BOARD OF DIRECTORS' AGENDA

MEETING HELD IN PUBLIC

To be held at 1pm on Thursday 25 September 2025
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref No.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB099/25	**Chair's welcome and note of apologies** ***Purpose:*** *To record apologies for absence and confirm the meeting is quorate.*	*Verbal*	Chair	
TB100/25	**Patient and Staff Story** ***Purpose:*** *To **receive** the patient and staff story*	*Presentation*	Chair	
TB101/25	**Declaration of Interests concerning agenda items** ***Purpose:*** *To record any interests relating to agenda items*	*Verbal*	Chair	**13:00** (20 mins)
TB102/25	**Minutes of the previous meeting held on 31 July 2025** ***Purpose:*** *To **approve** the minutes of the previous meetings*	*Report*	Chair	
TB103/25	**Matters Arising and Action Logs** ***Purpose:*** *To consider matters arising not included on the agenda, review outstanding and approve completed actions.*	*Report*	Chair	
WELL LED FRAMEWORK				
TB104/25	**Chair's Report** ***Purpose:*** *To **receive** the Chair's Report.*	*Verbal*	*Chair*	**13:20** (05 mins)
TB105/25	**Consent Agenda** • ***Senior Information Risk Owner (SIRO) Report*** ***Purpose:*** *To **approve** the Senior Information Risk Owner (SIRO) Report*	*Report*		**13:25**
TB106/25	**Chief Executive's Report** ***Purpose:*** *To **receive** the Chief Executive's Report.*	*Report*	*CEO*	**13:25** (10 mins)

TB107/25	**Board Assurance Framework** ***Purpose:*** *To **approve** the Board Assurance Framework.*	*Report*	*DCG*	**13:35** (10 mins)
TB108/25	**Board Effectiveness – Well Led Framework** ***Purpose:*** *To **receive** the Board Effectiveness – Well Led Framework.*	*Verbal*	*DCG*	**13:45** (10 mins)
	IMPROVING CARE, TRANSFORMING LIVES			
TB109/25	**Integrated Performance Report** ***Purpose:*** *To **receive** the Integrated Performance Report.*	*Report*	*Exec Directors*	**13:55** (20 mins)
TB110/25	**Quality Assurance Committee Chair's Report** ***Purpose:*** *To **receive** assurance on the work delegated to the Committee.*	*Verbal*	*QAC Chair*	**14:15** (05 mins)
TB111/25	**Our Assessment against the Independent Taskforce on Maternity and Neonatal Services** ***Purpose:*** *To **receive** the Our Assessment against the Independent Taskforce on Maternity and Neonatal Services*	*Report*	*CNO*	**14:20** (05 mins)
TB112/25	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Report** ***Purpose:*** *To **receive** the CNST Maternity Incentive Scheme Report.*	*Report*	*CNO + Director of Midwifery*	**14:25** (10 mins)
TB113/25	**Mortality Report** ***Purpose:*** *To **receive** the Mortality Report.*	*Report*	*MD*	**14:35** (10 mins)
TB114/25	**Medical Appraisal and Revalidation Report** ***Purpose:*** *To **approve** the Medical Appraisal and Revalidation Report.*	*Report*	*MD*	**14:45** (10 mins)
	COMFORT BREAK (10 mins)			**14:55**
	A GREAT PLACE TO WORK			
TB115/25	**People Committee Chair's Report** ***Purpose:*** *To **receive** assurance on work delegated to the committee.*	*Report*	*PC Chair*	**15:05** (05 mins)

TB116/25	**People and Culture Update** • *Workforce Workforce Race Equality Standard* • *Workforce Disability Equality Standard Reports* ***Purpose:*** *To **approve** the People and Culture Update.*	*Report*	*CoP*	**15:10** (10 mins)
	A HIGH PERFORMING PRODUCTIVE ORGANISATION			
TB117/25	**Finance and Investment Committee Chair's Report** ***Purpose:*** *To **receive** assurance on work delegated to the committee.*	*Report*	*F&I Chair*	**15:20** (05 mins)
TB118/25	**Audit and Risk Committee Chair's Report** ***Purpose:*** *To **receive** assurance on work delegated to the committee.*	*Report*	*ARC Chair*	**15:25** (05 mins)
	AN ORGANISATION THAT'S FIT FOR THE FUTURE			
TB119/25	**Winter Plan** ***Purpose:*** *To **receive** the Winter Plan.*	*Report*	*COO*	**15:30** (10 mins)
	A POSITIVE PARTNER			
TB120/25	**Questions to the Board** ***Purpose:*** *To discuss and respond to any questions received from the members of the public.*	*Verbal*	*Chair*	**15:40** (05 mins)
TB121/25	**Feedback from Board Walkabouts** ***Purpose:*** *To **receive** feedback following walkabouts.*	*Verbal*	*Members*	**15:45** (10 mins)
	CONCLUDING BUSINESS			
TB122/25	**Messages from the Board** ***Purpose****: To agree messages to be shared with all staff.*	*Verbal*	*Chair*	**15:55** (02 mins)
TB123/25	**Any Other Business** ***Purpose:*** *To **receive** any urgent business not included on the agenda*	*Report*	*Chair*	**15:57** (03 mins)
	Date and time of next meeting: • Thursday 27 November 2025			***16:00*** ***Close***

Chair: Niruban Ratnarajah

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

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

Name:	Position:	Interest Declared	Type of Interest
		Trustee Women for Well Women (Leigh)	Non-Financial Personal Interest
		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	Nothing to declare	
Sharon **White**	Chief of Strategy and Partnerships	Trustee George House Trust	Non-Financial Professional Interest
		Board Member of Bolton College	Non-Financial Professional Interest
		Partner employed by Trust	Non-Financial Personal Interest

GUIDANCE NOTES ON DECLARING INTERESTS

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

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

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

Types of Interests:

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

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

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

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

Draft Minutes of the Board of Directors Meeting

Held in Boardroom

Thursday 31 July 2025

Subject to the approval of the Board of Directors Meeting on Thursday 25 September 2025

Present

Name		Initials	Title
North	Martin	MN	Non-Executive Director and Deputy Chair (Chair)
Andrews	Francis	FA	Medical Director
Crofts	Seth	SC	Non-Executive Director
Ganz	Rebecca	RG	Non-Executive Director
Harriss	Sean	SH	Non-Executive Director
Katema	Sharon	SK	Director of Corporate Governance
Noden	Fiona	FN	Chief Executive
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

In Attendance

Carter	Rachel	RC	Associate Director of Communications and Engagement
Chadwick	Faye	FC	Divisional Nurse Director Community Services Division (for item 76)
Crompton	Victoria	VC	Corporate Governance Manager
Cotton	Janet	JC	Director of Midwifery (for item 86)
Samsudin	Hani	HS	Biomedical Scientist, Pathology (for item 88)
Houghton	Charlotte	CH	Energy and Sustainability Manager (for item 93)
Jackson	Clare	CJ	Assistant Director/Consultant in Public Health (for item 94)
McDonnell	Fiona	FM	Managing Director, iFM Bolton (for item 93)
Rigby	Lisa	LR	Assistant Director of Organisational Development
Karajada	Rafeedah	RK	Clerical Officer (for item 88)
Ramsell	Sharon	SR	Specialist Occupational Therapist (for item 76)

Apologies

Ratnarajah	Niruban	NR	Chair
Mawrey	James	JM	Chief of People/Deputy Chief Executive
White	Sharon	SW	Chief of Strategy and Partnerships

There were six observers in attendance

AGENDA ITEM	DESCRIPTION	Action Lead

TB074/25 Chair's Welcome and Note of Apologies

Martin North in his capacity as Chair welcomed everyone to the meeting and apologies for absence were as noted above.

TB075/25 Bolton System of Care Accreditation (BoSCA) Platinum Application – Critical Care Unit and Community Nursing Service (Central North Neighbourhood)

The Chief Nursing Officer introduced two teams that were being awarded Platinum status under the Bolton System of Care Accreditation (BoSCA), Services who had achieved two consecutive Gold ratings were eligible to apply for Platinum status.

The Critical Care Unit had submitted a Platinum application following Gold ratings in October 2023 and November 2024. The submission included a declaration of sustained Gold status and a portfolio evidencing a 12-month Quality Improvement (QI) project focused on reducing direct discharges home by 30% and achieving 100% safe discharges. Assessment by a multidisciplinary panel included a review of documentation, service walkarounds, and engagement with staff and patients, confirming alignment with CQC domains.

The Community Nursing Services (Central North Neighbourhood) had also applied for Platinum status, having achieved Gold in July 2022 and July 2023. Their application included a declaration of sustained Gold standards and a QI portfolio detailing efforts to ensure consistent discharge information, reduce inappropriate referrals, and improve patient experience. The panel confirmed alignment with CQC domains through documentation review, walkarounds, and staff engagement.

RESOLVED:

The Board of Directors ***approved*** the Bolton System of Care Accreditation (BoSCA) Platinum Application for Critical Care Unit and Community Nursing Service (Central North Neighbourhood)

TB076/25 Patient and Staff Story

The Chief Nursing Officer presented the story of Pat, a patient under the Neuro Rehabilitation Team following spinal surgery. Pat shared her recovery journey, highlighting the team's support and her significant progress.

Initially discharged with a poor prognosis and low mood, Pat was provided with a self-propelled wheelchair and home adaptations. Assessment revealed potential for improved mobility, and although neuropsychology support was offered, Pat chose to focus on physical rehabilitation. Over an extended period, Pat achieved

independent transfers, mobility with a walking stick indoors and outdoors, and stair negotiation. These gains enhanced her independence and emotional wellbeing.

Early equipment challenges were resolved collaboratively, ensuring her needs were met without distress. Pat expressed deep gratitude to the team, crediting their care with restoring a life she thought lost, and underscored the vital role of community neurorehabilitation in regaining independence and improving quality of life.

Staff Story
Sharon Ramsell, Specialist Occupational Therapist attended and shared the story of David Berry, Advanced Neuro Physiotherapist, who had supported Pat on her rehabilitation journey. Post-discharge, the Neuro Rehabilitation Team identified recovery potential and collaborative goals were set, and although neuropsychology support was declined, the patient's mood improved through therapeutic progress.

Interventions focused on lower limb strength, with orthotic support. The patient progressed from standing and stepping to walking short distances with a Zimmer frame. Adjusted pain relief and functional tasks enhanced independence in daily activities. The patient eventually used a walking stick indoors and outdoors, regained access to her garden, and resumed visits to her holiday home. David commended the patient's determination and the team's collaborative approach, noting the successful outcome required no changes to the therapeutic plan.

RG commended the team on an excellent story and asked how the Board could support them further. SR responded that one of the most challenging aspects of the role involved presenting cases to the panel to request specialist equipment required by patients. She emphasised that both she and her colleagues often had to act as the patients' advocates during this process.

FA queried whether the specific case had been reviewed, with particular reference to the differing outcomes. It was noted that the patient had been advised she would not walk again, which was subsequently proven to be incorrect. FA requested that a report be submitted to the Board reviewing the patient story, with particular focus on the differing outcomes and the incorrect prognosis given to the patient to provide assurance on the matter.

ACTION:
Prepare a report reviewing the patient story, with particular focus on the differing outcomes and the incorrect prognosis given to the patient.

TR thanked the team for the patient and staff story.

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

TB077/25 Declaration of Interests Concerning Agenda Items

The Board noted FN's ongoing declaration as Chair of Greater Manchester Maternity and Neonatal System Board GMEC Local Maternity and Neonatal System (LMNS) with regards to the CNST paper. The declaration was noted on the register. There were no other declarations in relation to the agenda items.

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

TB078/25 Minutes of the previous meetings

The Board received and approved the minutes of the meeting held on 29 May 2025, as a correct and accurate record of proceedings.

RESOLVED:
The Board of Directors ***approved*** the minutes from the meeting held on 29 May 2025.

TB079/25 Matters Arising and Action Logs

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

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

TB080/25 Chair's Update

The Deputy Chair thanked colleagues for their continued efforts despite the operational and financial challenges which were being faced by the Trust.

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

TB081/25 Consent Agenda

Complaints, Concerns and Compliments Report 2024/25

The Chief Nursing Officer presented the report which included a detailed analysis of the nature and number of complaints, concerns and compliments that were received from 01 April 2024 to 31 March 2025.

RESOLVED:
The Board of Directors ***approved*** the Complaints, Concerns and Compliments Report 2024/25.

TB082/25 Chief Executive's Report

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

- As part of the Our Voice change programme, the new 'Our Care' team was launched to explore why colleagues may or may not recommend the Trust for care or treatment.
- In June, the Trust restructured its clinical divisions from five to four, enhancing the organisation and management of medical services by grouping related specialties for more focused patient care delivery.
- Government's 10-Year Health Plan - the national plan sets a transformative direction for the NHS, shaped by public and workforce input. It focuses on three strategic shifts: hospital to community, analogue to digital, and treatment to prevention. The Trust was reviewing its strategy to align with the plan's objectives.
- Bolton Vision Board – 2040 Plan Launch – the borough's 2040 plan was launched, aligning with the Trust's Strategy, the Greater Manchester Plan, and the NHS 10-Year Health Plan. It addressed challenges such as cost-of-living pressures, health inequalities, and access to employment, aiming to make Bolton a thriving place to live, work, study, invest, and visit.

RG acknowledged the positive level of community engagement reflected in the report and noted it was encouraging to see.

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

TB083/25 Board Assurance Framework (BAF)

The Director of Corporate Governance presented the BAF which included updated Risk Appetite Statements agreed by the Board in December 2024. As part of the update:

- A new strategic risk, CO10a – Resilience against Cyber Threats, had been added to reflect the increasing national escalation in cyber incidents and the Trust's evolving digital landscape.
- It was proposed CO12 be expanded to reflect the Trust's ambition to become a net zero healthcare provider, in line with the NHS Net Zero Plan which commits the NHS to achieving net zero emissions by 2040.

The BAF had been presented to all relevant Committees who had been asked to review the robustness of the controls in place and evaluate the effectiveness of the assurance mechanisms supporting those controls. This process ensured the BAF continued to provide a reliable basis for strategic oversight and risk-informed decision-making.

AS emphasised the importance of reviewing the current risk scores, noting that whilst the estate was listed as the highest risk on the BAF, other significant organisational issues may warrant reconsideration of this ranking. FN concurred, highlighting that the financial risks required urgent escalation. It was agreed that finance would be escalated as the Trust's highest risk.

TR advised that the Director of Corporate Governance and Director of Clinical Governance were working on the risk appetite and SK confirmed that the Risk Management Framework would be presented in September.

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

TB084/25 Integrated Performance Report

The Chief Operating Officer reported on the Trust's operational performance during June, and highlighted the following key points:

- Continued pressure was noted in community care, particularly regarding patients with no criteria to reside. Whilst this reflected common cause variation, the lower patient levels were now relatively stable.
- Ambulance handovers within 15 minutes were within normal variation. May performance had shown special cause improvement due to targeted improvement work.
- Urgent care metrics deteriorated in June and July, attributed to medical staffing shortages in the Emergency Department (ED) linked to changes in pay rates. Staffing levels were expected to improve from August.

- Q1 attendances totalled 36,412, up from 34,690 in the corresponding period in the previous year - an increase equivalent to approximately five additional days.
- 18-week performance gradually improved, though benchmarking showed a gap compared to the best-performing GM Trusts.
- 62-day cancer performance exceeded national standards with strong benchmarking against GM and national peers.

Quality and Safety

The Chief Nursing Officer and Medical Director provided a comprehensive update on quality and safety matters. The Chief Nursing Officer advised there had been a positive reduction on Category 2 and 3 pressure ulcers within the Medicine and Surgery Divisions. Within Integrated Community Services, an increase in Category 3 pressure ulcers was reported. All cases had been reviewed, with no concerns identified regarding the quality of care provided.

A total of 12 cases of Clostridium Difficile were reported in June, contributing to 19 cases across Quarter One. The Trust remained 10 cases below the Q1 trajectory and had recorded 24 fewer cases compared to the same period in 2024/25.

The Trust was the best performer in Greater Manchester (GM) for MRSA and E. coli bacteremia rates. As of 25 July 2025, the Trust had recorded 475 days since the last hospital-onset MRSA case.

The Medical Director advised that progress towards the NHS England (NHSE) job planning compliance target of 95% by October 2025 was on track and overall compliance was being closely monitored. Summary Hospital-level Mortality Indicator (SHMI) remained within the expected range, and Venous Thromboembolism (VTE) compliance within the Medicine Division was improving.

Ongoing challenges with inpatient clinical correspondence persisted across all divisions due to multifaceted issues. This work stream was aligned with the Administration Modernisation programme, and accelerated solutions were required to meet standards.

Finance

The Chief Finance Officer, presented the Month 3 status advising:

- A year to date deficit of £6.1m which was adverse to plan by £1.8m. Externally the Trust was reporting a forecast in line with plan at break-even, which represented the best-case scenario. The most-likely scenario was a deficit of

£21.6m based on delivering the risk-rated Cost Improvement Programme (CIP) value of £28m and mitigating some known risks.
- Agency spending was 2.2% of pay costs compared to NHSE target of 1.5%.
- Current cash of £10.4m compared to plan of £2.4m, due to capital, pay award, deficit support and education monies received up front and not yet spent. Underlying cash position was £4.4m overdrawn. The Trust would be overdrawn in August unless minimum £7m cash support was received.
- Year to date capital spend was £2.2m compared to a plan of £2.6m.

Workforce

The Assistant Director of Organisation Development reported that:
- Compulsory Training compliance had reached 94.35%, the highest level since September 2021.
- Agency usage continued to decline across the Trust. Remaining usage was concentrated in hard-to-recruit Medical and Allied Health Professional roles, with exit plans in place to further reduce reliance.
- Appraisal Rates had decreased by 0.5% to 84.7%. The new FABB appraisal process had been launched with face-to-face training available as required.
- Clerical staffing growth had been observed, with an increase of 6.4WTE between April 2024 and June 2025. MARS exits were expected to reduce this and work was underway to analyse the source and rationale for the growth.

SH noted that performance and quality metrics were currently satisfactory; however, concerns remained regarding the financial position. He cautioned that increased focus on financial matters could potentially place pressure on quality, and advised that this be kept under review.

AS queried the timeline for completion of the Emergency Care Improvement Support Team (ECIST) work and asked how well prepared the Trust was for the upcoming winter period. RW confirmed the ECIST work had concluded, and the Trust was awaiting the final report. She added that winter planning was underway, with the Winter Plan scheduled to be presented to the Board in September.

In response to AS's query on the impact of recent strike action, RW advisedthat the Trust had cancelled 58 outpatient appointments and 32 procedures, which would affect some of the longer-waiting patients, particularly those classified as lower acuity.

RESOLVED:

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

TB085/25 Quality Assurance Committee Chair's Report

Fiona Taylor presented the Chair's Reports from the Quality Assurance Committee meeting held on 28 May 2025 and provided a verbal update from the meeting held on 30 July 2025, highlighting the following key points:

- BAF - C01 Improving Access to Services: Quality governance systems had shown improvement, with the associated risk score reduced from 16 to 12.

  Risk Appetite Narrative: Work ongoing to refine and align interpretations across the Trust, with updated narrative expected by December.

  C02 Culture of Innovation and Collaboration: the Medical Director emphasised the importance of continued constructive challenge to ensure progress. The Chief Nurse noted significant strides in shaping organisational culture and supporting staff to contribute effectively.

  C03 Health Improvement and Illness Prevention: updates highlighted to actions and assurances in line with the 10-Year Plan. A key development was the upcoming presentation of the Bolton All-Age Prevention and Health Inequalities Framework to the Board.

- Clinical Correspondence: Inpatient correspondence continued to show special cause improvement. Outpatient correspondence within five working days remained a challenge; however, a new digital dictation system was being trialled as part of the administrative modernisation review.

- Diagnostics – performance was below standard, particularly in Audiology, but an improvement plan was in place.

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

TB086/25 Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Report

The Director of Midwifery presented the report advising that all ten safety action work streams had been established and were progressing well. Notification of the CNST year 6 financial award was due to be received by the Director of Finance.

The service was awarded a significant assurance rating and score of 99% following the submission of the Safety Action 6 evidence relating to the implementation of the Saving Babies Lives Care bundle in the service.

The service also continued to make good progress with the attainment of the required training elements prior to the 30 November 2025.

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

TB087/25 People Committee Chair's Report

Sean Harriss presented the Chair's Reports from the People Committee meeting held on 15 July 2025, highlighting the following key points:

- BAF - The BAF had been reviewed with discussion focussing on the controls and assurances in place.
- Resource and Retention Update - The Whole Time Equivalents (WTE) had increased since November 2024. June 2025 had seen a reduction, but the Trust was still above plan. Overall use of Bank had reduced in May 2025 but also remained above plan. Further discussions would take place at the Financial Improvement Group and Executive Directors regarding potentially revising the workforce plan in order to meet the financial challenges.
- Job Planning Update - NHSE expected 95% of medical staff to have a job plan signed off by October 2025. 66% of the medical workforce met the standard. 23% of job plans were in the sign off process and could be rapidly progressed to being approved. Work was being undertaken within departments and Divisions to progress all other plans to completion.

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

TB088/25 Our Leaders Programme and Culture Update

The Assistant Director of Organisational Development presented the report which set out the themes, evaluation and next steps on the Our Leaders Development Programme and introduced Hani Samsudin, Biomedical Scientist and Rafeedah Karajada, Clerical Officer who attended to provide their staff story following attendance at the Our Leaders Programme.

RK shared her experience as a participant in the Our Leader Programme, noting that it had provided valuable insight into the wider workings of the Trust. She had suggested that incorporating real-life scenarios into the sessions would enable managers to reflect on and discuss potential improvements.

She discussed opportunities for improving career progression and recognition across the Trust, with particular reference to Laboratory Services. It was noted that providing colleagues with transferable skills would support development.

HS reflected on her 14-year career at the Trust, stating that progression had been slow and that greater opportunities to gain broader experience through cross-departmental exposure would be beneficial.

RK further advised that she had received mentorship from the Divisional Nurse Director for the Families and Diagnostics Division and had engaged in discussions around developing career pathways for other colleagues.

An issue had been raised around the booking annual leave during Eid within Laboratory Services, noting that whilst every effort was made to apply a fair and consistent approach, the high number of Muslim colleagues within the department presented a challenges. Support from the Trust was requested to enable more equitable arrangements during religious periods.

TR commended the professionalism and openness of colleagues and acknowledged awareness of cultural challenges within certain areas of the Trust. He emphasised that staff voices were being heard and actions were being taken to address these concerns. However, he suggested that further dialogue may be needed to further explore how barriers can be removed, and this should be considered going forward.

FN thanked colleagues for sharing their experiences and proposed that the Trust considered how best to support staff in gaining broader experience outside of their current roles. She suggested the development of a talent pool or programme to facilitate this. FN also highlighted the importance of ensuring that all faiths were supported, particularly to enable colleagues to spend time with their families during religious observances.

SC asked how participation in the Our Leaders Programme had supported them in their development. Both HS and RK confirmed that the programme had helped to build their confidence and had demonstrated that they possessed leadership capabilities.

AS requested that they returned to the Board of Directors in 12 months to provide a progress update.

ACTION:
HS and RK to return to a Board of Directors meeting in 12 months' time to provide a progress update.

RESOLVED:
The Board of Directors ***received*** the Our Leaders Programme and Culture Update

TB089/25 Finance and Investment Committee Chair's Report

Rebecca Ganz presented the Chair's Report from the meetings held on 28 May and 25 June 2025, and provided a verbal update from the meeting held on 23 July 2025; highlighting the following key points:

- The Trust had a Cost Improvement Programme (CIP) target of £36.9m, of which all opportunities had been identified and had achieved the set milestones for Q1 in that 100% schemes identified and 66% of schemes were implemented or fully developed.
- The risk rated profile of the opportunities was £27.5m, of which £24.4m were fully developed or delivered.
- Greater Manchester (GM) had a CIP target of £655m, of which £608m of opportunities had been identified; the risk adjusted delivery was £406m. Bolton's positive on CIP identification had improved to being mid Provider peers.
- The Trust had a revenue deficit in Month 3 of £1.4m with a year to date deficit of £6.1M with a £1.8M variance to plan largely due to under delivery of CIP and income inflation.
- Cash was above plan by £8.0m. The underlying cash position was overdrawn by £4.4m and cash support would be needed from Month 5.
- Capital spend in month was £0.5m which was slightly below plan.
- Forecast scenarios show a best case of hitting plan, a likely case of a £21.6m deficit, and a worst case of £35m deficit.

RG noted that it had been anticipated this financial year would present significant challenges, and that external cash support would likely be required at some stage.

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

TB090/25 Audit and Risk Committee Chair's Report

Alan Stuttard presented the Chair's Report from the meeting held on 25 June 2025; highlighting the following key points:

- Audited Annual Accounts 2024/25 - The Chief Finance Officer highlighted the year-end deficit of £8.9m on the face of the accounts, but an actual financial performance deficit of £0.6 million.
- The Audit and Risk Committee approved the Audited Annual Accounts for 2024/25 and recommended approval by the Board of Directors.
- Forvis Mazars Audit Completion Report 2024/25 - The Committee received the report confirming that the Trust's financial statements present a true and fair view, with no significant issues identified. An unqualified audit opinion was expected. Under Section 8 (Value for Money), a significant weakness was noted in relation to financial sustainability, specifically the CIP, reliance on non-recurrent deficit support, and potential cash support in 2025/26. The Chair confirmed these concerns aligned with the financial position.

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

Audit and Risk Committee Annual Report 2024/25

Alan Stuttard presented the Audit and Risk Committee Annual Report 2024/25 report, which summarised the Committee's membership, meeting effectiveness, governance arrangements, and key activities during the year. This included oversight of internal controls, assurance on governance, risk and financial management, and the review and approval of the Trust's Annual Report and Accounts.

In preparing the report, the Chair of the Audit and Risk Committee was of the view the Committee had taken appropriate steps to perform its duties as delegated by the Board of Directors and it had no cause to raise any issues of significant concern with the Board arising from its work during 2024/25.

RESOLVED:
The Board of Directors ***approved*** the Audit and Risk Committee Annual Report 2024/25.

TB091/25 Charitable Funds Committee Chair's Report

Martin North presented the Chair's report from the meeting held on 02 June 2025; highlighting the following key points:

- Purchase of surgical robot table - The Committee noted that the purchase of the surgical robot table, had previously been supported in principle. However, due to end of year Capital Departmental Expenditure Limits (CDEL), the table was purchased by the Trust rather than the Charity. The Committee discussed whether a retrospective grant should be made to the Trust or whether charitable funds should be prioritised elsewhere.
- Prioritisation of charitable funds - The Committee discussed prioritisation of available funds, and agreed a formal process was required to ensure funds were prioritised in line with Trust need, rather than on a first come, first served basis. The Charity team would work with Deputy Divisional Directors to support forward planning.

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

TB092/25 Health and Safety Annual Report 2024/25

The Chief Nursing Officer presented the report which provided assurance that the Trust remained fully compliant with all relevant Health and Safety legislation during the reporting period. A total of 18 Liabilities to Third Parties (LTPS) claims were received, representing a reduction of 10 compared to the same period in 2023/24.

Health, Safety and Welfare training compliance consistently exceeded the 85% target throughout the year. A notable reduction of 216 Health and Safety incidents were reported via the Safeguard system, with the most significant decrease observed in the "Violent, Aggressive or Disruptive Behaviour" category, which fell by 155 incidents.

RESOLVED:
The Board of Directors ***approved*** the Health and Safety Annual Report 2024/25.

TB093/25 Green Plan

The Chief Finance Officer introduced Fiona McDonnell, Managing Director, iFM Bolton and Charlotte Houghton, Energy and Sustainability Manager who presented the Green Plan for Bolton NHS Foundation Trust 2025-2030.

The Green Plan was supported by an internal action plan, which detailed the steps required to achieve the actions. A re-launch plan was also being drafted to ensure the Green Plan was communicated throughout the Trust.

RG queried funding opportunities; FM reported that iFM had secured £500k in external funding over the previous six months. FLT asked about penalties for not meeting carbon targets and CH confirmed the Trust was already subject to fines, with broader penalties expected post-2050.

LR queried how colleagues could contribute daily; it was confirmed that areas such as transport and recycling were key, and a sustainability relaunch with communications was planned for September. FN invited the team to participate in a "Fiona's Friday" takeover in September to promote sustainability initiatives.

RESOLVED:
The Board of Directors ***approved*** the Green Plan.

TB094/25 Bolton 2040 Borough Plan

Clare Jackson, Assistant Director/Consultant in Public Health attended to present the Bolton 20240 Plan which sets out a bold and inclusive vision for Bolton to become a thriving, inclusive Borough by 2040, where people want to live, work, study, invest and visit. It is structured around six missions and underpinned by the principles of prevention, investment, and sustainable growth.

CJ also provided a presentation the Bolton All Age Prevention and Inequalities Framework which provided a practical, evidence-based model for embedding prevention across all services. It promoted a shared language and approach to addressing the root causes of poor outcomes, with emphasis on proportionate universalism, intersectionality, and system-wide collaboration.

Together, the documents were fully aligned with Ambition 5 of the Strategy as they reinforced shared priorities including reducing health inequalities, strengthening community voice, improving access to opportunity, and delivering integrated, and place-based services.
RG praised the Prevention and Inequalities Framework as both powerful and accessible. FA queried what further action the Trust could take on prevention. CJ explained that the framework was about levering the system to work differently. She noted that the framework had been developed for Bolton as a whole, and it was now for the Trust to determine its approach, with her support available for the journey.

RESOLVED:
The Board of Directors ***received*** the Bolton 2040 Borough Plan and Bolton All Age Prevention and Inequalities Framework.

TB095/25 Questions to the Board

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

TB096/25 Feedback from Board Walkabouts

SH reported visiting M5, where initial challenges with the Electronic Patient Record (EPR) rollout were noted, alongside concerns regarding staff training, development, and progression. His visit to Cardiology was positive, with only minor EPR-related issues observed.

FLT visited the Antenatal Clinic, where concerns were raised about patient waiting times and screen visibility at reception. Her visit to Castle Hill was well received, with positive feedback on team co-location. She also visited the Single Point of Access team, who despite being small, effectively managed enquiries from across Bolton.

AS visited G3, where staff were enthusiastic about the upcoming new facility. One concern was raised about the transition between antenatal and postnatal care, though overall feedback was positive.

RG visited the Finance Team, who had recently transitioned to a new ledger system. Whilst the change had been challenging, the team demonstrated strong commitment and resilience.

SC visited Same Day Emergency Care (SDEC), where staff were highly engaged with ongoing changes, and the visit was viewed positively.

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

TB097/25 Messages from the Board

The messages from the Board were agreed.

TB097/25 Any Other Business

There being no 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 25 September 2025 at 1pm in the Boardroom.

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

July 2025 Actions

Code	Date	Context	Action	Who	Due	Comments
FT/25/04	31/07/2025	Patient Story	Prepare a report reviewing the patient story, with particular focus on the differing outcomes and the incorrect prognosis given to the patient.	FA	Sep-25	
FT/25/05	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	

Key

complete	agenda item	due	overdue	not due

Report Title:	Senior Information Risk Owner (SIRO) Report 2024-25.			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	25 September 2025		Discussion	✓
Executive Sponsor	Chief of Strategy and Partnerships Senior Information Risk Owner (SIRO)		Decision	

Purpose of the report	The report summarises IG activities and issues from July 2024 to June 2025, sets objectives for the coming year, and provides assurance against the Data Security and Protection Toolkit (DSPT) standards for data security in health and social care.

Previously considered by:	The report was presented at the Audit and Risk Committee meeting held on 17 September 2025.

Executive Summary	The report outlines the key activity, achievements and issues relating to Information Governance (IG) within the Trust for the period 01 July 2024 to 30 June 2025 and state objectives for the forthcoming year. The report also provides assurance against the Data Security and Protection Toolkit (DSPT) requirements, which reflect the national standards and legislation for data security and protection in health and social care. ▪ **Cyber Risk Management:** the report assures the Board of effective oversight and management of cyber crisis, including independent scrutiny and assurance measures. ▪ **Cyber Security & IG Policies:** Effective cyber crisis oversight is in place, supported by independent assurance and policies aligned with UK GDPR/NIS and NHS obligations ▪ **FOI Request Statistics:** The Trust received 923 requests and achieved a compliance rate of 85%, an improvement of 28% from previous year. ○ **Complaints to ICO:** None ▪ **Subject Access Requests (SARs):** 3549 managed; 100% compliance in Medical Legal, 41% was achieved in Litigation due to staffing issues. ▪ **Information Governance Training:** IG training met the 95% target in 4 months; maintained 94% in the remaining 8 months. ▪ **Data Protection Incidents:** There were 197 Information Governance incidents reported, with three reported to the ICO. ▪ **Internal Audit Findings:** MIAA reviewed the DSPT process and found “High Risk”. For the overall assurance and “High Confidence” for the veracity of the organisation self-assessment. ▪ **Accreditations and Certifications:** The Trust maintains ISO 27001, ISO 9001 and Secure Email Standards certifications, demonstrating its commitment to data security and quality management. **Recommendations for 2025-26:** These include aligning Information Asset and Data Flow Mapping Registers with the updated structure of clinical divisions, maintaining a current and comprehensive contracts register, strengthening cybersecurity measures - including the implementation and enforcement of Multi-Factor Authentication (MFA) and conducting annual Business Continuity Planning exercises focused on our Essential Functions.

Proposed Resolution	The Board of Directors are asked to ***receive*** the Senior Information Risk Owner (SIRO) Report

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

Summary of key elements / Implications		
Implications	Yes /No	If Yes, State Impact/Implications and Mitigation
Finance		
Legal/ Regulatory	Yes	**Impact** **Regulatory compliance** against the following laws UK GDPR/DPA2018, NIS Directive, Civil Contingency Act 2004 and NHS England T&Cs. Failure to comply can result in legal penalties, loss of trust, and potential harm to patients due to compromised data security. **Operational Impact:** The new approach will affect how people, processes, and technology are evaluated and assured in terms of cyber security and information governance. This may require significant changes in Trust practices and additional resources to meet the expected achievement levels, mainly within the Emergency Planning Department. **Mitigations** **Comprehensive Assessment:** Conduct a thorough scoping exercise to understand which information, systems, and networks support essential functions and should be included in the DSPT return. This ensures that all critical areas are covered and compliant with the regulations. **Collaboration and Training:** Engage various departments, including Emergency Planning, IT, and Information Asset Owners, to ensure a collaborative approach to compliance. Provide training and resources to staff to enhance their understanding of the new requirements and their roles in maintaining compliance. **Regular Audits and Reviews:** Implement regular audits and reviews to monitor compliance with the DSPT and CAF standards. This helps identify any gaps or areas for improvement and ensures continuous adherence to the regulations.
Health Inequalities		
Equality, Diversity and Inclusion		

Prepared by:	Deiler Carrillo, Head of Information Governance and Data Protection Officer (DPO)	**Presented by:**	Sharon White, Chief of Strategy and Partnerships

Glossary – definitions for technical terms and acronyms used within this document

DSP	Data Security and Protection
DSPT	Data Security and Protection Toolkit
DPIA	Data Privacy Impact Assessment
ESR	Electronic Staff Record
FOI	Freedom of Information Act
ICO	Information Commissioner's Office
IG	Information Governance
ISMS	Information Security Management System
KLOEs	Key Lines of Enquiry
NDG	National Data Guardian
NHS	National Health Service
NIS	Network and Information Systems Regulation
QMS	Quality Management System
SAR	Subject Access Request
SIRO	Senior Information Risk Officer
UK GDPR	United Kingdom General Data Protection Regulation
DPA 2018	Data Protection Act 2018
DPO	Data Protection Officer
ISO	International Organisation for Standardization. It is an independent, non-governmental international organisation that develops and publishes standards to ensure the quality, safety, and efficiency of products, services, and systems.
ISO 27001	Is an internationally recognised standard that sets forth the requirements for establishing, implementing, maintaining, and continually improving an Information Security Management System (ISMS).
ISO 9001	Is the international standard that defines the requirements for a Quality Management System (QMS).

NHS Bolton NHS Foundation Trust

Bolton NHS Foundation Trust

Information Governance Annual Report 2024-25

Contents

Executive Summary

This report is intended to provide assurance to the SIRO and the Board by outlining key activities, achievements, and issues relating to Information Governance (IG) within the Trust for the reporting period 1st July 2024 to 30th June 2025, and by setting out objectives for the forthcoming year. It also evidences how the Trust continues to meet its obligations under relevant legislation, including the UK GDPR, the Data Protection Act 2018, and the Caldicott Principles, through robust governance frameworks and the implementation of the Data Security and Protection Toolkit.
Bolton NHS Foundation Trust is officially recognised and registered as a data controller with the Information Commissioner's Office (reference number Z1499998). The Trust has designated the relevant roles, as outlined in Section 2.

Recommendation to the Committee

The Information Governance Group is requested to:

- **RECEIVE** and **ACCEPT** this annual report which provides assurance on the Information Governance and Security activity for the period 1st July 2024 to 30th June 2025.

Information Governance Annual Report
1st July 2024 to 30th June 2025 (2024-25)

1. Introduction

The purpose of this report is to outline key activity, achievements and issues relating to Information Governance (IG) within the Trust for the period 2024-25 and state objectives for the forthcoming year.

Improving Information Governance is a key NHS priority. This is reflected in national standards set out in the Data Security and Protection Toolkit (DSPT), which the Trust is required to complete and submit every year, specifically at the end of June every year.

Completion of DSPT demonstrates that the organisation is compliant with the following legislation and guidance framework:

- UK General Data Protection Regulation (UK GDPR) and Data Protection Act 2018 (DPA 2018).
- Network and Information Systems Regulation (NIS Directive), as an Operator of Essential Services.
- Compliance with the expected data security standards for health and social care for holding, processing or sharing personal data.
- Readiness to access secure health and care digital methods of information sharing, such as NHS mail and Summary Care Records, Greater Manchester Care Record (GMCR).
- Good data security to the CQC as part of the Key lines of Enquiry (KLOEs).
- Freedom of Information Act 2000.
- Access to Health Records Act 1990.
- Computer Misuse Act 1990.
- Common Law Duty of Confidentiality.
- Privacy and Electronic Communications

The Trust Information Governance Department has undertaken a programme of work covering a number of activities in order to provide assurance against the Data Security and Protection Toolkit requirements. This report summarises the outcomes of the key work programme over the period.

2. Key Trust Roles & Reporting Structure over the Period

2.1 Senior Information Risk Officer (SIRO), Director of Strategic Transformation, Strategy & Planning

The SIRO is the Executive Board member who is familiar with information risks and provides the focus for the management of information risk at Board level. She must provide the Chief Executive with assurance that information risk is being managed appropriately and effectively across the organisation and for any services contracted for by the organisation.

2.2 Caldicott Guardian

The Caldicott Guardian is the senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Caldicott Guardian plays a key role in ensuring that the NHS, Councils with Social Services responsibilities and partner organisations satisfy the highest practicable standards for handling patient identifiable information.

2.3 Data Protection Officer/Head of Information Governance

The Data Protection Officer is the Head of Information Governance and the role involves:

- Informing and advising the Trust about complying with UK General Data Protection Regulation (UK GDPR) and other data protection legislations.
- Supporting and monitoring compliance with internal audits.
- Advising on and monitoring Data Protection Impact Assessments, advising on whether a DPIA is necessary, how to conduct one and expected outcomes.
- Cooperating with the ICO.
- Submission of the Data Security and Protection Toolkit (DSPT).
- Data protection incidents investigations.

2.4 Reporting Structure for Information Governance

The Information Governance Group has oversight of the work of the Information Governance team and progress towards the Trust's Information Governance strategic objectives.

Updates and relevant reporting documentation including relevant policy approvals go to the Risk and Audit Committee. In terms of governance:

- To provide assurance to the Board on the effective and adequacy of oversight in the management of cyber risk including appropriate levels of independent scrutiny and assurance.
- Receive the results of the Annual DSPT audit and receive assurance over the Trust's plans to address any areas of improvement identified.
- Receive an Information Governance Annual Report focussed on compliance with data protection and Freedom of Information (FOI) rules number/type of breaches; and plans to develop and improve compliance.
- Receive assurance on the quality of data relied on for decision-making, plans on maintaining proper controls over data quality, including regular independent audits.

Please see appendix A the Governance Structure in terms of the reporting structure.

3. Data Security and Protection Toolkit: 01st July 2024 – 30th June 2025

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool produced by NHS England that allows organisations to measure their performance against the data security and information governance requirements mandated by the Department of Health and Social Care, notably the 10 data security standards set by the National Data Guardian.

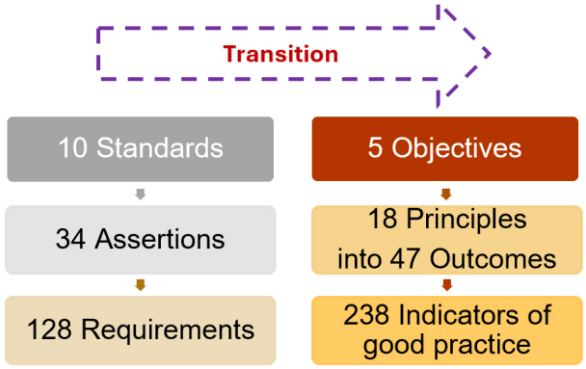
This information standard is published under section 250 of the Health and Social Care Act 2012. Completion of the DSPT is therefore a contractual requirement specified in the NHS England Standard Conditions contract and it remains Department of Health and Social Care policy that all bodies that process NHS patient information for whatever purpose provide assurances via the DSPT.

3.1 Changes for 2024-25

The Data Security and Protection Toolkit (DSPT) undertook a significant transformation to align with the evolving cyber security landscape. In September 2024, the DSPT adopted the National Cyber Security Centre's Cyber Assessment Framework (CAF) as the foundation for cyber security and information governance assurance. The change to the CAF-aligned DSPT demonstrates the commitment made in the Department of Health and Social Care's (DHSC) cyber security strategy to 2030.

This shift introduces a new structured around CAF's Objectives, Principles, and Outcomes, rather than the previous 10 data security standards. The CAF is designed to promote sound decision-making through broad principles, moving away from a checklist-based approach. While the overall expectations for cyber and IG controls remain broadly consistent, the framework introduces more rigorous standards in areas deemed critical by NHS England and the Department of Health and Social Care.

This marks a fundamental change in how organisations evidence compliance, requiring a renewed focus on strategic outcomes and risk-based assurance over the coming months.



Objective A – Managing risk. Establish strong risk management frameworks, with key roles and accountability.
Objective B – Protecting against cyber-attack and data breaches. Implement and maintain robust security controls that safeguard critical systems and sensitive data.
Objective C – Detecting cyber security events. Enhance detection capabilities to rapidly identify and respond to potential incidents.
Objective D – Minimising the impact of incidents. Develop effective response, recovery and business continuity plans to limit the consequences of any security breach.
Objective E – Using and sharing information appropriately. Ensure that data handling practices meet legal and ethical standards and that information sharing supports security without compromising privacy.

For the 2024–25 period, the Data Security and Protection Toolkit (DSPT) comprises 238 indicators of good practice, distributed across 47 outcomes aligned to five overarching objectives.

Data Security & Protection Toolkit 2024-25

Objective A – Managing risk

- **A1 - Governance**
  - A1.a - Board Direction
  - A1.b - Decision-making & approval
  - A1.c - Roles & responsibilities
- **A2-Risk Management**
  - A2.a - Assurance
  - A2.b - Risk Management Process
- **A3-Asset Management**
  - A3.a - Asset management
- **A4-Supply chain**
  - A4.a - Supply chain

Objective B- Protecting against cyber-attack and data breaches

- **B1-Policies, processes and procedures**
  - B1.a - Policy, process and procedure development
  - B1.b - Policy, process and procedure implementation
- **B2-Identity and access control**
  - B2.a - Device management
  - B2.b - Identity and access management (IdAM)
  - B2.c - Identity verification, authentication and authorisation
  - B2.d - Privileged user management
- **B3-Data security**
  - B3.a - Data in transit
  - B3.b - Media/equipment sanitisation
  - B3.c - Mobile data
  - B3.d - Stored data
  - B3.e - Understanding data
- **B4-System security**
  - B4.a - Secure by design
  - B4.b - Secure configuration
  - B4.c - Secure management
  - B4.d - Vulnerability management
- **B5-Resilient networks and systems**
  - B5.a - Backups
  - B5.b - Design for resilience
  - B5.c - Resilience preparation
- **B6-Staff awareness and training**
  - B6.a - Culture
  - B6.b - Training

Objective C – Detecting Cyber Security Events

- **C1-Security monitoring**
  - C1.a - Generating alerts
  - C1.b - Identifying security incidents
  - C1.c - Monitoring coverage
  - C1.d - Monitoring tools and skills
  - C1.e - Securing logs
- **C2-Proactive security event discovery**
  - C2.a - Proactive attack discovery
  - C2.b - System abnormalities for attack detection

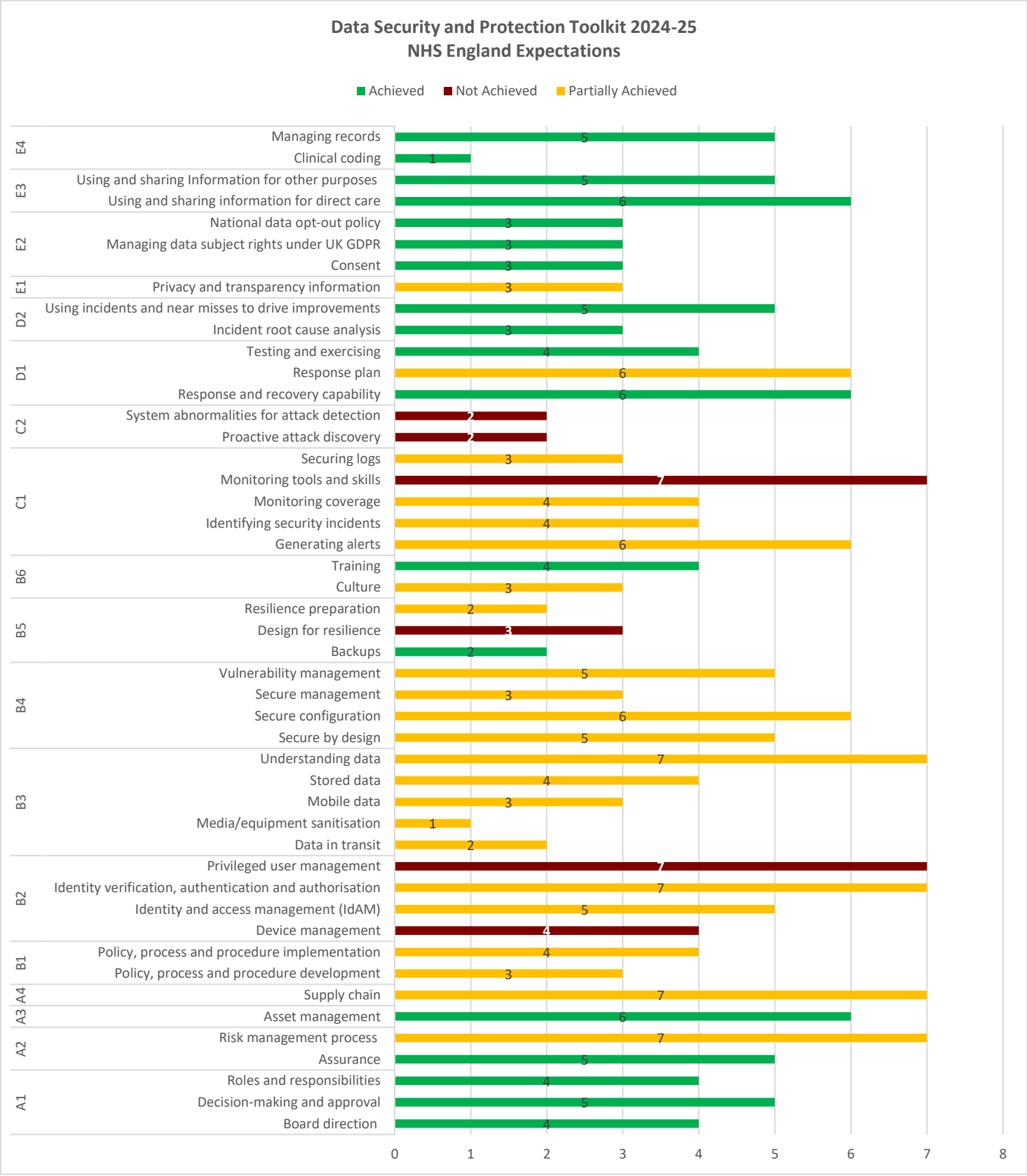
Objective D – Minimising the Impact from Incidents

- **D1-Response and recovery planning**
  - D1.a - Response and recovery capability
  - D1.b - Response plan
  - D1.c - Testing and exercising
- **D2-Lessons learned**
  - D2.a - Incident root cause analysis
  - D2.b - Using incidents and near misses to drive improvements

Objective E – Using and Sharing information appropriately

- **E1-Transparency**
  - E1.a - Privacy and transparency information
- **E2-Upholding the rights of individuals**
  - E2.a - Consent
  - E2.b - Managing data subject rights under UK GDPR
  - E2.c - National data opt-out policy
- **E3-Using and sharing information**
  - E3.a - Using and sharing information for direct care
  - E3.b - Using and sharing Information for other purposes
- **E4-Records management**
  - E4.a - Clinical Coding
  - E4.b - Managing records

NHS England has set expectations for organisations to achieve expected outcomes for each objective, the full list of expectations and Trust submission can be found in Appendix B and on the graph below:



3.2 Essential Functions

In addition to the key updates around cyber security, one of the most significant changes the Trust must address for 2024–25 is the requirement to identify and manage Essential Services.

Before the Trust started our Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT) submission, **we needed to conduct a scoping exercise to understand which information, systems and networks support your essential functions (critical services) and should therefore be included in the scope of your DSPT return.**

This guidance explains what essential functions are in the context of health and care, how you should conduct your scoping exercise, and what other important factors you should consider.

Defining Essential Functions

Your essential functions are all the parts of your organisation that are necessary to deliver your organisation's services. Where relevant, this will include considerations of:

- Any essential services for operators of essential services designated under the Network and Information System (NIS) Regulation.
- Any statutory purpose for statutory organisations.
- The purpose for which your organisation is constituted.

In practice, your essential functions may equate to all your critical business processes.

Scoping example

An example of how essential functions and systems of healthcare services may be broken down.

Essential services (example for NHS trust and foundation trust:

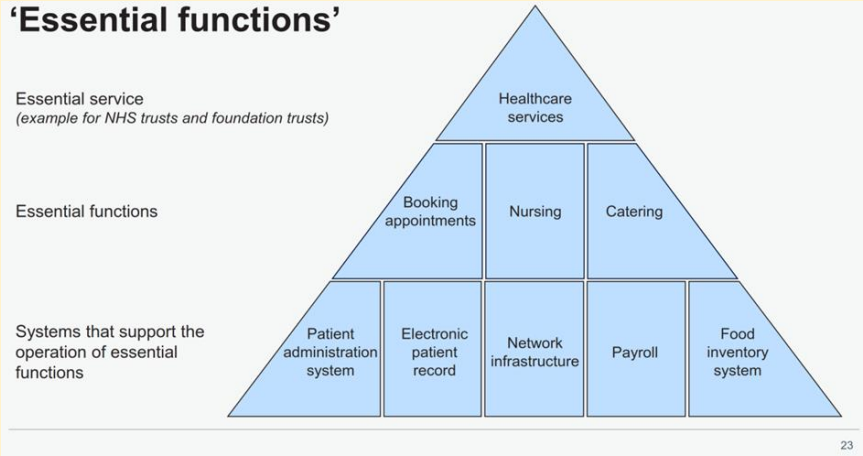
- Healthcare services

Essential functions:

- Booking appointments
- Nursing
- Catering

Systems that support the operation of essential functions:

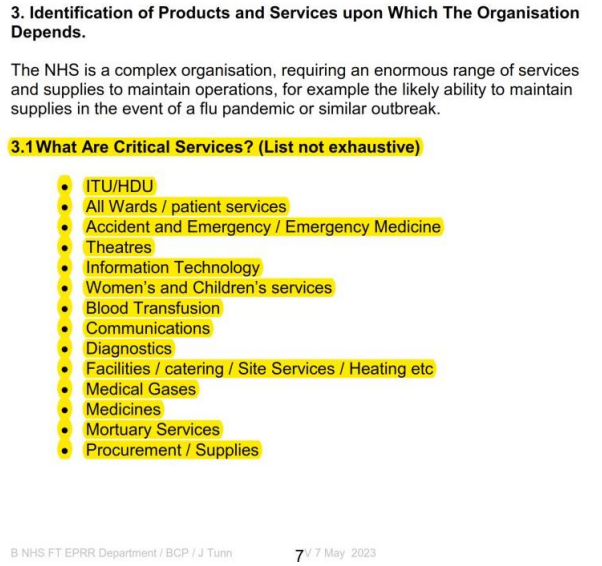
- Patient administration system
- Electronic patient record
- Network infrastructure
- Payroll
- Food inventory system



Trust Essential Services

The current list of critical services within the Trust are part of the Emergency Planning policies, currently these are held within the Business Continuity Procedure (Page 7).

- ITU/HDU
- All Wards / patient services
- Accident and Emergency / Emergency Medicine
- Theatres
- Information Technology
- Women's and Children's services
- Blood Transfusion
- Communications
- Diagnostics
- Facilities / catering / Site Services / Heating etc
- Medical Gases
- Medicines
- Mortuary Services
- Procurement / Supplies



3. Identification of Products and Services upon Which The Organisation Depends.

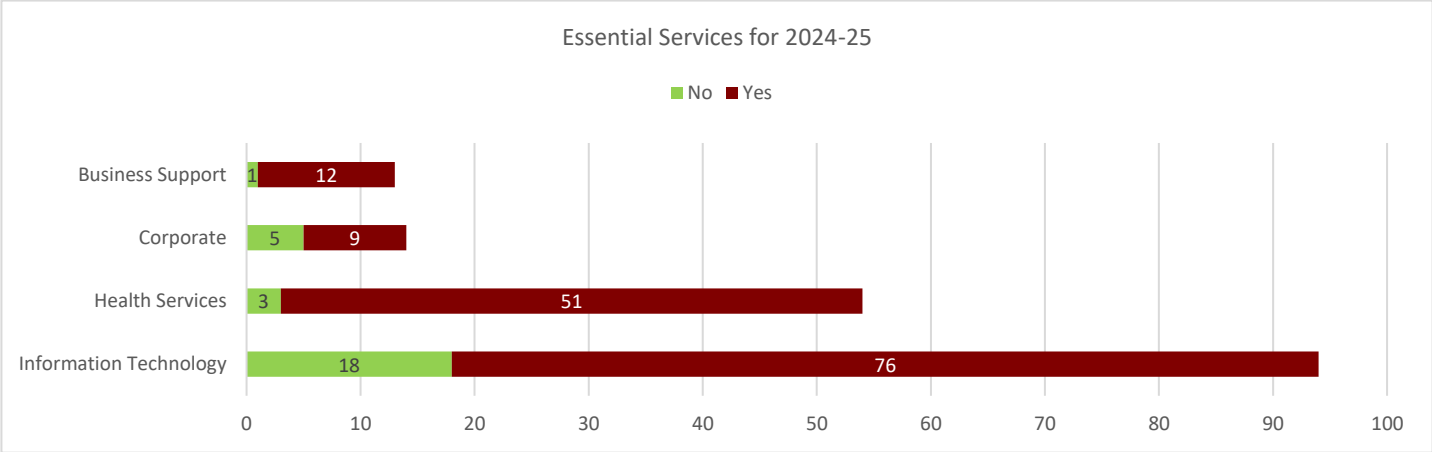
The NHS is a complex organisation, requiring an enormous range of services and supplies to maintain operations, for example the likely ability to maintain supplies in the event of a flu pandemic or similar outbreak.

3.1 What Are Critical Services? (List not exhaustive)

- ITU/HDU
- All Wards / patient services
- Accident and Emergency / Emergency Medicine
- Theatres
- Information Technology
- Women's and Children's services
- Blood Transfusion
- Communications
- Diagnostics
- Facilities / catering / Site Services / Heating etc
- Medical Gases
- Medicines
- Mortuary Services
- Procurement / Supplies

B NHS FT EPRR Department / BCP / J Tunn 7 V 7 May 2023

For the 2024-25 period, we assessed a total of 175 systems that support our essential functions**. Of these, 148 have been considered eligible to be covered under the Data Security and Protection Toolkit for this period.**



The systems have been further categorised based on the essential functions they support. Additionally, corporate services have been included, as these were previously not part of the critical functions, such as financial and workforce systems.

Health Services

- ITU/HDU
- All Wards / patient services
- Accident and Emergency / Emergency Medicine
- Theatres
- Women's and Children's services
- Blood Transfusion
- Diagnostics
- Medicines
- Mortuary Services
- Medical Devices *

Information Technology

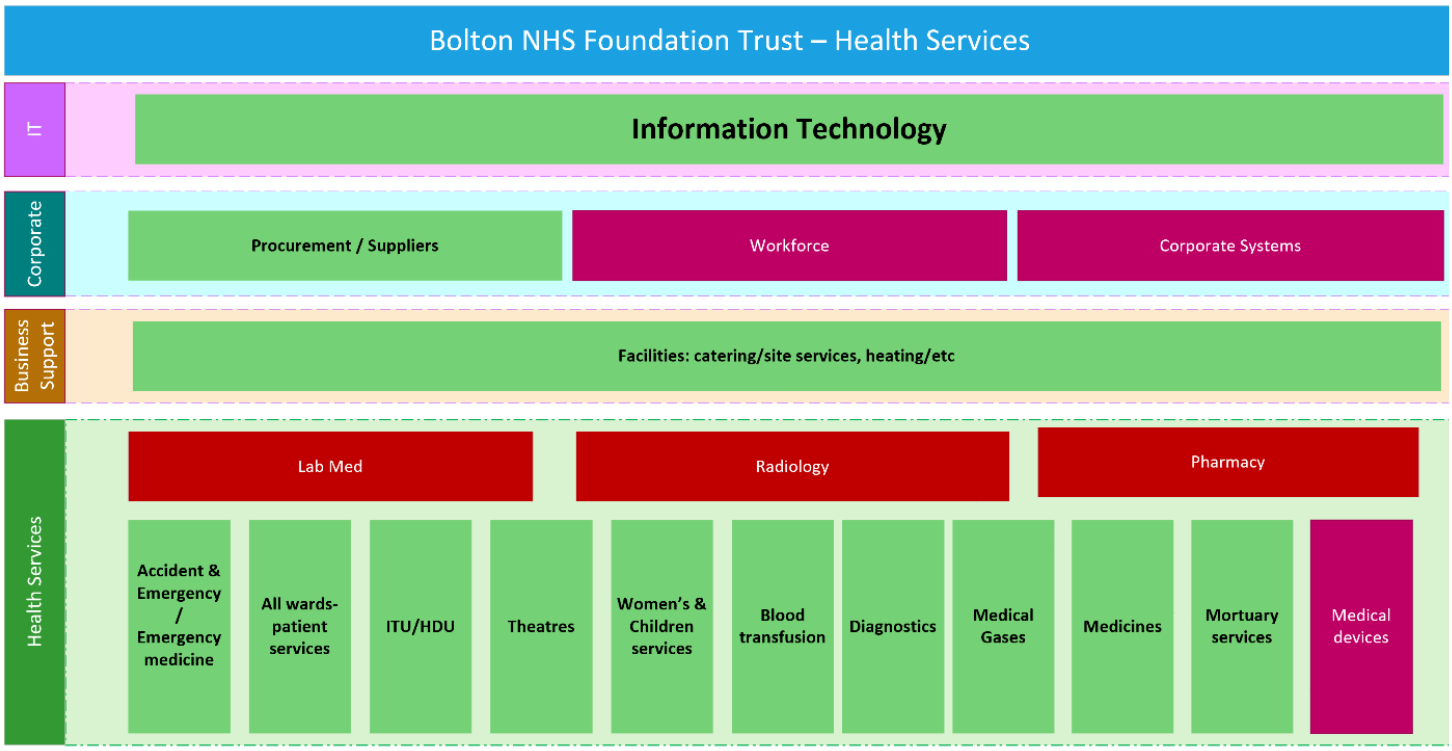
- Information Technology
- 3rd party services

Corporate

- Communications
- Procurement / Supplies
- Staffing*
- Business support*

Business Support

- Facilities / catering / Site Services / Heating etc
- Medical Gases

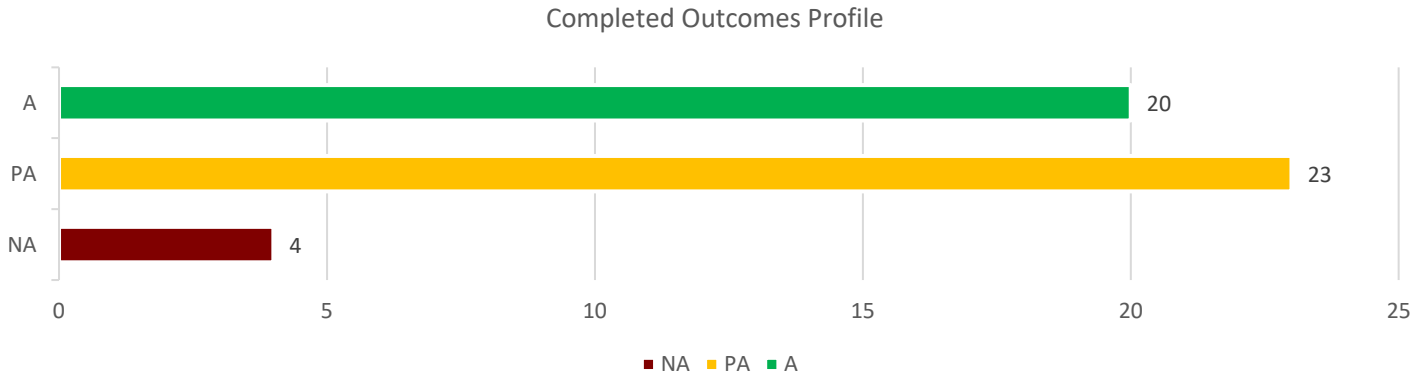


3.3 Data Security and Protection Toolkit submission

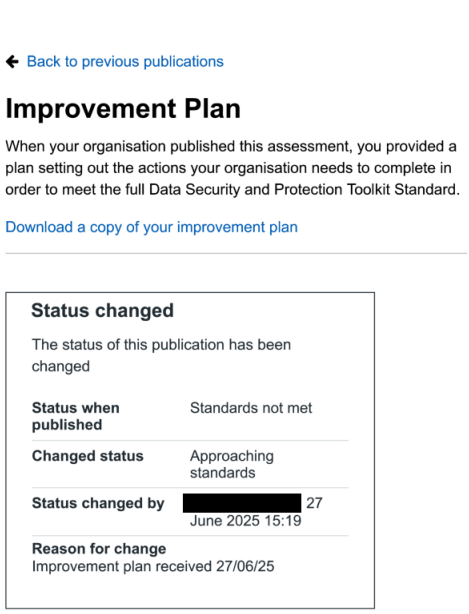
Bolton NHS Foundation Trust has made considerable progress across the 5 objectives in scope to meet the toolkit requirements for the 2024-25 period.

For this period the Trust completed 47 outcomes as follows:

Not Achieved	Partially Achieved (PA)	Achieved (A)
4	23	20



The Trust did not meet four of the audited expectations; however, it successfully achieved some outcomes that were initially anticipated to fall short. An improvement plan was submitted to NHS England and has been accepted, our status of "Standards Not Met" changed to "Approaching Standards"



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Improvement Plan

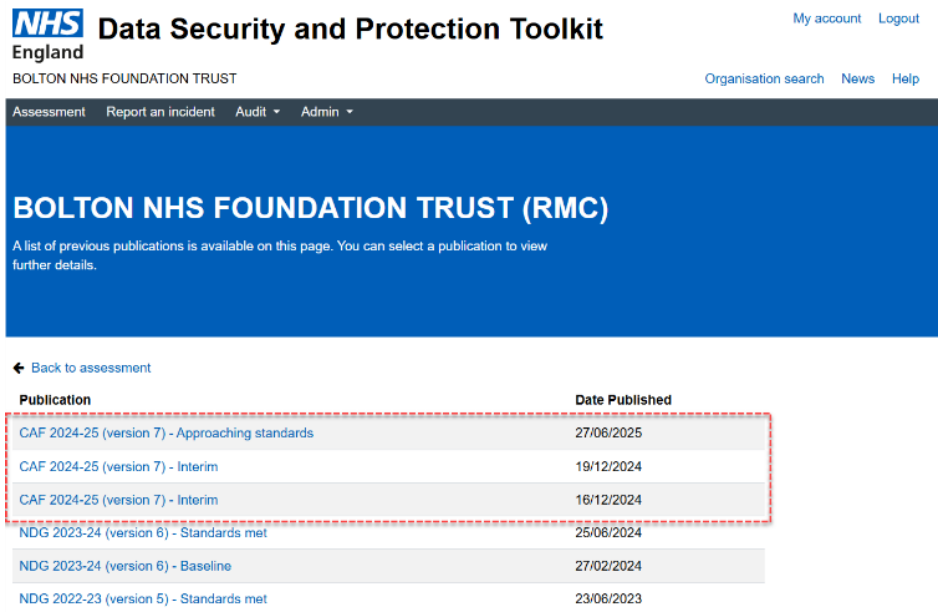
When your organisation published this assessment, you provided a plan setting out the actions your organisation needs to complete in order to meet the full Data Security and Protection Toolkit Standard.

Download a copy of your improvement plan

Status changed

The status of this publication has been changed

Status when published	Standards not met
Changed status	Approaching standards
Status changed by	[redacted] 27 June 2025 15:19
Reason for change	Improvement plan received 27/06/25



NHS England **Data Security and Protection Toolkit**

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Publication	Date Published
CAF 2024-25 (version 7) - Approaching standards	27/06/2025
CAF 2024-25 (version 7) - Interim	19/12/2024
CAF 2024-25 (version 7) - Interim	16/12/2024
NDG 2023-24 (version 6) - Standards met	25/06/2024
NDG 2023-24 (version 6) - Baseline	27/02/2024
NDG 2022-23 (version 5) - Standards met	23/06/2023

Bolton NHS Foundation Trust submitted at the end of June and meet NHS England Standards.

Status	Date Published
CAF 2024-25 (version 7) Approaching standards	27/06/2025
CAF 2024-25 (version 7) Baseline	19/12/2024
2023-24 (version 6) Standards Met	25/06/2024
2023-24 (version 6) Baseline	27/02/2024
2022-23 (version 5) Standards Met	23/06/2023
2022-23 (version 5) Baseline	24/02/2023

A Task & Finish Group was established by the SIRO to implement all auditor recommendations for the DSPT compliance. The group held its first meeting on 11 July 2025. The action plan includes defined timescales and assigned ownership, enabling the SIRO to track each action against specific individuals for accountability and progress monitoring.

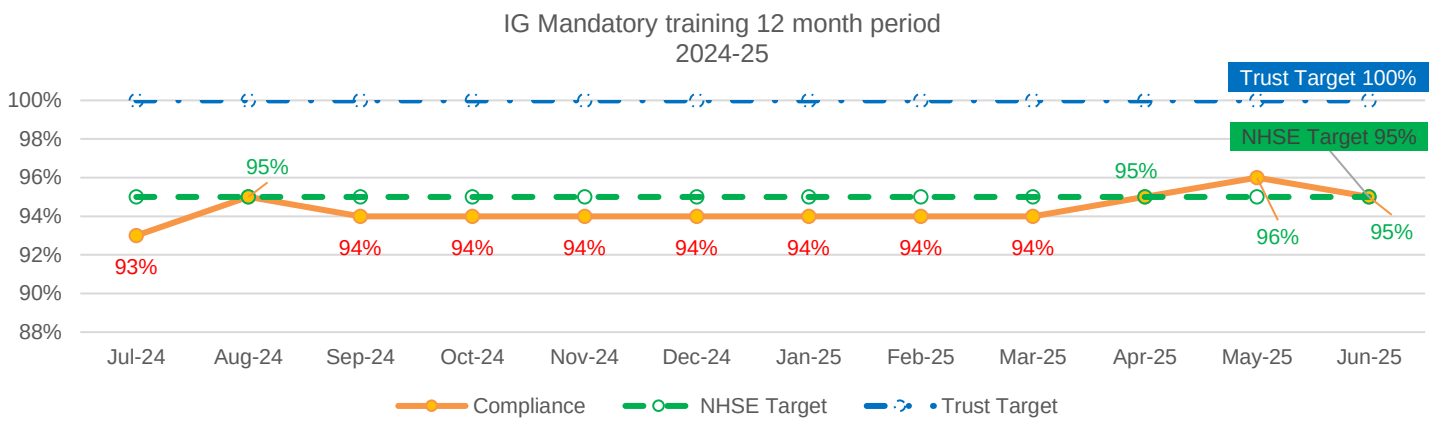
A complete list of the principles and outcomes, along with NHS England expectations and Trust achievements, is provided below:

	Health and care CAF element		NHSE Expectations	Trust Assessment Results
	Principle	Outcome		
Objective A - Managing risk	Governance	A1.a Board direction	A	A
		A1.b Roles and responsibilities	A	A
		A1.c Decision-making	A	A
	Risk management	A2.a Risk management process	PA	PA
		A2.b Assurance	A	A
	Asset management	A3.a Asset management	A	A
	Supply chain	A4.a Supply chain	PA	NA
Objective B - Protecting against cyber attack and data breaches	Policies, processes and procedures	B1.a Policy, process and procedure development	PA	PA
		B1.b Policy, process and procedure implementation	PA	PA
	Identity and access control	B2.a Identity verification, authentication and authorisation	PA	NA
		B2.b Device management	NA	PA
		B2.c Privileged user management	NA	PA
		B2.d Identity and access management (IdAM)	PA	PA
	Data security	B3.a Understanding data	PA	PA
		B3.b Data in transit	PA	PA
		B3.c Stored data	PA	PA
		B3.d Mobile data	PA	PA
		B3.e Media / equipment sanitisation	PA	NA
	System security	B4.a Secure by design	PA	PA
		B4.b Secure configuration	PA	PA
		B4.c Secure management	PA	PA
		B4.d Vulnerability management	PA	PA
	Resilient networks and systems	B5.a Resilience preparation	PA	PA
		B5.b Design for resilience	NA	PA
		B5.c Backups	A	A
	Staff awareness and training	B6.a Culture	PA	PA
		B6.b Training	A	A

	Health and care CAF element		NHSE Expectations	Trust Assessment Results
	Principle	Outcome		
Objective C - Detecting cyber security events	Security monitoring	C1.a Monitoring coverage	PA	PA
		C1.b Securing logs	PA	PA
		C1.c Generating alerts	PA	PA
		C1.d Identifying security incidents	PA	PA
		C1.e Monitoring tools and skills	NA	PA
	Proactive security event discovery	C2.a System abnormalities for attack detection	NA	A
		C2.b Proactive attack discovery	NA	A
Objective D - Minimising the impact of incidents	Response and recovery planning	D1.a Response plan	PA	NA
		D1.b Response and recovery capability	A	A
		D1.c Testing and exercising	A	A
	Lessons learned	D2.a Incident root cause analysis	A	A
		D2.b Using incidents and near misses to drive improvements	A	A
Objective E - Using and sharing information appropriately	Transparency	E1.a Privacy and transparency information	PA	PA
	Upholding the rights of individuals	E2.a Managing data subject rights under UK GDPR	A	A
		E2.b Consent	A	A
		E2.c National data opt-out policy	A	A
	Using and sharing information	E3.a Using and sharing information for direct care	A	A
		E3.b Using and sharing information for other purposes	A	A
	Records management	E4.a Managing records	A	A
		E4.b Clinical coding	A	A

4. Information Governance training

The Trust has successfully met the 95% target set by NHS England in four instances within the last year, with our highest achievement being 96%. As a Trust, we are dedicated to consistently reaching our monthly targets, reflecting our commitment to excellence and patient care.



5. Information Governance/ Cyber Security Related Policies – Keeping Up to Date

Keeping Trust documentation up to date and relevant in terms of the Information Governance/Information Security is critical for ensuring and maintaining an appropriate level of Information Governance.

During 2024-25 the following policies have been reviewed and approved:

Information Governance Policies

No	Dept.	Information Governance	Type	Version	Expire date
1	IG	Records Management Policy	Policy	6.2	20/01/2025
2	IG	CCTV Policy	Policy	1.1	01/08/2025
3	IG	Freedom of Information Policy	Policy	6.3	08/08/2025
4	IG	Information Risk Management Policy	Policy	4.2	16/02/2026
5	IG	Health Record Keeping Policy	Policy	5.4	20/04/2026
6	IG	National Data Opt-Out Policy	Policy	1.0	18/01/2027
7	IG	Data Protection Policy	Policy	8.4	20/02/2028
8	IG	Information Governance Framework	Policy	1.0	19/09/2027
9	IG	Information Sharing Policy	Policy	1.3	20/02/2028
10	IG	Data Protection by Design and Default Policy	Policy	1.0	17/04/2028
11	IG	Personal Data Breach Procedure	SOP	8.4	20/02/2028
12	IG	Registration Authority Procedure	SOP	3.3	15/01/2026
13	Communications	Social Media Policy	Policy	5	24/05/2027
14	Business Intelligence	Data Quality Policy	Policy	2	30/08/2027
15	Business Intelligence	Responsible use of Artificial Intelligence Policy	Policy	1.34	15/05/2028

Cyber Security Policies
As part of the Informatics certification process under ISO 27001 the following policies are in the process to be approved, to meet national standards from the National Cyber Security Centre.

No	Dept.	Cyber Security Policies	Type	Version	Expire date
1	IT	Email and Internet Usage Policy	Policy	4.4	20/01/2025
2	IT	Information Security Policy	Policy	6.0	16/03/2026
3	IT	Mobile Device Management	Policy	1.0	15/02/2027
4	IT	Network Security Policy	Policy	1.0	15/02/2027
5	IT	Patching and CareCert Policy	Policy	1.0	24/05/2027
6	IT	Password, Single Sign On and Multi Factor Authentication Policy	Policy	1.0	24/05/2027
7	IT	Clear Desk and Screen Policy	Policy	1.0	21/11/2027
8	IT	Encryption Policy	Policy	1.0	21/11/2027
9	IT	Access Control Policy	Policy	1.0	17/04/2028
10	IT	Vulnerability Management Policy	Policy	1.0	PDOG
11	IT	Cyber Incident Response Plan	Policy	1.0	PDOG
12	IT	IT Business Continuity Plan	Policy	1.0	PDOG
13	IT	M365 Overall Policy	Policy	1.0	Draft
14	IT	Ms Teams Policy	Policy	1.0	Draft
15	IT	Secure Transfer of Data Policy	Policy	1.0	Draft
16	IT	Information Classification Policy	Policy	1.0	Draft
17	IT	Backups Policy	Policy	1.0	Draft

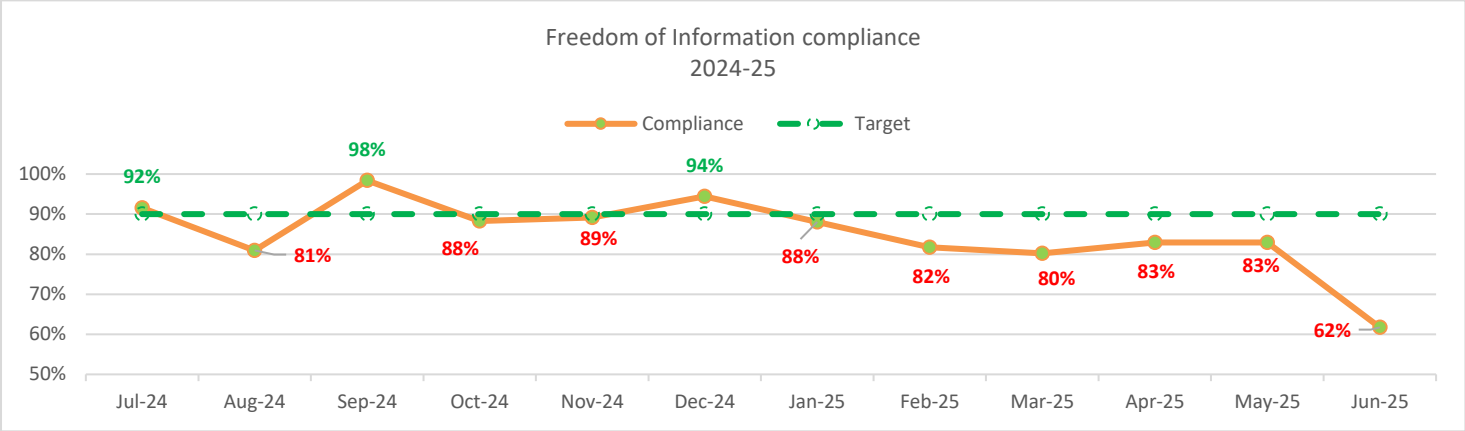
6. Freedom of Information (FOI) Request

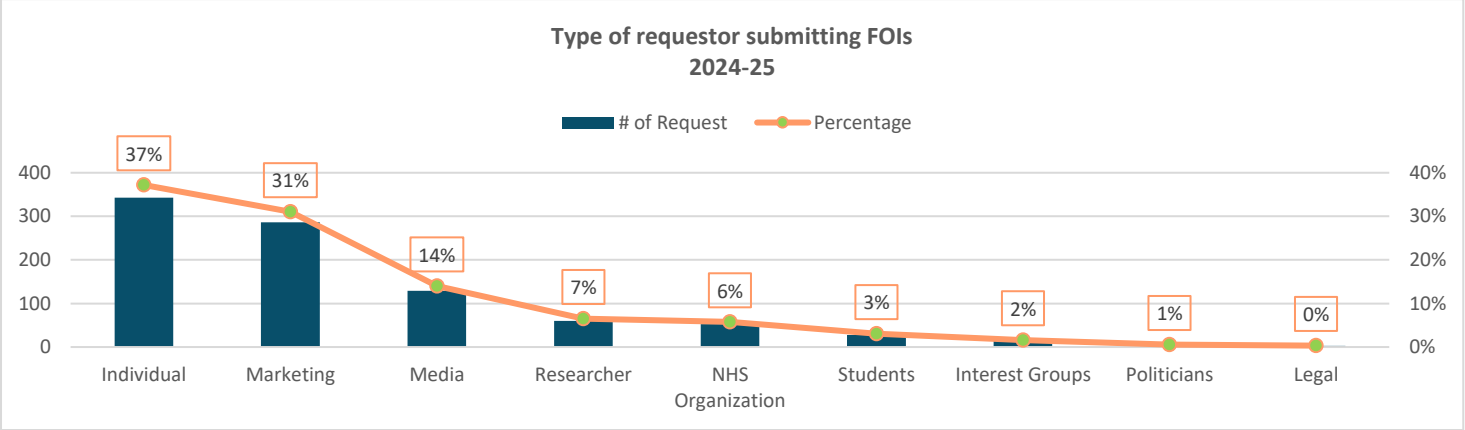
The Freedom of Information Act 2000 provides a general right of access to recorded information held by any public authority. Anyone can make a request for information – there are no restrictions on the requesters' nationality or where they live.

Under the Freedom of Information Act 2000, the Trust must respond to all written requests for information within 20 working days. Failure to comply with this deadline could lead to a complaint by the specific requestor to the Information Commissioners Office (ICO). The ICO has the power to serve a Decision Notice on the public authority for failing to comply with the 20-working day deadline.

	2023/24	**2024/25**
Total number of requests	937	923
# of request completed within 20 days	536	780
Compliance	**57%**	**85%**

During the 2024/25 reporting period, 85% of the 923 total requests were completed within the statutory 20-day timeframe, representing a significant improvement in compliance compared to 2023/24, when only 57% of 937 requests met the same standard. This progress reflects ongoing efforts to enhance responsiveness, although it is important to note that timely compliance is dependent on the cooperation and efficiency of the respective divisions in providing the necessary information. **Note***: the month of June is not complete yet, end 20/07/25.*





6.1 Complaints raised to the ICO

No complaints to the ICO during this period.

6.2 Section 50 Decision Notices

Under section 50 of the Freedom of Information Act 2000, the ICO has the power to issue section 50 Decision Notices on a public authority after a requestor has made a complaint to the ICO about the manner in which a public authority has handled its FOI request.

No decision notices served to the Trust for this period.

7. Subject Access Requests

The main legislative measures that give rights to individuals to receive a copy of their data and other supplementary information:

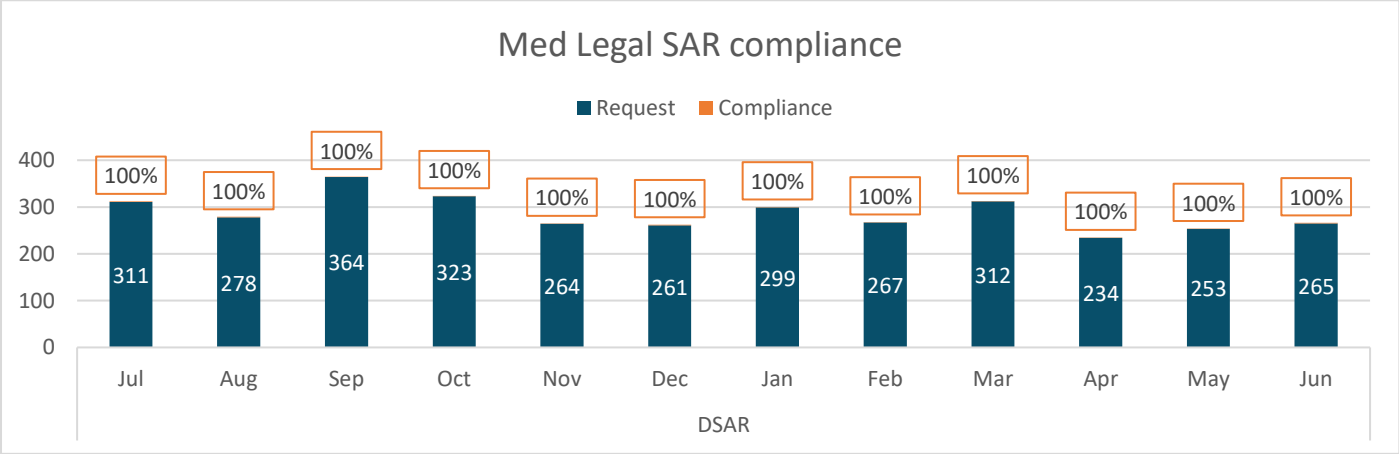
- The UK GDPR and Data Protection Act 2018 - rights for living individuals to access their own records. The right can also be exercised by an authorised representative on the individual's behalf (for example, a solicitor).
- The Access to Health Records Act 1990 - rights of access to deceased patient health records by specified persons.

- The Medical Reports Act 1988 - right for individuals to have access to reports, relating to themselves, provided by medical practitioners for employment or insurance purposes.

Under the Data Protection Act 2018 and Access to Health Records Act 1990 the Trust must give individuals the right of access to their personal information. An individual can send a subject access request requiring the personal information about them held by the Trust, and to provide them with a copy of that information. The Trust has a calendar month to respond to a valid request as part of the UK General Data Protection Regulation (UK GDPR).

7.1 Subject Access Requests from patients – Medical Legal Department

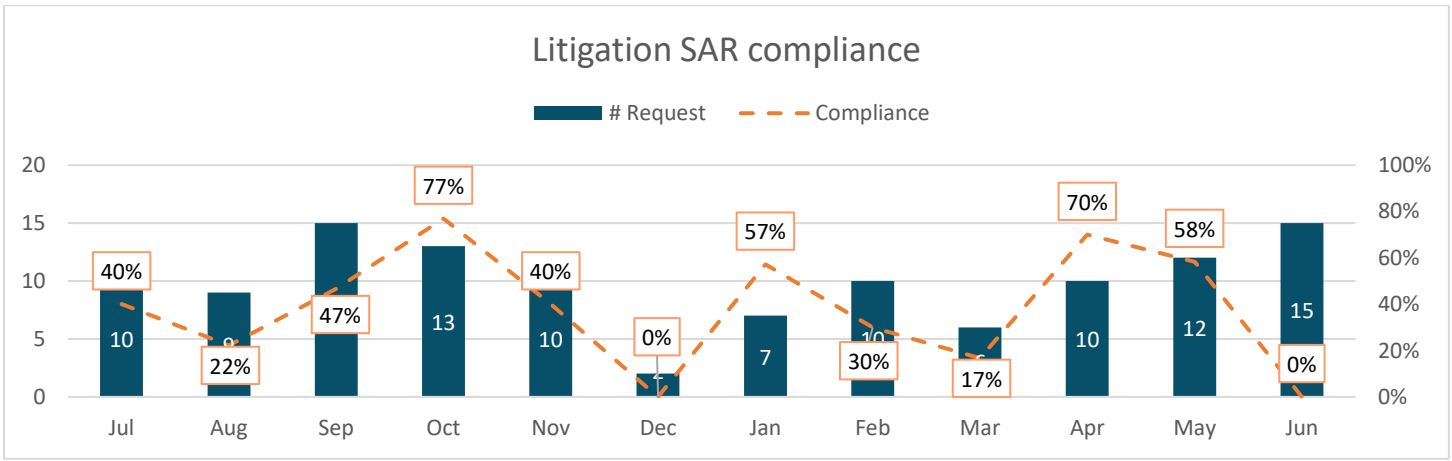
The table below shows subject access request compliance rate within 2024/25:



There were 3431 subject access requests in total during this period made to the Medical Legal Department, with an average compliance of 100%.

