0	0	0
END rate in month <7days	Information only		0.2	0.7	0.5	0	0	0	0
Late Neonatal deaths	Information only		0	0	1	0	1	0	0
PSII Incidents (New only)	0	2	0	0	1	0	0	0	0
MNSI referrals (Steis reportable)			2	1	0	0	1		
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0	0
Moderate harm events	0	1	0	3	1	4	0	0	0
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	98.7%	99.5%	99.5%	97.70 %	98.98 %	98.91 %	99.49 %
The Co-ordinator is the named person providing 1:1 care (Br+)	0	1	0	0	1	0	0	0	0

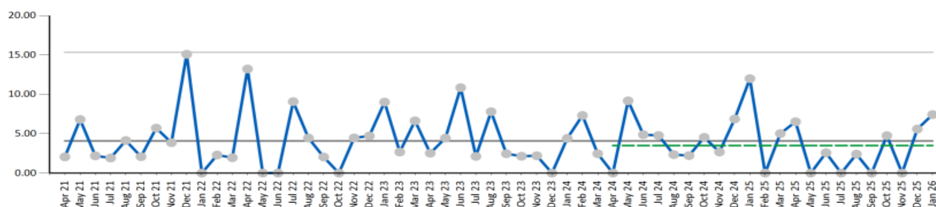
BAPM compliance ratio/nurses acuity indirect (neonatal unit)	>99%	<79%	100%	100%	91%	96%	85.87 %	100%	91%
Fetal monitoring training compliance (overall)	<90%	>80%	96%	91%	88%	90%	97%	99%	96%
PROMPT training compliance (overall)	<90%	>80%	96.00 %	89.00 %	90.00%	90.00 %	92%	99%	95%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:19	1:19	1:19	1:19	1:20	1:16	1:19
RCOG benchmarking compliance	Information only		86%	100%	94%	100%	100%	100%	NA
Compensatory rest breaches			0	0	0	0	0	1	NA

The dashboard highlights common cause variation in the number of cases of stillbirth cases within the service in Q3.

Five intrapartum stillbirths were reported during the Q3 (October – December 2025) period of which one pregnancy had known abnormalities, one had died at an earlier gestation and delivered with their twin and two of the pregnancies had undetected growth restriction. The initial reviews undertaken indicated that all care was delivered in accordance with guidance. All cases will now progress to the perinatal mortality review tool analysis in order to identify any learning.

Three cases of stillbirth occurred in January 2026 of which one is progressing as a level 4 incident due to missed opportunities in the care pathway to exclude or diagnose obstetric cholestasis which may have affected the management plan and measuring of the fundal height as the growth did not follow the expected trajectory. It was also noted that there was a missed opportunity to provide the lady with an interpreter in triage. Immediate actions have been identified to prevent further recurrence.

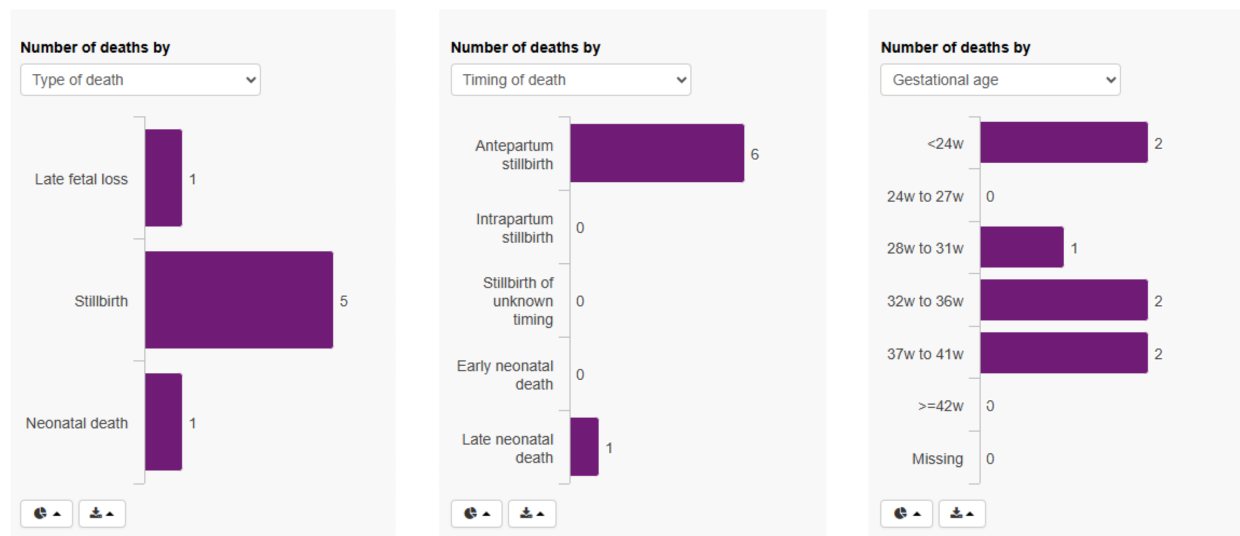
Table 3 – Stillbirth Incidence up to January 2026



Perinatal Mortality

All perinatal deaths reported on the dashboard are also monitored using the MBRRACE real time data monitoring tool (Table 4). This tool enables the maternity service to identify trends in the incidence of deaths and associated actions.

Table 4: MBRRACE real time monitoring tool data reflecting deaths reported by type to MBRRACE during the Q3 period October 2025 – December 2025.



One neonatal death was reported in Q3 at Bolton in the extreme prematurity cohort of babies on the Neonatal Unit (less than 24 weeks).The case has been reviewed in detailed by the neonatal service and the review identified no care issues identified which would have made no difference to the outcome were identified for the baby (Grade B).Two other cases of neonatal death were noted in the Trust quarterly review report that are to be noted: one case exceeding the 28 day neonatal reporting period and one case relating to the death of a preterm Bolton baby that subsequently occurred at another provider following transfer of care.

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.

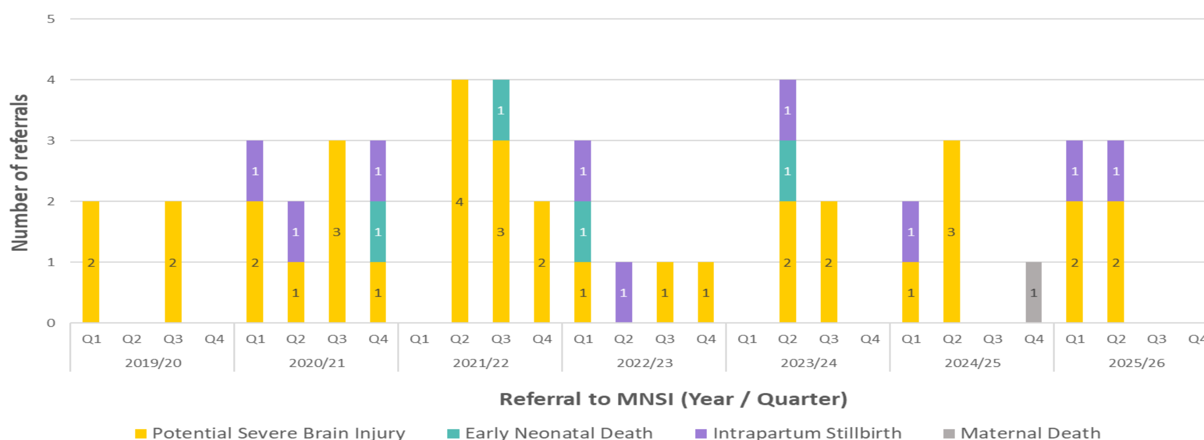
The thematic review of the 10 maternity cases highlighted areas for improvement in the clinical care pathway, particularly concerning antenatal CTG interpretation, escalation processes, triage systems, and documentation practices. While established protocols like the Birmingham Symptom-Specific Obstetric 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.

0 cases were reported to MNSI during the October - December 2025 reporting period.

Table 5: MNSI cases



One MNSI case investigation (MI-041156) concluded during Q3 2025/26 and the learning recommendations related to the need to support mothers whose first language is not English ensuring the planning for translation where possible and ensuring the timely escalation of care so that birth is not delayed.

External assurance requests

During the period October - December 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 Q3 2025/2026 scorecard review (Appendix 3) 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 Q3 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.

Delays in treatment were noted as a theme in the triangulation of complaints and incident themes. In response an additional board road has been introduced on Delivery Sute to improve multidisciplinary working and oversight of clinical risk within the service and the service escalation policy has been updated to ensure appropriate support is provided when required.

4.3 Workforce

As a minimum standard Trust Boards are expected to 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. The next report is due in May 2026.

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

The December 2025 report detailed in table 6 highlights a overfill of shifts on ward G3 in month and an underfill of non-registered staffing on Central Delivery Suite and the Neonatal Unit. In response a professional judgement review of staffing levels has been 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 commenced their new roles in January 2026.

Table 6: Trust safe staffing report – December 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		**92.11%**	**91.71%**	**91.19%**	**100.10%**	**8.87**	**8.81**	**0.06**	↓	
Ward B1 [E00028]	300 - GENERAL MEDICINE	98.63%	91.94%	101.33%	109.61%	7.17	7.24	0.06	↑	
CCU (Coronary Care Unit) [E00016]	320 - CARDIOLOGY	99.56%	97.12%	100.00%	103.23%	9.03	8.69	-0.34	↓	
Ward C1 [E00005]	320 - CARDIOLOGY	99.95%	95.14%	100.14%	100.00%	5.52	5.44	-0.08	↓	
Ward C2 [E00007]	300 - GENERAL MEDICINE	98.34%	89.03%	100.00%	97.54%	6.87	7.01	0.14	↑	
Ward C3 [E00011]	301 - GASTROENTEROLOGY	103.35%	85.33%	100.16%	99.91%	6.66	6.68	0.02	↑	
Ward C4 [E00035]	300 - GENERAL MEDICINE	99.85%	91.96%	100.00%	99.94%	7.11	7.00	-0.11	↓	
Ward D3 [E00013]	340 - RESPIRATORY MEDICINE	108.16%	96.93%	109.72%	106.51%	7.23	7.23	0.00	↑	
Ward D4 [E00015]	340 - RESPIRATORY MEDICINE	99.28%	97.91%	98.92%	106.45%	8.02	8.02	0.00	↑	
Ward H3 - Stroke [E00027]	328 - STROKE MEDICINE	96.28%	97.99%	100.00%	102.15%	6.41	6.95	0.54	↑	
Critical Care Unit (E00147)	192 - CRITICAL CARE MEDICINE	74.71%	81.72%	80.38%	54.84%	24.22	22.62	-1.60	↓	
Surgery E3 (E00119)	100 - GENERAL SURGERY	100.43%	95.95%	96.34%	100.00%	6.89	9.84	2.95	↑	
Orthopaedic Male E4 (E00077)	110 - TRAUMA & ORTHOPAEDICS	100.08%	95.59%	96.86%	101.61%	8.50	7.73	-0.77	↓	
Orthopaedic Female F4 (E00078)	110 - TRAUMA & ORTHOPAEDICS	100.48%	108.46%	96.13%	116.07%	8.23	8.51	0.28	↑	
Antenatal - Ward G3 [E00176]	501 - OBSTETRICS	132.26%	81.57%	90.30%	100.14%	8.39	7.51	-0.88	↓	
Postnatal G4 [E00177]	501 - OBSTETRICS	102.29%	91.88%	83.77%	95.84%	8.85	8.76	-0.09	↓	
Central Delivery Suite (CDS) [E00183]	501 - OBSTETRICS	86.25%	80.51%	83.83%	95.16%	42.48	35.19	-7.29	↓	
Neonatal Unit [E00185]	422 - NEONATOLOGY	74.70%	41.58%	80.77%	74.19%	11.58	11.37	-0.21	↓	

Obstetric cover

During the period July – September 2025 two maternity diverts were enacted due to obstetric staffing issues in Q3. The obstetric staffing business case to realign the workforce structure has since been approved by CRIG.

The Q3 2025/2026 RCOG clinical attendance audit report reflected activity between October - December 2025. The audit demonstrated 100% compliance with the required standards each month with a consultant being in attendance all of the 30 cases.

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.

In response 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 to seek approval to recruit to the additional staffing resource required.

Neonatal nursing cover

The BAPM staffing levels highlight that safe neonatal nursing cover was provided during the Q3 period with an average BAPM compliance of 93.96% during Q3. A business case is in progress to seek a funding uplift to attain staffing to fulfil 100% occupancy levels.

Bank approval was authorised during this period to mitigate the acknowledged circa 15wte 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 which has been attained for the majority of training metrics. Further improvement is required with regard to cultural competency training by non-registered staff and for e learning training for medical colleagues.

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 CCV2 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.

Table 7 – Training compliance in accordance with core competency framework as of end of December 2025 submitted for the Q3 reporting period.

Qualifying period and submission dates to LMNS (Use LMNS Email GMEC.LMNS@nhs.net)			Sept - Dec 2025				
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	96	96	96		
		NCSCT E-learning	100	100	0		
		Risk Perception Training for ANC staff	100	0	0		
	Element 2: Fetal Growth Surveillance	E-learning for Health Module	96		61		
		Serial Fundal Height Face to face training and competency	96		96		
		Face to face training	96		96		
	Element 3: Reduced Fetal Monitoring	E-learning for Health module	96		61		
		Face to face training	96		96		
	Element 4: Fetal monitoring	see Core Competency 2					
	Element 5: Preterm Birth	E-learning for Health module	96	0	61	0	0
		Face to face training	96	0	96	0	0
	Element 6: Diabetes in Pregnancy	Face to face training	96	0	96		
2	**Fetal Monitoring GMEC Package:**						
	Full day Fetal monitoring training to include CTG,	Face to face training	97		98		

	Antenatal and Intermittent Auscultation						
	CTG competency	GMEC Competency document	95		82		
	Intermittent Auscultation Competency	GMEC Competency document	95		0		
3	**Maternity Emergencies - Multidisciplinary Team - Full day**	Face to face training	94	96	98	95	0
4	**Equality, Equity and Personalised Care**	Face to face training	96	0	91	0	0
	Cultural Competency and Cultural Safety in maternity care	Face to face training	96	32	91	0	0
5	**Care during Labour and Immediate Postnatal Period**	Face to face training	96	0	91	0	
6	**Neonatal Basic Life Support**	Face to face training	94	96	0	0	0

Staff feedback

The board safety champions and perinatal leadership team last met on the 15 January 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.

Further listening events have been held with clinical areas to understand the operational challenges impacting upon performance and enable the identification of solutions to address the issues highlighted.

Additional staff and service user feedback received from the safety champion walkabouts is detailed in Appendix 2.

Freedom to speak up.

One concern was raised from the maternity service via FTSU in Q3 2025/2026. The case related to inappropriate attitudes and behaviours.

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

During Q3 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

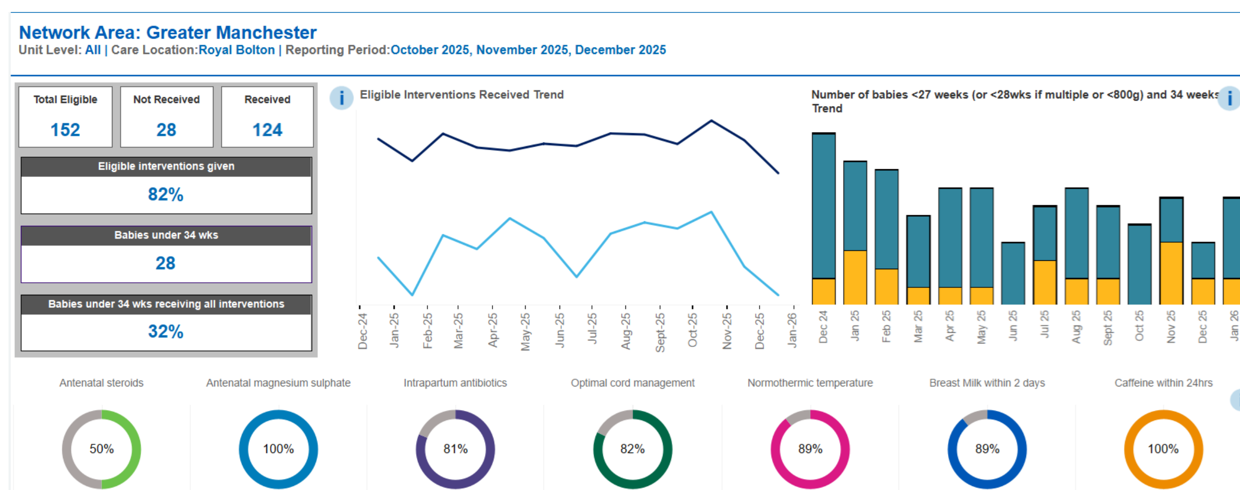
In Q3 common cause variation was noted in the number of Friends and Family responses leading up to December 2025 to 20.2% with an increase in satisfaction noted in birth responses to 93.4%.

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 82% of eligible interventions were administered in Q3 yet highlighted a slight deterioration in overall improvement in performance. To be noted further improvement is still required with regard to the uptake of antenatal steroids prior to birth.

Table 8 Perinatal optimisation measures Q3 2025-2026



Saving Babies Lives Care Bundle Implementation

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. 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.

4.2 External Assurance

Moss Dashboard

The Maternity Outcomes Signal System (MOSS) has been developed by NHS England in response to the first recommendation in the Reading the Signals East Kent report to

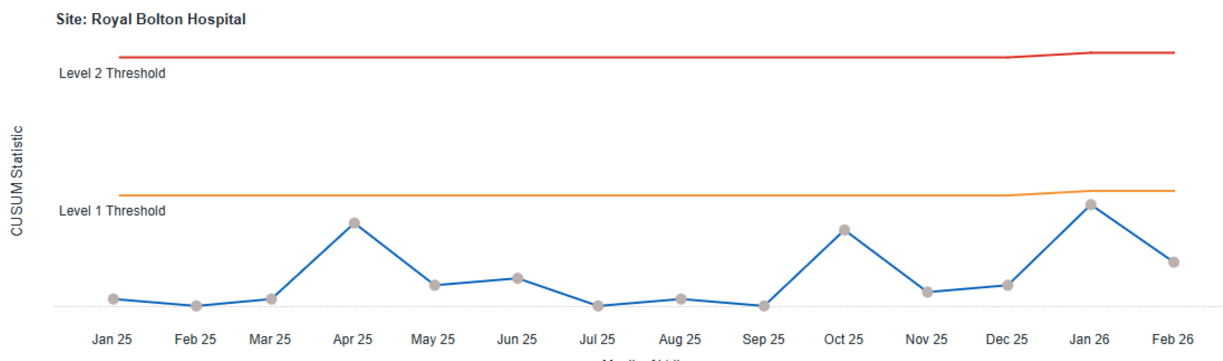
'*identify valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers for national mandatory use'*.

MOSS aims to identify signals about potential critical safety issues in maternity intrapartum care that could lead to adverse outcomes and is intended to be used as part of routine safety monitoring within the Perinatal Quality Oversight Model (PQOM).

The chart currently produces 'signals' of potential safety issues in maternity care using term stillbirth and term neonatal death data up to 28 days.

The Trust has received no formal alert notifications to date following submission of data to the dashboard.

Table 9 MOSS dashboard reflecting Trust data for the period January 2025 – February 2026



Equality monitoring dashboard

A new Maternity and Neonatal Equalities Dashboard has been published to support trusts to tackle disparities and ensure every woman and baby receives safe, personalised and compassionate care, regardless of their ethnicity or background.

The interactive dashboard will enable trusts to understand where disparities are greatest, enabling them to take action to improve maternity and neonatal care for black, Asian and mixed ethnicity women, and those from deprived areas.

The initial data highlighted that the Trust has a higher distribution of maternity clients in the most deprived quintile (30.4%) and also a higher Asian / Asian British demographic (23.3%) when compared to the England average (18.3%).

The dashboard data will be used to inform service planning.

Maternity bundle

A new Maternal Care Bundle (MCB) has been launched that sets best practice standards across 5 areas of clinical care has been launched, for implementation by NHS providers and commissioners across England. The aim is to reduce maternal mortality and morbidity and reduce inequalities in these adverse outcomes.

The 5 elements of the bundle are:

Venous thromboembolism (VTE) – reducing thrombotic events in early pregnancy by risk assessing all pregnant women at the earliest opportunity before antenatal booking and providing rapid access to thromboprophylaxis for those identified as at high risk.

Pre-hospital and acute care – ensuring unwell pregnant women receive the right care at the right time through improving access to urgent obstetric and maternal medicine care; and implementing a common approach to the monitoring, identification and management of maternal deterioration across all care settings.

Epilepsy in pregnancy – improving control of seizures by ensuring timely access to specialist multidisciplinary epilepsy care during and after pregnancy.

Maternal mental health – improving the identification and response to perinatal mental health concerns through the consistent use of National Institute for Health and Care Excellence (NICE) recommended screening tools and timely referral to appropriate specialist support.

Obstetric haemorrhage – improving the management of haemorrhage through standardised approaches to timely identification, escalation and response to obstetric bleeding, along with ongoing multidisciplinary review and learning.

All NHS trusts providing maternity services and ICBs are responsible for fully implementing the MCB by March 2027 and this includes:

- benchmarking current compliance and developing an improvement plan with trajectories for sign off by the Trust board.
- providing regular reports to the trust board on implementation against this plan and trajectories, so that the board can oversee, support and challenge local delivery. Trust boards should also ensure the involvement of all relevant services in the planning and delivery of interventions. This will include relevant medical and surgical specialties, gynaecology and urgent and emergency care, as appropriate ensuring that where local plans do not meet nationally recommended pathways, timescales or performance, or where local delivery subsequently deviates from these plans, this is escalated to the regional NHS England team.
- engaging with maternal medicine networks. This means co-producing and complying with the local network's protocol for the management and referral of

medical problems in pregnancy, across all relevant medical specialties and settings.

- ensuring local reporting of routine care data relating to key process and outcome measures for each element as defined in the national implementation tool when released in Q4 2025/2026.

Neonatal review

The NHS is looking at how to improve neonatal services across the North West of England. The main reason why these services need to change is to ensure that in the future they are able to meet national care standards set for all NHS neonatal units.

In December 2019, NHS England published The Neonatal Critical Care Review (NCCR), which set out a series of new national care standards for improving the safety and effectiveness of neonatal care. In 2024, they were also added to the Neonatal Critical Care Service Specification. Based on the latest patient activity data for 2024-2025, only 3 units in the region meet these new activity standards, out of a total of 19 neonatal units for which the standards apply.

A summary of the case for change has been shared with all neonatal staff and comments are being sought via a survey prior to the 6 March 2026. Feedback gathered from staff, parents and carers during this engagement will be used to help inform the next phase of planning for improving neonatal services. Trusts were advised to consider the operational running of the service and process of care planning and governance oversight.

Urgent review of homebirth services following Prevention of Future Deaths report

The Trust received notification via formal letter on the 26 November 2025 of the need for an urgent review of homebirth services following a prevention of futures deaths report issued following a recent maternal death relating to homebirth.

In response a regional North West group has been established and baseline assessment has been completed by all providers. The Trust is currently working with provider peers to establish a Charter to define the standards required of providers who offer a homebirth service.

6. Summary

This report provides assurance of the ongoing monitoring of the relevant maternity and neonatal schemes and of progress to date with regard to the CNST year 7 maternity incentive scheme.