7.2 Subject Access Requests from patients – Litigation Department

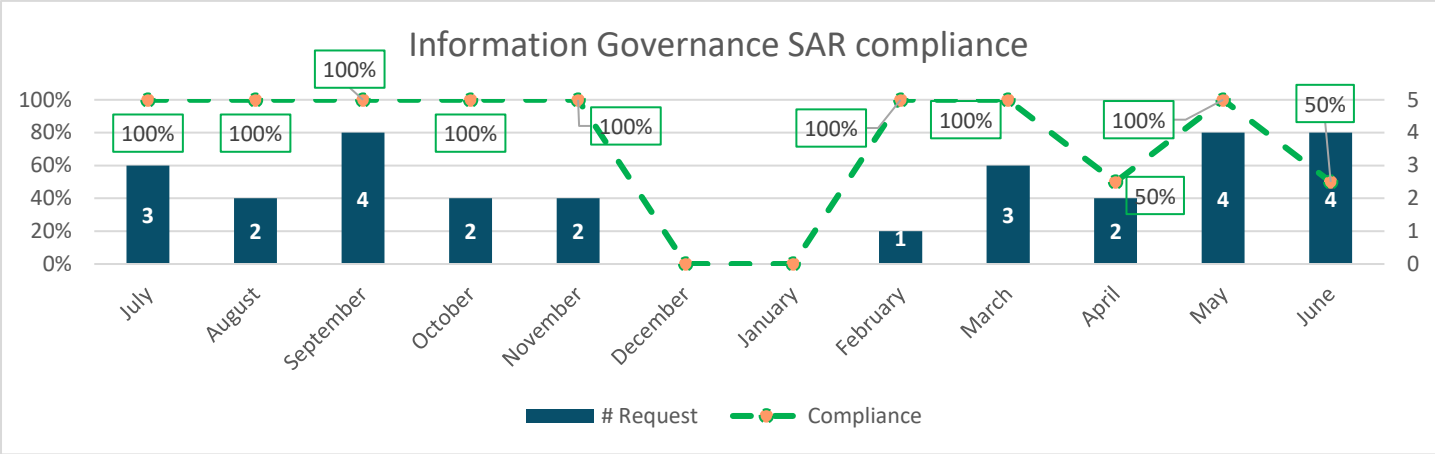
The table below shows subject access request compliance rate within 2024/25:



There were 118 subject access requests in total during this period made to the Litigation Department, with an average compliance rate of 41%. Compliance within the Litigation Department has been impacted due to the loss of staff.

7.3 Subject Access Requests from patients/staff – Information Governance Department

The table below shows subject access request compliance rate within 2024/25:

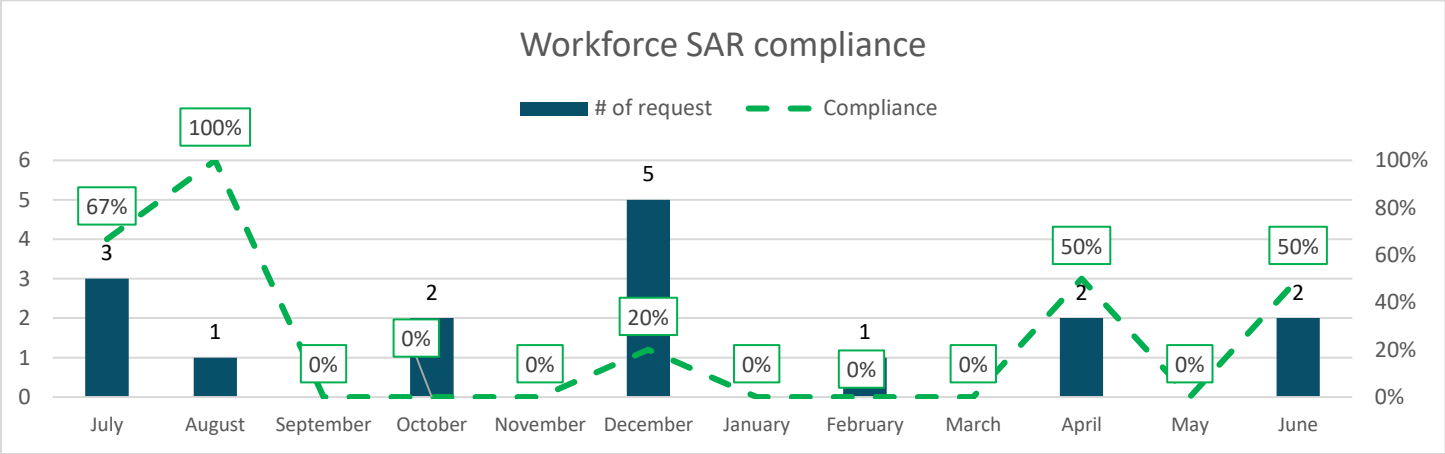


During this reporting period, a total of 27 subject access requests were received by the Information Governance team. The department maintained an average compliance rate of 100%.

All requests processed by the Information Governance team were extended by an additional two months. This extension was necessary to allow sufficient time for reviewing a high volume of emails and applying appropriate redactions in accordance with data protection requirements.

7.4 Subject Access Requests from staff – Workforce

The table below shows subject access request compliance rate within 2024/25:



There were 16 subject access requests in total during this period made to Workforce, with an average compliance rate of 38%.

8. Data Protection Incidents

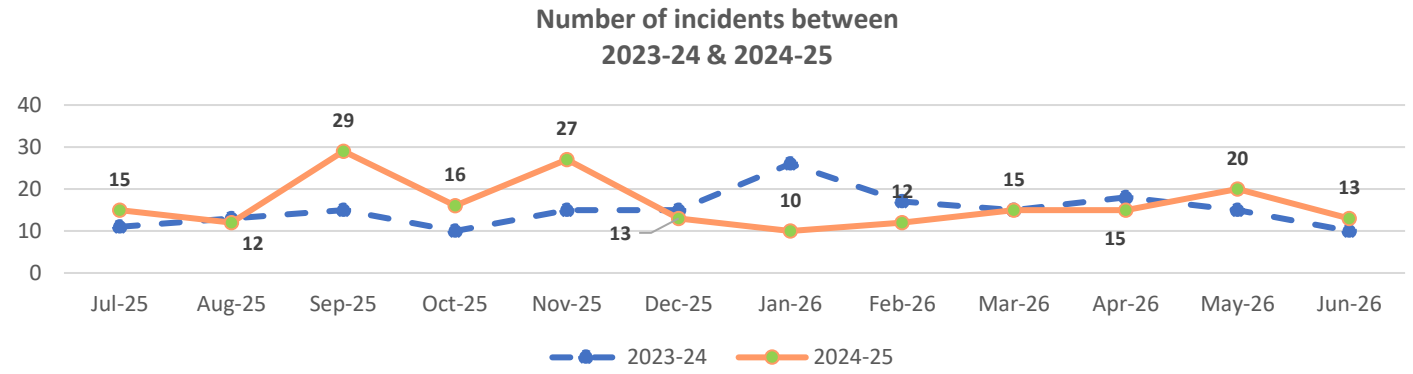
Patient confidentiality and security of information about service users is very important to the Trust. Confidential information is held largely in electronic and paper form, when is electronic information this is within different systems, for example EPR, PAS, ESR, E-rostering.

All incidents that involve the loss or unauthorised disclosure of personal information are reported centrally and are closely monitored on the Trust's Safeguard system. In addition to local clinical and corporate incident management and reporting tools, the personal data breaches incidents that reach the threshold to be reported via the Data Security Protection Toolkit, which reflects the reporting requirements of the UK GDPR, and the Networks and Information System (NIS Directive) Regulations and ICO.

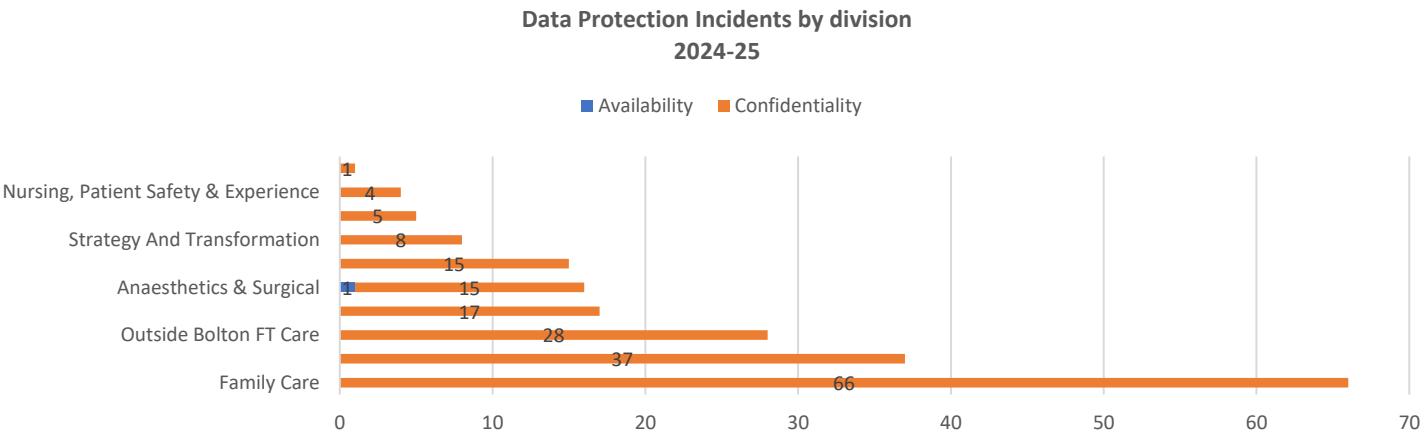
The Trust has a duty to report a notifiable breach to the Information Commissioner's Office without undue delay, and within 72 hours after we became aware of the incident. Once submitted, the notification will be sent to NHS Digital, the Information Commissioners Office (ICO) and other regulators and sometimes the Department of Health, depending in the score of the incident.

The below table shows the number of reported Information Governance incidences for this reporting timeframe within Safeguard.

During 2024/25 there were **197** Information Governance incidents reported via Safeguard.



- **From the 197 incidents there were three incidents reported externally (Information Commissioners Office (ICO) via the Data Security and Protection Toolkit.**
- **During the specified period, there were three claims made under UK GDPR. All claims remain ongoing, and no payments have been made to date. However, a total reserve of £13,000 has been allocated to cover the anticipated costs associated with these claims.**



8.1 Incidents reported externally.

No.	Reference	Reported	What happened	Reported to
1	41100	10/02/2025 15:20	Patient-Confidentiality breach, staff accessed digital records without being part of the team delivering care.	ICO
2	40288	09/12/2024 11:35	On or around 4th December a patient's medical records related to 28th March 23 containing highly sensitive information in relation to physical injuries and medications, were accessed, printed and sent to another patient along with their own medical records.	ICO
3	38128	23/07/2024 09:52	Multiple system outages/unavailable on a national scale, systems as below: LE2.2 ORMIS Allocate Health Suite including Health Roster, Employee Online, Safe Care, Planner, 247Time, e-Job Planning EMIS (GP Practices)	ICO

Cause	Qtr3			Qtr4			Qtr1			Qtr2			Grand
	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Total
Breach Of Patient Confidentiality	15	12	21	16	27	13	10	12	15	15	20	13	**189**
Breach Of Staff Confidentiality			5										**5**
Theft/Loss Of Docs Containing Patient Info			3										**3**
Grand Total	**15**	**12**	**29**	**16**	**27**	**13**	**10**	**12**	**15**	**15**	**20**	**13**	**197**

Among these, the highest number of incidents are related to breach of patient confidentiality. This includes appointment letters were sent to patient's old address, emails sent to wrong recipients, patient letters sent to wrong patients.

To address the concerns regarding the high number of incidents within the Family Division, the committee has requested a report from the Governance Lead in Family Division. In response to the increase in incidents, an action plan has been implemented to learn from these incidents and prevent their recurrence. This plan includes specific measures and strategies aimed at improving processes and protocols to ensure the safety and well-being of all involved. It is a proactive step towards mitigating risks and enhancing the division's ability to manage and respond to such situations effectively.

Every incident is individually assessed by the Head of IG/ IG Department and advice given to prevent the reoccurrence of this happening for example further training, raising team awareness, poster/checklist/ advice and developing letter templates for patients affected. The Information Governance team continues to issue guidance and provide training to prevent reoccurrences in order to improve information governance and information security compliance.

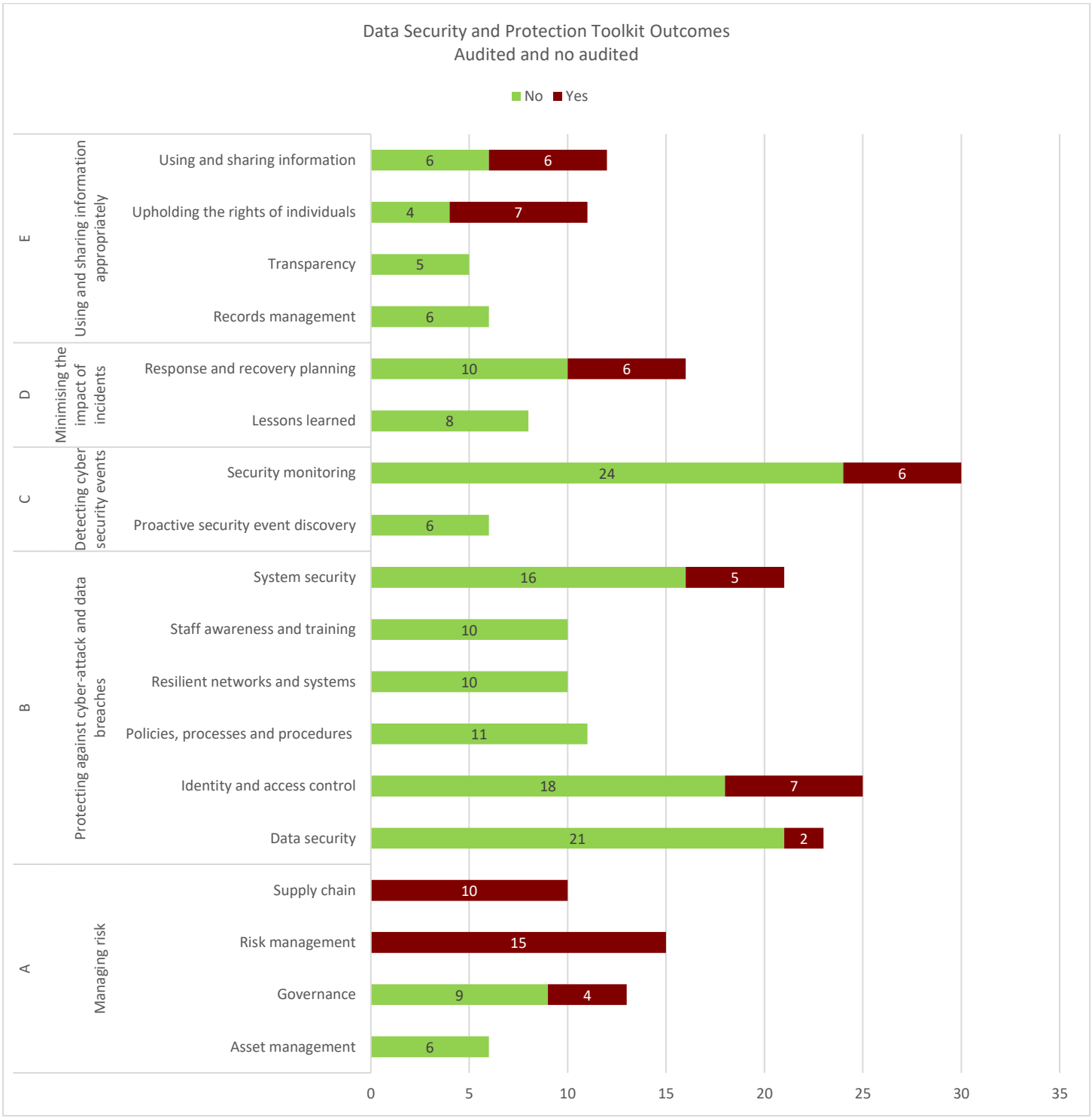
9. Internal Audit Findings

MIAA was commissioned by the Trust to carry an assessment on the readiness for the submission of the toolkit as per Data Security and Protection Toolkit Independent Assessment Framework mandated by the Department of Health.

The auditors reviewed 12/47 outcomes across the DSPT CAF Framework. These outcomes were pre-determined as in-scope by NHS England. This Executive Summary outlines the two report outputs in line with

the guidance and framework methodology and the key findings.

For 2024-25 there are a total of 68/238 indicators of good practice requirements to be audited under the framework, from the not achieve, partially achieve and achieve.



9.1 Auditor key findings and conclusions

MIAA review followed the CAF-aligned DSPT Independent Assessment Framework and Guidance published by NHSE. We have reviewed 12 outcomes across the 5 objectives in the Cyber Assessment Framework. NHSE mandated 8 outcomes to be audited for 2024/2025, the organisation was required to select and formally approve a further 4 outcomes to be audited. The scope of the audit has been approved by BHFT and the independent assessor.

As a result of our evidence assessment and interviews with key stakeholders, we have delivered 4 outcomes with findings and recommendations for management response and follow up, in total: 4 High Risk. We have also delivered 8 outcomes, assessed as meeting the NHS England minimum profile, that do not require management responses but have recommendations to strengthen evidence or controls further.

Areas of good practice identified have been included within section 9.2 of this report, along with the detailed findings and associated management actions which have been discussed and accepted by BHFT.

Overall Assurance Rating (NHSE profile for the in-scope outcomes)	Veracity of the organisation's self-assessment
We have assessed 12 outcomes, and found that, for 8 outcomes, the organisation has met the minimum achievement level. However, we also found that for 4 outcomes were rated as not meeting minimum achievement levels. We assessed the **risk** in these areas and outcomes reviewed as: **High Risk**	We have assessed 12 outcomes, and found that, for 10 outcomes, our rating aligned with the organisation's self-assessment. However, we also noted that, for the remaining 2 outcomes, our rating did not align with the organisation's self-assessment, resulting in a Low level of deviation between the independent and self-assessment. We assessed the confidence level of the Independent Assessor in the veracity of the self-assessment as: **High Confidence**

9.1.1 Overall Assurance Rating (NHSE profile for the in-scope outcomes)

Objective	Outcome	Minimum achievement level (as per the NHSE profile set for 24/25)	Assessment result	Minimum achievement level met	Overall assurance assessment
A	A2.a	Partially Achieved	Agreed	Met	High Risk
	A4.a	Partially Achieved	Not Agreed	Not Met	
B	B2.a	Partially Achieved	Not Agreed	Not Met	
	B4.d	Partially Achieved	Agreed	Met	
C	C1.a	Partially Achieved	Agreed	Met	
D	D1.a	Partially Achieved	Not Agreed	Not Met	
E	E2.b	Achieved	Agreed	Met	
	E3.a	Achieved	Agreed	Met	
A	A1.a_DIS	Achieved	Agreed	Met	
	A2.b_DIS	Achieved	Agreed	Met	
B	B3.e_DIS	Partially Achieved	Agreed	Not Met	
E	E2.a_DIS	Achieved	Agreed	Met	

9.1.2 - Veracity of the organisation's self-assessment

Objective	Outcome	Minimum achievement level (as per the NHSE profile set for 24/25)	Organisation's self-assessment (Met / Not Met)	Auditor assessment (Met / Not Met)	Deviation (No of IGP#s that differ)			Overall confidence level
					NA	PA	A	
A	A2.a	Partially Achieved	Met	Met	0 of 8	0 of 7		HIGH
	A4.a	Partially Achieved	Not Met (agreed verbally / DSPT to be updated)	Not Met	*2 of 6	*6 of 7		
B	B2.a	Partially Achieved	Not Met	Not Met	*0 of 5	*6 of 7		
	B4.d	Partially Achieved	Met	Met	0 of 5	0 of 5		
C	C1.a	Partially Achieved	Met	Met	0 of 4	0 of 4		
D	D1.a	Partially Achieved	Met	Not Met	0 of 4	4 of 6		
E	E2.b	Achieved	Met	Met	0 of 4		0 of 3	
	E3.a	Achieved	Met	Met	0 of 6		0 of 6	
A	A1.a_DIS	Achieved	Met	Met	0 of 4		0 of 4	
	A2.b_DIS	Achieved	Met – once submission completed	Met	0 of 3		0 of 5	
B	B3.e_DIS	Partially Achieved	Met	Not Met	1 of 1	1 of 1		
E	E2.a_DIS	Achieved	Met	Met	0 of 2		0 of 3	

Key: - * Agreed Not Met

9.2 Areas of good practice

There is a well-designed process for the compilation and review of the evidence required to support the Trust's annual Toolkit submission. An action plan is maintained by the Data Protection Officer, which assigns responsibility for the preparation of supporting evidence to responsible officers. Some of the good practices are as follows:

During the review the auditors noted the following areas of good practice:

- The Trust had zero Network and Information Systems (NIS) / cyber related incidents reportable to the Information Commissioner's Office (ICO) in 2024/25.
- The Information Asset Register (IAR) had been extended to include essential functions. The Data Privacy Officer (DPO) had led the collation of essential functions list and arranged meetings with a wide range of stakeholders to review and confirm controls and risks.
- A wide range of stakeholders had engaged in in the audit of this Trust-wide DSP toolkit.

- Information Asset Owners (IAOs) were being matured and embedded and the role and responsibilities for IAOs / procurement, especially for cloud-based systems clarified.
- The Trust had formally appointed an Emergency Preparedness Readiness and Response (EPRR) lead in December 2024.
- A new vulnerability management policy and cyber incident response plan were evidenced.
- A separate network for medical devices – Virtual Local Area Network (VLAN) had been implemented in 2024/25.
- IT had onboarded the Trust to a range of NHS England solutions / employed a range of threat intelligence sources and technology solutions to strengthen threat monitoring.

9.3 MIAA findings and recommendations

The following details key areas of risk or where improvements in the control framework are required, for the in-scope outcomes reviewed:

Finding name	Finding description
Supply Chain Governance	**Supply Chain (A4.a)** **1.** Ensure that risks relating to the supply chain and extended supply chain have been identified and documented for all essential functions and that they have been discussed / reviewed. **2.** Confirm assurance from the most critical suppliers of mutual support during incidents. **3.** Evidence regular supplier assurances for all essential functions regarding their cyber security and information governance practices / information shared with a supplier is protected from cyber-attack and is covered by appropriate legal protection.
Identity Management	**Identity and access controls (B2.a)** **1.** Complete the gap analysis of all essential functions for Multi Factor Authentication (MFA) and embed as part of Trust processes. **2.** Formalise improvement plans for MFA exemptions / exceptions to minimise risks / eliminate exceptions for essential functions and evidence how exceptions / exemptions are tracked / reported and approved by the SIRO.
Media / Equipment Disposal	**Media and Equipment Sanitisation (B3.e)** **1.** Formalise the disposal contracts for the safe and secure disposal of equipment by the IT team / medical device auctioneer and any maintenance contractor. **2.** Formalise the process for sanitisation of IT equipment is detailed to ensure repeatable and consistent processes are being followed for IT and non-IT systems

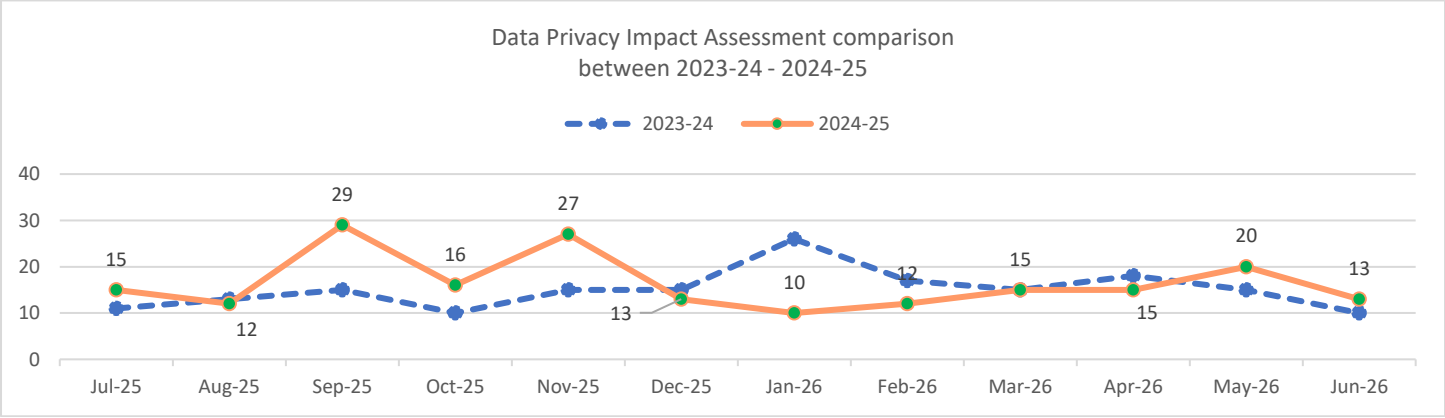
Incident Response Coverage	**Response Plan (D1.a)** **1.** Review / update the major incident plan and strengthen alignment with the new cyber incident response plan. **2.** Ensure that the Trust Incident Response Plan covers all essential functions including non-IT systems, covers likely scenarios for all essential functions, details how the plan / supporting documentation covers the Trust obligations as a data controller or processor and includes plans for notifying all impacted system partners. **3.** Schedule a quarterly audit for hard copy documentation and upload a formal debrief report for a recent incident.
Governance and Assurance Framework and policies	Mature and embed the governance, risk and assurance framework for oversight of the essential functions for 2025/26. As part of the alignment of policies for 2025/26, evidence policies include: **a)** the approach to the security and governance of information, systems and networks supporting the operation of essential functions **b)** an overarching communication process to ensure that all relevant staff are aware of the contents of the policies. **c)** explaining the remit of groups reporting lines up to the accountable board level member(s), especially whilst the Trust is undergoing transformation.
DSPT	**The Trust should complete and agree an overarching improvement plan with NHS England, as applicable.**

A Task and Finish Group has been established by the SIRO to implement the actions recommended by the auditor. The group held its inaugural meeting on 10 July 2025 and is now actively working through the agreed improvement plan to ensure timely and effective resolution of the identified issues.
A summary of the improvement plan can be found in Appendix B.

10. Data Privacy Impact Assessments

Under UK GDPR, Data Privacy Impact Assessments became mandatory for high-risk processing. This is part of the Privacy by Design ethos. The Trust had previously been using DPIAs where new technologies were introduced and they are becoming common place for the Trust as we mostly deal with health information which is a special category of information (similar to DPA 1998 sensitive data) under UK GDPR. We currently use a tool derived from the Information Commissioner's guidance.

In 2024-25 we finished 197 DPIAs, but some of the DPIAs are not approved yet because they need more information or they are complicated projects that require a staged approach to assess the risks.



Some of the challenges we face as a department to meet the Trust responsibilities are as follow:

- Divisions and service managers need to take responsibilities and ownership of the completion of DPIAs, as department managers they need to know why they want to bring a new system or process into the Trusts, know the risk associated with the specific project, etc. **as a department we are here to help and support through the whole process but departments need to complete the DPIA.**
- Poor information within the DPIA making difficult for us to assess the risk associated with the project and delaying the approval.
- One of the main problems we are currently facing is that projects are being authorised without an approved DPIA, this then requires a retrospective DPIA which is in itself challenging, even moreso if we cannot approve a DPIA due to it posing a large risk to the Trust.
- Departments need to plan ahead their projects and to consider privacy by design at an early stage of the project, DPIAs needs to be completed in a timely manner and submitted to the IG Department for approval.

11. Accreditations & Certifications

As a NHS Trust we have accreditations and certifications to reassure partners, customers, suppliers and other stakeholders that Trust operational procedures and processes comply with best practice standards.

11.1 Ensuring Data Security: Our ISO 27001 accreditation

We are proud to have been accredited for the past seven years. It is testament to our unwavering commitment to data security and confidentiality. This accreditation is particularly significant as it solidifies our position as a trusted partner within the NHS.

ISO 27001 is an internationally recognised standard that sets forth the requirements for establishing, implementing, maintaining, and continually improving an Information Security Management System (ISMS).

Attaining ISO 27001 certification involves a comprehensive audit process conducted by independent assessors to ensure that an organisation’s information security measures are robust and effective.

Why ISO 27001 Matters in Healthcare:

In the healthcare sector, where the protection of sensitive patient information is paramount, ISO 27001 accreditation serves as a critical benchmark. The NHS, being a data-intensive environment, demands stringent measures to safeguard patient records, medical histories, and other confidential information. Our ISO 27001 certification underscores our commitment to upholding the highest standards of information security, providing peace of mind to our clients in the healthcare industry.

Achieving ISO 27001 accreditation is a significant milestone for S&SHIS as it reinforces our commitment to excellence in information security, particularly within the NHS. Our clients can be confident that their sensitive data is in safe hands, backed by internationally recognised best practices. As we continue to evolve in an ever-changing digital landscape, our ISO 27001 certification positions us as a reliable partner dedicated to ensuring the highest standards of data security in healthcare.

11.2 Ensuring Data Security: Our ISO 9001 accreditation

We are proud to have been accredited for the past seven years. It is testament to our unwavering commitment to data security and confidentiality. This accreditation is particularly significant as it solidifies our position as a trusted partner within the NHS.

ISO 9001 is the international standard that defines the requirements for a Quality Management System (QMS). A Quality Management System enables organisations to manage their processes and systems in order that customer and other stakeholder requirements can be achieved. At its core is the principle of continuous improvement.

Attaining ISO 9001 certification involves a comprehensive audit process conducted by independent assessors to ensure that an organisation's information security measures are robust and effective.

Why ISO 9001 Matters in Healthcare:

ISO 9001 ensures our quality of service is clear, repeatable and defines our commitment to creating products and services that consistently meet both customer and regulatory requirements.

11.3 Ensuring Data Security: Secure Email Standards (DCB1596)

We are proud to have been accredited for the past seven years. It is testament to our unwavering commitment to data security and confidentiality. This accreditation is particularly significant as it solidifies our position as a trusted partner within the NHS.

All emails that include health and care information sent to and from health and social care organisations are required to meet the secure email standard (DCB1596), if the organisation does not use NHSMail. The information standard is published under section 250 of the Health and Social Care Act 2012.

The secure email standard sets out the minimum requirements for a secure email service. Meeting the secure email standard means that an organisation's email system is secure enough to keep sensitive information safe. This covers the storage and transmission of email, including where email is used for the sharing of patient identifiable data. The standard includes:

- The information security of the email service
- Transfer of sensitive information over insecure email
- Access from the internet or mobile devices
- Exchange of information outside the boundaries of the secure standard

Why DCB1596 Matters in Healthcare:

Confidential data is a key focus for cyber-attackers, with health and social care organisations a popular target.

To help secure sensitive data, emails that include health and care information sent to and from health and social care organisations are required to meet the Secure Email Standard (DCB1596).

12. Recommendation and priorities for 2025-26 period

❖ Information Governance Group/SIRO

- To support the delivery of the Data Security and Protection Toolkit (DSPT) two sub-groups will be established under the oversight of the Information Governance Group:
  - **Group 1: Essential Functions** – A stakeholder panel will be formed to assess risks associated with systems supporting essential functions services. This group will include representatives with expertise in Information Governance, IT, Procurement, Clinical Safety, and Emergency Planning. Their role will be to evaluate and mitigate risks to ensure continuity and resilience of essential services.
  - **Group 2: DSPT Task and Finish Group** – This group will consist of representatives from departments across the Trust that contribute to the DSPT. Its purpose is to coordinate input, ensure timely completion of toolkit requirements, and address any issues that arise during the submission process.
- Mature and embed the roles of the Information Asset Owners and Information Asset Administrators roles within the Trust and as part of the governance framework for essential functions.
- The development of a Procurement Framework Policy is needed to clearly define expectations for procurement activity across the Trust. The policy will need to outline the Trust's requirements for goods and services, ensure alignment with regulatory and legislative standards, and embed robust due diligence processes for assessing providers. Due diligence checks will include financial stability, legal compliance, data protection standards, and operational capability, ensuring that all suppliers meet the Trust's requirements before engagement.

❖ IG/Divisions:

- The Information Governance Department and divisions to continue to mature and prioritise the Information Assets and Data Flow Mapping Registers. One of the significant impacts identified is that the work undertaken during 2024–25 will need to be reviewed and adapted to align with the Trust's new divisional structures.
- Support from the divisions is essential for this work, as they are the only ones who can identify the type of asset they hold and how information is shared within their departments.

❖ Procurement:

- The Trust should maintain an up-to-date and comprehensive contracts register.
- Contracts processing personal data should be tracked, accredited, and regularly reviewed.
- An assurance strategy for the contract's lifetime should be formalised, specifying roles and responsibilities for both parties (Trust and supplier).
- Conduct a gap analysis and seek further assurance for any anomalies identified.

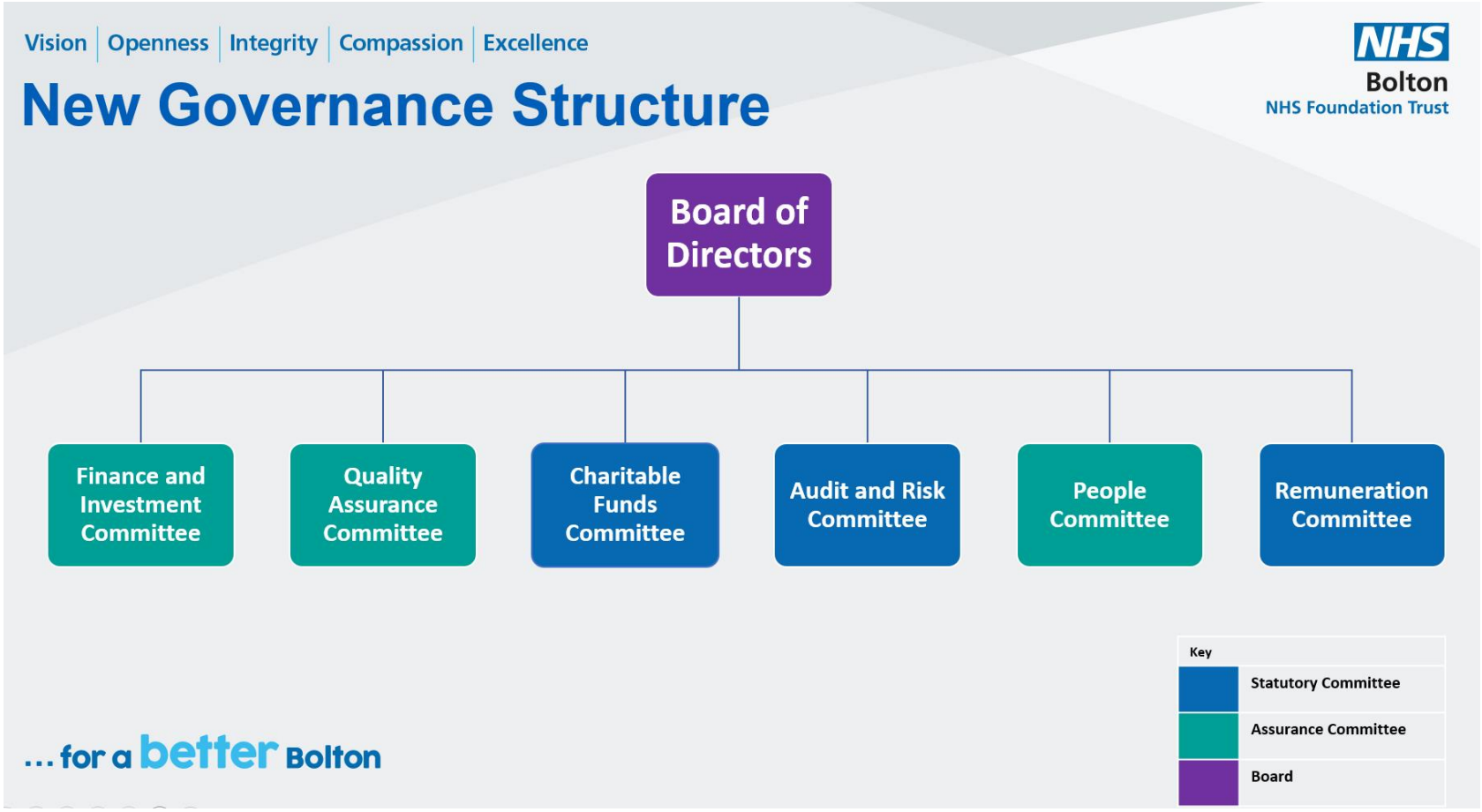
❖ Informatics:

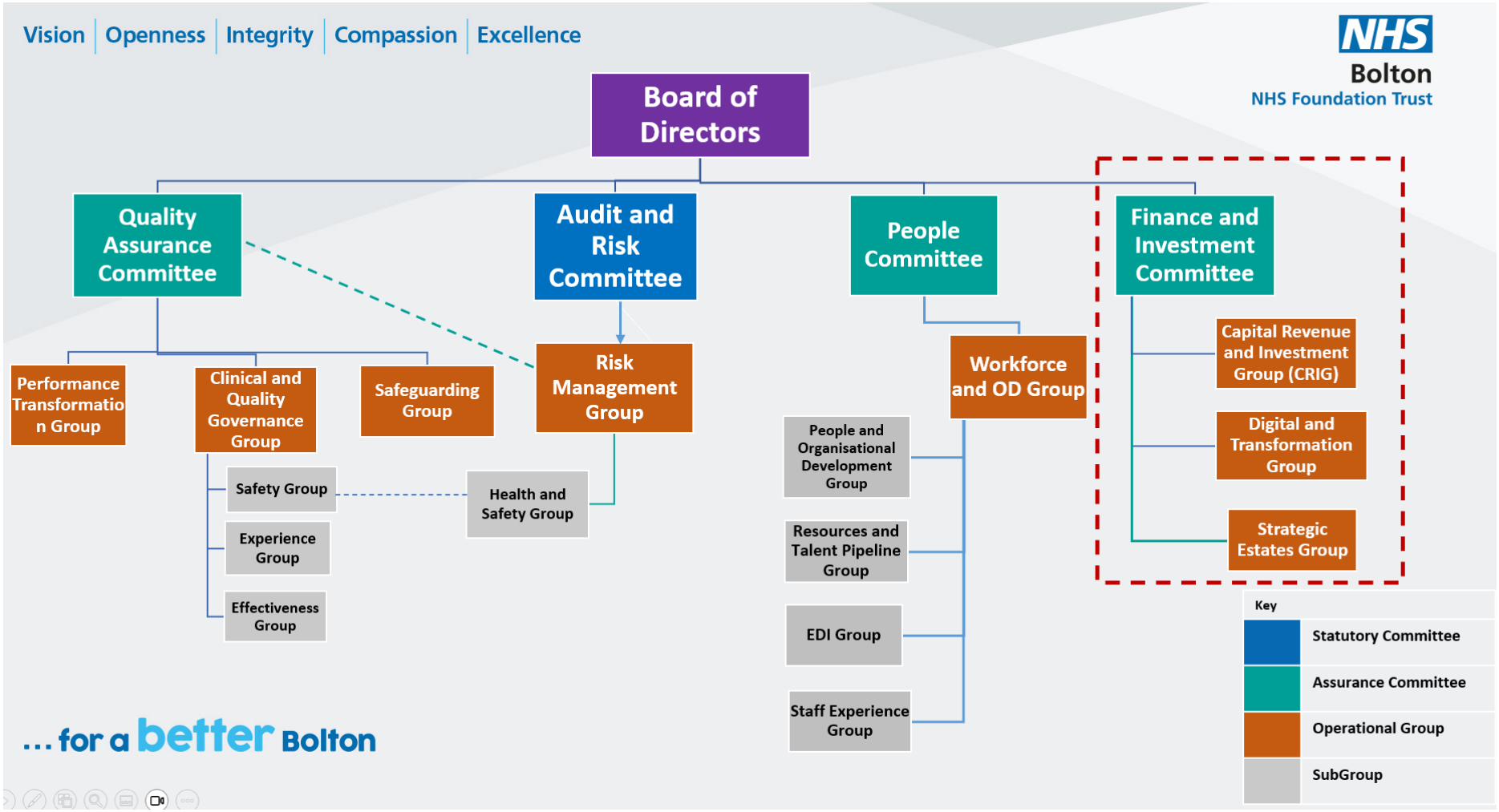
- Prioritise penetration test recommendations to mitigate cybersecurity risks.
- Report any recommendations that cannot be fixed promptly or will take longer than expected via the Risk Register.
- Digital Strategy need to be updated to reflect the Department of Health and Social Care (DHSC) cyber strategy to 2030. This update will ensure our approach reflects national priorities for building cyber resilience across health and social care, including a focus on reducing risk, protecting personal data, and enhancing response and recovery capabilities.

❖ Emergency Planning:

- Conduct an annual tabletop exercise for Business Continuity Planning (BCP) within the divisions.
- Understand essential functions and dependencies of services (internal or external).
- Completion of business impact analysis will produce a functional BCP, while for others, it may highlight necessary improvements.

Appendix A – Trust Governance Structure




Vision | Openness | Integrity | Compassion | Excellence
NHS Bolton NHS Foundation Trust
Board of Directors
Quality Assurance Committee
Audit and Risk Committee
People Committee
Finance and Investment Committee
Performance Transformation Group
Clinical and Quality Governance Group
Safeguarding Group
Risk Management Group
Workforce and OD Group
Capital Revenue and Investment Group (CRIG)
Digital and Transformation Group
Strategic Estates Group
Safety Group
Experience Group
Effectiveness Group
Health and Safety Group
People and Organisational Development Group
Resources and Talent Pipeline Group
EDI Group
Staff Experience Group
Key
Statutory Committee
Assurance Committee
Operational Group
SubGroup
... for a better Bolton

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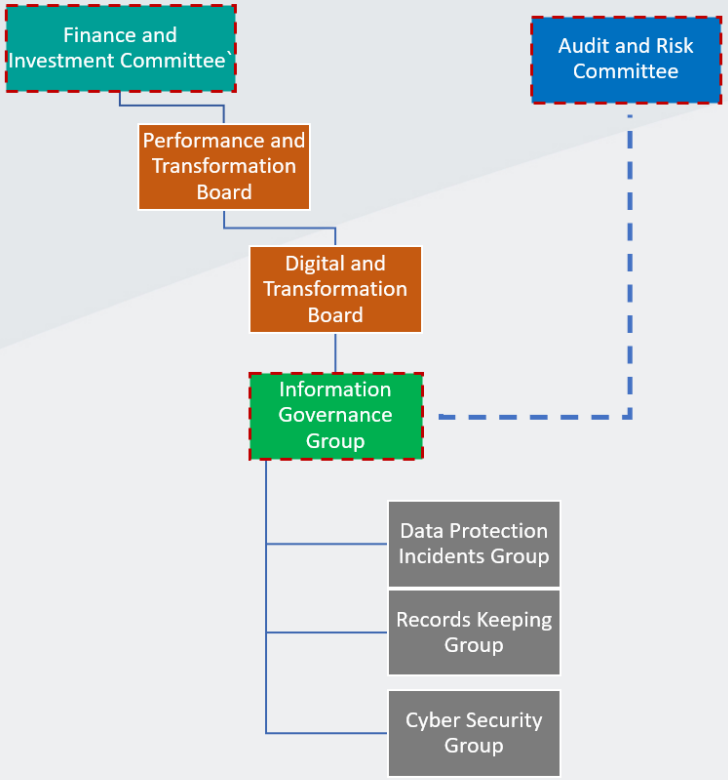


NHS Bolton NHS Foundation Trust

Audit & Risk Committee TOR extract

- To provide assurance to the Board on the effective and adequacy of oversight in the management of cyber risk including appropriate levels of independent scrutiny and assurance.
- Receive the results of the Annual DSP toolkit audit and receive assurance over the Trust's plans to address any areas of improvement identified.
- Receive an Information Governance Annual Report focussed on compliance with data protection and Freedom of Information (FOI) rules number/type of breaches; and plans to develop and improve compliance.
- Receive assurance on the quality of data relied on for decision-making, plans on maintaining proper controls over data quality, including regular independent audits.

... for a better Bolton

Appendix B – DSPT Improvement Plan

DSPT Outcome	Indicator of good practice (IGP)	What actions do you plan to take to meet the requirement? Please provide details of any milestones. This should include any action required to ensure the activity is funded and resourced to achieve the planned completion date.	Action Owner	Priority (High Medium Low)	Initial Planned Completion date	Status *(Not Started, Completed, On-going, No further work planned)*	Provide the plan to achieve the outstanding actions required to meet the outcome/or link to a more detailed plan
A4.A	PA#2	**Evidence that the organisation knows the extent of the supply chain supporting the all the essential functions by completing a gap analysis.**	Procurement / IG	High	30/09/2025	On-going	Due dilligence checks against the contract started but is not completed yet, is missing copy of the contracts for some of the essential functions
A4.A		**Evidence that risks relating to the supply chain and extended supply chain have been identified and documented for all essential functions and that they have been discussed / reviewed.**	Procurement / IG	High	30/09/2025	Not Started	1. Identify all essential functions within the Trust. **Completed** 2. Conduct a comprehensive risk assessment for each essential function, focusing on supply chain and extended supply chain risks. 3. Document the identified risks in a centralised risk register. 4. Schedule and conduct review meetings with relevant stakeholders to discuss the identified risks. 5. Ensure that all discussions and reviews are documented and stored for future reference. 6. Implement any necessary mitigation measures based on the discussions and reviews. 7. Regularly update the risk register and review process to ensure ongoing risk management.
A4.A		**Review / confirm access for DPO/ Cyber to the contract register**	Procurement	High	30/09/2025	Not Started	Access to be provided by Procurement to IG and IT
A4.A		**During 25/26 progress the work planned around Atamis to classify contracts and strengthen due diligence checks.**	Procurement / IG	High	30/09/2025	On-going	All contracts held by the divisions need to be within Atamis
A4.A	PA#3	**Evidence a contract register / asset register mapping all the essential functions.**	Procurement / IG	High	30/09/2025	On-going	Part of A4.a-PA#2
A4.A		**Evidence that the essential functions contracts include appropriate security and data protection obligations including the right to audit.**	Procurement	High	30/09/2025	Not Started	Part of A4.a-PA#2

A4.A		**Going forward, review / incorporate changes in legal and regulatory guidance and best practice such as NHS England's voluntary charter for suppliers and new Cyber Security and Resilience Bill (July 2025).**	Procurement / IG	High	30/09/2025	Not Started	Procurement Policy
A4.A		**Review the new terms and conditions for security schedule for NHS contracts (schedule 11) once the guidance is published.**	Procurement	High	30/09/2025	Not Started	Procurement Policy
A4.A	PA#4	**Evidence all essential function data flows / third-party connections are documented including those for legacy contracts / those not subject to a DPIA.**	IG	High	30/09/2025	Not Started	via the Task & Finish Group
A4.A		**Evidence assurance that the third-party connections meet / continue to the Trust's security and IG requirements.**	IT	High	30/09/2025	Not Started	Via the Access Control Policy and Network Security Policy, Code of Connection Form
A4.A	PA#5	**Strengthen policy / procedures for third-party accreditation/ audit / exit for instance, for systems outside IT**	Procurement / IG	High	30/09/2025	Not Started	Procurement Policy
A4.A		**Strengthen processes for reporting of incidents for third parties / off premise systems / formalise measures to aid response to incidents involving third parties.**	Procurement / IG	High	30/09/2025	Not Started	Procurement Policy
A4.A		**Evidence assurance from most critical suppliers of mutual support during incidents.**	Procurement / IG	High	30/09/2025	Not Started	Procurement Policy
A4.A		**Embed closer working with procurement, IAO, IG, Cyber, EPRR, as planned.**	Procurement / IG	High	30/09/2025	Not Started	Procurement Policy
A4.A	PA#6	**Evidence regular supplier assurances for all essential functions regarding their cyber security and information governance practices / information shared with a supplier is protected from cyber-attack.**	Procurement / IG	High	30/09/2025	Not Started	Annual request of assurance by Procurement to 3rd parties

A4.A		**Strengthen evidence of confidence in information sharing with suppliers supporting all essential functions / processes followed.**	Procurement / IG	High	30/09/2025	Not Started	Procurement Policy
A4.A	PA#7	**Evidence regular supplier assurances for all essential functions regarding their cyber security and information governance practices / that information shared with a supplier is covered by appropriate legal protection.**	Procurement / IG	High	30/09/2025	Not Started	Part of A4.a-PA#2
A4.A		**Continue to progress the review of legacy / BAU contracts.**	Procurement	High	30/09/2025	Not Started	Part of A4.a-PA#2
B2.a	PA#2	**Continue to progress the improvement plans to remediate generic accounts for IT and medical devices.**	IT	High	30/09/2025	On-going	Part of the Pen Test remediation plan
B2.a		**Continue to assess non-IT essential functions for generic accounts including staff , privilege and suppler accounts.**	IT/Divisions	High	30/09/2025	On-going	Manual audit for systems not managed by IT
B2.a		**Enhance the controls in place for the Estate systems, by strengthening access controls / assurance over IFM / maintenance contractor(s).**	IFM system owners	High	30/09/2025	Not Started	Manual audit for systems not managed by IT
B2.a	PA#4	**Complete the gap analysis of essential functions for MFA and embed and mature as part of the DPIA / IAR / PMO / IAO processes across the Trust.**	IT / IG	High	30/09/2025	On-going	As part of the review of the Password and MFA Policy
B2.a		**Evidence how exceptions are tracked / reported and approved by the SIRO for IT and non-IT essential functions.**	IT / IG	High	30/09/2025	On-going	As part of the review of the Password and MFA Policy
B2.a	PA#5	**Review / confirm all remote access employs individual authentication and authorisation.**	IT	High	30/09/2025	On-going	Via Access Control Policy monitoring of access

B2.a		**Continue to strengthen processes to manage medical devices / onboard cloud-based systems.**	EBME/IT	High	30/09/2025	On-going	Via the following policies: - Data Protection by Design and Default - Medical Devices SOP for procurement devices - IT Policies
B2.a	PA#6	**Evidence an annual audit of users (non-IT managed) essential functions.**	IAO/IAA	High	30/09/2025	On-going	Manual audit for systems not managed by IT
B2.a	PA#7	**Remediate / strengthen accounts identified as part of the recent external assessments for any accounts identified as being weak**	IT	High	30/09/2025	On-going	Part of the Pen Test remediation plan
B2.a		**Review / strengthen password policy, as planned.**	IT	High	30/09/2025	On-going	As part of the review of the Password and MFA Policy
B2.a	B2.a	**Confirm that the policy has been updated to make explicit permitted exceptions / exemptions and has been approved at IG Committee prior to submission**	IT	High	30/09/2025	On-going	As part of the review of the Password and MFA Policy
B2.a		**Formalise improvement plans for MFA exemptions / exceptions to minimise risks / eliminate exceptions for all essential functions.**	IT	High	30/09/2025	On-going	As part of the review of the Password and MFA Policy
B2.a		**For exceptions for all essential functions ensure they are understood, documented, risk assessed and internally approved (by an authorised individual such as the SIRO), and subject to annual review.**	IT	High	30/09/2025	On-going	As part of the review of the Password and MFA Policy
B3.E	PA#1	**1. Formalise the disposal / equipment sanitisation contracts / service level agreements in place and ensure roles and responsibilities with regards sanitisation are documented / agreed to ensure the safe and secure disposal of equipment by the medical device auctioneer / estates / the maintenance contractor.**	Procurement / IT	High	30/09/2025	Not Started	Contract to be in place
B3.E			Procurement / EBME	High	30/09/2025	Not Started	Contract to be in place
B3.E			IT	Medium	30/09/2025	Completed	IT SOPs to be linked together and mention the disposal of the assets

B3.E		**2. Formalise the process for the sanitisation of IT equipment in the IT SOP to ensure repeatable and consistent processes are being followed for IT / non-IT systems**	EBME	Medium	30/09/2025	Not Started	Policy for Medical Devices need to be updated to reflect medical devices as a managed service and for the devices owned by the Trust for the disposal process
D1.A	PA#1	**Evidence review / update of the Major Incident Plan (due Mar 2025) and strengthen how the Trust overarching Incident Response Plan (Major Incident Plan) / new Cyber Incident Response Plan/ covers the new community based essential functions**	EPRR	High	30/09/2025	Not Started	EPRR policies to be updated to reflect Essential Functions and Cyber Incident Response Plan
D1.A		**Wider issue - During 2025/26 - the organisation is undergoing significant change / transformation including rollout of an EPR to community.**	Head of Digital Systems/ EPRR	High	30/09/2025	Not Started	New BCP for community services and end user perspective
D1.A		**As the Trust continues to transform regularly confirm on call arrangements are in place for all essential functions in the Trust.**	Essential Functions Task & Finish Group	High	30/09/2025	Completed	Policy has been updated reflecting Essential Function but is going through the approval process, is on the last stage, it will be approved by PDOG on the 19/06/2025
D1.A	PA#3	**Evidence training of IAOs and strengthen coordination between EPRR, BC leads and IAOs**	EPRR	High	30/09/2025	Not Started	Within Emergency Planning policies
D1.A		**For 25/26 include further representatives from IAOs at the EPRR group and publish BC leads.**	EPRR	High	30/09/2025	Not Started	As part of Emergency Planning policies
D1.A		**Wider issue - resiliency of limited staff to cover on call arrangements**	Brett Walmsley/Farouk Patel	High	30/09/2025	Not Started	IT Managers on call / Team restructure
D1.A		**Wider Issue - formalise roles and responsibilities being captured within**	Brett Walmsl	High	30/09/2025	Not Started	Via DPIA process

		incident response plans for consortium led solutions.	ey/Farouk Patel				
D1.A	PA#4	**Evidence engagement will stakeholders from all essential functions.**	Essential Functions Task & Finish Group	Medium	30/09/2025	On-going	Task & Finish Group for Essential Functions
D1.A		**Confirm the frequency of updating hard copies of documentation / evidence a quarterly audit for hard copy documentation**	EPRR	Medium	30/09/2025	On-going	This is reviewed every 3 months as part of their audits
D1.A	PA#6	**Confirm the role of the Incident Response Plan in coordinating the notification of all impacted system partners.**	IG / IT/ EPRR	Medium	30/09/2025	On-going	As part of EPRR policies
D1.A		**Confirm the process for IAOs notifying impacted systems partners for an incident / ensure that all third-party contacts are documented,**	IG / IT/ EPRR	Medium	30/09/2025	On-going	As part of EPRR policies

Report Title:	Chief Executive's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	25 September 2025		Discussion	
Executive Sponsor	Chief Executive		Decision	

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

Previously considered by:	Not Applicable.

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

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

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

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

Prepared by:	**James Mawrey, Deputy Chief Executive**	**Presented by:**	**James Mawrey, Deputy Chief Executive**

Ambition 1: Improving care, transforming lives

Our Specialist Mental Health Midwives have launched a brand new walk and talk group to support mums and parents with their mental health. 'Steps of Support' welcomes pregnant women, mums, partners and babies to take part in short walks around Bolton's parks with the aim of bringing people together for conversation and to enjoy the outdoors. The new walk and talk group aims to break down those barriers by creating a safe space for mums and parents to meet others who can relate so they can speak about their experiences and build new connections and friendships.

Royal Bolton Hospital has been officially recognised as an outstanding performer for a screening test that identifies a sight-threatening eye condition in preterm babies. The Neonatal Unit screens babies born at less than 32 weeks of pregnancy or of a birthweight under 1501g that are at risk of developing retinopathy of prematurity (ROP), a condition that affects blood vessels in babies eyes and can cause severe problems with vision. An annual audit by the National Neonatal Audit Programme (NNAP) found Bolton had a screening rate of 95.9%, significantly above the national average of 80%, ensuring at risk babies are able to receive treatment before it becomes severe and preventing the risk of sight loss.

Our Shine Sexual Health Service has launched a gonorrhoea vaccination programme for Bolton residents. The vaccine is being offered to mainly to gay, bisexual and other men who have sex with men (GBMSM) who are considered at highest risk. People of other genders and sexualities may also be eligible if assessed to be at high risk.

Ambition 2: A great place to work

The shortlist for our annual FABB Awards 2025 has been revealed. The annual event recognises the incredible contributions of health and care staff in the organisation and across Bolton. This year, more than 600 nominations were received for our staff across 11 award categories, each recognising the inspiring work that's taking place every day to provide care, support and treatment to local communities. This year's categories include Greener Future, Quality and Safety, People's Choice, and for the first time the Charity Support of the Year to recognise individuals and organisations who have shown exceptional commitment to supporting our charity, whether through personal dedication, fundraising efforts, or advocacy. The fully sponsored event will take place on 10th October at the Toughsheet Community Stadium in Horwich.

Our Organisational Development and Human Resources teams continue to actively review and enhance the support available to our staff, who despite the ongoing challenges, consistently demonstrate remarkable resilience and dedication. One key initiative is the continuation of the Our Leaders programme, which this month celebrated its 500th participant. This programme is open to colleagues at all levels across the Trust, from those new to leadership to our most experienced senior leaders. It offers practical tools, valuable insights, and meaningful development opportunities tailored to every stage of the leadership journey. At its heart, Our Leaders is about strengthening leadership capability across the

organisation - ensuring we all have the confidence and skills to support our teams effectively, especially during these demanding times.

The Trust has been recognised nationally for its commitment to neurodiversity inclusion and the support it offers to staff. Our dedicated Neurodiversity Inclusion and Support Group has been named a finalist in this year's HPMA Excellence in People Awards, making the shortlist for the Browne Jacobson Award for Excellence in Employee Engagement. As part of our ongoing efforts to create a more inclusive and supportive workplace for neurodivergent colleagues, the Trust established a Neurodiversity Support Group. This initiative is designed to foster a culture of understanding, empowerment, and psychological safety - encouraging colleagues to speak up and contribute to meaningful organisational change. These efforts reflect our broader commitment to employee engagement and wellbeing, and we are proud to see the group recognised at a national level. The winners will be announced at the awards ceremony in Birmingham on Tuesday 20 November 2025.

The University of Manchester has awarded us with a gold award for providing an 'excellent standard' to medical students who are on placement in Elderly Care and Microbiology. Students in the fifth year of their medical degree, who are asked to complete an evaluation of each placement they attend, provided an average score of 4.98 out of 5 for their experience at Royal Bolton Hospital. The evaluations highlight teams involved in the education of medical students who provide an excellent standard, which led to the University of Manchester to introduce Recognition of Excellence awards, based on the mean placement score.

From 15 – 21 September we are marking National Inclusion Week, which is dedicated to celebrating inclusion and taking action to build inclusive workplaces. This presents an opportunity to reaffirm why our values and behaviours are central to who we are, and to remind everyone of the importance of creating a safe, inclusive, and respectful environment for our staff, patients, visitors, and the wider community. As part of our commitment, all colleagues are invited to access our Equality, Diversity and Inclusion (EDI) blended learning bundle, which offers a wide range of resources covering topics such as race, ethnicity, and allyship.

We are now in receipt of our 2025 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (DES) data which is reflective of the progress we have made in key areas including representation, equal career progression, reasonable adjustments and discrimination. Our People Committee has recently approved the priorities identified to ensure further improvements are made, and the reports will be published externally in full on 31 October 2025.

Ambition 3:
A high performing, productive organisation

NHS England has launched a new interactive performance dashboard as part of the NHS Oversight Framework 2025/26, reinforcing its commitment to transparency and continuous improvement across NHS services. The dashboard offers a clear view of how NHS trusts are performing in key areas such as urgent and emergency care, elective services, and mental health. For the first time, both NHS leaders and the public can explore league tables comparing local trusts across England - at both service-specific and overall levels. This has already attracted attention from local, regional, and national media outlets.

Our Trust has been ranked 59th nationally and is among the top two in Greater Manchester. We welcome all feedback and use it as a catalyst for improvement. While there are areas where we perform strongly, we recognise there is always more to do and remain committed to working with our partners to deliver the highest quality care for our patients. The dashboard also shows how trusts are segmented (1 to 4) based on performance against NHS Oversight Framework metrics. High-performing trusts in Segment 1 may be granted greater autonomy, while those in Segment 4 may receive targeted support. Trusts facing significant challenges may be placed in Segment 5, accessing intensive support through the Recovery Support Programme. This publicly available tool empowers patients with transparent, easy-to-understand data, helping them make informed decisions about their care.

Within the NOF, the Trust has achieved the highest national ranking (Level 1 - High Performing) for patient safety - an outstanding accomplishment that reflects our collective commitment to excellence. This rating is based on four key indicators: staff confidence in raising concerns (from the NHS Staff Survey), and our performance in infection control - specifically the number of MRSA, C-Difficile, and E-Coli infections.

We have been ranked 1st out of 134 acute trusts for MRSA and C-Difficile rates (with 1 being the best performer). This achievement is a testament to the dedication and collaboration of our entire workforce - from frontline clinical teams and the Infection Prevention and Control Team, to our Domestic, Estates, and Facilities colleagues who continue to uphold exceptional standards of cleanliness and environmental care.

This month our clinical divisions and corporate directorates have engaged their teams in 'Super September' - a month-long initiative designed to prepare us for the winter period. It focuses on improving patient flow, patient experience, and operational performance to ensure we deliver timely, safe, and effective care - especially under pressure - and sustain the progress made over the past year. Throughout the month, several initiatives are being rolled out across the organisation to improve patient care and streamline our services including the introduction of a rapid response cleaning team, criteria-led discharge, senior oversight of discharge planning board rounds and long length of stay reviews – helping us to identify and address delays to get our patients home at the earliest opportunity. The month's activity will be evaluated to understand how good practice can be sustained beyond the improvement month.

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

Ensuring our organisation is fit for the future continues to be a key area of focus – and making the best use of digital technology is central to that vision. As part of this, we have extended the rollout of Sunrise™ Electronic Patient Record (EPR), powered by Altera Digital Health, to our Community and Outpatient services. The go-live marks a major milestone in its digital transformation journey and in supporting care beyond the hospital by joining up patient records across acute and community settings. This latest rollout builds on the successful implementation of Altera's EPR technology across emergency and inpatient care settings, via a single, integrated platform. This expansion marks a significant step forward in improving continuity of care, streamlining clinical workflows, and enhancing the quality and safety of patient information across the Trust. It reflects our commitment to harnessing technology to support our teams and deliver better outcomes for the communities we serve.

A new system has also launched in our laboratories to make it easier for clinicians to process millions of patient test results. More than eight million tests are carried out in the hospital's laboratories every year to support diagnosis, treatment and management for a wide range of conditions. The multi-million pound investment in a new Laboratory Information Management System (LIMS), supplied by Clinysis, will ensure for a more efficient and productive process now and for years to come. Bolton is the first Trust to go live with the full system in Greater Manchester, following four years of planning and preparation to replace the previous system which was more than 30 years old.

Our Trust is part of the Greater Manchester Pathology Network, which serves nearly three million people across seven NHS trusts and collectively conducts more than 71 million tests every year. Investing in technology for real-time access will mean a quicker diagnosis for patients, allowing them to get the treatment they need as soon as possible.

As part of our financial recovery plan, we remain focused on identifying efficiencies and reducing expenditure across the organisation while maintaining the quality and safety of our care. Significant effort has gone into reviewing our operations to uncover smarter, more sustainable ways of working. We are currently partnering with PricewaterhouseCoopers (PwC) to conduct a detailed analysis of the key drivers behind our financial deficit. Their findings will inform a comprehensive Improvement Plan, aligned with our Operational Planning processes, aimed at closing the financial gap over the next three years. Current workstreams include a full review of existing Cost Improvement Programmes (CIPs), the implementation of robust cost control measures, and the acceleration of productivity and benchmarking initiatives. The final plan will be presented to the Board of Directors in January 2026.

Ambition 5: A positive partner

Our testing laboratory recently opened its doors to children for the very first time, offering a behind-the-scenes look into the fascinating world of healthcare science. Ten-year-old Peyton joined her parents, Sarah and Ben, for our inaugural Harvey's Lab Tour - a unique initiative designed to help young patients and their families feel more at ease by showing them what happens to their samples and introducing them to the biomedical scientists who play a vital role in diagnosis and treatment. Peyton, who lives with a rare genetic condition requiring regular blood tests and overnight hospital stays, was eager to explore the laboratory and meet the team who help turn test results into answers. Families interested in taking part can contact our hospital's Play Specialists, who work closely with laboratory teams to tailor each visit to the child's individual needs. Harvey's Lab Tours is proudly run in partnership with the Institute of Biomedical Science, and reflects our commitment to compassionate, patient-centered care - right down to the smallest details.

A mum and dad, whose daughter received life-saving care in our Neonatal Unit 21 years ago, are aiming to raise thousands of pounds for Our Bolton NHS Charity to help other families. Keeley and Ben King's daughter, Millie, was born on 29 August 2004 at just 24 weeks and 4 days, weighing only 1lb 7oz. Millie was given a 30% chance of survival and spent 107 nights in hospital, fighting for her life and receiving vital care and support from the dedicated nurses and doctors in the Neonatal Unit. To celebrate Millie's 21st birthday and show their thanks to the hospital, Keeley and her family are aiming to raise thousands of pounds for the hospital's Neonatal Unit to help fund resources that will help other families in the future.

A long-standing supporter of Our Bolton NHS Charity with his employer, Pay Smart Carpets, has helped Royal Bolton host it's first-ever 'Saturday Night Supper', to feed and support parents, carers and families whose children are staying in hospital overnight. Chris Mealing, from Pay Smart Carpets, visited the children's ward on Saturday 26 July armed with food worth more than £120 so that parents could enjoy a treat without the worry of the leaving the ward or having to fund their evening meal. More than a dozen patients and their families, including parents, carers, siblings and visitors, were able to enjoy the treats alongside ward staff.

We have invited our members and members of the public to attend the Trust's Annual Members' Meeting on Wednesday 15 October 2025. This event offers a unique opportunity to hear about the Trust's achievements over the past year and hear about exciting plans for the future of healthcare in the town.The meeting will be held in the Lecture Theatre from 1.00pm to 3.00pm in the brand new Bolton School of Medicine, located on the Royal Bolton Hospital site. Attendees will have the chance to engage directly with the Trust's leadership and learn more about ongoing projects and strategic priorities.

Report Title:	Board Assurance Framework Q1 Update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	25 September 2025		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	

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

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

Executive Summary	The Board Assurance Framework (BAF) provides a structured mechanism for evaluating whether the Trust has robust controls in place to manage strategic risks, and for assessing the effectiveness of the assurance provided through those controls. The BAF has been presented to all relevant Committee meetings ahead of Board consideration. Committees have been asked to review the robustness of the controls in place and evaluate the effectiveness of the assurance mechanisms supporting those controls. This process ensures the BAF continues to provide a reliable basis for strategic oversight and risk-informed decision-making. Due to the timing of the Quality Assurance Committee (QAC) and Finance and Investment Committee, a verbal update will be provided at the Board meeting.

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

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

✓	✓	✓	✓	✓

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

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

Board Assurance Framework Explanatory Notes

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

1. INTRODUCTION

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

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

2. Strategic Alignment

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

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

Each Strategic Risk is supported by:

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

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

2.1. Executive Oversight

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

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

3. RISK MANAGEMENT

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

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

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

Risk Categorisation Matrix

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

Key

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

3.3. **Principal Risks**

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

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

4. RISK APPETITE

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

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

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

Each Risk Appetite Statement is categorised as follows:

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

5. Recommendation:

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

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

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

Corporate Objective		Principal Risk	Risk Appetite	Risk Rating	Exec Lead	
Ambition 1: Improving care, transforming lives						
CO1	Deliver high quality, safe care to everyone who uses our services and make sure that everyone has a positive experience of our care	If the Trust does not provide safe, high-quality, and effective patient care, then overall experience of care may be adversely affected resulting in poor clinical outcomes, an inability to meet patients' evolving needs, increased health inequalities and unsustainable services	Avoid	**12** 4 x 3	Chief Nursing Officer	⟷
CO2	Create a culture where staff can innovate and collaborate to improve care	If the Trust does not create a culture where staff can innovate and collaborate to improve care, then it will be unable to support or take an innovative approach to healthcare research to adapt to the changing needs of our patients resulting in sub-optimal response to the needs of its patients and staff	Cautious	**12** 4 x 3	Medical Director	⟷
CO3	Play our part in improving health and preventing illness, so that people live healthier lives	If the Trust does not play its part in improving health and preventing illness, then the Trust will be unable to plan and respond to the needs of its community leading to an increase in health inequalities, unsustainable services and poor clinical outcomes	Cautious	**12** 4 x 3	Chief of Strategy and Partnerships	⟷

Corporate risks rating 15 and above aligned with **Ambition 1 – Improving Care Transforming Lives**

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

Severity Likelihood		1.Rare	2. Minor	3. Moderate	4. Major	5. Catastrophic
1	Rare					
2	Unlikely					
3	Possible			1595 2937		
4	Likely			6491	5425	
5	Certain			1869		6344

CO.1: Improving access to our services

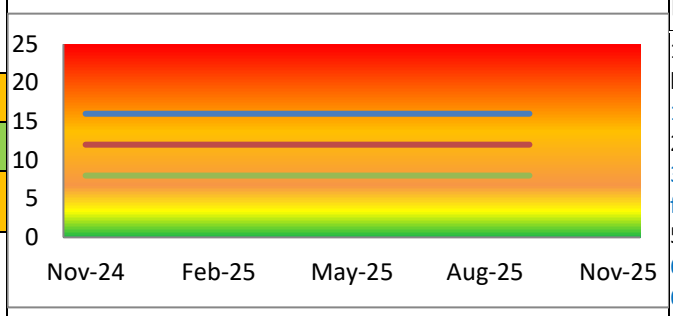
EXECUTIVE LEAD: CHIEF NURSING OFFICER

Risk Appetite: **AVOID**

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

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

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



Link to Risks on Corporate Risk Register

1595 (15) Critical care delayed discharges & mixed sex accommodation breaches
1869 (15) lack of ENT outpatient capacity
2937 (15) Orthopaedic Interface Service (OIS) waiting times
3330 (15) Waiting time for Glaucoma new patient appointments and follow-up
5425 (16) Delivery of Urgent Care Performance Standards
6344 (16) Unavailability of Abatacept
6491 (15) Failure of ambulatory cardiac monitoring analysis software
~~6549 (16) Risk stratification and health optimisation in pre-op assessment~~

Issues impacting achievements of our objective

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

KPIs / Measures

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

Controls

- Quality Account Priorities
- Quality Improvement Plan
- Patient Safety Incident Response ~~Framework /~~ Plan
- Being Open Policy (includes duty of candour)
- Enabling professional priorities established for Nursing, Midwifery, AHPs and Health-care scientists (NMAHP&HCS),
- Accreditation (BoSCA) escalation framework
- Safeguarding Assurance Framework
- Quality 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
-

Assurances

1st line of Defence (Operational management)

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

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

Reports to Quality Assurance Committee and Board, namely:

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

3rd Line of Defence (Independent or external assurance)

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

Actions

1. ~~Scoping~~ procurement of a digital solution to support with provision of aggregated data / thematic analysis**.** Expected (business case) presentation March 2025). ~~July 25 Update: Revised Target Date Q3 2025~~
   Update Sep 25: Target Date of Q3 25/26 remains
2. ~~Roll~~ Roll out and embedding of community safer nursing acuity tool – **Target Completion Date 30.03.25** ~~July 25 Update: Relaunched and revised target completion Q2 2025~~
   Update Sep 25: Relaunched and next safer nursing care tool scheduled for September 2025.
3. Development of Risk Management Framework with stakeholder engagement **Target Completion Date ~~30.12.2023.~~ Update Sep 25:** Risk Management Framework has been drafted with wider discussions with Executive Team to discuss new approach planned. Target date for implementation is December 2025.
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**
   Update Sep 25: Pilot meeting had in Community Services. To discuss next steps with CNO and DNDs in September 2025**.**
5. Review of Divisional Quality Governance (Families and Diagnostics) **Target completion date Q2**
   Update Sep 25: Divisional restructure has necessitated changes in Divisional Governance**.**
6. Review of Maternity specific outcomes against peer using available data (and new national datasets) **Target Completion Q3 2025**
7. Aqua facilitated Board Development on Continuous Improvement and Learning Organisation **Update Sep 25:** Board Development occurred in August 2025. Roadmap being developed to focus next steps towards QMS**.**
8. Improvement plan to attain full compliance with NHSE workforce safeguards: **Target Completion Date 31.3.2026**
9. Completion of National research and development gap analysis tool (SORT); **Target Completion Date 31.3.26**
10. Provision of inclusive patient experience / service user feedback that represents all users; **Target Completion Date 31.3.26**
11. Agreement of initial NMAHP clinical outcomes for stratification by ethnicity and deprivation; **Target Completion Date 31.3.2**

Gaps in Control

- 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

Gaps in Assurance

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

Committee Feedback

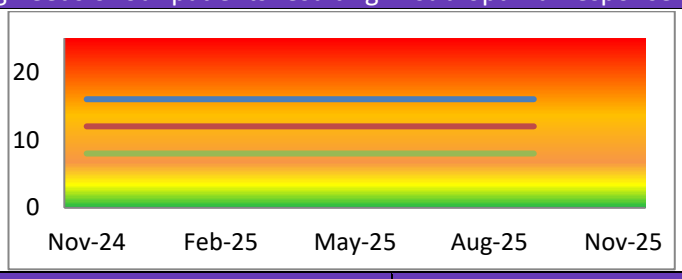
As a result of a review of the Corporate Risk Register, the following risks have now been moved to Ambition 3 with oversight from F&I

- 6193 (16) Reduced bed capacity DUE TO RAAC within the Maternity
- 6145(15) Maternity Theatres ventilation failures F&I
- Risk 6549 Surgery Pre assessment (J block outpatients) Previous score 16, reduced score 12.

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

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

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



Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

- Missed opportunities for improvement or implementation of evidence-based interventions.
- Inadequate clinical data in EPR systems and inadequate integration and development of digital systems restricts innovation, learning, and evidence-based decision-making.
- Varied work practices, clinical commitments, and lack of shared values hinder effective collaboration across teams and with primary care.
- Absence of a structured innovation pathway and insufficient funding for pilot schemes to enable innovation.
- Lack of infrastructure undermines the development of a robust research programme.

KPIs / Measures

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

Controls

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

Assurances

1st line of Defence (Operational management)

- Quarterly Quality Account updates to CG&QA committee
- 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

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

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

3rd Line of Defence (Independent or external assurance)

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

Actions

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

Gaps in Control

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

Gaps in Assurance

Reporting and oversight of innovation and collaboration

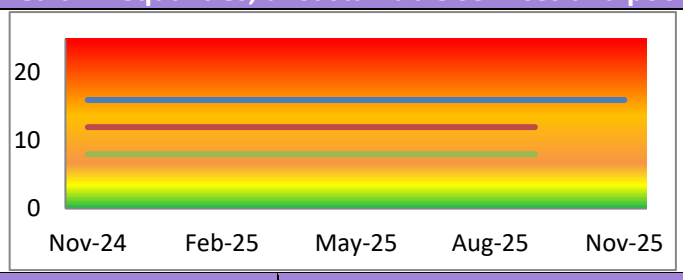
Committee Feedback

The Committee reviewed the BAF and accepted the change in risk appetite to **CAUTIOUS** from Open and acknowledged this will be further reviewed after the follow-on session in December.

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

STRATEGIC RISK 3: If the Trust does not 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.

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



Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

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

KPIs / Measures

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

Controls

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

Assurances

1st line of Defence (Operational management)

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

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

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

3rd Line of Defence (Independent or external assurance)

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

Actions

1. Enhancing links between primary, community, secondary, and social care to ensure people get the services and advice they need promptly. **July 25 Update:** Plan for provider collaborative developed (**Review March 2026)**
   Sep 25 Update Plan for provider collaborative
2. Making Every Contact Count implemented and reviewed in Community Division **Target Completion Date: March 2026.**
   Sep 25 Update: Division piloting MECC
3. Identifying and involving carers in care planning, decision making and discharge so that we improve experience. **Target Completion Date: March** 2026
   Sep 25 Update: Ongoing with review
4. Board level discussion on our Socio Economic Duty and Action Plan. **Target Completion Date:** March 2026
   Sep 25 Update: Date provisionally planned for Feb 26
5. Health Inequalities Action Plan reviewed and refreshed. **Target Completion Date**: March 2026
   Sep 25 Update: Complete with oversight HIEG
6. Ensuring continuity of care in our Maternity Services for those at most risk and from most deprived areas. **Target Completion Date: March 2026**
   Sep 25 Update: Ongoing with oversight from CGQG
7. Ensure Health Inequalities Framework is embedded into the organisation **– Ongoing into 2026 Sep 25 Update:** Ongoing with oversight through HIE

Gaps in Control

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

Gaps in Assurance

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

Committee Feedback

The Committee reviewed the BAF and accepted the change in risk appetite to **MINIMAL** from Seek and acknowledged this will be further reviewed after the follow-on session in December.

AMBITION 2: A GREAT PLACE TO WORK

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

Lead Committee: People Committee

Lead Directors: Chief People Officer

Our Objectives	OUR IN-YEAR PRIORITIES	ENABLING PLANS
CO.4 Improve the experience of our staff and make our organisation a great place to work. **CO.5 Help all staff to unlock their potential** **CO.6 Ensure that our workforce reflects the population we serve**	• Reduce Worked Whole Time Equivalents in line with our operational plan • Deliver sickness absence rates of <4.8% • Reduce overall vacancy rate lower than 4% by 2025 • Maintain / Improve our staff satisfaction levels as measured by the NHS Staff Survey • Improve our Workforce Inequalities metrics as measured by the WRES/WDES and Gender Pay Gap	• Operational Plan • Our People Plan • Equality, Diversity and Inclusion Plan 2022-26

Corporate Objective		Principal Risk	Risk Appetite	Risk Rating	Exec Lead	Lead Commitee	Trend Analysis
Ambition 4: An organisation that's fit for the future				S xL			
CO4	Improve the experience of our staff and make our organisation a great place to work.	If the Trust does not achieve its Ambition (To be a great place to work) then it will be unable to recruit, retain and support staff to maximise their potential	Cautious	**16** 4 x 4	Chief People Officer	People Committee	⟺
CO5	Help all staff to unlock their potential	If staff are not supported to unlock their full potential, then we risk reduced performance, lower morale, and missed opportunities for innovation and improvement	Cautious	**16** 4 x 4	Chief People Officer	People Committee	⟺
CO6	Ensure that our workforce reflects the population we serve	If our workforce does not reflect the diversity of the population we serve, then we risk reduced public trust, diminished service effectiveness and potential reputational harm.	Cautious	**16** 4 x 4	Chief People Officer	People Committee	⟺

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

Current risks rating 15+ aligned with Ambition 2 **– A Great Place to Work**

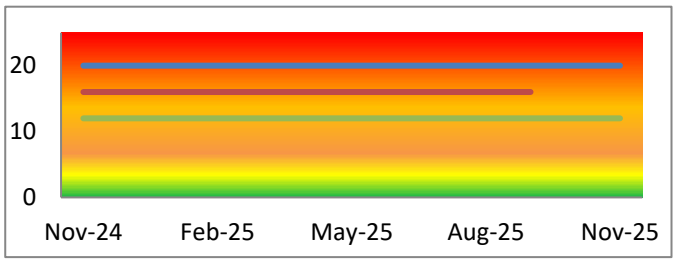
Severity / Likelihood		1.Rare	2. Minor	3. Moderate	4. Major	5. Catastrophic
1	Rare					
2	Unlikely					
3	Possible					
4	Likely				6418 6422 6498	
5	Certain			6438		

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

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

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

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



Link to Risks on Corporate Risk Register

6418 (16) Resident Doctor staffing levels
6422 (16) General Surgery CT on call rota
6438 (15)Insufficient staffing within the pharmacy team 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 levels ~~resulting in low recruitment and retention of staff with the right skills and values~~ 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

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
- Year-on-year improvement in % staff with protective characteristics reflective of the population we serve.

Controls

Experience

- Operational Plan
- Executive Vacancy Panel (monthly)
- Executive Variable Pay Panels (daily/weekly)
- 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 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)
- ~~EDI Action Plan monitored at People Committee quarterly~~
- ~~Our VOICE Change Programme reports to People Committee and Board~~

3rd Line of Defence (Independent or external assurance)

- NHS Staff Survey
- 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
   Sep 25 Update: Ongoing with regular reviews.
2. Review of Trust Well Being offer and financial well-being in light of cost of living pressures and national issues on pay. **Target Completion Date: March 2026**
3. Regular meeting and expansion of Community voices group. **Target Completion Date: December 2025: Sep 25 Update: Ongoing**
4. EDI Plan to be revised and complement the existing People Plan. Revised Target Completion Date March 2025.
   Sep 2025 Update: **Revised Target Completion December 2026**
5. Refreshed Vacancy Control Process from 1 September, 2025 (meets monthly).
6. Executive Variable Pay Panels have all been set up from 1 September, 2025
7. Reset Programme launches end of September / early October, 2025 to support high levels of organisational change.
8. Medical E Rostering roll out plan to commence in October, 2025

Gaps in Control

Gaps in Assurance

Committee Feedback

The People Committee received the updated BAF at the September meeting. As a result of a review of the Corporate Risk Register, the following risks has now been added following approval at RMG.

6498 (16) Changes to Additional Clinical Activity Pay (Locum bank rates) for Resident and SAS Doctors

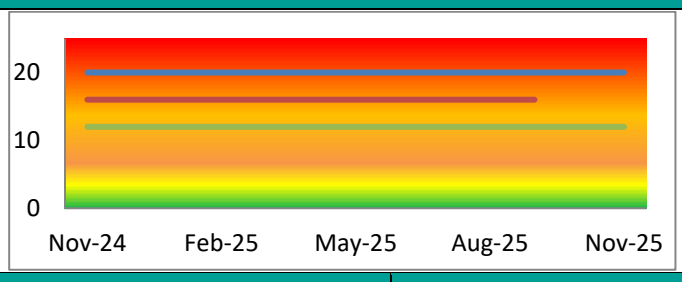
CO.5: Help all staff to unlock their potential

EXECUTIVE LEAD: CHIEF PEOPLE OFFICER

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

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

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



Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

- ~~Operational pressures impacting the release of staff to undertake their key training requirements~~
- ~~Low staff engagement and satisfaction levels 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.~~
- ~~Poor management and provision of health and wellbeing support to staff, leading to an increase in sickness absence rates.~~
- Poor provision of health and wellbeing support to staff, leading to an increase in sickness absence rates.
- Low staff engagement and satisfaction levels, resulting in low recruitment and retention of staff with the right skills and values

KPIs / Measures

- Continue to achieve and sustain an appraisal rate of 85% and deliver a year-on-year improvement in the % reporting that their appraisal helps them to perform their role
- ~~Overall Trust vacancy rate lower than 4% by 2025~~
- To achieve compulsory training rates of 95% or greater
- 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
- Year-on-year improvement in % staff with protective characteristics reflective of the population we serve.

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 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)
- ~~Resourcing and Talent reports to PC~~
- ~~Divisional People Committees reports to People Committee~~

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
- ~~Equality Delivery System (EDS) 2022~~
- ~~ICB EDI contract monitoring~~
- Report and attendance at Bolton Locality Workforce Group

Actions

1. Agile Working Action plan in place overseen by the agile working group including review of the Policy, roll out plan for equipment and risk assessments. **Target Completion Date: March 2026** **Sep 25 Update**: Ongoing with regular reviews
2. Review of Trust Well Being offer and financial well-being in light of cost of living pressures and national issues on pay. **Ongoing Target Completion Date: March 2026** **Sep 25 Update**: Ongoing with regular review
3. Our Voice Programme commenced with regular reports to People Committee and Executive Directors Group on a bi-monthly basis. **Target Completion Date: March 2026** **Sep 25 Update**: Ongoing with regular reviews
4. Regular meeting and expansion of Community voices group. **Target Completion Date: March 2026** **Sep 25 Update**: Ongoing with regular review
5. Reset Programme launches end of September / early October to support high levels of organisational change
6. Refreshed EDI Assurance Committee established in Quarter 1. Ongoing review
7. Refreshed presentation of EDI to People Committee to provide more helicopter position in Quarter 1, Ongoing review

Gaps in Control

Gaps in Assurance

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

Committee Feedback

The People Committee received the updated BAF at the September 2025 meeting. As a result of a review of the Corporate Risk Register, the following risks has now been added following approval at RMG.

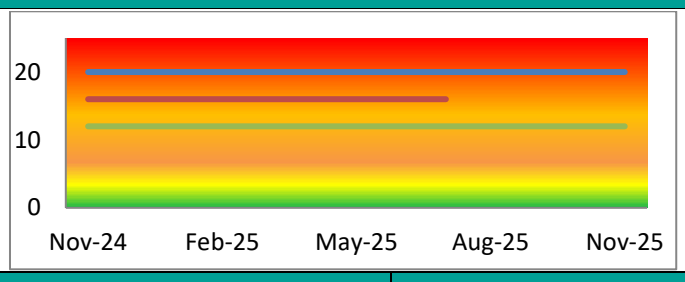
6498 (16) Changes to Additional Clinical Activity Pay (Locum bank rates) for Resident and SAS Doctors

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

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

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

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



Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

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

KPIs / Measures

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

Controls

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

Assurances

1st line of Defence (Operational management)

- Staff Survey (quarterly and annually)
- WRES and WDES (quarterly and annually)
- EDI Assurance Committee
- Staff Experience Inclusion Steering Group
- ~~Report and monitoring of EDS standards at Equality Diversity and Inclusion Steering Group~~
- ~~Reports to Staff Experience Inclusion Steering Group~~
- ~~Reports to Workforce and OD Group~~

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

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

3rd Line of Defence (Independent or external assurance)

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

Actions

1) Regular meeting and expansion of Community voices group. **Target Completion Date: March 2026**
Sep 25 Update: Ongoing with regular reviews
2) EDI Plan to be revised and complement the existing People Plan. **Revised Target Completion Date March 2026**
Sep 25 Update: Ongoing with regular review
3) Refreshed EDI Assurance Committee established in Quarter 1. Ongoing review
4) Refreshed presentation of EDI to People Committee to provide more helicopter position in Quarter 1, Ongoing review

Gaps in Control

Revised EDI Action Plan

Gaps in Assurance

Committee Feedback

The People Committee received the updated BAF at the September 2025 meeting. As a result of a review of the Corporate Risk Register, the following risks has now been added following approval at RMG.