This report includes the data relating to Q3 2025/2026 perinatal quality oversight model implementation and provides assurance that the Trust is working towards implementation of the national maternity care bundle, participating in the neonatal critical care stakeholder

engagement events and submitting data to the new Maternity Outcomes Signal System (MOSS) dashboard.

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. 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 22.05.2025**	11.07.2025
96927	NND	1	27+	15.01.2025 AN care at Preston	15.03.2025	16.01.2025	**External Support 29.05.2025**	15.07.2025
97050	SB	0	35+4	24.01.2025	24.05.2025	24.01.2025	**External Support 08.05.2025**	24.07.2025
97091	ENND	0	22+6	25.01.2025	25.05.2025	25.01.2025	**External Support 08.05.2025**	25.07.2025
97179	ENND	1	22+2	31.01.2025	31.05.2025	31.01.2025	**External Support 12.06.2025**	31.07.2025
97164 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
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	**External Support 08.01.2026**	31.01.2026
99736 MNSI	SB	4	41+6	01.08.2025	01.10.2025	04.08.2025	**External Support 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	**External Support 08.01.2026**	28.02.2026
100038	NND	1	27+5	28.08.2025 To 30.08.2025	30.10.2025	31.08.2025	ARRANGED 26.02.2026	28.02.2026
100164	NND	1	36+0	14.08.2025 To	07.11.2025	07.09.2025	**External Support**	07.03.2026

				07.09.2025			**15.01.2026**	
100265	NND	0	23+5	10.09.2025 To 13.09.2025	13.11.2025	13.09.2025	**External Support 15.01.2026**	13.03.2026
100728	SB	1	37+0	12.10.2025	12.12.2025	13.10.2025	ARRANGED 12.03.2026	12.04.2026
100844	SB	1	39+0	23.10.2025	24.10.2025	23.12.2025	ARRANGED 12.03.2026	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 Joint case	NND	0	32+1	27.11.2025	Post NND excluded from CNST standard	N/A	N/A	N/A
101526	SB	3	33+0	08.12.2025	08.02.2026	09.12.2025	09.12.2025	08.06.2026
101713	SB	1	30	19.12.2025	N/A	N/A	N/A	N/A
101804	SB	0	33+5	23.12.2025	23.02.2026	24.12.2025	24.12.2025	23.06.2026
101951	SB	3	39+1	39+1	04.03.2026	08.01.2026	08.01.2026	04.07.2026
102027	SB	1	39+3	39+3	13.03.2026	14.01.2026	14.01.2026	13.07.2026
102176	SB	0	28+1	28+1	25.03.2026	25.01.2026	25.01.2026	25.07.2026

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	25.02.26 Evidence received to demonstrate topic has been covered in previous induction teaching and also will be covered in future teachings	**2**
2.	To ensure training is delivered during induction in relation to fluid management.	31.03.26	Sundaram Shanmuga	25.02.26 Fluid management in neonates admitted to NICU updated for use in training.	**3**
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	25.02.26 Training audit received 96.73% of staff trained in fetal growth risk assessment, surveillance and management. Clinical audits (internal Trust) received. During Quarter 3 2025 the detection rate of babies <3rd centile was 70.0% which is higher than the National GAP average for Q£ of 62.8%. There has been a consistently higher than the national average rate demonstrated over the past 3 quarters.	**4**
4.	Learning within GMEC to be undertaken relating to the sharing of information for clients	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.	**3**

	who access care at multiple Trusts.			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.	
5.	Evident throughout labour and postnatal period that xx was not reviewed by a doctor. This is due to labour progressing Share learning throughout obstetric and midwifery teams that bereaved patients require a review.	31.03.26	Anjum Noureen, Consultant Obstetrician. Kathryn Bolton, Central Delivery Suite, Ward Manager	Evidence within huddles about the importance of doctor reviews for bereavement women, shared with the maternity staff.	**2**
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	31.01.26	Dr Anjum Noureen, Obstetric Consultant	10.10.2025 Consultant M.H presented training at preterm study day that included the extreme prematurity pathway. See Email. Dr A.N to share in doctors teaching the pathway.	**3**

	share with obstetric and neonatal team about importance of this documentation and pathway.				
9.	Ensure GMEC guideline is updated to include need for Consultant review following 3 or more reported incidents	31.03.26	MDT approach	SOP immediately removed from practice. Director of Midwifery has liaised with author of RFM North West Guideline in relation to obstetric reviews. PSII commissioned and action plan created	**3**
10	Use short iTime when giving IPPV during initial resus and stabilization. share case during neonatal training. To include within resuscitation training, NLS training and induction of new starters. To provide assurance through attendance and training data that this is being delivered through training.	31.08.2026	Sundaram Shanmuga, Neonatal Consultant		**2**
11	Medical and nursing documentation should be thorough so that it reflects the accurate timeline of events. To provide evidence that it has been shared with the neonatal team the importance of	31.08.2026	Cath Bainbridge, Neonatal Matron		**2**

	documentation to ensure a timeline of events.				
12	It was identified the policy was not followed with timing of auscultation whilst an inpatient on the antenatal ward, policy recommends twice a day, however it was identified gaps of over 24 hours. To provide evidence of huddles, staff meetings where policies have been discussed	31.05.2026	Fiona Jarvis, Antenatal Ward Manager		2
13	Drop in temperature when central lines were inserted. Need to monitor the temperature and act accordingly when central lines are inserted as there is a risk for the babies to drop their temperature. Share case in teaching.	31.12.2026	Sundaram Shanmuga, Neonatal Consultant		2

Appendix 2 - Staff and patient feedback from the safety walk rounds.

You Said	We did
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.
January 2026	Visit undertaken to Delivery Suite to seek staff feedback on the implementation of the Consultant board rounds introduced in response to staff feedback in October 2025. Staff provided assurance of consistency of implementation and reliability of process.

Appendix 3 - Claims scorecard Q3 2025/2026

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Triangulation of Trust Scorecard, incident and complaints review – Q3 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 only common and associated theme identified following triangulation of the maternity incidents and complaints for Q3 2025 with the new claims scorecard 2015-2025, includes delays in treatment/time critical activity.

Themes from complaints Q3

The three primary themes accounting for nearly half of all concerns raised in Q3 25-26 were **Delays in treatment** (20%) **Communication(13**%) and **Nursing care** (13%) the remaining 54% of complaints were distributed across various minor categories with not obvious trends. The top three concerns raised as part of the complaints and concerns procedure and were specific to the Central Delivery Suite.

Incident themes: Cause Group 1

578 incidents were reported within the maternity specialty throughout Q3 2025. The Top five highest impact incidents have been outlined below and include one category 4 harm, and four category 3 or moderate harm incidents. 195 sustained minor harm, and the remaining sustained no harm. All incidents have been mitigated prior to closure in keeping with Trust incident management policies.

Actual Impact	Cause 1
3-Moderate (Significant But Not Permanent Harm)	Delayed/Cancelled Time Critical Activity
4-Severe (Serious Permanent/long Term Harm)	Third/Fourth Degree Tear
3-Moderate (Significant But Not Permanent Harm)	Fetal Monitoring
3-Moderate (Significant But Not Permanent Harm)	Third/Fourth Degree Tear
3-Moderate (Significant But Not Permanent Harm)	NNU - Unexpected Admission

Actions to be taken in response

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 was approved at Quality Assurance Committee in November 2025

Report Title:	Antimicrobial Stewardship (AMS) Update			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	26 March 2026		Discussion	
Executive Sponsor	Chief Nursing Officer/DIPC		Decision	

Purpose of the report	This paper provides an update on current AMS performance against national targets and priorities for improvement over the next 12-months

Previously considered by:	Infection Prevention and Control Committee

Executive Summary	The Trust is performing strongly across key AMR metrics but with areas for improvement. Current antibiotic consumption levels, particularly for Watch and Reserve antibiotics, are better than national averages, and the Trust ranks in the top half of acute providers in England for both overall usage and reductions achieved from the 2019/20 baseline. The recommended three AMS priority areas proposed for Board level approval: 1. Increase use of access antibiotics from 50% to 60% by January 2027 (interim 55% by June 2026). 2. Increasing the rate of IV-to-oral antimicrobial switch, achieving a 10% reduction in IV prescribing by January 2027 compared with the 2023 four-quarter baseline; including embedding IV-to-oral switch forcing functions into the Trust electronic prescribing systems 3. Introduce mandatory AMS training for all prescribers, pharmacists and nurses, with compliance reporting planned for June 2026 and January 2027; training for prescribers and pharmacists from April 2026, with training for nurses to be incorporated into a revised Level 2 IPC training package targeted for June 2026 and January 2027. These priorities align with national targets and are clinically achievable, supporting safer, narrower-spectrum prescribing, reduced resistance risk, and appropriate antimicrobial usage. Overall, the Trust demonstrates strong stewardship performance and readiness to deliver the required improvements, with clear governance, executive oversight,

	and measurable objectives in place to reduce AMR risk and improve antimicrobial prescribing practice.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Antimicrobial Stewardship Update.

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	**No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	
Legal/ Regulatory	**No**	
Health Inequalities	**No**	
Equality, Diversity and Inclusion	**No**	
Is a Quality Impact Assessment required		

Prepared by:	Dr Katy Edwards- Consultant microbiologist Richard Catlin Divisional Nurse Director/Deputy Diretor Infection PreventionControl	**Presented by:**	Dr Pradeep Subudhi- Consultant Microbiologist Richard Catlin Divisional Nurse Director/Deputy Diretor Infection PreventionControl

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Antimicrobial Stewardship Update

March 2026

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Act now: protect our present, secure our future

- In November 2025 NSHE wrote to all acute NHS Trust chief executives
- Highlighted challenges and risks of rising antimicrobial resistance (AMR)
- Challenged providers to
  - Identify where they are now
  - Identify 3 key priorities to address

To:
- Trusts and integrated care boards:
  - chairs
  - chief executive officers

cc.
- Chief nurses
- Medical directors
- Chief pharmacists

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

November 2025

Dear colleagues,

Act now: protect our present, secure our future

The World Health Organisation has declared antimicrobial resistance (AMR) as one of the top global public health and development threats, and AMR is listed on the UK government's National Risk Register.

As a senior NHS leader, your commitment is critical to tackling AMR and protecting patient safety.

We are writing to you with a **call to action** – to work with your prescribers and your clinical leads to make the changes required to meet the targets in the national action plan for AMR.

Why Action Is Urgent

Antimicrobial resistance is not a future challenge – it's happening now.

While overall antibiotic prescribing is decreasing, prescribing in secondary care is rising. Rates of Gram-negative bloodstream infections are increasing and already exceed the 2028/29 targets in most areas.

In the UK, AMR is associated with **twice as many deaths annually as breast cancer**. It makes infections harder or sometimes impossible to treat, prolonging illness and increasing the risk of harm or death. AMR also drives up healthcare costs and threatens the delivery of safe and effective care across the NHS.