6498 (16) Changes to Additional Clinical Activity Pay (Locum bank rates) for Resident and SAS Doctors

AMBITION 3: A HIGH PERFORMING, PRODUCTIVE ORGANISATION
PRINCIPAL RISK: IF THE TRUST DOES NOT OPTIMISE PROCESSES OR ADHERE TO STANDARDS THEN THIS MAY HARM SERVICE PRODUCTIVITY AND EFFICIENCY, LEADING TO REGULATORY ACTION AND FINANCIAL INSTABILITY.
Lead Committee: Finance and Investment Committee
Lead Directors: Chief Finance Officer and Chief Operating Officer

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

Corporate Objective		Principal Risk	Risk Appetite	Risk Rating	Exec Lead	Lead Commitee	Trend Analysis
Ambition 4: An organisation that's fit for the future							
CO7	Improving accesses to our services	If the Trust does not deliver reliable compliance of the operational standards, then this may result in regulatory action.	Minimal	16 4x4	COO	Finance and Investment Committee	⇔
CO8	Being Efficient and Productive	If the Trust does not optimise its processes, this could negatively impact productivity and efficiency, resulting in unsustainable services	Cautious	16 4x4	CFO/ COO	Finance and Investment Committee	⇔
CO9	Delivering Financial Sustainability	If the Trust does not deliver its Financial Plan, then it will fail to meet its financial objectives, which could negatively affect the Trust's long-term financial sustainability.	Minimal	20 4x5	CFO	Finance and Investment Committee	↑

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

Current risks rating 15+ aligned with Ambition 3 - **A High Performing, Productive Organisation**

Severity Likelihood		1.Rare	2. Minor	3. Moderate	4. Major	5. Catastrophic
1	Rare					695
2	Unlikely					
3	Possible					6145
4	Likely				5245 6193 6540 6541 6542 6543	6537 6539
5	Certain					

CO7: Improving access to our services

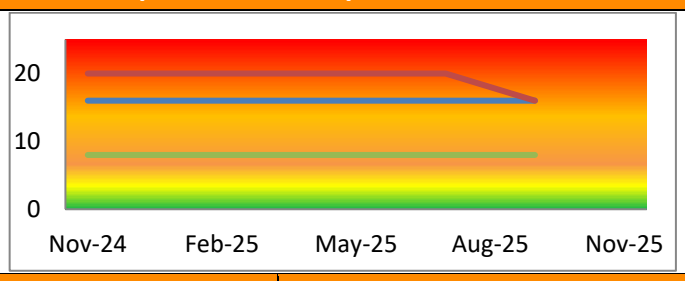
EXECUTIVE LEAD: CHIEF OPERATING OFFICER

Risk Appetite: **MINIMAL**

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

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

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



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 diagnostic capacity within cancer pathways~~
- 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

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
- Escalation Policy, Access Policy and Discharge Policy now refreshed and implemented
- Urgent care assurance meeting with GM
- Tier 2 meetings with the regional team about elective care delivery.
- Support from the Elective Care Improvement Team (ECIST)
- Support from the Emergency Care Intensive Support Team (ECIST)

Assurances

1st line of Defence (Operational management)

- Monthly Integrated Performance Management (IPM) meetings to review performance data
- Divisional Risk Registers at RMC
- Review of assurance programmes at Performance & Transformation Group ~~Board~~
- 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 Sep 25: On track and ongoing
2. Development of a workplan following conclusion of the Internal Audit review of waiting list management. **(Target Completion Date December 2025)**
   Update Sep 25: On track and ongoing
3. Full Implementation of actions following the ECIST review for both Emergency and Elective Care. **(Target Completion Date March 2026)**
   Update Sep 25: Action is progressing and on track
4. Development of productivity tracker to monitor efficiencies. **(Target Completion Date March 2026)**
   Update Sep 25: Ontrack and ongoing

Gaps in Control

Lack of monitoring of the effectiveness of policies

Weak monitoring of the implementation of ward SAFER principles

Lack of a robust Capacity & Demand planning cycle

Gaps in Assurance

Committee Feedback

The Board approved the the **MINIMAL** Risk Appetite Statement and approved the decrease in Likelihood to 4

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

CO.8 - Being efficient and productive

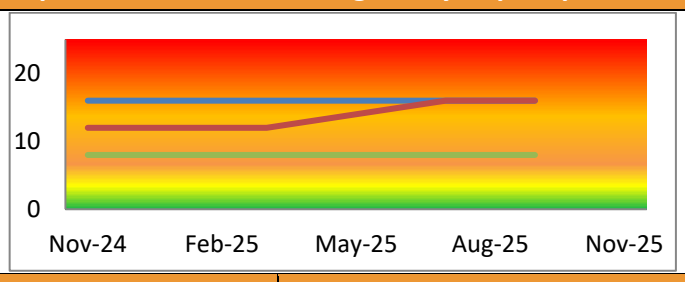
EXECUTIVE LEAD: CHIEF FINANCE OFFICER AND CHIEF OPERATING OFFICER

Risk Appetite: **CAUTIOUS**

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

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

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	4	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

Controls

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

Assurances

1st line of Defence (Operational management)

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

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

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

3rd Line of Defence (Independent or external assurance)

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

Actions

1. Use of patient-level costing and income reporting at Divisional level benchmarking. **Target Completion Date: Q2 2025/26**
   Update Sep 25: Action Progressing
2. Understand impact of contract reconciliation work and implications of the 10 year plan. **Target Completion Date: Q3 2025/26**
   Update Sep 25: Action Progressing
3. Improved activity and income reporting **Target Completion Date: Q3 2025/26**
   Update Sep 25: Action Progressing
4. A review of income and contract performance due to national funding pressures**. Target Completion Date: Q3 2025**
   Update Sep 25: Action Progressing

Gaps in Control

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

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

Gaps in Assurance

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

Committee Feedback

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

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

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

CO.9: Delivering Financial Sustainability

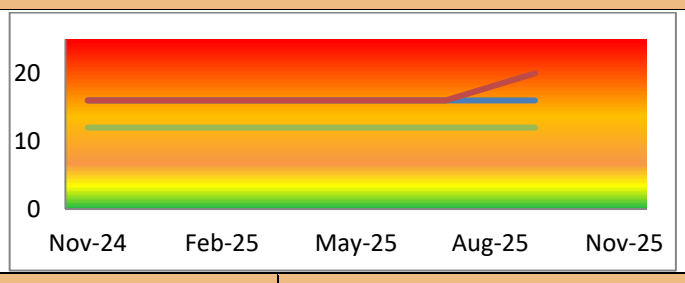
EXECUTIVE LEAD: CHIEF FINANCE OFFICER

Risk Appetite: MINIMAL

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

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

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



Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

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

KPIs / Measures

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

Controls

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

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**
   Update Sep 25: Action Progressing
2. Clarity on GM Financial Strategy **Ongoing to be reviewed**
   Update Sep 25: Action Progressing
3. Expanded use of Model Hospital benchmarking reporting. **Target Completion Q.4 2025**
   Update Sep 25: Action Progressing
4. Implement the outcome of the Drivers of Deficit Financial improvement work and resulting Action Plan. **Target Completion Q3 2025**
   Update Sep 25: Action Progressing

Gaps in Control

- GM ICB overarching strategy

Gaps in Assurance

- Model Hospital benchmarking reporting to F&I Committee

Committee Feedback

The Board approved the **MINIMAL** Risk Appetite Statement.

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

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

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

Corporate Objective		Principal Risk	Risk Appetite	Risk Rating	Exec Lead	Lead Commitee	Trend Analysis
Ambition 4: An organisation that's fit for the future							
CO10	Being digitally enabled and inclusive	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	⇔
CO10a	Cyber Security	If the Trust experiences a cyber-attack and lacks effective defences and recovery plans, Then it may face serious disruption to patient care, data security, and regulatory compliance, with prolonged downtime and delayed recovery**.**	Avoid	**16** 4 x 4	CSP	Finance & Investment Committee	⇔
CO11	Improving our estate	If the Trust does not provide compliant and reliable premises and supporting infrastructure then personal safety and business effectiveness will be compromised resulting in potential harm, service disruption and potential statutory breach.	Avoid	**20** 4 x 5	CFO	Finance & Investment Committee	⇔
CO12	Proactively planning for the future	If the Trust fails to proactively plan for the future, it will negatively affect service provision and hinder the overall achievement of the Strategy	Minimal	**16** 4 x 4	CFO	Finance & Investment Committee	⇔

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

Current risks rating 15+ aligned with Ambition 4 - **An Organisation That Is Fit For The Future**

Severity Likelihood		1.Rare	2. Minor	3. Moderate	4. Major	5. Catastrophic
1	Rare					
2	Unlikely					
3	Possible					6009 5747 5929
4	Likely				3194 5926 6245	
5	Certain			6491 6428 6145		5869

CO.10a - Being digitally enabled and inclusive

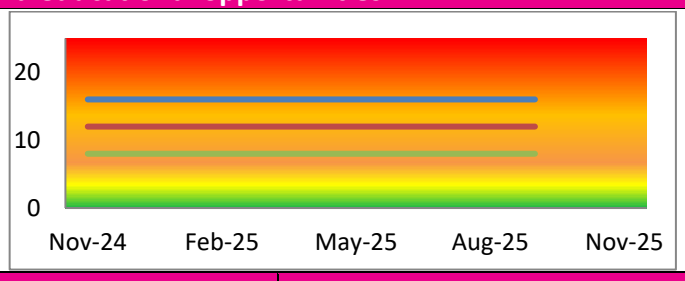
EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS

Risk Appetite: **MINIMAL**

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

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

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



Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

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

KPIs / Measures

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

Controls

- Board approved Digital Plan
- Lead Bolton Borough wider Partnership
- Digital Performance and Transformation Board
- Digital Maturity Matrix
- Data Protection Toolkit Annual assessment
- External and Internal Audit reports
- 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)

Assurances

1st line of Defence (Operational management)

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

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

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

3rd Line of Defence (Independent or external assurance)

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

Actions

1. Refresh Digital Strategy – **Target Completion Date: March 2026**
   Update Sep 25: Action progressing
2. System for staff feedback – **Target Completion Date: March 2025**
   July 25 update: Complete
   Update Sep 25: Quarterly survey in place. Action plan and you said we did to be put in place
3. Digital and Data capacity and demand assessment by internal audit - **Target Completion Date: March 2026**
   Update Sep 25: Action progressing
4. Maternity EPR Rollout – **Target Completion Date: March 2026**
   Update Sep 25: Action progressing
5. ~~Community and OPD Rollout - **Completed: July 2025**~~
6. Laboratory Information Management System (LIMs) roll out – **August 2026**
   Update Sep 25: Action progressing
7. Digital Strategy refresh**. Target Completion Date: March 2026**
   Update Sep 25: Action progressing

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).
- Laboratory Information Management System software system used to manage and track laboratory samples, associated data, and laboratory workflows.

Gaps in Assurance

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

Committee Feedback

The F&I Committee received the BAF and

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

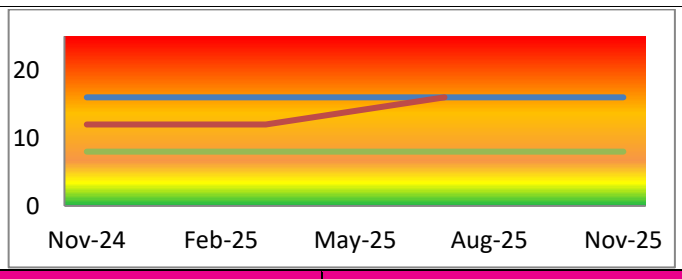
A review of the current Risk Score of 12 has been initiated to confirm its continued relevance and effectiveness. This will ensure the score accurately reflects the current risk environment, aligns with the organisation's risk appetite, and informs appropriate mitigation and decision-making.

There are no other proposed changes

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

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

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	4	4	2
Risk Score	16	16	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
- Investment for the right technology to allow an effective recovery time

KPIs / Measures

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

Controls

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

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)

- Reports to GM Provider Oversight Meeting (POM)
- GM Provider Oversight Meetings
- Model Hospital benchmarking reporting to F&I Committee
- PLICs reporting
- Independent assurance reports from Internal and external audit reviews
- DSPT external audit to Audit & Risk committee

Actions

1. Review of digital team responsibilities to put a dedicated Cyber security role in place. **Target Completion Nov 2025**
   Update Sep 25: Action progressing
2. Cyber Sub Group to be established with the needed representation from divisions **Target Completion Nov 2025**
   Update Sep 25: Action progressing
3. Complete the recommendations from the Toolkit submission and MIAA report **Target Completion Nov 2025**
   Update Sep 25: Action progressing
4. Review Cyber risks on the corporate risk register and BAF following the go live of Community and Outpatient EPR and national escalation in Cyber Incidents – **August 2025**
   Update Sep 25: Action progressing
5. Penetration test recommendation to be prioritised and actioned by Digital Services. Target Completion march 2026.
   Update Sep 25: Action progressing

Gaps in Control

Completion of the recommendations from the cyber security review

Completion and implementation of the recommendations from the IT Disaster Recovery Review

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

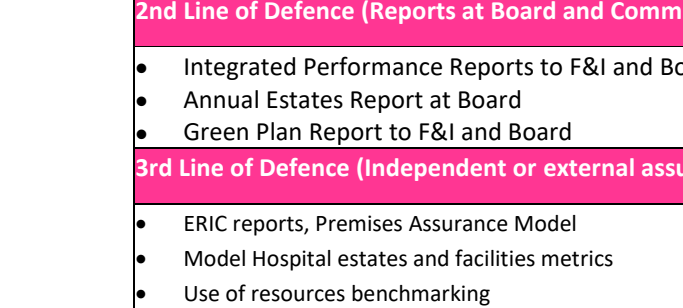
Committee Feedback

The F&I Committee reviewed the Risk Score, Controls, Assurance, and the identified gaps in both Control and Assurance. It also considered the actions currently in place to address these gaps. No further changes were proposed at this stage, and the Committee was satisfied that the framework continues to reflect the organisation's current risk posture and mitigation efforts

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

STRATEGIC RISK 11: If the Trust 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
5926 (16) Site-wide building management system upgrade
6145 (15) Maternity Theatres ventilation failures
5929 (15) Site wide roofing repairs

Issues impacting achievements of our objective

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

KPIs / Measures

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

Controls

- Estates Strategy and supporting Business Cases to make the case for external capital to CRIG, F&I, Board
- Established links to GM and NHSE
- Capital processes to ensure correct prioritisation
- Links with local partners including LA, University
- Membership of Bolton Strategic Estates Group
- Premises Assurance Model
- Enterprise Asset Management CAFM
- 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. **Target Completion Date**: **December 2025**
2. Monitor and manage the aging estate and escalate urgent issues with the estates. **Target Completion Date: December 2025**
3. Review and formalisation of Strategic Estates Group to F&I. **Target Completion Date: Q3 2025**

Gaps in Control

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

Gaps in Assurance

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

Committee Feedback

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

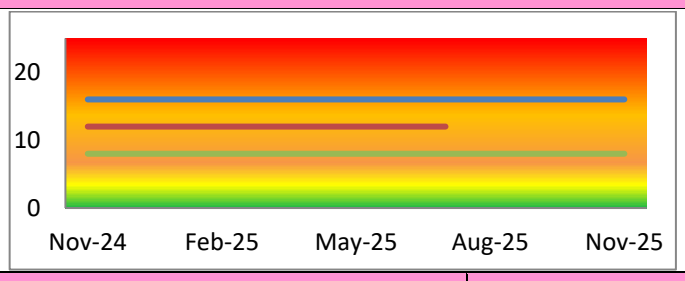
No further changes were proposed at this stage, and the Committee was satisfied that the framework continues to reflect the organisation's current risk posture and mitigation efforts

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

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

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

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



Link to Risks on Corporate Risk Register

6245 (16) Elective Care microscope obsolescence issued

Issues impacting achievements of our objective

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

KPIs / Measures

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

Controls

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

Assurances

1st line of Defence (Operational management)

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

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

Reports to F&I Board

3rd Line of Defence (Independent or external assurance)

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

Actions

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

Gaps in Control

Pay and non pay controls require further enhancement

Gaps in Assurance

- Model Hospital benchmarking reporting to F&I Committee
-

Committee Feedback

The F&I Committee received the updated BAF at the July 2025 meeting. As part of its review, the Committee examined the Risk Score, Controls, Assurance, and the identified gaps in both Control and Assurance. It also considered the actions currently in place to address these gaps.

There are no other proposed changes

AMBITION 5: A POSITIVE PARTNER

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

Lead Committee: Executive Committee through Trust Management Committee

Lead Director: Chief of Strategy and Partnerships

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

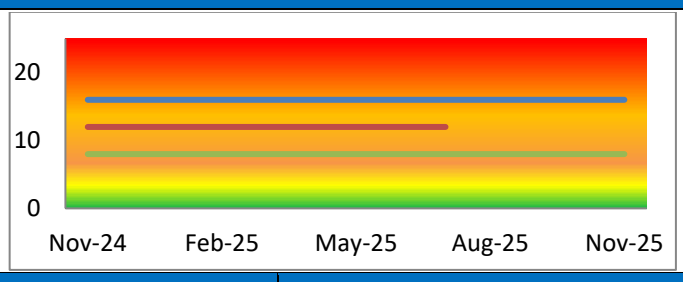
CO13: Developing our neighbourhoods

EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS

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

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

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



Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

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

KPIs / Measures

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

Controls

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

Assurances

1st line of Defence (Operational management)

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

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

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

3rd Line of Defence (Independent or external assurance)

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

Actions

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

Gaps in Control

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

Gaps in Assurance

Committee Feedback

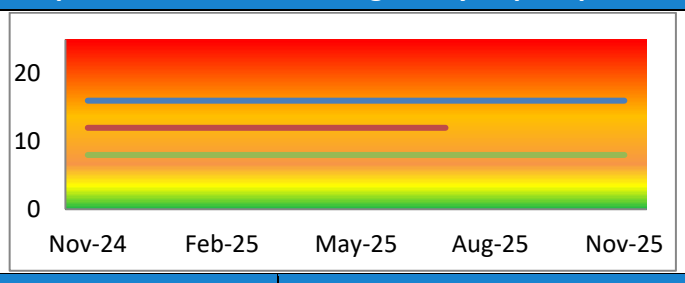
The Board reviewed the BAF and accepted the change in risk appetite to OPEN from SEEK and acknowledged this will be further reviewed after the follow-on session in December 25.

There were no further changes requested December 2024.

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

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

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



Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

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

KPIs / Measures

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

Controls

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

Assurances

1st line of Defence (Operational management)

Deputy Place Based Lead attendance monthly at Executive Directors

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

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

3rd Line of Defence (Independent or external assurance)

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

Actions

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

Gaps in Control

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

Gaps in Assurance

Committee Feedback

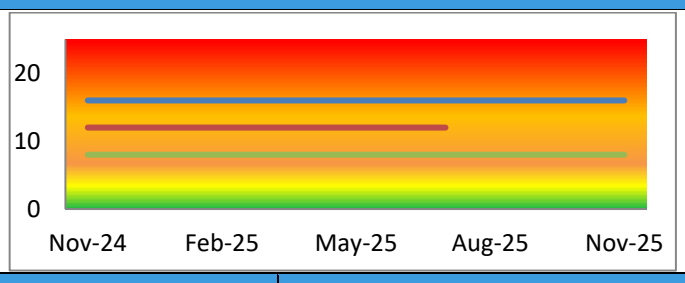
The Board reviewed the BAF and accepted the change in risk appetite to OPEN from SEEK and acknowledged this will be further reviewed after the follow-on session in December 25.

There were no further changes requested

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

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

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



Link to Risks on Corporate Risk Register

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

Issues impacting achievements of our objective

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

KPIs / Measures

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

Controls

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

Assurances

1st line of Defence (Operational management)

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

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

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

3rd Line of Defence (Independent or external assurance)

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

Actions

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

Gaps in Control

Substantive membership and participation in service transformation programmes within GM.

Development of Local pathology, radiology and pharmacy clinical service strategies

Gaps in Assurance

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

Committee Feedback

The Board reviewed the BAF and accepted the change in risk appetite to MINIMAL from SEEK and acknowledged this will be further reviewed after the follow-on session in December 25.

There were no further changes requested.

Report Title:	Integrated Performance Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	25 September 2025		Discussion	✓
Executive Sponsor	Deputy Chief Executive and Chief People Officer		Decision	

Purpose of the report	To present the Month 5 Integrated Performance Report

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

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

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

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

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

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

Bolton NHS Foundation Trust

Integrated Performance Report

August 2025

Guide to Statistical Process Control

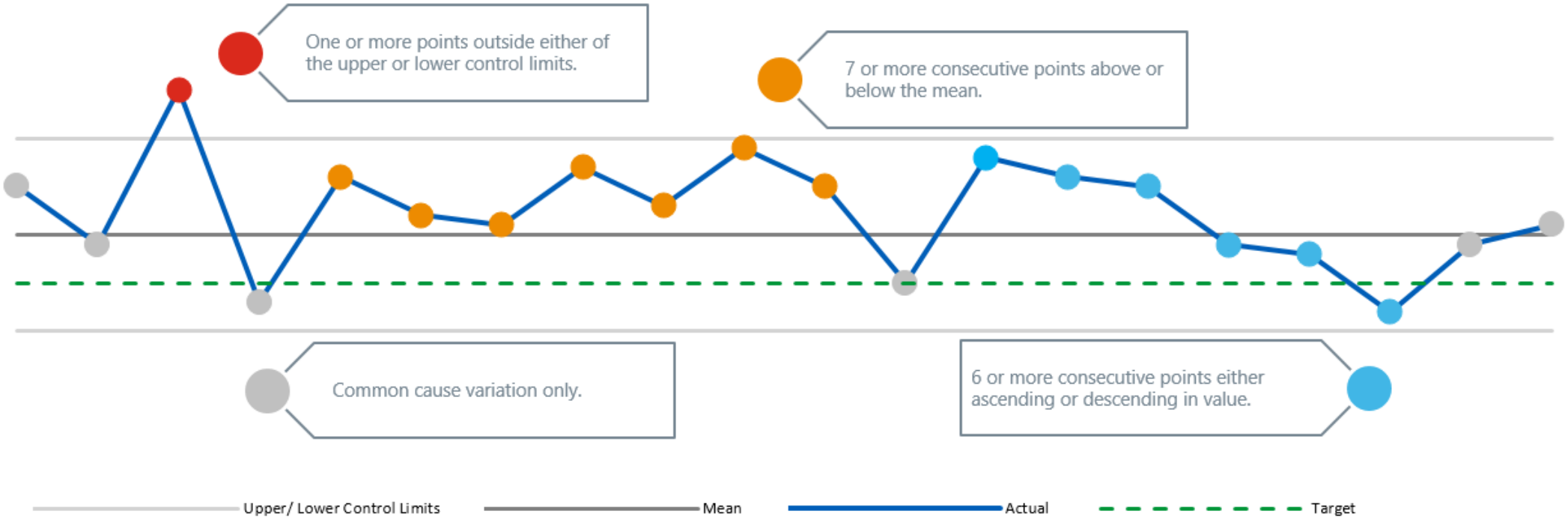
Bolton
NHS Foundation Trust

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

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

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

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



Executive Summary

NHS Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
	Common	H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	12	2	3	0	2	1	3	12
Infection Prevention and Control	10	0	0	0	0	0	0	7
Mortality	5	2	1	0	0	0	0	3
Patient Experience	16	0	0	0	0	2	0	14
Maternity	10	0	0	0	0	1	0	8
Operational Performance								
Urgent Care	8	2	2	0	1	2	6	5
Elective Care	7	0	5	1	2	2	6	4
Cancer	2	1	0	0	0	0	0	3
Community Care	3	3	2	0	0	0	2	6
Workforce								
Sickness, Vacancy and Turnover	2	0	2	0	0	0	2	1
Organisational Development	1	3	0	0	2	1	2	3
Agency	0	0	2	1	0	0	0	0
Finance								
Finance	2	0	0	0	1	0	0	0
Appendices								
Heat Maps								

Variation

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

Assurance

P	We can be confident in consistantly meeting the required level of performance for this KPI.
F	Indicates that we should not expect to achieve the required level of performance for this KPI.
?	We cannot be confident in consistently achieving the required level of performance as the target is within the range of common cause variation.

Performance

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

Quality and Safety - Harm Free Care

NHS Bolton NHS Foundation Trust

During the reporting period, Category 2 and 3 pressure ulcers across both inpatient and community settings remained within common cause variation. However, learning from recent incidents has highlighted key areas for improvement in both practice and documentation.
Hospital-acquired pressure ulcers included 12 Category 2 cases (across Medicine, Surgery, and Family Care & Diagnostics) and 5 Category 3 cases (Medicine and Surgery).
Device-related factors contributed to 2 Category 3 and 1 Category 2 cases.

Learning from incidents and alignment with the Pressure Ulcer change package.
Change 2: Managing and Mitigating Risk – Regular Repositioning
Learning has highlighted the importance of embedding repositioning practices into daily routines. Aspects of Change Package 2 are being implemented, including the use of safety huddles to identify patients at higher risk and the introduction of a daily repositioning champion to support regular mobilisation and repositioning.
An audit will be undertaken in M9 to assess how reliably these practices have been embedded and to identify opportunities for wider adoption across clinical areas.
Change 3: Pressure Relieving Equipment and Devices
Improvements have been noted in the use of appropriate equipment tailored to specific risk areas, including heel offloading and spinal protection.
Change 6: Engaging Patients in Pressure Ulcer Prevention
Divisional reviews have shown strengthened engagement with patients and carers, with a focus on early identification of deterioration and timely escalation.

Reliability audit
A Trust-wide audit will be conducted across inpatient clinical areas to assess the consistent application of the Pressure Ulcer Change Package. Staff will be asked a set of reliability questions, including an additional item under Change 2 to determine whether repositioning is supported by a standardised schedule or trigger. Responses will be anonymous and analysed centrally to inform future improvement actions.

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

Falls
Inpatient falls per 1000 bed days remains within common cause variation. There were 0 falls with harm in the reporting period. Progress on improvement measures continues to be monitored through the Patient Safety Committee which seeks assurance that learning from incidents and necessary actions have been embedded into clinical practice.

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

Patient Safety Alert
One patient safety alert is overdue. The Surgery Division have reviewed the alert however evidence of this alert being actioned is awaited. As per guidance from Procurement this alert cannot be closed without evidence of action as it relates to a patient facing product

Patient Safety Incident Investigation turnaround performance by agreed deadline
In Month 5 there was one PSII report scheduled for sign off from Family & Diagnostics Division. This was not approved within the 60 day approval deadline as the report was initially submitted late and on review by divisional team required additional details. A new sign off panel date has been rescheduled for 19/09/25.

There are currently five further PSII's in progress and on track.

	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%	93.6%	Aug-25		>= 95%	96.7%	Jul-25	>= 95%	95.8%	
9 - Never Events	= 0	0	Aug-25		= 0	1	Jul-25	= 0	1	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	4.03	Aug-25		<= 5.30	4.46	Jul-25	<= 5.30	4.11	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	0	Aug-25		<= 1.6	2	Jul-25	<= 8.0	7	
15 - Number of Acute Inpatient incidences - pressure damage (category 2)	<= 6.0	14.0	Aug-25		<= 6.0	5.0	Jul-25	<= 30.0	52.0	
620 - Number of Acute Inpatient incidences - pressure damage (category 3 plus unstageables)	<= 1	5	Aug-25		<= 1	2	Jul-25	<= 3	21	
17 - Number of Acute Inpatient incidences - pressure damage (category 4)	= 0.0	0.0	Aug-25		= 0.0	0.0	Jul-25	= 0.0	0.0	
18 - Number of Community incidences - pressure damage (category 2)	<= 7.0	17.0	Aug-25		<= 7.0	7.0	Jul-25	<= 35.0	58.0	
621 - Number of Community incidences - pressure damage (category 3 plus unstageables)	<= 4	7	Aug-25		<= 4	14	Jul-25	<= 20	45	
20 - Number of Community incidences - pressure damage (category 4)	<= 1.0	0.0	Aug-25		<= 1.0	2.0	Jul-25	<= 5.0	6.0	
535 - Community patients acquiring pressure damage - significant learning category 2		0	Aug-25			0	Jul-25		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Aug-25			0	Jul-25		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Aug-25			0	Jul-25		0	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	78.3%	Aug-25		>= 95%	76.3%	Jul-25	>= 95%	77.3%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	61.4%	Aug-25		>= 95.0%	64.3%	Jul-25	>= 95.0%	61.1%	

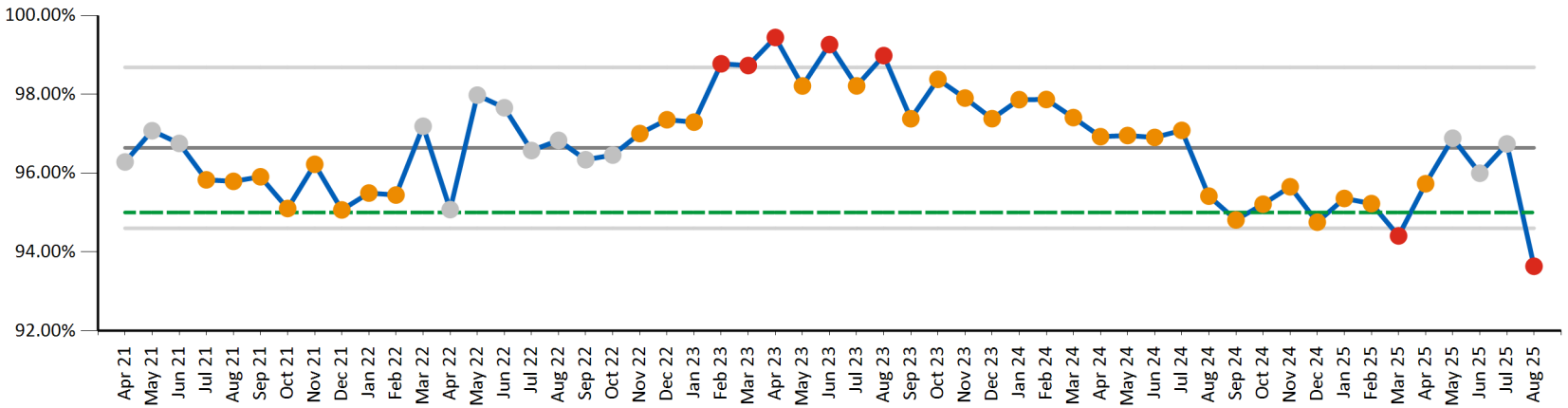
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
86 - Patient Safety Alerts - Trust position	= 100%	50.0%	Aug-25		= 100%	100.0%	Jul-25	= 100%	80.0%	
88 - Nursing KPI Audits	>= 85%	96.3%	Aug-25		>= 85%	96.3%	Jul-25	>= 85%	96.2%	
91 - Patient Safety Incident Investigation turnaround performance by agreed deadline	= 100%	0.0%	Aug-25		= 100%	0.0%	Jul-25	= 100%		
8 - Same sex accommodation breaches	= 0	17	Aug-25		= 0	13	Jul-25	= 0	59	

6 - Compliance with preventative measure for VTE

Special cause variation with deteriorating performance

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

4/6



Latest

Plan	Actual	Period
>= 95%	93.6%	Aug-25

Previous

Plan	Actual	Period
>= 95%	96.7%	Jul-25

Year to Date

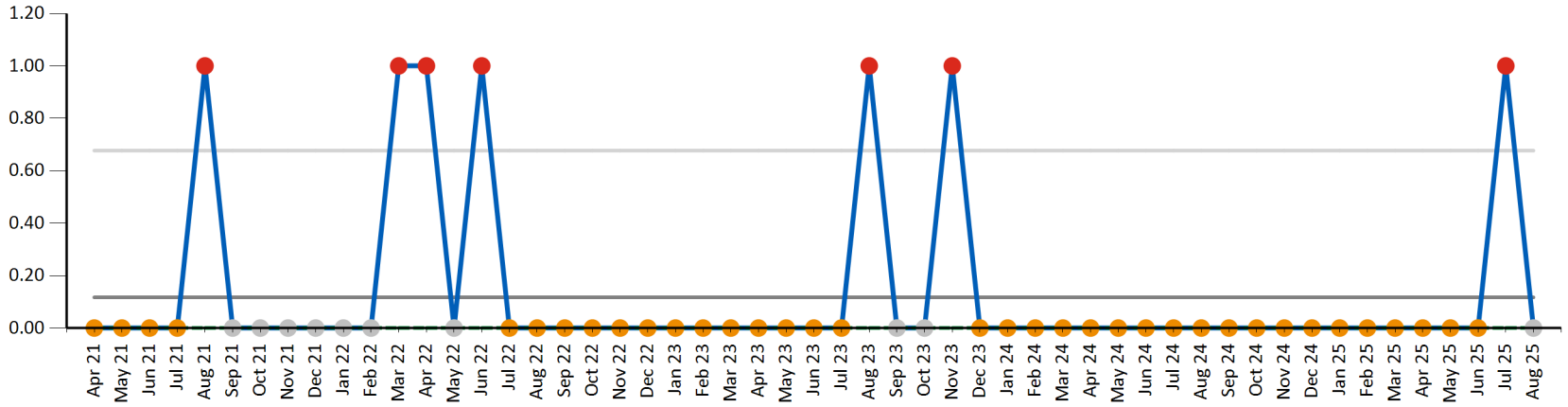
Plan	Actual
>= 95%	95.8%

9 - Never Events

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
= 0	0	Aug-25

Previous

Plan	Actual	Period
= 0	1	Jul-25

Year to Date

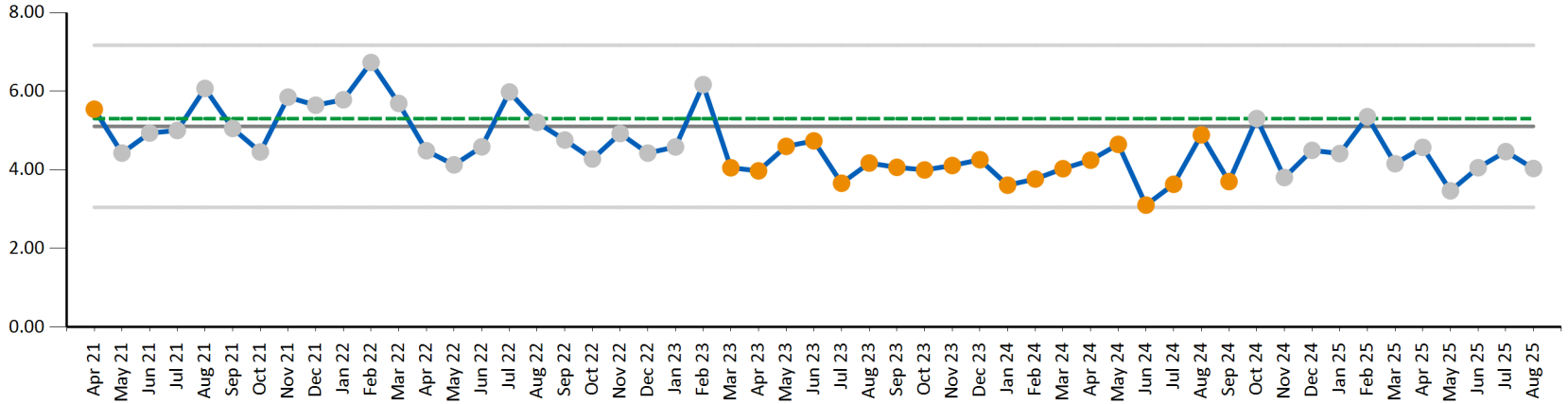
Plan	Actual
= 0	1

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

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 5.30	4.03	Aug-25

Previous

Plan	Actual	Period
<= 5.30	4.46	Jul-25

Year to Date

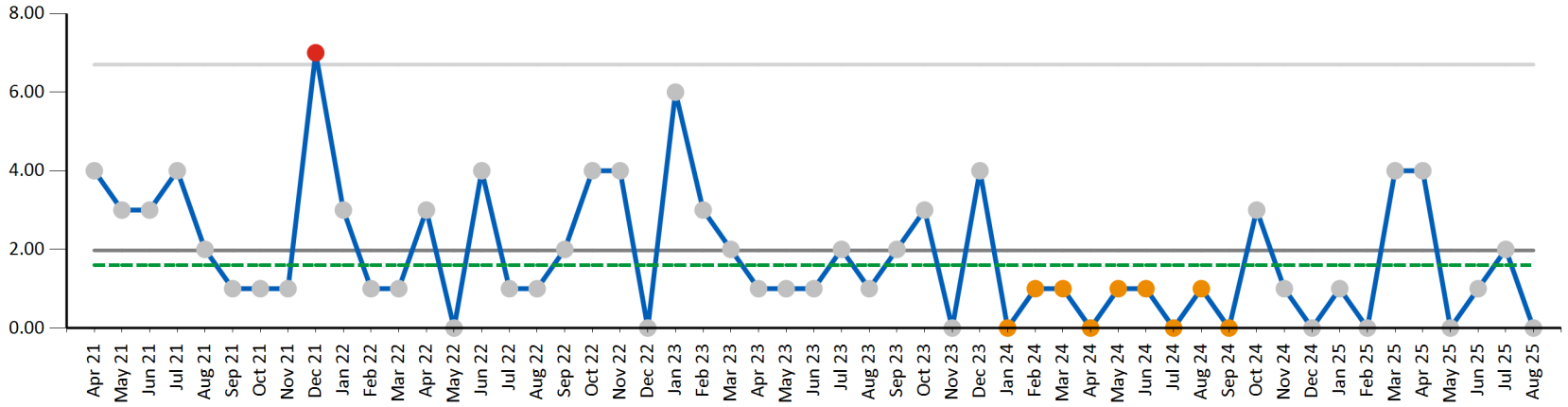
Plan	Actual
<= 5.30	4.11

14 - Inpatient falls resulting in Harm (Moderate +)

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 1.6	0	Aug-25

Previous

Plan	Actual	Period
<= 1.6	2	Jul-25

Year to Date

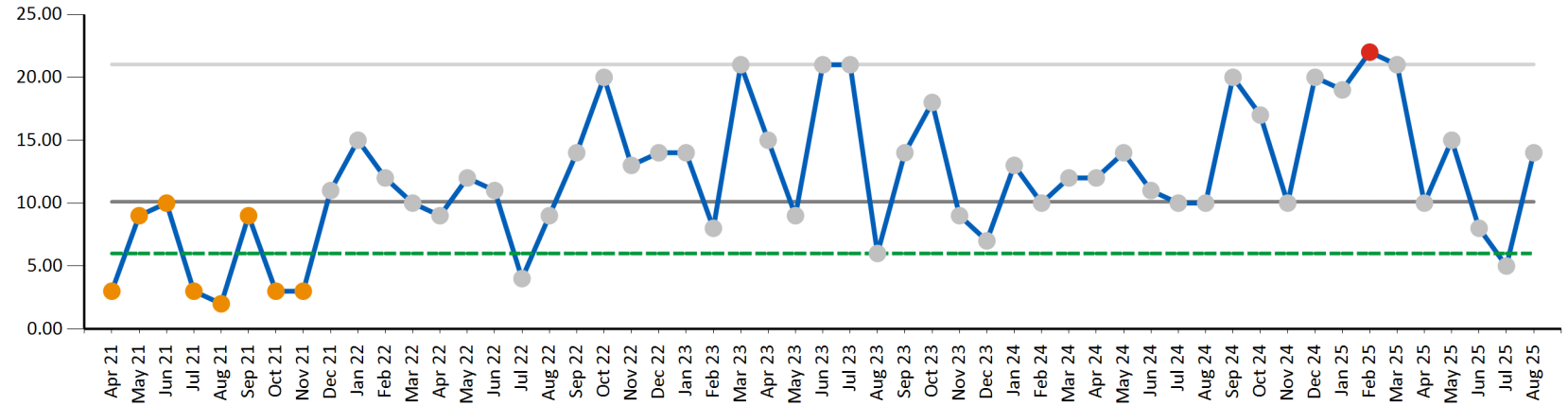
Plan	Actual
<= 8.0	7

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

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 6.0	14.0	Aug-25

Previous

Plan	Actual	Period
<= 6.0	5.0	Jul-25

Year to Date

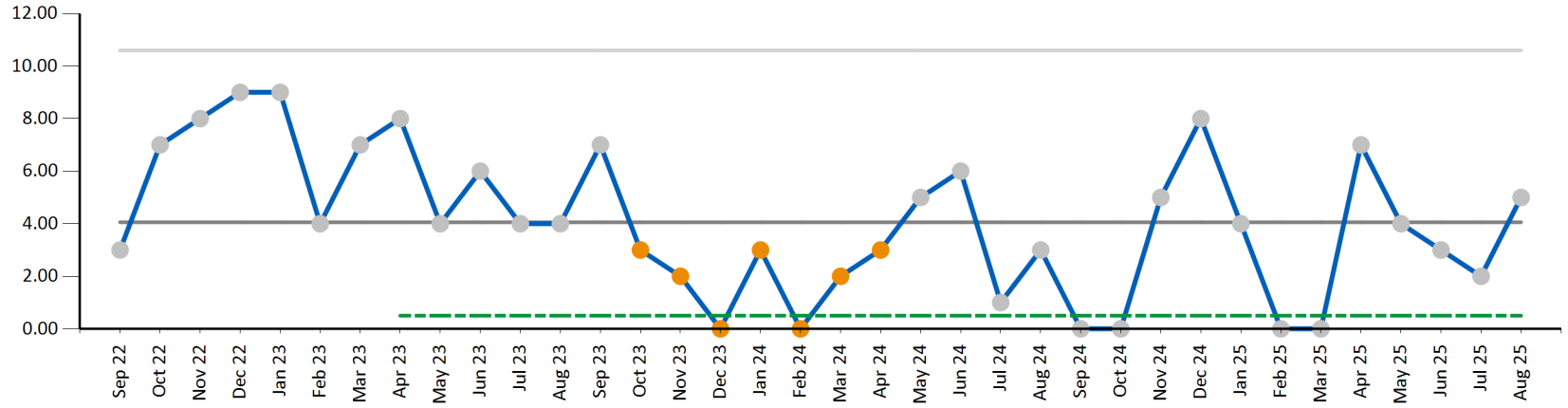
Plan	Actual
<= 30.0	52.0

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

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 1	5	Aug-25

Previous

Plan	Actual	Period
<= 1	2	Jul-25

Year to Date

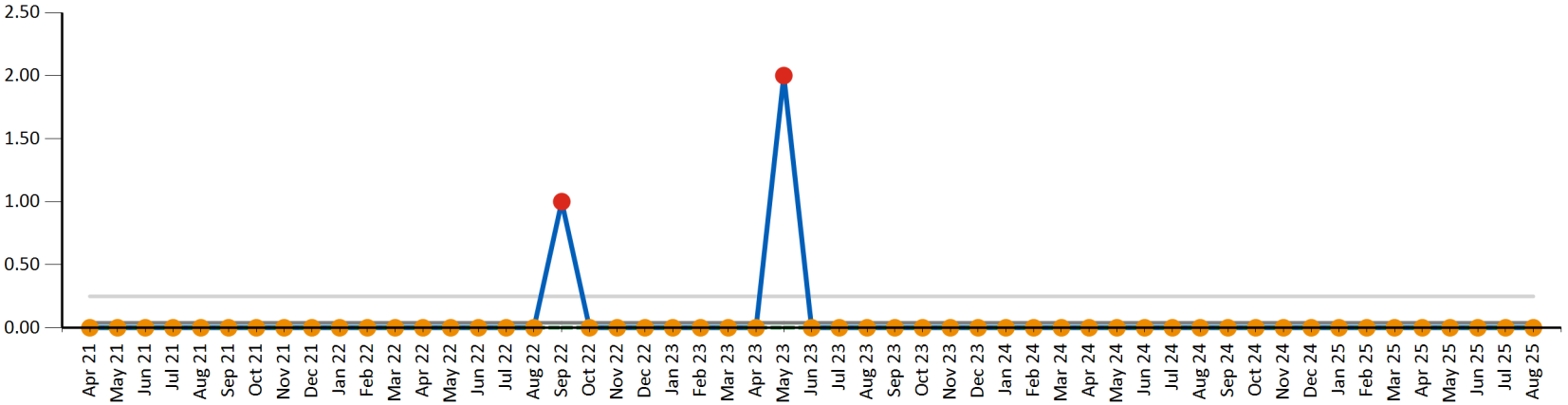
Plan	Actual
<= 3	21

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

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
= 0.0	0.0	Aug-25

Previous

Plan	Actual	Period
= 0.0	0.0	Jul-25

Year to Date

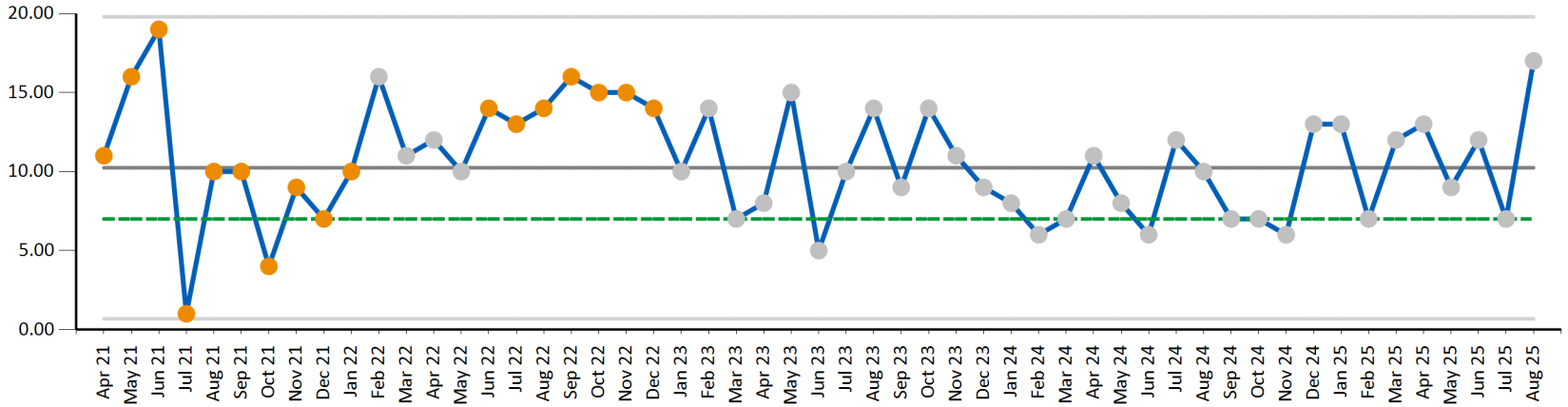
Plan	Actual
= 0.0	0.0

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

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 7.0	17.0	Aug-25

Previous

Plan	Actual	Period
<= 7.0	7.0	Jul-25

Year to Date

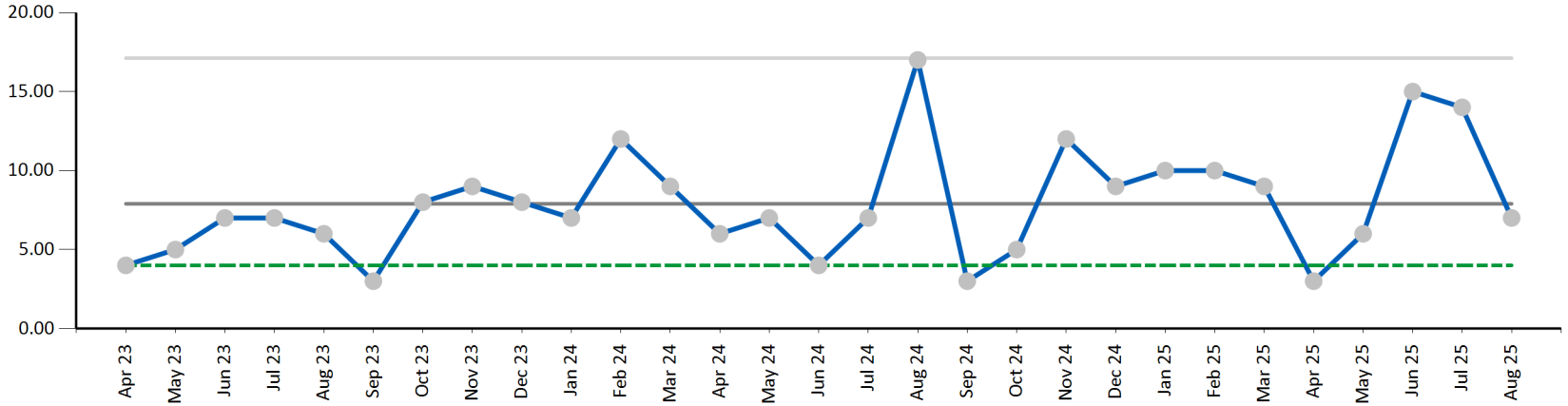
Plan	Actual
<= 35.0	58.0

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

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 4	7	Aug-25

Previous

Plan	Actual	Period
<= 4	14	Jul-25

Year to Date

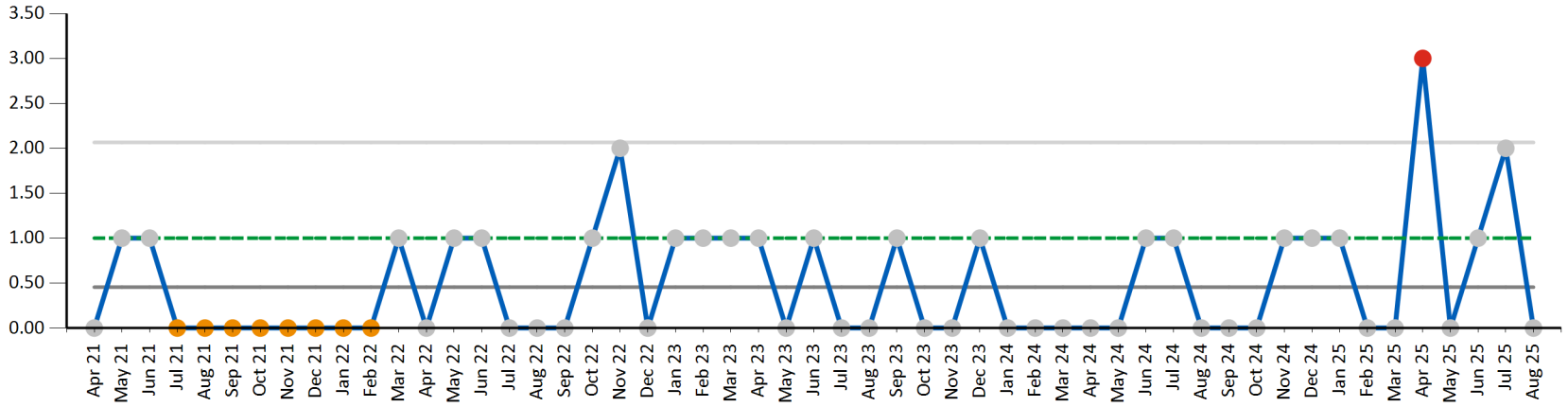
Plan	Actual
<= 20	45

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

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 1.0	0.0	Aug-25

Previous

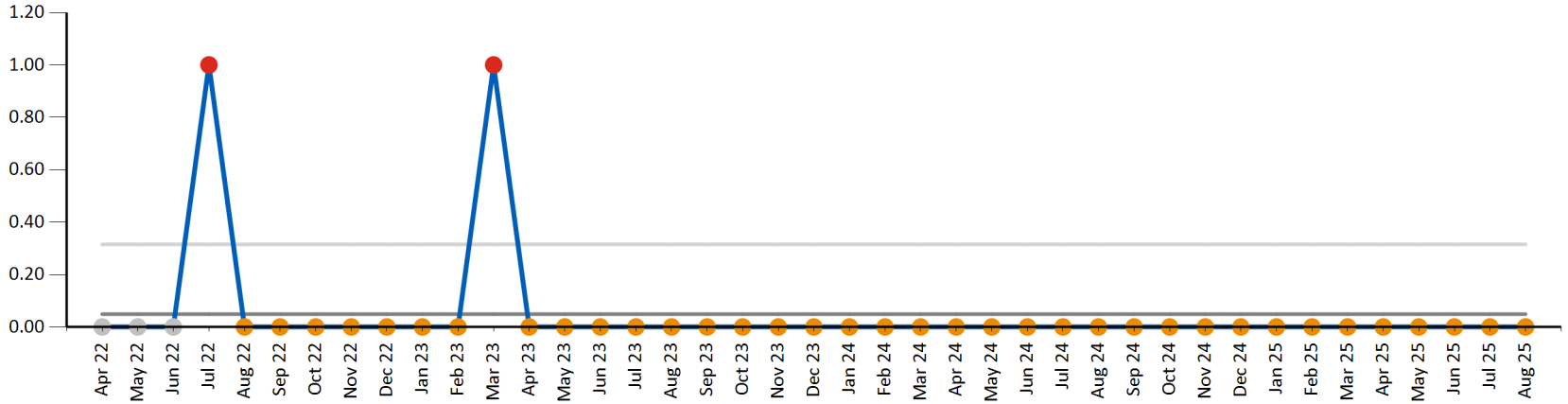
Plan	Actual	Period
<= 1.0	2.0	Jul-25

Year to Date

Plan	Actual
<= 5.0	6.0

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Aug-25

Previous

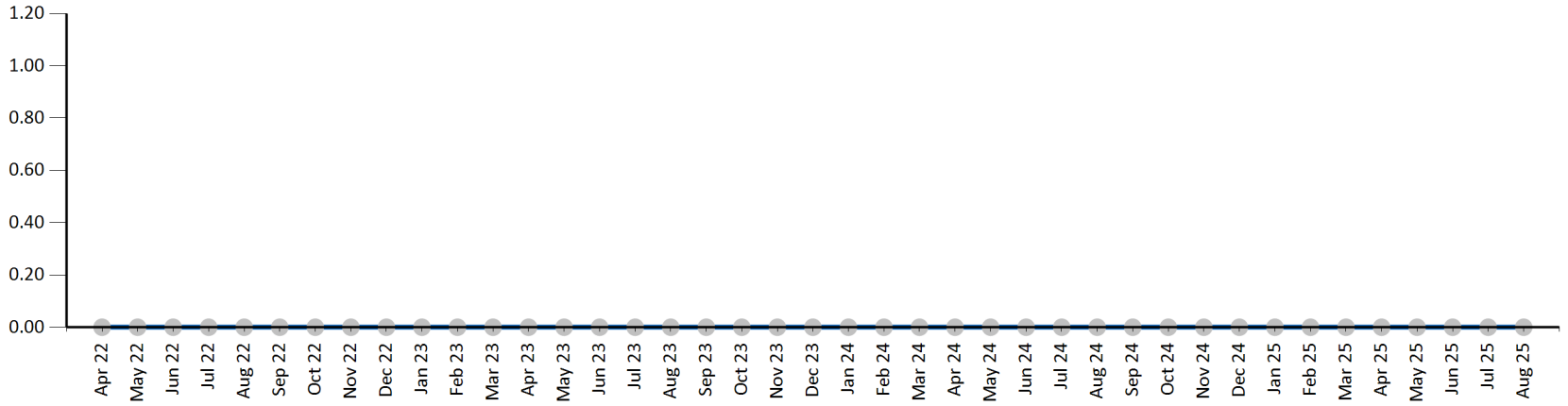
Plan	Actual	Period
	0	Jul-25

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Aug-25

Previous

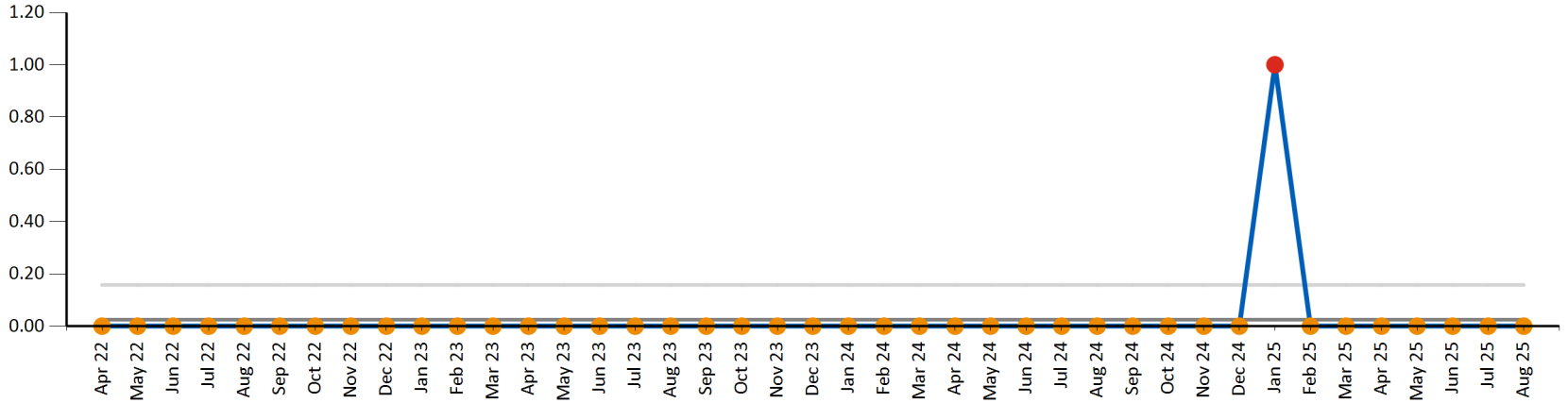
Plan	Actual	Period
	0	Jul-25

Year to Date

Plan	Actual
	0

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Aug-25

Previous

Plan	Actual	Period
	0	Jul-25

Year to Date

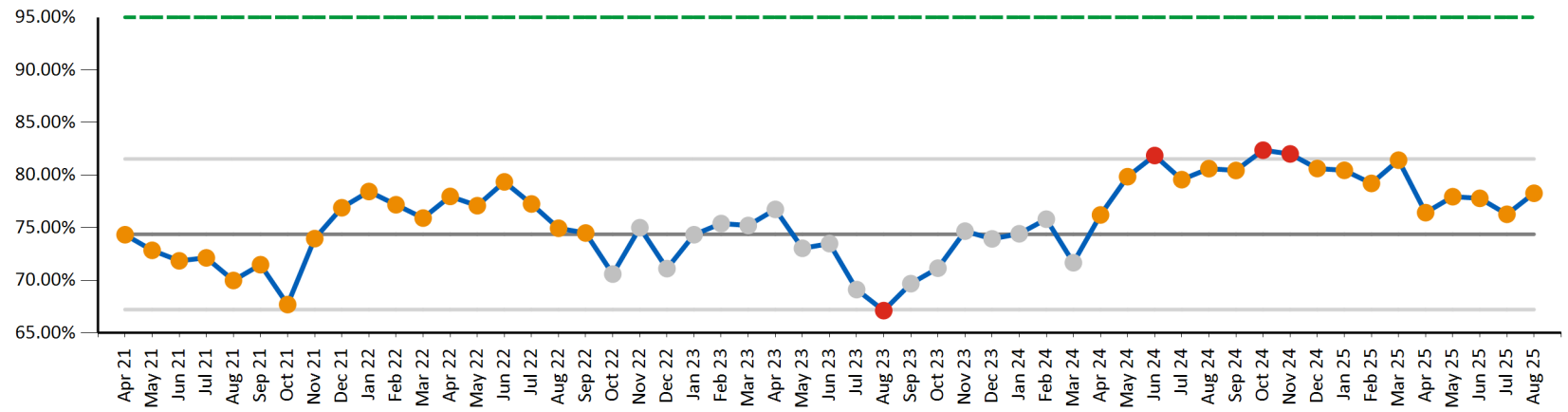
Plan	Actual
	0

30 - Clinical Correspondence - Inpatients %<1 working day

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	78.3%	Aug-25

Previous

Plan	Actual	Period
>= 95%	76.3%	Jul-25

Year to Date

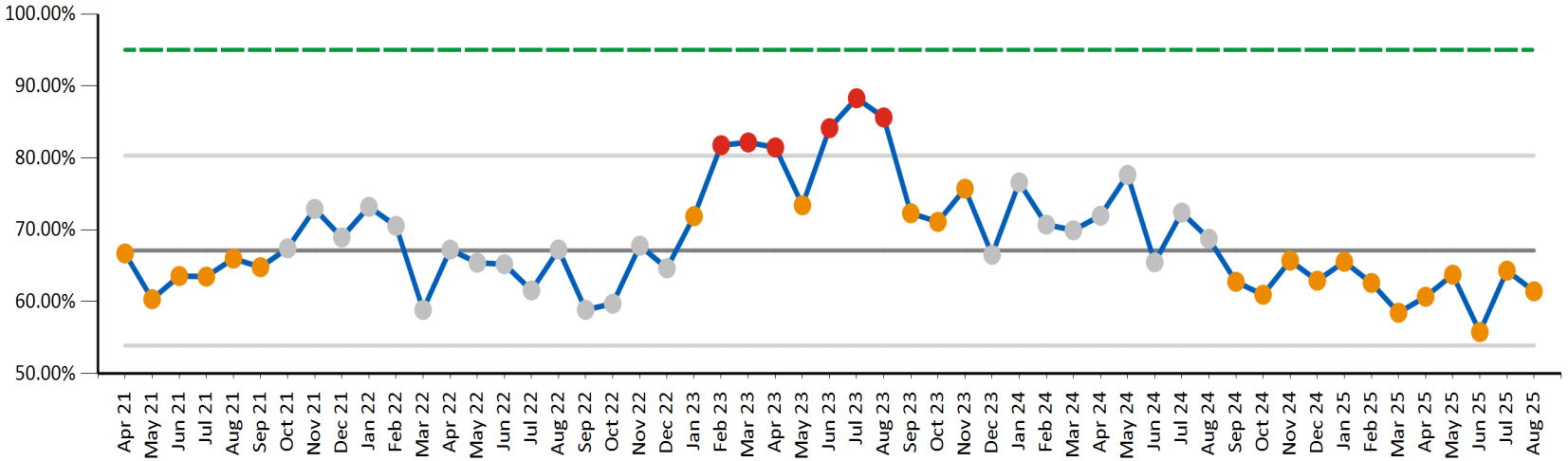
Plan	Actual
>= 95%	77.3%

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%	61.4%	Aug-25

Previous

Plan	Actual	Period
>= 95.0%	64.3%	Jul-25

Year to Date

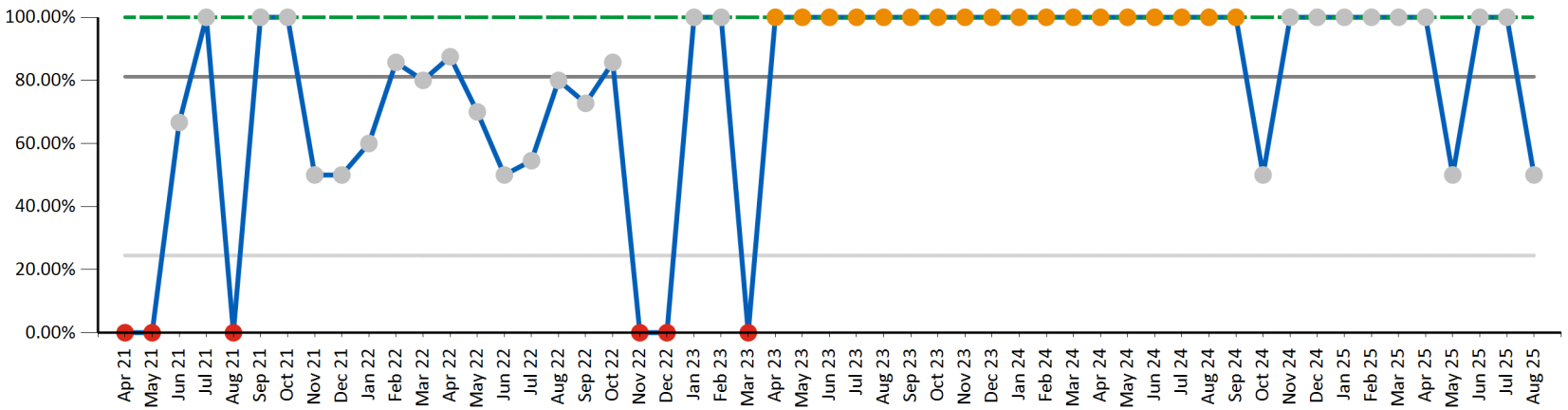
Plan	Actual
>= 95.0%	61.1%

86 - Patient Safety Alerts - Trust position

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
= 100%	50.0%	Aug-25

Previous

Plan	Actual	Period
= 100%	100.0%	Jul-25

Year to Date

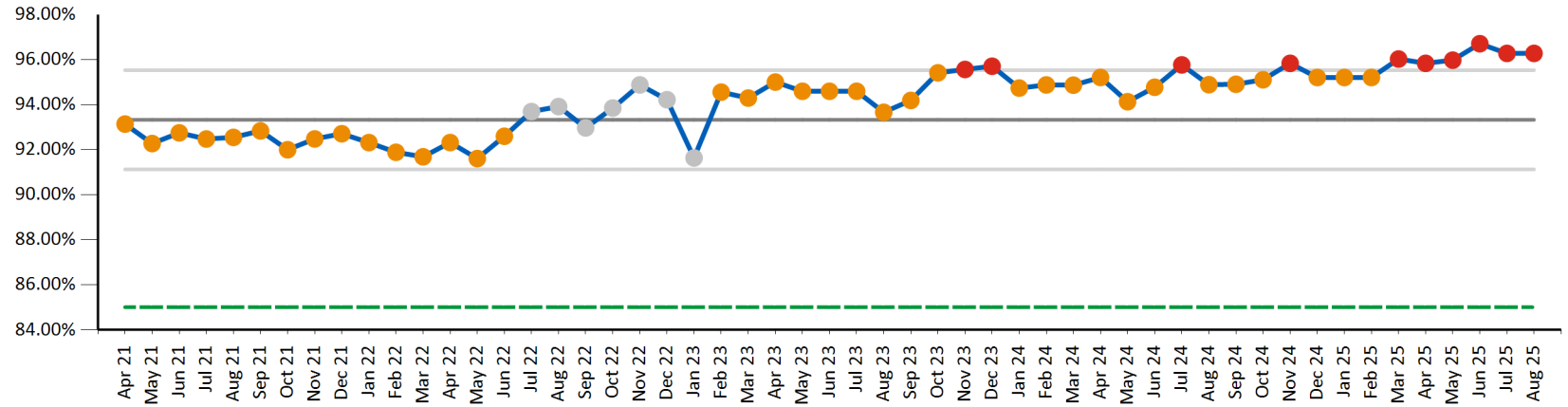
Plan	Actual
= 100%	80.0%

88 - Nursing KPI Audits

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

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

Previous

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

Year to Date

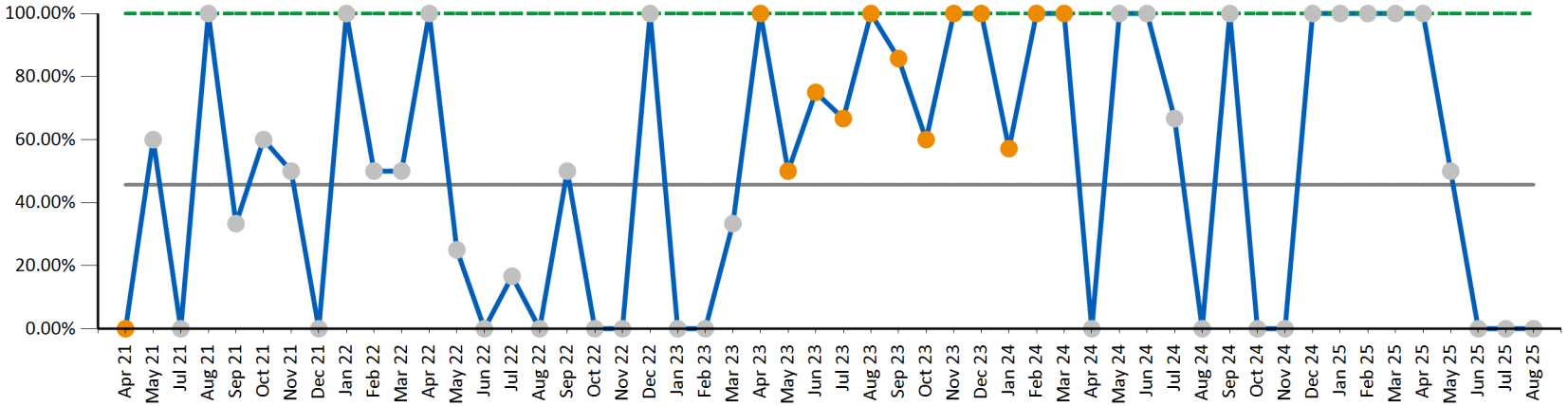
Plan	Actual
>= 85%	96.2%

91 - Patient Safety Incident Investigation turnaround performance by agreed deadline

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
= 100%	0.0%	Aug-25

Previous

Plan	Actual	Period
= 100%	0.0%	Jul-25

Year to Date

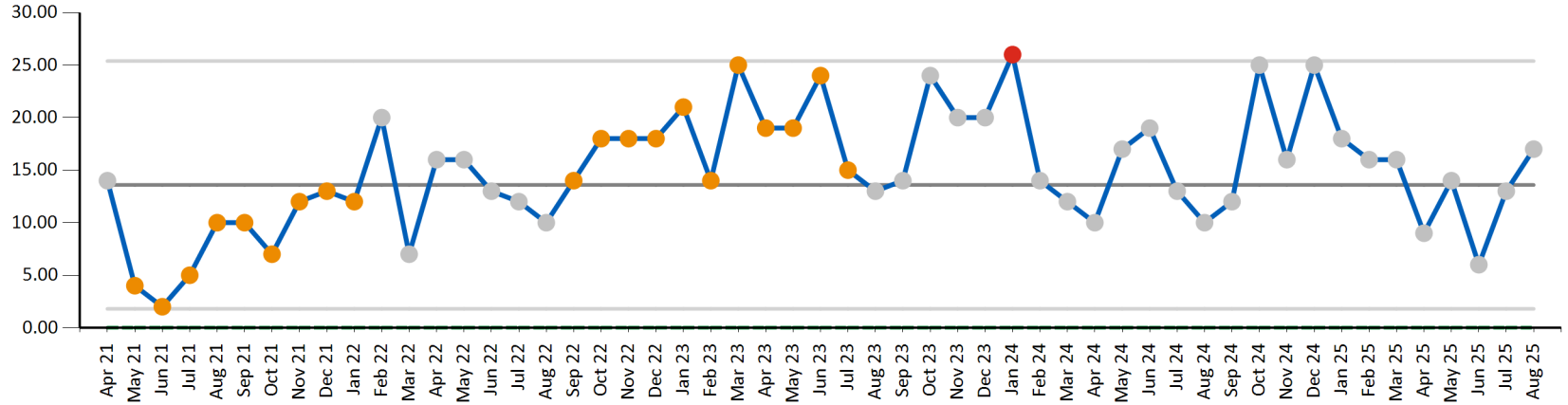
Plan	Actual
= 100%	

8 - Same sex accommodation breaches

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	17	Aug-25

Previous

Plan	Actual	Period
= 0	13	Jul-25

Year to Date

Plan	Actual
= 0	59

Quality and Safety - Infection Prevention and Control

NHS Bolton NHS Foundation Trust

As acknowledged in the NHS National League Tables published in September the Trust has performed very well in relation to MRSA bacteraemia and C-Difficile infections ranking 1st out of 134 providers. The IPC service is seeking to understand the method of calculation for better insight to the Board as it is based on the national 'in-year' targets and not overall count.

To the end of August, it had been more than 512 days since the last case, the second longest period between cases since mandatory surveillance started in 2004.

Healthcare associated CDT cases remain an area of review but on this same measure. There were 10 cases in August - two fewer than in June and July (12 cases in each month); the performance remains in common cause variation but there have been year-on-year improvements. There have been 27 fewer cases to the same point in 2024/25. The clinical divisions continue to embed the QI collaborative change package and the Regional Lead Pharmacist has shared a review of the Trust antimicrobial formulary with some areas to make change which will contribute to improved antimicrobial stewardship and reduce the likelihood of CDT cases linked to antibiotic use.

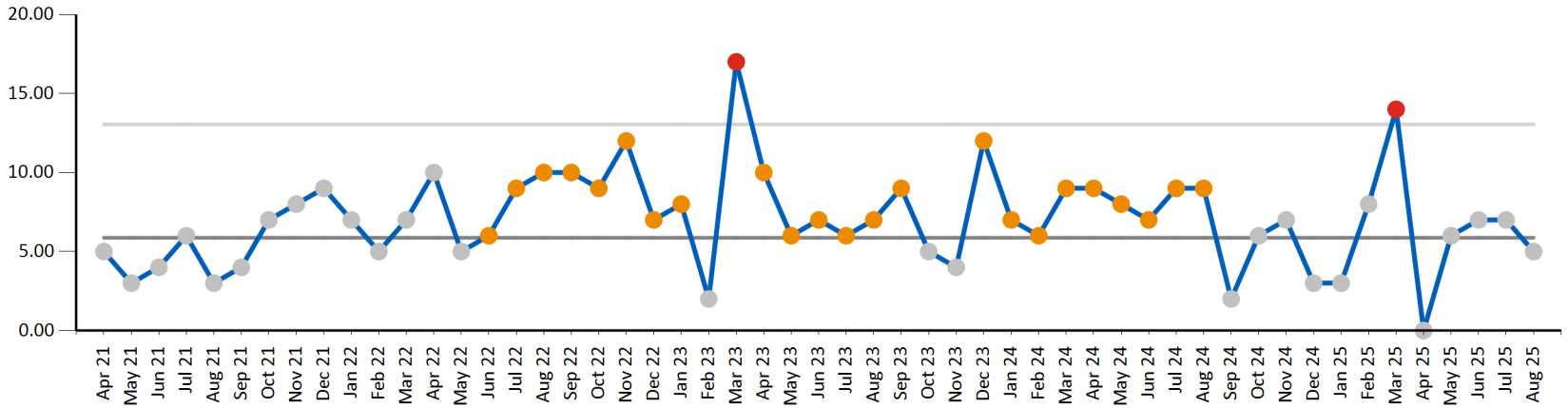
MIAA will commence progress against these actions over the coming month for additional assurance.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
215 - Total Hospital Onset C.diff infections		5	Aug-25			7	Jul-25		25	
346 - Total Community Onset Hospital Associated C.diff infections		5	Aug-25			5	Jul-25		16	
347 - Total C.diff infections contributing to objective	<= 10	10	Aug-25		<= 10	12	Jul-25	<= 50	41	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Aug-25		= 0	0	Jul-25	= 0		
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 5	6	Aug-25		<= 5	6	Jul-25	<= 26	28	
219 - Blood Culture Contaminants (rate)	<= 3%	3.8%	Aug-25		<= 3%	4.0%	Jul-25	<= 3%		
304 - Total Trust apportioned MSSA BSIs	<= 1.0	2.0	Aug-25		<= 1.0	4.0	Jul-25	<= 5.0	11.0	
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	2	Aug-25		<= 1	2	Jul-25	<= 3	9	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	0	Aug-25		= 0	1	Jul-25	= 0		

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
491 - Nosocomial COVID-19 cases		2	Aug-25						21	

215 - Total Hospital Onset C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	5	Aug-25

Previous

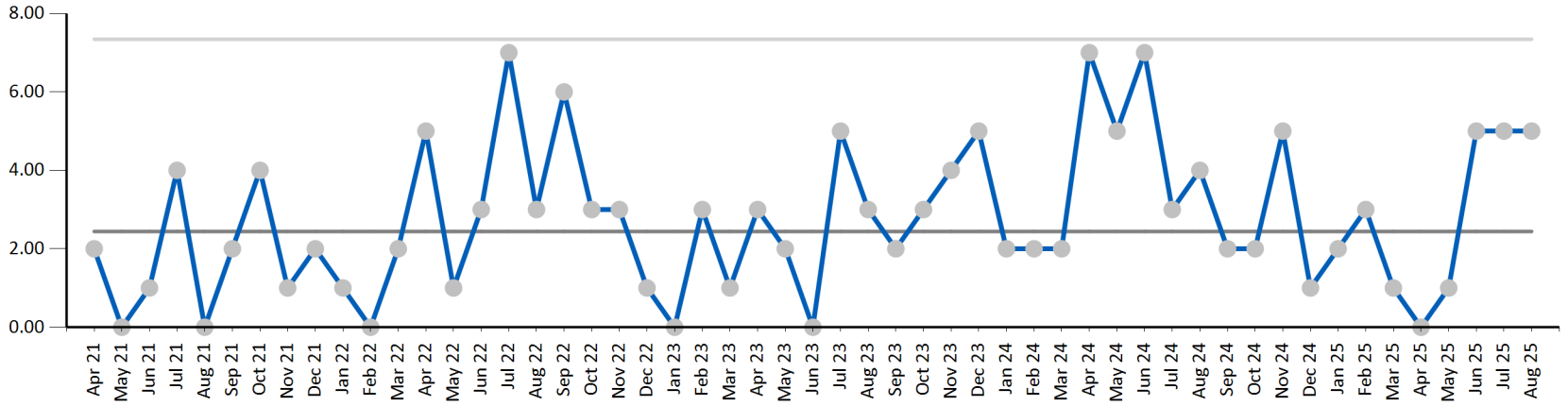
Plan	Actual	Period
	7	Jul-25

Year to Date

Plan	Actual
	25

346 - Total Community Onset Hospital Associated C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	5	Aug-25

Previous

Plan	Actual	Period
	5	Jul-25

Year to Date

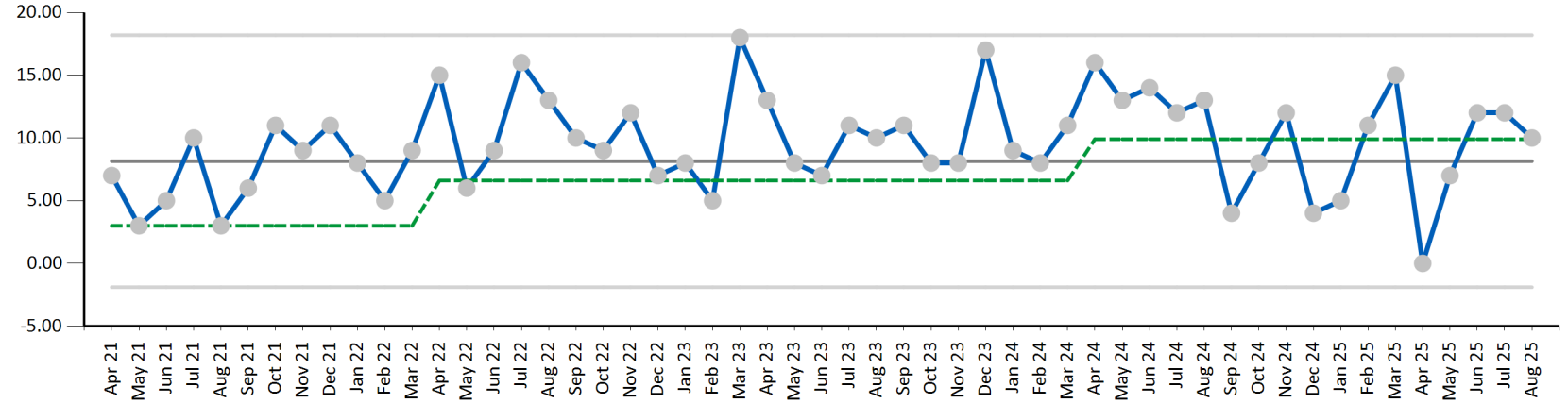
Plan	Actual
	16

347 - Total C.diff infections contributing to objective

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 10	10	Aug-25

Previous

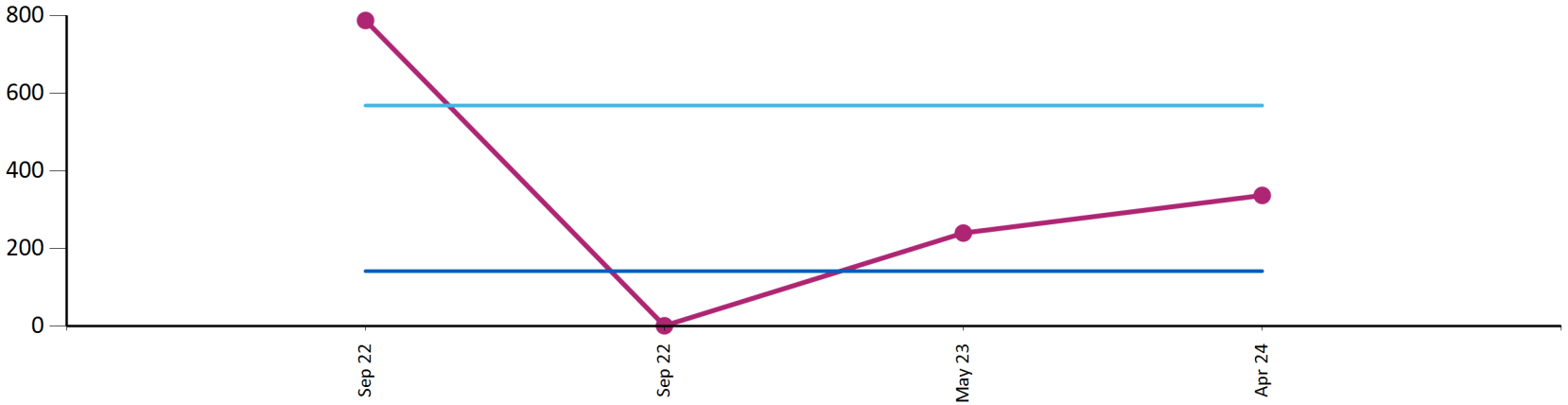
Plan	Actual	Period
<= 10	12	Jul-25

Year to Date

Plan	Actual
<= 50	41

217 - Total Hospital-Onset MRSA BSIs

0/6



Latest

Plan	Actual	Period
	0	Aug-25

Previous

Plan	Actual	Period
	0	Jul-25

Year to Date

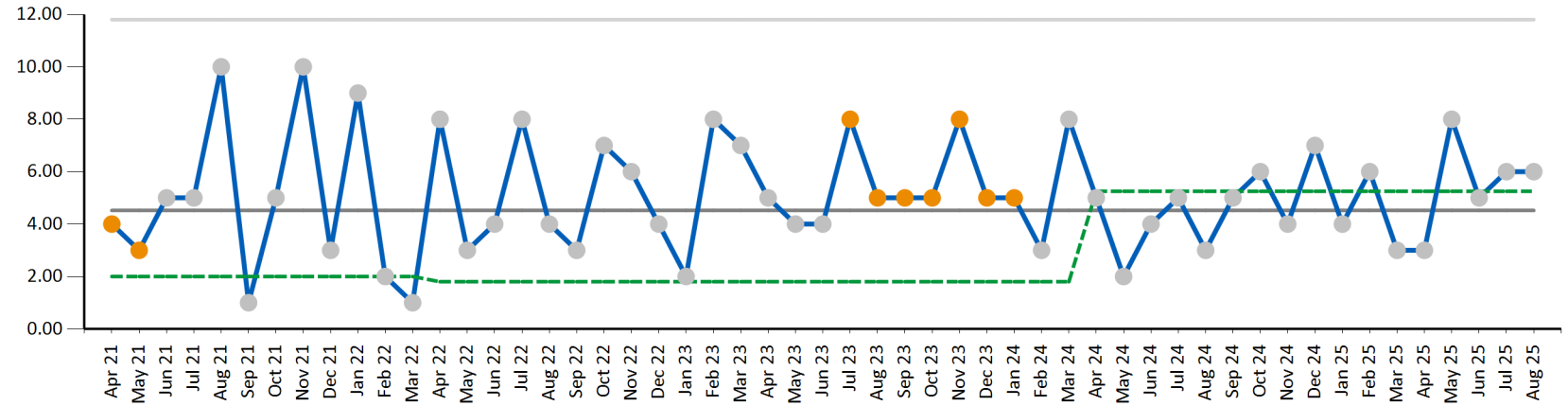
Plan	Actual

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

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 5	6	Aug-25

Previous

Plan	Actual	Period
<= 5	6	Jul-25

Year to Date

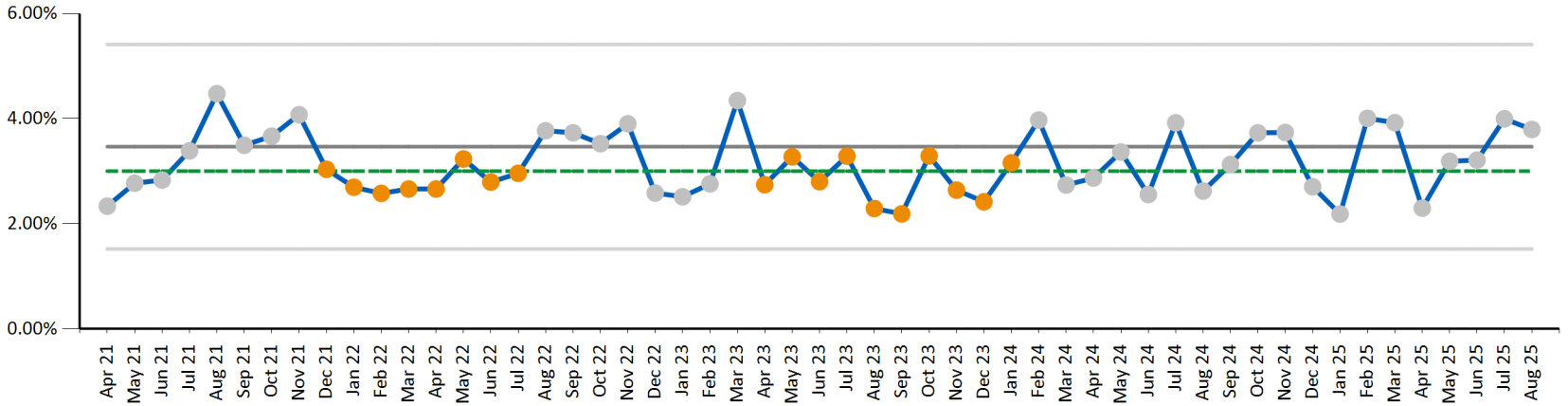
Plan	Actual
<= 26	28

219 - Blood Culture Contaminants (rate)

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 3%	3.8%	Aug-25

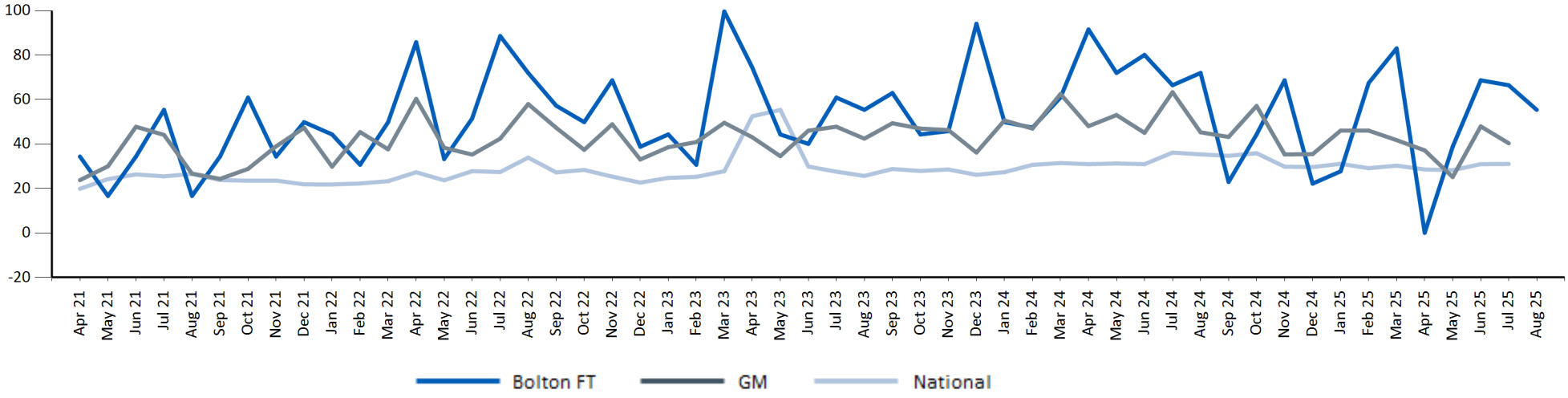
Previous

Plan	Actual	Period
<= 3%	4.0%	Jul-25

Year to Date

Plan	Actual
<= 3%	

549 - C Diff Rate Comparison

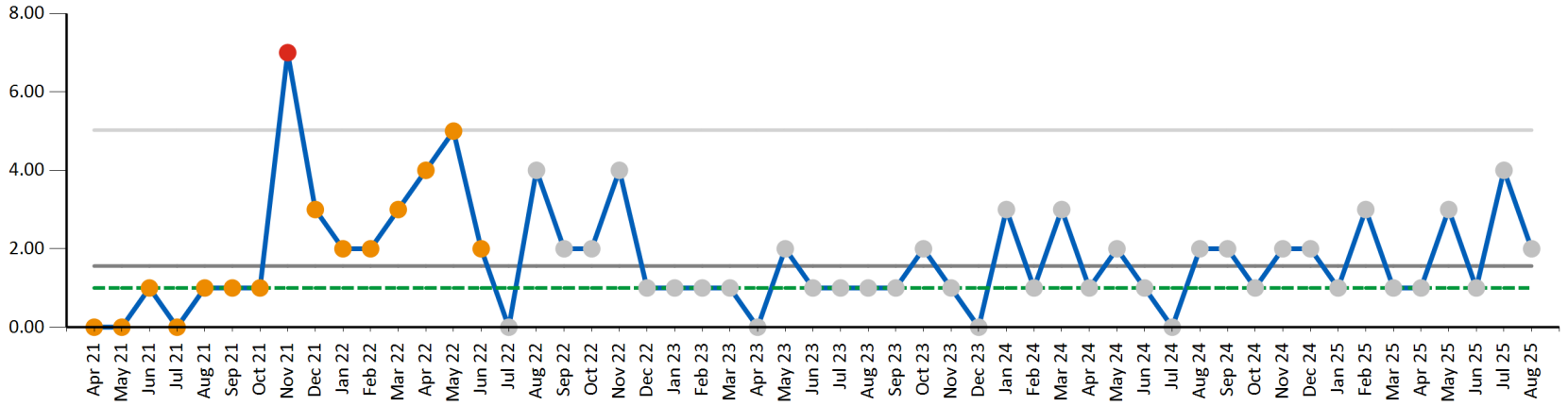


304 - Total Trust apportioned MSSA BSIs

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 1.0	2.0	Aug-25

Previous

Plan	Actual	Period
<= 1.0	4.0	Jul-25

Year to Date

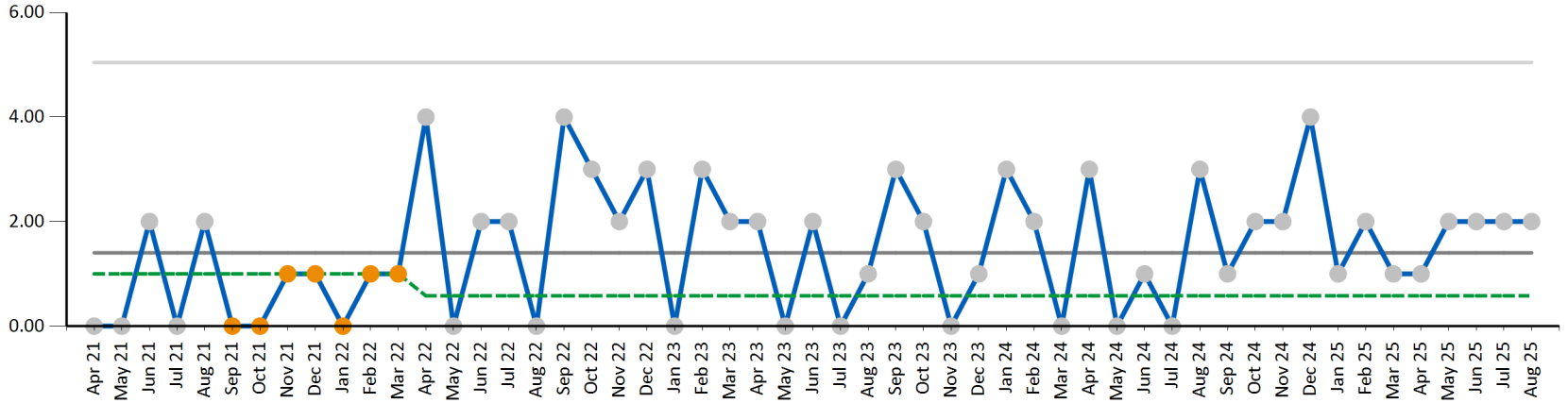
Plan	Actual
<= 5.0	11.0

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 1	2	Aug-25

Previous

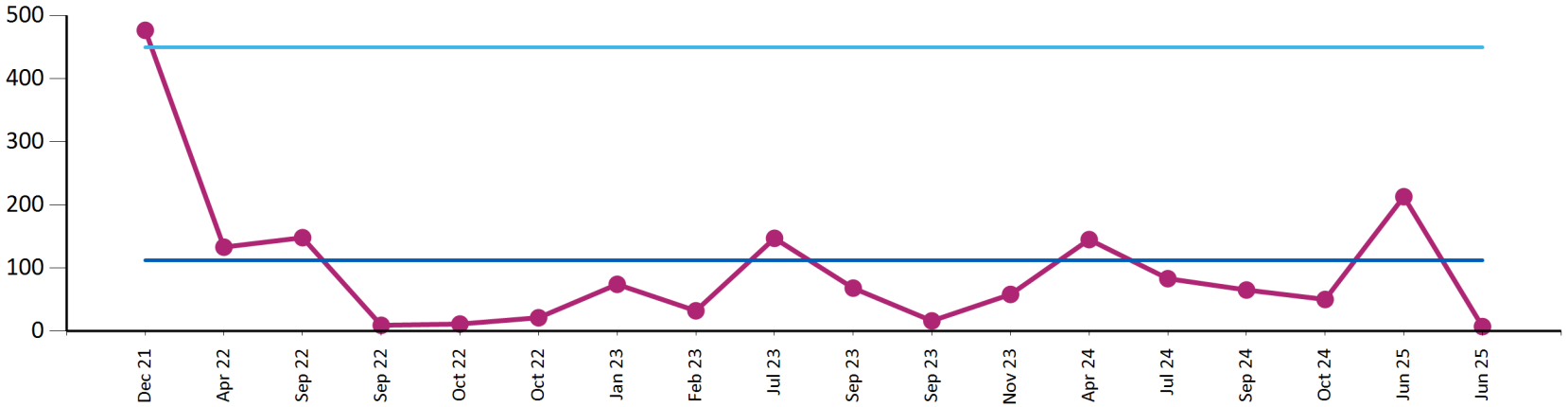
Plan	Actual	Period
<= 1	2	Jul-25

Year to Date

Plan	Actual
<= 3	9

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

0/6



Latest

Plan	Actual	Period
	0	Aug-25

Previous

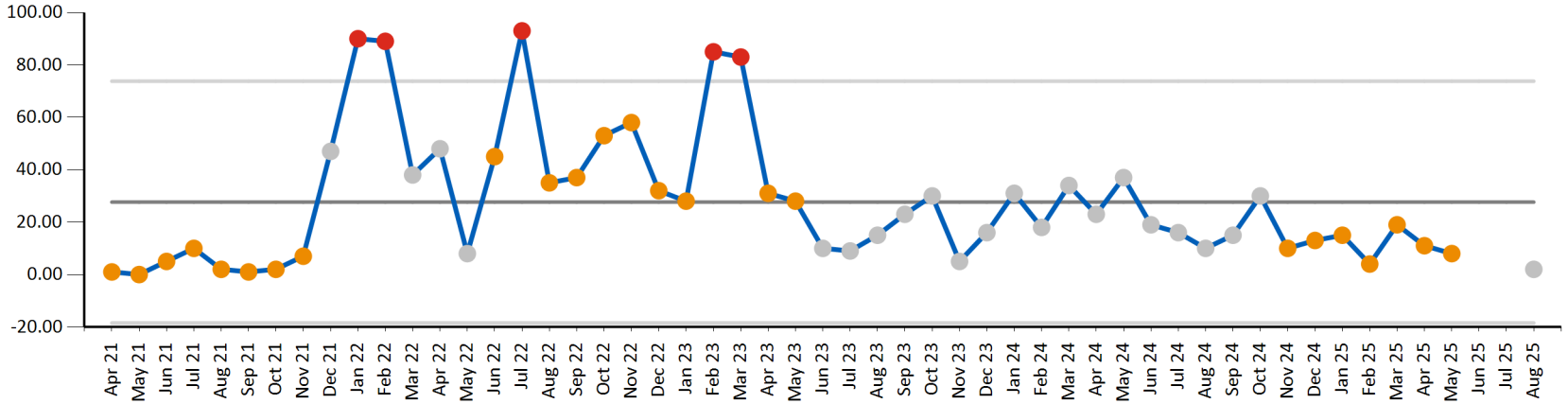
Plan	Actual	Period
	0	Jul-25

Year to Date

Plan	Actual

491 - Nosocomial COVID-19 cases

Common cause variation.



Latest

Plan	Actual	Period
	2	Aug-25

Previous

Plan	Actual	Period
		Jul-25

Year to Date

Plan	Actual
	21

Quality and Safety - Mortality

Bolton NHS Foundation Trust

Crude – in month rate is below Trust target and average for the timeframe and is showing as 18 points below the mean showing improved special cause. It has now remained in control for more than three years.

HSMR – in month figure is above the average for the period, however, remains in control. The 12 month rolling average to May 2025 is 109.56 which is an 'Amber' alert when compared to other Trusts, this alert has fallen from 'Red' since the last report.

SHMI – in month figure is below the average for the time period and remains in control. The published rolling average for the period May 2024 to April 2025 is 113.9 which is "as expected".

The proportion of Charlson comorbidities is above average for the time frame. The depth of recording remains in control and is above 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%	Aug-25		>= 85%	95.0%	Jul-25	>= 85%	92.2%	
495 - HSMR		140.19	May-25			104.80	Apr-25		140.19	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	100.61	Mar-25		<= 100.00	130.76	Feb-25	<= 100.00		
12 - Crude Mortality %	<= 2.9%	1.8%	Aug-25	L	<= 2.9%	1.9%	Jul-25	<= 2.9%	1.7%	
519 - Average Charlson comorbidity Score (First episode of care)		4	May-25	H		4	Apr-25		9	
520 - Depth of recording (First episode of care)		6	May-25			6	Apr-25		12	
521 - Proportion of fully coded records (Inpatients)		97.4%	Jun-25	H		97.1%	May-25		97.9%	

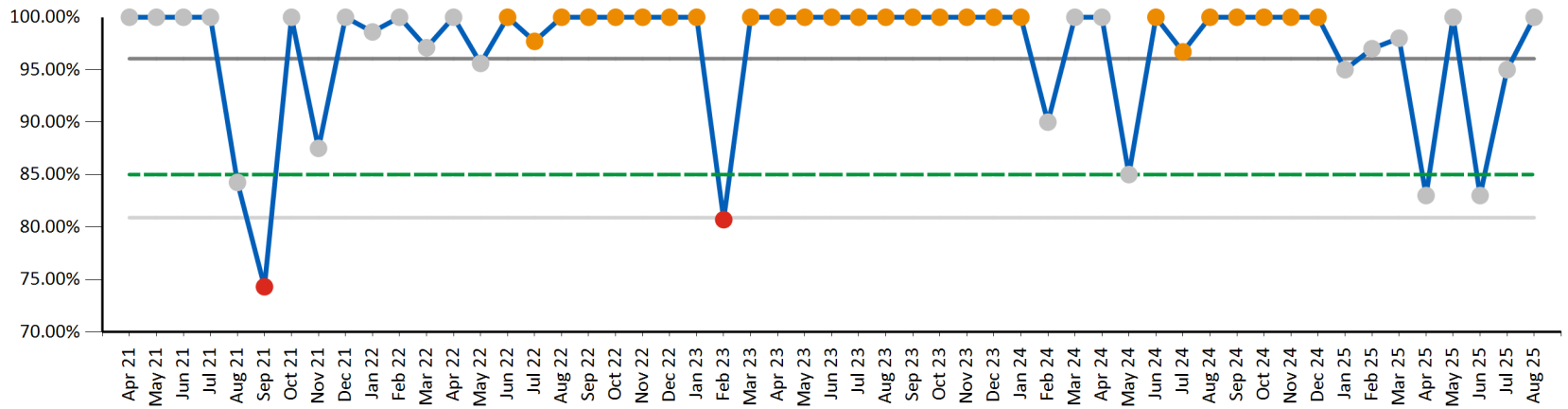
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS)		7.20	Aug-25			2.20	Jul-25			

3 - National Early Warning Scores to Gold standard

Common cause variation.

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

4/6



Latest

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

Previous

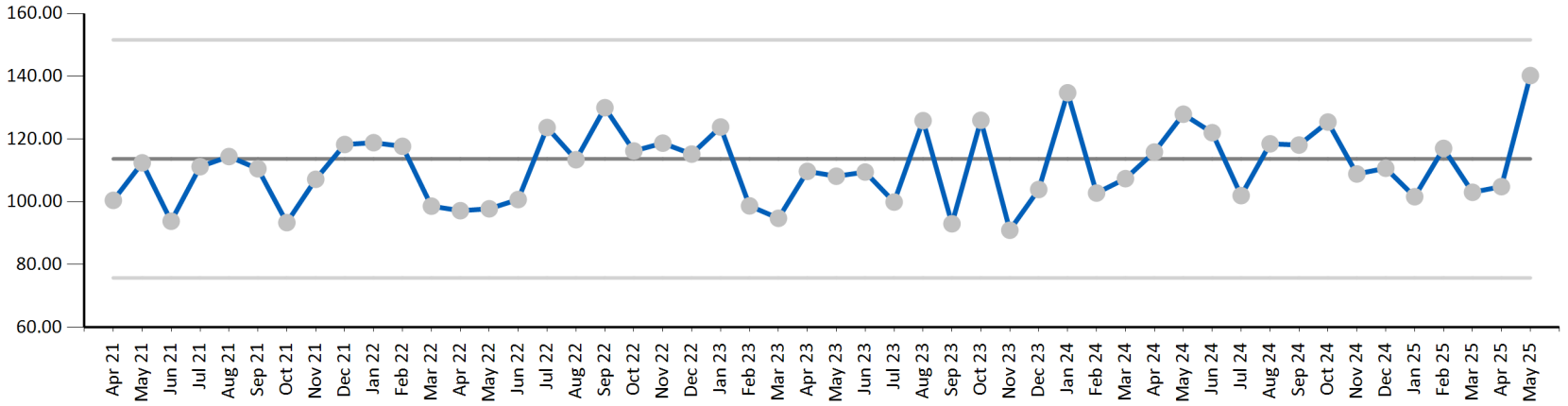
Plan	Actual	Period
>= 85%	95.0%	Jul-25

Year to Date

Plan	Actual
>= 85%	92.2%

495 - HSMR

Common cause variation.



Latest

Plan	Actual	Period
	140.19	May-25

Previous

Plan	Actual	Period
	104.80	Apr-25

Year to Date

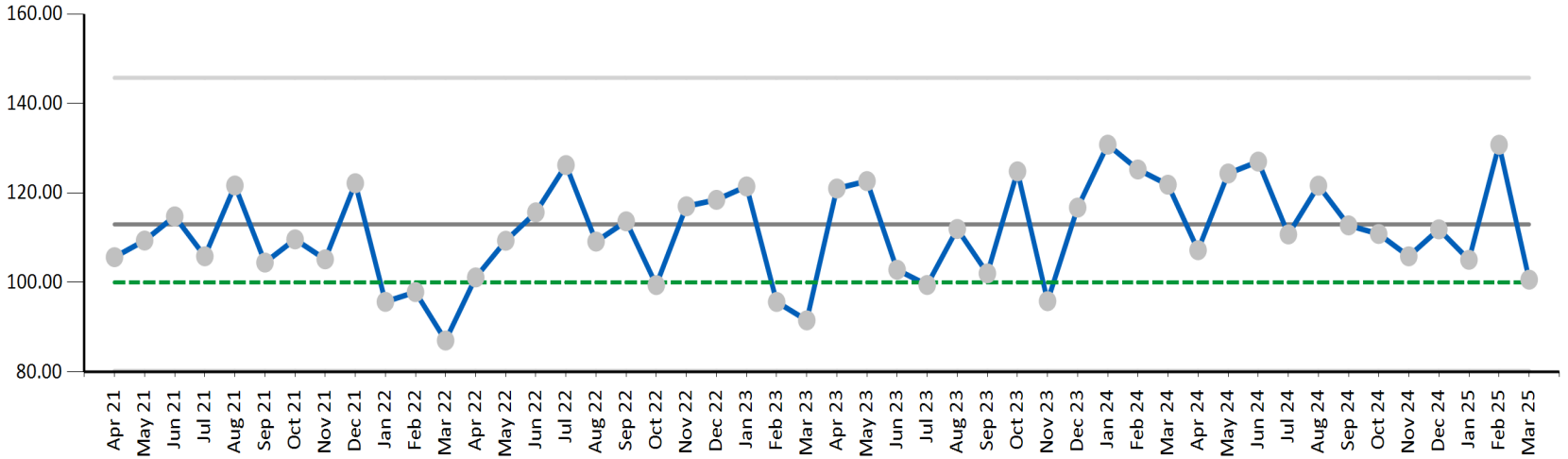
Plan	Actual
	140.19

11 - Summary Hospital-level Mortality Indicator (SHMI)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
< = 100.00	100.61	Mar-25

Previous

Plan	Actual	Period
< = 100.00	130.76	Feb-25

Year to Date

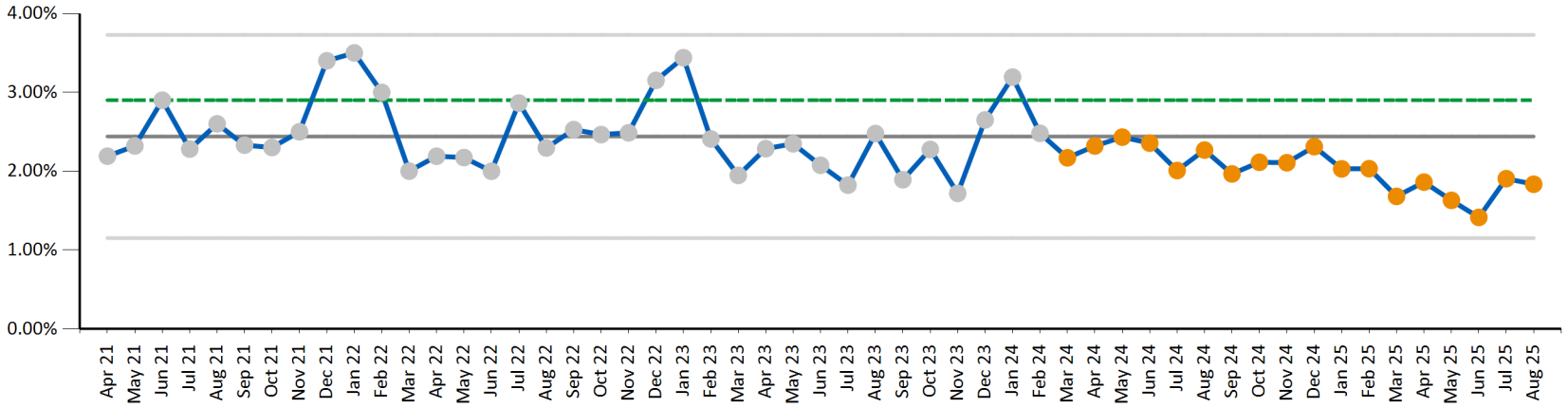
Plan	Actual
< = 100.00	100.61

12 - Crude Mortality %

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 2.9%	1.8%	Aug-25

Previous

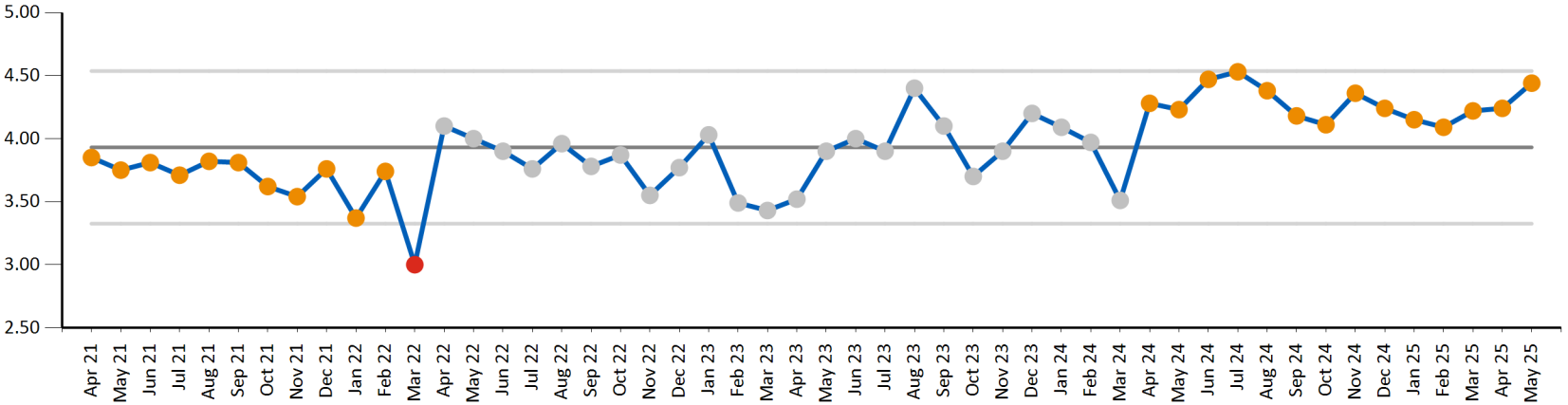
Plan	Actual	Period
<= 2.9%	1.9%	Jul-25

Year to Date

Plan	Actual
<= 2.9%	1.7%

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	4	May-25

Previous

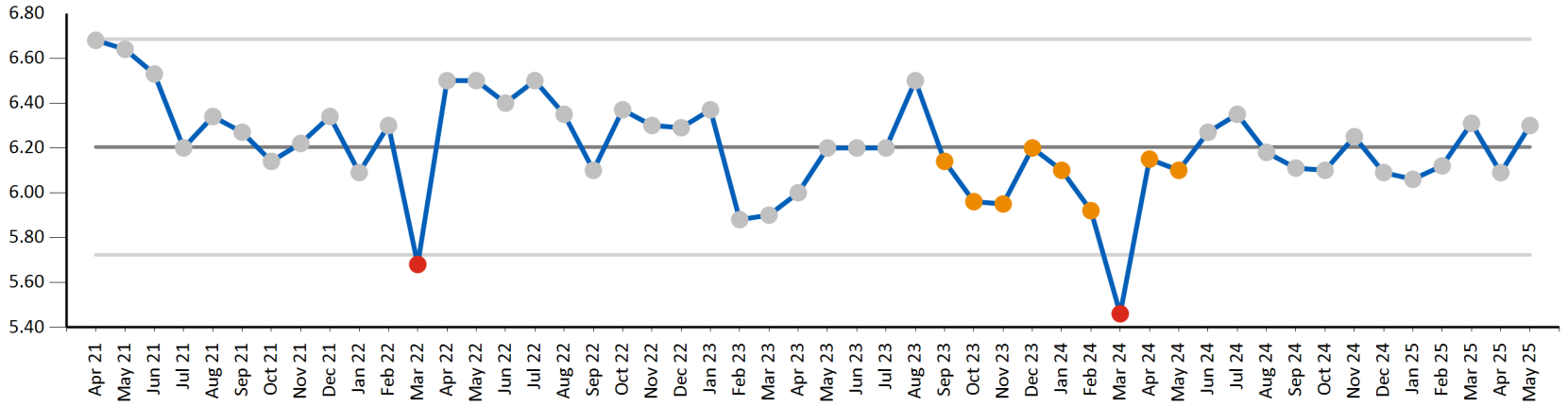
Plan	Actual	Period
	4	Apr-25

Year to Date

Plan	Actual
	9

520 - Depth of recording (First episode of care)

Common cause variation.



Latest

Plan	Actual	Period
	6	May-25

Previous

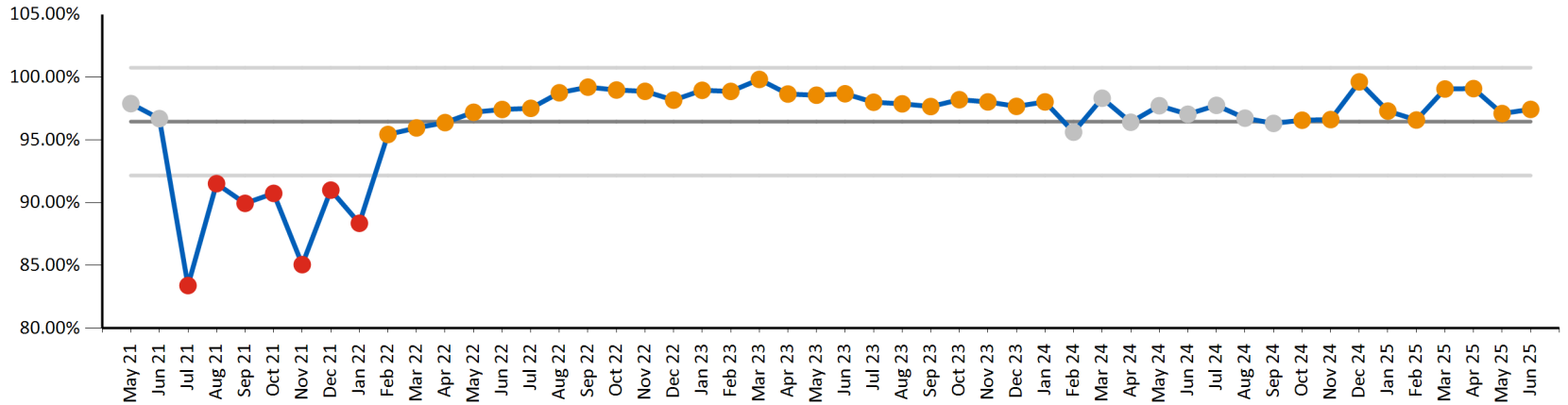
Plan	Actual	Period
	6	Apr-25

Year to Date

Plan	Actual
	12

521 - Proportion of fully coded records (Inpatients)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	97.4%	Jun-25

Previous

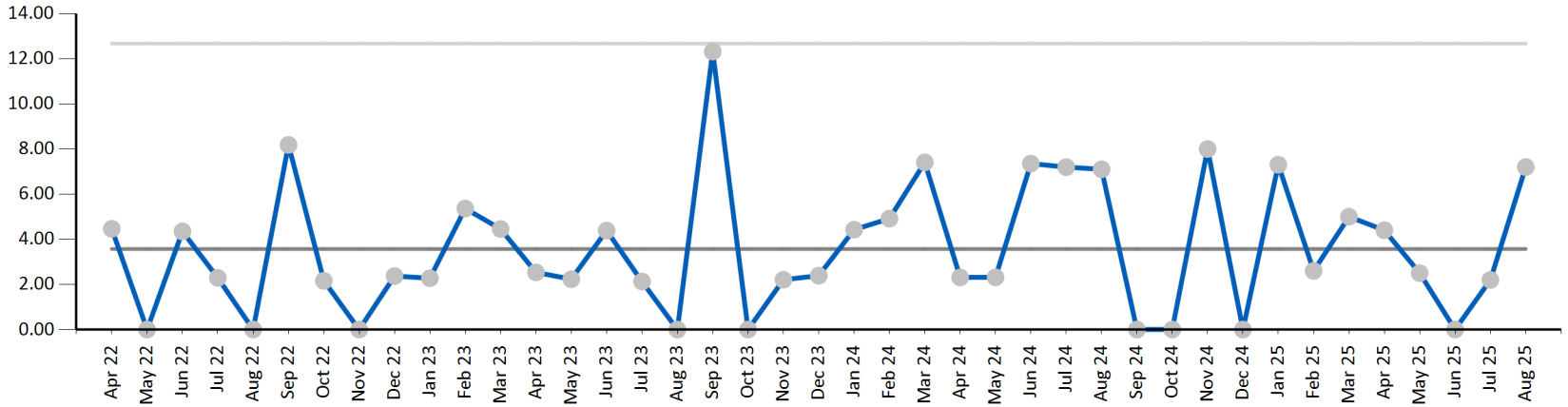
Plan	Actual	Period
	97.1%	May-25

Year to Date

Plan	Actual
	97.9%

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

Common cause variation.



Latest

Plan	Actual	Period
	7.20	Aug-25

Previous

Plan	Actual	Period
	2.20	Jul-25

Year to Date

Plan	Actual

Quality and Safety - Patient Experience

NHS Bolton NHS Foundation Trust

FFT Response and Satisfaction rates
Emergency Department response rates remain below the planned 20% local target rate. ED satisfaction rates remain below the target of 90%, but are within the range of common cause variation. ED predominately use an electronic text message system for FFT responses messages. They also review patient experience feedback from a variety of other different sources e.g. FFT responses in paper form and have a Patient Experience Improvement Plan with oversight at ED Governance.
Paediatric ED responses use a colourful paper model which is distributed by all staff and the option of a QR code is available for older children. Completion of FFTs is supported by an onsite Play Worker, or HCAs in their absence, to encourage participation.
Inpatient response rates remain within common cause variation however are below target.
Inpatient satisfaction rates are however above the target rate of 90%.

Work continues via the Quality Patient Experience Forum to ensure patient feedback leads to real, meaningful improvements in our services. By teaming up with our EDI (Equality, Diversity & Inclusion) Team and Patient Experience colleagues, we've developed ways to gather feedback that truly reflects the needs and experiences of our local population.
We're collecting both quantitative data and qualitative feedback, making sure we hear from a wide range of voices — especially those who might not always be represented. To keep things fair and unbiased, we've also made sure our senior clinical leaders are directly engaging with patients, families, and carers to understand what their experience has been like while under our care.
This hands-on approach will help us to spot barriers, improve access, and shape services that work better for everyone.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	14.4%	Aug-25		>= 20%	18.4%	Jul-25	>= 20%	14.9%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	83.9%	Aug-25		>= 90%	83.2%	Jul-25	>= 90%	84.7%	
80 - Inpatient Friends and Family Response Rate	>= 30%	23.9%	Aug-25		>= 30%	26.4%	Jul-25	>= 30%	26.5%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	96.1%	Aug-25		>= 90%	98.2%	Jul-25	>= 90%	97.1%	
81 - Maternity Friends and Family Response Rate	>= 15%	20.4%	Aug-25		>= 15%	23.7%	Jul-25	>= 15%	25.6%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	90.1%	Aug-25		>= 90%	92.0%	Jul-25	>= 90%	93.0%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	11.5%	Aug-25		>= 15%	16.3%	Jul-25	>= 15%	19.1%	

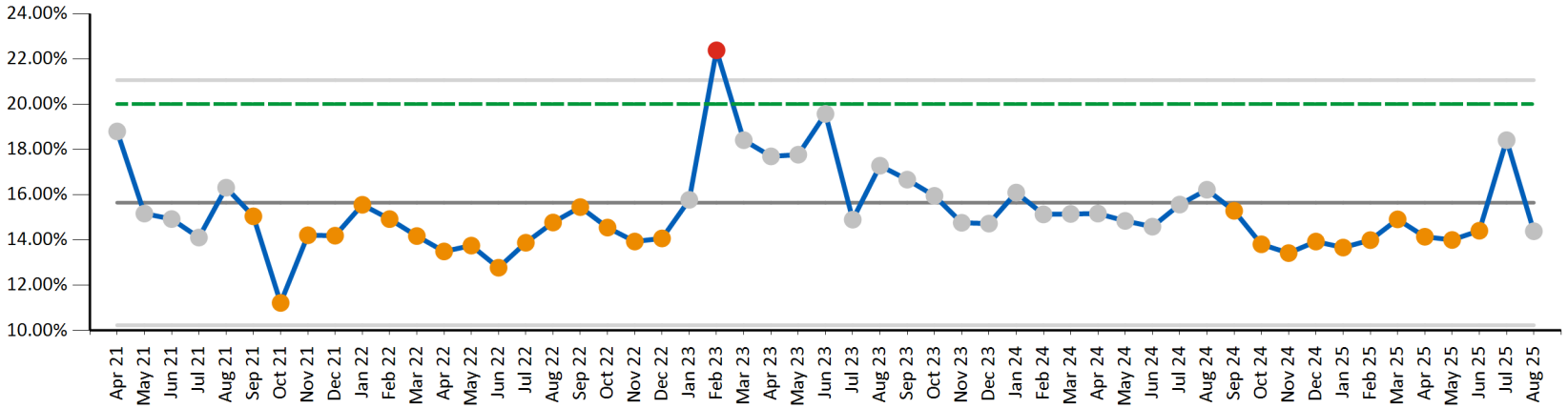
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	95.9%	Aug-25		>= 90%	98.7%	Jul-25	>= 90%	97.2%	
83 - Birth - Friends and Family Response Rate	>= 15%	34.9%	Aug-25		>= 15%	42.6%	Jul-25	>= 15%	40.3%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	87.8%	Aug-25		>= 90%	89.7%	Jul-25	>= 90%	90.7%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	20.8%	Aug-25		>= 15%	13.9%	Jul-25	>= 15%	19.5%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	86.4%	Aug-25		>= 90%	79.5%	Jul-25	>= 90%	89.2%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	14.4%	Aug-25		>= 15%	19.7%	Jul-25	>= 15%	22.2%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	94.8%	Aug-25		>= 90%	95.8%	Jul-25	>= 90%	95.2%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Aug-25		= 100%	100.0%	Jul-25	= 100%	100.0%	
90 - Complaints responded to within the period	>= 95%	84.2%	Aug-25		>= 95%	100.0%	Jul-25	>= 95%	89.8%	

200 - A&E Friends and Family Response Rate

Common cause variation.

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

0/6



Latest

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

Previous

Plan	Actual	Period
>= 20%	18.4%	Jul-25

Year to Date

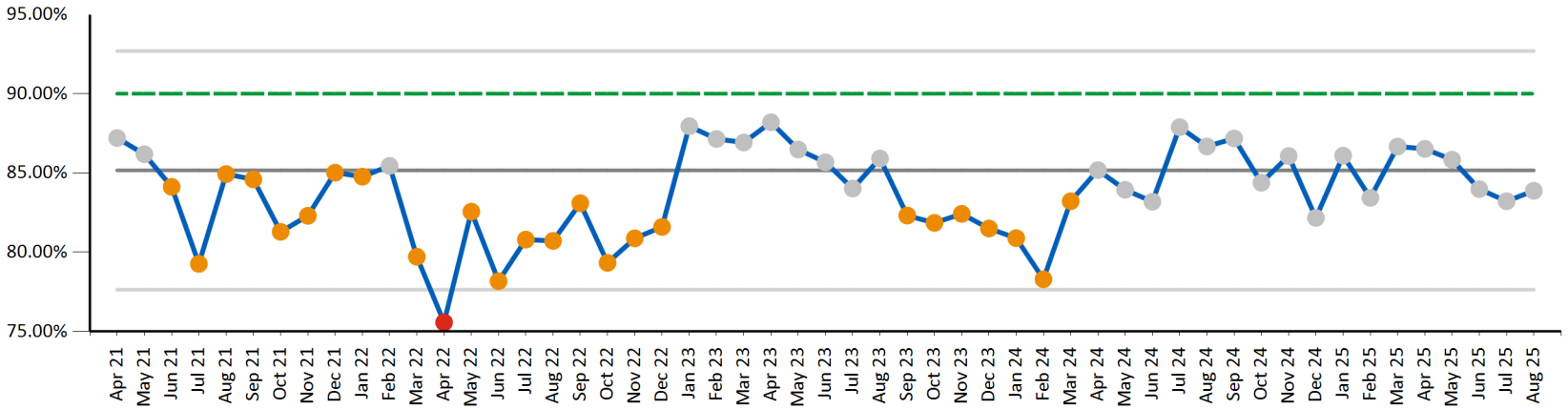
Plan	Actual
>= 20%	14.9%

294 - A&E Friends and Family Satisfaction Rates %

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 90%	83.9%	Aug-25

Previous

Plan	Actual	Period
>= 90%	83.2%	Jul-25

Year to Date

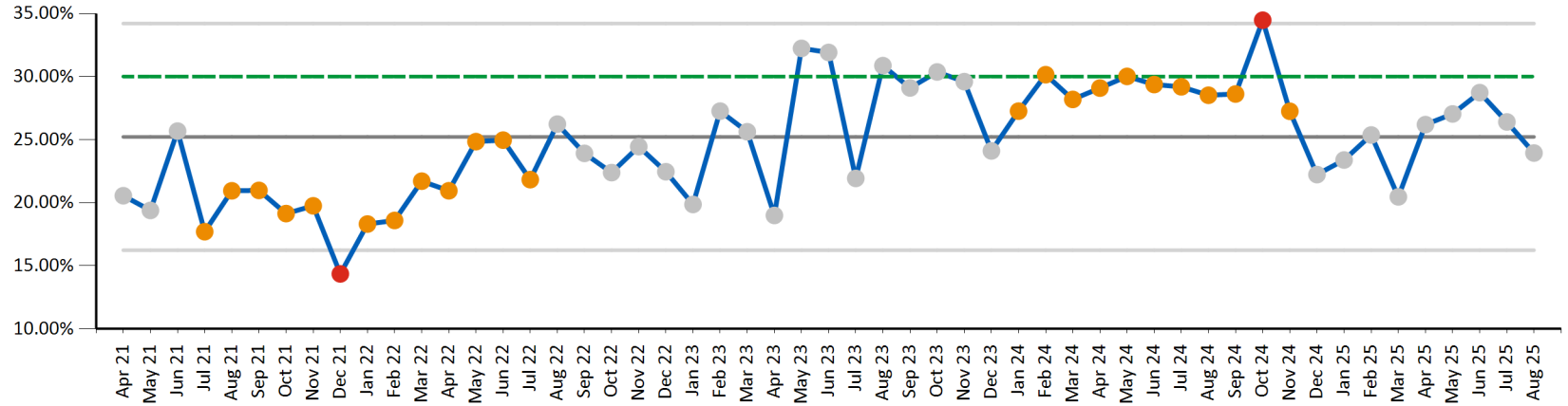
Plan	Actual
>= 90%	84.7%

80 - Inpatient Friends and Family Response Rate

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 30%	23.9%	Aug-25

Previous

Plan	Actual	Period
>= 30%	26.4%	Jul-25

Year to Date

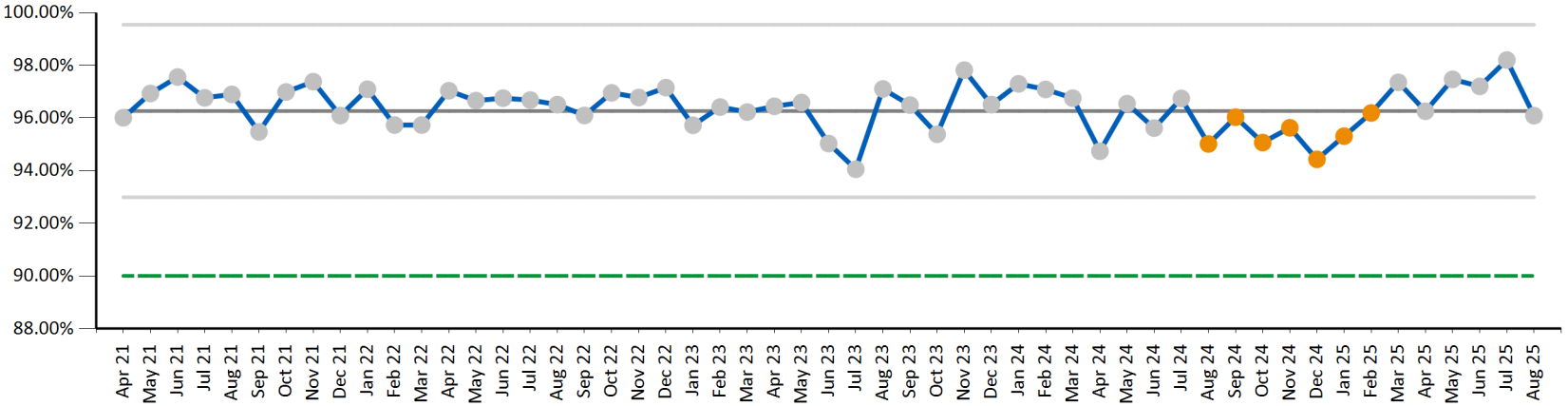
Plan	Actual
>= 30%	26.5%

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

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 90%	96.1%	Aug-25

Previous

Plan	Actual	Period
>= 90%	98.2%	Jul-25

Year to Date

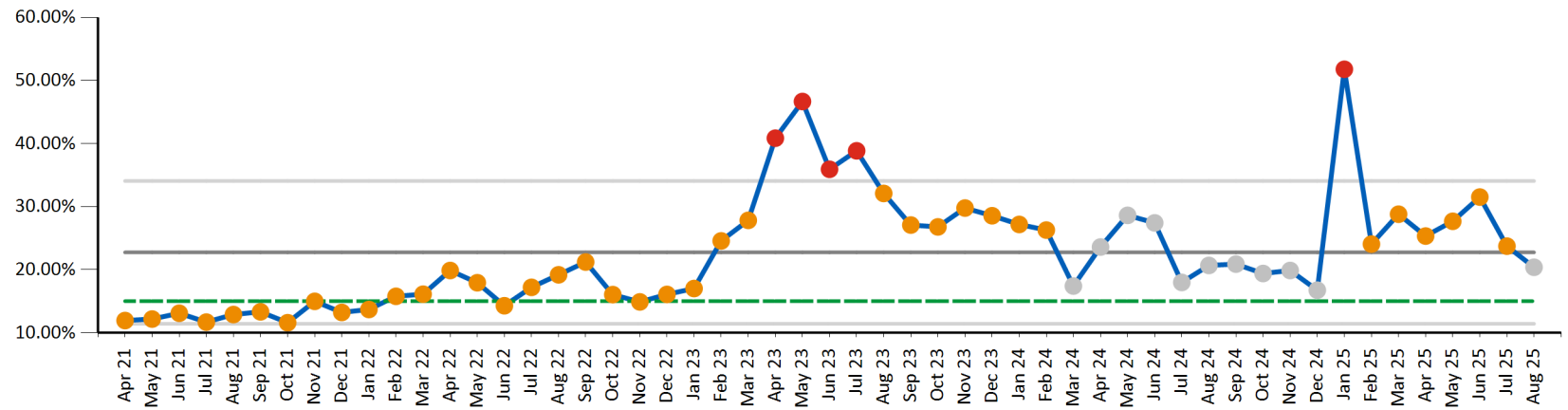
Plan	Actual
>= 90%	97.1%

81 - Maternity Friends and Family Response Rate

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 15%	20.4%	Aug-25

Previous

Plan	Actual	Period
>= 15%	23.7%	Jul-25

Year to Date

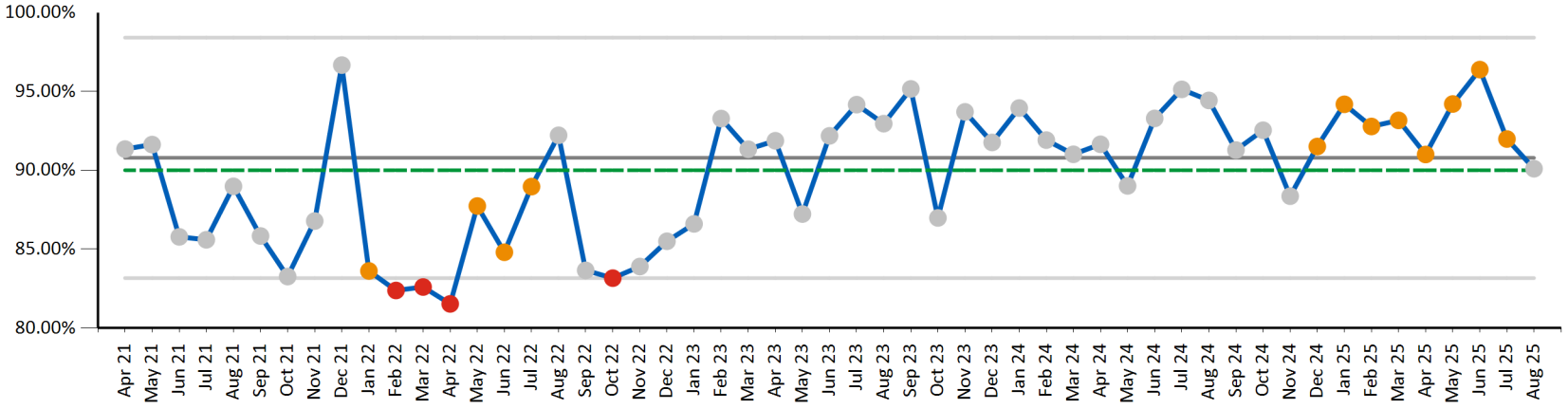
Plan	Actual
>= 15%	25.6%

241 - Maternity Friends and Family Test - Satisfaction %

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 90%	90.1%	Aug-25

Previous

Plan	Actual	Period
>= 90%	92.0%	Jul-25

Year to Date

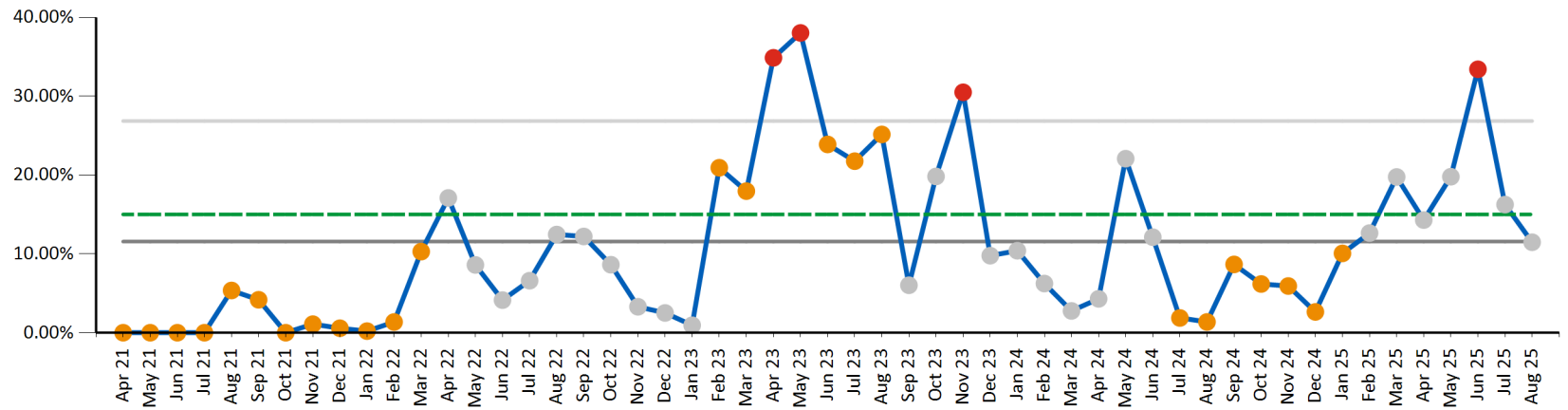
Plan	Actual
>= 90%	93.0%

82 - Antenatal - Friends and Family Response Rate

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
>= 15%	11.5%	Aug-25

Previous

Plan	Actual	Period
>= 15%	16.3%	Jul-25

Year to Date

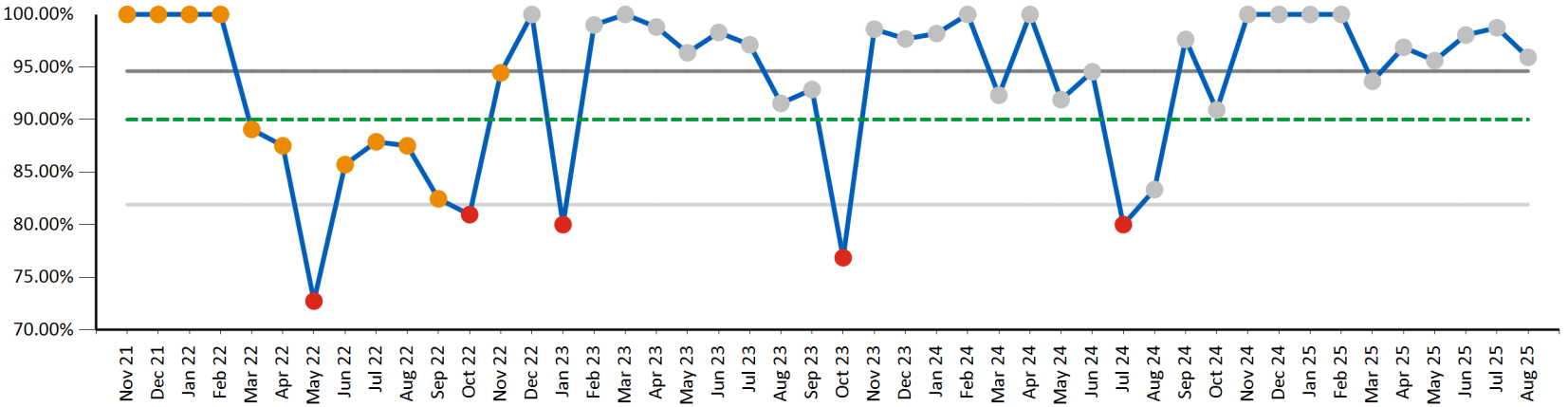
Plan	Actual
>= 15%	19.1%

242 - Antenatal Friends and Family Test - Satisfaction %

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 90%	95.9%	Aug-25

Previous

Plan	Actual	Period
>= 90%	98.7%	Jul-25

Year to Date

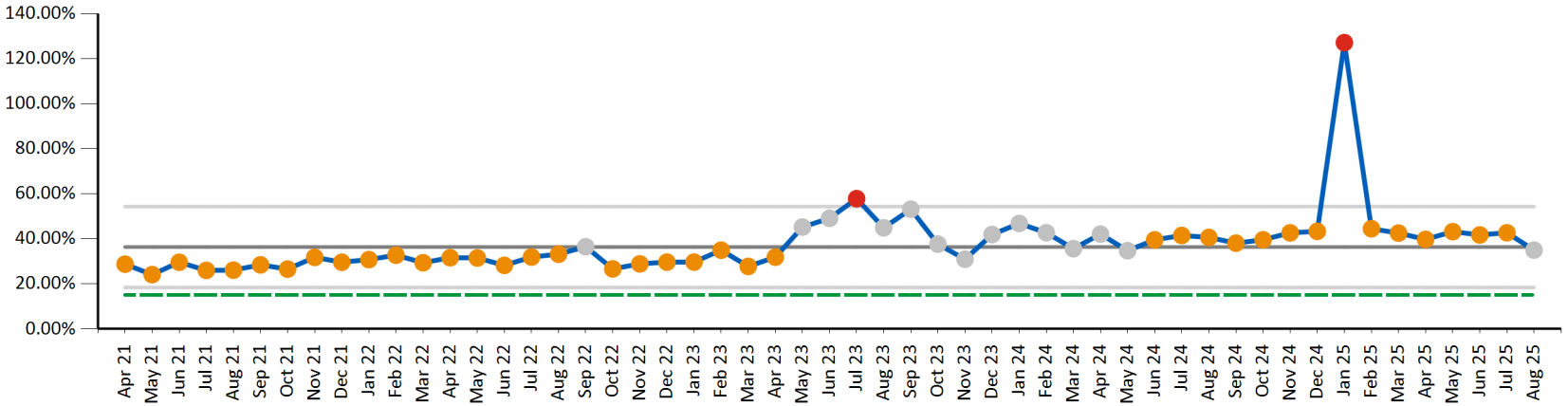
Plan	Actual
>= 90%	97.2%

83 - Birth - Friends and Family Response Rate

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 15%	34.9%	Aug-25

Previous

Plan	Actual	Period
>= 15%	42.6%	Jul-25

Year to Date

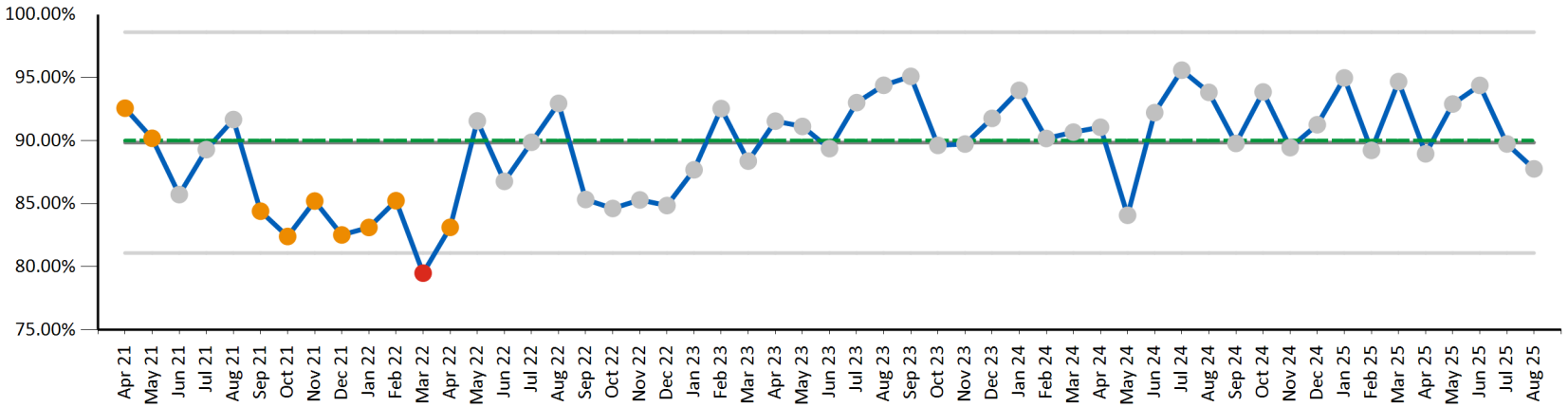
Plan	Actual
>= 15%	40.3%

243 - Birth Friends and Family Test - Satisfaction %

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
>= 90%	87.8%	Aug-25

Previous

Plan	Actual	Period
>= 90%	89.7%	Jul-25

Year to Date

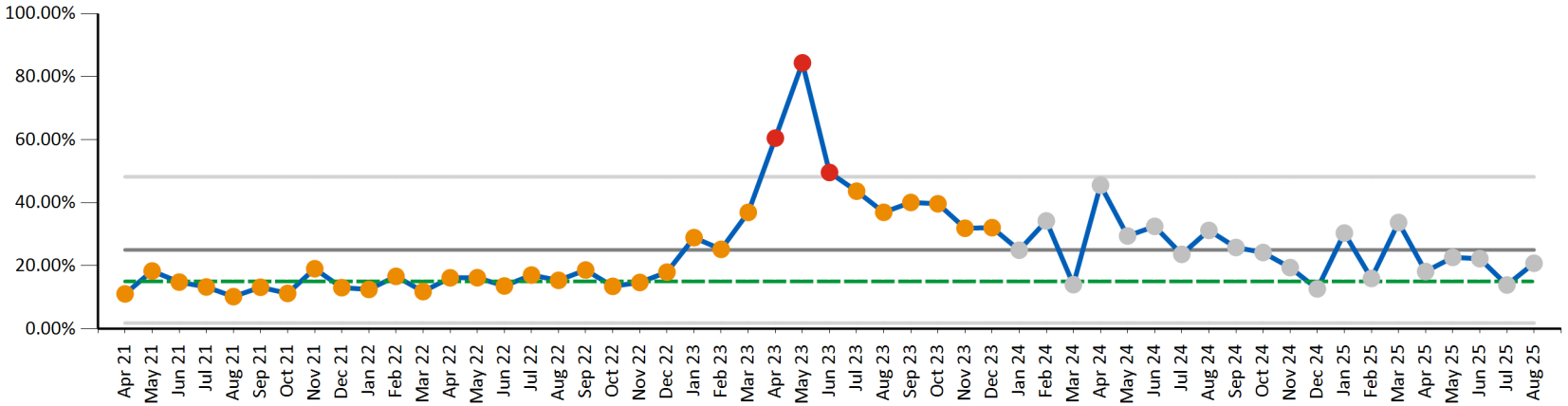
Plan	Actual
>= 90%	90.7%

84 - Hospital Postnatal - Friends and Family Response Rate

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 15%	20.8%	Aug-25

Previous

Plan	Actual	Period
>= 15%	13.9%	Jul-25

Year to Date

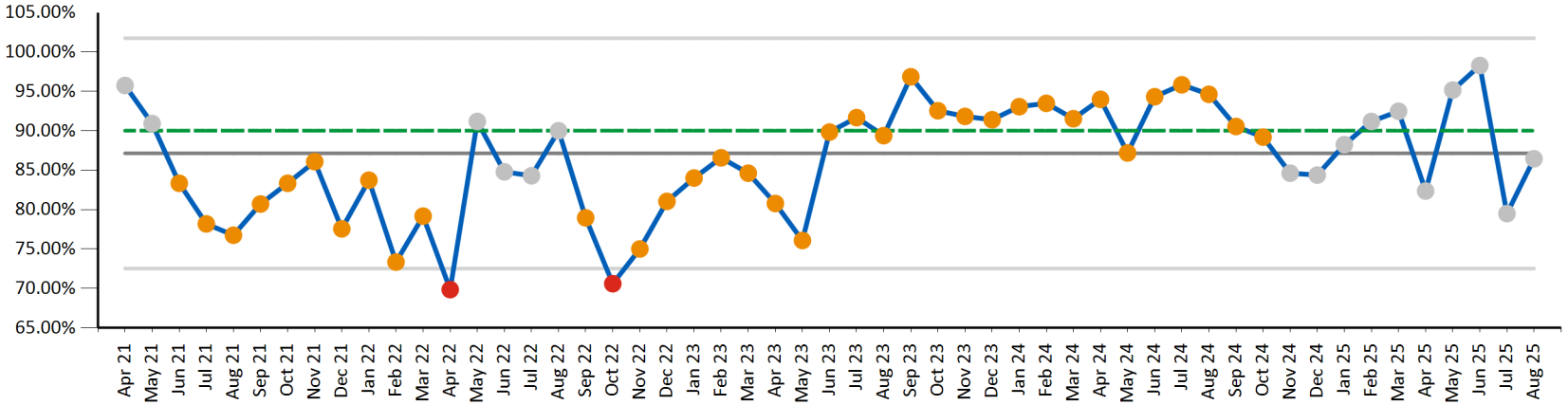
Plan	Actual
>= 15%	19.5%

244 - Hospital Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

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

3/6



Latest

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

Previous

Plan	Actual	Period
>= 90%	79.5%	Jul-25

Year to Date

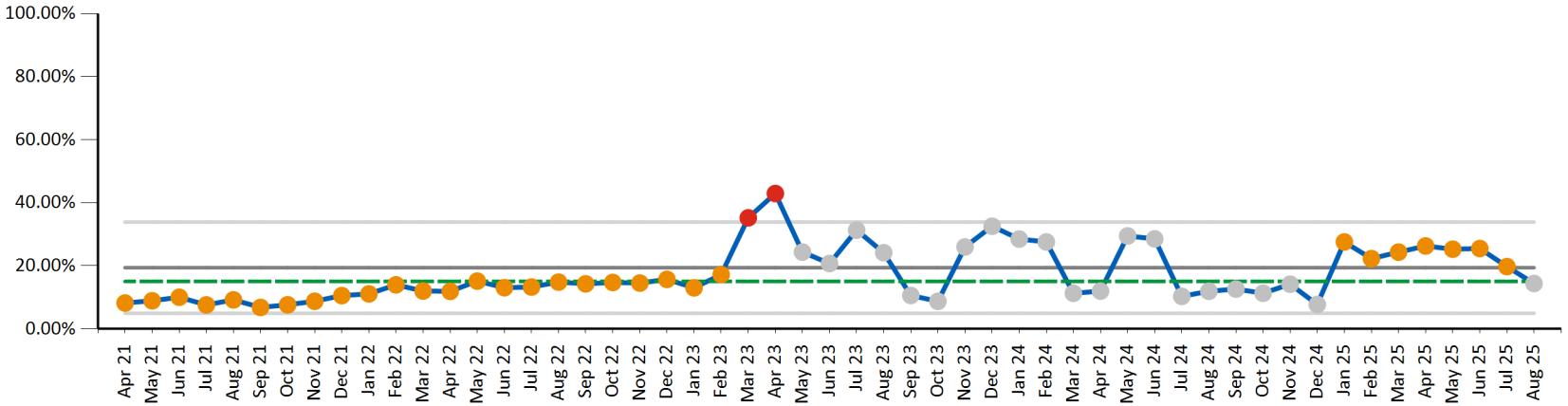
Plan	Actual
>= 90%	89.2%

85 - Community Postnatal - Friend and Family Response Rate

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 15%	14.4%	Aug-25

Previous

Plan	Actual	Period
>= 15%	19.7%	Jul-25

Year to Date

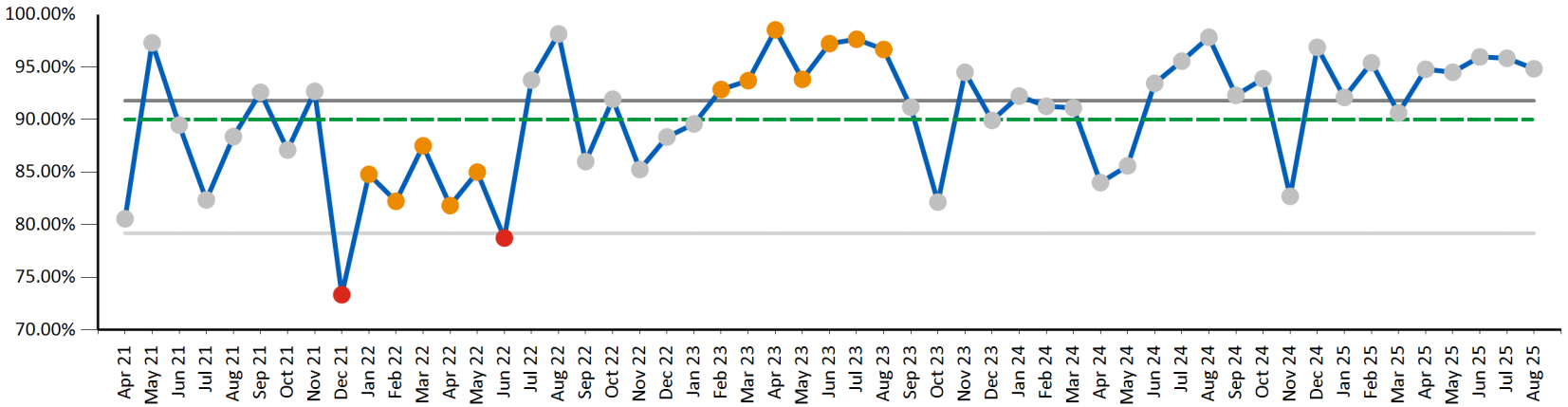
Plan	Actual
>= 15%	22.2%

245 - Community Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 90%	94.8%	Aug-25

Previous

Plan	Actual	Period
>= 90%	95.8%	Jul-25

Year to Date

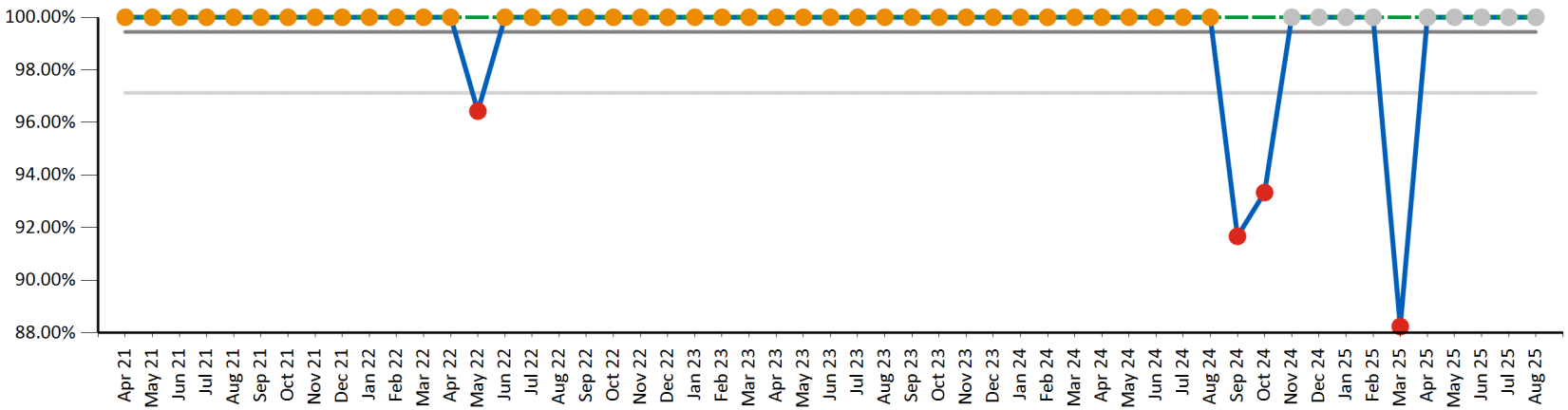
Plan	Actual
>= 90%	95.2%

89 - Formal complaints acknowledged within 3 working days

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
= 100%	100.0%	Aug-25

Previous

Plan	Actual	Period
= 100%	100.0%	Jul-25

Year to Date

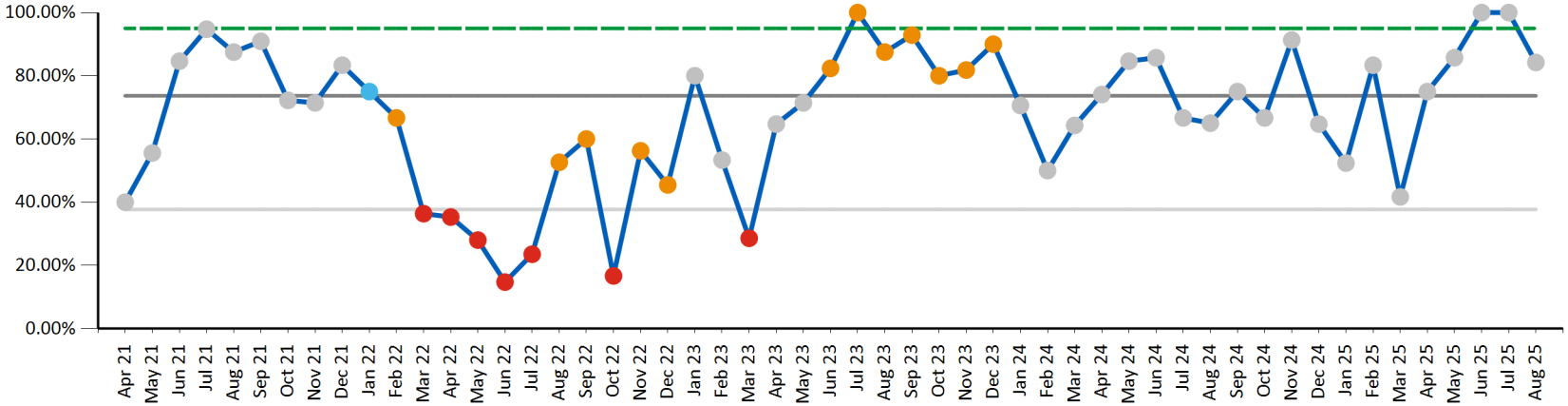
Plan	Actual
= 100%	100.0%

90 - Complaints responded to within the period

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
>= 95%	84.2%	Aug-25

Previous

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

Year to Date

Plan	Actual
>= 95%	89.8%

Quality and Safety - Maternity

Friends and Family Response Rate – Response rate has decreased to 20.4% in month from 31.5% with antenatal responses seeing the biggest decrease. Further work to be undertaken within the antenatal services to increase response rates. Overall maternity satisfaction has also decreased in month from special cause variation of 96.4% in June to 90.1% in August.

Maternity Stillbirth Rate (excluding termination of pregnancy (TOPS) – No cases reported in June or July, 1 case reported in August 2025. The second REACH circles are currently being recruited to (involves 8-10 pregnant women who live close together having their antenatal care and education in a community setting together) with a focus on the pregnant cohort between 24-27 weeks gestation. An update will be presented to Quality Assurance Committee in September 2025.

¾ degree tears – There has been a sustained low rate of 1.9% in month. Recruitment to the perinatal pelvic health Midwifery post Band 7 0.6wte has been successful – all other posts within the team already in place.

1:1 care in labour – Compliance rate 99.5% in month. Action plan in place as per CNST requirements – staff recruitment positive – -9WTE Registered Midwife deficit anticipated by October 2025. These posts are currently out to advert.

Booked by 12+6 is a clinical indicator relating to the timing of the initial antenatal booking visit that ensures women access care in a timely way and are still in a position to have a scan and antenatal screening blood tests taken. A slight decrease is noted in month from 91% compliance reported in June to 90.8% in August 2025 however, a notable improvement from 84.3% reported in February 2025. This has improved following the introduction of an early bird antenatal session as a pilot at Ingleside.

Booked by 10 weeks (target reflects bookings by 10+0 gestation as per national standard which removes the impact of ultrasound booking scan date changes made and associated impact). Trust performance has seen an increase to at 69.2%. This has improved following the introduction of an early bird antenatal session as a pilot at Ingleside.

Inductions of labour delayed by >24 hours – 37.4% of induction of labour cases were delayed by 24 hours in August 2025 – this is noted to be a common cause variation in the statistical process chart evaluation and coincides with periods of high activity. Work remains ongoing to scope additional bed capacity to relieve pressure in the service with a current focus on expansion of the maternity triage capacity scheduled for Sept 2025. The current escalation process has been reviewed and a new Maternity escalation tool has been devised, alerting the senior team to delays of more than 24hrs. The introduction of Matron of the Day will support the senior oversight.

Breastfeeding initiation – Continues to improve noting an increase in month to 72.57% from 69.57% in July 2025 - significant staffing changes to be noted within team. Baby Friendly stage 2 implementation delayed until spring 2026 in response.

Preterm birth (less than 37 weeks gestation) – An increase noted in month with 8.4% reported in August 2025. Review of preterm referral pathway being undertaken in response to recent incident. The service has seen an increase in the number of inter uterine transfers from other providers.

Number of complaints received – There have been 9 complaints received in the month of August compared with 6 in July 2025. Themes relate to the lack of communication around plans of care and delays in transfer to the Labour Ward. Ward Managers encouraged to walk around their areas daily to intercept any concerns.

The GMEC maternity analysis toolkit has highlighted the Trust has a higher rate of incidence for some metrics when compared to the GM average over the past twelve months. In response it has been flagged to GMEC LMNS that the performance of the tertiary level maternity service at Bolton needs to be compared with comparator tertiary peers to identify areas of outlier status and thus a revision is being made to the maternity analysis toolkit to address this concern. The service is currently compliant with all perinatal

quality surveillance monitoring requirements, however is reviewing the process of the perinatal quality surveillance review within the service and liaising with other providers to ascertain best practice prior to enacting change to improve oversight and surveillance

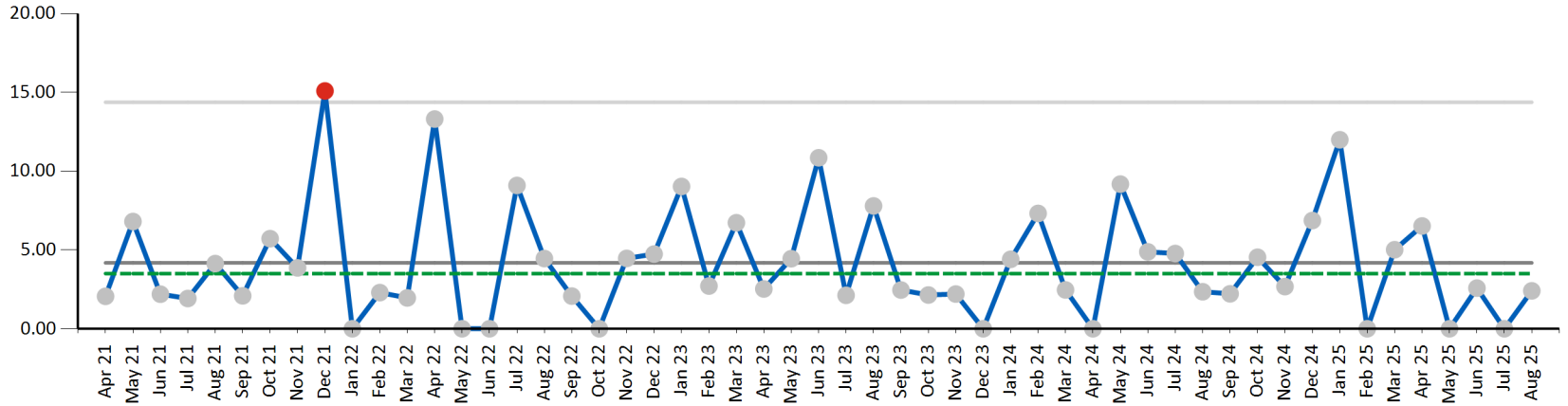
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births (excludes termination of pregnancy)	<= 3.50	2.40	Aug-25		<= 3.50	0.00	Jul-25	<= 3.50	2.37	
23 - Maternity -3rd/4th degree tears	<= 3.5%	1.9%	Aug-25		<= 3.5%	3.7%	Jul-25	<= 3.5%	2.6%	
202 - 1:1 Midwifery care in labour	>= 95.0%	99.5%	Aug-25		>= 95.0%	98.7%	Jul-25	>= 95.0%	99.2%	
203 - Booked 12+6	>= 90.0%	90.5%	Aug-25		>= 90.0%	92.3%	Jul-25	>= 90.0%	91.5%	
586 - Booked 10+0		69.2%	Aug-25			74.7%	Jul-25		67.9%	
204 - Inductions of labour - delayed > 24 hours	<= 40%	37.4%	Aug-25		<= 40%	36.4%	Jul-25	<= 40%	35.7%	
210 - Initiation breast feeding	>= 65%	72.57%	Aug-25		>= 65%	69.57%	Jul-25	>= 65%	69.66%	
213 - Maternity complaints	<= 5	5	Aug-25		<= 5	3	Jul-25	<= 25	9	
319 - Maternal deaths (direct)	= 0	0	Aug-25		= 0	0	Jul-25	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	8.4%	Aug-25		<= 6%	8.3%	Jul-25	<= 6%	7.8%	

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

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 3.50	2.40	Aug-25

Previous

Plan	Actual	Period
<= 3.50	0.00	Jul-25

Year to Date

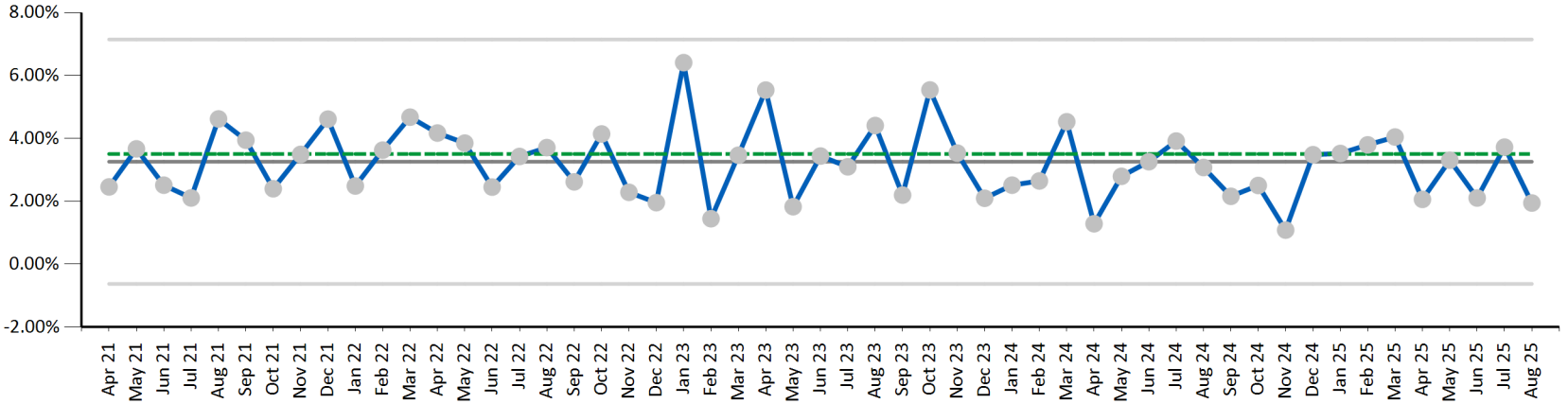
Plan	Actual
<= 3.50	2.37

23 - Maternity -3rd/4th degree tears

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 3.5%	1.9%	Aug-25

Previous

Plan	Actual	Period
<= 3.5%	3.7%	Jul-25

Year to Date

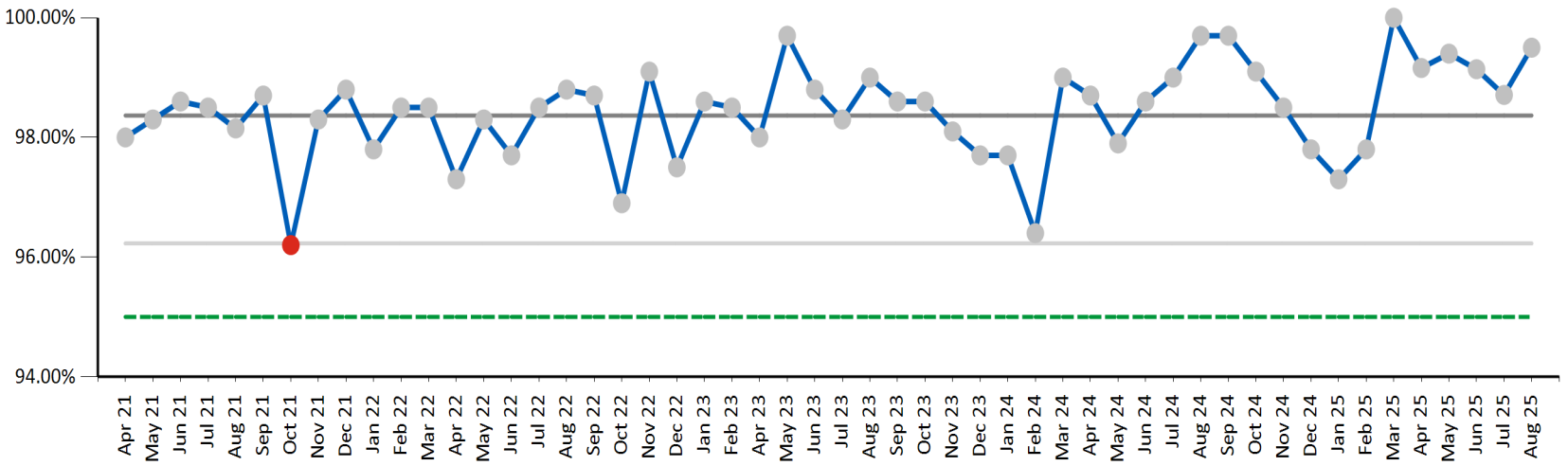
Plan	Actual
<= 3.5%	2.6%

202 - 1:1 Midwifery care in labour

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 95.0%	99.5%	Aug-25

Previous

Plan	Actual	Period
>= 95.0%	98.7%	Jul-25

Year to Date

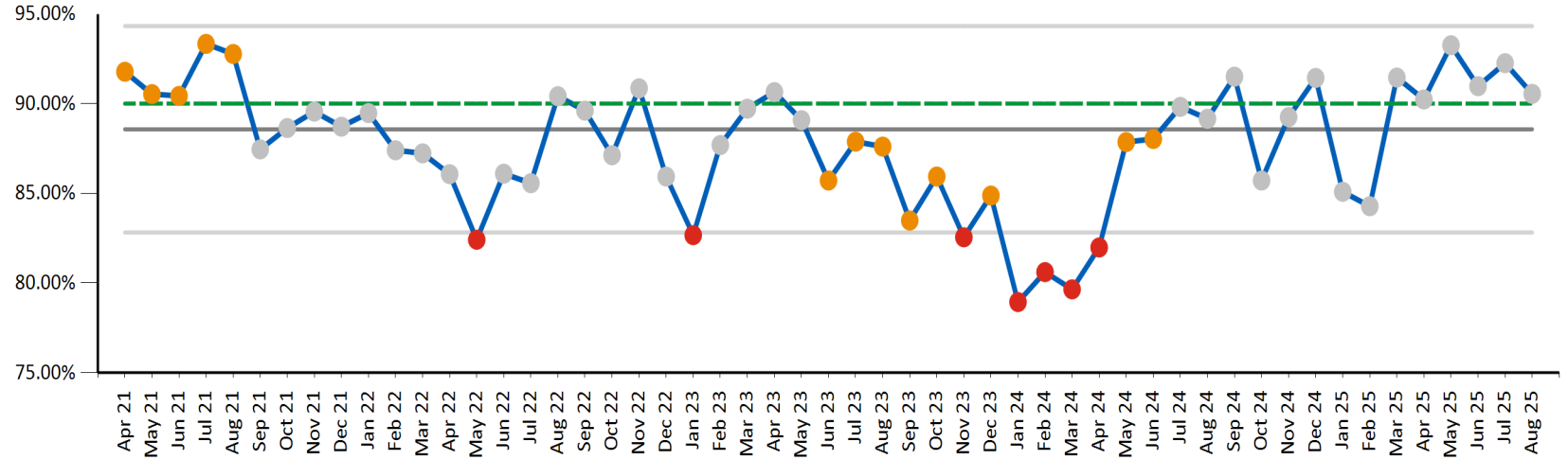
Plan	Actual
>= 95.0%	99.2%

203 - Booked 12+6

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 90.0%	90.5%	Aug-25

Previous

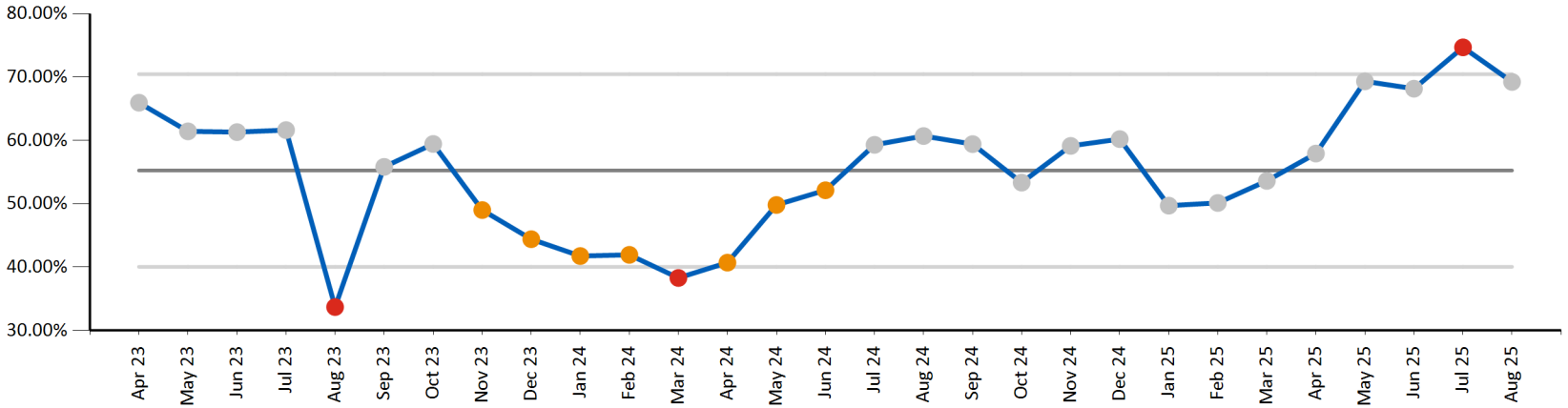
Plan	Actual	Period
>= 90.0%	92.3%	Jul-25

Year to Date

Plan	Actual
>= 90.0%	91.5%

586 - Booked 10+0

Common cause variation.