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The Problem – rising resistance

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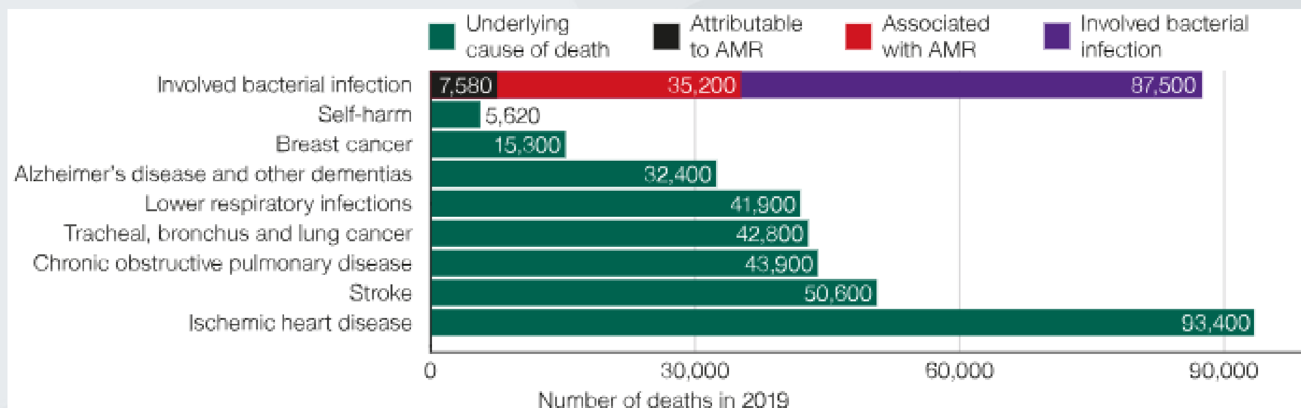

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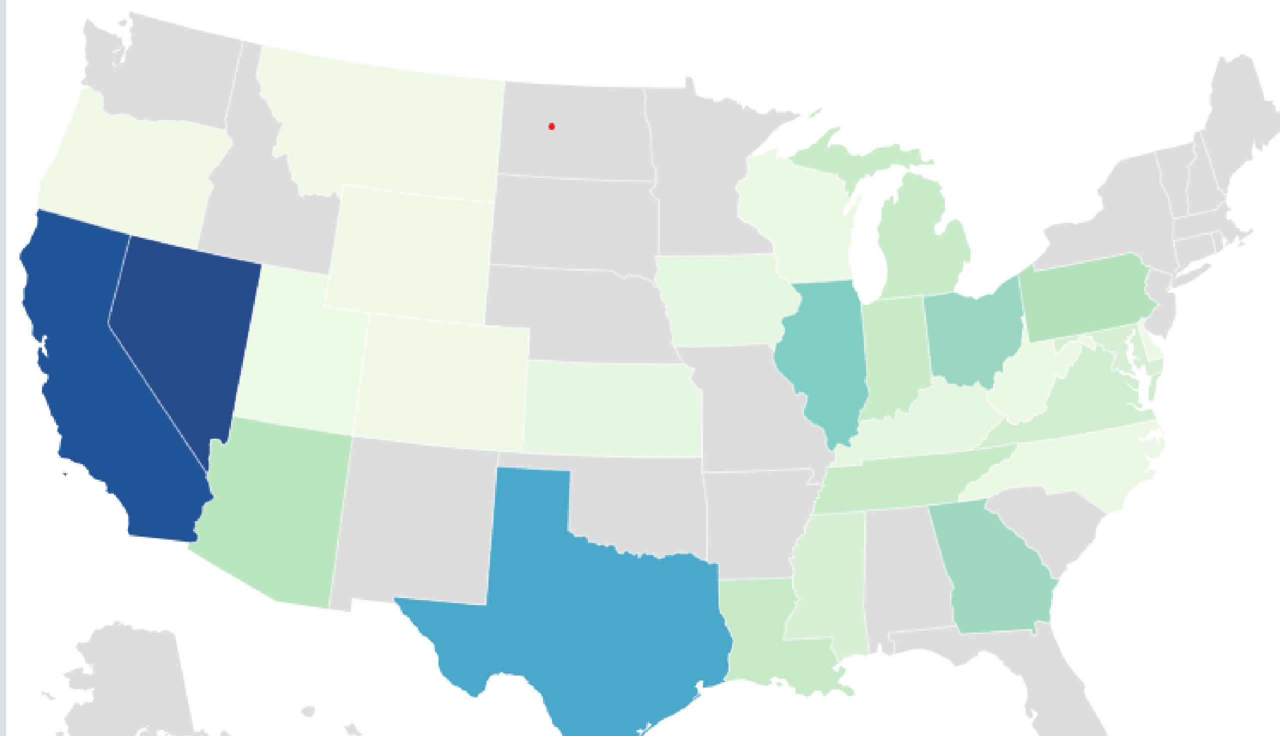
The Problem – rising resistance

What is Candidozyma auris? Fungal pathogen and emerging global health threat

Blog Editor, 29 May 2025 - Protecting the country's health, UKHSA science

Two Petri dishes containing Candidozyma auris (C. auris)

Cases of Candida auris in 2025



The Problem – resistance & mortality

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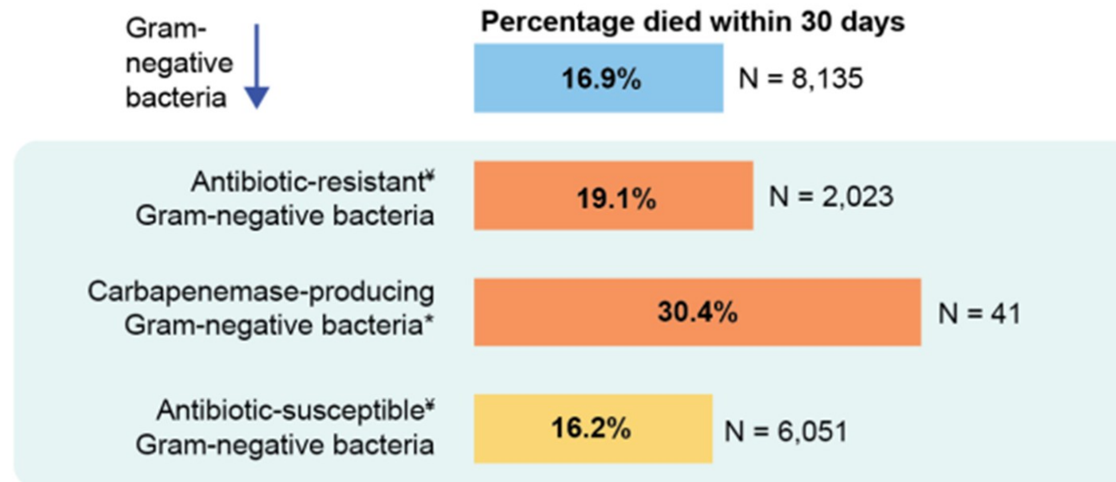

The Solution – Confronting antimicrobial resistance 2024 to 2029

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Recent AMS developments at Bolton

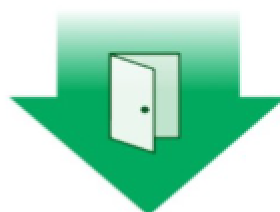
- Dashboard
- ARK
- Diagnosis based order sets

Making You Aware of AWaRE

NHS Bolton NHS Foundation Trust

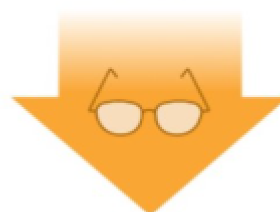
Figure 1: An image summarising the Access, Watch and Reserve categories.

Access



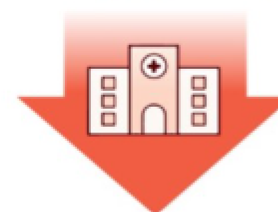
- antibiotics with narrow spectrum of activity
- fewer side effects
- lower resistance potential
- first or second choice antibiotics recommended for empiric treatment of the most common infections

Watch



- broader-spectrum antibiotics
- higher resistance potential
- first or second choice antibiotics indicated for a limited number of infective syndromes
- their use should be carefully monitored

Reserve



- "last resort" antibiotics
- new antibiotics
- for highly selected patients (life-threatening infections due to multi-drug-resistant bacteria)
- closely monitored and prioritised as targets of stewardship programmes to ensure continued effectiveness

Some antibiotics do not fit into one of these 3 classifications, for example those that are only used to treat very specific conditions, and are classed as "Other".

UK-adapted AWaRe classification, Gov.uk

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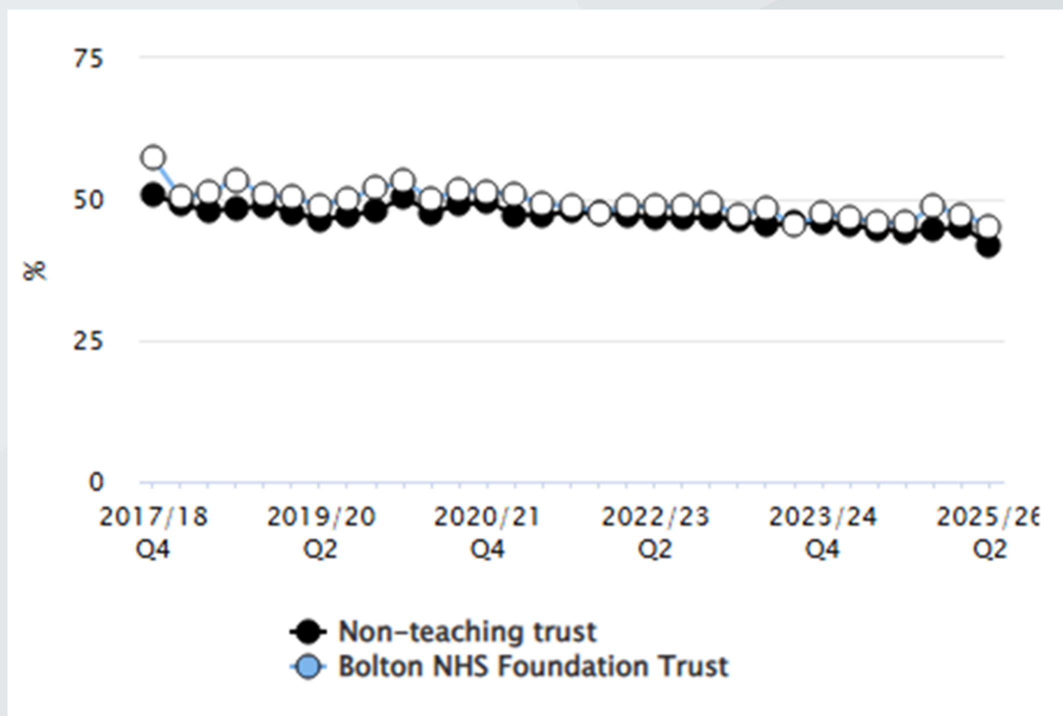
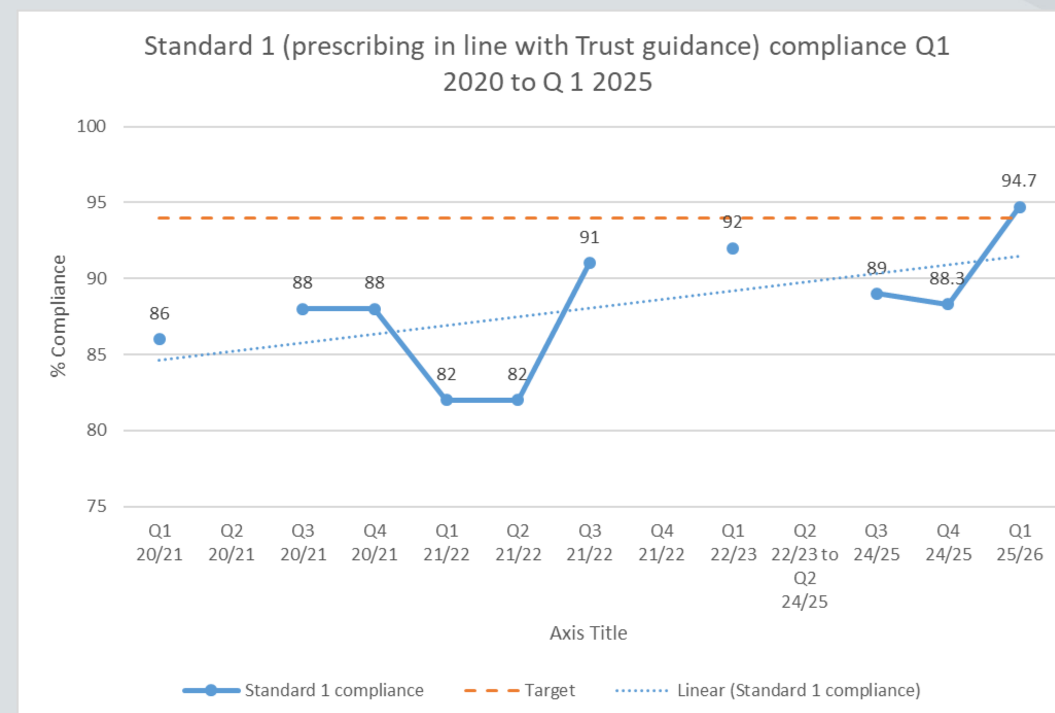
How We're Doing