Latest

Plan	Actual	Period
	69.2%	Aug-25

Previous

Plan	Actual	Period
	74.7%	Jul-25

Year to Date

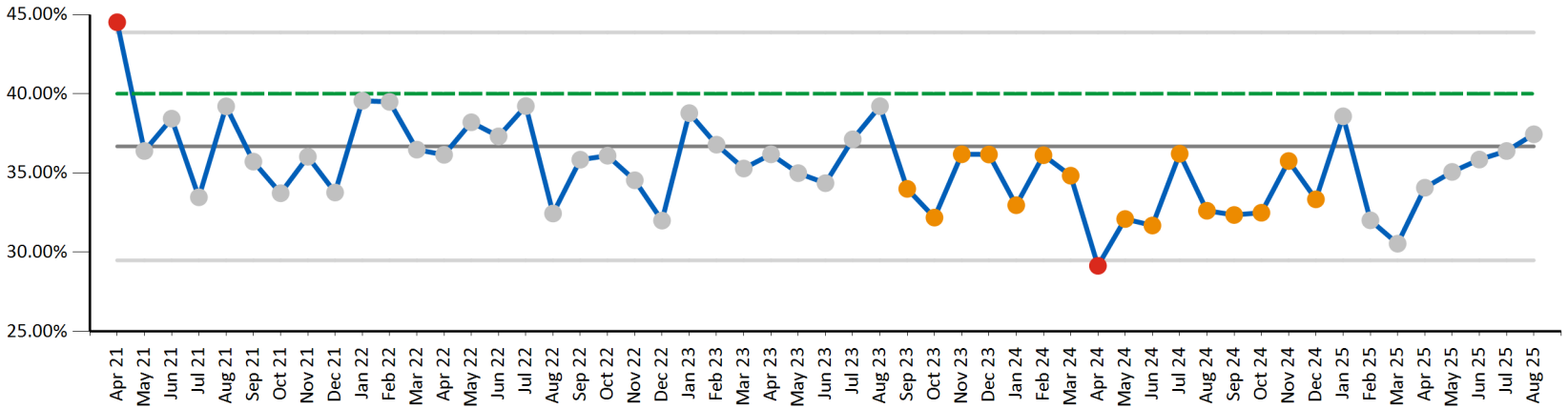
Plan	Actual
	67.9%

204 - Inductions of labour - delayed > 24 hours

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 40%	37.4%	Aug-25

Previous

Plan	Actual	Period
<= 40%	36.4%	Jul-25

Year to Date

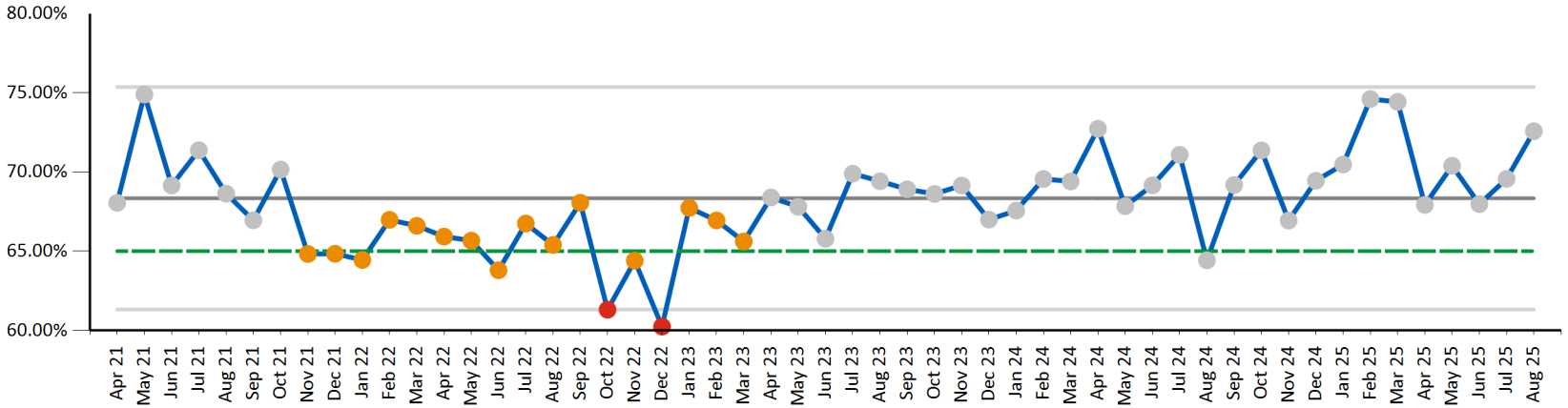
Plan	Actual
<= 40%	35.7%

210 - Initiation breast feeding

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 65%	72.57%	Aug-25

Previous

Plan	Actual	Period
>= 65%	69.57%	Jul-25

Year to Date

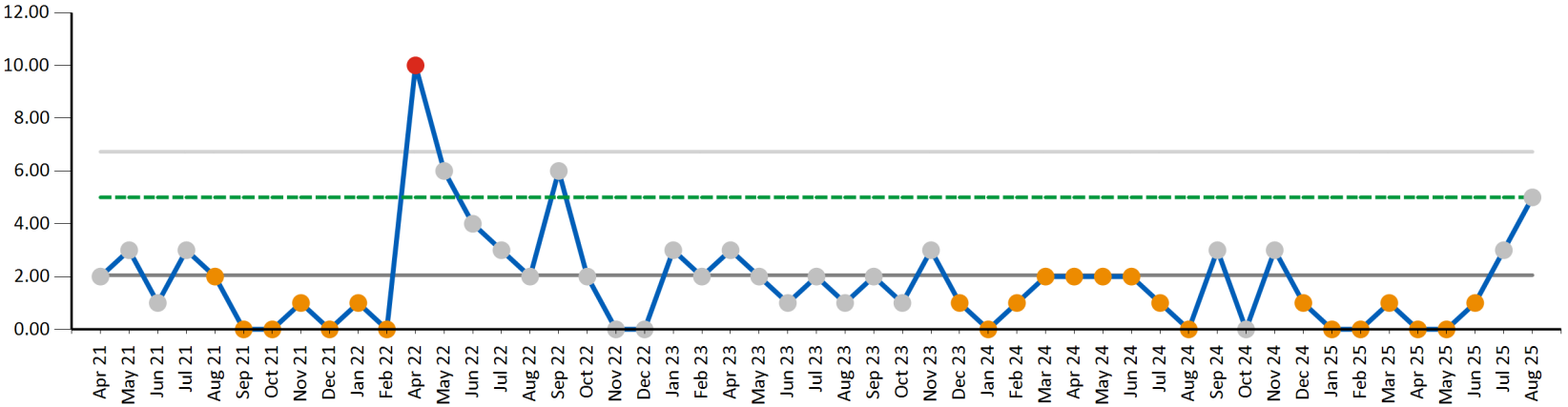
Plan	Actual
>= 65%	69.66%

213 - Maternity complaints

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 5	5	Aug-25

Previous

Plan	Actual	Period
<= 5	3	Jul-25

Year to Date

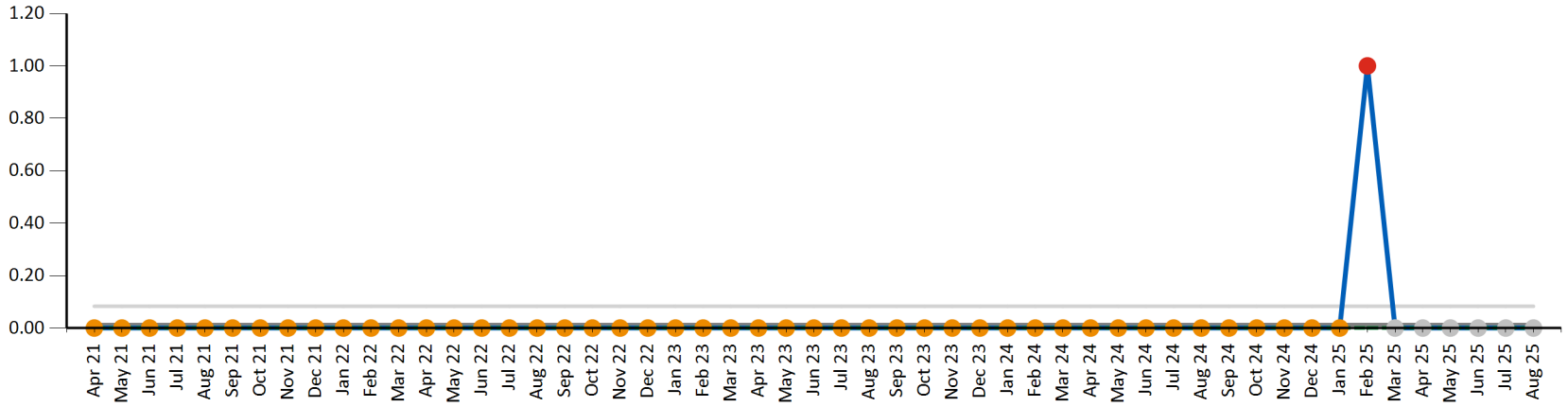
Plan	Actual
<= 25	9

319 - Maternal deaths (direct)

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
= 0	0	Aug-25

Previous

Plan	Actual	Period
= 0	0	Jul-25

Year to Date

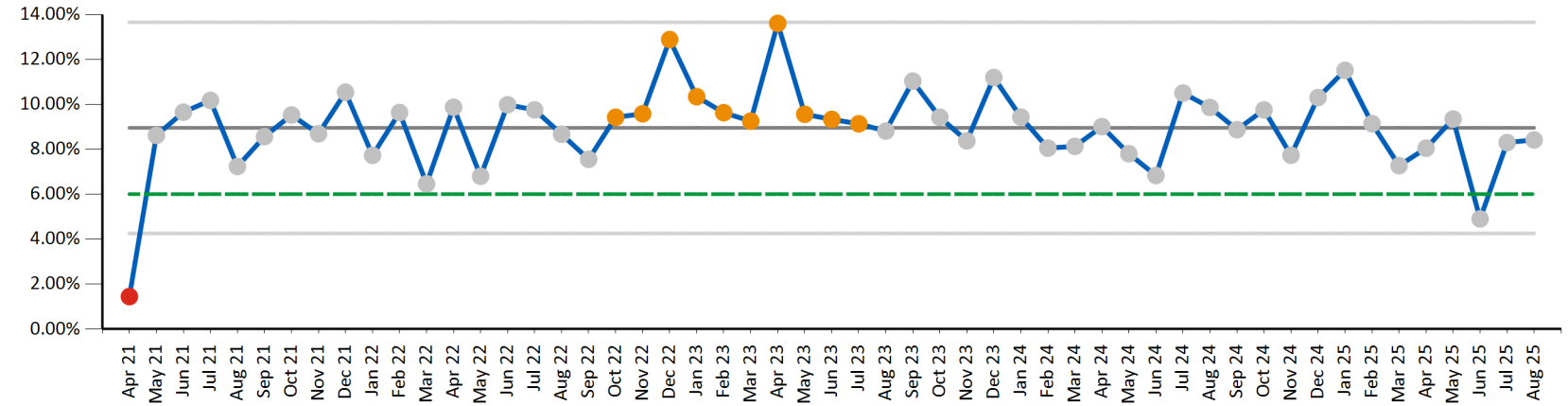
Plan	Actual
= 0	0

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

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 6%	8.4%	Aug-25

Previous

Plan	Actual	Period
<= 6%	8.3%	Jul-25

Year to Date

Plan	Actual
<= 6%	7.8%

Operational Performance - Urgent Care

NHS Bolton NHS Foundation Trust

Urgent Care

In August 2025, performance against the all-types 4-hour standard was 64.6%; this is static from July 2025 and a 5% deterioration compared to August 2024. All-types 4-hour performance remains below the trust operating plan of 76% for August 2025.

Ambulance handovers within 15 minutes fell to 54.8% in August 2025 from 60.8% in July 2025 however, this metric continues to demonstrate special cause improvement. Ambulance handovers within 30 minutes fell to 84.8% in August 2025 from 87.1% in July 2025 and handovers within 60 minutes improved by 0.4% to 97.21% in August 2025; both metrics remain within common cause variation.

In August 2025 the total A&E 12-hour waits was 864. Whilst this is an increase of 123 patients when compared to July 2025, performance remains in special cause improvement.

In August 2025, non-elective length of stay improved by 0.19 days month-on-month and is now at 4.66 days, this metric is demonstrating special cause improvement with August performance an astronomical point outside of the control range. G&A bed occupancy increased from 82.9% in July 2025 to 85.6% in August 2025; bed occupancy remains below the trust plan of 92%. Re-admissions within 30-days of discharge has remained static at 11.4%, this metric remains in common cause variation and is performing better than the trust plan of 13.5%.

NOF

For August, our fractured neck of femur performance decreased slightly to 48.5%, with 16 of 33 eligible patients getting to theatre within the 36 hour window. Of the 17x patients who breached the target, the vast majority of the patients (10) related to delays due to theatre capacity, exacerbated with consultant annual leave over August, with 5x relating to optimisation of patients including anticoagulants, and 2x due to delay in admission. Additional theatre capacity which has been introduced in the past few months has had a positive impact on performance overall, with average time to theatre dropping for the last four months consecutively. Mortality has also improved to under the national average when adjusted for casemix. A robust action plan continues to be progressed.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
53 - A&E 4 hour target	>= 76%	64.6%	Aug-25		>= 75%	64.8%	Jul-25	>= 76%	66.2%	?
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	54.8%	Aug-25	H	>= 65.0%	60.8%	Jul-25	>= 65.0%	57.4%	F
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	84.8%	Aug-25		>= 95.0%	87.1%	Jul-25	>= 95.0%	86.0%	F
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100%	97.21%	Aug-25		= 100%	96.79%	Jul-25	= 100%	95.85%	?
539 - A&E 12 hour waits	= 0	864	Aug-25	L	= 0	741	Jul-25	= 0	3,857	F
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	48.5%	Aug-25	L	>= 75%	51.4%	Jul-25	>= 75%	44.0%	?

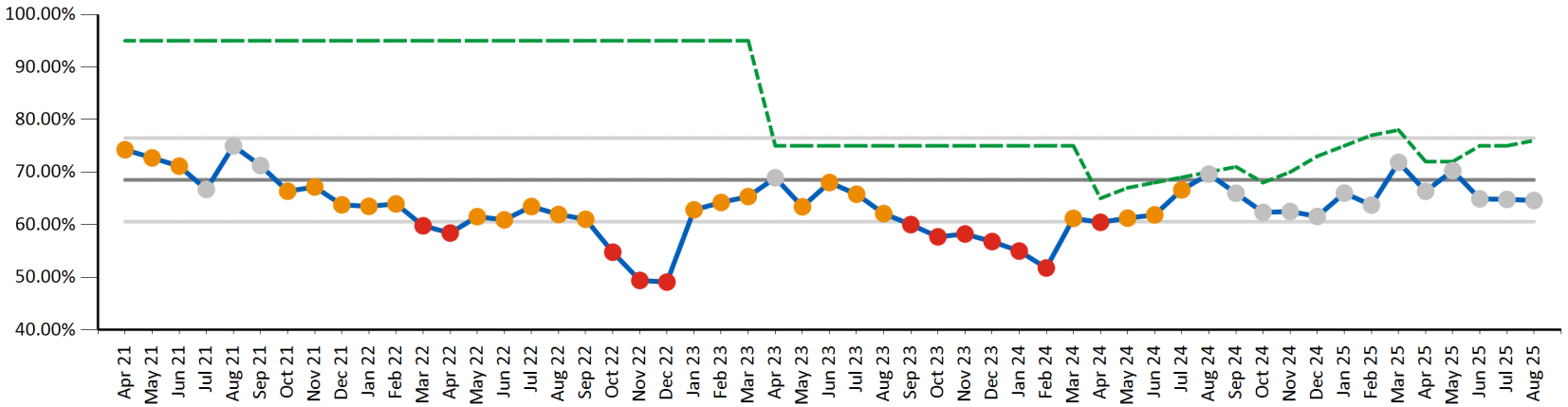
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
56 - Stranded patients - over 7 days	<= 200	259	Aug-25		<= 200	228	Jul-25	<= 200	259	F
307 - Stranded Patients - LOS 21 days and over	<= 69	86	Aug-25		<= 69	77	Jul-25	<= 69	86	?
541 - Adult G&A bed occupancy	<= 92.0%	85.6%	Aug-25		<= 92.0%	82.9%	Jul-25	<= 92.0%	85.9%	P
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.66	Aug-25	L	<= 3.70	4.85	Jul-25	<= 3.70	4.91	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	11.4%	Jul-25		<= 13.5%	11.7%	Jun-25	<= 13.5%	11.3%	P
554 - 2 Hour Urgent Community Response %	<= 70.0%	77.2%	Aug-25		<= 70.0%	87.8%	Jul-25	<= 70.0%	82.1%	?
555 - 2 Hour Urgent Community Response Referrals	>= 358	263	Aug-25	H	>= 358	279	Jul-25	>= 1,790	1,271	F

53 - A&E 4 hour target

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 76%	64.6%	Aug-25

Previous

Plan	Actual	Period
>= 75%	64.8%	Jul-25

Year to Date

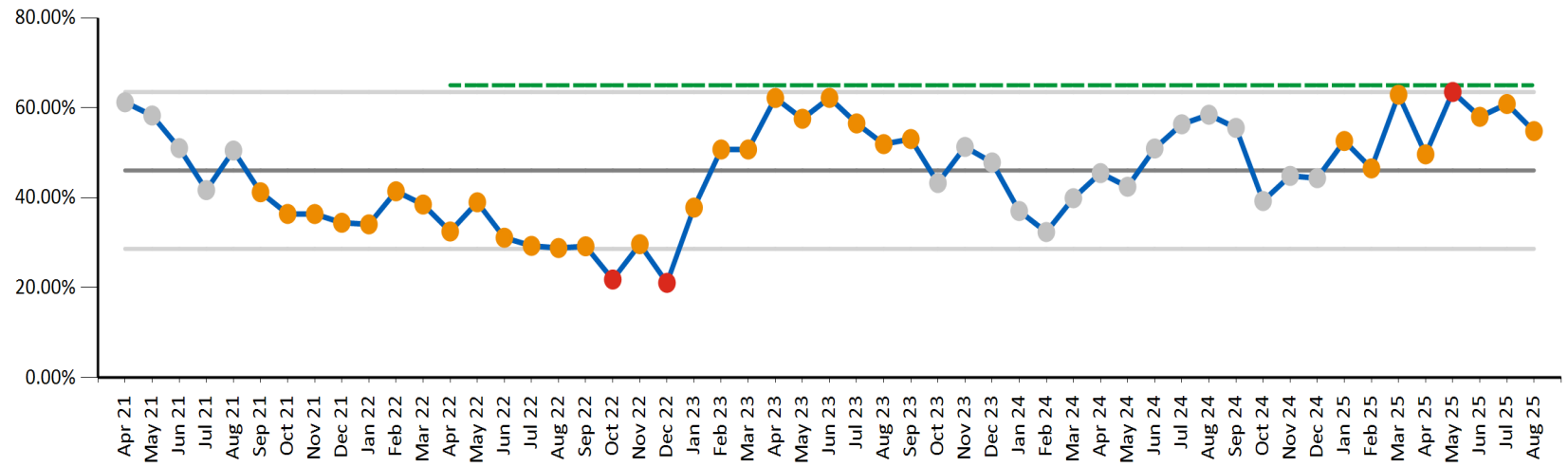
Plan	Actual
>= 76%	66.2%

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

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 65.0%	54.8%	Aug-25

Previous

Plan	Actual	Period
>= 65.0%	60.8%	Jul-25

Year to Date

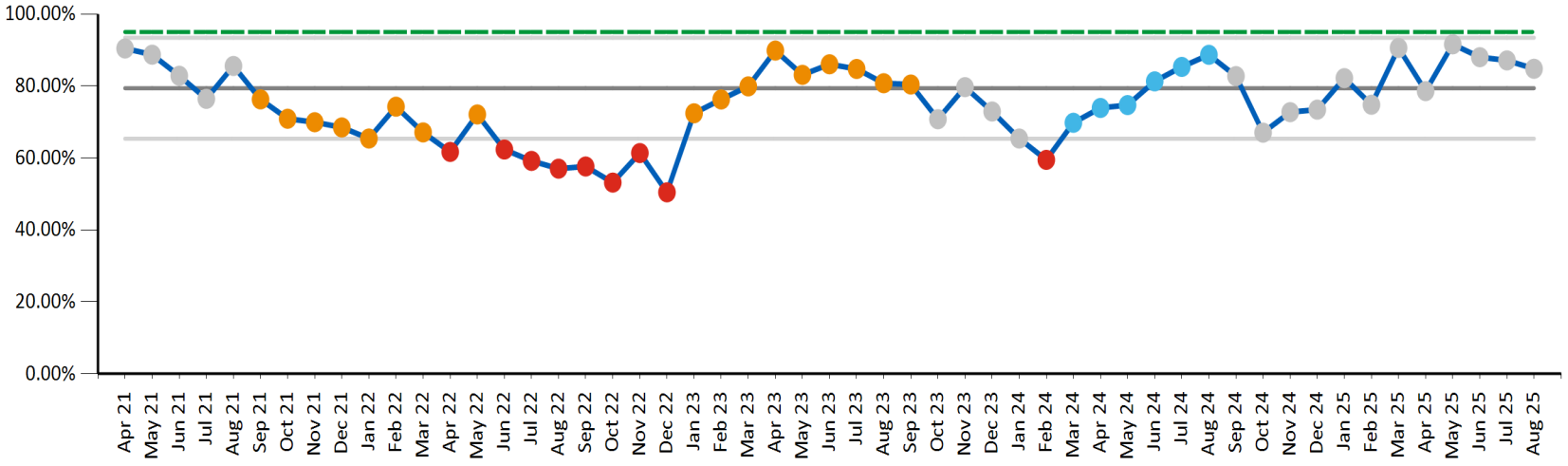
Plan	Actual
>= 65.0%	57.4%

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95.0%	84.8%	Aug-25

Previous

Plan	Actual	Period
>= 95.0%	87.1%	Jul-25

Year to Date

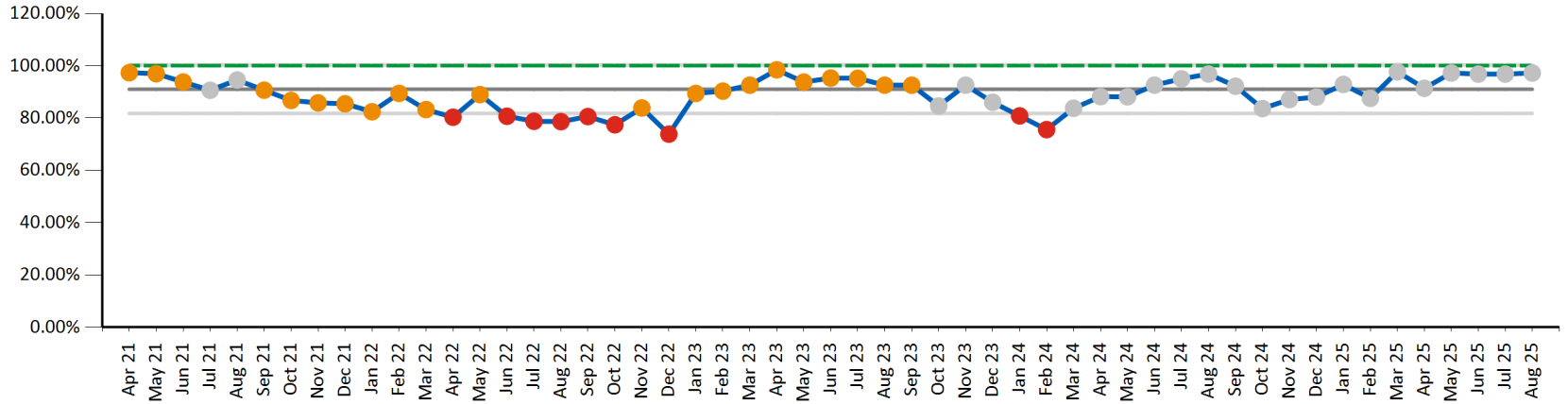
Plan	Actual
>= 95.0%	86.0%

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
= 100%	97.21%	Aug-25

Previous

Plan	Actual	Period
= 100%	96.79%	Jul-25

Year to Date

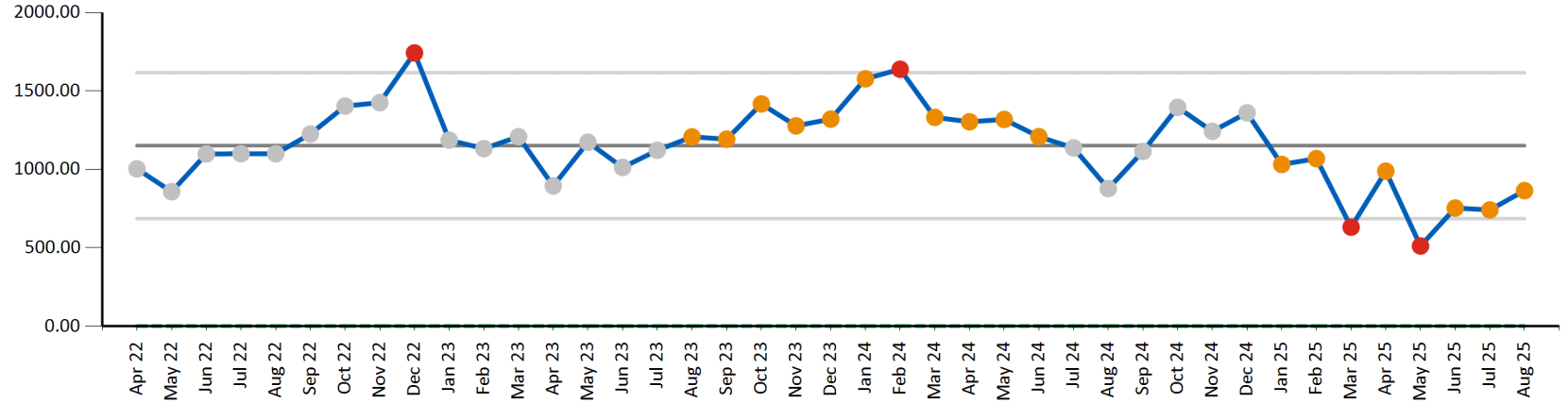
Plan	Actual
= 100%	95.85%

539 - A&E 12 hour waits

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	864	Aug-25

Previous

Plan	Actual	Period
= 0	741	Jul-25

Year to Date

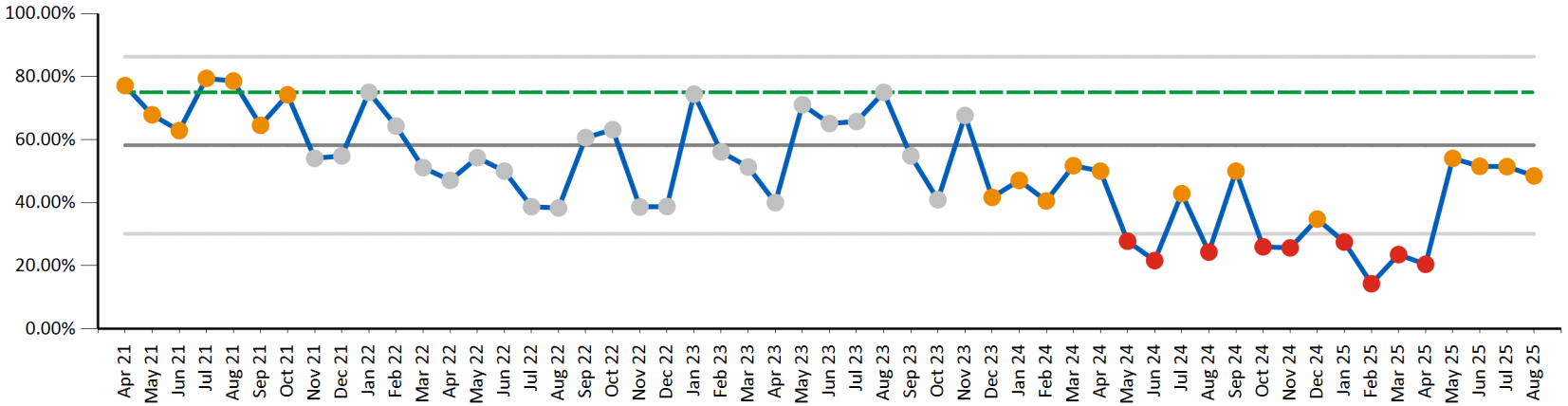
Plan	Actual
= 0	3,857

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

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 75%	48.5%	Aug-25

Previous

Plan	Actual	Period
>= 75%	51.4%	Jul-25

Year to Date

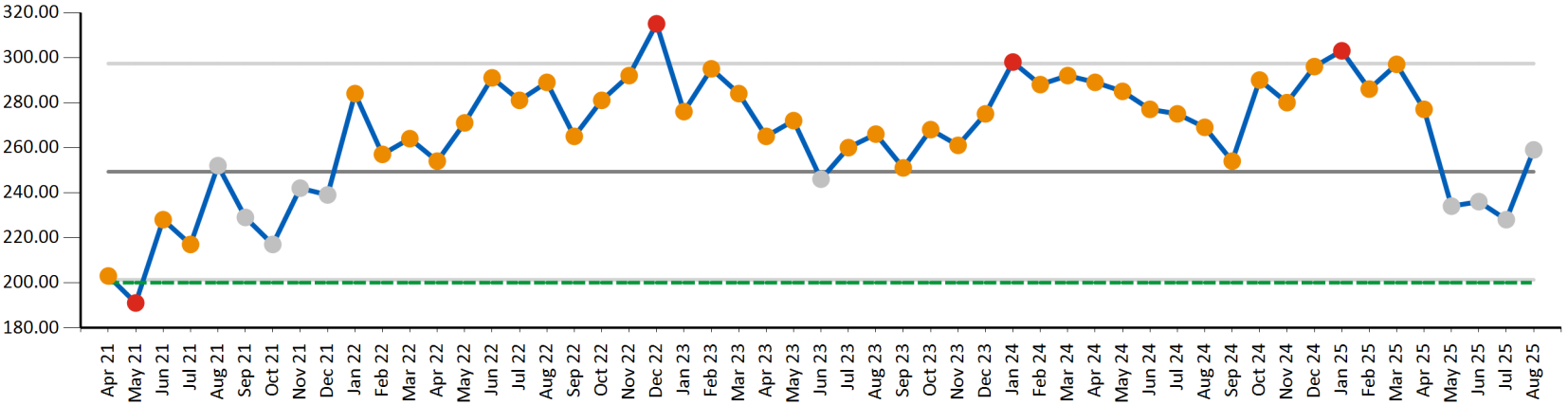
Plan	Actual
>= 75%	44.0%

56 - Stranded patients - over 7 days

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 200	259	Aug-25

Previous

Plan	Actual	Period
<= 200	228	Jul-25

Year to Date

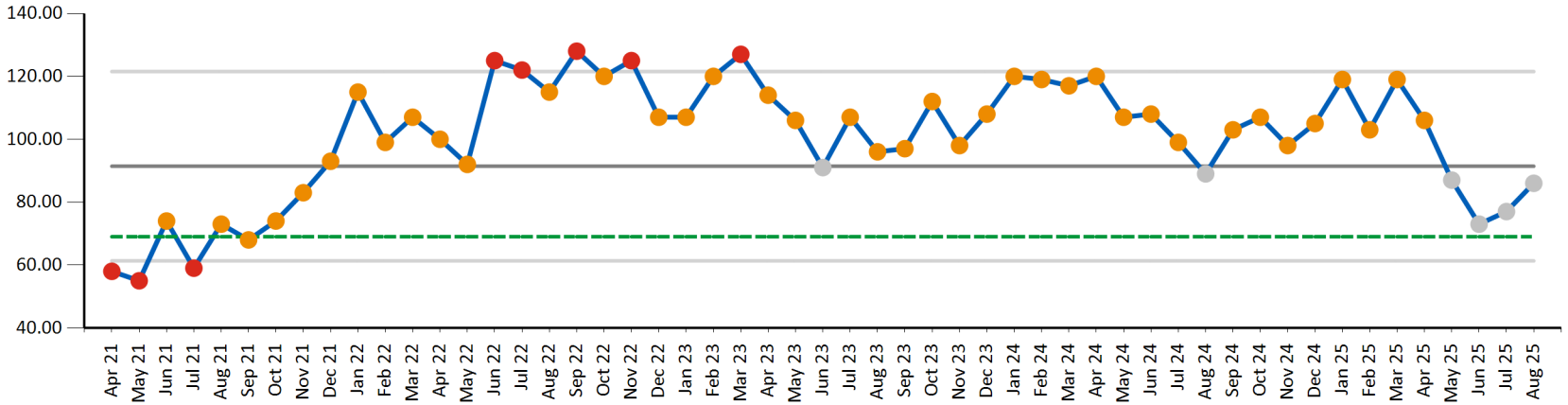
Plan	Actual
<= 200	259

307 - Stranded Patients - LOS 21 days and over

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 69	86	Aug-25

Previous

Plan	Actual	Period
<= 69	77	Jul-25

Year to Date

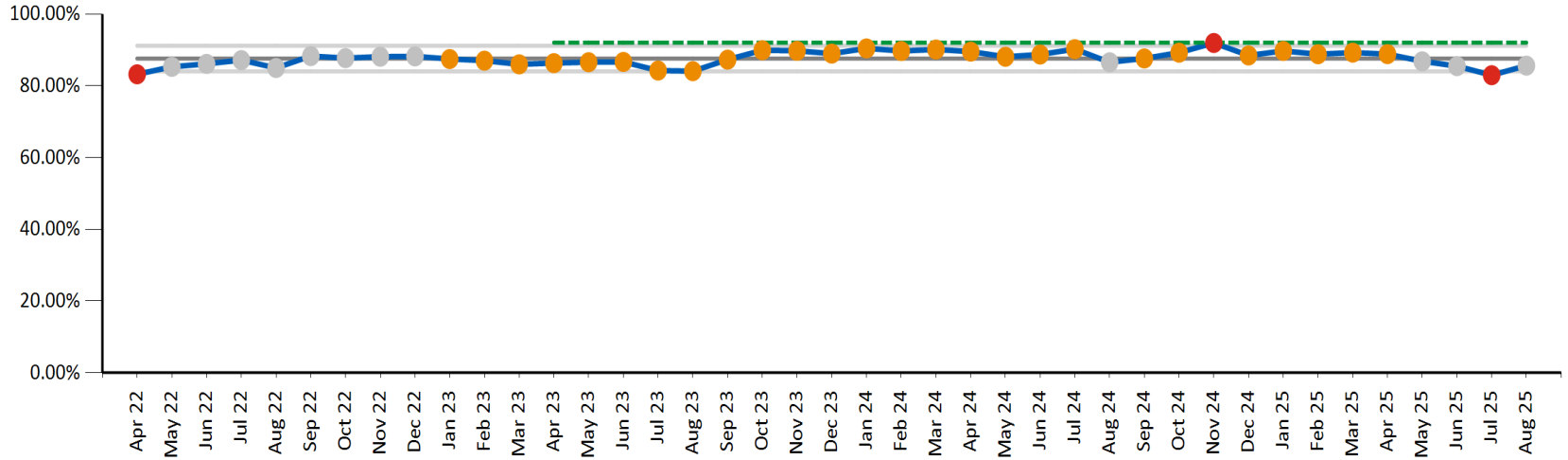
Plan	Actual
<= 69	86

541 - Adult G&A bed occupancy

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 92.0%	85.6%	Aug-25

Previous

Plan	Actual	Period
<= 92.0%	82.9%	Jul-25

Year to Date

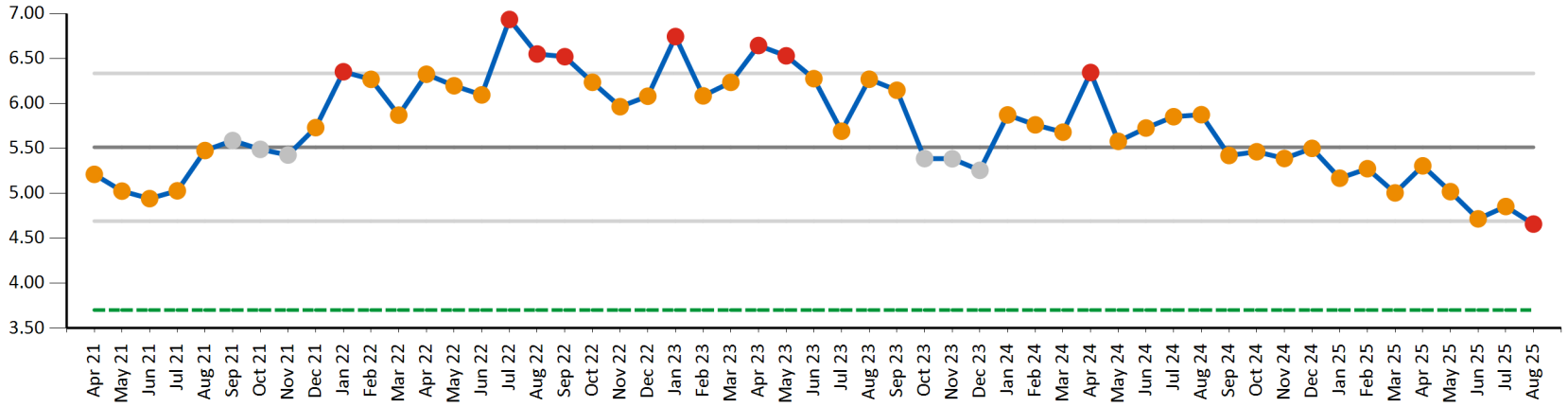
Plan	Actual
<= 92.0%	85.9%

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	4.66	Aug-25

Previous

Plan	Actual	Period
<= 3.70	4.85	Jul-25

Year to Date

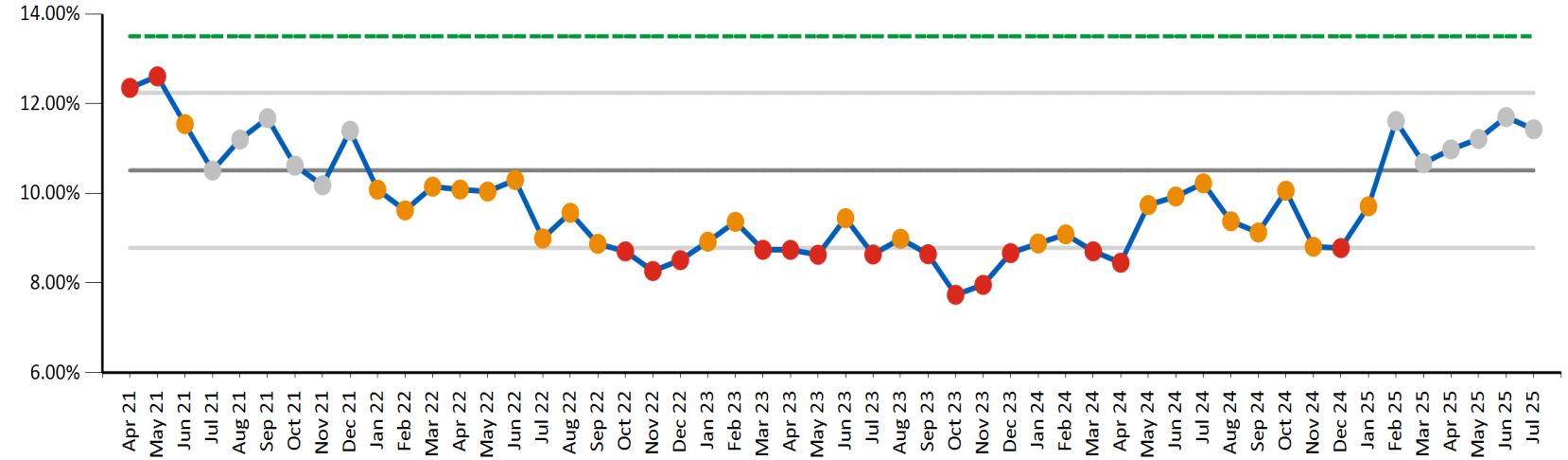
Plan	Actual
<= 3.70	4.91

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%	Jul-25

Previous

Plan	Actual	Period
<= 13.5%	11.7%	Jun-25

Year to Date

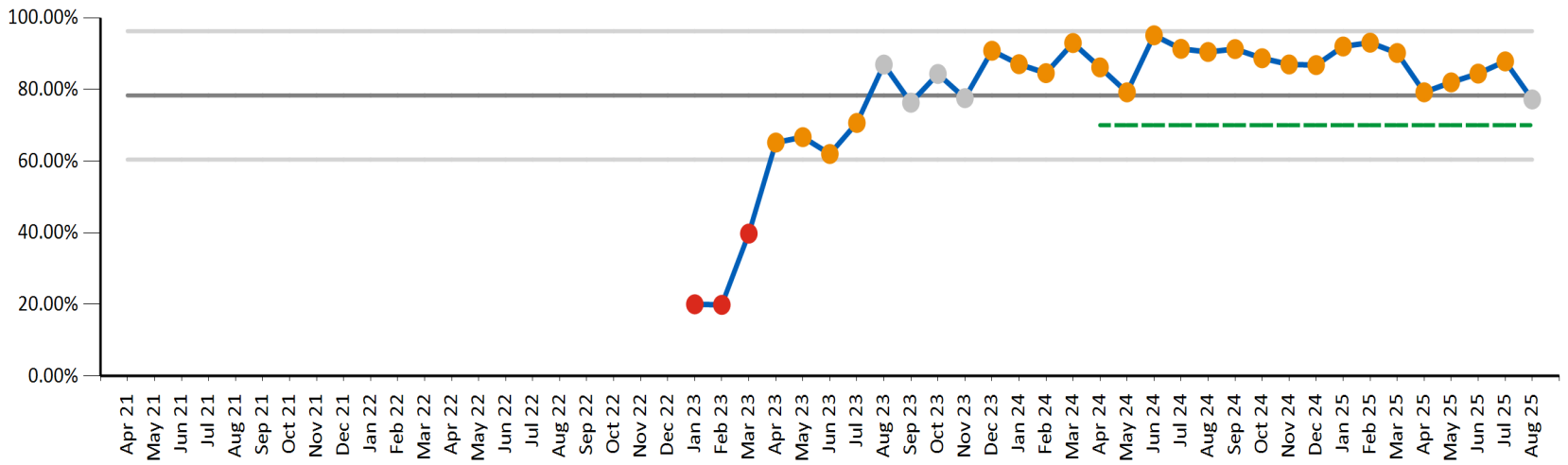
Plan	Actual
<= 13.5%	11.3%

554 - 2 Hour Urgent Community Response %

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 70.0%	77.2%	Aug-25

Previous

Plan	Actual	Period
<= 70.0%	87.8%	Jul-25

Year to Date

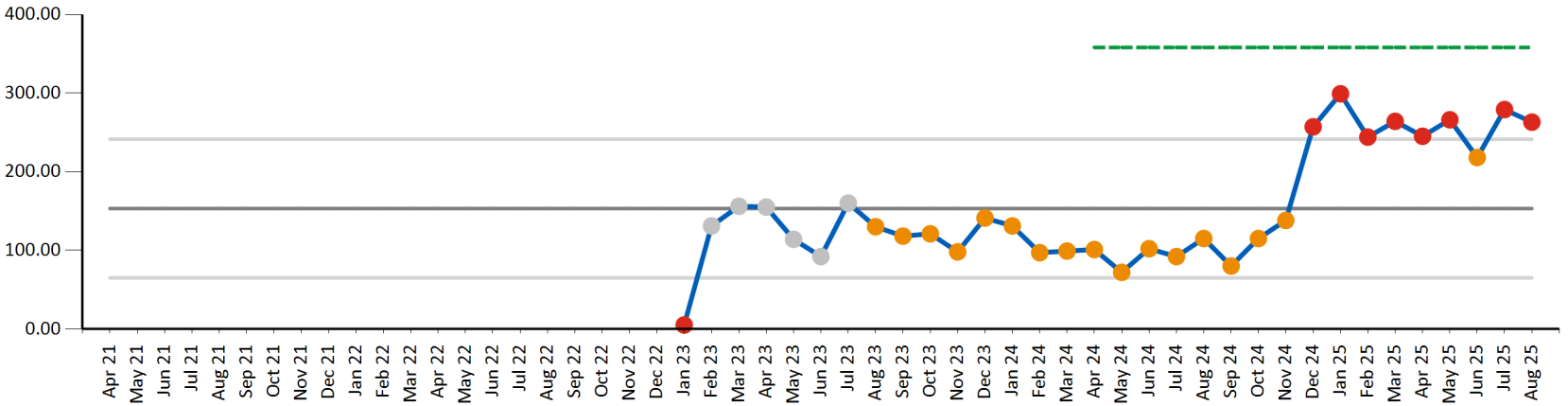
Plan	Actual
<= 70.0%	82.1%

555 - 2 Hour Urgent Community Response Referrals

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 358	263	Aug-25

Previous

Plan	Actual	Period
>= 358	279	Jul-25

Year to Date

Plan	Actual
>= 1,790	1,271

Operational Performance - Elective Care

NHS Bolton NHS Foundation Trust

RTT

We finished August with 0x 78-week breaches, which is the first time since April 2020.

We finished August with 28x 65-week breaches. 4x of these patients were patients awaiting graft material, 11x patients were associated with capacity constraints, 11x were patients with complex pathways, and 2x patients chose to delay their treatment.

We finished August with 1,153x 52-week breaches, which is an improvement compared to last month. We continue to track largely in line with our trajectory when adjusted for the impact of the industrial action in July.

Our overall waiting list size remained largely static at 37,521 patients.

DM01

The final position for August 2025 is 14.3% with 509 patients waiting longer than 6 weeks for a diagnostic test (operating plan standard is 5%). This is a 3.5% improvement on July 2025.

This is largely driven by Cystoscopy, Urodynamics and Audiology.

Audiology remains the biggest concern. Additional activity has taken place at weekends throughout August, seeing a reduction in the number of patients waiting overall as well as a reduction in those waiting more than 6 weeks. Improvement work is continuing to further reduce our longest waiting patients in the coming months.

	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%	58.0%	Aug-25	L	>= 92%	57.2%	Jul-25	>= 92%	56.6%	F
314 - RTT 18 week waiting list	<= 38,187	37,521	Aug-25	H	<= 38,500	37,565	Jul-25	<= 38,187	37,521	P
42 - RTT 52 week waits (incomplete pathways)		1,153	Aug-25	L		1,230	Jul-25		6,085	
540 - RTT 65 week waits (incomplete pathways)	<= 896	28	Aug-25	L	<= 910	35	Jul-25	<= 4,613	119	P
526 - RTT 78 week waits (incomplete pathways)	= 0	0	Aug-25	L	= 0	1	Jul-25	= 0	5	F
527 - RTT 104 week waits (incomplete pathways)	= 0	0	Aug-25	L	= 0	0	Jul-25	= 0	0	F
72 - Diagnostic Waits >6 weeks %	<= 5%	14.3%	Aug-25	L	<= 5%	17.8%	Jul-25	<= 5%	14.4%	F
489 - Daycase Rates	>= 85%	80.1%	Aug-25		>= 85%	85.0%	Jul-25	>= 85%	81.1%	?

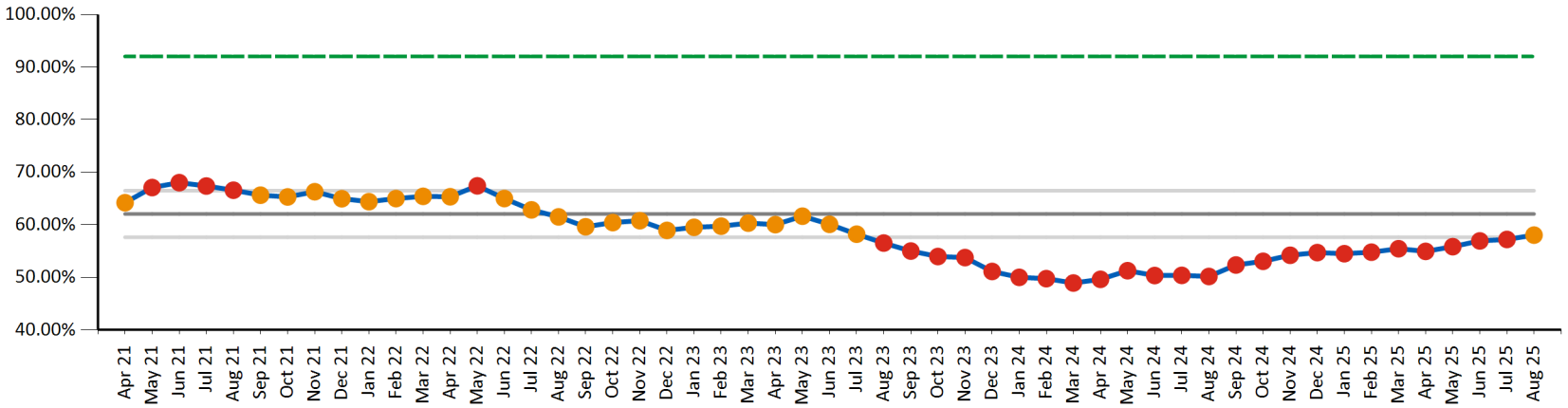
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
582 - Theatre Utilisation - Capped		74.9%	Aug-25			73.5%	Jul-25		75.3%	
583 - Theatre Utilisation - Uncapped		79.3%	Aug-25	L		76.4%	Jul-25		79.1%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.2%	Jul-25		<= 1%	1.8%	Jun-25	<= 1%	1.8%	?
62 - Cancelled operations re-booked within 28 days	= 100%	62.9%	Jul-25		= 100%	76.6%	Jun-25	= 100%	29.5%	?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.27	Aug-25		<= 2.00	3.11	Jul-25	<= 2.00	3.06	?
309 - DNA Rate - New	<= 6.3%	9.7%	Aug-25		<= 6.3%	9.6%	Jul-25	<= 6.3%	9.5%	F
310 - DNA Rate - Follow up	<= 5.0%	9.0%	Aug-25		<= 5.0%	9.0%	Jul-25	<= 5.0%	9.0%	F

41 - RTT Incomplete pathways within 18 weeks %

L Special cause variation with deteriorating performance

F We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 92%	58.0%	Aug-25

Previous

Plan	Actual	Period
>= 92%	57.2%	Jul-25

Year to Date

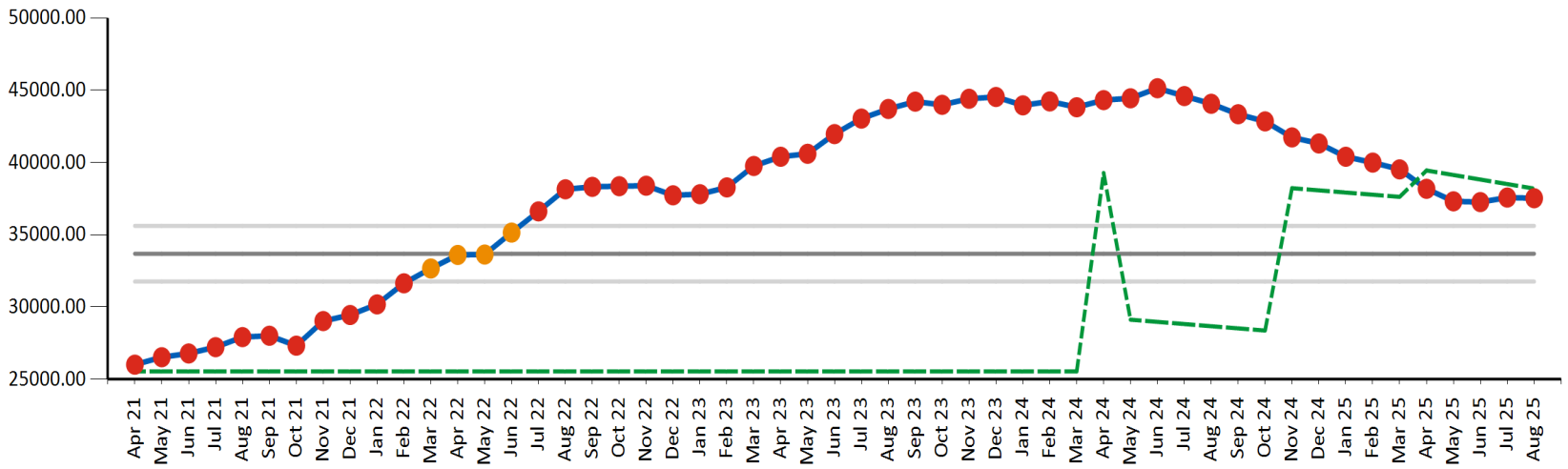
Plan	Actual
>= 92%	56.6%

314 - RTT 18 week waiting list

Special cause variation with deteriorating performance

Target will be regularly met.

5/6



Latest

Plan	Actual	Period
< = 38,187	37,521	Aug-25

Previous

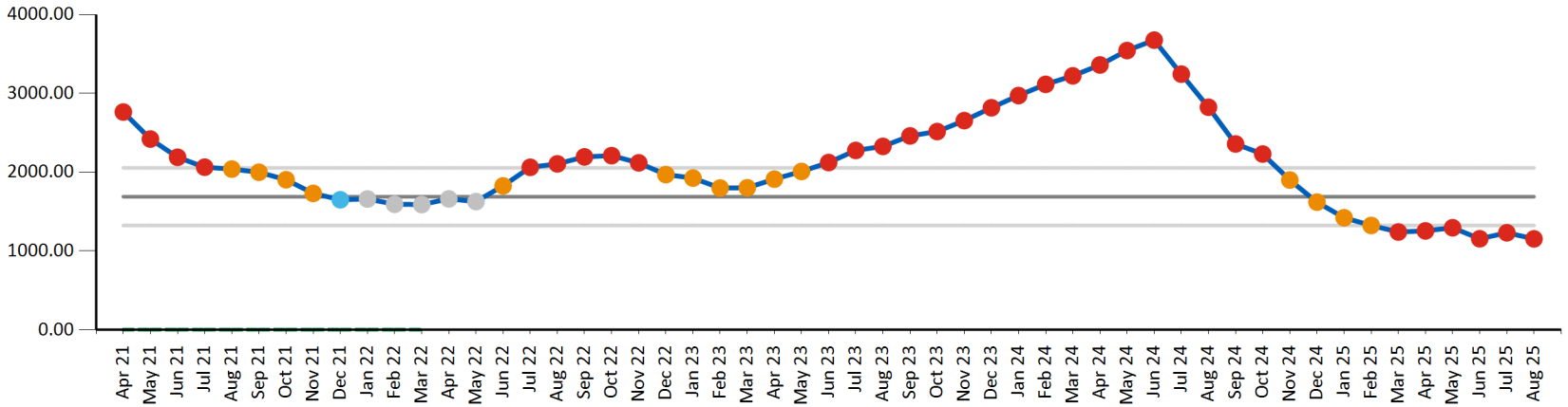
Plan	Actual	Period
< = 38,500	37,565	Jul-25

Year to Date

Plan	Actual
< = 38,187	37,521

42 - RTT 52 week waits (incomplete pathways)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	1,153	Aug-25

Previous

Plan	Actual	Period
	1,230	Jul-25

Year to Date

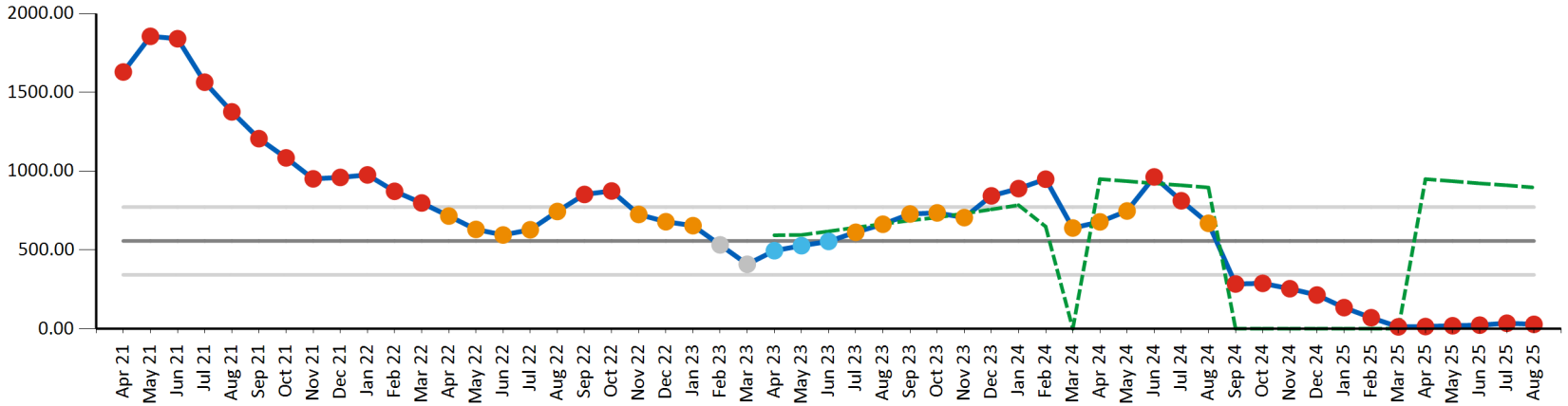
Plan	Actual
	6,085

540 - RTT 65 week waits (incomplete pathways)

Special cause variation with improving performance

Target will be regularly met.

5/6



Latest

Plan	Actual	Period
<= 896	28	Aug-25

Previous

Plan	Actual	Period
<= 910	35	Jul-25

Year to Date

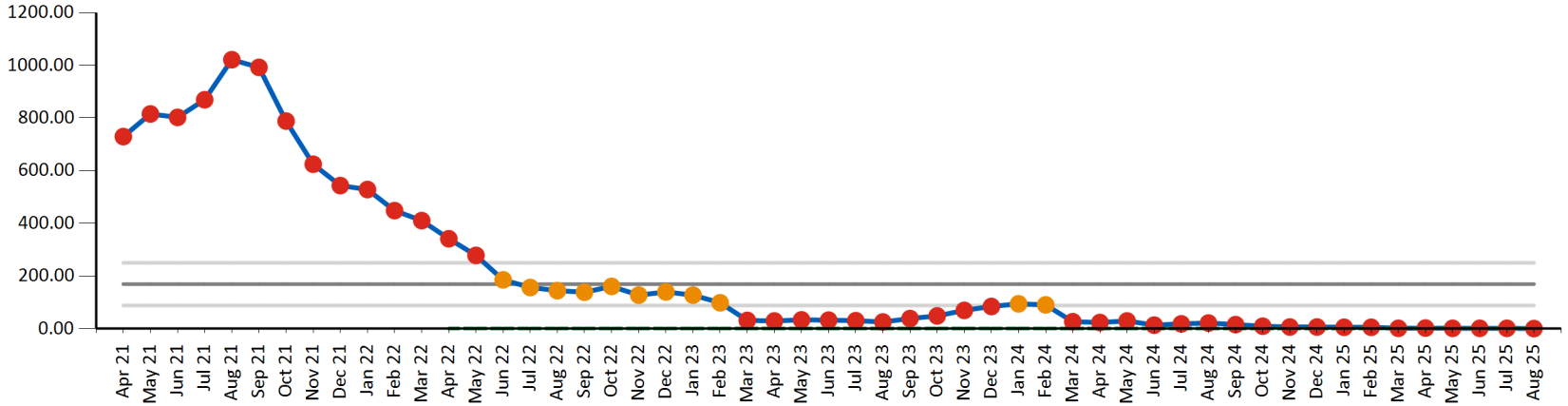
Plan	Actual
<= 4,613	119

526 - RTT 78 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

1/6



Latest

Plan	Actual	Period
= 0	0	Aug-25

Previous

Plan	Actual	Period
= 0	1	Jul-25

Year to Date

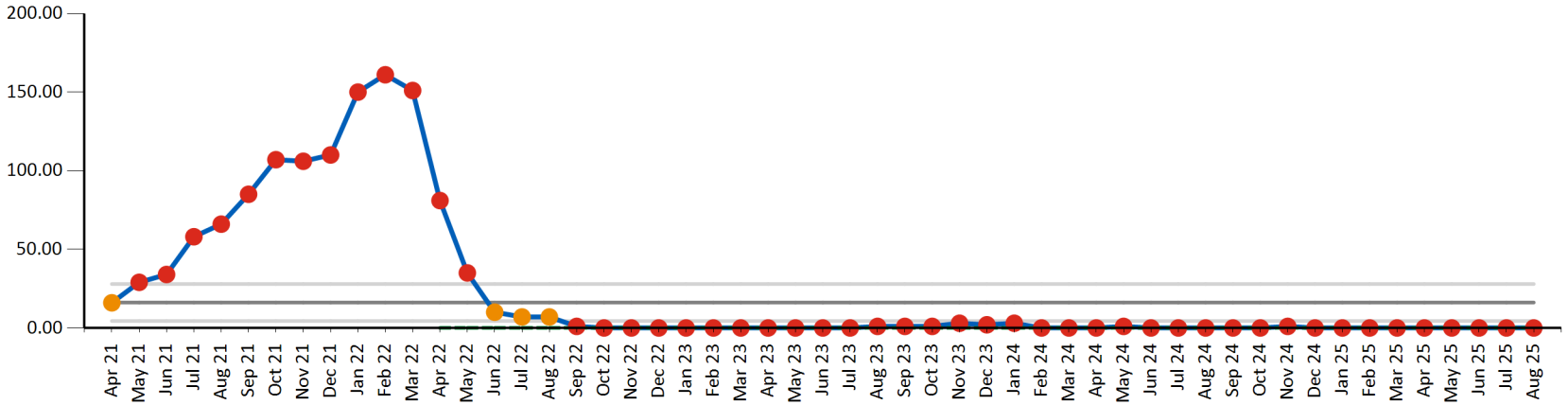
Plan	Actual
= 0	5

527 - RTT 104 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

6/6



Latest

Plan	Actual	Period
= 0	0	Aug-25

Previous

Plan	Actual	Period
= 0	0	Jul-25

Year to Date

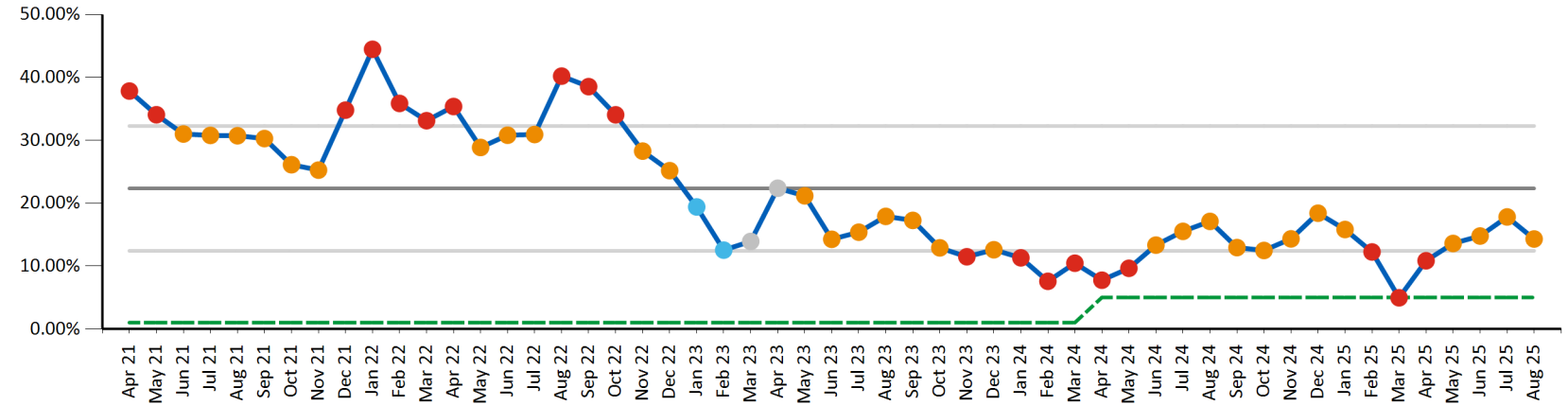
Plan	Actual
= 0	0

72 - Diagnostic Waits >6 weeks %

Special cause variation with improving performance

We will regularly fail to meet the target.

1/6



Latest

Plan	Actual	Period
<= 5%	14.3%	Aug-25

Previous

Plan	Actual	Period
<= 5%	17.8%	Jul-25

Year to Date

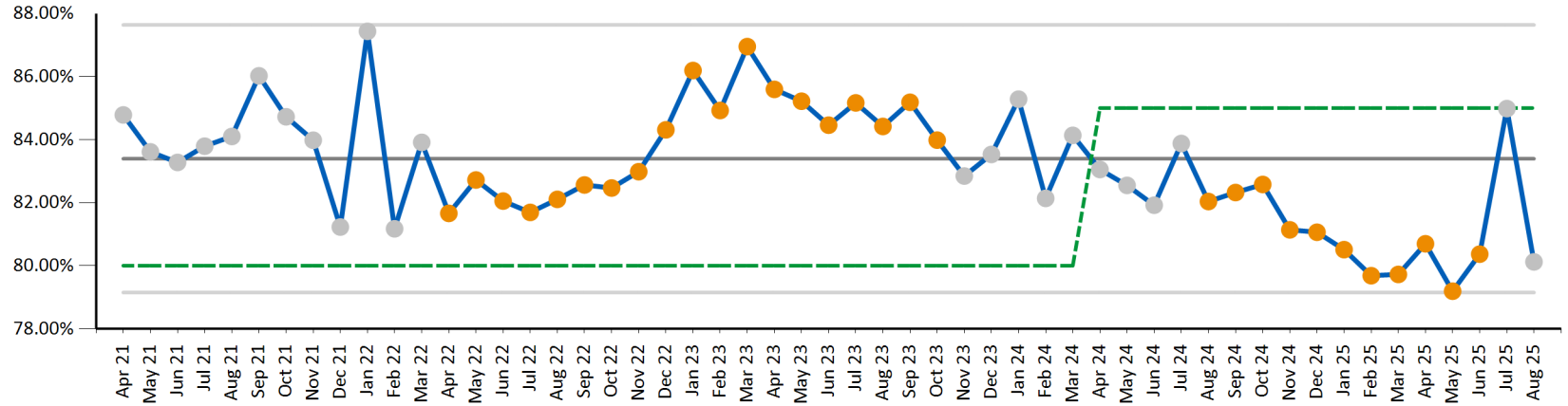
Plan	Actual
<= 5%	14.4%

489 - Daycase Rates

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 85%	80.1%	Aug-25

Previous

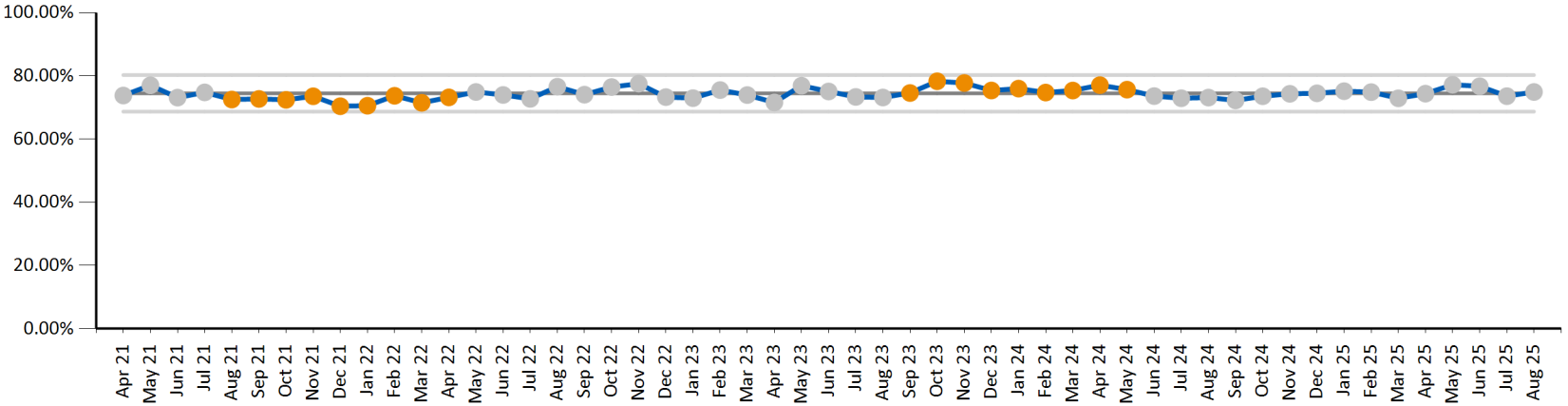
Plan	Actual	Period
>= 85%	85.0%	Jul-25

Year to Date

Plan	Actual
>= 85%	81.1%

582 - Theatre Utilisation - Capped

Common cause variation.



Latest

Plan	Actual	Period
	74.9%	Aug-25

Previous

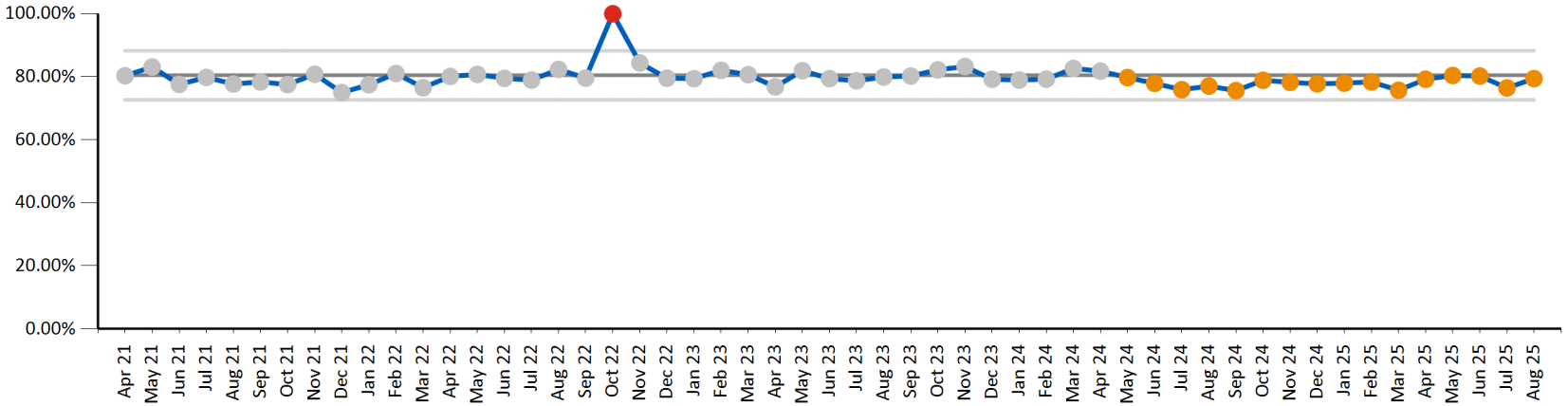
Plan	Actual	Period
	73.5%	Jul-25

Year to Date

Plan	Actual
	75.3%

583 - Theatre Utilisation - Uncapped

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	79.3%	Aug-25

Previous

Plan	Actual	Period
	76.4%	Jul-25

Year to Date

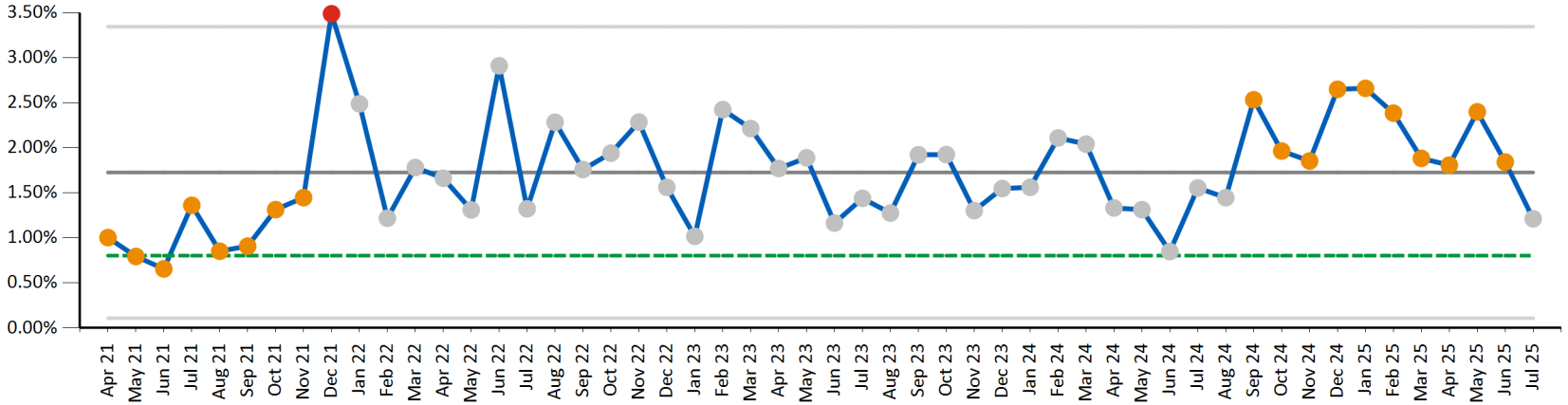
Plan	Actual
	79.1%

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 1%	1.2%	Jul-25

Previous

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

Year to Date

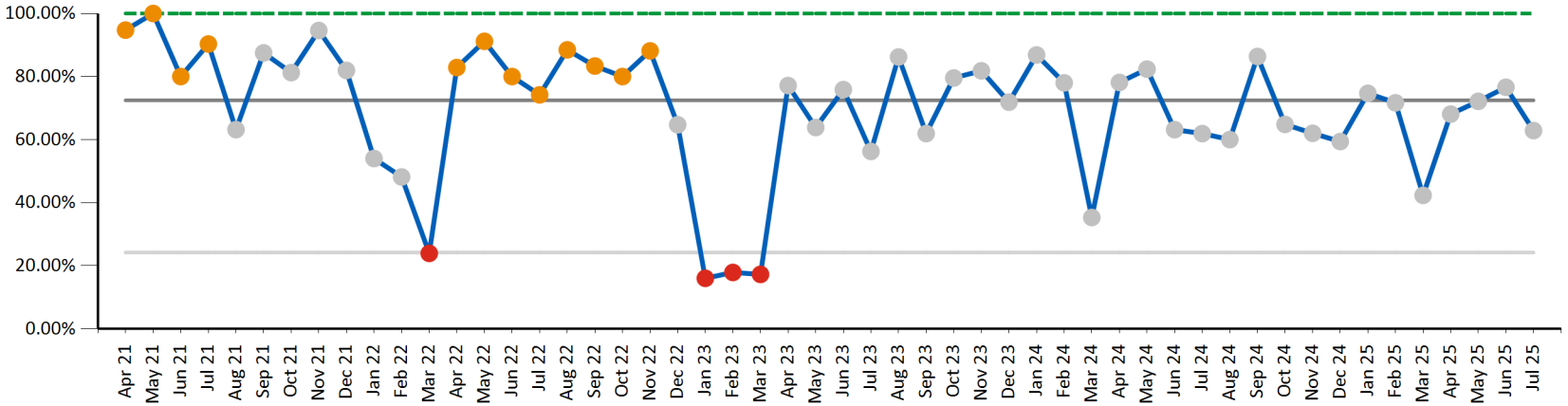
Plan	Actual
<= 1%	1.8%

62 - Cancelled operations re-booked within 28 days

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
= 100%	62.9%	Jul-25

Previous

Plan	Actual	Period
= 100%	76.6%	Jun-25

Year to Date

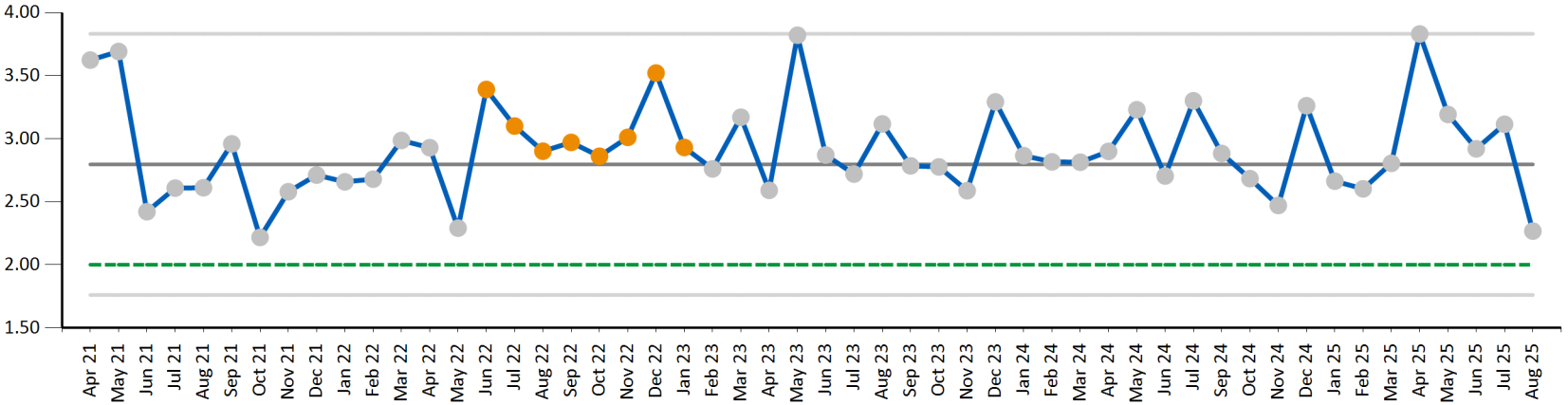
Plan	Actual
= 100%	29.5%

65 - Elective Length of Stay (Discharges in month)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 2.00	2.27	Aug-25

Previous

Plan	Actual	Period
<= 2.00	3.11	Jul-25

Year to Date

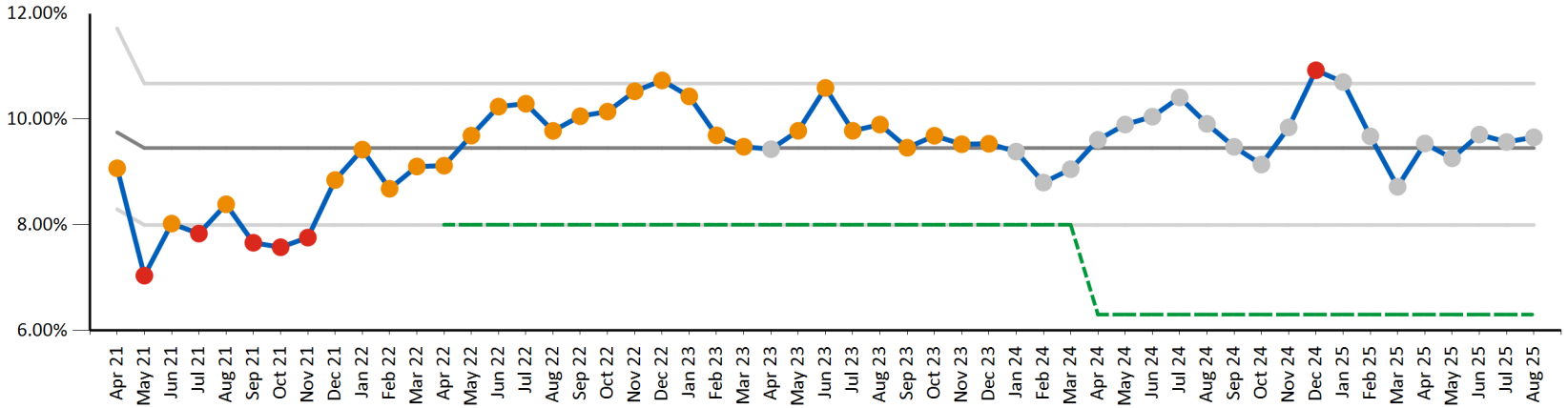
Plan	Actual
<= 2.00	3.06

309 - DNA Rate - New

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

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

Previous

Plan	Actual	Period
<= 6.3%	9.6%	Jul-25

Year to Date

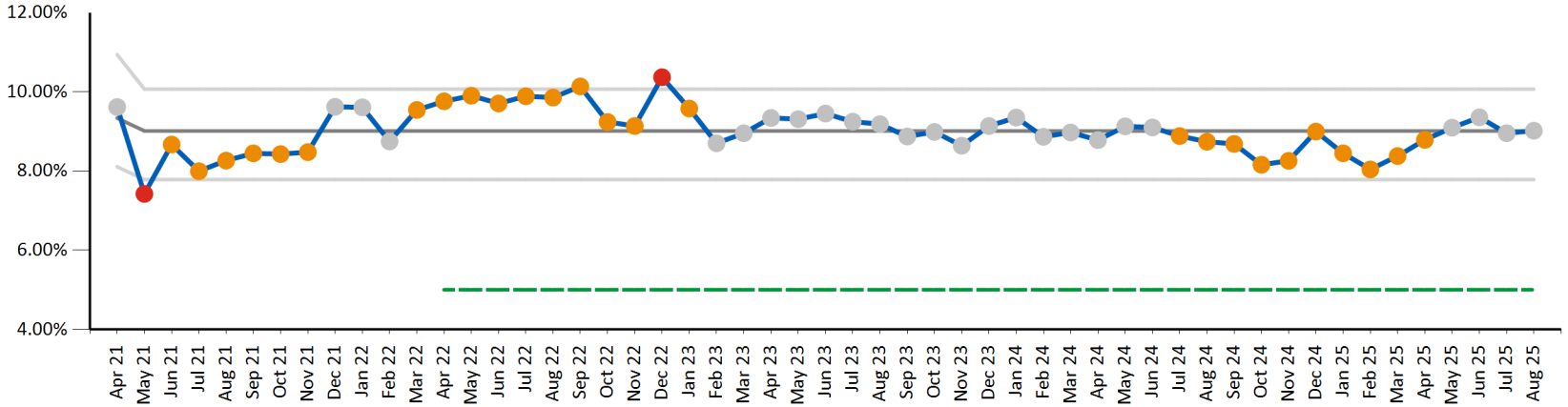
Plan	Actual
<= 6.3%	9.5%

310 - DNA Rate - Follow up

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5.0%	9.0%	Aug-25

Previous

Plan	Actual	Period
<= 5.0%	9.0%	Jul-25

Year to Date

Plan	Actual
<= 5.0%	9.0%

Operational Performance - Cancer

NHS Bolton NHS Foundation Trust

For July, we achieved the faster diagnosis standard, and the 31-day treatment standard.
We failed to achieve the 62-day standard, performing at 83.77% against the 85% target. It is expected that we will also fail the 62-day standard in August due to a number of issues including radiology capacity affecting Breast pathways, an increase in Gynaecology patients requiring local surgery, and reduced capacity provided for the Plastic Surgery service through an SLA with MFT. A recovery plan is being pulled together to ensure recovery to achieving the 62-day standard as soon as possible.

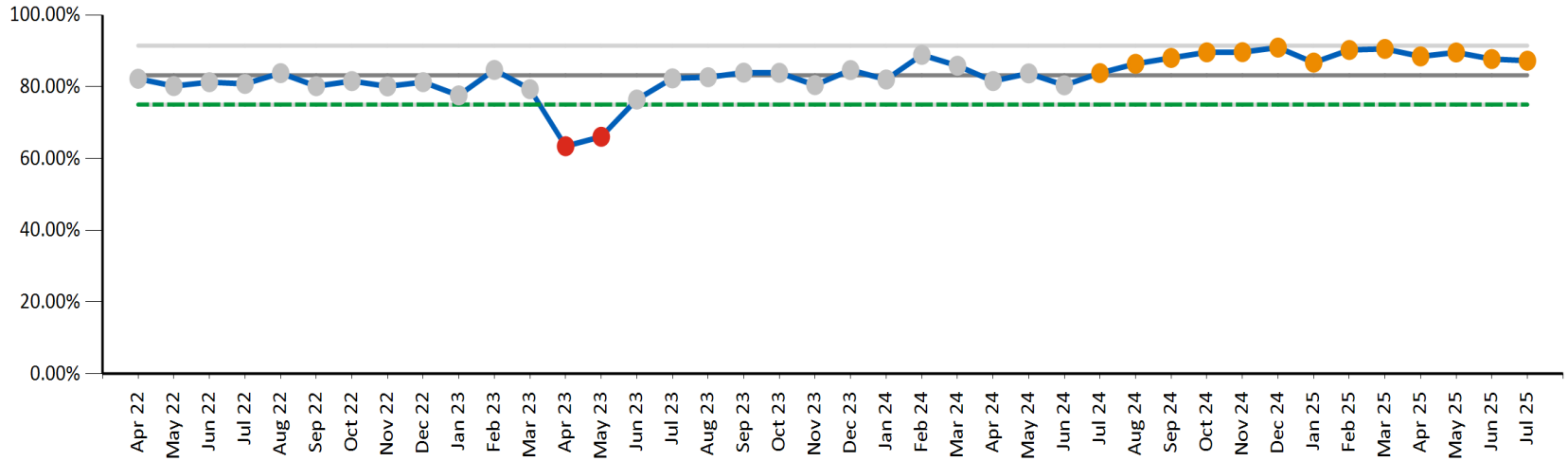
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
542 - Cancer: 28 day faster diagnosis	>= 75.0%	87.2%	Jul-25	H	>= 75.0%	87.7%	Jun-25	>= 75.0%	88.2%	?
584 - 31 Day General Treatment Standard	>= 96%	98.1%	Jul-25		>= 96%	98.6%	Jun-25	>= 96%	98.1%	?
585 - 62 Day General Standard	>= 85%	83.8%	Jul-25		>= 85%	86.5%	Jun-25	>= 85%	86.2%	?

542 - Cancer: 28 day faster diagnosis

H Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
>= 75.0%	87.2%	Jul-25

Previous

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

Year to Date

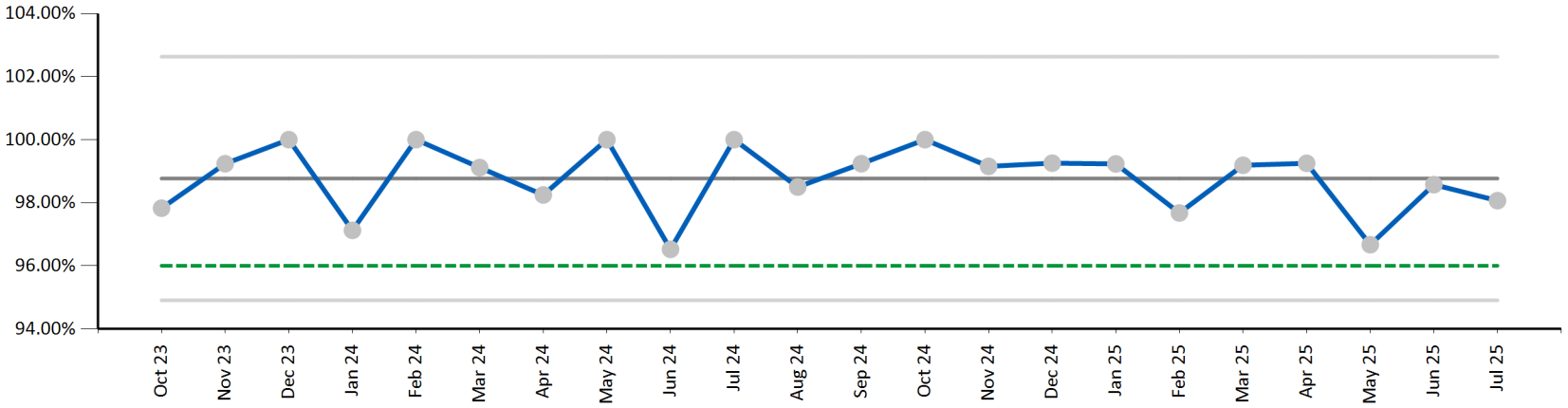
Plan	Actual
>= 75.0%	88.2%

584 - 31 Day General Treatment Standard

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 96%	98.1%	Jul-25

Previous

Plan	Actual	Period
>= 96%	98.6%	Jun-25

Year to Date

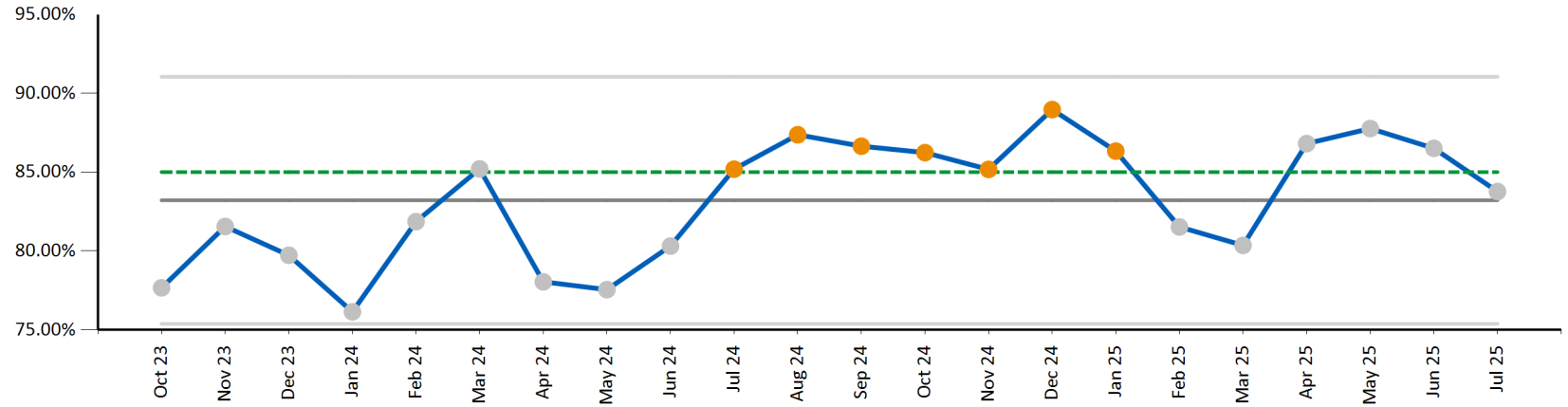
Plan	Actual
>= 96%	98.1%

585 - 62 Day General Standard

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
>= 85%	83.8%	Jul-25

Previous

Plan	Actual	Period
>= 85%	86.5%	Jun-25

Year to Date

Plan	Actual
>= 85%	86.2%

Operational Performance - Community Care

NHS Bolton NHS Foundation Trust

NCTR

In Month 5, the average number of patients with No Criteria to Reside (NCTR) has reduced to 73. NCTR lost bed reduced to 392 from 451 and this is under the operational plan of 400. This improved position has been supported by the daily grip and control of the Integrated Discharge Team leadership and the now established out of area team within IDT.

GM locality agreed target of 75 was achieved and maintained for M5 demonstrating effective flow through the system for Bolton residents residing in GM hospitals. Bolton is the only locality in GM to meet the target consistently throughout the year.

Emergency Department deflections and 2Hr UCR

ED deflections for Month 5 have decreased to 531 from 619 and remain above the plan of 400. The number of deflections has continued to remain above 500 and this demonstrates the impact of the continued work by the Admission Avoidance Team (AAT) and Home First.

Further improvements to ED deflections are expected incrementally over the remainder of the year, based upon the nationally mandated target of 180 referrals per 100,000 population per month for 2 hr UCR for 2025/2026. The AAT leadership team have in place a robust improvement plan, aligned to the national standard, which includes implementation of new pathways, improved engagement and embedding of call before you convey as business-as-usual practice.

In M5, a decrease in 2hr UCR performance to 77.2% from 87.8%, this decrease is related to ongoing data validation issues. It is expected to return to normal variation for M5 once this data validation has been completed with BI.

0-5 Years Mandated Contacts

The performance for 0-5 Years Mandated Contacts, whilst not achieving the standard, continues to demonstrate special cause improvement, with the latest August position being 87%.

EHCP compliance

Compliance was 96% in month with performance above target for three concurrent months . Robust processes are in place to monitor and escalate delays.

Looked after Children

Initial Health Assessment performance reduced to 84% in August versus the 95% standard. 49 assessments were required in month which is the highest since October 2024.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	531	Aug-25		>= 400	619	Jul-25	>= 2,000	2,847	
493 - Average Number of Patients: with no Criteria to Reside	<= 93	73	Aug-25		<= 92	75	Jul-25	<= 93	73	
494 - Average Occupied Days - for no Criteria to Reside	<= 360	392	Aug-25		<= 360	451	Jul-25	<= 1,800	2,775	

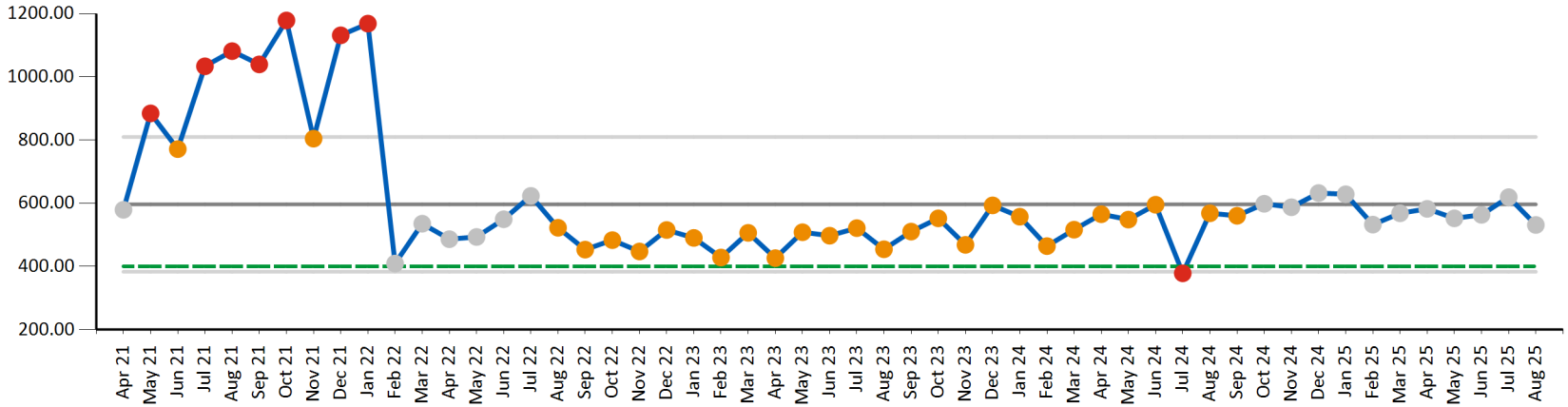
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
267 - 0-5 Health Visitor mandated contacts	>= 95%	87%	Aug-25	H	>= 95%	89%	Jul-25	>= 95%	87%	F
269 - Education, health and care plan (EHC) compliance	>= 95%	96%	Aug-25	H	>= 95%	98%	Jul-25	>= 95%	96%	?
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse	>= 90.0%	84.0%	Aug-25		>= 90.0%	88.0%	Jul-25	>= 90.0%		?
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales	>= 90.0%	92.0%	Aug-25		>= 90.0%	96.0%	Jul-25	>= 90.0%		?
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools	>= 90.0%	100.0%	Aug-25	H	>= 90.0%	100.0%	Jul-25	>= 90.0%		?

334 - Total Deflections from ED

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 400	531	Aug-25

Previous

Plan	Actual	Period
>= 400	619	Jul-25

Year to Date

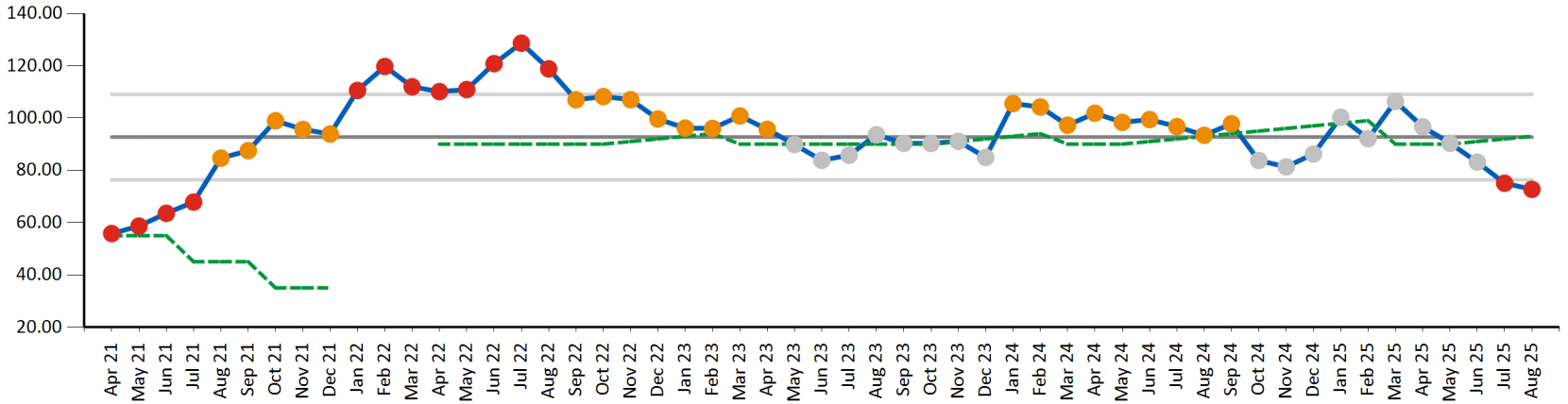
Plan	Actual
>= 2,000	2,847

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

Special cause variation with improving performance

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

3/6



Latest

Plan	Actual	Period
<= 93	73	Aug-25

Previous

Plan	Actual	Period
<= 92	75	Jul-25

Year to Date

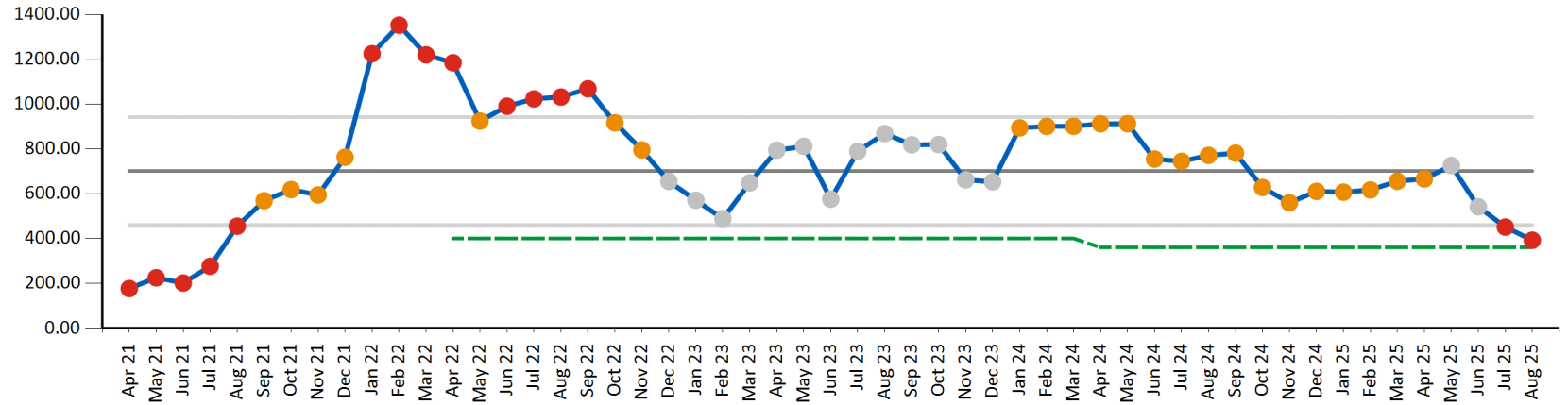
Plan	Actual
<= 93	73

494 - Average Occupied Days - for no Criteria to Reside

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 360	392	Aug-25

Previous

Plan	Actual	Period
<= 360	451	Jul-25

Year to Date

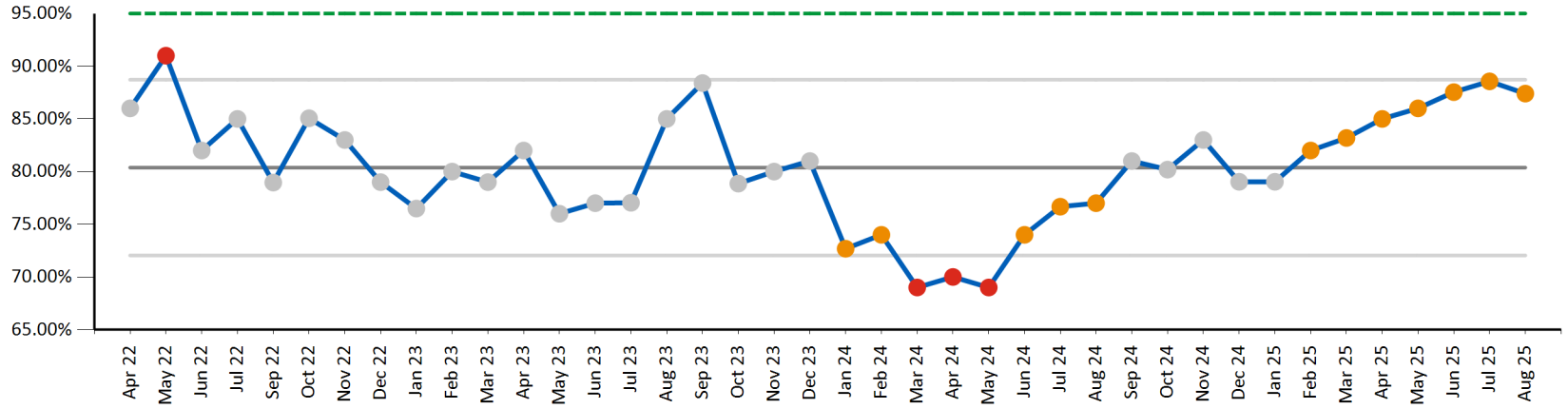
Plan	Actual
<= 1,800	2,775

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%	Aug-25

Previous

Plan	Actual	Period
>= 95%	89%	Jul-25

Year to Date

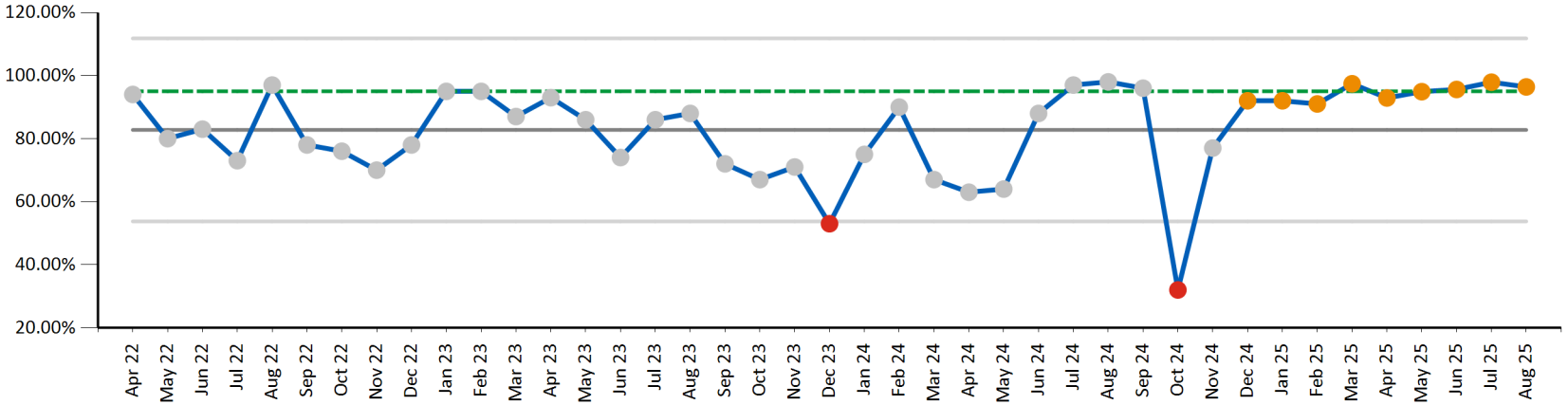
Plan	Actual
>= 95%	87%

269 - Education, health and care plan (EHC) compliance

Special cause variation with improving performance

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

4/6



Latest

Plan	Actual	Period
>= 95%	96%	Aug-25

Previous

Plan	Actual	Period
>= 95%	98%	Jul-25

Year to Date

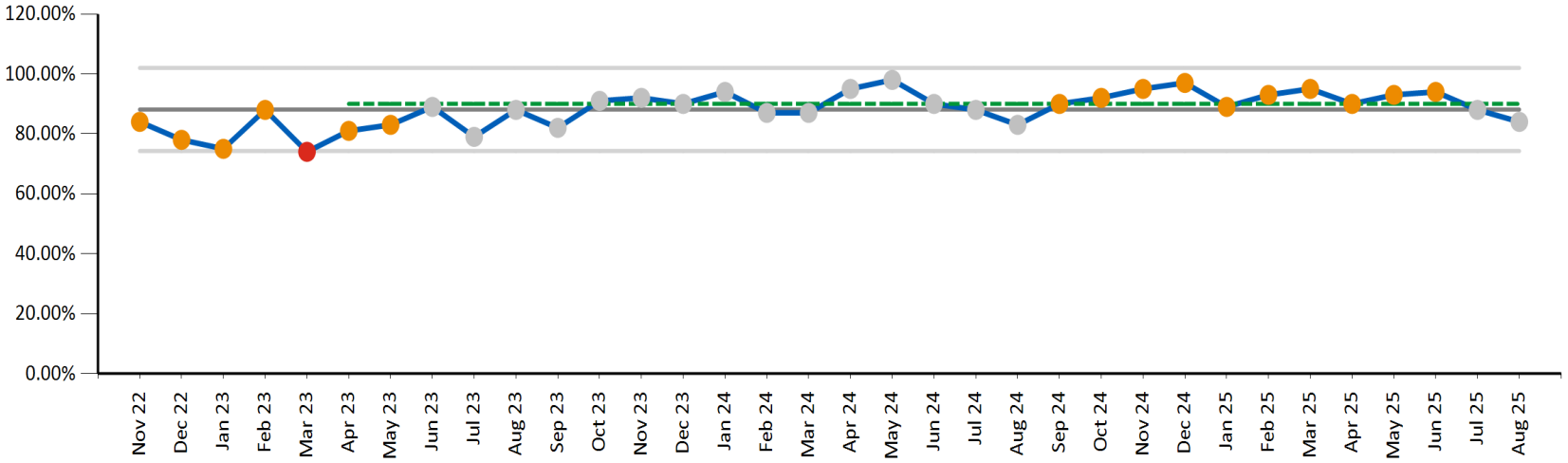
Plan	Actual
>= 95%	96%

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

Common cause variation.

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

4/6



Latest

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

Previous

Plan	Actual	Period
> = 90.0%	88.0%	Jul-25

Year to Date

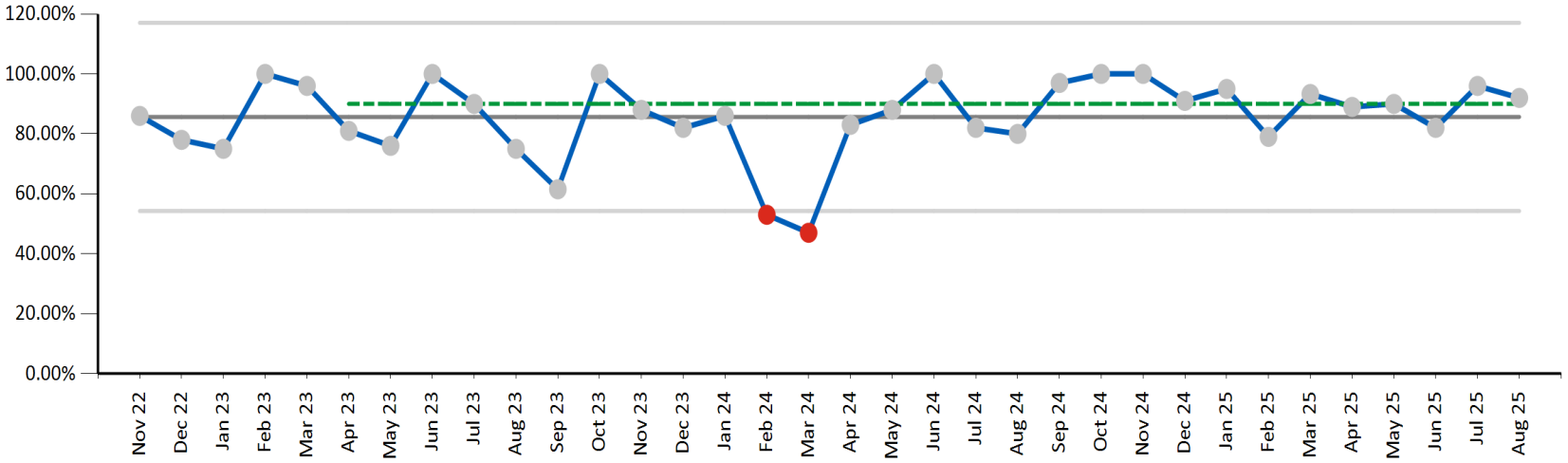
Plan	Actual
> = 90.0%	

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

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
> = 90.0%	92.0%	Aug-25

Previous

Plan	Actual	Period
> = 90.0%	96.0%	Jul-25

Year to Date

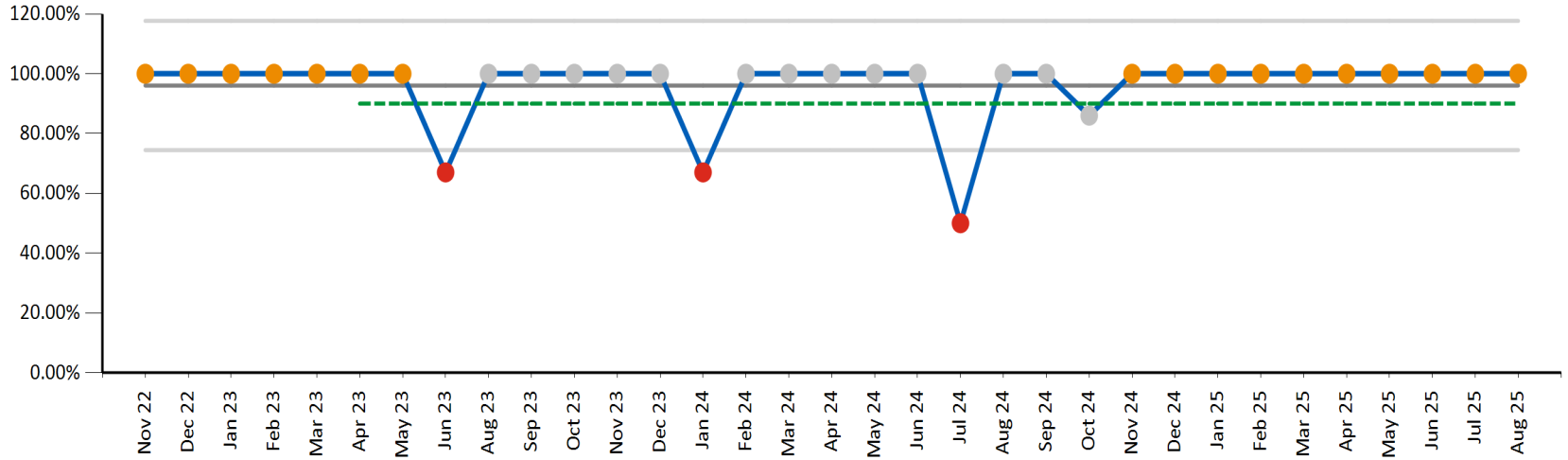
Plan	Actual
> = 90.0%	

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

Special cause variation with improving performance

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

6/6



Latest

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

Previous

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

Year to Date

Plan	Actual
> = 90.0%	

Workforce - Sickness, Vacancy and Turnover

Bolton NHS Foundation Trust

Sickness:
Sickness has increased slightly in August 25 at 5.55% compared to 5.37% in July 2025. There has been an increase in sickness absence in across the majority of Divisions and teams with the exception being within the Surgical Division which saw a reduction of 0.88%. Each Division and corporate function continues to undertake a review of sickness, with an increased focus on providing wellbeing support through Occupational Health and wider wellbeing initiatives. The Divisional and Workforce teams continue to work together to closely monitor sickness, and provide a range of health and well-being support to our staff.

Turnover:
Turnover has mirrored our expectations for 2025/26 at a stable and static rate of 11.6% in-month.

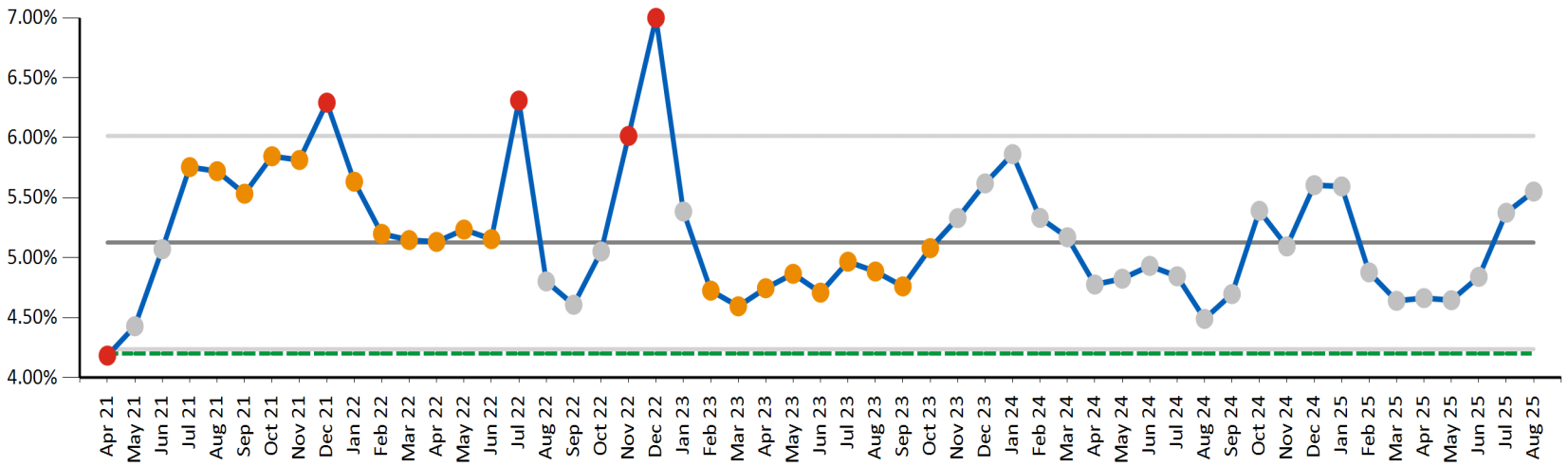
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	5.55%	Aug-25		<= 4.20%	5.37%	Jul-25	<= 4.20%	5.01%	F
120 - Vacancy level - Trust	<= 6%	4.62%	Mar-25		<= 6%	5.08%	Feb-25	<= 6%		?
121 - Turnover	<= 9.90%	11.67%	Aug-25	L	<= 9.90%	11.90%	Jul-25	<= 9.90%	11.33%	F
366 - Ongoing formal investigation cases over 8 weeks		0	Aug-25	L		0	Jul-25		0	

117 - Sickness absence level - Trust

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 4.20%	5.55%	Aug-25

Previous

Plan	Actual	Period
<= 4.20%	5.37%	Jul-25

Year to Date

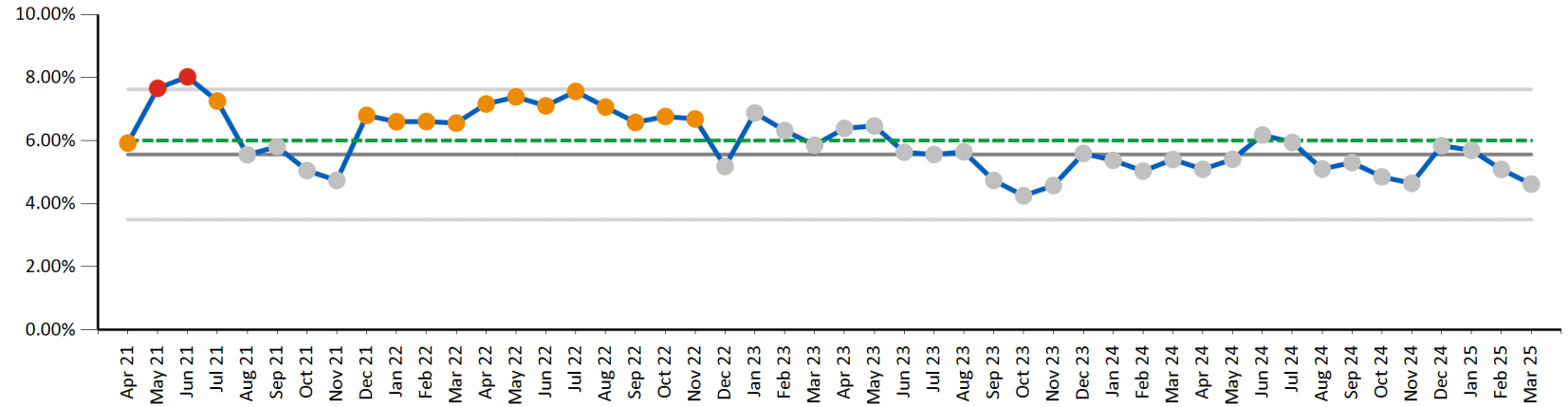
Plan	Actual
<= 4.20%	5.01%

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

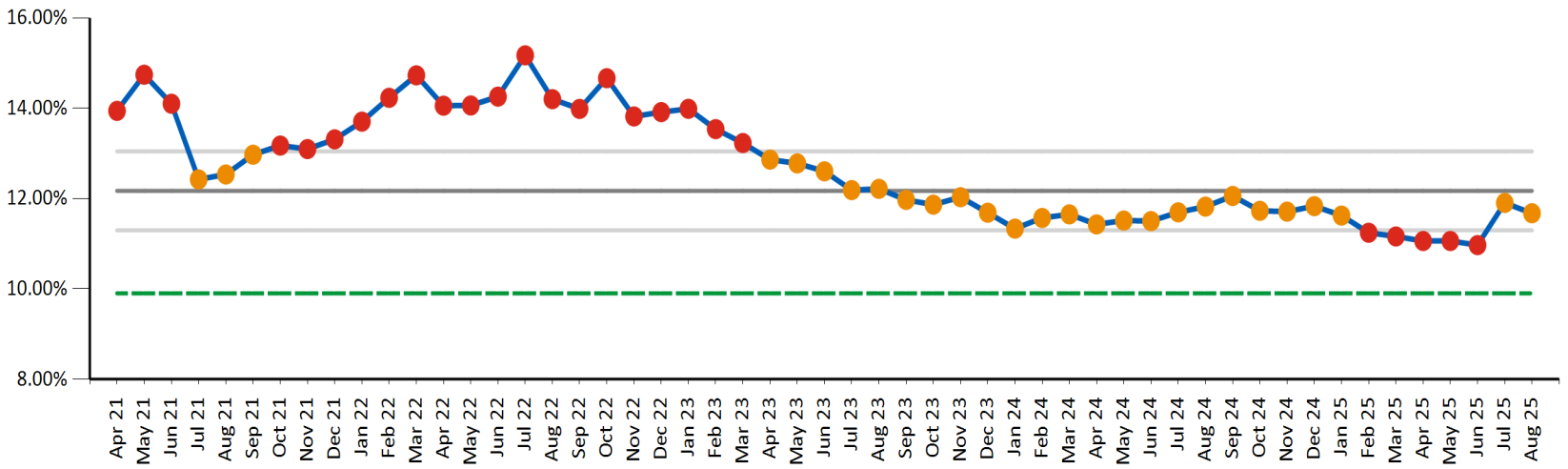
Plan	Actual
<= 6%	5.31%

121 - Turnover

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
< = 9.90%	11.67%	Aug-25

Previous

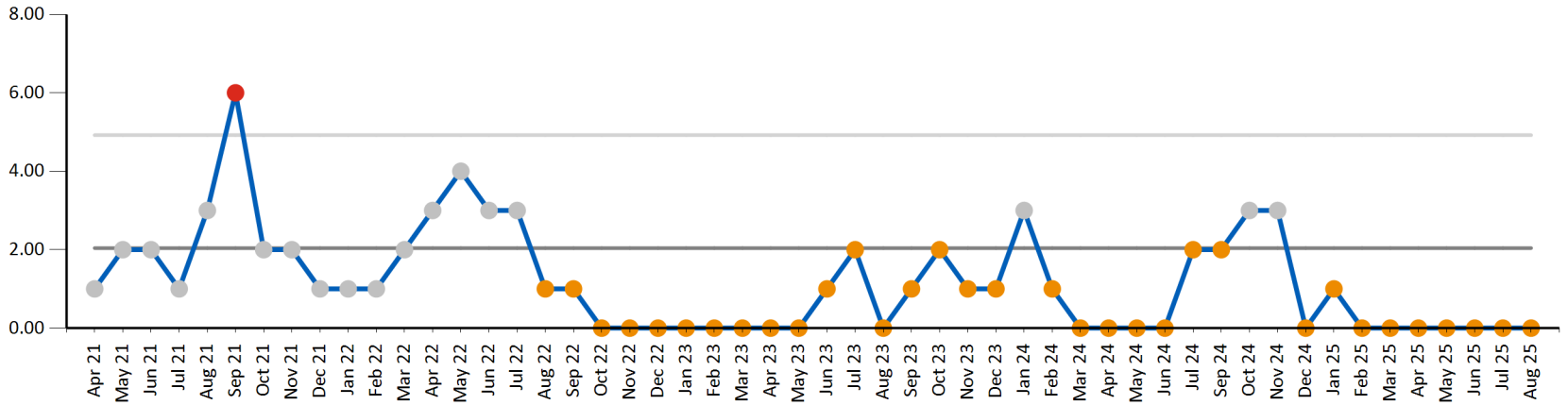
Plan	Actual	Period
< = 9.90%	11.90%	Jul-25

Year to Date

Plan	Actual
< = 9.90%	11.33%

366 - Ongoing formal investigation cases over 8 weeks

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Aug-25

Previous

Plan	Actual	Period
	0	Jul-25

Year to Date

Plan	Actual
	0

Workforce - Organisational Development

NHS Bolton NHS Foundation Trust

Compulsory training

The improvement in month to 94.24% demonstrates the ongoing commitment for the divisional and directorate teams to focus on Compulsory training. The areas of concern remain those subjects that require face to face training (BLS/ M&H) and we continue to work closely with Divisions on reducing DNA, with reminders going out from this month. It is pleasing to report the improvement made in safeguarding level 3 subjects, since the e-learning option was introduced.

Trust Mandated Training

All subjects with the exception of Aseptic Non touch Technique (ANTT = 83%) have surpassed the 85% target. The divisional practice educators have strengthened their training / assessment package for ANTT with the focus on train the trainer at ward/dept level. A further review is being undertaken, focusing on how completed assessments are being updated on ESR in preparation for timely reporting.

Appraisal

Whilst overall across the Trust appraisal compliance has reduced this month from 85.2% to 84.8%, a slight shift was anticipated following Divisional reconfiguration. However, three of the four new clinical divisions have still maintained compliance above the 85% compliance target. The uptake on FABB appraisal training for managers and colleagues remains very positive and messaging about the importance of quality FABB check in and appraisal conversations, continues to be emphasised in the Our Leaders programme.

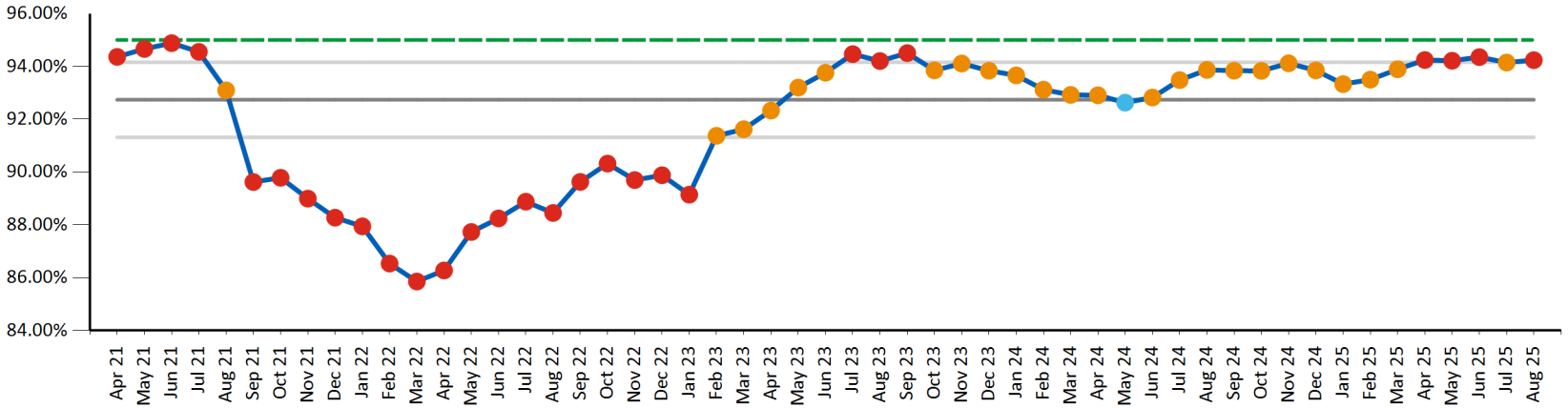
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Compulsory Training	>= 95%	94.2%	Aug-25	H	>= 95%	94.1%	Jul-25	>= 95%	94.2%	F
38 - Staff completing Trust Mandated Training	>= 85%	92.0%	Aug-25	H	>= 85%	92.1%	Jul-25	>= 85%	91.9%	P
39 - Staff completing Safeguarding Training	>= 95%	94.60%	Aug-25		>= 95%	94.23%	Jul-25	>= 95%	94.39%	?
101 - Increased numbers of staff undertaking an appraisal	>= 85%	84.8%	Aug-25	H	>= 85%	85.3%	Jul-25	>= 85%	85.0%	?
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	45.5%	Q1 2025/26	L	>= 66%	51.8%	Q4 2024/25	>= 66%		?
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	51.4%	Q1 2025/26	L	>= 80%	54.9%	Q4 2024/25	>= 80%		F

37 - Staff completing Compulsory Training

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	94.2%	Aug-25

Previous

Plan	Actual	Period
>= 95%	94.1%	Jul-25

Year to Date

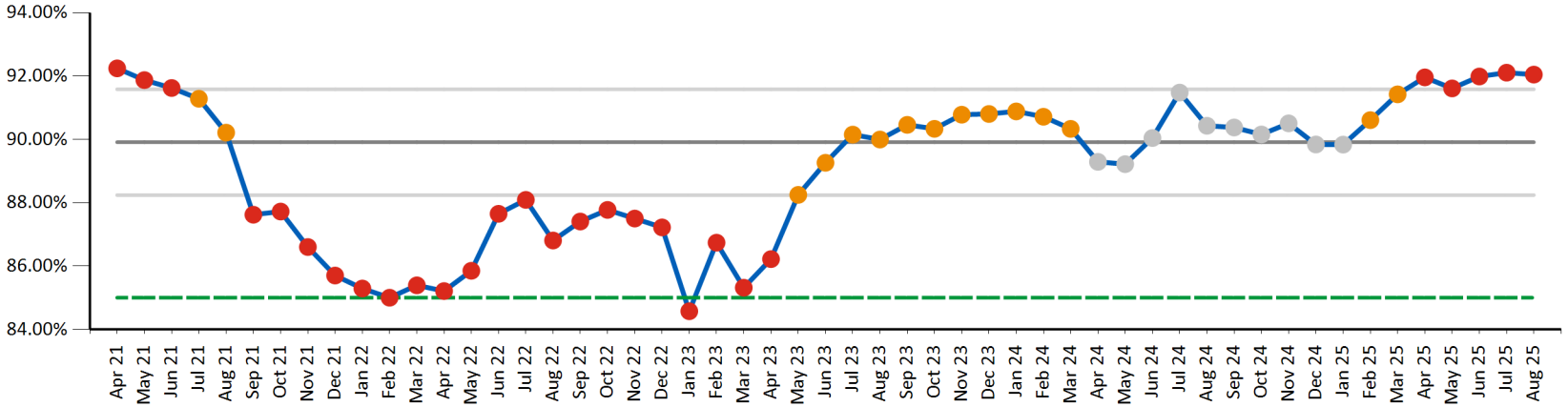
Plan	Actual
>= 95%	94.2%

38 - Staff completing Trust Mandated Training

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	92.0%	Aug-25

Previous

Plan	Actual	Period
>= 85%	92.1%	Jul-25

Year to Date

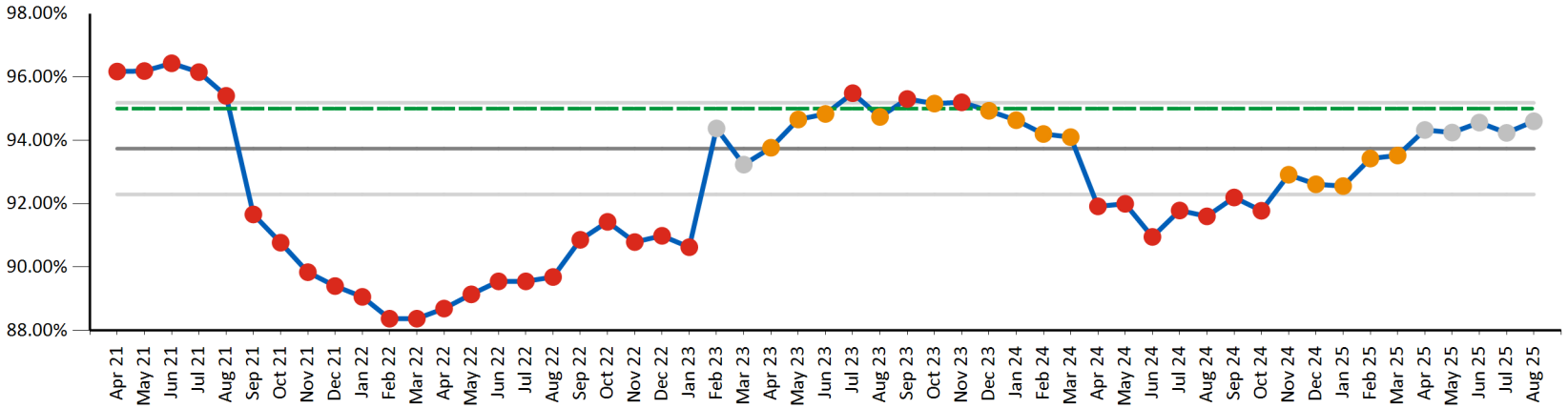
Plan	Actual
>= 85%	91.9%

39 - Staff completing Safeguarding Training

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 95%	94.60%	Aug-25

Previous

Plan	Actual	Period
>= 95%	94.23%	Jul-25

Year to Date

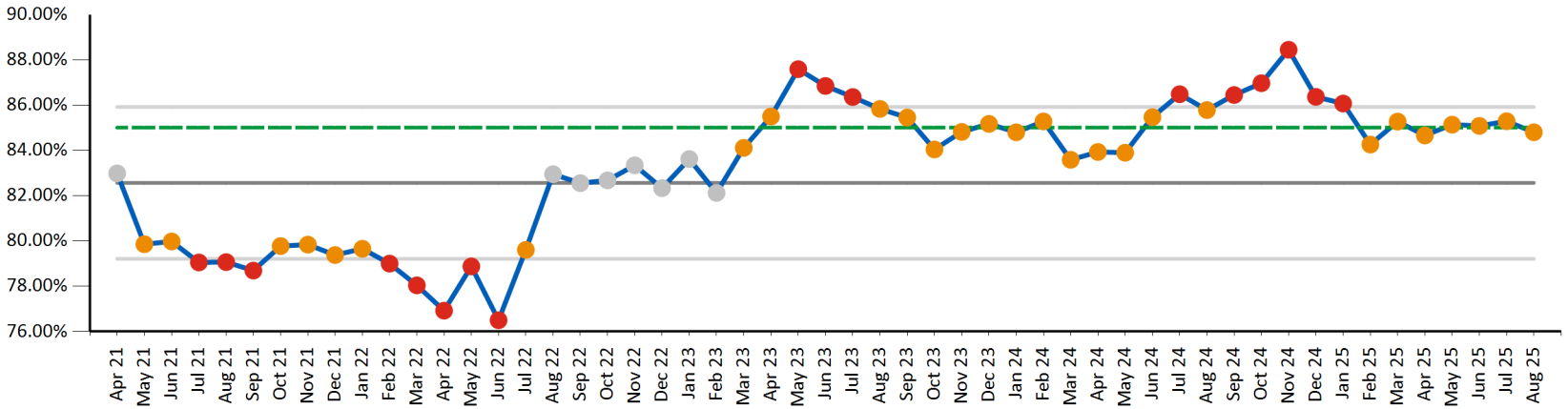
Plan	Actual
>= 95%	94.39%

101 - Increased numbers of staff undertaking an appraisal

Special cause variation with improving performance

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

4/6



Latest

Plan	Actual	Period
>= 85%	84.8%	Aug-25

Previous

Plan	Actual	Period
>= 85%	85.3%	Jul-25

Year to Date

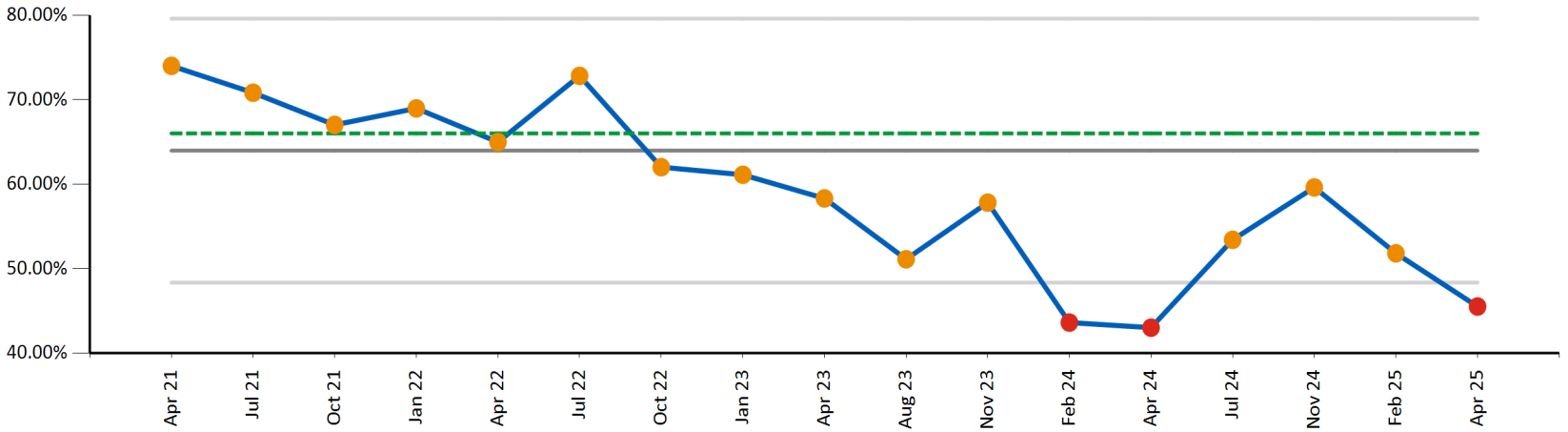
Plan	Actual
>= 85%	85.0%

78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)

Special cause variation with deteriorating performance

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

0/6



Latest

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

Previous

Plan	Actual	Period
>= 66%	51.8%	Q4 2024/25

Year to Date

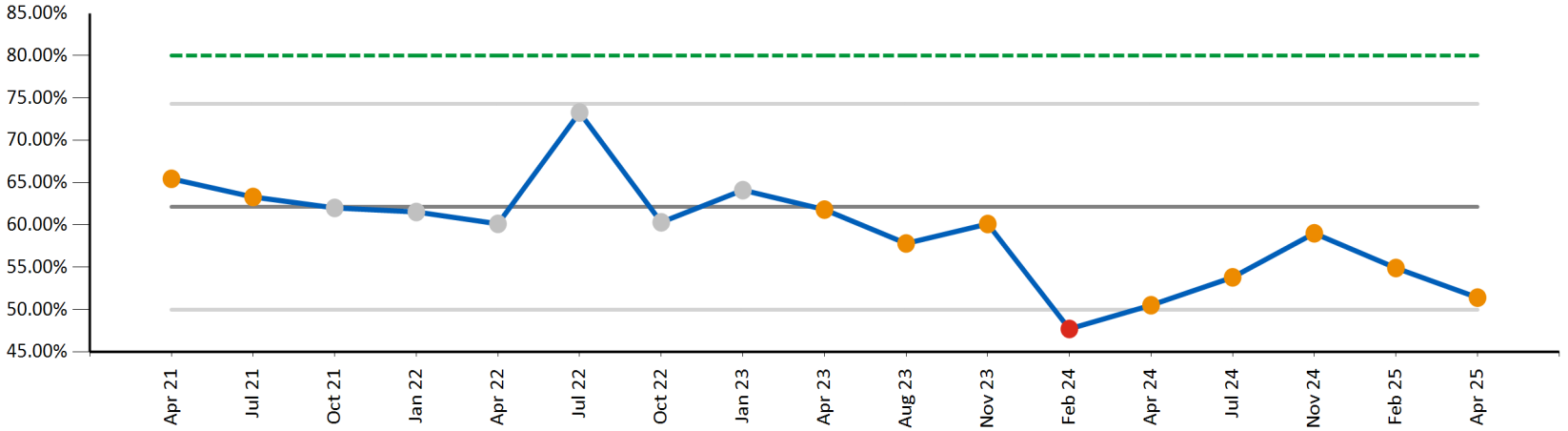
Plan	Actual
>= 66%	

79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

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

Previous

Plan	Actual	Period
>= 80%	54.9%	Q4 2024/25

Year to Date

Plan	Actual
>= 80%	

Workforce - Agency

Bolton NHS Foundation Trust

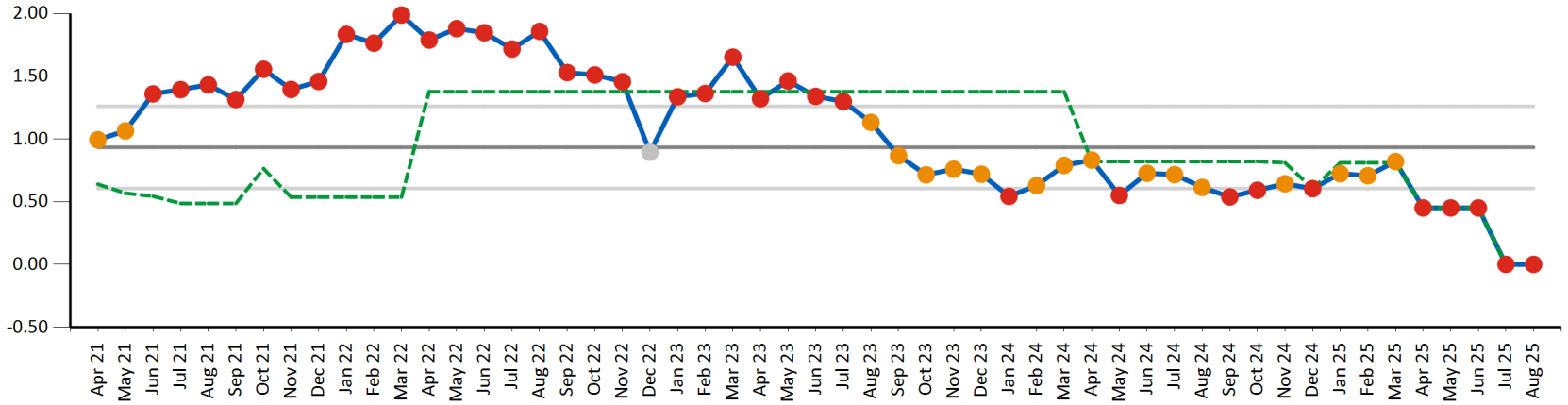
Usage of agency remains relatively low with a small increase of 2 WWTE noted in August 2025 (mainly as a result of Resident Doctors industrial action in that month). Despite low agency WWTE we are still over the NHSE spend targets for agency, this is due to the fact that most of our remaining agency is for high-cost medical and AHP roles. We have plans to reduce this though in line with positive recruitment activity and with 'switch' of agency workers to our bank.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)		0.00	Aug-25	L	= 0.00	0.00	Jul-25	<= 1.35	1.35	
111 - Annual ceiling for Nursing Staff agency spend (£m)		0.02	Aug-25	L	<= 0.02	0.02	Jul-25	<= 0.08	0.10	
112 - Annual ceiling for Medical Staff agency spend (£m)		0.55	Aug-25	H	<= 0.55	0.53	Jul-25	<= 2.07	2.60	

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

Special cause variation with improving performance

2/6



Latest

Plan	Actual	Period
	0.00	Aug-25

Previous

Plan	Actual	Period
= 0.00	0.00	Jul-25

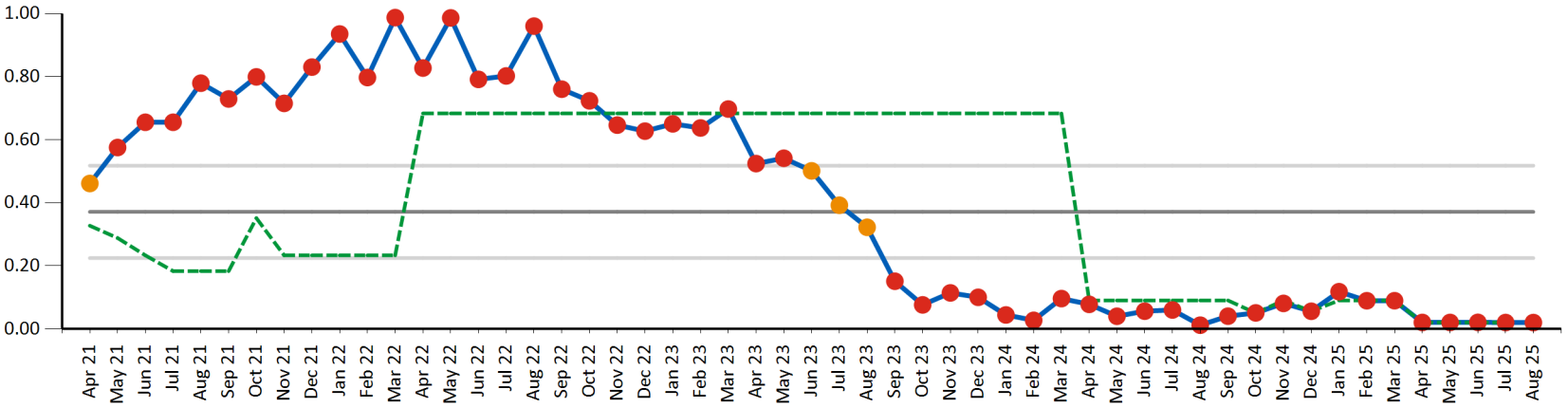
Year to Date

Plan	Actual
<= 1.35	1.35

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

Special cause variation with improving performance

1/6



Latest

Plan	Actual	Period
	0.02	Aug-25

Previous

Plan	Actual	Period
<= 0.02	0.02	Jul-25

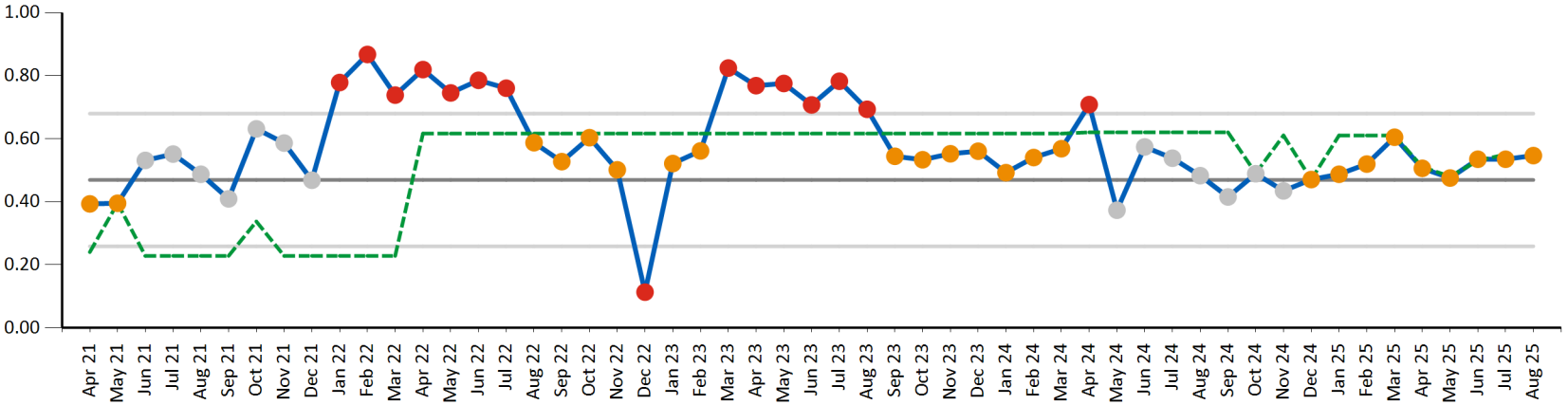
Year to Date

Plan	Actual
<= 0.08	0.10

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

Special cause variation with deteriorating performance

4/6



Latest

Plan	Actual	Period
	0.55	Aug-25

Previous

Plan	Actual	Period
<= 0.55	0.53	Jul-25

Year to Date

Plan	Actual
<= 2.07	2.60

Finance - Finance

Bolton
NHS Foundation Trust

Surplus / (Deficit)
The Trust is reporting a cumulative deficit of £10.1m largely due to CIP under-delivery partially offset by income inflation not yet being spent (incremental drift and non-pay inflation).

Forecast
The external forecast has been reported as meeting plan. There are some significant risks to achieving this, even if the CIP target is delivered in full, with mitigations needed for existing issues and a residual gap needing to be addressed. The mid-case and worst-case scenarios are being re-assessed based on known risks and potential mitigations. The range of forecasts will narrow as the year progresses and risks/mitigations materialise.

Income
Commissioner income is based on contractual and budget values, including above-plan Planned Care Variable Income performance of £0.9m YTD. Additional Injury Cost Recovery Scheme income of £0.4m has been recognised in-month, bringing the YTD value to £1.9m. Q1-2 Deficit Support funding is now secured at £3.3m although Q3-4 could be at risk. It is assumed that there will be no clawback of any variable income such as CDC.

Pay
WTEs and underlying Pay Costs have reduced in month driven by leavers (including MARS), there is an adverse variance against CIP delivery. Worked WTEs are now slightly adverse to the Trust plan although this is forecast to worsen in M6-7.

Non Pay
Non Pay costs have reduced by £0.2m since M4, mainly due to Utilities. The main driver of the adverse YTD variance is under-delivery of CIP, although NR CIP of £1.3m has been delivered through Stock Adjustments resulting from implementation of the Genesis system.

Non Operating
Interest received has been slightly higher than planned.

Cash
The Trust was above plan by £10.3m in Month 5. PDC funding cash has provided a temporary benefit of £1.5m and some other cash has been received in advance. The underlying cash position is an overdrawn position of £12.4m and it is anticipated that further cash support will be required during 2025/26, starting in November.

CIP Delivery
Increase in in-month delivery from M4 to M5 due to non-recurrent Genesis and Injury Cost Recovery Scheme, achievement is still under plan and £1.1m of the in-month value is due to technical items. There are minimal opportunities for further central non-recurrent items to support delivery in 2025/26.

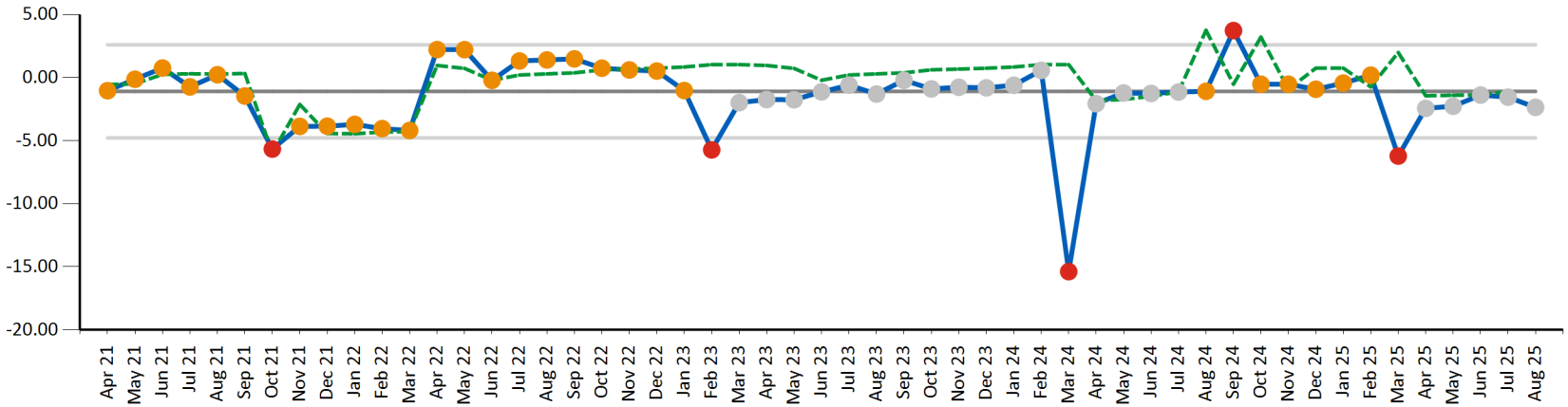
Capital
£48.8m of capital budget for the year, the majority is anticipated from Q2 onwards

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)		-2.4	Aug-25		>= -1.1	-1.6	Jul-25	>= -5.4	-10.0	
222 - Capital (£ millions)		0.6	Aug-25		>= 2.5	0.6	Jul-25	>= 5.2	3.4	
223 - Cash (£ millions)		9.5	Aug-25		>= -4.7	9.5	Jul-25		9.5	

220 - Control Total (£ millions)

Common cause variation.

0/6



Latest

Plan	Actual	Period
	-2.4	Aug-25

Previous

Plan	Actual	Period
>= -1.1	-1.6	Jul-25

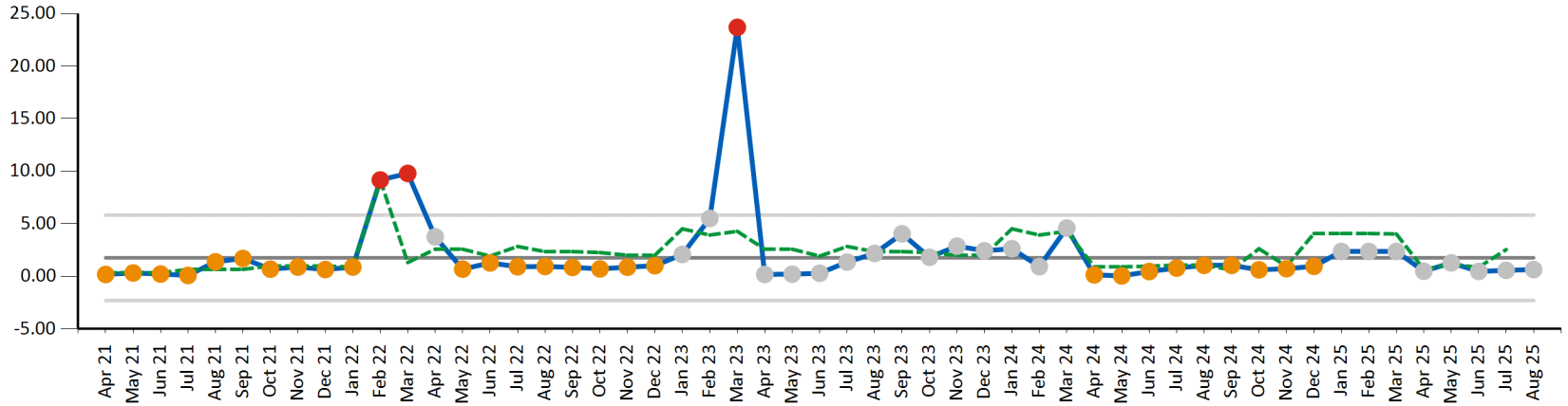
Year to Date

Plan	Actual
>= -5.4	-10.0

222 - Capital (£ millions)

Common cause variation.

1/6



Latest

Plan	Actual	Period
	0.6	Aug-25

Previous

Plan	Actual	Period
>= 2.5	0.6	Jul-25

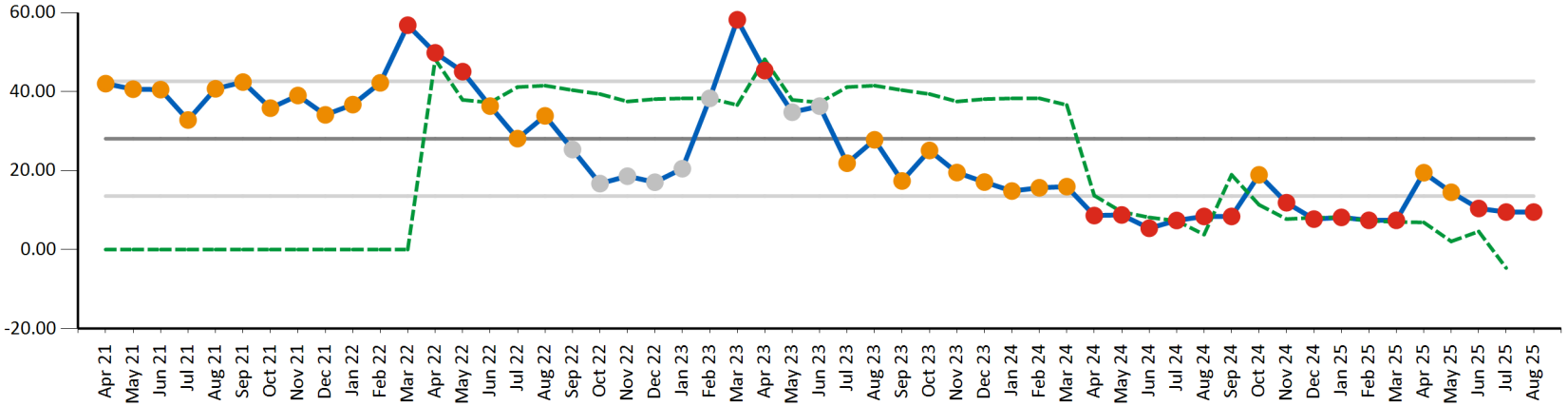
Year to Date

Plan	Actual
>= 5.2	3.4

223 - Cash (£ millions)

Special cause variation with deteriorating performance

5/6



Latest

Plan	Actual	Period
	9.5	Aug-25

Previous

Plan	Actual	Period
>= -4.7	9.5	Jul-25

Year to Date

Plan	Actual
	9.5

Report Title:	Quality Assurance Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	25 September 2025		Discussion	
Executive Sponsor	Quality Assurance Committee Chair		Decision	

Purpose of the report	The purpose of this report is to provide an update and assurance to the Board of Directors on the work delegated to the Quality Assurance Committee.

Previously considered by:	The matters included in the Chair's report were discussed and agreed at the Quality Assurance Committee meeting held in July 2025.

Executive Summary	This report provides a summary of key matters discussed at the QAC meeting held on 30 July 2025. It outlines the assurances received by the Committee in relation to the Trust's quality governance, patient safety, and clinical effectiveness. There are no Alerts that require the attention of the Board. Due to the scheduling of the September Board meeting, a verbal update on the Committee's discussions will be provided. A full written report, capturing the outcomes and recommendations from the September meeting, will be submitted to the subsequent Board meeting for formal consideration.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Quality Assurance Committee Chair's Report.

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

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

Prepared by:	Victoria Crompton, Corporate Governance Manager	**Presented by:**	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:	30 July 2025	**Date of next meeting:**	25 September 2025
Chair	Fiona Taylor	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING:

- Integrated Performance Report
- Board Assurance Framework
- Compliments, Concerns & Complaints 2024/2025
- Health & Safety Annual Report
- Maternity Incentive Scheme Year 6 Progress Update (CNST Update)
- Coding and Risks
- Recording of VTE Compliance
- Audiology Update
- Serious Incident Investigation Reports x 3Clinical Governance and Quality Committee Chair's Report
- Performance and Transformation Board Chair's Report

ALERT

Agenda items	Action Required
No items of Alert.	

ADVISE

Patient Story – Integrated Community Services - the Committee heard the recovery journey of a patient, whose progress was enabled by community-based services, particularly the Neuro Rehabilitation Team. Physiotherapist Dave played a key role, using specialist equipment and a person-centred approach. The Group reflected on the story, highlighting the importance of clear, compassionate communication, fostering hope while managing expectations, and ensuring patients fully understand their condition.

Integrated Performance Report
Chief Nurse

- Pressure Ulcers (Category 2): Misclassification issues were addressed by introducing a new process requiring photographic evidence, contributing to a reduction in cases.
- Mixed Sex Accommodation: Breaches are decreasing, with notable improvement in Medicine and Surgery Divisions.
- C-Diff: The Trust achieved an 11% reduction, remaining within expected variation. Antimicrobial stewardship is being strengthened, with a pilot led by the Surgery Medical Director.
- Maternity Services – Patient Experience: Response rates improved to 33.4%, with satisfaction reaching 96.4%. Ongoing concerns remain regarding delays in the Induction of Labour process. Incident themes are under review, and work is underway to increase capacity.

Medical Director Report:

- Clinical Correspondence: Inpatient correspondence shows continued improvement. Outpatient turnaround remains a challenge; a digital dictation trial is underway.

- SHMI: The latest figure (114.8) is 'as expected'. Removal of Type 5 patients may negatively affect the trend. Coding improvements are in progress, with a detailed update due in September. A future SHMI Board Development session is under consideration.

Chief Operating Officer Report

- ED Performance declined in June, with a similar trend expected in July due to medical staffing pressures and recent pay rate changes.
- Stranded Patients: Notable reductions in patients delayed over seven and 21 days, supported by ECIST collaboration.
- Fractured Neck of Femur: Performance had improved. Staffing concerns were noted, though the middle-grade rota had strengthened significantly, improving resilience.
- Re-admissions in Urgent Care**:** Remained within common cause variation but continued to be monitored.
- Elective Care**:** All metrics were trending positively, with improvements in the 18-week target and reductions in waiting lists.
- Diagnostics (D01): Performance was below standard, particularly in Audiology, but an improvement plan was in place.
- Integrated Community Services**:** "No criteria to reside" numbers were strong, reflecting the dedication of the teams.
- 0–19 Health Visitor Contacts**:** This area was showing signs of improvement

Compliments, Concerns & Complaints 2024/25: The total number of complaints increased slightly compared to the previous year, with 84 resolved through meetings—a 31% rise. Response performance remains at 71%, below the 95% target. Compliments have increased, and a new centralised system is now in place to capture them across all Divisions..

Health & Safety Annual Report: Between April 2024 and March 2025, the Trust received 18 claims—a reduction—and reported 216 fewer health and safety incidents, notably fewer involving violence or aggression. Moving and Handling Level 2 training compliance fell short of the 95% target; weekly sessions will be introduced.

Audiology Update: The Audiology service continues to face waiting list pressures in both Paediatric and Adult pathways, reflecting wider diagnostic and elective service challenges. A national data collection is underway, with the final report pending. A clinical prioritisation process is in place, with no reported harm to date. Feedback is being escalated via Provider Oversight Meetings and will inform a formal GM/ICB workstream, supported by an action plan.

Serious Incident Investigation Reports: The Committee noted all reports were thorough, had followed due process, and provided assurance that appropriate actions and improvement plans are in place.

Maternity Incentive Scheme – Year 7 (CNST): All ten safety workstreams are progressing well, with significant assurance received and a 99% score for Safety Action 6. Training targets remain on track for the 30 November 2025 deadline. Progress continues on the One-Stop Diabetes Service, though challenges remain. Perinatal quality surveillance is under review. The Trust is meeting all CNST and perinatal framework requirements, though further strengthening of action plans was recommended. The Committee approved the report's recommendations..

ASSURE
Board Assurance Framework – The BAF has been updated to reflect the Trust's new Strategic Ambitions and revised Risk Appetite Statements. Key updates: • C01 – Improving Access: Risk score reduced from 16 to 12 due to improved quality governance. • Recommended Place for Care: Progress noted; initiatives like *Our Voice* are supporting improvement. • BOSCA Accreditation: 59% of wards/departments now scoring silver or above, close to the 60% 2029 target. • Risk Appetite: Work continues to refine and align understanding across the organisation, with an updated narrative expected by December. • C02 – Innovation & Collaboration: Continued constructive challenge encouraged to drive progress; strong cultural developments reported. • C03 – Health Improvement & Prevention: Updates align with the 10-Year Plan. The Bolton All-Age Prevention & Health Inequalities Framework will be presented to the Board. A strategic review session is scheduled for October. **VTE Compliance:** New national guidance requires VTE assessments within 14 hours of admission. Updated compliance data has been submitted to NHS England. The Committee approved alignment with the new standard (Option Two), and an action plan is in place to meet the trajectory..
New Risks identified at the meeting: No new risks.
Review of the Risk Register: N/A

Meeting Attendance 2025												
Members	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Fiona Taylor	✓		✓		✓		✓					
Martin North	✓		✓		✓		✓					
Seth Crofts	✓		✓		✓		✓					
Becks Ganz	A		✓		n/a		n/a					
Francis Andrews	✓		✓		✓		✓					
Tyrone Roberts	✓		✓		✓		✓					
Rae Wheatcroft	✓		✓		✓		✓					
Sharon Katema	✓		✓		✓		✓					
✓ = In attendance A = Apologies												

Report Title:	Our Assessment against the Independent Taskforce on Maternity and Neonatal Services			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	25 September 2025		Discussion	
Executive Sponsor	Chief Nurse		Decision	

Purpose of the report	This report outlines the Trust response to the Independent Taskforce on Maternity and Neonatal Services formal letter..

Previously considered by:	**Clinical Governance and Quality Group – 03 September 2025.** Report was discussed and approved. Discussion revolved around next iteration of the report and consensus was that it would be beneficial to understand what measures are in place to monitor progress of the actions/work in progress and also how we demonstrate the impact of the actions/work undertaken to ensure this is have the intended impact. Request that prior to Quality Assurance Committee alignment also be made to previous assurance provided following the Independent Review of Greater Manchester Mental Health Trust (GMMH), with update on current position.

Executive Summary	A formal letter was issued to all Trusts on the 23 June 2025 by Sir Jim Mackey announcing a rapid independent investigation into maternity and neonatal services, the establishment of an independent taskforce, alongside immediate actions to improve care. The letter outlined areas of focus for every local NHS Board with responsibilities relating to maternity and neonatal care. This report provides assurance that the Trust is actively monitoring the key areas of focus within the maternity and neonatal services relating to the management of poor behaviour, engagement with families, culture development, monitoring outcome and tackling inequalities within current service provision. The areas of focus included in the letter align with learning from previous reviews including the findings from the independent review of GMMH. The Board has previously received assurance of measures the trust has in place to respond to the learning from GMMH. Current position against these areas of focus has also been included.

Proposed Resolution	The Committee are asked to ***receive*** the Our Assessment against the Independent Taskforce on Maternity and Neonatal Services

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

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

Prepared by:	Janet Cotton – Director of Midwifery / Divisional Nurse Director on behalf of the Family Care Divisional Quadrumvirate Stuart Batees, Director of Quality Governance	**Presented by:**	Tyrone Roberts, Chief Nurse.

1. Introduction

This report outlines the Trust response to the formal letter received from Sir Jim Mackey dated 23 June 2025.

2. Background

A formal letter was issued to all Trusts on the 23 June 2025 by Sir Jim Mackey dated 23 June 2025 announcing a rapid independent investigation into maternity and neonatal services, the establishment of an independent taskforce, alongside immediate actions to improve care.

The letter outlined areas of focus for every local NHS Board with responsibilities relating to maternity and neonatal care namely:

- Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.
- Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.
- Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.
- Review the approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.
- Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions.

Learning from the independent review of Greater Manchester Mental Health Trust (GMMH) published in 2024, made similar recommendations, including:

- Ensure patients, families and carers' at the centre of their service delivery and heard at every level of the organization
- A strong clinical voice must be evidenced, heard, and championed from Board to floor
- Boards must have culture that places quality of care as its upmost priority, underpinned by compassionate leadership
- Boards must ensure workforce levels adapt to manage safety challenges and ensure stability across staffing groups
- Boards must have a clear understanding of the quality of its estate and the impact on delivery of high quality care
- Boards must ensure that governance structure (and culture applied within) supports timely escalation and right info / right time

The Board has previously received assurances of the systems, processes in place in response to the recommendations from the GMMH report.

3. Progress to date

In response to the formal letter a benchmarking review of the ongoing assurance measures in relation to the defined areas of focus was undertaken in maternity and neonatal services.

Area of focus	Expectation	Assurance measure
Managing poor behaviour	Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.	- Incivility workshops included on mandatory training - Safeguard reporting of incidents and management are reported by exception - Completion of the perinatal cultural leadership programme by the perinatal quadrumvirate team - Ongoing implementation of disciplinary and early resolution Trust policy to address adverse behaviours - Use of cultural dashboard at Divisional and Trust level - Programmed and ad hoc leader walk-about from 'Board to Ward' - New 'Our Way' behaviour framework launching autumn 2025
Listening to families	Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.	- Trust 'being open' policy replaced 'duty of candour' policy and mandates open and transparency regardless of level of harm & puts patient at the centre. Includes face to face discussion with patients/families including Exec level as required - Appointment of Maternity and Neonatal Voice Partnership (MNVP) 0.6WTE engagement lead and 0.6WTE MNVP lead to support the services to facilitate listening to clients and hard to reach groups - MNVP/Trust co-produced action plan that includes themes from Care Quality Commission (CQC) maternity survey including free text comments - Robust freedom to speak up pathway with quarterly reporting of themes to sub committees of the board - Incident management policy (including duty of candour expectations) - Early resolution policy - Disciplinary policy and process

		- Patient Advice and Liaison (PALS) /complaints process - Patient storied shared at Board level and defined sub committees monthly.
Promoting culture	Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.	- Organisational 'Our Leaders' programme launched 2024 for all leaders and aspiring leaders along with leadership framework which sets out what it means to be a leader at Bolton Foundation Trust - Roll out wider 360 appraisal format for all formal leadership roles due 25/26 - Nurse, midwife, Allied Health Professional (AHP) & healthcare scientist monthly communication forums enabling 'face to face' conversations with Chief Nurse - Divisional, Professional specific and Board programme of walk-about and ad-hoc - MNVP lead and engagement lead in post - MNVP action plan ongoing - Inclusion of perinatal quality surveillance in maternity quality forum as standing agenda item - MNVP bespoke engagement sessions held in hospital and community settings to seek the voice of the clients - Our Voice Change Programme provides the opportunity for staff to get involved in improvements that matter most – now in phase 2 building on success and tangible changes led by change teams over the last 18 months
Data oversight	Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.	- Benchmarking assessment undertaken to demonstrate full compliance with delivery of perinatal quality surveillance monitoring requirements for maternity services - Robust internal quality governance triangulating qualitative and quantitative data and all insights data - Updated maternity specific patient safety and incident review framework themes expected September 2025, based on current and historical themes to demonstrate impactful lesson learning and current improvement work streams - Refresh of maternity speciality quality agenda to include perinatal quality surveillance oversight as from September

		- Inclusion of maternity specific metrics and statistical process control (SPC) analysis in integrated board reports and Trust Board of Director reports
Tackling inequalities and discrimination within services including tracking variation	Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions.	- Areas of potential learning, e.g. Stillbirth, subject to review which includes ethnicity and deprivation. Maternity 'reach' programme commenced July 2025 targeting Bolton population groups with a disproportionate adverse outcome compared to locality demographics - Greater Manchester and Eastern Cheshire (GMEC) Equity and Equality programme implementation ongoing - Anti-Racist framework statement and commitments - Workforce Race Equality Standards (WRES)/Workforce Disability Equality Standards (WDES) data - Education/development opportunities offered to defined groups - Ongoing delivery of the equality and equity programme outcomes that now align with new NHS England inequalities reduction framework - Analysis of client outcomes using equity indicators
Anti-discrimination programme	A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.	- Awaited

There is also a maternity improvement action plan in place aligned to Patient Safety Incident Reponse framework and Maternity and Newborn Safety investigation themes.

There remains a continued focus on culture within maternity service. The SCORE (Safety Culture, Communication, Organisational Reliability and Engagement) survey has been completed. This is a survey used to measure the safety culture within services, with results providing insights into perceived

culture to improve staff wellbeing and service quality. Action plan from this will be monitored via bi-monthly Clinical Negligence Scheme for Trusts (CNST) report.