NHS Bolton NHS Foundation Trust

Proportion of Watch and Reserve (broadest spectrum) agents out of total Trust antimicrobial use



Trust compliance with guidelines or as per advice from microbiology



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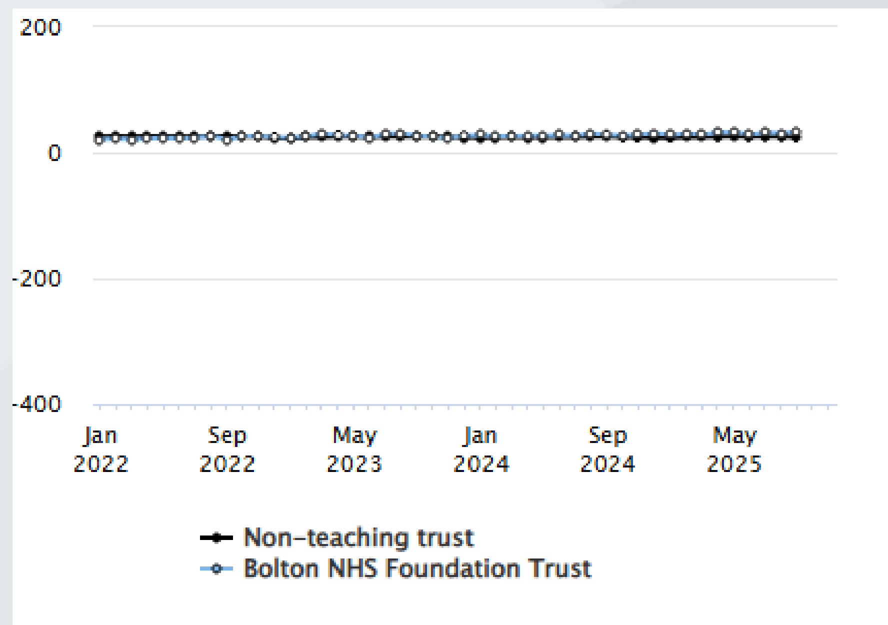
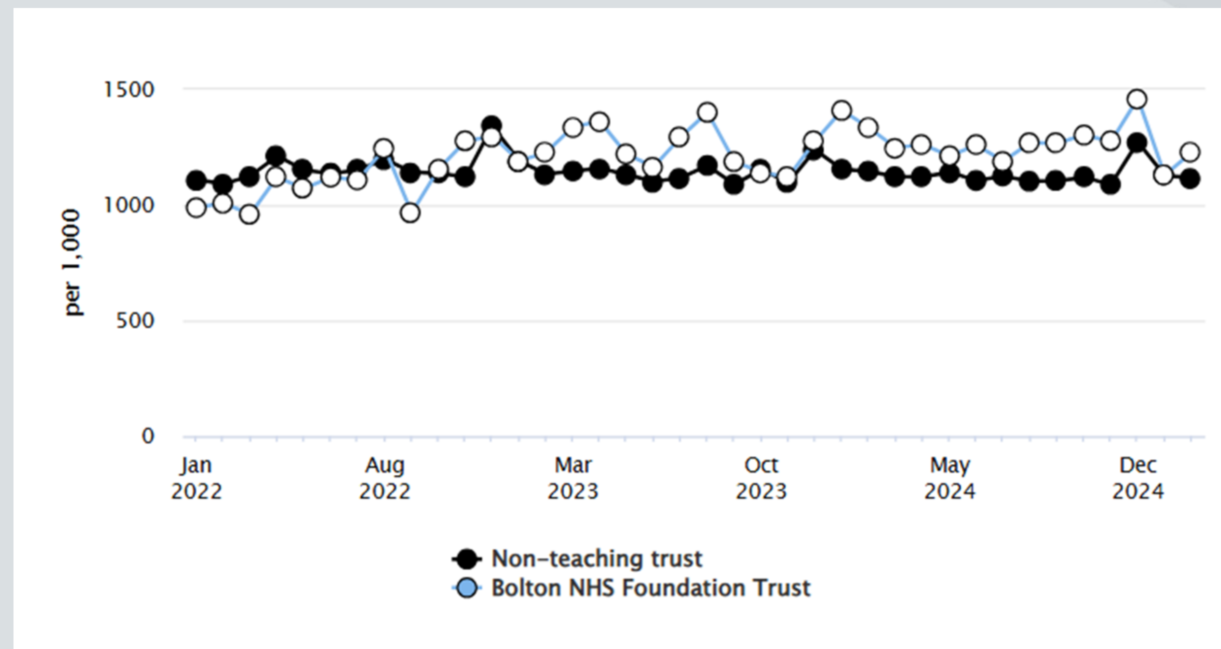
How We're Doing

Use more IV antimicrobials compared to peers (non-teaching Trusts). Last quarter:

- RBH: 33%
- Nationally: 25%



IV antibiotics – daily defined doses (DDD)/1000 admissions by month



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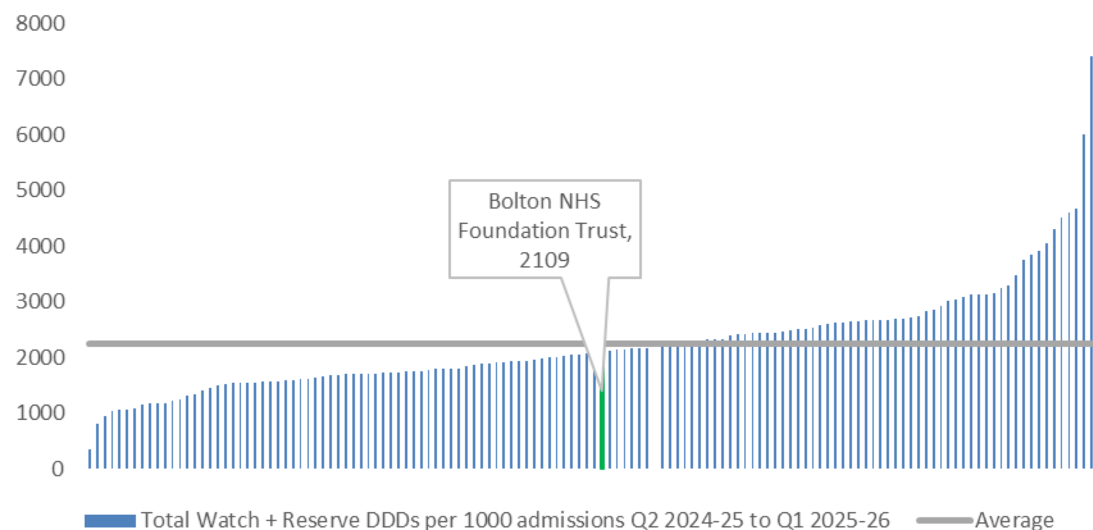
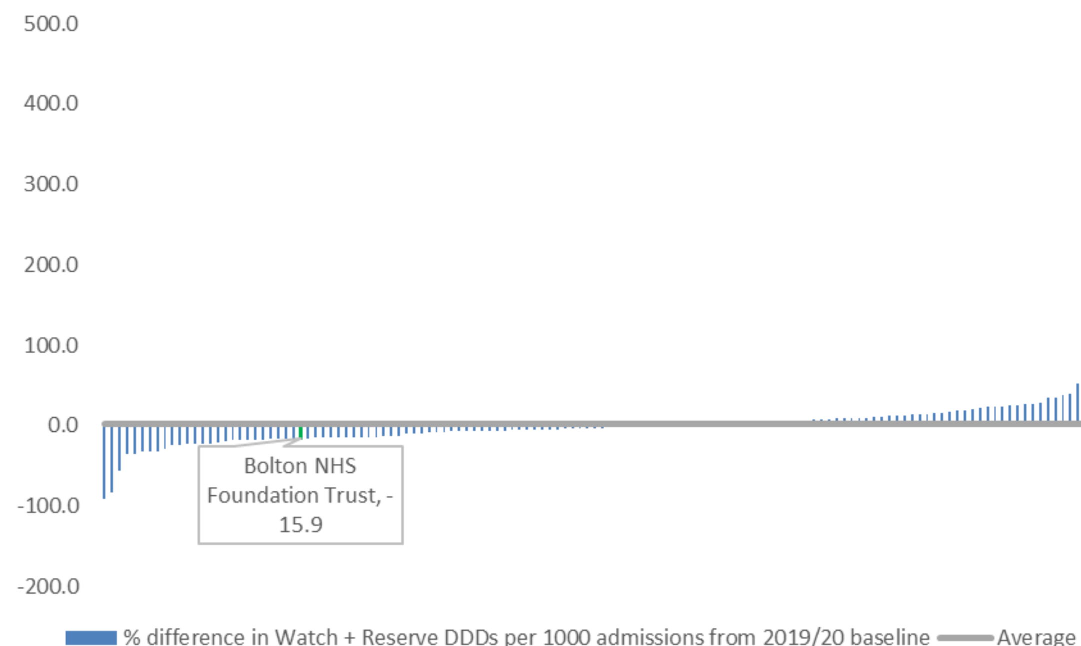
How We're Doing

NHS Bolton NHS Foundation Trust





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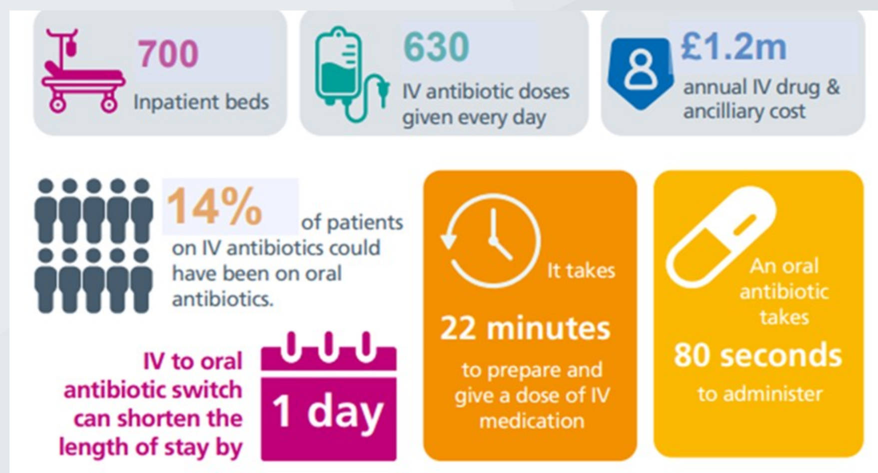
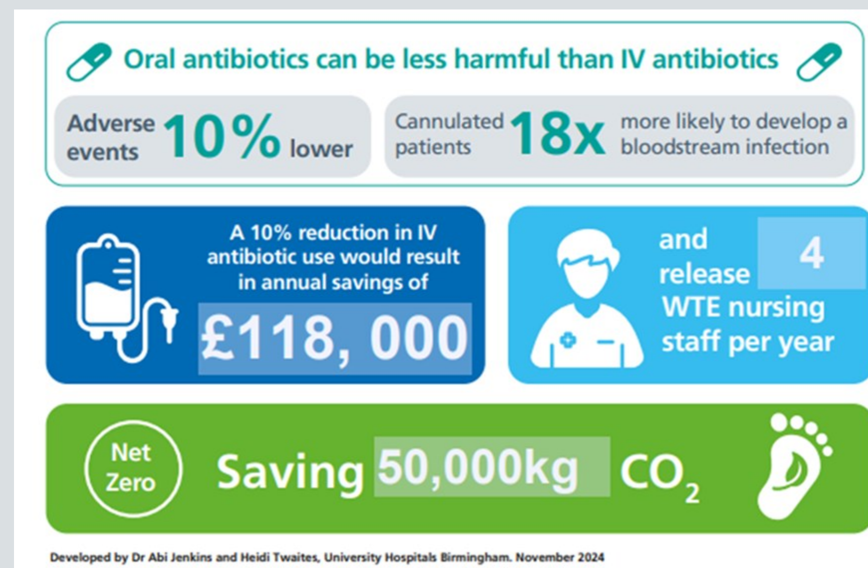
Positive Impact of Reducing IV Antimicrobial Use





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Priorities

1. Increase use of Access antibiotics from 50% to 60% by January 2027 (interim 55% by June 2026).
2. Increasing the rate of IV-to-oral antimicrobial switch, achieving a 10% reduction in IV prescribing by January 2027 compared with the 2023 four-quarter baseline
   - Including embedding IV-to-oral switch forcing functions into the Trust electronic prescribing systems
3. Introduce mandatory AMS training for all prescribers, pharmacists and nurses, with compliance reporting planned for June 2026 and January 2027.
   - Training for prescribers and pharmacists from April 2026, with training for nurses to be incorporated into a revised Level 2 IPC training package targeted for June 2026 and January 2027.

Risks to Delivery

- Antimicrobial pharmacist WTE time:
  - Review how to support AMP provision to support audit of performance and to progress quality improvement
- Clinical pressures
  - May adversely affect clinician willingness to engage in additional AMS activities/quality improvement work
- Financial

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Reporting Mechanisms

- Antimicrobial Stewardship Committee to report into IPC Committee
- DIPC as accountable Executive
- Quarterly progress on defined objectives

NHS England

To: • Trusts and integrated care boards:
  - chairs
  - chief executive officers

cc. • Chief nurses
• Medical directors
• Chief pharmacists

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

November 2025

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As a senior NHS leader, your commitment is critical to tackling AMR and protecting patient safety.

We are writing to you with a **call to action** – to work with your prescribers and your clinical leads to make the changes required to meet the targets in the national action plan for AMR.

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Actions Required by Q1 2026

The national action plan for AMR sets ambitious targets. Meeting them will require coordinated, sustained action across all levels of the NHS.

To ensure your organisation is on track to meet AMR targets, we ask that you take the following actions **by the end of Q1 2026**:

Board-Level Review & Executive oversight

1. Schedule a joint presentation to your board from IPC and AMS teams covering:

    - Current performance against national AMR targets
    - Benchmarking using the latest English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) report and AMR information found on Model Health System, together with the thresholds for each trust to reduce exposure to antibiotics, announced in the Medium Term Planning Framework[1], and shortly to be issued.
    - Key concerns and immediate actions required

Risk and Capability Assessment

2. Complete the following assessments to i) Evaluate current performance and compliance ii) Identify gaps in leadership, workforce capability, and resource allocation and iii) Inform risk registers and strategic planning.

    - The national infection prevention and control **board assurance framework**
    - The ICB Antimicrobial Stewardship **Self-Assessment Toolkit**

Set Priorities and Deliver Improvement

3. By April 2026, agree and publish three priority areas for AMR improvement within your organisation. For each priority:

    - Define specific, measurable objectives.
    - Assign executive-level accountability.
    - Establish timelines and reporting mechanisms.

Progress should be reviewed quarterly, with a formal update to the board at least annually.

Thank you for your continued leadership in confronting this growing threat to patient safety and public health.

Yours sincerely,

Dr Claire Fuller
National Medical Director
and AMR Senior
Responsible Officer
NHS England

Duncan Burton
Chief Nursing Officer
for England

Dr Shona Arora
Interim Chief Medical Advisor
UK Health Security Agency

[1] Medium term planning framework - delivering change together 2026/27 to 2028/29 p17

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Report Title:	2026/27 Quality Accounts Improvement Priorities			
Meeting:	Board of Directors	**Action Required**	Assurance	
Date:	26 March 2026		Discussion	✓
Executive Sponsor	Chief Nursing Officer		Decision	✓

Purpose of the report	The purpose of the report is to provide an options appraisal to enable the approval of the three Quality Account Improvement Priorities for 2026/27

Previously considered by:	Previously considered by Clinical Governance & Quality Group on 04 March 2026 who approved the proposed Quality Account Improvement Priorities, noting balanced focus across safety, experience and effectiveness. Confirmed alignment with the 2026/27 Level 1 strategic priorities. Noted that alternative options would continue operationally using existing QI methods.

Executive Summary	The Board of Directors is asked to note the requirement to select three Quality Account Improvement Priorities to focus on during 2026/27, which must demonstrate a clear link to quality improvement/patient safety. An options appraisal with rationale is included at Appendix One. The proposed improvement priorities are: 1. Improving patient communication and shared decision making – year 2 and extend to year 3 2. Releasing time to care – year 2 3. Understanding health inequalities

Proposed Resolution	The Board of Directors is asked to ***approve*** the three proposed priorities for the Quality Account 26/27.

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	
Is a Quality Impact Assessment required	No	

Prepared by:	Stuart Bates, Director of Clinical Governance	Presented by:	Tyrone Roberts, Chief Nursing Officer

Introduction:

The Quality Account annual report requires organisations to select **three** improvement priorities for the forthcoming financial year and to publish progress in these areas in the following year's report. Priorities must demonstrate a clear link to quality improvement/patient safety.

For reference, Quality Account priorities for 2025/26 were:

- Recognition and response to patient deterioration – two-year priority 2024/25 and 2025/26
- Improving communication with our patients – two-year priority 2025/26 and 2026/27
- Releasing time to care - two-year priority 2025/26 and 2026/27.

The Quality Account annual reporting cycle has commenced for 2025/26 and an option appraisal of potential priorities for 2026/27 is in appendix 1

Summary and recommendations:

The following priorities are proposed for consideration and were approved by the Clinical Governance and Quality Group:

1. Improving patient communication and shared decision making – year 2 and extend to year 3.
2. Releasing time to care – year 2
3. Understanding health inequalities

Recognition and response to the deteriorating patient improvement work will continue through the improvement collaborative and subsequent change package roll-out sustainment phase.

Other options considered included are:

- Clinical correspondence
- Cancer lost to follow-up

Please note, if not selected as a priority for 26/27, improvement work the above may still be commissioned e.g. linked to divisional improvement through the quality planning cycle, clinical correspondence improvement work through proposed divisional medical director improvement programme

The Board of Directors is asked to approve the three proposed priorities for the Quality Account Improvement Priorities for 26/27.

Appendix 1 – QA improvement priorities 2026/27 – option appraisal

Link to Trust Ambitions	Proposed QA 26/27	Rationale	Measure/s	Owner/oversight
Improving safety, effectiveness & experience	Improving patient communicate and share decision making	Year 2 – sustain response improvement and roll out to 2 Qs to Non FFT areas Year 3 - 27/28 Sustainment of response rates and thematic analysis of data to highlight and address areas for improvement	• Minimum 30 responses to 2 Qs (was I treated with dignity and respect and was I involved in decision making) per month per FFT eligible team / dept. / ward by 30/04/26 • Evidence inclusivity in feedback from service users such as no / reduced capacity (carers), non-English as first language • Agreement of scope for the 2 Qs (was I treated with dignity and respect and was I involved in decision making) in non FFT areas by 30/06/26 • Achievement of at least 2 information for returns for non FFT areas by 31/03/27 • Experience of Care framework self-assessment completion by 30/06/26	Quality Patient Experience Forum (R Bradley)
Improving safety, effectiveness & experience	Releasing Time to Care	Year 1 – initial scoping and RPIW postponed to 09/02 due to operational pressures Year 2 – deliver the plan outlined from first RPIW	• Nursing & HCA Documentation to reduce by XX*% by 31/03/27 (duplicate/obsolete documentation) – currently quantifying baseline	D Fletcher
Playing our part in improving health	A focus on health inequalities	Current inability to understand patient access/experience variation across client groups to understand how improvements can be made	• By 31/03/27, every clinical specialty to have a suite of disaggregated clinical outcome metrics to track quality of care and identify areas of inequity for targeted improvement plans	R Munshi/ S Kimber-Craig

Improving safety, effectiveness & experience	Cancer lost to follow-up	Incidents related to cancer patients not receiving (receiving timely treatment and impact on outcomes)	• % reduction in cancer patients lost to follow by 31/03/27 (need to define and understand baseline)	R Munshi/ N Caffrey -
Improving safety, effectiveness & experience	Clinical Correspondence	Variable performance across trust on IP and OP clinical correspondence – potential LoS increase and ongoing treatment for patients post discharge/appointment	• % increase in clinical correspondence compliance rates	R Munshi/ N Caffrey -

Report Title:	People Committee AAA Chair Report			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	26 March 2026		Discussion	
Executive Sponsor	People Committee Chair		Decision	

Purpose of the report	The purpose of this report is to provide an update and assurance to the Board of Directors on the work delegated to the 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 17 March 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:	Martin North, People Committee Chair	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:	17 March 2026	Date of next meeting:	19 May 2026
Chair	Martin North	Meeting Quoracy	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Revised Terms of Reference
- Board Assurance Framework
- Workforce Delivery
- People & Culture Update inc NHS Staff Survey results
- Health & Wellbeing Report
- Transforming Peoples Services
- ACP Workforce Strategic Review
- IFM Monthly People Report
- Steering Group Chair Reports
- Divisional People Committee Chair reports

ALERT

Workforce Delivery

- The Trust was under our submitted 25/26 WWTE plan in-month by 46 WWTE but over our stretch trajectory (to take us to 6176 WWTE by year end) by 53 WWTE.
- Work is ongoing to mitigate the gap within the stretched WWTE required number by the end of year and will continue into 2026/27.
- The increase in WWTE has largely been driven by temporary staffing, not substantive.
- Sickness absence remains static and above KPI target at 6.48% (stress/anxiety/depression, & musculoskeletal issues, respiratory issues, are the main drivers).

Action

Extraordinary Board Meeting taking place 17 March to discuss and agree Medium Term Plan including workforce numbers.

Further discussions will take place around workforce planning at the March Board of Directors.

People & Culture Update inc NHS Staff Survey Results

The NHS Staff Survey Results for 2025 showed that all nine People Promise themes/elements have all significantly declined from 2024. When looking at our scores compared to the sector five of the nine People Promise themes/elements are significantly worse than our sector comparators. Final results were published on the 12 March 2026.

Action

- Improve how we communicate and deliver care by involving patients and staff in shaping service improvements.
- Helping our staff stay well at work.
- Building on the strong leadership, inclusion and team working already seen in many areas.
- Strengthening access to learning and development opportunities at all levels.

ADVISE

Health & Wellbeing Report

Overall, the sickness absence position remains challenging following the winter period. A number of key work streams have been put in place and continue to be developed to support our staff to be healthy and remain in work.

ASSURE

Revised Terms of Reference

The Terms of Reference have been updated following the annual review and were approved by the Committee.

Board Assurance Framework

Since the BAF was last presented there has been no change to the overall risk score or to the agreed risk appetite. All actions have been reviewed and those that remain in progress will be updated once the Trust's strategic priorities for 2026-27. A Board development session on Risk Appetite is scheduled for April, which will include a review of the current appetite levels and the Trust's broader approach to strategic risk.