Further to the GMMH, current position in relation to mitigations in place:

Improvement action	Risk	Mitigation	Update
Ensuring the voices of patients /carers and families (1)	Sub-optimal inclusivity across organisation; neuro-divergence / non-English speaking / care received in own home	Complaints process in place. PALS service in place.	In place and ongoing
		Participate in National patient surveys and also Friends and Family Tests (FFT).	In place and ongoing
		Vulnerable user group with lived experience establishing Q2 24/25	Initial meeting held in July 2025. Work plan in place and reporting via Quality, Patient Experience Forum (QPEF).
		Adoption of Health-watch – a vision for 2023 framework. Aligned to current patient &family experience group with focus on; accessible information standard / access to services / person centred care	Gap analysis completed. Quarterly Healthwatch reports with Divisional updates to QPEF. Healthwatch representative attends QPEF.
		National 'worry & concern pilot / Martha's rule' – Bolton Foundation Trust (BFT) selected for pilot roll-out	Martha's Rule – all components rolled out into adult inpatient areas in the acute Trust. Martha's Rule telephone line for paediatric inpatient has been approved Part of National improvement collaborative until 31st March 2026.

		Ask, Listen, Do – feedback, concerns and complaints to improve the experience of those with autism or a learning disability and their families and carers.	FFT accessibility improved so now available in 10 most common non-English languages. Awareness raising of experiences of patients with learning disability via Oliver McGowan mandatory training. Exploring how identify experience of those with protected characteristics.
Reliability of a strong clinical voice from 'ward to board' (2, 3, 4)	Our experiences at work are often determined by our interactions with our line manager, thereby reliability of leadership competence critical Inclusivity of staff voice (protected characteristics)	New Leadership programme launching Q2 24/25	Our Leaders programme established an ongoing. Over 500 staff attended to date.
		Talent mapping initially across Nursing, Midwifery and AHP aligned to National framework to support development	Completed
		Review of organisational values and behaviours framework	Our Way behaviour framework to be launched on October 2025
		Re-establish senior medical staff committee	In place and ongoing.
		Walk-rounds; Board members	In place and ongoing
		Ongoing implementation of quality improvement plan / capability building	Quality Improvement plan developed and published. Overseen at Clinical Governance & Quality Group
		Review of wider Quality Improvement methodologies to embed as the management method'	Board development in August 2025. AQuA commissioned to develop roadmap to becoming learning organisation and embedding Quality Management System.

		Reciprocal mentoring / staff councils / getting to equity programme	Staff networks increased with engagement to prioritise attendance at Our Leaders Reciprocal mentoring – to be included in phase 2 of Our Leaders
Quality of care provision (3)	Inextricable link to operational demand. Ongoing non-elective and elective demand is greater than capacity available. Risk to both patient and staff experience	Urgent care improvement group, led by Medical Director.	Group has been replaced by new divisional reporting. Biweekly Urgent Care Improvement Programme, led by Divisional Director of Operations for Medicine. This group monitors performance and deliver of urgent care performance. Group reports into Performance and Transformation Group. Weekly oversight of metrics at Executive Directors and biweekly safety wall led by Chief Nurse.
		Launch of Professional shared decision making councils	Initial discussions held. Plan to agree next steps via Chief Nursing Officer - Senior Management Team meeting
		Monitoring via individual performance meetings (IPM), Clinical Governance & Quality Group & Quality Assurance Committee	In place and ongoing
Safe staffing assurance (5)	Hard to recruit to posts Staff fatigue / moral injury	Monitoring through people committees & Risk Management Committee	In place and ongoing

		Continued adherence to NICE validated safe staffing tools including safer nursing care tool and birth rate plus (registered nursing / midwifery) & wider	Continued use of Safer Nursing Care Tool (SNCT) census validation bi annually for inpatient and paediatrics. Emergency Department and community SNCT delayed due to National revision of tool.
		Provision of additional services for staff well-being	Multiple services in place to support staff well-being. Available via BOB. Divisional well-being champions in place. Two staff well-being days held.
Quality of Estate (6)	Ongoing maintenance requirements Reinforce Autoclave Aerated Concrete (RAAC) and impact on operational capacity (Maternity, medicine and surgery)	Full visibility of risks with detailed business cases / plans 'ready' in event of additional capital available	In place and ongoing along with NHS England support and guidance.
		Clear prioritisation discussed at risk management committee	In place. Also discussed via IFM governance processes and through to Executive team.
		Options appraisals underway regarding RAAC mitigation	Initial RAAC decant plans approved by Executive team in March 2024. RAAC eradication business case completed in June 2024.
		Premises Assurance Model (PAM) completed and submitted annually	In place and ongoing
Governance systems (7)	Reliability of divisional quality governance systems and processes Effectiveness of Board assurance framework to drive	Good Governance Institute recommendations in implementation phase. Proposal for internal audit review Q4 24/25	Action plan completed and signed off via Clinical Governance & Quality Group
		Peer review of Corporate governance underway Q4 23/24 and Q1 (24/25)	Completed in Q4 23/24 and Q1 24/25. Outcome resulted in changes to Board and Committees.

	organisational business		Further peer review undertaken by external colleague currently on the Aspiring Chief Executive Porgramme. Review to be discussed at Board in September 2025.
		MIAA have reviewed assurance framework	Annual review took place in Q4 24/25. Whilst there is no assurance rating, the recommendations issued mean there is conitinuous learning which improves on the use and applicability of the Board Assurance Framework.
		CQC Well-Led report stated "*Leaders operated governance processes that had recently been strengthened and were in the main effective."*	In line with all providers, the Trust will be undertaking the Provider Capability Assessment with a view to sign off in October 2025.
Shared learning (9, 10, 11)	Cross-divisional learning Cross provider (Greater Manchester / National learning) CQC internal reconfiguration creating relationship inconsistency / new regulatory framework	Bi-annual learning from experience report Divisional representation at all serious incident Panels	In place and ongoing. Shared with Bolton ICB for wider learning. Serious Incident panels amended to Patient Safety Incident Iinvestigation (PSII) Sign off panel in line with Patient Safety Incident Response Framework (PSIRF)
		PSIRF roll out from 01.24	In place and continues. PSIRF local priorities under review and updated plan to be presented at Clinical Governance & Quality Group in October 2025.
		CQC relationship meetings re-commenced and table top internal reviews against new framework commenced.	In place and scheduled – next meeting scheduled for October 2025.

4. Summary

This report provides assurance that the Trust continues to actively monitoring the key areas of focus within the Trust and the maternity and neonatal services relating to the management of poor behaviour, engagement with families, culture development, monitoring outcome and tackling inequalities within current service provision. This aligns with ongoing pieces of work that also respond to the findings of the GMMH independent review.

Appendix 1 – Letter from Sir Jim Mackey

Classification: Official

NHS England

To:
- Trust CEOs and chairs

cc.
- ICB CEOs
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

23 June 2025

Dear colleague

Maternity and neonatal care

Today, the Secretary of State for Health and Social Care has announced a rapid independent investigation into maternity and neonatal services. He has also announced an independent taskforce, alongside immediate actions to improve care.

This announcement comes on the back of significant failings in maternity services in parts of the NHS and we need – with real urgency – to understand and address the systemic issues behind why so many women, babies and families are experiencing unacceptable care.

It is clear that we are too frequently failing to consistently listen to women and their families when they raise concerns and too many families are being let down by the NHS. There remain really stark inequalities faced by Black and Asian women and women in deprived areas. In addition, we continue to have significant issues around safety and culture within our maternity workforce.

These have been persistent issues over recent years, so we now need to act with urgency to address these. The vast majority of births in England are safe and we have teams providing good and outstanding maternity and neonatal care every day. However, the variation in quality and performance across the NHS underscores why we can't accept the status quo.

So, between now and December, the independent investigation will conduct urgent reviews of up to 10 trusts where there are specific issues. We'll meet with relevant leaders of several organisations over the next month and while there will be some challenging conversations, we are really keen to hear what more we can be doing to support you to go further and faster in improving maternity and neonatal care.

In the meantime, we ask every local NHS Board with responsibilities relating to maternity and neonatal care to:

- Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.

PRN02043

- Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.
- Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.
- Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.
- Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.

This is really challenging for all of us and the most important step we have to take to rebuild maternity and neonatal care is to recognise the scale of the problem we have and work together to fix it.

This will require us all to work together and this includes teams where care is outstanding where you will have a role to play in sharing best practice and supporting others to return their services to where their communities and staff want and need them to be. We hope you understand the importance of this and, as always, please get in touch if you want to discuss this ahead of the CEO call later in the week.

Sir Jim Mackey
Chief Executive

Duncan Burton
Chief Nursing Officer for England

Report Title:	Clinical Negligence Scheme for Trusts (CNST) year 7 update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	25 September 2025		Discussion	✓
Executive Sponsor	Chief Nurse		Decision	✓

Purpose of the report	The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services and ongoing work with regard to the NHS Resolution Clinical Negligence Scheme for Trusts year 7 (CNST) Maternity Incentive Scheme (MIS).

Previously considered by:	Clinical Governance and Quality Committee on 03 September 2025. Comments from the meeting are included on page one of this report. Quality Assurance Committee - 24 September 2025

Executive Summary	Key highlights: • 22 recommendations are yet to commence and are currently classified as red. It is anticipated all requirements will be fulfilled during the CNST year 7 programme. • All Safety Action 2 requirements have been completed and the provisional results indicate all requirements have been achieved. • The Trust is non-compliant with the British Association of Perinatal Medicine national Tier 3 standards of medical staffing that relate to Consultant presence for at least 12 hours per day. Progress has been made since the year 6 submission and a business case is in progress to address the funded establishment deficit. • The recent Q1 2025/2026 North West Neonatal Operational Delivery Network neonatal nursing submission confirmed that the current service establishment for the declared cots should be 110.78WTE to meet 100% occupancy rate. The service currently has a funded establishment of 105.94WTE and thus a business case will be submitted in due course to seek the additional funded uplift. • The Trust will need to declare non-compliance with the element within Safety Action 7 relating to the Maternity and Neonatal Voices Partnership (MNVP) Lead infrastructure requirements as the service is currently unable to fulfil quorate attendance at the defined meetings with the current establishment funded by the Greater Manchester and Eastern Cheshire (GMEC) Local Maternity and Neonatal System (LMNS). For assurance NHS Resolution have confirmed that providers can still attain full compliance with this element if appropriate escalation is undertaken

	by the provider via the LMNS to the regional perinatal quality surveillance meeting during the CNST year 7 period. • This report fulfils the quarterly perinatal quality surveillance monitoring requirements and includes detail relating to the national minimum data set reporting requirements and Q1 triangulation scorecard for 2025/2026.

Proposed Resolution	The Board of Directors is asked to ***receive*** the report noting non-compliance with the neonatal nursing and neonatal medical British Association of Perinatal Medicine national standards of medical and nursing staffing levels, progress attained since the year 6 scheme and action to be taken in response. ***Approve*** the action plans, escalation to the LMNS regarding non-compliance with the Maternity and Neonatal Voices Partnership (MNVP) Lead infrastructure requirements for further escalation via the LMNS to the regional perinatal quality surveillance meeting as per CNST requirements, and the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required.

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

Summary of key elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	Potential impact upon maternity incentive scheme fund reimbursement.
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Janet Cotton, Director of Midwifery Tyrone Roberts, Chief Nurse	**Presented by:**	Janet Cotton, Director of Midwifery Tyrone Roberts, Chief Nurse

Glossary – definitions for technical terms and acronyms used within this document

ATAIN	Avoiding Term Admissions into Neonatal Units
BAPM	British Association of Perinatal Medicine
CNST	Clinical Negligence Scheme for Trusts
GMEC	Greater Manchester and East Cheshire
ICB	Integrated Care Board
MIS	Maternity Incentive Scheme
NIPE	Newborn and Infant Physical Examination
NWNODN	North West Neonatal Operational Delivery Network
NHSR	NHS Resolution
PMRT	Perinatal Mortality Review Tool
PQSM	Perinatal Quality Surveillance Model
PROMPT	Practical Obstetric Multi-Professional Training
LMNS	Local Maternity and Neonatal System
MBRRACE	Mothers and babies; reducing risk through audit and confidential enquiries
RCOG	Royal College of Obstetricians and Gynaecologists

Summary of additional detail requested by Clinical Governance and Quality Committee meeting following presentation of the paper on the 3 September 2025.

1. Clarification requested as to whether harm occurred when consultant did not attend post partum haemorrhage incidents as per RCOG guidance. Clarification provided learning from all incidents shared at the audit meeting held on 15 August 2025.

2. Appendix 6 – Amendment to update May 2024 - Decision taken not to proceed with purchase of giraffe unit for G4 as incubators can be used for transfer of heated mattress cots if ventilation support not required.

3. Table 1 – Assurance requested regarding red rating of actions not yet commenced. 22 recommendations are yet to commence and as such they are classified as red currently. It is anticipated that all requirements will be fulfilled during the CNST year 7 programme.

4. Perinatal Quality Oversight Model - A revised perinatal quality oversight model was published on the 26 August 2025 and in response the reporting requirements will be amended in future reports as per guidance.

5. Thematic Learning – Assurance provided that the thematic learning detailed in the report aligns with the themes identified in the Patient Safety Inicdent Framework maternity plan for 2025/2026.

6. Obstetric Staffing in Triage – Detail reviewed by Divisional Medical Director to confirm accuracy.

1. Introduction

The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services and ongoing work with regard to the NHS Resolution Clinical Negligence Scheme for Trusts year 7 (CNST) Maternity Incentive Scheme (MIS).

The incentive scheme continues to support safer maternity and perinatal care by driving compliance with ten safety actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

2. CNST year 7 progress tracker

Progress with regard to attainment of the CNST recommendations is detailed in Table 1. All work streams have now been established and are progressing well.

22 recommendations are yet to commence and as such they are classified as red currently. It is anticipated that all requirements will be fulfilled during the CNST year 7 programme with appropriate escalation undertaken for defined elements as required to attain full compliance as detailed in this report.

Table 1: - CNST year 7 progress tracker as of 23 August 2025

Overview of progress on MIS year 7 safety action requirements

*Mandated Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	7	0	0	7
2	0	2	0	0	2
3	0	4	2	0	6
4	13	6	0	0	19
5	0	11	1	0	12
6	0	8	1	0	9
7	0	3	1	0	4
8	0	21	0	0	21
9	1	6	2	0	9
10	8	1	0	0	9
Total	22	69	7	0	98

Key:

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

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

Mandatory updates

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 1 December 2024 to 30 November 2025 to the required standard?

a) **Notify all death:** All eligible perinatal deaths should be notified to MBRRACEUK within seven working days.

b) **Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.

c) **Review the death and complete the review**: For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. **For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.**

d) **Report to the Trust Executive**: Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024.

All cases within the monitoring period have been reviewed to the required standard as detailed in Appendix 1 and this has been cross checked with the national reporting database. The thematic learning and ongoing actions from all cases completed to date is detailed within Appendix 1a.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

The July 2025 data submission of the maternity services dataset (MSDS) has been used as the assessment period within the year 7 scheme and data fields relating to the birth weight and ethnic category have been used as the assessment criteria.

The Trust formally made the required data submission prior to the deadline and the provisional data report indicates that all required standards have been met. The Trust is now awaiting formal publication of the results.

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

The service has a detailed action plan in place to progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice (Appendix 2)**.** The action plan will continue to be shared periodically during the year 7 scheme to evidence ongoing progression of the actions as per scheme requirements.

The service can evidence preparation for the delivery of care to neonates from 34 weeks gestation has commenced.

Following receipt of the hot cots funded by the hospital charity implementation was initially delayed to allow time for staff to complete their training. The cots are now in use.

Work on the quality improvement project remains ongoing to reduce term admissions to the neonatal unit and improve thermoregulation of the babies following delivery. Preparations for the implementation of the national Newborn Early Warning Track and Trigger chart (NEWTT2) continue and the guideline is currently awaiting ratification at Trust level. An update on the progression of the project was last presented to the LMNS on the 12 August 2025 and a further update is scheduled for the 12 September 2025.

Modelling of staffing for the future transitional care model is currently being scoped and will be included in the upcoming Birth Rate Plus reassessment due in autumn 2025. Full implementation of the revised transitional care service will not be realised until the opening of the first floor renovation with increased cot capacity in 2027.

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

a**) Obstetric medical workforce**

The service continues to monitor compliance of consultant attendance at the clinical situations listed in the RCOG workforce document and this is detailed in the safety champion's dashboard (table 3). Trusts are required to ensure they are compliant with consultant attendance in person and can demonstrate a minimum of 80% compliance with the standard.

The Q1 2024/2025 RCOG clinical attendance audit report has been published reflecting activity between April – June 2025. The report demonstrated 90% compliance with the required standard with a consultant being in attendance for 34/38 of the cases. The 4 cases of non-compliance related to failure to attend a post-partum haemorrhage which is

a time sensitive event in which management cannot be delayed whilst the consultant attends. Learning from the audit was shared at the clinical audit forum held on the 15 August 2025.

The audit of cases relating to compliance with RCOG locum guidance has now been completed and highlights that improvements are required in the commencement of access to digital services for locums who work in the maternity service prior to commencement of the shift. The audit details will be shared with digital colleagues to enable improvement actions to be taken in response.

a**) Anaesthetic medical workforce**

A copy of the anaesthetic roster reflecting the period January – July 2025 has been submitted to evidence a duty anaesthetist is available 24 hours a day. The Trust also has an operating policy that outlines the requirement that a duty anaesthetist is immediately available for the obstetric unit and has clear lines of accountability to the anaesthetic consultant at all times, in accordance with the Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1.

c) Neonatal medical workforce

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

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

A detailed review of the medical workforce has been undertaken by the Clinical Director using a neonatal medical workforce tool (Appendix 4) and this has identified a gap of 7.5PAs in the current Tier 3 staffing level.

To be noted progress has been made since the assessment undertaken in 2024 as 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 detailed action plan is in place to address this deficit – see appendix 4a. Ongoing monitoring will continue to be undertaken via risk 6597 on the risk register.

d) Neonatal nursing workforce

The Neonatal Unit endeavour to achieve and continue to strive for > 70% qualified in speciality (QIS) trained at direct cot side care with ongoing recruitment and progression of staff to undertake further training. The service currently has a total of 84.4% QIS in post to provide direct patient care.

The recent Q1 NWNODN submission confirmed that the current service establishment for the declared cots should be 110.78WTE of which 77.55WTE should be QIS to meet 100% occupancy rate. The service currently has a funded establishment of 105.94WTE that includes 75.08WTE QIS in post that fulfils the requirement of 72.13WTE to meet the average 80% occupancy rate. As the average occupancy rate during Q1 was 79.59% the staffing levels met the required standard during Q1.

The Trust is formally required to record compliance to BAPM Nurse staffing standards using the nursing workforce calculator (Appendix 3) and evidence actions identified in an action plan (Appendix 3a). Progress has been made since the last review was undertaken as part of the CNST year 6 scheme as the staffing deficit has reduced and additional funded staff have been appointed such as a psychologist to support the staff and families. The compliance deficit will continue to be monitored via risk 6598 on the risk register.

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

The bi-annual maternity staffing paper that fulfils the requirements of the scheme was presented to the Board of Directors in May 2025. The next report is due in November 2025.

Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies Lives Care Bundle version three?

A quarterly assurance saving babies lives care bundle implementation update session was held on the 17 June 2025 chaired by the LMNS acting on behalf of the ICB and Trust providers.

Evidence was submitted prior to the session by the lead specialist midwife for external scrutiny of the LMNS. In response the Trust received a significant assurance grading with an overall 99% compliance rating awarded with regard to completion of all required elements and per national and LMNS requirements (Appendix 5). The Trust self-assessment grading submitted with the evidence aligned fully with the LMNS grading for all elements. The need to develop a one stop clinic for pregnant women with diabetes was highlighted as an area of future service development.

An update was also provided on the quality improvement work that has been undertaken over the past twelve months to reduce preterm births and to optimise care for babies born early. The update confirmed the maternity service participation in the Partner research trial that aims to identify women at risk of preterm birth or placental problems early in pregnancy that may lead to stillbirth.

The maternity service has been allocated to the intervention arm in the Partner trial; a clinical trial that involves the use of a clinical decision support tool to identify women at risk of pregnancy complications and ensure appropriate referral to relevant pathways. Referral to the preterm birth clinic has been a theme identified in recent incidents and this will be negated by the use of the app and identification of appropriate persons for referral.

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

The Trust will need to declare non-compliance with the element within Safety Action 7 relating to the Maternity and Neonatal Voices Partnership (MNVP) Lead infrastructure requirements as the service is currently unable to fulfil quorate attendance at the defined meetings with the current establishment funded by the Greater Manchester and Eastern Cheshire (GMEC) Local Maternity and Neonatal System (LMNS) by 30 November 2025 as per requirements. Likewise training for the MNVP leads to attend the perinatal mortality review group has not yet commenced and this is required prior to attendance.

Approval is required for escalation to be undertaken in response to the Local Maternity and Neonatal System (LMNS). They will then in turn escalate further to the regional perinatal quality surveillance as per CNST requirements.

In response the Integrated Care Board will be expected to develop an action plan in response to the escalation and monitor progress. There is an expectation that MNVP's are required to be commissioned and function in line with the guidance by the end of the Three Year Delivery plan in 2026.

For assurance NHS Resolution have confirmed that providers can still attain full compliance with this element if appropriate escalation is undertaken by the provider via the LMNS to the regional perinatal quality surveillance meeting during the CNST year 7 period.

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

The service is progressing well with regard to attainment of the profession specific CNST training elements as detailed in table 2. A monthly meeting is held to oversee challenges and ensure each trajectory remains on track to meet the required 90% standard.

Table 2 – Training compliance as of 08 August 2025

Course	Total	Advanced Neonatal Practitioners	Consultant Obstetricians	Obstetric Medical Doctors	MSW	HCA	Midwives	Neonatal Consultants	Neonatal Doctors	Neonatal Nurses	Obstetric Anaesthetic Consultant	Obstetric Anaesthetist
Total	**57.01%**	**100.00%**	**66.07%**	**67.79%**	**88.37%**	**95.12%**	**54.44%**	**80.00%**	**69.23%**	**79.37%**	**95.45%**	**100.00%**
PROMPT	**96.67%**	NA	**100.00%**	**100.00%**	**96.77%**	**100.00%**	**96.11%**	NA	NA	NA	**95.45%**	**100.00%**
Fetal Monitoring Core Competency Stds.	**95.65%**	NA	**90.48%**	**100.00%**	NA	NA	**95.76%**	NA	NA	NA	NA	NA
Fetal Monitoring GMEC Comp. Assessment	**61.80%**	NA	**90.48%**	**100.00%**	NA	NA	**95.76%**	NA	NA	NA	NA	NA
Neonatal Life Support	**89.62%**	**100.00%**	NA	NA	NA	NA	**92.61%**	**80.00%**	**81.82%**	**83.19%**	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 3 July 2025 and discussed the cultural action plan and other pertinent safety issues.

The current area of shared focus being supported by the Board level safety champion relates to the plan to relocate the maternity triage department and Antenatal Day Unit service to Ward R1 to increase bed capacity and ensure care can be delivered in accordance with the Birmingham symptom specific triage system (BSOTS). The plan was approved by the Executive Directors (including the Chief Nurse / Board Safety Champion) on the 21 July 2025 and is due to be enacted in early September

As part of the work of the safety champions walkabouts are held bi-monthly. Information gathered continues to be collated and shared in a 'You Said – We Did' simple format and displayed in clinical areas (Appendix 6).

The perinatal quadrumvirate and safety champions agenda has been merged into one meeting as three of the members hold dual roles. The perinatal quadrumvirate have now completed an executive coaching course funded by Health Innovation Manchester and in addition two culture coaches have been trained.

Although the cultural action plan collated in response to the SCORE survey undertaken in 2024 has been completed the focus of the multi-disciplinary team remains on the promotion of effective team working with the introduction of an additional 10am MDT safety huddle scheduled for September 2025 to improve multi-disciplinary awareness and working culture. A cultural workshop has also recently been held to increase awareness

of differing pressures and was well attended by all staff groups including trainees and facilitated by a Consultant obstetrician.

Safety Action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025

The Q1 2025/2026 audit findings confirmed that two there were 2 eligible cases reported to MNSI during the period 1 April 2025 to the 30 June 2025. Both cases were appropriately referred to the Early Notification Scheme (ENS) due to a potential brain injury, namely Hypoxic Ischemic Encephalopathy (HIE). Both families received written information about the role of MNSI and the early notification scheme and duty of candour has been satisfied in both cases. The formal duty of candour letters were included in the formal audit report collated.

4. Ongoing monitoring

The requirement for maternity services to ensure a consistent and methodical service oversight was defined in the Ockenden report published in 2020 recommendations and the 'Implementing a revised perinatal quality surveillance model (PQSM) guidance published in 2020.

In response Board level safety champions have presented a locally agreed dashboard to the Trust Board quarterly since November 2022 as detailed in table 3. The dashboard fulfils part of the requirements of the perinatal surveillance reporting guidance. Additional required datasets from staff / service user feedback sessions are displayed in Appendix 6.

The dashboard is used in conjunction with monthly integrated performance management reports to evidence that a monthly review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set. The dashboard will continue to be presented by a member of the perinatal leadership team to provide supporting context.

Table 3 – Safety Champions locally agreed dashboard

CQC rating	Overall	Safe	Effective	Caring	Well -Led	Responsive
Regional Support Programme	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good

Indicator	Goal	Red Flag	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	June 25
CNST attainment	Information only								
Critical Safety Indicators									
Births	Information only		434	412	383	397	457	396	387
Maternal deaths direct	0	1	0	0	1	0	0	0	0
Still Births			3	5	0	2	3	0	1
Still Birth rate per thousand	3.5	≥4.3	6.9	12.0	0	5.0	6.5	0	2.6
HIE Grades 2&3 (Bolton Babies only)	0	1	0	0	0	0	1	1	1
Early Neonatal Deaths (Bolton Births only)	Information only		0	3	1	2	2	1	0
END rate in month <7days	Information only		0	7.3	2.6	5.0	4.4	2.5	2.6
Late Neonatal deaths	Information only		1	0	0	0	0	0	1
PSII Incidents (New only)	0	2	0	0	0	0	0	0	1
MNSI referrals (Steis reportable)			0	0	1	0	2	0	1
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0	0
Moderate harm events	0	1	0	0	1	0	7	1	1
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	97.8%	97.3%	97.8%	100.0%	99.2%	99.4%	99.1%
The Co-ordinator is the named person providing 1:1 care (Br+)	0	1	0	0	0	0	0	0	0
BAPM compliance ratio/nurses acuity indirect (neonatal unit)	>99%	<79%	95%	95%	90%	101%	100%	97%	100%
Fetal monitoring training compliance (overall)	<90%	>80%	92%	91%	90%	90%	92%	95%	94%
PROMPT training compliance (overall)	<90%	>80%	99.00%	96.00%	96.00%	97.16%	95.00%	96.00%	96.00%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:20	1:20	1:19	1:19	1:19	1:19	1:19

RCOG benchmarking compliance	Information only	82%	100%	100%	100%	100%	87.5%	83%
Compensatory rest breaches		0						
Proportion of MWs who would recommend the Trust as a place to work or receive treatment	Annual							
Proportion of speciality trainees in obs and gynae who responded excellent or good on the rating of clinical supervision out of hours	Annual							

In line with the PQSM, on a quarterly basis a review must be undertaken of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback (Appendix 6). A review of actions undertaken in response to the culture survey or equivalent should also be undertaken. The last analysis was included in the May 2025 Board report.

A revised perinatal quality oversight model was published on the 26 August 2025 and in response the reporting requirements will be amended in future reports as per guidance.

Ongoing monitoring of the metrics continues to be undertaken at bi-monthly safety champion meetings with the perinatal quadrumvirate leadership team where any additional support required of the Board is identified and escalated. The next meeting is scheduled for the 11 September 2025.

Staffing

The safety champion's dashboard provides assurance that the British Association of Perinatal Medicine compliance neonatal nursing standards were met during the Q1 period despite the funded establishment not meeting 100% occupancy standards as per BAPM standards. This was in part due to the reduced cot capacity following the completion of estates works.

From a midwifery perspective the midwife: birth ratio (based upon hours worked) was also within the required parameters with a ratio of 1:19 attained and a 99.1% midwifery care in labour compliance score was attained. The RCOG Consultant clinical attendance audit also demonstrated 90% compliance with the required standard during Q1 2025/2026.

Obstetric staffing

The service is required to report obstetric staffing gaps on the Delivery Suite rota as part of the perinatal quality surveillance monitoring and oversight. During the period Q1 April – June 2025 there were 6 gaps on the Delivery Suite rota as follows:

- 3 April 2025 – Junior grade gap – long day CDS
- 10, 11, 28 April 2025 – Consultant on call non-resident gaps overnight
- 30 April 2025 – Middle grade gap – long day CDS
- 30 June 2025 – Middle grade gap – evening CDS

In such circumstances that are normally caused by short term sickness and emergency leave the duties are reallocated from other areas in the maternity unit if bank/agency cover cannot be sourced so appropriate cover can be provided on Delivery Suite.

A recent benchmarking review has also been undertaken of staffing levels within the maternity triage department in accordance with the RCOG best practice paper relating to maternity triage published in 2023. The review highlighted significant challenges in the current medical staffing cover within the maternity triage department: particularly out of hours. In response the service currently has secured medical cover at weekend up to 5pm of a junior grade resident doctor and out of hours cover is provided by the on call team. Due to a shortage in junior and middle grade cover this does mean that provision is still a risk if there is short notice sickness.

The team acknowledge that improvements are needed in rota management and rota visibility across medical, midwifery and operation teams, this is being reviewed with in the rota management team.

A detailed review of the staffing has been undertaken in response and a business case to address funded gaps in medical staffing establishment is in progress.

Actual versus planned registered and non-registered staffing

On a six monthly basis the actual versus planned maternity staffing levels are included in the maternity bi-annual staffing report presented to the Board of Directors. This data was last shared in May 2025 and the next report is due in November 2025.

In order to fulfil the quarterly perinatal quality surveillance reporting requirements for completeness the data reflecting the period January to June 2025 is detailed below:

The maternity service strives to ensure safe staffing levels at all times and to correlate the quality and safety indicators with the safe staffing levels. The planned staffing levels

outlined in Table 4 highlight the fill rates achieved for registered and unregistered staff incorporating staff in post and additional temporary staff.

Assurance can be provided that agency and bank shifts were, and continue to be offered to mitigate staffing gaps and pressures when indicated. Safety risks were mitigated within the service by redeploying staff within the service and clinical areas on a daily basis. Table 4 shows gaps in Registered Midwife staffing levels on G3, despite use of bank and agency usage the fill rates on ward G3 during the period January to June 2025. There was a notable overfill of non-registered staff on G3 during the day prior to realignment of the staffing templates following a professional judgement tool review by Matrons and midwifery leaders in November 2024.

Table 4 –Actual versus planned maternity staffing levels – January to June 2025

Ward/Team	Grade Type Category	Day/ Night	Jan-25 Fill %	Feb-25 Fill %	Mar-25 Fill %	Apr-25 Fill %	May-25 Fill %	Jun-25 Fill %
Central Delivery Suite (CDS) [E00183]	Registered	Day	104.20%	99.94%	100.14%	101.22%	91.23%	90.75%
	Non-Registered	Day	76.78%	82.63%	91.57%	93.99%	94.27%	92.04%
	Registered	Night	100.86%	96.33%	97.61%	100.91%	87.34%	86.60%
	Non-Registered	Night	91.88%	92.67%	97.67%	98.33%	100.32%	96.89%
Antenatal - Ward G3 [E00176]	Registered	Day	82.82%	71.77%	75.24%	81.69%	71.29%	85.65%
	Non-Registered	Day	175.37%	184.80%	178.16%	190.17%	189.79%	149.30%
	Registered	Night	91.62%	89.66%	84.93%	89.32%	74.77%	73.37%
	Non-Registered	Night	100.00%	100.00%	96.76%	103.45%	96.66%	93.33%
Postnatal G4 [E00177]	Registered	Day	91.71%	93.64%	95.13%	96.75%	103.14%	102.34%
	Non-Registered	Day	97.57%	90.86%	95.33%	98.46%	101.35%	92.32%
	Registered	Night	95.31%	92.84%	62.53%	79.89%	88.77%	91.89%
	Non-Registered	Night	98.92%	100.00%	99.35%	96.83%	99.04%	101.18%

Thematic Learning

Thematic learning has been elicited from incidents reported on the Safeguard system and triangulated with the thematic findings identified in the last Maternity and Newborn Safety Investigation quarterly review.

This learning has been triangulated with themes identified within the Maternity and Newborn Safety Investigation quarterly review; informed by 30 referrals made 01 Apr-19 and 06 Jun-25, where final reports had been completed as detailed in Table 5.

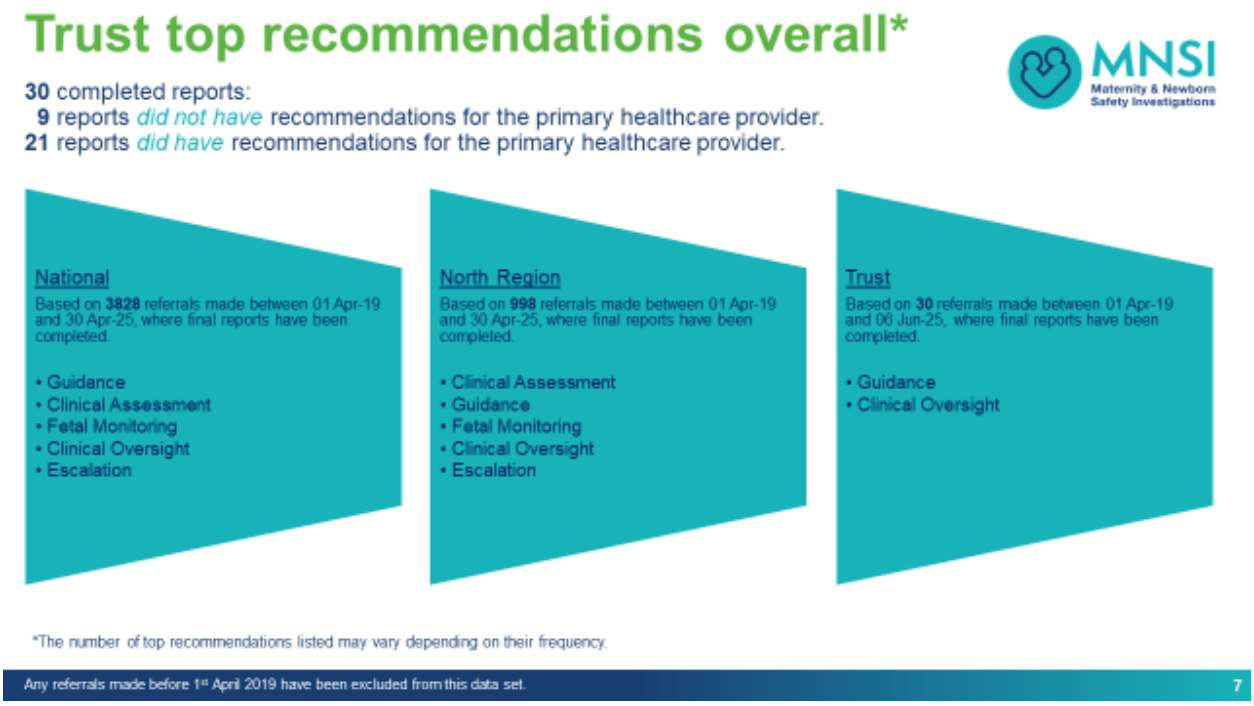
The three main themes identified have been used to inform the maternity Patient Safety Incident Review Framework (PSIRF) plan for 2025/2026 namely.

- Unplanned admissions to the Neonatal Unit
- Failure to follow protocols/escalate
- Delay in treatment that has caused moderate harm

For completeness a review of the ongoing quality improvement projects is also being undertaken to ascertain what actions have been taken to date to address the themes identified and highlight additional areas for service improvement.

An independent review of NHS Resolution claims data and early notification scheme data has also been requested by the Trust to enable a further triangulation of themes. This work will be presented to the Trust Clinical Governance and Quality Committee in October / November 2025.

Table 5 – MNSI quarterly review – June 2025 – Trust recommendations.



Claims Scorecard

The Q1 2025/2026 scorecard review (Appendix 7) triangulates the Trust claims score card (that includes claim data from 1 April 2013 – 31 March 2023) with contemporary incident and complaint data received within the maternity service during Q1.

Despite an obvious time lag between claims, incident and complaints data, triangulating the associated data can be used to ensure learning takes place from the themes identified.

The following themes were identified following triangulation of the maternity incidents and complaints:

- Delay in clinical assessment.
- Communication
- Escalation

Ongoing quality improvement work is in progress to address the themes highlighted. Significant improvement has been reported in compliance with the maternity early warning score following the recent quality improvement work and embedding of the new tool in ward and triage clinical areas.

5. Summary

This report provides assurance of the ongoing monitoring of the relevant CNST action plans within the year 7 scheme and of defined key performance safety metrics relating to the perinatal quality surveillance model.

6. Recommendations

It is recommended that the Board of Directors:

i. Receive the contents of the report.

ii. Approve the action plans detailed within this report.

iii. Approve the escalation to the LMNS regarding non-compliance with the Maternity and Neonatal Voices Partnership (MNVP) Lead infrastructure requirements for further escalation via the LMNS to the regional perinatal quality surveillance meeting as per CNST requirements.

iv. Note non-compliance with the neonatal nursing and neonatal medical British Association of Perinatal Medicine national standards of medical and nursing staffing levels, progress attained since the year 6 scheme and action to be taken in response.

v. Approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required.

Appendix 1 – Perinatal mortality review tool cases as from 1 December 2024

Case ID no	SB/NND/ TOP/LATE FETAL LOSS	Notify within 7 working days	Gestation	DOB/ Death	PMRT Started 2 Months Deadline Date	Date parents informed/concerns questions	External Member present at review panel	Report published within 6 months
96354	SB	1	24+4	04.12.2024	04.02.2025	04.12.2024	**External support 17.04.2025**	04.06.2025
96351	NND	1	29+1	04.12.2024	04.02.2025	04.12.2024	**External support 17.04.2025**	04.06.2025
96412	SB	1	33+1	09.12.2024	09.02.2025	10.12.2024	**External Support 15.05.2025**	09.06.2025
96482	LFL	3	22-23	13.12.2024	13.02.2025	16.01.2025	**External Support 15.05.2025**	13.06.2025
96621	LFL	1	22+3	26.12.2024	26.02.2025	26.12.2024	**External Support 29.05.2025**	26.06.2025
96707	SB	1	38+5	31.12.2024	31.02.2025	31.12.2024	**External Support 13.03.2025**	31.06.2025
96723	SB	0	24+3	03.01.2025	03.03.2025	03.01.2025	**External Support 22.05.2025**	03.07.2025
96783	SB	1	37+1	06.01.2025	06.03.2025	07.01.2025	External Was Arranged Did not attend	06.07.2025
96865	SB	0	31+4	11.01.2025	11.03.2025	13.01.2025	**External Support 22.05.2025**	11.07.2025
96927	NND	1	27+	15.01.2025 AN care at Preston	15.03.2025	16.01.2025	**External Support 29.05.2025**	15.07.2025
97050	SB	0	35+4	24.01.2025	24.05.2025	24.01.2025	**External Support 08.05.2025**	24.07.2025
97091	ENND	0	22+6	25.01.2025	25.05.2025	25.01.2025	**External Support 08.05.2025**	25.07.2025
97179	ENND	1	22+2	31.01.2025	31.05.2025	31.01.2025	**External Support 12.06.2025**	31.07.2025

97164	ENND	0	32+3	02.02.2025	02.06.2025	02.02.2025	**External Support 10.07.2025**	02.08.2025
97466	NND	0	35+2	24.02.2025	24.04.2025	24.02.2025	**External Support 10.06.2025**	24.08.2025
97672	NND	1	26+2	07.01.2025 09.03.2025	09.05.2025	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	Arranged For 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	Arranged For 14.08.2025	02.10.2025
98062	SB	1	40+4	04.04.2025	04.06.2025	04.04.2025	TBC 28.08.2025	04.10.2025
98164	SB	1	34+0	14.04.2025	15.06.2025	14.04.2025	TBC 04.09.2025	15.10.2025
98259	LFL	1	22+1	18.04.2025	18.06.2025	19.04.2025	TBC 11.09.2025	18.10.2025
98238	LFL	2	22+6	19.04.2025	19.06.2025	21.04.2025	TBC 11.09.2025	19.10.2025
98346	SB	3	39+6	25.04.2025	25.06.2025	28.04.2025	TBC 18.09.2025	25.10.2025
98847	NND	1	22+2	03.06.2025	03.08.2025	03.06.2025	TBC 06.11.2025	03.12.2025
98956	SB	0	24+6	11.06.2025	11.08.2025	11.06.2025	TBC Burnley	11.12.2025
99066	SB	1	37+4	18.06.2025	18.08.2025	19.06.2025	TBC 06.11.2025	18.12.2025
99250	NND	1	24+4	14.04.2025 To 01.07.2025	01.09.2025	02.07.2025	TBC 27.11.2025	01.01.2026
99636	NND	1	23+3	29.07.2025 To 30.07.2025	30.09.2025	31.07.2025	TBC 27.11.2025	31.01.2026
99736	SB	4	41+6	01.08.2025	01.10.2025	04.08.2025	TBC 04.12.2025	04.12.2025

Stillbirths and late fetal losses				
Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
20	1	8	11	1

Neonatal and post-neonatal deaths				
Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
15	1	6	7	1

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

Ref	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1.	Antenatal booking appointment to be completed within recommended timeframe	Trudy Delves	01/10/2024	08.10.24 Ongoing Improvement Plan for Maternity Bookings in place. Self-referral booking process progressing with digital support. Monitoring of compliance undertaken monthly via IPM pack of 10+0 and 12+6 pathways. 08.08.24 Sustained improvement in 12+6 and 10+0 booking performance as per IPM pack.	4
2.	Inclusion in the ASAP national programme to promote early booking	Trudy Delves	01/10/2024	17.12.24 Link made with lead from national ASAP programme and initial draft communications shared.	4
3.	CO monitoring to be undertaken at each appointment	Trudy Delves	01/10/2024	08.10.24 CO monitors in clinics and all areas. Maternity Tobacco Dependency Midwife allocated training time on new SBLV3 training day agenda. 22.11.24 Ongoing audit of compliance continued in accordance with CNST guidance	4
4.	Domestic Abuse question to be asked at booking appointment	Trudy Delves / Jayne Maguire	01/12/2024	08.10.24 Undertake audit of compliance and identify actions to be undertaken in response. 17.06.25 Audit completed by Named Midwife for safeguarding	4

5.	Triage BSOT assessment to be undertaken with evidence of audit	Emma Jones	01/10/2024	08.10.24 BSOTS action plan and review of triage in progress. 30.08.24 BSOTs audit ongoing as per clinical audit schedule to monitor delays in assessment and actions as appropriate.	**4**
6.	Syntometrine given to a patient with hypertension. Contraindicated in the management of blood pressure.	Kathryn Bolton	30.12.2025	30.10.24 Information shared in huddle week commencing 30.12.2024.	**4**
7.	Sepsis 6 pathway to be followed	Lizzy Dean / Emma Jones	01/3/2025	08.10.24 National MEWS in process of being implemented as a formal project. 26.02.24 National MEWS launched in service 17.06.25 Audits of compliance ongoing quarterly with regard to sepsis screening. Full assurance received in June 2025 audit.	**4**
8.	Targeted offer for multigravida families in highest risk areas to be considered using REACH pregnancy circles service.	Trudy Delves	01/03/2025	18.12.24 REACH pregnancy circle training commenced. 20.02.24 REACH circles to areas of high deprivation to be piloted. 09.07.25 First circle delivered on 9 July 2025	**4**
9.	No bereavement care since death of baby	Seema Kala	31.01.2025	03.01.25 Review of funding for counselling offer for bereaved families completed. Funding secured for an external service to provide this offer. Counselling sessions with Talk Changes, funded by Maternity Bereavement Fund.	**4**
10.	Book ANDU appointment at point of discharge	Emma Jones	30.04.2025	All Ward Clerk staff on CDS advised and trained to offer appts at the point of	**4**

				discharge from Triage rather than advise woman to call to make subsequent apt.	
11.	Glucose Tolerance testing clinic to be delivered in accordance with national standards	Debra Smith	31.05.25	16.6.25 GTT clinic reinstated in line with national guidance.	**4**
12.	Lack of clarity within the regional guideline as to the starting gestation of which SFH should commence from. For those on a low risk pathway	Lauren Goddard	31.03.2025	12/3/25 Confirmation received from GMEC LMNS at SBL Champions meeting on 11/03/25 that publication of latest version of the FGR guideline (with amended wording re when to commence SFH measurement from) is expected by 31st March. On-going audit of SFH compliance monitored via SBL assurance process 100% compliance achieved and maintained. Audits shared via audit meeting and also in FGR face to face training on Mandatory Training Day 4 (Saving Babies Lives)	**4**
13.	This mother only had partial investigations for underlying metabolic and/or haematological abnormalities as per the local guideline.	Seema Kala	01.04.2025	The checklist for postnatal bloods are in every grab bag with a signature checklist. This was updated in December 2024. Continuing monitoring of postnatal blood tests are being reviewed through the PMRT review tool.	**4**
14.	Postnatal Blood tests not performed	Kathryn Bolton and Seema Kala	01.12.2024	Update in CDS weekly staff huddle shared on the 11.11.2024. Checklist for postnatal bloods in every bereavement care pack. Continuing monitoring of postnatal blood tests are being reviewed through the PMRT review tool.	**4**
15.	Progress in labour not recorded on partogram	Seema Kala	31.07.2025	Bereavement midwives include this on study day.	**4**

16.	Delay in diagnosis of pre-eclampsia due to not obtaining the placental growth factor result (PIGF)	Sara Luke	31.08.2025	Visual learning slide created (see evidence attached) and confirmed with consultant JB that information correct (all information obtained from policies). Learning Slide, policies and PlGF appendix sent via email (see evidence attached) to all ward managers and matrons to disseminate with teams. Laminated copies put in all antenatal areas: G3, CDS, Triage and ANDU	**4**
17.	Incorrect risk assessment at booking due to unclear category of abdominal surgery.	30.09.2025	Elizabeth Dean	Antenatal guideline needs to be reviewed by policy owner and obstetric team. 15.5.25 Policy now clearly states types of abdominal surgery that may impact upon pregnant and require consultant review.	**4**
18.	To review the current process in Community and ANC with the aim of improving the referral system to reduce the likelihood of this recurring	31.07.2025	Trudy Delves	Referral sent to antenatal email that was no longer in use and did not receive a return to sender email. The evidence that this inbox is no longer in use has been uploaded to the incident 271106. Maternity shared learning sent to the division 31.07.2025	**4**
19.	The leadership team to review the current RFM processes in ANDU	31.07.2025	Elizabeth Dean	ANDU now has designated BSOT midwife, RFM pathway aligned to be the same as maternity triage. Triage and ANDU to be relocated together in September 2025 RFM BSOT audit being undertaken by team lead in ANDU, under separate action.	**4**

Appendix 2 – Transitional care – 34+4 action plan with updates.

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	Transitional Care Lead	1.1 Appoint a Transitional Care Lead	Complex Care Matron	January 2024	**29.01.2024** TC lead commenced post.	4
2	Workforce Funding	2.1 Seek additional funding for staffing to ensure 24/7 cover, with BAPM guidance of TC staffing ratio being at least 1:4	Director of Midwifery / Operational Business Manager	January 2026	**09.05.2025** TC Lead and Matron met with the operational Business manager to prepare a TC staffing model case. **08.08.25** Meeting held with HOM. Agreed TC staffing to be included in upcoming BR+ staffing review	2

					planned for autumn 2025.	
3	Provision of service	3.1 Confirm location of TC service to be provided	Director of Midwifery / Lead NNU Consultant	March 2025	**06.11.2024** HOM confirmed TC infants will receive service within the new remodel of intrapartum services, with 4 beds being allocated for the most vulnerable of TC infants and all other TC infants will be allocated alternative beds within intrapartum services. NNU Lead consultant discussed with HOM SCBU cots availability, for TC service provisions. **27.01.2025** Divisional Director of Operations shared an update of the redevelopment plans, TC cots allocated within the 1st floor plans and opposite the neonatal resus room.	**4**

		3.2 Audit available equipment for TC service	TC Lead	August 2025	**01.05.2025** Audit completed with Q4 2025 TC SOP, adequate equipment available for managing Jaundice and thermoregulation and NEWTT observations.	**4**
4	Training	4.1 Ensure maternity staff are appropriately trained to provide safe and effective care to neonates from 34-weeks gestation	TC Lead	December 2025	**03.10.2023** Training plan to be developed to include a training passport. **21.05.2025** TC Lead met with NNU ANNP and with the NNU Consultant, discussed the training can commence once the NEWTT 2 guideline and Aquatherm cots are launched, for assurance the gestation can be managed appropriately. **08.08.25** Aquatherm cots in use – NEWTT 2 awaiting launch.	**3**

		4.2 Design a TC pathway for infants who require naso-gastric feeds and all maternity staff to complete a training package	NNU Consultant, NNU ANNP, TC Lead	January 2026	**10.06.2024** Staff competencies for NG feeding designed. **03.10.2024** Guideline completed, however awaiting plans for model of care to be confirmed prior to dissemination and approval with consultant team. **21.05.2025** TC Lead met with NNU ANNP and with the NNU Consultant, unable to progress the pathway safely until NEWTT 2 guideline launched.	**2**
		4.3 Introduce the Aquatherm heated mattresses to be used within intrapartum areas to support thermoregulation and all maternity staff to sign an equipment competency after training	TC Lead	June 2025	**24.10.2024** Delivery to the trust of 8 Aquatherm heated mattresses**.** **30.05.2025** Aquatherm cots launched into practice following delivery of training package.	**4**

5	Clinical Governance	5.1 Ensure accessible and evidence-based guidance to underpin clinical practice and a robust audit cycle	TC Lead	Quarterly	**20.06.2025** Q4 2025 TC SOP sent to HOM, with 100% compliance reported.	**4**
		5.2 Audit NNU local service activity of 34-weeks gestation infants in Q1 and Q2 2024 admitted to NNU, to benchmark the care requirements for this group of infants.	TC Lead	September 2025	**02.12.2024** Audit data collected with an audit population of babies born between 34+0 weeks and 34+6 weeks that was admitted to NNU and recorded on BadgerNet. **12.12.2024** Audit data analysed and to be formatted into a report to share with HOM, Complex care Matron and NNU consultants. **24.04.2025** TC Lead to meet with NNU ANNP to discuss data, in relation to staff teaching for 34 weeks' gestation TC pathway. **21.05.2025** TC Lead met with NNU ANNP and with the NNU Consultant, to	**3**

					extend audit and include data from Q3 2024, Q4 2025.	
6	Service user experience	6.1 Link with Maternity & Neonatal Voice's Partnership (MNVP) for any service user feedback for 34-weeks gestation experiences, to refine the care model that can be provided within TC	TC Lead	September 2025	**08.08.25** Engagement MNVP lead appointed. TC lead to meet with MNVP engagement lead to seek views of service users	**2**
		6.2 Review resources available on BAPM, ODN network and design a parental leaflet for TC service	TC Lead, Matron for complex care	December 2025	**02.07.2025** TC leaflet version 1 designed and shared with families, awaiting feedback to progress.	**3**

Appendix 3 – SA4 - Neonatal nurse workforce calculator

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 110.78, of which 77.55 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	105.94	93.10	98.85	7.09	-5.75
Total reg nurses	101.78	88.94	90.83	10.95	-1.89
Total QIS	84.78	75.08	72.13	12.65	2.95
Total non-QIS	17.00	13.86	18.70	-1.70	-4.84
Total non-reg	4.16	4.16	8.01	-3.85	-3.85
Reg nurses as % nursing staff	96.1%	95.5%	91.9%		
QIS as % reg nurses	83.3%	84.4%	79.4%		

Appendix 3a – Neonatal nurse workforce action plan

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	Achieve neonatal nursing staffing requirements as per Clinical Reference Group workforce tool.	1. Ensure 6.32 WTE (Band 5 and Band 6 inclusive) staffing deficit reported in bi-annual staffing review and escalated to the Chief Nurse.	Divisional Nurse Director Neonatal Matron	Feb 26	Current staffing deficit calculated using Trust staff list (vacancies and new starters) included and North West Operational Delivery network staffing tool (Non-direct cot side care Last reported in July 25). On-going recruitment continues with dates for new starters (x5 WTE) August 25 and September 25 (not included on Q1 return attached)	2
		2. Ensure that 70% of the Neonatal workforce are QIS trained (Qualified in Speciality) as per BAPM standards .	Neonatal Matron	Feb 26	BAPM optimum standards for Neonatal care suggest that 70% of the “Nursing establishment” should be QIS trained. The latter is not explicit to direct and non-direct Neonatal nurse staffing. For transparency, the NNU inclusive nursing	4

					establishment is 72% therefore is compliant as per BAPM. However, when we review direct cot side care the actual figure is at this time 62%. The latter is what we endeavour to achieve and continue to strive for with ongoing recruitment and progression of staff to undertake further training. 4x staff have recently completed the QIS training successfully with a further 4x staff identified to undertake the training in September 25.	
		3. Secure funding to appoint to the vacancies	Neonatal Matron	Feb 26	All posts funded within current establishment and within NCCR allocation.	**4**
		4. Recruit to vacant Psychology position	Divisional Nurse Director OBM Neonatal Matron	March 24	08.11.23 Funding secured as part of NCCR monies May 22 to support Allied Health and Psychology presence on the Neonatal unit to support CNST, Ockenden and NCCR recommendations. 1/8/24 Successful recruitment of 2x Psychologist providing unit support at a shared 0.5WTE. 2x Psychologist now in	**4**

					post since August 24.	
		5. Collate a business case to seek funding up to 100% occupnacy rate	Business Manager	March 2026	20.08.25 Action allocated	

Appendix 4 – Neonatal medical staffing assessment

Medical workforce: Quantify the medical workforce PAs/WTE needed for your unit, based on the BAPM standards:– Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021) | British Association of Perinatal Medicine (bapm.org) Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018) | British Association of Perinatal Medicine (bapm.org) Identify the gap between the current and required medical workforce after allocation of trainees	PAs now	Ideal PAs	PA GAP	Comments
Lead Clinician - (Protected PAs for being neonatal lead)	1.5	2	0.5	
Lead Clinician for Education and Training (protected PAs for neonatal)	0.5	0.75	0.25	
	BAPM Compliant Y/N	WTE needed to be compliant		
Tier 1	Yes	0		Currently in terms of WTE, we do not have any gaps in Tier 1 rota. However this is dynamic and changes in September and march every year with the deanery trainees change. The locally employed clinical fellows also usually work on the neonatal unit to gain experience for a year and then leave to either go to paediatrics or to apply for paediatric specialty training. Currently we have 3 locally employed clinical fellows. One clinical fellow is due to leave in September (Dr. TN), but another clinical fellow will be moved to her post. This medic was appointed due to increased requirements due to sections in main theater, but this post has not been approved
Tier 2	sultants contribut	0		Deanery Tier 2 allocation should ideally be at 4 WTE, however due to current paediatric trainees working patterns, almost all of them are LTFT. So we usually get between 2.4 - 3.2 trainees. In view of this we have appointed two clinical fellows to reduce locum spend. Ideally, since consultants contribute to tier 2 cover, we are compliant, but this has made the tier 3 cover non- compliant. If we could employ 2 more tier 2 doctors, that would mean that we will be able to free up consultants from working tier 2 shifts. this would help us to
Tier 3	No	0.75	7.5	An additional 7.5 PAs to us would help us to be BAPM compliant. Since last update, we have increased consultant presence on the unit for 12 hours to 214 days in a year.
ANNP	Yes	0		Our ideal team would be staffed with 2 tier 1s at night. One way to achieve this would be to have one ANNP and one tier 1 medic. We will apply for funding for training ANNPs.
Physician's Associate	-	-		
MTIs	-	-		we have gained approval for a MTI scheme at Bolton and are able to advertise and recruit when needed to this.
Other - please describe	-	-		

Appendix 4a Neonatal medical staffing action plan to meet BAPM standards

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	Achieve BAPM Tier 3 (consultant) presence on the unit for at least 12 hours per day (generally expected to include two ward rounds/handovers)	1. Assess compliance with standard	Operational Business Manager – Neonates	December 2025 – extended In year 7 scheme)	**August 2025 update:** Resident tier 3 cover has been increased from 2 days a week last year, to around 214 days a year. This has been achieved by releasing 2 of our consultants from some Tier 2 shifts and reallocating them to resident tier 3 shifts. Two other consultants also provide resident cover on their hot weeks over	

					the weekend (3.25 weeks a year, since they are still doing resident tier 2 work). All the PAs in the department have now been used up. So, we are in the process of making a business case to request additional consultant PAs to cover the rest of the days as well as to get two additional middle grade doctors, which will effectively free up our consultants from doing tier 2 work. This will help us to provide 365 days resident cover for 12 hours. **August 2024:** Commenced resident tier 3 cover two	

					days per week. Two new consultants have commenced in post working shifts on the tier 2 rota and some shifts on the tier 3 rota. Recruited one clinical fellows for tier 2 rota, and we have enough trainees from the deanery to free up consultants to provide more tier 3 work. Small number of PAs, which we are planning to allocate to the consultants to undertake, more tier 3 work and move closer to BAPM compliance. Benchmarking tool indicates 2WTE required to	

					achieve BAPM standard.	
		2. Secure funding to appoint to the vacancies	Operational Business Manager – Neonates Clinical Director	February 2024	Complete	
		3. Recruit to vacant positions	Clinical Director	June 2024	Complete - Two new consultants in post	
		4. Continue with job planning for consultants to understand current position then a business case will be created	Clinical Director	December 24	Aug 25 update: job planning completed. Necessary PAs worked out (around 7.5 per week), and business case process currently underway.	
		5. Further review for additional funding to be undertaken following job planning review	Operational Business Manager – Neonates Clinical Director	December 25	Aug 25 update: as above.	
		6. Develop business case for the additional 2WTE Consultant Neonatologists to	Operational Business Manager – Neonates	December 25	Aug 25 update: as above.	

			achieve BAPM compliance for 12 hours consultant presence.	Clinical Director			

Appendix 5 – Saving Babies Lives LMNS assurance rating – June 2025

BFT

Implementation Grading

Significant Assurance - Except for specific weaknesses identified the activities and controls are suitably designed and operating with sufficient effectiveness to provide reasonable assurance that the control environment is effectively managed.

Implementation Progress

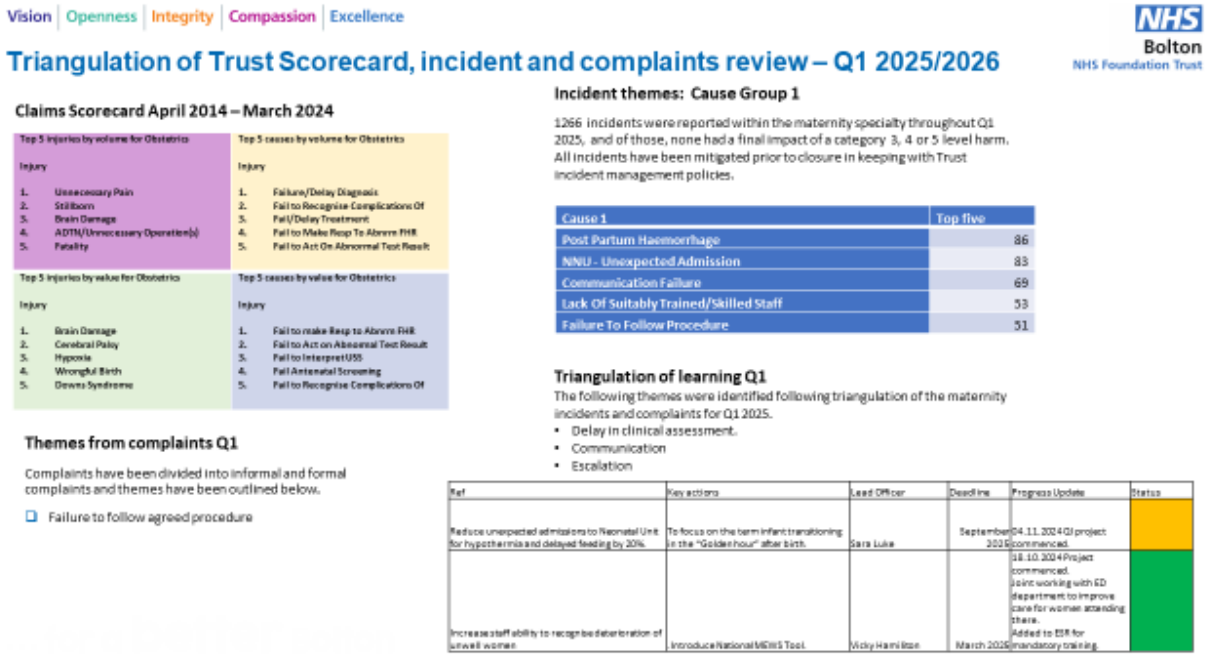
Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%
All Elements	TOTAL	Partially implemented	99%	Partially implemented	99%

Appendix 6 - Staff and patient feedback from the safety walk rounds.

You Said	We did
May 2024 Lack of bed capacity remains an ongoing concern for staff.	Staff briefed on the submission of the RAAC business case to NHS England and the interim actions taken to reduce the ongoing pressure such as the provision of an extra doctor at weekends and a NIPE Midwife to support activity. Options appraisal in progress to consider short to medium term actions to be taken until all works completed.
Battery pack needed in baby resuscitation units to ensure heating can be provided during transfer to other areas.	Decision taken not to proceed with purchase of giraffe unit for G4 as incubators can be used for transfer of heated mattress cots if ventilation support not required.
July 2024 Additional ward equipment required	Request made for additional equipment to be provided namely: - CTG machines on G3 - Additional computer G4 - Medicine trolley for G4 - Examination of the newborn equipment.
September 2024 Room for telephone Triage awaited	Estates request approved for sink removal in consultant room Work commenced – October 2024
Staff not aware of progress of RAAC works	Engagement sessions scheduled to promote staff and service user engagement.
Midwifery staffing	Professional judgement review of all clinical areas undertaken and staff will be realigned to the new allocations Staffing consultation process due to commence early in 2025.

November 2024 Trolley needed with rails to support the safe transfer of patients to CDS when required	Trolley provided
January 2025 Antenatal QR code used to collect patient feedback needs updating. Posters to be relocated in cubicle areas with ANDU	Communication team contacted to refresh QR survey offer Posters to be relocated by ward lead.
April 2025 Focus on walk around was on culture of staff	Informal feedback received on day of visit Staff survey feedback received in Division and shared in engagement sessions 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

Appendix 7 – Q1 2025/2026 claims scorecard triangulation report



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NHS Bolton NHS Foundation Trust

Triangulation of Trust Scorecard, incident and complaints review – Q1 2025/2026

Claims Scorecard April 2014 – March 2024

Top 5 injuries by volume for Obstetrics	Top 5 causes by volume for Obstetrics
Injury	Injury
1. Unnecessary Pain	1. Failure/Delay Diagnosis
2. Stillborn	2. Fail to Recognise Complications Of
3. Brain Damage	3. Fail/Delay Treatment
4. ADTN/Unnecessary Operation(s)	4. Fail to Make Resp To Abnorm 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 Abnorm FHR
2. Cerebral Palsy	2. Fail to Act on Abnormal Test Result
3. Hypoxia	3. Fail to Interpret USS
4. Wrongful Birth	4. Fail Antenatal Screening
5. Downs Syndrome	5. Fail to Recognise Complications Of

Themes from complaints Q1

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

- Failure to follow agreed procedure

Incident themes: Cause Group 1

1266 incidents were reported within the maternity specialty throughout Q1 2025, and of those, none had a final impact of a category 3, 4 or 5 level harm. All incidents have been mitigated prior to closure in keeping with Trust incident management policies.

Cause 1	Top five
Post Partum Haemorrhage	86
NNU - Unexpected Admission	83
Communication Failure	69
Lack Of Suitably Trained/Skilled Staff	53
Failure To Follow Procedure	51

Triangulation of learning Q1

The following themes were identified following triangulation of the maternity incidents and complaints for Q1 2025.

- Delay in clinical assessment.
- Communication
- Escalation

Ref	Key actions	Lead Officer	Deadline	Progress Update	Status
Reduce unexpected admissions to Neonatal Unit for hypothermia and delayed feeding by 20%.	To focus on the term infant transitioning in the "Golden hour" after birth.	Sara Luke	September 2025	04.11.2024 QI project commenced.	
Increase staff ability to recognise deterioration of unwell women	Introduce National MEWS Tool.	Vicky Hamilton	March 2025	18.10.2024 Project commenced. Joint working with ED department to improve care for women attending there. Added to ESR for mandatory training.	

Report Title:	Mortality Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	25 September 2025		Discussion	✓
Executive Sponsor	Dr Francis Andrews, Medical Director		Decision	

Purpose of the report	To provide assurance to the Board of Directors on the Trust mortality metrics status and to outline actions for further improvement.

Previously considered by:	CGQ Committee (03 September 2025) Quality Assurance Committee (24 September 2025)

Executive Summary	The SHMI has reduced from the last report to 114.88, which is in the expected range. The HSMR still sits as an outlier. The crude mortality rate for the organisation remains low in comparison to national data and has reduced in line with expected annual cyclical patterns. Sepsis is a currently an amber alert. An audit of cases in that diagnostic group will be undertaken to understand why we are seeing that trend. In addition to reviewing the data quality for these patients, the Mortality Steering Group is collaborating with the Deteriorating Patient Group to undertake the following actions to ensure that there is the appropriate recognition and response to deteriorating patients: • A Training Needs Analysis for medical staff • Implementing and tracking training compliance for all relevant staff members • Review of the existing process of sepsis screening to determine compliance with current NICE guidance • Presentation of Patientrack NEWS compliance data for divisional review The Q1 neonatal mortality report is included as an Appendix. There are 3 reported deaths in this time period. None has been found to have any care concerns influencing outcome. The Board of Directors should note that the mortality metrics will be impacted negatively by the NHS Digital introduction of Type 5 attendances, those using SDEC. A paper on the impact of this change will be tabled at the next QAC.

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

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

Summary of key elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	Mortality metrics form part of the NOF for Trusts and failure to meet expected standards *may* impact on Trust finances.
Legal/ Regulatory	Yes	Mortality reporting is an regulatory requirement.
Health Inequalities	Yes	There is recognised variation in mortality rates between those from groups with different protected characteristics; Trust understanding of this and monitoring where feasible will mitigate this.
Equality, Diversity & Inclusion	No	

Prepared by:	Liza Scanlon, BI Analyst Sophie Kimber Craig, AMD Dr Sundaram, Neonatologist	**Presented by:**	Dr Francis Andrews, Medical Director

Glossary – definitions for technical terms and acronyms used within this document

DPG	**Deteriorating Patient Group**
MSG	**Mortality Steering Group**
SHMI	**Summary hospital-level mortality indicator** The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days (inclusive) of discharge. The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected', 'as expected' or 'lower than expected' when compared to the national baseline.
HSMR	**Hospital standardised mortality ratio** A quality indicator in healthcare that compares the number of deaths in a hospital to the expected number of deaths, taking into account patient factors like age and illness severity. An HSMR of 100 means the number of deaths is as expected, while a score over 100 indicates more deaths than expected, and a score under 100 indicates fewer than expected.
FCE	**Finished consultant episode –** A period of hospital care from a single consultant which forms the dataset for all hospital episode statistics

Bolton NHS Foundation Trust Mortality report (August 2025)

1. Introduction

This report provides details of:

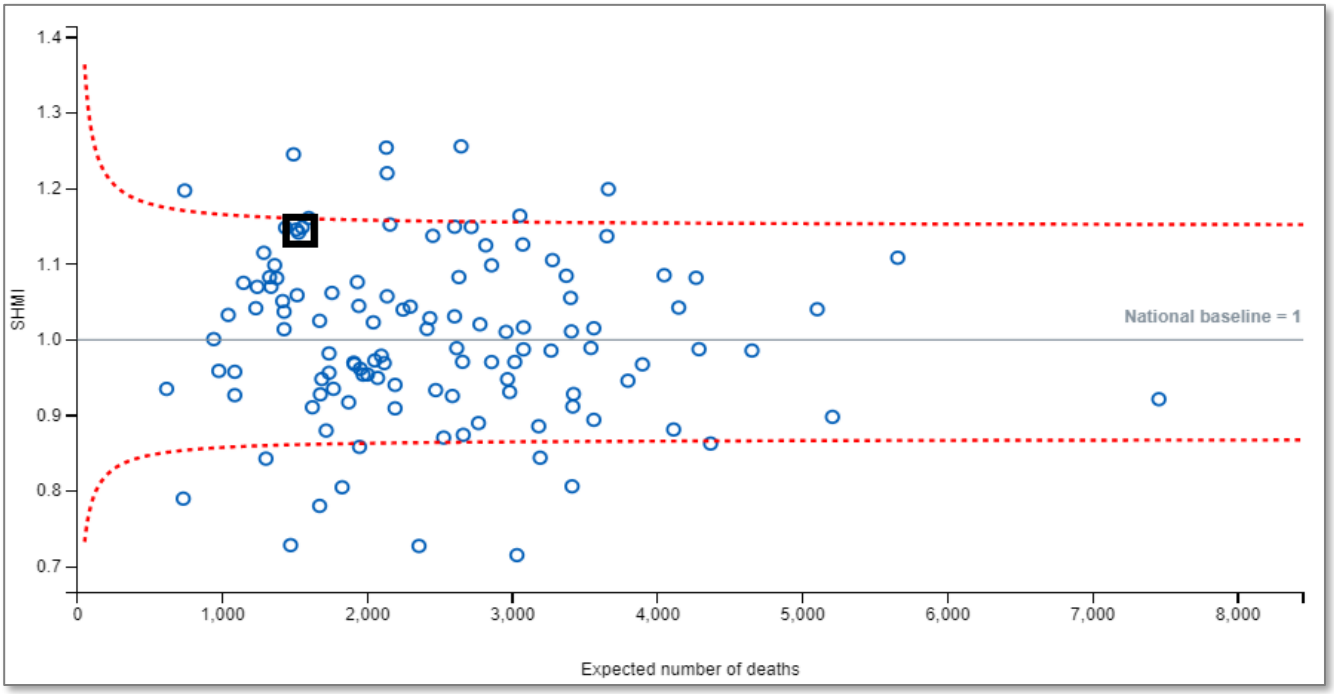
- The current mortality metrics for the Trust
- Outlying diagnostic groups
- Progress on the mortality action plan, including actions to improve accurate recording of diagnosis and Charlson comorbidities, with the steps to reduce the number of short spells
- Coding compliance

The neonatal mortality report is provided in Appendix 1.

2. Headline mortality metrics for Trust

2.1 *SHMI*

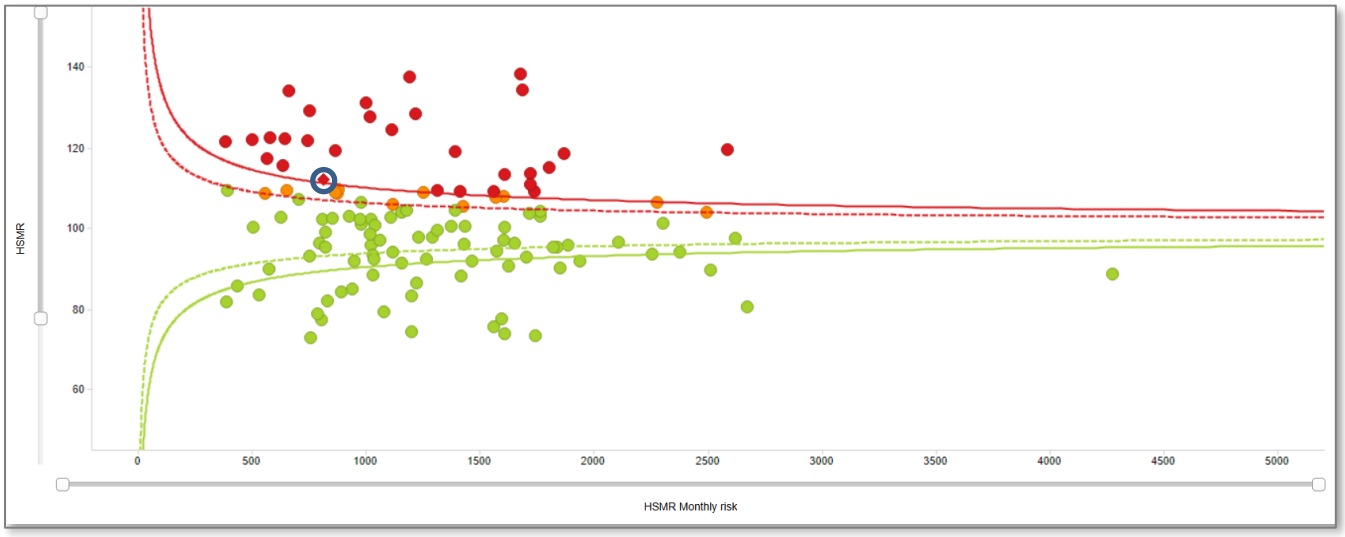
NHS Digital data for SHMI (March 2024 to February 2025) shows Bolton at 114.88, which is "within expected" range. The SHMI has fallen since the last reported figure of 118.34[1].



[1] Patients with Covid are now included in SHMI if the discharge date is from September 2021. This is following a national change in the NHS Digital methodology.

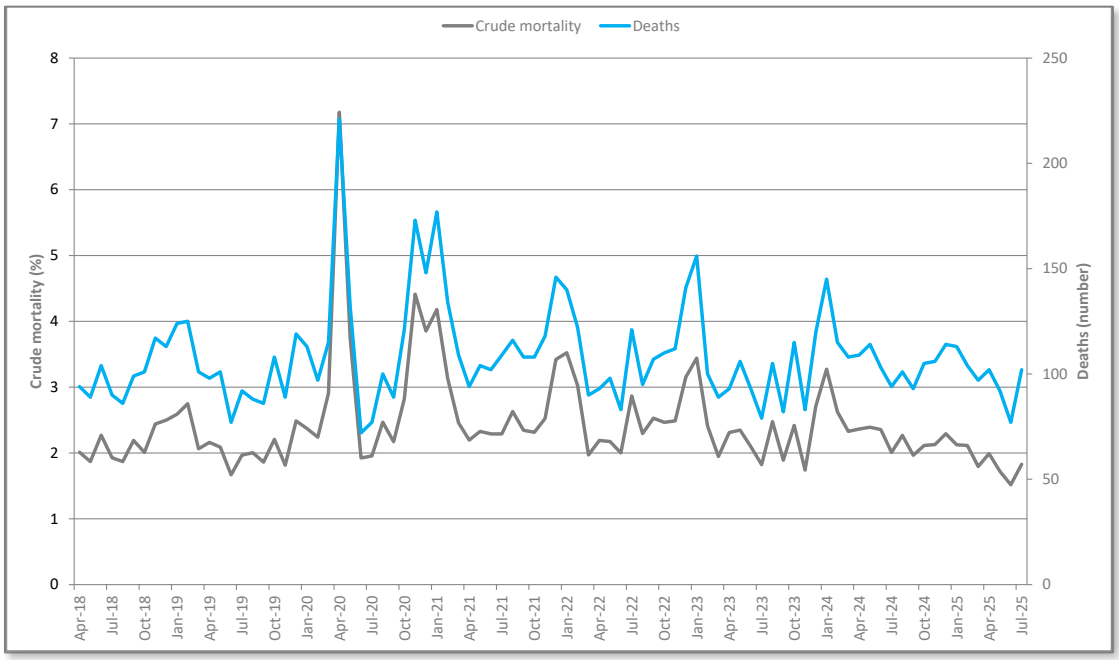
2.2 *HSMR (May 2024 to April 2025)*

The HSMR for May 2024 to April 2025 is 112.16. This is in the "higher than expected" range and therefore sits as an outlier, but as can be seen from the graph below, the Trust is very close to the edge of the funnel plot "as expected" range. In fact, the 95% confidence intervals for this reported metric are 105-119.68, which at the lower end would have the Trust sitting in range.



2.3 *Crude mortality rate (excluding day cases)*

There has been a drop in the number of observed deaths over spring 2025 which is the normal cyclical pattern (see graph on the following page). This will help to reduce both SHMI and HSMR as it is a decrease in the numerator for the metric calculations for both.



3. Outlying groups (May 2024 to April 2025)[2,3]

3.1 *SHMI*

Red Alert – Invalid Primary Diagnosis Group
These would be uncoded records at the time of 'freeze'. The majority of these deaths were outside of the hospital within 30 days, as the Coding Team prioritises coding the deaths occurring in hospital. The majority of the uncoded deaths were August–November 2024 when, although the deadline was met, there was a slight drop in the proportion of coded episodes. From December 2024 onwards, there have been no uncoded episodes or deaths, so we expect this alert to resolve.
Amber alert
There were no diagnosis groups causing an alert for the period May 2024 to April 2025

3.2 *HSMR*

Red Alert – Other perinatal conditions
Extensive work has been done by the team in Families and Diagnostics to ensure that there is comprehensive review of all neonatal deaths in the Trust, using the PMRT as per national standards. The full neonatal mortality report is provided in Appendix 1. In addition to this, a review of the primary diagnosis of has been undertaken by the Coding Manager. This has revealed that the Clinical Coders are categorising more babies as "well babies" than expected in comparison to other organisations. For example, babies born by emergency caesarean delivery due to peripartum fetal distress are being coded as being a "well baby" if there are no clinical concerns about its condition after birth. However, as there was antenatal concern prompting emergency delivery, this is not the correct diagnostic group. Further analysis is needed, but it is suggested that approximately 20 babies each month would instead be included in this "Other perinatal conditions" group, increasing the

[2] All data in this section is data from Healthcare Evaluation Data (HED) which excludes patients who have 'opted out' of their data being shared for research purposes so may vary slightly from published NHS Digital figures.
[3] For SHMI, using control limits in line with NHS Digital, any group alerting 'Red' would be outside of the 95% over dispersed confidence limit; 'Amber' over the 90% confidence limit. For HSMR, Any diagnosis group alerting 'Red' would be outside of the 99.8% confidence limit, 'Amber' would be over 95%.

denominator and therefore causing a reduction in the HSMR for this diagnosis. An update on this will be provided in the next quarterly mortality report.
Amber alert – Septicaemia (except in labour)
A clinical review of the records will be undertaken along with a review by Business Intelligence and Coding teams to review and identify any trends in the recent rise. Sepsis is also reviewed quarterly in the Trust through regular auditing and reporting to the DPG. In addition to reviewing the data quality for these patients and standard reporting, the Mortality Steering Group is collaborating with the Deteriorating Patient Group to undertake the following actions to ensure that there is the appropriate recognition and response to deteriorating patients, including those with sepsis: • A Training Needs Analysis for medical staff • Implementing and tracking training compliance for all relevant staff members • Review of the existing process of sepsis screening to determine compliance with current NICE guidance • Presentation of Patientrack NEWS compliance data for divisional review (in addition to the standard KPI data presented at IPM) The impact of these actions will be reported to the MSG via the DPG Chair's Report.
Amber alert – Pneumonia
This has begun to alert again following a period of being within the expected limits. The outcomes of a full review of patients recorded with pneumonia have been escalated via Mortality Outlying Data Group to the Mortality Steering Group. This identified, as per previous audits, that many patients with a *main condition being treated* as pneumonia are later determined not to have pneumonia. In addition, there is an under-recording of Charlson comorbidities.

4. Existing limitations on mortality metrics

A recent report by CHKS[4] summarised the existing limitations recognised in reporting of national mortality metrics. They said:

[4] CHKS (2024). Understanding your hospital performance metrics. Available at https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjuzd7S7aePAxVOXkEAHb_-G4YQFnoECD8QAQ&url=https%3A%2F%2Fwww.chks.co.uk%2Fuserfiles%2Ffiles%2FUnderstanding%2520Your%2520Hospital%2520Performance%2520Metrics%2520What%2520are%2520RAMI%252C%2520SHMI%2520and%2520HSMR.pdf&usg=AOvVaw2RDtc5mY6zk_Iuw-rAnCXu&opi=89978449

"Risk adjusted mortality measures provide a valuable tool in delivering a systematic approach to identifying those deaths requiring review and in ensuring that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to hospital boards. However, these measures do not account for variation that is not built into their design and some significant predictors of mortality are not included in the hospital data that is used to create the tools."

They described the following limitations:

Common limitations of risk adjusted mortality measures	
Accuracy of Clinical Coding	The data used to calculate risk adjusted mortality scores depend on accurate, compete and timely clinical coding, that is delivered to a high standard. All relevant clinical information must be accurately and consistently recorded in both target and peer data. For example, if some co-morbidities have not been recorded, the risk adjusted mortality measures will not accurately reflect the expected deaths.
Population Size	Risk adjusted mortality measures are designed to work across a large population, so when looking at smaller patient groups over relatively short periods of time a small number of random deaths could be highlighted as an anomaly. For example, if for a particular patient group there are 100 expected deaths it would be within the statistical confidence limits for the actual deaths to be between 70 and 130 deaths. The greater the sample group the greater the confidence in drawing any conclusion from mortality rates.
Statistical Method	Some data can have a significant impact on the expected death rate which is not collected in hospital episode statistics data. For example, two stroke patients of the same age and sex may have very different clinical presentations (extent of paralysis, state of consciousness, cognition, etc.) and, thus, different risk of death. Variables which have a significant impact but are not collected include: ▪ Severity of illness ▪ General health (fitness, nutrition, hydration, BMI, smoking status) ▪ Blood pressure ▪ Mental health
Models of Care	Hospitals and providers adopt slightly different care models this can lead to systemic differences entirely unrelated to the characteristics accounted for in the risk adjusted mortality measures. For example, providers delivering a fully integrated end of life pathway may have different outcomes to those providing only part of this pathway.
Independence of rare events	When observing rare events, the occurrence of one rare event has no impact on the likelihood of another occurrence in a short period of time. Therefore, it is possible to have a run of deaths in a particular patient group which has no underlying root cause. Over longer periods of time this will be regress to the mean, but random chance cannot be eliminated

Whenever viewing Trust mortality metrics, these limitations must be considered, alongside our recognised issues with data quality, which the actions included in this report and the mortality action plan are designed to address.

5. Progress on the mortality action plan

The action plan set out 3 key areas of focus for improving mortality across all divisions with the overarching emphasis on the assurance of care provided:

- Theme 1 – Accuracy of the primary diagnosis in the first FCE
- Theme 2 – Average comorbidity recording
- Theme 3 – Coding to flex date to allow collaboration between clinicians and coders

This following section will provide updates on completed actions on these themes and next steps to be taken.

5.1 *Theme 1 – Accuracy of the primary diagnosis in the first FCE*

Diagnostic groups

The mortality metrics are based around the diagnostic group into which the patient is entered, which is determined by the Coding Team's interpretation of the information recorded by the clinical team. The primary diagnosis, or *main condition being treated*, is important as it forms one element of the calculation around whether a patient is expected to die or not; the more serious conditions carry a heavier weighting in the statistical analysis for predicting death.

Previous audits have identified that the initial diagnosis does not always tally accurately with the clinical picture, nor the final cause of death (although that is to be expected in some patients, as their reason for admission may not be what they die from). There is also an element of interpretation required by the Coding Team to determine what constitutes the *main* condition being treated. This is particularly apparent, for example, during audit of the alerting pneumonia cases. In these audits of patients coded in the pneumonia group, many are found not to have pneumonia when using the specific Advancing Quality audit criteria.

Clinical members of the Mortality Steering Group have provided guidance on the best way to record diagnoses to ensure accurate grouping. The Coding Team have reviewed this data, but it should be recognised that due to the complexity and broad range of conditions that our patients exhibit, it is not easy to align this with specific clinical codes. The feasibility of this is under review and work will focus on education and training for new Resident Doctors in the meantime.

Short spells

In the previous report, data regarding our understanding of practice around "short spells" was provided. This is where the patient has their care moved between 2 or more consultants in a

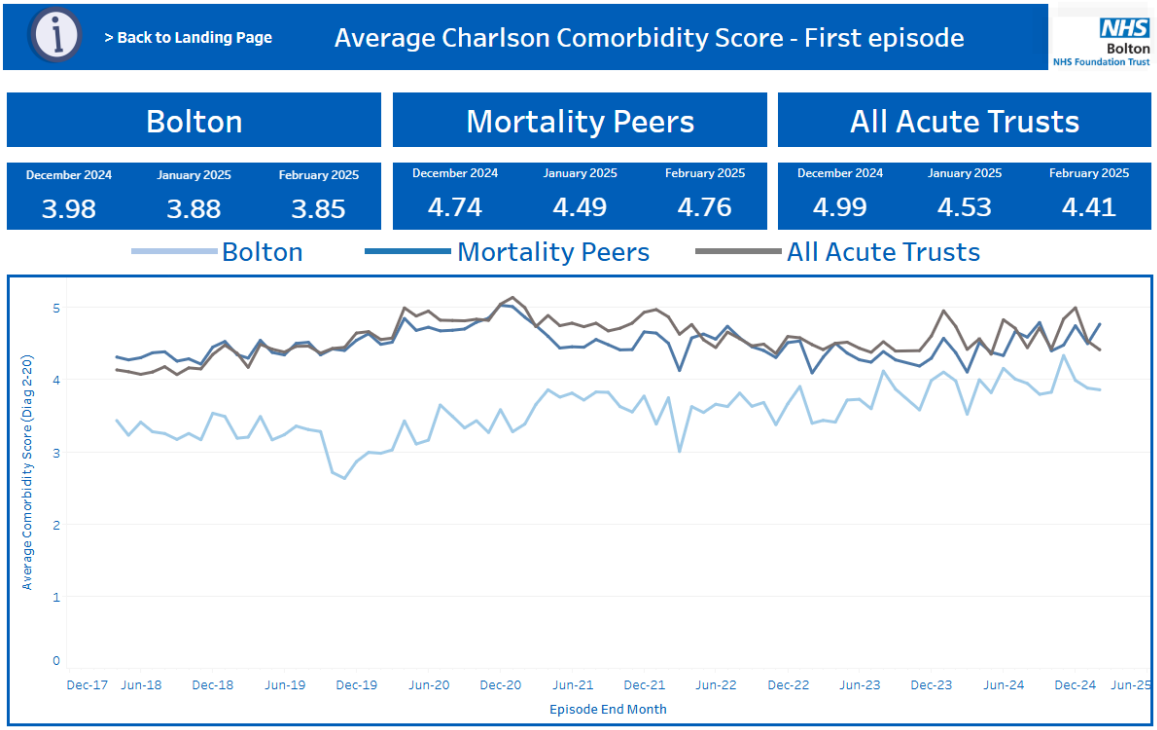
rapid timeframe. This affects our mortality metrics as historically, data has only been allowed to taken from the first finished consultant episode (FCE) and if these are erroneously short, there is a missed opportunity to maximise data collection.