Transforming Peoples Services

Greater Manchester's Transforming People Services (TPS) programme aims to modernise and scale HR services across the region's NHS organisations, improving efficiency, consistency, and colleague experience while supporting the national ambition for a digitally enabled, future-ready People Profession. The Trust is engaged in discussions for how People Services could be modernised with a GM approach.

ACP Workforce Strategic Review

The Committee were advised that the Trust is to implement a comprehensive ACP action tracker, standardise SPA allocation, strengthen supervision with job-planned consultant oversight, establish capability matrix, formalise annual scope reviews, and create divisional risk and succession plans. Governance will be embedded via the ACP Forum, reporting through Clinical Effectiveness structures, with alignment to evolving NHSE, HCPC and NMC expectations. This will support delivery of a consistent, future-ready ACP workforce model.

IFM Monthly People Report

- The IFM HR service has been brought into the Trust as a shared service.
- Establishment remained stable at 442 WTE.
- The Workforce dashboard was discussed, and it was noted that appraisal rates were low and sickness rates remained high. The Committee asked that the HR Team and IFM provide increased focus in these areas.

Steering Group Chair Reports

The Committee received the Chair reports from the Steering Group meetings which have taken place since the last People Committee.

Divisional People Committee Chair reports

The Committee received the Chair reports from the Divisional People Committee meetings which have taken place since the last People Committee.

New Risks identified at the meeting: None

Review of the Risk Register: None

Meeting Attendance 2025/26											
Members	**Jan**	**Mar**	**May**	**Jul**	**Sep**	**Nov**	**Jan**	**Mar**	**July**	**Sept**	**Nov**
James Mawrey	✓	✓	✓	✓	✓	✓	✓	✓			
Sean Harriss	✓	✓	✓	✓	✓	✓	✓	-			
Fiona Taylor	✓	✓	✓	✓	✓	✓	✓	A			
Tyrone Roberts	**A**	✓	✓	**A**	✓	**A**	✓	A			
Sharon White	✓	**A**	✓	✓	✓	**A**	✓				
Annette Walker	✓	✓	✓	✓	**A**	✓	✓	✓			
Ian Williamson							✓	✓			
Janet Hulston							✓	A			
Martin North							✓	✓			
Gita Bhutani								✓			
✓ = In attendance	A = Apologies	- = left the Trust									

NHS
Bolton
NHS Foundation Trust

Report Title:	Finance & Investment Committee AAA Chairs' Reports			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	26 March 2026		Discussion	
Executive Sponsor	Finance & Investment Committee Chair		Decision	

Purpose of the report	The purpose of these reports is to provide an update and assurance to the Board of Directors on the work delegated to the Finance and Investment Committee.

Previously considered by:	The matters included in the Chairs' reports were discussed and agreed at the Finance & Investment Committee.

Executive Summary	The attached reports from the Chair of the Finance and Investment Committee provide an overview of matters discussed at the meetings held on 28 January, and 25 February. The reports also set out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors. As the March Board meeting takes place before the Finance and Investment Committee convenes, the Chair's Report from the March meeting 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 Finance and Investment Committee will be escalated verbally to the Board by the Committee Chair at the meeting.

Proposed Resolution	The Board of Directors are asked to ***receive*** the Finance & Investment Committee Chair's Report from the meetings held on the 28 January, 25 February and 25 March 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:	Sharon Katema, Director of Corporate Governance	**Presented by:**	Sean Harriss, F&I Chair

ALERT | ADVISE | ASSURE (AAA)
Key Issues Highlight Report

Name of Committee /Group:	Finance & Investment Committee Meeting	**Reports to:**	Board of Directors
Date of Meeting:	28 January 2026	**Date of next meeting:**	25 February 2026
Chair	Sean Harriss	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Month 9 Finance Report
- Medium Term Planning
- Review of Finance Risk Register
- National Cost Collection
- Managed Equipment Service Contract Retender
- Community Business Case and Benefits
- Monthly Digital Update
- Main Entrance Business Case

ALERT

Agenda items	Action Required
Month 9 Finance Report • Cumulatively the adjusted deficit is £17.4m at month 9 which is adverse to plan by £10.4m. • The forecast outturn mid case was £14.4m which requires a £2.9m surplus in the remaining months of the year posing a risk. • Under delivery of CIP is driving a £1.9m adverse variance in month, £10.1m cumulatively partly mitigated by income inflation not yet being spent, the impact of which will be progressive through the year. • Planned Care Variable Income (previously known as 'ERF') performance is estimated to be below-plan for April to December this will be calculated again in arrears once all activity is fully priced, although payment relies on funding being available within the ICB. • The underlying cash position is overdrawn by £12.7m. In January £3.9m cash support was approved out of a £5.5m application. The February cash application has been rejected. An application for March is to be submitted. • Capital spend in month was £3.7m which is £2.2m below plan. Cumulative capital spend to date is £14.7m less than planned	**Action** • The Trust is to formally notify the ICB of not achieving plan and will discuss the required documents with the Chair of the Committee.
Medium Term Planning The Chief Finance Officer advised the Committee how the financial plan is to be delivered over a 3-year time frame to achieve break even. In year 1, this requires a run rate improvement of 5% which is £26m, resulting in a year end deficit of £14.1m. The associated required WWTE reductions have been modelled and partially included in the plan pending further detailed work on the development of CIP.	• To be discussed further at the Board of Directors meeting on 29 January 2026.

CIP plans are significantly behind the expected timescales which is to have all plans ready for implementation by mid-March.	

ADVISE

Monthly Digital Update

The Committee were provided with a digital update. Attention was drawn to the Maternity EPR scheme currently on red which has been a large undertaking initially due to go live in February 2026. A detailed report was provided to articulate the reasons this has been rescheduled following discussions with the Executive Directors. The focus is now on the redesign of the system before rolling it back out for user testing following lessons learnt. An update will be brought back to the Committee in March.

Review of Finance Risk Register

The report covered the period 01/10/25 – 31/12/25. The division had 10 risks on the risk register, seven of which scored above 12. The Committee were given assurance that risks within the division are managed proactively and effectively with regular reviews of mitigations and controls put in place.

National Cost Collection Index

The Associate Director of Finance provided a high-level summary of the published information from the 2024/25 National Cost Collection. The 2024/25 National Cost Collection Index (NCCI) for Bolton is 91 unadjusted and 93 after adjustment for Market Forces Factor (MFF). The NCCI for Bolton is indicative of operating slightly efficiently and is in line with previous years. It is one of the lower NCCI values within Greater Manchester. Deep Dives have begun on loss making specialties to understand the drivers of the costs and support the identification of areas of potential efficiency. Community data will be a prime focus over the next year. Drivers of the deficit are included in the papers for the Board of Directors meeting on the 29 January 2026.

ASSURE

Managed Equipment Service Contract Retender

The Committee were advised that this was being brought to the Committee due to requiring Board approval and will be brought back following premarket engagement. The Committee recommended the MES Contract Retender process for approval by the Board of Directors.

Community Business Case and Benefits

The Chief Operating Officer explained that there had been an ask from the Board of Directors in September to bring back the benefits realisation of this case to this Committee and the Quality Assurance Committee.

However, it was too early to provide benefits realisation at this point due to being in the implementation phase. The report will be brough back in 6 months' time.

Main Entrance Business Case

In November a business case was presented to the Committee for the redevelopment of the main entrance that will provide 558sqm of retail with five outlets and a new reception area, changing facilities and a dedicated staff wellness lounge.

Since then, discussions have taken place with other Trusts who have had new entrances built. Discussions are underway with the Trust's Auditors in relation to IFRS9, IFR16, and IFRS17 and to confirm that this is an off balance sheet transaction.

The case is to be presented to the Board of Directors on 29 January 2026 for approval.
New Risks identified at the meeting: None
Review of the Risk Register: N/A

Meeting Attendance 2026										
Members	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Sep**	**Oct**	**Nov**
Sean Harriss (Chair)	✓									
Annette Walker	✓									
Rae Wheatcroft	✓									
Sharon Katema	✓									
James Mawrey	✓									
Sharon White	✓									
Martin North	✓									
Janat Hulston	✓									
Ian Williamson	✓									
✓ = In attendance A = Apologies										

ALERT | ADVISE | ASSURE (AAA)
Key Issues Highlight Report

Name of Committee /Group:	Finance and Investment Committee	**Reports to:**	Board of Directors
Date of Meeting:	25 March 2026	**Date of next meeting:**	20 April 2026
Chair	Sean Harriss	**Meeting Quoracy**	Yes

AGENDA ITEMS TO BE DISCUSSED AT THE MEETING (report written prior to the meeting)

- Finance & Investment Terms of Reference for review
- Board Assurance Framework
- Finance Risk Register
- Month 11 Finance Report
- Going Concern Report Digital Programme Update
- Data and Coding Update
- Maternity EPR – Lessons Learnt and Go Live update

ALERT

Agenda items	Action Required

ADVISE

Finance Risk Register

- There are currently 17 risks scored at 15 or above that are aligned to F&I committee.
- Five of the 17 risks have an impact score of “5” (catastrophic).

Digital Programme Update (including EPR)

The update describes the projects which are active, those which are planned in for the next year and those which have been requested but are not yet scheduled. The Committee is advised of 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.

Data and Coding Update

- The backlog of coding has decreased due to normalised staffing levels and additional support from the Clinical Coding bank and agency.
- Clinical coding is recognised as a pressured service due to recruitment and retention challenges, increasing activity levels, and coding complexities.
- The introduction of the new OPCS (procedure codes) standard in April 2026 and the training required prior to the introduction is a major change and is expected nationally to slow the coding process down in the early stages of implementation whilst coders get used to the new coding schema.

Maternity EPR – Lessons Learn and Go Live Update

The Finance & Investment Committee is asked to note the current position and lessons learnt, endorse the February 2027 go-live window, and support a programme reset prioritising safety, quality, and sustainable delivery.

ASSURE

Finance & Investment Terms of Reference for review
The Finance & Investment Terms of Reference have been amended following an annual review and are brought to the Finance & Investment Committee for review and approval.

Board Assurance Framework
The Finance and Investment Committee is 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.

Going Concern Report
The Finance and Investment Committee is asked to confirm the 2025/26 annual accounts are prepared on a going concern basis.

New Risks identified at the meeting: None

Review of the Risk Register: N/A

Meeting Attendance 2026

Members	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Sean Harriss (Chair)	✓	✓										
Annette Walker	✓	A										
Rae Wheatcroft	✓	✓										
Sharon Katema	✓	✓										
James Mawrey	✓	✓										
Sharon White	✓	✓										
Martin North	✓	✓										
Janat Hulston	✓	✓										
Tiri Mutambasere		✓										
Ian Williamson	✓	**A**										
Seth Crofts	✓	✓										

✓ = In attendance A = Apologies

Report Title:	Audit and Risk Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 March 2026		Discussion	
Executive Sponsor	Audit and Risk Committee Chair		Decision	

Purpose of the report	To provide an update from the Audit and Risk Committee meetings held since the last Board of Directors meeting.

Previously considered by:	The matters included in the Chair's reports were discussed and agreed at the Audit and Risk Committee held in February.

Executive Summary	The attached Chair's Report from the Audit and Risk Committee provides a detailed summary of the key matters discussed at the Committee meeting held on 11 February 2026. It outlines the Committee's oversight activities and deliberations across a range of financial, governance, assurance, and risk-related areas. This report forms part of the committee's formal assurance framework and supports the Board in discharging its responsibilities for effective governance and oversight.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Audit and Risk Committee Chair's Report.

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

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

Prepared by:	Sharon Katema, Director of Corporate Governance	**Presented by:**	Tony Allen, Audit Committee Chair

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee /Group:	Audit and Risk Committee	**Reports to:**	Board of Directors
Date of Meeting:	11 February 2026	**Date of next meeting:**	06 May 2026
Chair	Tony Allen, Non-Executive Director	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- External Audit Plan and Fees
- Internal Audit Update
- Counter Fraud Update
- Review Losses and Special Payments
- Waivers Report
- Arrangements for the Annual Report
- Risk Management Committee Chair's Report

ALERT

Agenda items	Action Required
N/A	

ADVISE

Internal Audit Update

The Committee noted the completion of several reviews and discussed the delivery of the Internal Audit Plan, including the need for capacity to progress follow-up actions.

The Clostridium Difficile Toxin (CDT) Quality Spot Check Report was presented. The Committee discussed the Limited Assurance rating and the longstanding challenges relating to CDT compliance, with assurance regarding ongoing improvement work.

The Committee received the Did Not Attend (DNA) Controls Review Assignment Report, which provided Substantial Assurance over the Trust's processes. The Committee noted that despite strong controls, DNA rates remained higher than desired.

The Internal Audit Follow-Up Report, outlined progress on outstanding recommendations. The Committee discussed the realism of timescales and the process for granting extensions and noted that further work would be undertaken with Executive Directors to improve the position.

Counter Fraud Update

The Committee received a comprehensive update, including details of an ongoing criminal case in which charges had been issued. Assurance was provided regarding compliance work aligned with the 'failure to prevent fraud' duty and the preparatory steps for media handling.

ASSURE

External Audit Plan and Fees
The Committee received a detailed update from the external auditors, including confirmation of the issuance of the 2024/25 audit certificate and an outline of the timetable for the 2025/26 audit cycle. Assurance was provided that no significant changes in accounting requirements were expected for the year, and the implementation of the Trust's new ledger was discussed without concerns raised.

Losses and Special Payments
The Committee noted that at 31 December 2025, the Trust had incurred costs of £1,202k for losses and special payments. This included £64.9k for litigation payments; £74.2k in losses and ex-gratia payments and £1,063k relating to bad debts. iFM Bolton incurred no losses or special payments in 2025/26.

Waivers Report
The report outlined a significant reduction in the value of waivers compared with the previous year. The Committee discussed the distinction between acceptable and poor-practice waivers and noted ongoing work to strengthen controls, including the introduction of measures to reduce retrospective waivers. A report on retrospective orders will be received at the next meeting.

Arrangements for Annual Report
The Committee received the proposed arrangements and structure for the 2025/26 Annual Report, including the requirement to meet statutory deadlines and the oversight of the Quality Account.

Risk Management Group Chair's Reports from December 2025 and January 2026.
The Committee discussed the relationship between the Board Assurance Framework and the Corporate Risk Register, the principles underpinning risk scoring, and the Trust's approach to managing its risk profile. It was confirmed that risk management processes included robust challenge and that a Board development session on risk management is scheduled.

New Risks identified at the meeting: None

Review of the Risk Register: N/A

Meeting Attendance					
Members	**Feb**	**May**	**June**	**Sept**	**Dec**
Tony Allen	✓				
Sean Harris	✓				
Fiona Taylor	✓				

Tiri Mutambasere	✓				
Annette Walker	✓				
Sharon Katema	✓				

NHS
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Report Title:	Charitable Funds Committee Chair's Reports			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	26 March 2026		Discussion	✓
Executive Sponsor	Charitable Funds Committee Chair		Decision	

Purpose of the report	The purpose of this report is to provide an update and assurance to the Board of Directors on the summary of discussions, decisions made and issues raised at the Charitable Funds Committee meeting.

Previously considered by:	The matters included in the Chair's report were discussed and agreed at the Charitable Funds Committee.

Executive Summary	The attached report from the Chair of the Charitable Funds Committee provides an overview of matters discussed at the meetings held on 22 January and 03 March 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 is asked to ***receive*** the Chair's report for the Charitable Funds Committee.

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

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	Financial performance outlined in the Finance report and Centros update.
Legal/ Regulatory	Yes	Governance arrangements outlined in the introductory presentation (attached) and the terms of reference review and committee effectiveness survey report.
Health Inequalities	Yes	Our Bolton NHS Charity remains committed to playing an active role in tackling health and care inequalities as a positive partner and funder.
Equality, Diversity and Inclusion	Yes	Our Bolton NHS Charity remains committed to playing an active role in supporting equality, diversity and inclusion as a positive partner and funder.
Is a Quality Impact Assessment Required	No	

Prepared by:	Sarah Skinner, Charity Manager	Presented by:	Seth Crofts, Chair of Charitable Funds Committee

ALERT | ADVISE | ASSURE (AAA)
Key Issues Highlight Report

Name of Committee /Group:	Charitable Funds Committee	**Reports to:**	Board of Directors
Date of Meeting:	22 January 2026	**Date of next meeting:**	03 March 2026
Chair	Seth Crofts	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- An introduction to Our Bolton NHS Charity
- Q3 highlight report
- Dream 10 update
- Work programme for Q4 and 2026/27
- Finance report
- Applications for charitable funds
- Terms of reference
- Committee effectiveness survey

ALERT

Agenda items	Action Required
N/A	

ADVISE

N/A

ASSURE

An introduction to Our Bolton NHS Charity
The Committee received an introduction to Our Bolton NHS Charity, outlining the charity's role, governance structure, relationship with the NHS Trust, impact, and position within the NHS charity sector. The Committee also received an overview of the Charity's principles of expenditure and scheme of delegation for funding decisions, and key resources to support further reading.

Q3 highlight report
The Committee received and noted the Q3 highlight report, summarising recent and ongoing fundraising activity, examples of charity-funded projects, and an update on the NHS charity sector, including the evolving role of NHS Charities Together.

Dream 10 update
The Committee received and noted an update regarding the Dream 10 initiative, which prioritises strategic relationships with Dream 10 partners over immediate fundraising. 'Test drives' will be led by Executive and Non-Executive Directors with progress tracked through quarterly reporting to the Charitable Funds Committee.

Work programme for Q4 and 2026/27

The Committee received and noted the Q4 work programme update. Management responsibility will move to the Communications Team following the Charity Manager's successful MARS application. Priority-setting for the next 12 months will focus on clinical engagement, investment in equipment and initiatives that enhance patient experience and staff wellbeing, and alignment with the Trust's medium-term plan. The Committee also noted plans to increase fund balance visibility with divisions, support ward-led fundraising to ensure compliance and staff advocacy and continue brand development.

Finance report

The Committee received and noted the finance report for the nine months to December 2025. During this period, the Charity recorded a net decrease in funds of £29K, with income of £192K, primarily from legacies (£106K, including £90K for cardiology) and donations (£78K), and expenditure of £221K. The largest expenditure was £149K on the management fee, with £42K spent on medical and surgical equipment. Fund balances stood at £872K in December 2025.

Applications for charitable funds

Cardiology: Sonosite ST Ultrasound System - £21k (excluding VAT)

The Committee received a request for investment in two portable echocardiography machines, with a total cost of £107.5K (excluding VAT), to support both inpatient and outpatient cardiology services. The Committee noted that the principles of expenditure had been met and approved the use of charitable funds, subject to approval at CRIG.

Cardiology: Portable ECHO machines GE Vivid S70 – £107.5k (excluding VAT)

The Committee received a request for investment in a Sonosite ultrasound machine for cardiology, at a cost of £21K (excluding VAT). The Committee noted that the principles of expenditure had been met and approved the use of charitable funds, subject to approval at CRIG.

Terms of reference

The Committee considered the terms of reference for approval, noting minor updates including formatting and job titles. The Committee approved the terms of reference subject to clarification that deputies can attend and vote on behalf of absent Execs and NEDs, to ensure alignment with other Board committees.

Committee effectiveness survey

The Committee noted the results of the annual committee effectiveness survey, conducted to assess assurance against its terms of reference. Overall effectiveness was rated 98%, with strengths identified in understanding roles and responsibilities and alignment with charitable objectives. Areas for development include enhancing stakeholder engagement and strengthening corporate partnerships, which feature in the Q4 work programme and Dream 10 work. The Committee noted that the survey will be repeated in November 2026.

New Risks identified at the meeting: None

Review of the Risk Register:

Risks have now been transferred to the Safeguard system and will be reviewed quarterly and presented to Risk Management Committee as part of the 'Communications and Strategy' risk portfolio.

Meeting Attendance 2026/27											
Members	**Jan**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Tony Allen	✓										
Gita Bhutani	-										
Seth Crofts	✓										
Sharon Katema	A										
Rauf Munshi	✓										
Martin North	✓										
Annette Walker	A										
Sharon White	✓										
Ian Williamson	✓										
✓ = In attendance A = Apologies											

ALERT | ADVISE | ASSURE (AAA)
Key Issues Highlight Report

Name of Committee /Group:	Charitable Funds Committee (CFC)	Reports to:	Board of Directors
Date of Meeting:	03 March 2026	Date of next meeting:	11 June 2026
Chair	Seth Crofts, Non Executive Director	Meeting Quoracy	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Q4 highlight report (including Dream 10 update)
- Year in review 2025/26
- Finance report
- NHS Charities Together membership renewal options paper
- Management fee 2026/27

ALERT

Agenda items	Action Required
• N/A	• N/A

ADVISE

N/A

ASSURE

Q4 highlight report (including Dream 10 update)
The Committee received the Q4 highlight report, summarising recent and ongoing fundraising activity, progress on the Dream 10 corporate programme and the launch of a Ramadan dedication page. The committee also noted the contribution and recent passing of longstanding supporter Betty Swire. Betty's founding of the Redgate Memorial Garden continues to have a lasting impact on families and reflects the importance of meaningful stewardship across generations.

Year in review 2025/26
The Committee received a Year in review update which included an update on income, fundraising and storytelling. Plans for 2026 include strengthening Dream 10 corporate partnerships, improving communications and donor journeys, and continuing to champion the charity's impact. A full pipeline report will be brought to the Committee, with an interim update on equipment projects ready for donor engagement.

Finance report
The Committee received the finance report. During this period the charity recorded a net decrease of £93k for the 10 months to 31 January 2026, with £211k income and £296k expenditure. Legacy income totalled £111k, and overall fund balances stood at £858k. The committee discussed the management of existing funds, noting several restricted and low-value pots that could be better utilised. There was agreement on the need to accelerate spending and to support this, work will now focus on improving divisional visibility of available funds and encouraging more proactive use, with potential alignment to staff survey insights. A more strategic approach to deploying funds is expected to reduce balances, increase impact and reinforce the connection between donations and tangible outcomes.

NHS Charities Together membership renewal options paper
The Committee received a paper on NHS Charities Together membership renewal. NHS CT provides valuable peer support, shared resources, networking and new income-generating products, including a proposed national lottery that could complement the existing staff lottery. The committee agreed to renew membership for the peer-support benefits, while seeking further clarity on how the lottery would operate and its potential advantages and disadvantages before committing to adoption.

Management fee 2026/27
The Committee received the 2026/27 management fee report, which covers the cost of NHS staff time and administrative support for the charity. The annual review reflects changes in roles, efficiency, inflation and staffing. Recent MARS reductions and the transfer of management to the communications team are expected to significantly reduce the fee for 2026/27, with final costings being completed by finance and senior executives for approval in Q1.

New Risks identified at the meeting: None identified.

Review of the Risk Register:
Risks are reviewed quarterly and presented to Risk Management Committee as part of the 'Communications and Strategy' risk portfolio.

Meeting Attendance 2026/27											
Members	**Jan**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Tony Allen	✓	✓									
Gita Bhutani	-	✓									
Seth Crofts	✓	✓									
Sharon Katema	A	✓									
Rauf Munshi	✓	✓									
Martin North	✓	✓									
Annette Walker	A	✓									
Sharon White	✓	✓									
Ian Williamson	✓	✓									

✓ = In attendance A = Apologies