Training was provided to staff to reduce the incidence of this issue, as reported in the previous report. An audit of the impact of this training will be undertaken to determine its efficacy and whether any further steps are required to improve this further.

5.2 *Theme 2 – Average comorbidity recording*

On average, Bolton patients have a recorded Charlson average score around 1 lower than peers and the national average: this has slowly improved with the gap between peers and the national average reducing. This suggests our patients are healthier than those in the rest of the country, which does not equate with what we know about our patient population and the deprivation in the local area.

Despite improvements in the recording there remains a gap to Mortality Peers and All Acute Trusts. The successful inclusion of mandatory comorbidity recording with autopopulation of the Health Issues section of our EPR has shown a slow but increasing trend since its introduction in February 2024.



It is worth noting that for HSMR the total Charlson comorbidity score is used in the statistical modelling, but it differs for SHMI. In calculating whether a patient is expected to die or not, the SHMI categorises them by their Charlson comorbidity score as follows:

Category No.	Values
1	0
2	1 – 5
3	> 5

This might go some way to explain why there is often variance between our HSMR and SHMI values and also shows that a small improvement in our comorbidity recording may reap significant benefits in terms of our SHMI. Ongoing focus on ensuring we record the Charlson comorbidities, particularly where doing that moves the patient up to the next category, should result in improving metrics.

Review by BI and divisional teams of patients who have been readmitted repeatedly find a lack of consistency in Charlson scoring; the quantity and quality of the Charlson comorbidities recorded at each admission varies widely in some patients, sometimes with significant impact on the prediction as to whether they are expected to die or not. This consistency can be improved by completing Health Issues in EPR so the next admission of the patient will have the comorbidities already entered.

Specialty split of Charlson recording

The Charlson score at first episode is calculated as this is the episode that the majority of SHMI and HSMR would be based. Whilst the ASSD specialties fair reasonably when compared nationally, they are below the recording of Acute Adult peers. The following table shows the average Charlson comorbidities per speciality.

> Back to Landing Page

Average Comorbidity Charlson Score - First episode

Bolton	December 2024	January 2025	February 2025
	3.98	3.88	3.85

All Acute Trusts	December 2024	January 2025	February 2025
	4.99	4.53	4.41

Acute Adult	December 2024	January 2025	February 2025
	9.40	9.16	8.62

ASSD	December 2024	January 2025	February 2025
	4.65	3.92	4.68

Family Care	December 2024	January 2025	February 2025
	0.37	0.36	0.39

Bolton - Specialty

	December ..	January 20..	February 2..
100 - General surgery	4.10	3.97	3.72
101 - Urology	5.35	3.56	6.83
103 - Breast surgery	2.00	6.71	4.15
104 - Colorectal surgery	6.13	6.25	0.00
110 - Trauma & orthopaedics	5.78	4.38	5.97
120 - Ear nose and throat	2.64	1.85	1.97
130 - Ophthalmology	1.00	5.60	5.90
180 - Emergency medicine	2.30	5.14	0.00
300 - General internal medicine	9.20	8.09	7.74
301 - Gastroenterology	10.17	11.36	8.56
302 - Endocrinology	6.80	0.00	29.00
303 - Clinical haematology	7.33	5.25	12.00
320 - Cardiology	7.87	10.09	9.08
340 - Respiratory medicine	6.78	9.47	8.87
420 - Paediatrics	0.23	0.37	0.36
422 - Neonatal critical care	0.00	0.09	0.00
424 - Well babies	0.00	0.00	0.00
430 - Elderly medicine	11.10	13.30	11.01
501 - Obstetrics	0.41	0.40	0.39
502 - Gynaecology	0.98	0.55	0.74

All Acute Trusts - Specialty

	December 2..	January 20..	February 2..
100 - General surgery	3.62	3.28	3.34
101 - Urology	5.29	4.88	5.15
103 - Breast surgery	5.80	5.92	5.60
104 - Colorectal surgery	4.25	3.83	3.89
110 - Trauma & orthopaedics	5.03	4.50	4.53
120 - Ear nose and throat	2.68	2.37	2.50
130 - Ophthalmology	2.47	2.66	2.49
180 - Emergency medicine	4.67	4.52	4.04
192 - Intensive care medicine	6.93	6.08	6.45
300 - General internal medicine	8.18	7.26	7.21
301 - Gastroenterology	7.92	6.98	6.76
302 - Endocrinology	9.66	8.87	8.89
303 - Clinical haematology	6.66	6.11	5.84
320 - Cardiology	8.66	7.76	7.85
340 - Respiratory medicine	8.87	7.85	7.79
420 - Paediatrics	0.31	0.29	0.31
422 - Neonatal critical care	0.02	0.02	0.02
424 - Well babies	0.00	0.00	0.00
430 - Elderly medicine	13.57	12.02	12.15
501 - Obstetrics	0.41	0.41	0.40
502 - Gynaecology	1.00	0.95	0.99

It is accepted that there is work to do to improve the data quality and recording of information in the patients' records on the part of the clinicians. It has been difficult to work on digital solutions to help with this in the last quarter due to the Digital team's focus on the implementation of the outpatient EPR. There is an opportunity for improvements in recording data in the Health Issues section when diagnoses are made by the speciality in the outpatients' clinics, which will improve depth of coding and average comorbidity recording. There is a need for training for senior staff to ensure that this is achieved.

Plans to provide educational sessions to the new Resident Doctors on Coding and Recording are being made. Work with speciality teams to improve specific areas of practice is also being undertaken, such as with the orthopaedic team to optimise the use of clinical time while ensuring complete datasets.

5.3 *Theme 3 – Coding to flex date to allow collaboration between clinicians and coders*

The ideal situation to optimise our data quality is for clinicians and Clinical Coders to work alongside each other on the wards recording information in real time. This would reduce the need for the Coders to interpret clinical information from the records, sometimes long periods

of time post-discharge. However, due to capacity in the Coding Team, there is always a backlog of work to complete to ensure compliance with the usual freeze and flex deadlines, which prevents this from being feasible at this time. The Coding Team always prioritise the patients who die in the Trust.

Automation, increasing use of SOPs on interpreting clinical coding and streamlining of medical forms in the EPR all help to improve this situation. There is ongoing work with the Digital and speciality teams to progress this.

6. Learning from deaths report

There has only been one meeting of the Learning from Deaths Committee since the last quarterly report due to one cancelled session and the August meeting being stood down as per Trust practice. In light of this, it is proposed that a full Learning from Deaths report will be brought in the next mortality report.

To enhance learning and to ensure that the Trust can provide data on all patients who die within the Trust to the CQC (as per requests in previous inspections), work is ongoing with the Business Intelligence team to compile a database of all deaths in the organisation. This collates data on every person who dies in the Trust or within 30 days of discharge. It includes:

- Day, date and location of death
- Demographic details, including address to consider the impact of deprivation on outcomes
- Cause of death, including outputs from the Medical Examiner's review
- Whether the case was referred to the Coroner and the outcomes of that process
- Whether the patient was involved in a PSII
- SJR details, if completed, and areas of concern regarding care provision

The final element of this database to be finalised is the outputs from speciality morbidity and mortality reviews. The team will work with divisions to develop a suitable tool to garner the relevant information from those reviews. It is also proposed that divisions provide reports on the outcomes of those meetings to the Mortality Steering Group to create better visibility of that clinical review of care.

7. Changes in NHS Digital methodology – impact on mortality metrics

The Board of Directors should note that the mortality metrics will be impacted negatively by the NHS Digital introduction of Type 5 attendances, those using SDEC. In summary, modelling undertaken by the Business Intelligence lead for mortality suggests that there may be an increase in SHMI of around 7% with this change. Understanding the impact is difficult as there are multiple assumptions to be made and not all organisations will switch over their reporting

methods at the same time. To that end, the peer group to whom the Trust is compared will also be reviewed to ensure it provides the best comparator organisations.

A full paper produced in collaboration with the Chief Data Analyst on the impact of this change will be tabled at QAC when the methods for enacting this change practically is understood.

8. Conclusion

The Board of Directors is asked to receive this quarterly mortality report.

9. Appendices

9.1 *Appendix 1 – Neonatal Mortality Report*

NEONATAL MORTALITY Q1 2025 - 26

Author: Dr Sundaram, Mortality Lead, RBH

Date of report: 1st July 2025

1. Mortality Dashboard

The latest MBRRACE-UK Perinatal Mortality Surveillance Report examining perinatal deaths in 2022 has found that extended perinatal mortality rates have decreased across the UK in 2022 (UK extended perinatal mortality rate: 5.04 per 1,000 total births) after a rise in 2021, although rates remain higher than both 2019 and 2020. Stillbirth rates per 1,000 total births in 2022 were lower across all the devolved nations except Scotland, where there was a small increase: 3.35 (UK); 3.33 (England); 3.31 (Scotland); 3.63 (Wales); and 3.49 (Northern Ireland). Neonatal mortality rates per 1,000 live births in 2022 for the UK were 1.69 and across all the devolved nations; 1.67 (England); 1.59 (Scotland); 1.91 (Wales); and 2.29 (Northern Ireland).

The MBRRACE-UK perinatal mortality report for 2023 births for Royal Bolton Hospital have noted that stabilised & adjusted stillbirth rate is 3.42 per 1,000 total births, and stabilised and adjusted extended perinatal mortality rate is 4.57 per 1,000 total births. This is around the average for similar Trusts & Health Boards. The stabilised and adjusted neonatal mortality rate is 1.15 per 1,000 live births and this is lower than the average for similar Trusts and Health Boards. There is significant variation in neonatal mortality rates at Trusts and Health Boards with a Level 3 Neonatal Intensive Care Unit.

The end of year annual neonatal mortality report will provide a detail of all neonatal deaths, both on NICU and labour ward, all deaths before discharge, deaths at home or in another organisation after delivery and / or care in RBH neonatal unit. The total mortality and the rate of death per 1000 births will be used as a dashboard metric.

Table 1. RBH NICU Mortality past 12 months

NICU	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
Discharges	92	78	68	80	91	101	104	71	77	101	93	62
Died @ RBH	2	1	0	1	1	1	3	1	3	2	0	1
Died at another unit	1	0	0	1	0	1	1	0	0	0	0	0
Died at home	0	0	0	0	0	0	0	0	0	0	0	0
Births	417	425	450	440	374	439	412	383	397	457	396	387
Mortality rate per 1000 births	7.1	2.3	0	4.5	2.6	4.5	9.7	2.6	7.5	4.3	0	2.5

Table 2 shows the quarter 3 mortality report for neonates at RBH and is part of the regular reporting to confirm that there is surveillance of the mortality rates related to the clinical activity of the department. This is reported to the neonatal NWODN (North-West Operational Delivery Network) and the CDOP (Child Death Overview Panel). Babies who died following transfer to other care setting will be reviewed through their local PMRT.

Table 2. Neonatal mortality Q1 2025 - 26

NICU	Apr 25	May 25	Jun 25
Discharges	101	93	62
Total mortality	2	0	1
Births	457	396	387

Table 3. Mortality after discharge from NICU Q1 2025 - 26

	Apr 25	May 25	Jun 25
St Mary's Hospital	0	0	0
Alder Hey Children's Hospital	1	0	0
Home	0	0	0
Hospice	0	0	0

Table 4, 5 and 6 detail the breakdown of the deaths by age, gestation and cause. As one of the regional NICU in the northwest, we accept in-utero and postnatal transfers of high-risk babies requiring intensive care after birth and have an increased risk of mortality

Table 4. All mortality by age

	2023	2024	2025
Early neonatal death (≤7 days)	13	10	8
Late neonatal death (>7 - ≤28days)	4	3	2
Post neonatal death (>28 days)	6	4	1

Table 5. All mortality by gestation

	2022	2023	2024	2025
Peri-viable preterm (<24 weeks)	5	13	6	5
Extremely preterm (24 - <28weeks)	6	3	4	3
Very preterm (28 - <32 weeks)	3	2	2	1
Moderate preterm (32 - <34weeks)	0	1	1	1
Late preterm (34 - <37 weeks)	3	1	2	1
Term (37 - <42 weeks)	3	3	2	0
Post term (>42 weeks)	0	0	0	0

Table 6. All mortality by primary category of death

	2022	2023	2024	2025
Prematurity	5	11	7	5
Respiratory disease	2	2	2	1
Infection	2	2	1	0
Hypoxic Ischemic Encephalopathy	3	3	2	2
Genetic	2	0	0	0
Congenital	1	0	0	1
Metabolic	0	0	2	0
Cardiovascular	1	0	0	0
NEC	2	3	1	1
Renal	1	2	1	1
Other	1	0	1	0

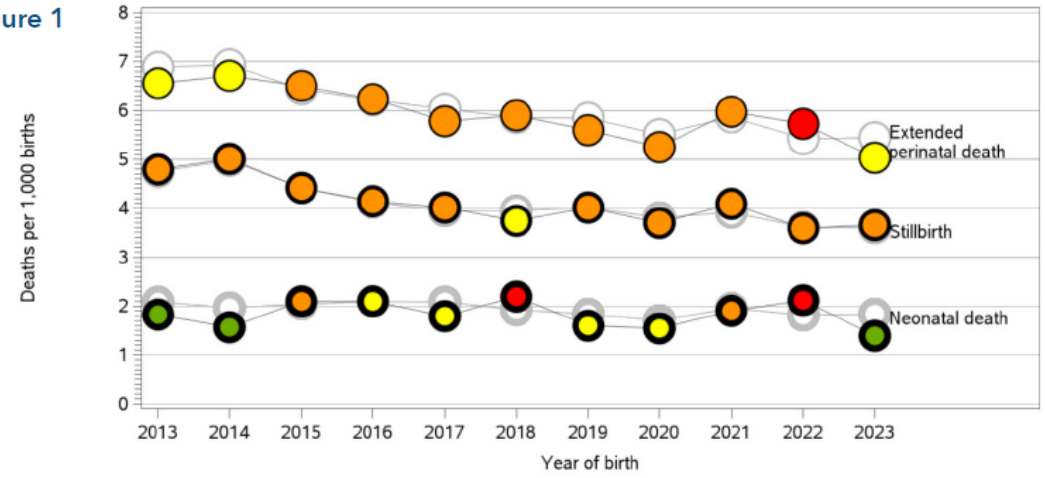
Benchmarking Data

We benchmark our mortality through MBBRACE nationally and figure 1 demonstrates mortality rates over time, the grey lines demonstrate UK average for the RBH comparator group i.e. other level 3 NICUs.

Stabilised & adjusted mortality by year of birth

Stabilised & adjusted mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth. Due to updates to the data and improvements to the statistical methodology used, these results might differ slightly from those in previous reports

Figure 1



2. Neonatal mortality reviews

All neonatal deaths on NICU go through a series of reviews, first a rapid review, followed by a detailed notes review and then using the standardised national perinatal mortality review tool (PMRT). Reviews are planned for 6-8 weeks after the baby has died. Each case is then assigned a grade (A-D, see below) for neonatal care.

	Grading of care of the baby from birth up to the death of the baby (PMRT).
Grade A	No issues with care identified from birth up to the point the baby died.
Grade B	Care issues identified which would have made no difference to the outcome for the baby.
Grade C	Care issues identified which may have made a difference to the outcome for the baby.
Grade D	Care issues identified which were likely to have made a difference to the outcome for the baby.

Local mortality review outcomes and learning are shared within the department and at the Clinical Effectiveness Group for Cheshire and Mersey NWODN. The PMRT outcomes are reported to the regional child death overview panel (CDOP).

The PMRT process promotes parental engagement, all parents are informed of the review process at the time the baby dies, followed up with a letter describing the process and how they can engage is provided. Any comments / questions / concerns which the parents send in are addressed as part of the review and parents are offered an appointment to discuss the response thereafter and a letter detailing the PMRT outcome is provided following the appointment.

	Q2 2024-25	Q3 2024-25	Q4 2024-25	Q1 2025-26
All mortality	4	5	8	3
NICU deaths	2	3	5	2
Delivery room deaths	1	0	2	1
Deaths at other hospital	1	2	1	0
Deaths at home / hospice	0	0	0	0
RBH inborn	4	5	8	3
Mortality rate / 1000 births	3.0	3.9	6.7	2.4
RBH inborn mortality rate /1000 births	3.0	3.9	6.7	2.4
RBH neonatal mortality rate / 1000 births	3.0	3.9	5.8	2.4
Rapid reviews completed	3.0	4	8	3
Notes review completed	6	4	8	3
PMRT reviews completed	4	4	5	0
No of deaths where care issues have been graded C or D	0	1	0	0

Learning from deaths from Q1 2025 - 26

All the reviews have been completed for the 3 deaths. (2 NICU deaths, 1 death in the delivery room.)

Neonatal Care

Of all the reviews done, no care issues have been identified for 2 babies (Grade A) and care issues identified which would have made no difference to the outcome for 1 baby.(Grade B)

Learning Points

1. Early initiation of palliative care plan for very sick preterm babies.
2. Monitor lung expansion on CXR while on HFOV and decrease MAP accordingly.
3. Consider THAM to correct metabolic acidosis, if serum Na+ is high.

Action Plan

	Practice change	Action	Timeframe	Responsibility
1	Early initiation of palliative care plan for very sick preterm babies.	To discuss in the consultant meeting and mortality meeting	3 months	Dr Sundaram

There have been no system errors or failures identified.

Report Title:	Medical Appraisal and Revalidation Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	25 September 2025		Discussion	✓
Executive Sponsor	Medical Director		Decision	✓

Purpose of the report	The purpose of this report is to provide assurance that governance systems for appraisal and revalidation and professional standards for non-training grade medical staff are in place and fit for purpose.

Previously considered by:	N/A

Executive Summary	The 2024-2025 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement sets out the information and metrics that a designated body (in this case, the Trust) is expected to report upwards, to assure compliance with the NHS and GMC regulations and commitment to continual quality improvement in the delivery of professional standards for doctors. • There has been an increase of 56.98% in the number of doctors since 2013, which has resulted in the existing support for Appraisal and Revalidation remaining extremely challenging. Further review of capacity and the impact of the financial pressures, including not being able to replace administration staff remains a significant challenge to full compliance and quality • The Medical Appraisal and Revalidation 2024 Policy review has been completed and is due for review again in 2027 • An A&R peer review has been undertaken and associated action plan has been created • There is an increasing shortfall of appraisers to meet the organisational appraisal need. We have not been successful in securing help from the NHS emeritus scheme. However, plans include utilisation of WLI payments and a centralisation of the A&R budgets to manage cross charging across divisions more effectively. • A business case will be prepared for the recruitment of the shortfall of appraisers • A review of the system for the inclusion of outlying clinical outcomes and

	complaints and serious incidents feeding into the appraisal forms will be completed • A quality assurance process for responding to concerns about a doctor in our organisation will be designed for reporting into People Committee • An SOP will be developed to support arrangements associated with bias and discrimination free processes are in place for responding to concerns about a doctors practice To note, there are two versions of the submission within this paper – one for Bolton NHS Foundation Trust and one for Bolton Hospice as Dr Francis Andrews acts as Responsible Officer for Bolton as a separate submission for each organisation is required for compliance

Proposed Resolution	The Board of Directors is asked to ***approve*** the Medical Appraisal and Revalidation 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:	Nicola Caffrey, Corporate Business Manager for the MD	**Presented by:**	Dr Francis Andrews, Medical Director

	Dr Francis Andrews, Medical Director Rabeya Rashid, Appraisal and Revalidation Officer		

Glossary – definitions for technical terms and acronyms used within this document

A&R	**Appraisal and Revalidation**

2024-2025 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2025**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2024-2025 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Bolton Hospital NHS Foundation Trust
What type of services does your organisation provide?	Acute District hospital providing NHS health care services

	Name	**Contact Information**
Responsible Officer	Dr Francis Andrews	Francis.andrews@boltonft.nhs.uk
Medical Director	Dr Francis Andrews	Francis.andrews@boltonft.nhs.uk
Medical Appraisal Lead	Dr Wyn Price	Wyn.price@boltonft.nhs.uk
Appraisal and Revalidation Manager	Joanne Warburton	Joanne.warburton@boltonft.nhs.uk
Additional Useful Contacts	Rabeya Rashid	Rabeya.rashid@boltonft.nhs.uk
	Lynne Hardy	Lynne.hardy@boltonft.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes/ No	No

If yes, who is this with?

Organisation:
Please describe arrangements for Responsible Officer to report to the Board:
Date of last Responsible Officer Report to the Board:
Action from last year:

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of:
Bolton Hospital NHS Foundation Trust can confirm that:
1A (i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	None
Comments:	The medical director was appointed as RO in August 2018
Action for next year:	No action required.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Business case for funding to increase administrative support for A&R
Comments:	With a 56.98% increase of doctors since 2013, the existing support for A&R is no longer sufficient however the current financial situation in the NHS means this business case had to be put on hold for the foreseeable future
Action for next year:	Reassess financial situation and potential for business case submission.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	No action required
Comments:	The Trust utilises the Premier IT appraisal and revalidation system to maintain accurate records. There are new starter reports from ESR, Induction registers, Pre-employment revalidation checklists and GMC Connect notifications inform of new starters to the Trust.
Action for next year:	No action required

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	None – policy next due for review in May 2027
Comments:	Policy available on the Trust intranet
Action for next year	None – policy next due for review in May 2027

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes

Action from last year:	Review feedback report received following the recent peer review
Comments:	Peer review took place with neighbouring Trust in March and May 2024 with identified actions reviewed by the clinical lead for Appraisal and Revalidation. Issues identified included incomplete private practice declarations, arrangements for locally employed doctors and change to quality assurance process for appraisals.
Action for next year:	To use the RAG report to track and monitor progress for improvements, with the actions held and progressed through the A&R team.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	None
Comments:	For locum doctors, there is a specific induction process and their continuing professional development/appraisal/revalidation is the responsibility of the doctor and their agency but Bolton NHS FT provide informal support where necessary For locally employed doctors, all information relevant to appraisal is supplied within a welcome email and training is offered. Unfortunately due to a significant appraiser shortage, it is not always possible to fulfil appraisal requirements before a short term contract doctor leaves the Trust.
Action for next year	None

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	None
Comments:	The Trust uses the Premier IT appraisal system. The appraisal portfolio is compliant with the latest national requirements and is based on the GMC framework for good medical practice. We additionally now have a

	private practice declaration form as part of the processes. Due to administration capacity, there is not a consistent recording of outlying clinical outcomes or complaints and serious incidents feeding into the appraisal forms
Action for next year:	Review system for the inclusion of outlying clinical outcomes and complaints and serious incidents feeding into the appraisal forms

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	Continue ongoing process
Comments:	Special circumstances and postponements agreed where a doctors has not been able to achieve timely annual appraisal i.e. long term sickness, maternity or shortage of appraisers. There is an escalation process within the A&R policy for doctors who do not qualify for special circumstances and who do not engage, involving the RO and the GMC
Action for next year:	Additional support will be offered to doctors new to the UK in the form of having a meeting with the Clinical Lead and/or an accessible presentation which is now available on our intranet to help educate on the importance of appraisal and revalidation. This is in addition to the existing introduction email that is sent to all new starters.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	None – next due for update in May 2027
Comments:	Ratified and uploaded to the Trust intranet in May 2024
Action for next year:	None – next due for update in May 2027

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	No
Action from last year:	Looking at alternative means for appraisals to remove the backlog. We are engaging with the NHS Emeritus consultant scheme to source more appraisers
Comments:	There is currently a shortfall in the number of appraisers and we have been unable to secure help from the NHS emeritus scheme. Recruitment by invitation has not been successful increasing numbers significantly. Other avenues have been explored which have not been fruitful. Currently the RO and CL for A&R are working towards centralising A&R funding and retaining appraisers with upcoming retirement as bank staff.
Action for next year:	RO and CL for A&R are working towards centralising A&R funding and retaining appraisers with upcoming retirement as bank staff.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	Continue to monitor attendance and training requirements for appraisers and arrange refresher training as necessary.
Comments:	Appraisers attend initial training through external providers funding by their study leave budget. Appraiser network meetings are held every 6 months to support quality and consistency of appraiser performance and updates. Appraiser feedback is collected and fed back to appraisers for their own appraisals. A quality assurance of the medical appraisal processes include the utilisation of the PROGRESS document and formal training by MIAD
Action for next year:	To continue as above

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	To continue
Comments:	The A&R team hold monthly meetings with the RO to discuss issues and concerns. An A&R action plan and appraisal figures is monitored via the People committee.
Action for next year:	To continue as above.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Implement email notifications to encourage patient and colleague feedback to take place in year 2 of a revalidation cycle to ensure completion and inclusion in a completed appraisal cycle and avoid revalidation deferral recommendations.
Comments:	We are compliant with protocols
Action for next year:	Continue as above.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed

with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Implement email notifications to encourage patient and colleague feedback to take place in year 2 of a revalidation cycle to ensure completion and inclusion in a completed appraisal cycle and avoid revalidation deferral recommendations.
Comments:	Every doctor is kept fully abreast with recommendation especially where it is likely that a deferral or non-engagement recommendation will be made. In January-February 2025, the A&R Officer emailed all doctors in year 2 and 3 of the currently revalidation cycle to initiate patient and colleague feedback.
Action for next year:	Continue as above

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	To establish reports for SUI's and Never Events for uploading to doctors portfolios – this has been delayed due to maternity leave and sickness leave in the team
Comments:	RO is heavily involved in clinical governance e.g. quality committee member, PSIRF. All directorates have an active clinical governance lead.
Action for next year:	Inadequate admin resource has delayed this implementation and the upcoming maternity leave of the A&R officer.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	Re-establishment of complaints team providing quarterly list of doctors involved in complaints including locums.
Comments:	Information from appraisals, complaints, incident reports, outside agencies and direct reports to the medical directors team are monitored and actioned
Action for next year:	To strengthen inclusion processes within appraisal documentation

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	To establish reports for SUI's and never events for uploading to doctors portfolios.
Comments:	HED data is available upon request for Consultants which is downloaded as a pdf report. Complaints reports are uploaded for all doctors, including reports with a nil return. Patient and Colleague feedback is completed via the electronic appraisal system, Premier IT, which is uploaded directly to a doctor's portfolio. Establish reports for PSIRF (no longer SUI) and Never Events has been deferred due to short staffing and upcoming maternity leave of A&R Officer.
Action for next year:	RO to discuss with Director of Quality Governance to set up a system to receive these reports is currently in discussion.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	None
Comments:	There is a well-established process including capability, conduct and remediation policy and disciplinary policy. GMC fair decision process followed. Bank of trained investigators.
Action for next year:	None

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	No
Action from last year:	A report does need to come to people committee to analyse these cases. A report will be provided in November 2024, and in future after the end to the financial year.
Comments:	All concerns raised with the RO are discussed with the deputy director of people and the PPAS to ensure a fair and proportionate response. We follow the 10 recommended practices in the GMC best practice document Principles of a good investigation.
Action for next year:	To establish a quality assurance process to report into People committee

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	To review this process to ensure it is being adhered to.
Comments:	Process has been agreed with Medical workforce business partner to provide information for incoming and outgoing doctors.
Action for next year:	To continue existing processes.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	To continue existing processes
Comments:	The capability and conduct for medical staff policy includes the NHS England Just Culture Guide which encourages managers to treat staff in a consistent, constructive and fair way. A second independent opinion is sought for cases going to formal investigation. RO/investigators EDI mandatory trained.
Action for next year:	To continue existing processes supported by the development of a clear SOP to support these arrangements

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	To provide assurance to People Committee following relevant national reports and reviews
Comments:	This process is undertaken by the MD, but there is a need to provide a response to the people committee after review of relevant national reports for assurance.
Action for next year:	To be actioned by the MD

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Incorporate these standards into the medical leadership programme. There have been 3 successful medical leadership cohorts which align to the Messenger recommendations
Comments:	The trust has adopted collaborative leadership and organisational values through the 'our leaders' leadership training and 'our voice' change programme. The RO chairs the DEI assurance group, managers are accredited e.g. through eh CMI, there is a unified FABB appraisal system, clear NED effective recruitment and development and top talent recruitment into challenged areas.
Action for next year:	Continuation of the embedded approach

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	To continue existing processes
Comments:	TRAC electronic system for completion of all pre-employment checks in line with NHS Employment Check Standards for all substantive staff, bank medical staff and foundation doctors before employment. All agency medical staff are sourced through accredited agency partners, through NHS framework agreements.
Action for next year:	To continue existing processes to ensure that all doctors from overseas training programmes undertake the GMC 'welcome to UK practice' and implement results of recent quality scoring trial

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	None
Comments:	There is comprehensive clinical governance including clinical audit committee and quality assurance committee and sub groups to monitor excellence in clinical care
Action for next year:	None

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	MD/RO actively supports programme

Comments:	The Trust 'Our Voice' programme to supports compassion, fairness, respect diversity and inclusivity. the RO is a sponsor for the BAME network and the Trust has the new 'our way' standards that promote these values and behaviours
Action for next year:	None

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	None
Comments:	Our Voice programme, extensive FTSUG and champions embedded and monitored at People Committee. Trust developing quality improvement function to support learning
Action for next year:	None

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	None

Comments:	These mechanisms are embedded in our policies around capability, conduct and remediation and the disciplinary policy and consultation is sought when these policies are reviewed
Action for next year:	These processes will be reviewed by the Medical Director

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	A report does need to come to people committee to analyse these cases. A report will be provided in November 2024, and in future after the end to the financial year and needs to be on the people committee workplan.
Comments:	Only a small number of formal and disciplinary cases are undertaken each year but the characteristics do need reporting annually. A report is now sent to People Committee to analyse cases.
Action for next year:	To continue existing processes

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	Action plan following peer review (delayed by sickness)

Comments:	RO attends and contributes to all network meetings. There is no higher level RO quality review process. A peer review programme was completed with WWL NHS Trust in March and May 2024. Action plan created and followed to monitor and track progress.
Action for next year:	To continue existing processes

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	418
Total number of appraisals completed	358
Total number of appraisals approved missed	37
Total number of unapproved missed	23
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	127
Total number of late recommendations	7
Total number of positive recommendations	87
Total number of deferrals made	40
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	7
Total number of trained case managers	2
Total number of concerns received by the Responsible Officer[2]	16
Total number of concerns processes completed	15
Longest duration of concerns process of those open on 31 March (working days)	Not known
Median duration of concerns processes closed (working days)[3]	Not known
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	20.5
Total number of new employment checks completed before commencement of employment	20.5
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

- Business case for increase A&R administrative support-this has been deferred due to the Trust financial restrictions on administration staffing increases
- Peer review has been undertaken by WWL NHS FT
- Serious incidents are still not being uploaded to appraisals
- MPIT transfer process is now in place with HR
- National report impact not yet undertaken
- Duration of concerns not implemented yet

Actions still outstanding

- Recruitment of more appraisers
- Centralising funding for appraisals-recent executive approval for this
- Establish reports for PSIRF (SUI) and Never Events information flow into appraisals
- Appraisal QA process – currently underway
- Portfolio Audit - % of portfolio audit whether legal claims, audit attendance and Never Events are declared.
- Private Practice Policy to be introduced

Current issues

One of the main issues facing A&R has been the significant shortage of medical appraisers however recruitment to this role has not been without effort from the A&R team. This has effected the timeliness of some appraisals and approved postponements have been applied to their portfolio.

All WLI funding has been utilised to reduce backlog of appraisals due to appraiser shortage which has been useful in the short term until more permanent measures are implemented.

Maternity leave within the A&R team is not being covered due to the freeze on admin posts and this is causing capacity constraints within the team Recording of the duration of investigations needs to be embedded
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
• Reassess financial situation and potential for business case submission • Use the RAG report to track and monitor progress for improvements. • RO and Clinical Lead for A&R are in the process of developing a sustainable plan to recruit more appraisers via a centralised budget • Additional support will be offered to doctors new to the UK in the form of having a meeting with the Clinical Lead and/or an accessible presentation to help educate on the importance of appraisal and revalidation. This is in addition to the existing introduction email that is sent to all new starters. • RO and CL for A&R are working towards centralising A&R funding and retaining appraisers with upcoming retirement as bank staff. • Database of cases amended so length of investigations can be calculated
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Appraisal and Revalidation is well-established at Bolton NHS FT. There are challenges because of the increasing number of doctors with a reduction in the supporting team; incorporation of serious incidents into appraisal needs to be finalised. Appraisal shortages are impacting on timeliness of appraisals and the funding for them is now being centralised within the A&R team. A recent peer review from WWL was largely favourable but did recommend a declaration of private practice form, and a more efficient quality assurance process, both of these have been implemented.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Bolton Hospital NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

2024-2025 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Bolton Hospice
What type of services does your organisation provide?	Hospice care

	Name	**Contact Information**
Responsible Officer	Dr Francis Andrews	Francis.andrews@boltonft.nhs.uk
Medical Director	Dr Aurelia (Ellie) McCann	Ellie.mccann@boltonhospice.org
Medical Appraisal Lead	Dr Wyn Price	Wyn.price@boltonft.nhs.uk
Appraisal and Revalidation Manager	Joanne Warburton	Joanne.warburton@boltonft.nhs.uk
Additional Useful Contacts	Leigh Vallance (CEO)	Leigh.Vallance@boltonhospice.org
	Lynne Hardy	Lynne.hardy@boltonft.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes/ No	Yes

If yes, who is this with?

Organisation: Bolton Hospice
Please describe arrangements for Responsible Officer to report to the Board: Annual report to the Board of Directors
Date of last Responsible Officer Report to the Board: October 2024
Action from last year: None

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of:
Bolton Hospital NHS Foundation Trust can confirm that:
1A (i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	None
Comments:	The medical director for Bolton FT was appointed as RO for Bolton Hospice in 2023
Action for next year:	No action required.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Business case for funding to increase administrative support for A&R in Bolton FT to be able to support
Comments:	With a 56.98% increase of doctors since 2013, the existing support for A&R is no longer sufficient however the current financial situation in the NHS means this business case had to be put on hold for the foreseeable future
Action for next year:	Reassess financial situation and potential for business case submission.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	No action required
Comments:	The Trust utilises the Premier IT appraisal and revalidation system to maintain accurate records. There are new starter reports from ESR, Induction registers, Pre-employment revalidation checklists and GMC Connect notifications inform of new starters to the Trust.
Action for next year:	No action required

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	None – policy next due for review in May 2027
Comments:	Policy available on the Bolton FT Trust intranet
Action for next year	None – policy next due for review in May 2027

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	Review feedback report received following the recent peer review
Comments:	Peer review took place with neighbouring Trust in March and May 2024 with identified actions reviewed by the clinical lead for Appraisal and Revalidation. Issues identified included incomplete private practice declarations, arrangements for locally employed doctors and change to quality assurance process for appraisals.
Action for next year:	To use the RAG report to track and monitor progress for improvements, with the actions held and progressed through the A&R team.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	None
Comments:	For locum doctors, there is a specific induction process and their continuing professional development/appraisal/revalidation is the responsibility of the doctor and their agency but Bolton NHS FT provide informal support where necessary For locally employed doctors, all information relevant to appraisal is supplied within a welcome email and training is offered. Unfortunately due to a significant appraiser shortage, it is not always possible to fulfil appraisal requirements before a short term contract doctor leaves the Trust.
Action for next year	None

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	None

Comments:	The Trust uses the Premier IT appraisal system. The appraisal portfolio is compliant with the latest national requirements and is based on the GMC framework for good medical practice. We additionally now have a private practice declaration form as part of the processes. Due to administration capacity, there is not a consistent recording of outlying clinical outcomes or complaints and serious incidents feeding into the appraisal forms
Action for next year:	Review system for the inclusion of outlying clinical outcomes and complaints and serious incidents feeding into the appraisal forms

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	Continue ongoing process
Comments:	Special circumstances and postponements agreed where a doctors has not been able to achieve timely annual appraisal i.e. long term sickness, maternity or shortage of appraisers. There is an escalation process within the A&R policy for doctors who do not qualify for special circumstances and who do not engage, involving the RO and the GMC
Action for next year:	Additional support will be offered to doctors new to the UK in the form of having a meeting with the Clinical Lead and/or an accessible presentation which is now available on our intranet to help educate on the importance of appraisal and revalidation. This is in addition to the existing introduction email that is sent to all new starters.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	None – next due for update in May 2027
Comments:	Ratified and uploaded to the Trust intranet in May 2024
Action for next year:	None – next due for update in May 2027

1B(iv) Our organisation has the necessary number of trained appraisers[5] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	No
Action from last year:	Looking at alternative means for appraisals to remove the backlog. We are engaging with the NHS Emeritus consultant scheme to source more appraisers
Comments:	There is currently a shortfall in the number of appraisers and we have been unable to secure help from the NHS emeritus scheme. Recruitment by invitation has not been successful increasing numbers significantly. Other avenues have been explored which have not been fruitful. Currently the RO and CL for A&R are working towards centralising A&R funding and retaining appraisers with upcoming retirement as bank staff.
Action for next year:	RO and CL for A&R are working towards centralising A&R funding and retaining appraisers with upcoming retirement as bank staff.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	Continue to monitor attendance and training requirements for appraisers and arrange refresher training as necessary.
Comments:	Appraisers attend initial training through external providers funding by their study leave budget. Appraiser network meetings are held every 6 months to support quality and consistency of appraiser performance and updates. Appraiser feedback is collected and fed back to appraisers for their own appraisals. A quality assurance of the medical appraisal processes include the utilisation of the PROGRESS document and formal training by MIAD
Action for next year:	To continue as above

[5] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	To continue
Comments:	The A&R team hold monthly meetings with the RO to discuss issues and concerns. An A&R action plan and appraisal figures is monitored via the People committee.
Action for next year:	To continue as above.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Implement email notifications to encourage patient and colleague feedback to take place in year 2 of a revalidation cycle to ensure completion and inclusion in a completed appraisal cycle and avoid revalidation deferral recommendations.
Comments:	We are compliant with protocols
Action for next year:	Continue as above.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Implement email notifications to encourage patient and colleague feedback to take place in year 2 of a revalidation cycle to ensure

	completion and inclusion in a completed appraisal cycle and avoid revalidation deferral recommendations.
Comments:	Every doctor is kept fully abreast with recommendation especially where it is likely that a deferral or non-engagement recommendation will be made. In January-February 2025, the A&R Officer emailed all doctors in year 2 and 3 of the currently revalidation cycle to initiate patient and colleague feedback.
Action for next year:	Continue as above

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	To establish reports for SUI's and Never Events for uploading to doctors portfolios – this has been delayed due to maternity leave and sickness leave in the team
Comments:	RO is heavily involved in clinical governance e.g. quality committee member, PSIRF. All directorates have an active clinical governance lead.
Action for next year:	Inadequate admin resource has delayed this implementation and the upcoming maternity leave of the A&R officer.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	Re-establishment of complaints team providing quarterly list of doctors involved in complaints including locums.
Comments:	Information from appraisals, complaints, incident reports, outside agencies and direct reports to the medical directors team are monitored and actioned
Action for next year:	To strengthen inclusion processes within appraisal documentation

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	To establish reports for SUI's and never events for uploading to doctors portfolios.
Comments:	HED data is available upon request for Consultants which is downloaded as a pdf report. Complaints reports are uploaded for all doctors, including reports with a nil return. Patient and Colleague feedback is completed via the electronic appraisal system, Premier IT, which is uploaded directly to a doctor's portfolio. Establish reports for PSIRF (no longer SUI) and Never Events has been deferred due to short staffing and upcoming maternity leave of A&R Officer.
Action for next year:	RO to discuss with Director of Quality Governance to set up a system to receive these reports is currently in discussion.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	None
Comments:	There is a well-established process including capability, conduct and remediation policy and disciplinary policy. GMC fair decision process followed. Bank of trained investigators.
Action for next year:	None

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	No
Action from last year:	A report does need to come to people committee to analyse these cases. A report will be provided in November 2024, and in future after the end to the financial year.
Comments:	All concerns raised with the RO are discussed with the deputy director of people and the PPAS to ensure a fair and proportionate response. We follow the 10 recommended practices in the GMC best practice document Principles of a good investigation.
Action for next year:	To establish a quality assurance process to report into People committee

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	To review this process to ensure it is being adhered to.
Comments:	Process has been agreed with Medical workforce business partner to provide information for incoming and outgoing doctors.
Action for next year:	To continue existing processes.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	To continue existing processes

Comments:	The capability and conduct for medical staff policy includes the NHS England Just Culture Guide which encourages managers to treat staff in a consistent, constructive and fair way. A second independent opinion is sought for cases going to formal investigation. RO/investigators EDI mandatory trained.
Action for next year:	To continue existing processes supported by the development of a clear SOP to support these arrangements

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	To provide assurance to People Committee following relevant national reports and reviews
Comments:	This process is undertaken by the MD, but there is a need to provide a response to the people committee after review of relevant national reports for assurance.
Action for next year:	To be actioned by the MD

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Incorporate these standards into the medical leadership programme. There have been 3 successful medical leadership cohorts which align to the Messenger recommendations
Comments:	The trust has adopted collaborative leadership and organisational values through the 'our leaders' leadership training and 'our voice' change programme. The RO chairs the DEI assurance group, managers are accredited e.g. through eh CMI, there is a unified FABB appraisal

	system, clear NED effective recruitment and development and top talent recruitment into challenged areas.
Action for next year:	Continuation of the embedded approach

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	To continue existing processes
Comments:	TRAC electronic system for completion of all pre-employment checks in line with NHS Employment Check Standards for all substantive staff, bank medical staff and foundation doctors before employment. All agency medical staff are sourced through accredited agency partners, through NHS framework agreements.
Action for next year:	To continue existing processes to ensure that all doctors from overseas training programmes undertake the GMC 'welcome to UK practice' and implement results of recent quality scoring trial

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	None
Comments:	There is comprehensive clinical governance including clinical audit committee and quality assurance committee and sub groups to monitor excellence in clinical care
Action for next year:	None

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	MD/RO actively supports programme
Comments:	The Trust 'Our Voice' programme to supports compassion, fairness, respect diversity and inclusivity. the RO is a sponsor for the BAME network and the Trust has the new 'our way' standards that promote these values and behaviours
Action for next year:	None

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	None
Comments:	Our Voice programme, extensive FTSUG and champions embedded and monitored at People Committee. Trust developing quality improvement function to support learning
Action for next year:	None

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes

Action from last year:	None
Comments:	These mechanisms are embedded in our policies around capability, conduct and remediation and the disciplinary policy and consultation is sought when these policies are reviewed
Action for next year:	These processes will be reviewed by the Medical Director

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	A report does need to come to people committee to analyse these cases. A report will be provided in November 2024, and in future after the end to the financial year and needs to be on the people committee workplan.
Comments:	Only a small number of formal and disciplinary cases are undertaken each year but the characteristics do need reporting annually. A report is now sent to People Committee to analyse cases.
Action for next year:	To continue existing processes

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	Action plan following peer review (delayed by sickness)

Comments:	RO attends and contributes to all network meetings. There is no higher level RO quality review process. A peer review programme was completed with WWL NHS Trust in March and May 2024. Action plan created and followed to monitor and track progress.
Action for next year:	To continue existing processes

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	4
Total number of appraisals completed	4
Total number of appraisals approved missed	0
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	0
Total number of late recommendations	0
Total number of positive recommendations	0
Total number of deferrals made	0
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	0
Total number of trained case managers	0
Total number of concerns received by the Responsible Officer[6]	0
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March (working days)	Not known
Median duration of concerns processes closed (working days)[7]	Not known
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	0
Total number of new employment checks completed before commencement of employment	0
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[8]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

[6] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[7] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

[8] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

- Business case for increase A&R administrative support-this has been deferred due to the Trust financial restrictions on administration staffing increases
- Peer review has been undertaken by WWL NHS FT
- Serious incidents are still not being uploaded to appraisals
- MPIT transfer process is now in place with HR
- National report impact not yet undertaken
- Duration of concerns not implemented yet

Actions still outstanding

- Recruitment of more appraisers
- Centralising funding for appraisals-recent executive approval for this
- Establish reports for PSIRF (SUI) and Never Events information flow into appraisals
- Appraisal QA process – currently underway
- Portfolio Audit - % of portfolio audit whether legal claims, audit attendance and Never Events are declared.
- Private Practice Policy to be introduced

Current issues

One of the main issues facing A&R has been the significant shortage of medical appraisers however recruitment to this role has not been without effort from the A&R team. This has effected the timeliness of some appraisals and approved postponements have been applied to their portfolio.

All WLI funding has been utilised to reduce backlog of appraisals due to appraiser shortage which has been useful in the short term until more permanent measures are implemented.

Maternity leave within the A&R team is not being covered due to the freeze on admin posts and this is causing capacity constraints within the team

Recording of the duration of investigations needs to be embedded

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
• Reassess financial situation and potential for business case submission • Use the RAG report to track and monitor progress for improvements. • RO and Clinical Lead for A&R are in the process of developing a sustainable plan to recruit more appraisers via a centralised budget • Additional support will be offered to doctors new to the UK in the form of having a meeting with the Clinical Lead and/or an accessible presentation to help educate on the importance of appraisal and revalidation. This is in addition to the existing introduction email that is sent to all new starters. • RO and CL for A&R are working towards centralising A&R funding and retaining appraisers with upcoming retirement as bank staff. • Database of cases amended so length of investigations can be calculated
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Appraisal and Revalidation is well-established at Bolton NHS FT. There are challenges because of the increasing number of doctors with a reduction in the supporting team; incorporation of serious incidents into appraisal needs to be finalised. Appraisal shortages are impacting on timeliness of appraisals and the funding for them is now being centralised within the A&R team. A recent peer review from WWL was largely favourable but did recommend a declaration of private practice form, and a more efficient quality assurance process, both of these have been implemented.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Bolton Hospital NHS Foundation Trust for Bolton Hospice

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Report Title:	People Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	25 September 2025		Discussion	
Executive Sponsor	Chief People Officer		Decision	

Purpose of the report	The purpose of this report is to provide an update and assurance to the Board of Directors on the work delegated to the People Committee.

Previously considered by:	The matters included in the Chair's report were discussed and agreed at the People Committee.

Executive Summary	The attached report from the Chair of the People Committee provides an overview of matters discussed at the meeting held on 16 September 2025. The report also sets out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors.

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	Yes	An optimal workforce is key to the delivery of our financial plan.
Legal/ Regulatory	Yes	Adherence to employment legislation is a key responsibility for our organisation.
Health Inequalities	Yes	Ensuring our workforce is representative of the population we serve and free from discrimination is critical to equal patient care.
Equality, Diversity and Inclusion	Yes	Ensuring everyone in our organisation has equal opportunities, regardless of their abilities, their background or their lifestyle is critical to good patient care. As a diverse organisation we appreciate the differences between people and treating people's values, beliefs, cultures and lifestyles with respect.

Prepared by:	James Mawrey, Chief People Officer	Presented by:	Sean Harriss, Non-Executive Director

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee:	People Committee	**Reports to:**	Board of Directors
Date of Meeting:	16 September 2025	**Date of next meeting:**	18 November 2025
Chair	Sean Harriss	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Resourcing and Workforce Plan Performance
- People & Culture Update
- Resident Doctor 10 Point Plan
- Employee Relations quarterly report
- GMC National Training Survey Results 2025
- 2024/2025 Appraisal and Revalidation Submission to NHS England NW
- NHS England Self-Assessment for Placement Providers 2025
- Board Assurance Framework
- Steering Group Chairs' reports
- Divisional People Committee Chairs' reports
- Freedom to Speak up quarterly report

ALERT

Agenda Items

ADVISE

Resourcing and Workforce Plan Performance

Key points to note included:

- Usage of substantive staffing reduced by 51 WWTE in July 2025 and by a further 14 WWTE in August 2025 mainly because of MARS exits resulting in being under our plan for both months. The financial better of MARS however will not materialise until the next financial year.
- Bank WWTE reduced significantly in July 2025 by 47 WWTE, and by a further 2 WWTE in August 2025.
- Agency remains relatively low from a usage perspective, reducing by 3 WWTE in July and going up by two in August (mainly because of Resident Doctors industrial action in that month).
- Turnover has mirrored our expectations at stable and static rate of 11.6%.

People & Culture Update

An update on the following areas were provided:

- **A revised proposal of the RESET programme –** There are two phases, an initial foundation-building phase from September to December followed by a focus on delivering priorities from January with content tailored to support leaders in managing changing and embedding the desired behaviours.
- **Compulsory and Trust mandated training (CATM) -** The Committee reviewed National and local changes to mandatory training, including the rollout of a digital passport for new clinical staff, with discussions on compliance, assessment quality, and the impact of new requirements such as the Oliver McGowan training.
- **EDI - 2025 WRES / WDES data and recommendations -** The latest data shows improvement in WRES metrics with more work needed on WDES. Overall priorities remain consistent with the strategic plan. The full EDI report will be reviewed by the EDI Assurance Group in October and presented to the Board in November. Although the high level findings will be included in September Board papers.

ASSURE

Board Assurance Framework

Updates to the BAF were welcomed which reflected Committee feedback from July. The framework now includes expanded corporate objectives and updated risks. The Committee discussed the importance of linking agenda items and strategic assurance to the BAF, with a commitment to review its effectiveness at both the start and end of the People Committee meeting.

Resident Doctor 10 Point Plan

NHS England has launched a comprehensive 10 Point Plan to improve the working lives of resident doctors. This initiative will be implemented within 12 weeks and will be embedded into the NHS Oversight Framework and the 10-Year Health Plan. There is a list of 10 actions that Trusts are required to complete to ensure that Resident doctors are supported. The Committee supported the actions being taken.

Employee Relations quarterly report

The Committee were provided with the details of the ER activity in the organisation. The People Committee were assured that the level of activity was proportionate for an organisation of this size. There did not appear to be any disparity between colleagues from protected characteristics.

Freedom to Speak up quarterly report

The FTSU Guardian highlighted the following key points from the report:

- 32 Concerns raised in Q1 via the freedom to speak up route.
- There was a decrease in staff raising concerns in this quarter, but a subsequent increase is expected.

The People Committee were assured that the level of activity was proportionate for an organisation of this size that invests in FTSU.

GMC National Training Survey Results 2025

The GMC National Survey Results 2025 gathers views of trainees around the quality of their training and the environments they work in. The survey identified issues in general surgery and obstetrics, particularly for GP trainees, with problems related to induction, supervision, and rota gaps, though other specialties showed improvement. Committee noted the actions being taken in this area.

2024/2025 Appraisal and Revalidation Submission to NHS England NW

The Medical Director reported on the annual submission for Appraisal and Revalidation, noting a growing number of doctors to appraise, a shortage of appraisers, and administrative resource challenges. There are ongoing efforts to improve quality assurance and maintain compliance and described recent engagement with NHS England Northwest on these issues.

NHS England Self-Assessment for Placement Providers 2025

The NHS England Self-Assessment is an annual process by which organisations carry out their own quality evaluation against a set of standards. The report requires the Trust to confirm whether standards are being met across all professions/learner groups. The report includes the opportunity to share areas of good practice as well as highlighting current challenges. Educational leads from across professions have contributed to the report and once approved the report will be submitted to NHS England using the online portal. The Medical Director highlighted the complexity of funding flows for medical education, the need for

greater transparency, and ongoing work with finance colleagues to clarify budgets and overheads related to training. Committee noted the actions being taken in this area.

Steering Group Chairs' reports
The reports were provided for information. There was nothing to escalate.

Divisional People Committee Chairs' reports
The reports were provided for information. There was nothing to escalate.

New Risks identified at the meeting: None

Review of the Risk Register: None

Meeting Attendance 2024/25

Members	Nov	Jan	Mar	May	Jul	Sep	Nov
James Mawrey	✓	✓	✓	✓	✓	✓	
Francis Andrews	✓	✓	**A**	✓	✓	✓	
Sean Harriss	✓	✓	✓	✓	✓	✓	
Alan Stuttard	✓	✓	✓	✓	✓	✓	
Fiona Taylor	✓	✓	✓	✓	✓	✓	
Tyrone Roberts	✓	**A**	✓	✓	**A**	✓	
Sharon White	✓	✓	**A**	✓	✓	✓	
Annette Walker		✓	✓	✓	✓	**A**	
Rebecca Ganz				✓	**A**	**NA**	
Seth Crofts	✓	✓		✓	✓	✓	
Sharon Katema	✓	✓	**A**	✓	✓	✓	

✓ = In attendance A = Apologies

Report Title:	Culture Update & EDI Update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	25 September 2025		Discussion	✓
Executive Sponsor	Deputy Chief Executive and Chief People Officer		Decision	

Purpose of the report	The purpose of the report is to provide an update to the Board of Directors on culture improvement, aligned to the strategic ambition 'Great Place to Work.'

Previously considered by:	The paper was discussed at People Committee and requested a series of actions to be brought back to the next meeting (detailed within this Board report).

Executive Summary	The culture update relates to the RESET Programme – a revised proposal to cover the programme over two phases. The report also sets out high level content themes. The EDI update focuses specifically on the 2025 WRES (Workforce Race Equality Standard)/WDES (Disability Equality Standard) data and recommendations. The report requested the following of People Committee - Approve the revised, phased rollout of the RESET Programme - Support and champion the Phase 1 RESET Event, 'Leading Together' to build the culture and foundations to deliver organisational recovery and improvement - Note the 2025 WRES / WDES data and approve the priorities identified prior to external publication on 31st October 2025

Proposed Resolution	The Board is asked to ***receive*** the People and Culture Update noting the People Committee will oversee all relevant actions on behalf of the Board.

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

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**YES**	The Workforce & OD offer to support organisational change well will be a key resource to support effective implementation of our Financial Improvement Plan
Legal/ Regulatory		
Health Inequalities	**YES**	The requirement to complete Equality Impact Assessments for change programmes will support the Trust to address health inequalities
Equality, Diversity and Inclusion	**YES**	WRES / DES data is a statutory requirement

Prepared by:	Rahila Ahmed, EDI Lead Sarah Richards, Head of People Development Lisa Rigby, Assistant Director Organisational Development	**Presented by:**	Lisa Rigby, Assistant Director Organisational Development

1. Introduction

1.1 Culture Update – RESET Programme

The People Committee received the Organisatonal Culture Update, focusing on the RESET Programme. A full and detailed discussion took place around the revised internal offer to support the Trust through change, now split into 2 phases as follows:

Phase 1 – Leading Together – building the culture and foundations to deliver organisational recovery and improvement
Phase 2 – Delivering Together – being clear on our priorities and delivering the Improvement Plan

1.2 EDI Update – 2025 WRES / DES

The People Committee received the 2025 WRES / WDES data, noting improvements and areas of focus.

Board members will be aware that the WRES / WDES are both key areas of focus in our EDI Strategy. EDI and supporting staff through change remains critical priorities for Bolton Foundation Trust and are key components of the Trust Strategy and People Plan.

2. People Committee discussions and actions

2.1 Culture Update – RESET Programme

The Committee of the Board expressed their appreciation for the comprehensive presentation and noted the following points during their discussion:

- The leadership levels identified to physically attend the RESET events were noted as quite senior, however it was acknowledged that it is inpractical to invite all staff to a half day event. The expectation is that the principles and learning outcomes of the event are devolved to teams at all levels.
- The name 'RESET' was discussed. It was noted this was a working title and the programme is early in the development. The Committee felt it would be helpful to consider a range of alternative names for consideration with reommendations.
- There was a discussion around learning outcomes, how we will measure success of the programme and leadership responsibilities at all levels to manage change well. Work on this has already started and will be included as part of the programme.

2.2 EDI Update – 2025 WRES / DES

The Committee welcomed the clear presentation of the data and noted the following points during discussion:

- improvements in the WRES and WDES data, with an acknowledgement of more to do to deliver longer standing EDI priorities across the Trust
- supported the recommendations, with assurance that these remain in line with our EDI Plan
- to check the timescale of next Board update on the wider EDI Plan (since noted update due at November Board)

3. Recommendation to the Board of Directors

The Trust Board are asked to note the details of this paper and note that the People Committee and EDI Assurance Group will continue to oversee all relevant action.

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NHS Bolton NHS Foundation Trust

People and Culture Update

Board September 2025

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

Update on the RESET Programme

Since the last update to People Committee:

- Worked collaboratively across OD, Strategy and Communications and Engagement to shape the programme
- Engaged and involved the Executive Team and Divisional Leadership Teams to gain their ideas and input into the programme design and content
- Factored in quality, performance and lessons learned and good practice from previous change exercises
- Split the programme into 2 phases, aligned with the upcoming Improvement Plan
- In progress with identifying dates and audience for the Phase One RESET events with Divisions, Corporate Services and iFM
- We've been designing practical tools, resources and activities for leaders to communicate, engage and involve their teams and stakeholders

RESET Programme Overview

PHASE 1
Sep– Dec 2025

PHASE 2
Jan – March 2026

Leading Together RESET Event (SEP/OCT) Aimed at Senior Leadership Teams and their direct reports (approx. B8C+)	
Surgery	25.09.25
Community Services	02.10.25
Families and Diagnostics	15.10.25
Medicine	TBC
Corporate and iFM	06.10.25 Second date TBC

Delivering Together RESET Event (Jan/Feb) Aimed at a broader audience of leaders (approx. B8a+)	
Surgery	TBC
Community Services	29.01.26
Families and Diagnostics	TBC
Medicine	TBC
Corporate and iFM	TBC

RESET Cascade

Tools, resources and activities to give leaders the confidence to engage with their teams at a local level, cascading the same principles from the RESET events.

Phase 1 RESET Event

Purpose:

To set out your role as leaders in building strong foundations to deliver organisational recovery and improvement

Outcomes:

- ✓ Align with the principles of financial, performance and organisational improvements
- ✓ Clarify the story of where we are going as an organisation and why
- ✓ Bring the priorities of different plans and strategies into one united Improvement Plan, helping us to be the one same page
- ✓ Support leaders to manage and lead well through change *(Our Leaders framework/responsibilities)*
- ✓ Bring to life the expectations and mindsets for a compassionate and inclusive culture *(Our Way behaviours)*
- ✓ Provide practical tools, resources and activities for leaders to communicate, engage and involve their teams and stakeholders

Main Areas of Focus

Leadership

Reacting to the changing requirements of recovery and improvement

Culture and Mindset

Fostering a genuine belief at all levels that recovery and improvement is possible

Defining the Why

Clearly stating the purpose of recovery and improvement and helping people feel part of the story

12 months from now…what feedback do we want to be hearing?

"I understood the reason for changes"

"I was kept up to date"

"My manager took time to listen to me"

"People said thank you for my efforts"

"Team disagreements and behaviours were noticed and acted upon"

"In times of uncertainty we pulled together"

"Even when it was hard, we were kind to each and respectful"

"Every financial decision we made, we put patients first"

"My suggestions helped shape the changes"

"I'm proud of what we've achieved"

"I've enjoyed working with different people"

"We heard about the vision but nothing connected"

"We only heard about the changes after the decision was made"

"Nobody asked for our input"

"I hate coming into work"

"We don't feel like a team anymore"

"We're expected to do things differently but the old barriers are still there"

"It feels like the change was done to us"

"Every week the message changed so we didn't know what to focus on"

"They said it was about efficiencies but its all been about job cuts"

"I'm considering leaving, I no longer feel proud to work here"

"Working here isn't what I thought it was going to be like"

Impact of getting it right, or not…

- Staff survey and pulse survey results
- Workforce data e.g. sickness, exit interview, retention, wellbeing interventions, HR cases
- Staff feedback through staff engagement activities
- Participation in Our Leaders and other development activities
- WRES and WDES data
- FTSU data
- Divisional and directorate feedback e.g. listening events, team culture surveys (Our Way Team Tool), via FABB conversations
- Organisational performance

Decline

Improvement or Maintain

Phase 1 RESET Event - Focus and Content

Our Starting Point

- ✓ Context of recovery and improvement
- ✓ Improvement Plan/Principles of recovery
- ✓ Guided by Our Way
- ✓ What we need from leaders (Our Leaders)
- ✓ Starting with the story of why

We all LEAD by example

- ✓ Change
- ✓ Engage, involve and include
- ✓ Working together/ triumvirate working
- ✓ Performance and Motivation

We all BELONG

- ✓ Behaviour and mindsets
- ✓ Inclusion
- ✓ Teams Reforming and Changing

We are always IMPROVING

- ✓ Improvement approach and mindset
- ✓ Impact on patients
- ✓ Targeted transformation beyond improving what we do now

Our Commitment and Next Steps

- ✓ Next steps and actions to take
- ✓ Resources and tools to help cascade with team

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EDI Update

WRES and WDES

Improving care,
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Workforce Race Equality Standard 2025 Findings

- 7 indicators improved, 2 indicators deteriorated.
- Trust compares favourably to national averages in almost all areas.

WRES Indicator	2025 vs 2024 Change	Trend	National average 2024 Comparison
1. Workforce Representation	Increased from 20.6% to 23.2% (↑ 2.6%)	✓	Target: 28% (BAME local pop.) → 4.8% below target
2. Recruitment (Relative likelihood of White staff being appointed vs BME staff)	Improved from 1.61 to 1.34 (↓ 0.27)	✓	1.62 → 0.28 better
3. Disciplinary Process (Relative likelihood of BME staff entering formal process)	Increased from 0.78 to 0.90 (↑ 0.12)	✗	1.09 → 0.19 better
4. Access to Training/CPD (Relative likelihood of White staff accessing non-mandatory CPD)	Worsened from 0.99 to 1.01 (↑ 0.02)	✗	1.06 → 0.05 better
5. Bullying, Harassment & Abuse from Patients/Public (BME staff)	Reduced from 25.7% to 23.6% (↓ 2.1%)	✓	27.8% → 4.2% better
6. Bullying, Harassment & Abuse from Staff (BME staff)	Reduced from 23.56% to 20.7% (↓ 2.86%)	✓	24.9% → 4.2% better
7. Belief in Equal Career Progression Opportunities (BME staff)	Increased from 40.7% to 49.7% (↑ 9.7%)	✓	48.8% → 0.9% better
8. Discrimination from Manager/Colleague (BME staff)	Decreased from 18.9% to 14.9% (↓ 4%)	✓	15.5% → 0.6% better
9. BME Board Representation	Increased from 17.7% to 18.8% (↑ 1.1%)	✓	16.5% → 2.3% better

WRES 2025/26 Priorities

Our priorities remain in line with EDI Plan 2022–2026 ambitions and will be progressed and monitored by the 'Our People' Steering Group feeding into the EDI Assurance Group

- Ambition 2: Create a working environment, in which all staff can reach their full potential
- Ambition 3: Recruit and cultivate a workforce that represents Bolton's diversity

1. **Representation** – Increase BAME representation at AfC Band 6+, senior leadership and consultant level, and strengthen staff network involvement and visibility. (Trust 23.2% vs local population 28% → 4.8% gap).
2. **Inclusive Recruitment** – Equality advocate role on interview panels, inclusive recruitment training for hiring managers, and transparent shortlisting and appointment processes.
3. **Career Progression & Development** – Improve access to non-mandatory CPD and development opportunities (Indicator 4 worsened to Trust 1.01 vs national 1.08 although within non adverse range)and equal career opportunities through positive action programmes, the *Our Leaders* programme, and targeted coaching support.
4. **Harassment & Discrimination** – Maintain a zero tolerance policy and campaigns, embed anti-racist objectives for senior leaders and workstream groups, and strengthen staff confidence in reporting and accessing support.
5. **Governance & Monitoring** – Scrutinise disciplinary outcomes to ensure parity (0.90 vs national 1.09), with 6-monthly monitoring to prevent drift above parity.

Workforce Disability Equality Standard Findings

- 8 indicators improved, 2 deteriorated and 3 unchanged.
- Better than national averages in 6 areas, but gaps remain in representation, recruitment, harassment, career progression opportunities, reasonable adjustments and Board representation where no progress has been made.

WDES Indicator	2025 vs 2024 Change	Trend	National average 2024 comparison
1. Workforce Representation of Disabled Staff (AfC)	Increased from 4.9% to 5.2% (↑ 0.3%)	✓	National 5.7% → 0.5% below
2. Recruitment (Relative likelihood of non-disabled applicants being appointed vs disabled applicants)	Unchanged at 1.0	–	National 0.98 → 0.06 worse
3. Disciplinary Process (Relative likelihood of Disabled staff entering formal process)	Unchanged at 0.00	–	National 2.04 → 2.04 better
4(i). Harassment, Bullying & Abuse from Patients/Public (Disabled staff)	Increased from 27.4% to 30.0% (↑ 2.6%)	✗	National 30% → same
4(ii). Harassment, Bullying & Abuse from Managers (Disabled staff)	Decreased from 14.1% to 11.2% (↓ 2.9%)	✓	National 14.6% → 3.4% better
4(iii). Harassment, Bullying & Abuse from Colleagues (Disabled staff)	Increased from 21.0% to 21.8% (↑ 0.8%)	✗	National 23.8% → 2% better
4(iv). Reporting Abuse	Increased from 51.4% to 56.1% (↑ 4.7%)	✓	National 52.5% → 3.6% better
5. Belief in Equal Career Progression Opportunities (Disabled staff)	Increased from 47.9% to 51.1% (↑ 3.2%)	✓	National 52.2% → 1.1% worse
6. Presenteeism – Pressure to work despite feeling unwell	Decreased from 27.0% to 23.6% (↓ 3.4%)	✓	National 26.6% → 3% better
7. Feeling Valued (Disbaled staff satisfied with extent organisation values their work)	Increased from 36.8% to 39.3% (↑ 2.5%)	✓	National 36.9 % → 2.4% better
8. Reasonable Adjustments made by employer	Increased from 72.9% to 73.2% (↑ 0.3%)	✓	National 74.5% → 1.3% worse
9. Staff Engagement score	Increased from 6.55 to 6.57 (↑ 0.02)	✓	National 6.5 → Same
10. Board Representation	No change – 0% disabled board members	✗	5.2% below workforce benchmark (ESR)

WDES 2025/26 Priorities

Our priorities remain in line with EDI Plan 2022–2026 ambitions and will be progressed and monitored by the 'Our People' Steering Group feeding into the EDI Assurance Group

- Ambition 2: Create a working environment, in which all staff can reach their full potential
- Ambition 3: Recruit and cultivate a workforce that represents Bolton's diversity

1. **Improving Workforce Disability Representation** – Build confidence in declaration, tackle under disclosure and support psychologically safe environments
2. **Inclusive Recruitment** – Ensure recruitment outcomes are equitable and address the slight disparity (Trust 1.04 vs national 0.98)
3. **Addressing harassment & Abuse** – Strengthened focus on reducing harassment from patients and the public (metric 4i deteriorated by 2.6%), alongside bullying from colleagues, with actions responding directly to areas of deterioration and sustaining staff confidence in reporting (Trust 51.1% vs national 52.2%)
4. **Reasonable Adjustments** – Ensure consistent delivery of workplace adjustments, addressing the slight gap with national performance (Trust 73.2% vs national 74.5%)

Next steps

- ✓ Update to September Board with cover sheet summarising todays PC discussion
- ✓ Consult with Inclusion Staff Networks
- ✓ Publish the WRES / WDES report alongside the action plan on the Trust's external website by 31 October 2025.

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NHS Bolton NHS Foundation Trust

Summary

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

Ask of People Committee

Staff Engagement

- ✓ Approve the rollout of the RESET Programme as our Trust wide, collaborative approach to leading organisational recovery and improvement
- ✓ Support and champion the outcomes of the Phase 1 RESET Event, ‘Leading Together’ to build the culture and foundations to deliver organisational recovery and improvement

EDI

- ✓ Receive the 2025 WRES / DES data and approve the priorities identified prior to September Board and external publication on 31st October 2025
- ✓ Support oversight through EDI Assurance Group to sustain progress and address gaps

What makes us Proud / Worried

We are proud of…

- Improvements on WRES
- 500th Our Leaders Attendee and Our Leaders shortlisted for FABB Award
- Awarded Armed Forces Sliver accreditation from Defence Employee Recognition Scheme

We are worried about…

- The tools and resources needed to fully embed the RESET programme at pace
- The risk of the learning outcomes of the RESET programme not being effectively devolved to teams and the impact on staff engagement
- More to do on WDES

Report Title:	Finance & Investment Committee Chair Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	25 September 2025		Discussion	
Executive Sponsor	Chief Finance Officer		Decision	

Purpose of the report	The purpose of this report is to provide an update and assurance to the Board of Directors on the work delegated to the Finance and Investment Committee.

Previously considered by:	The matters included in the Chair's report were discussed and agreed at the Finance & Investment Committee meeting held on 23 July 2025.

Executive Summary	The attached Chairs' report provide a comprehensive overview of the key matters discussed during the F&I Committee meeting. The report outlines the strategic, financial and operational issues considered, the assurances received, and highlight specific areas of concern that warrant the attention of the Board of Directors. Due to the timing of the September Committee meeting, a verbal update will be presented to ensure timely communication of any urgent matters. A written report capturing the full outcomes of the September meeting will be included in the November Board meeting pack.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Finance & Investment Committee Chair's Report.

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

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

Prepared by:	Annette Walker Chief Finance Officer	Presented by:	Rebecca Ganz, Non-Executive Director

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

Name of Committee /Group:	Finance & Investment Committee Meeting	**Reports to:**	Board of Directors
Date of Meeting:	23 July 2025	**Date of next meeting:**	24 September 2025
Chair	Rebecca Ganz	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- CIP update
- Month 3 Finance Report
- Managed Equipment Service Contract Retender Process
- Finance & Investment Committee Annual Report
- High Value Supplier Register
- Board Assurance Framework
- Ventilation System for Ophthalmology Theatres 1 and 2
- EPR Update

ALERT

Agenda items	Action Required
CIP update • The Trust has a CIP target of £36.9m, of which all opportunities have now been identified and has achieved the set milestones for Q1 in that 100% schemes identified and 66% of schemes are implemented for fully developed. • The risk rated profile of the opportunities is £27.5m, of which £24.4m are fully developed or delivered. • GM has a CIP target of £655m, of which £608m of opportunities have been identified; the risk adjusted delivery is currently £406m. Of the opportunities identified, the £364m of schemes are implemented or fully developed. Bolton's positive on CIP identification has improved to being mid Provider peers.	**Action** • CIP under delivery to be discussed at the Board of Directors meeting on 31 July 2025.
Month 3 Finance Report • The Trust had a revenue deficit in Month 3 of £1.4m with a YTD deficit of £6.1M with a £1.8M variance to plan largely due to under delivery of CIP and income inflation. • Cash was above plan by £8.0m. The underlying cash position is overdrawn by £4.4m and cash support will be needed from Month 5. • Capital spend in month was £0.5m which is slightly below plan. • Cumulative capital spend is £0.4m less than planned. • Forecast scenarios show a best case of hitting plan, a likely case of a £21.6m deficit, and a worst case of £35m deficit.	**Action** • Approval from the Board required for NHSE cash support, based on a short-term advance from the ICB being pursued for August. • A clear Board decision required on the acceptable level of financial risk and associated cash support.

• Analysis has been undertaken the WTe profile for these scenarios. Initially the plan was to reduce head count by 250 in 25/26 which needs further review given the levels seen in months 1-3.	• A detailed analysis of the WTE profile to be understand in this context.

ADVISE

EPR Update

Maternity Services EPR is on track with user acceptance testing taking place. The go live date recommended by the Maternity EPR Board in June, is 24 Feb 2026.

EPR went live on the 18th of June in Out-Patients and Community Services. The project board continues to monitor outstanding services and deliverables. Issues arising following 'go live' were fewer than expected based on experience and are on track to be resolved to support the effective roll out.

Resourcing of the digital team continues to be 'red RAG rated' and is being monitored closely.

Board Assurance Framework

The BAF was revised and is aligned to the Trust's new Strategic Ambitions and now incorporates updated Risk Appetite Statements agreed by the Board in December. The updated version includes a new strategic risk on CO10a Resilience against Cyber Threats and it is proposed that CO12 be expanded to reflect the Trust's ambition to become a net zero healthcare provider, in line with the NHS Net Zero Plan.

ASSURE

Managed Equipment Service Contract Retender Process

The Committee noted the retendering process and timeline for the MES contract and it was agreed a six monthly update will be presented to the Committee.

Finance & Investment Committee Annual Report

The Committee received the Finance & Investment Committee Annual Report which provided a review of the activities of the Committee relating to the objectives set out in the Terms of Reference and in the context of the annual work plan.

High Value Supplier Register

The following revisions were made to the 2024/25 register were:

- Five suppliers have been added to the high value payments register.
- Increases in expenditure of £41.5m for 7 high value supplier payments.

The forecast High Value Supplier Payments register for 2025/26 includes 38 suppliers.
The High Value Supplier Register will be taken to the Board of Directors in July for approval.

Ventilation System for Ophthalmology Theatres 1 and 2

The Finance & Investment Committee approved the business case for the replacement ventilation system for Ophthalmology theatres 1 & 2.

New Risks identified at the meeting: *None identified.*

Review of the Risk Register: N/A

Meeting Attendance 2025/26											
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Jan**	**Feb**	**March**
Rebecca Ganz	✓	✓	✓	✓							
Annette Walker	**A**	✓	**A**	✓							
Rae Wheatcroft	✓	✓	✓	✓							
Sharon Katema	✓	✓	✓	✓							
James Mawrey	**A**	✓	**A**	**A**							
Sharon White	✓	✓	A	✓							
Sean Harriss	✓	**A**	✓	✓							
Martin North	✓	✓	**A**	✓							
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**		
✓ = In attendance A = Apologies											

Report Title:	Audit and Risk Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	25 September 2025		Discussion	
Executive Sponsor	Chief Finance Officer		Decision	

Purpose of the report	To provide an update from the Audit and Risk Committee meeting held since the last Board of Directors meeting.

Previously considered by:	The matters included in the Chair's reports were discussed and agreed at the Audit and Risk Committee held in June.

Executive Summary	The attached Chair's Report from the Audit and Risk Committee provides a detailed summary of the key matters discussed at the Committee meeting held on 17 September 2025. It outlines the Committee's oversight activities and deliberations across a range of financial, governance, assurance, and risk-related areas. The report highlights: • Key topics reviewed during the meeting, including internal and external audit updates, risk management developments, and compliance matters. • Sources of assurance received by the committee in relation to the Trust's systems of internal control, financial stewardship, and risk mitigation. This report forms part of the committee's formal assurance framework and supports the Board in discharging its responsibilities for effective governance and oversight.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Audit and Risk Committee Chair's Report.

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

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

Prepared by:	Alan Stuttard Non-Executive Director	**Presented by:**	Alan Stuttard Non-Executive Director

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee /Group:	Audit and Risk Committee	**Reports to:**	Board of Directors
Date of Meeting:	17 September 2025	**Date of next meeting:**	03 December 2025
Chair	Alan Stuttard, Non-Executive Director	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Senior Information Risk Owner (SIRO) Report
- External Audit Update/Progress Report
- Internal Audit Update
- Counter Fraud Update
- Review Losses and Special Payments
- Waivers Report
- Corporate Risk Register

ALERT

Agenda items	Action Required
Internal Audit Report Cancer Follow Up - Quality Spot Check Assignment Report – Limited assurance was given for Personalised Stratified Follow-Up (PSFU) in cancer pathways. The key risks identified include the inconsistent application of national/regional guidance, data quality and lack of risk stratification. Some improvements were underway, but there were dependencies on Greater Manchester systems and processes outside the Trust's direct control. The report wwould be escalated as an alert to the Board of Directors and referred to the Quality Assurance Committee for further review.	• Referred to Quality Assurance Committee for further review.

ADVISE

- **Counter Fraud Failure to Prevent Fraud** – the Committee received an update on the new "Failure to Prevent Fraud" offence under the Economic Crime and Corporate Transparency Act which came into effect on 01 September 2025. The Trust was taking steps to ensure compliance including risk assessments, policy updates and staff awareness. This would be highlighted to the Board for wider awareness, as the offence covers not just financial fraud, but also manipulation of performance data and other organisational benefits.

ASSURE

- **Information Governance Annual Report 2024-25 –** the Committee received the report which outlined key activities, achievements and issues related to Information Governance within the Trust for the period 01 July 2024 to 30 June 2025. Additionally the report provided assurance against the Data Security and Protection Toolkit (DSPT) requirements, which reflected the national standards and legislation for data security and protection in health and social care. The Committee were advised that the Trust was not compliant with the Data Security and Protection Toolkit (DSPT). It was noted that this issue was also addressed in the Internal Audit Report on the agenda.

- **MIAA Internal Audit Reports**
  - **Internal Audit Progress Report and Follow-Up of Recommendations:** The Committee received an update on the internal audit programme, including progress on planned reviews, and follow-up of outstanding recommendations. It was confirmed that 59 recommendations were followed up; 21 implemented; 17 not yet due; six partially implemented and 15 not yet implemented. Some older IT related recommendations remained open due to complexity. The Committee discussed the need for timely closure of historic actions and the CFO would focus on clearing any overdue recommendations for the next meeting.

  - **Theatre Productivity** - Substantial assurance was received for theatre utilisation controls. There were three medium risk recommendations which included formalising policies, improving specialty-level recovery plan monitoring, and deeper analysis of underperformance in utilisation rates. The Committee noted the distinction between assurance on controls and the separate challenge of driving actual productivity improvements, which would be monitored through routine board oversight.

  - **Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit (DSPT)** - the Trust did not achieve full DSPT compliance. Assessment took place against 12 outcomes and for eight outcomes, the organisation met the minimum achievement level. However, four outcomes were rated as not meeting the minimum achievement levels. The risk in these areas was assessed and outcomes reviewed as "High Risk". The key risks related to supply chain compliance and lacking multi-factor authentication. An improvement plan had been developed and agreed with NHS England.

    Internal audit confirmed that "high risk" was a common outcome across all Trusts this year due to the new framework and a number of Trusts had not achieved the required standards. The Trust's improvement plan has been approved by NHS England and as a consequence the four outcomes have been changed from 'Standards not met' to 'Approaching Standards'. Progress will be monitored and reported at future meetings. The target date set by NHS England for completion is 30 June 2026. .

    There was high confidence in addressing some of the actions, but supply chain and identity management were longer-term challenges. Capacity to deliver all required improvements would be reviewed and an update brought back in February 2026.

  - **Procurement and Fit and Proper Person Test Internal Audit Reports** – both reports received substantial assurance. Procurement recommendations focused on updating the procurement strategy, improving documentation for new supplier setup, and ensuring waiver reporting aligned with Standing Financial Instructions (SFIs). Fit and Proper Person checks were generally robust, with minor recommendations for evidence retention and policy alignment.
- **External Audit Update** – the Committee received an update on the status of the external audit, including pending clearance from the National Audit Office on the Trust Annual Accounts, progress on charitable funds and IFM audits, and early work on the general ledger transition, with no major concerns reported.

- **Counter Fraud Progress Report** – The Trust retained "green" rating for counter fraud standards. Ongoing investigations and case closures were noted, with continued delays noted in one long-standing case due to CPS scheduling.
- **Review Losses and Special Payments** – The Committee received the report for the Trust covering the period April to August 2025. The main issue was the Trust's bad debt provision which was just under £1.7m, mainly due to overseas visitors. The Committee noted the challenges in recovering these debts and that work was underway to improve identification and recovery processes.

- **Waivers Report** – the Committee noted that Waiver numbers had slightly increased compared to last year. Retrospective waivers remained a concern and were being monitored.

- **Corporate Risk Register** – the Corporate Risk Register was presented to the Committee for the first time noting that it would be presented to support the Board Assurance Framework. There had been a reduction in high-scoring risks from 45 to 29 since February 2024. The Committee noted the register was reviewed monthly by the Risk Management Committee. Overall the total number of risks had reduced and there was a more robust approach in place through the Risk Management Committee in monitoring the risks.

- **Risk Management Committee Chair's Reports** – the Chair's Reports from the meetings held in June, July and August were noted.

New Risks identified at the meeting:
None identified

Review of the Risk Register:
N/A

Meeting Attendance					
Members	**Feb**	**May**	**June**	**Sept**	**Dec**
Alan Stuttard	A	✓	✓	✓	
Sean Harris	A	✓	✓	✓	
Tosca Fairchild	✓	NA	NA	✓	
Fiona Taylor	✓	✓	✓	✓	
In Attendance	**Feb**	**May**	**June**	**Sept**	**Dec**
Annette Walker	✓	✓	✓	✓	
Sharon Katema	✓	✓	✓	✓	
✓ = In attendance A = Apologies NA = no longer a member					

Report Title:	Winter Plan 2025/26			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	25 September 2025		Discussion	✓
Executive Sponsor	Chief Operating Officer		Decision	✓

Purpose of the report	The Purpose of this report is to describe the key actions and approach Bolton NHS Foundation Trust is taking to manage winter demand for 2025/26.

Previously considered by:	Performance and Transformation Group and Quality Assurance Committee.

Executive Summary	The "Trust Winter Plan 25/26" outlines Bolton NHS Foundation Trust's strategy to manage winter demand while maintaining patient care quality and meeting recovery targets. The plan addresses the predicted increase in urgent care demand and the need for continuous improvement in urgent and elective care performance amid financial challenges Key initiatives include reducing elective care waiting times, improving cancer diagnosis standards, and enhancing A&E and ambulance response times. The plan also emphasises operational improvement programs across urgent, elective, and community care to boost productivity and patient outcomes. The winter plan aims to ensure patient safety, manage infections, shift care from hospitals to communities, and support staff wellbeing. It incorporates lessons from the previous winter and includes detailed bed modelling and capacity planning to handle winter.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Winter Plan.

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

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

Prepared by:	Michelle Cox, Director of Operations	**Presented by:**	Rae Wheatcroft, Chief Operating Officer

Glossary – definitions for technical terms and acronyms used within this document

A&E	Accident & Emergency
UEC	Urgent and Emergency Care
UCIP	Urgent Care Improvement Plan
ECIST	Emergency Care Improvement Support Team
GM	Greater Manchester
ICB	Integrated Care Board
NHSE	NHS England
UCIG	Urgent Care Improvement Group
RAAC	Reinforced Autoclaved Aerated Concrete
CDC	Community Diagnostic Centre
LoS	Length of Stay
SDEC	Same Day Emergency Care
GMMH	Greater Manchester Mental Health
IPC	Infection Prevention Control
TRiM	Trauma Risk Management
PIU	Patient Investigation Unit

Bolton NHS Foundation Trust 2025/26 Winter Plan

1. Introduction

The purpose of this paper is to describe the key actions and approach Bolton NHS Foundation Trust is taking to manage winter demand, whilst maintaining patient experience, meeting clinical quality indicators, and ensuring the key deliverables for recovery are achieved.

This year's winter plan has been formulated within the context of what is predicted to be a challenging winter, with a continuing increase in demand for urgent care services, the impact of Reinforced Autoclaved Aerated Concrete (RAAC) on the reduction of the bed base (year 2) and the need to continually improve urgent care and elective care performance throughout the year in an environment with high financial challenges. The plan has been developed in line with operational planning guidance for 25/26 focusing on key deliverable metrics at year end:

- Reduce the time people wait for elective care, improving the percentage of patients waiting no longer than 18 weeks for elective treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement.
- Continue to improve performance against the cancer 62- 2025/26 priorities and operational planning guidance 7 day and 28-day Faster Diagnosis Standard (FDS) to 75% and 80% respectively by March 2026
- Improve A&E waiting times and ambulance response times compared to 2024/25, with a minimum of 78% of patients seen within 4 hours in March 2026. Category 2 ambulance response times should average no more than 30 minutes across 2025/26
- Deliver a financial deficit position of £6.5million

2. Operational Improvement Plans

Bolton locality in 24/25 was placed in Tier 1 support for UEC by NHSE and following a year of support from ECIST colleagues and national scrutiny and support, we have now moved into Tier 2. Improvement and planning methodology demonstrated by ECIST continues to be used by the Trust and through the creation of three annual operational improvement programmes. The purpose of the operational improvement programmes is facilitating matrix team working across clinical divisions to deliver clear objectives with milestones and phased finish dates. The programme aims to improve operational standards, deliver the operational plan, and meet productivity goals. It fosters continuous improvement and upskilling to sustain initiatives, ultimately enhancing patient outcomes, staff experience, quality of care, and reducing costs.

The target is to deliver 2% productivity gains through three operational improvement plans:

- **Urgent Care Operational Improvement Plan Summary**

Phase 1 of the Urgent Care Improvement Programme was developed in response to the ECIST findings report in March 2024. Phase 1 is delivered and closed with sustainability plans in place to ensure teams don't revert to old ways of working. Phase 2 has been mobilised and will run from March to the end of September. Phase 2 includes key initiatives for delivery such as continuation of call before you convey as BAU, implementation of criteria led discharge, new model for GP direct, implementation of surgical SDEC and implementation of a planned investigation unit.

- **Elective Care Improvement Plan Summary**

The elective programme has been written to ensure we have a trust cross organisational plan and speciality specific improvement plans clearly articulated to reduce waiting times, enhance patient outcomes and ensure services are operating as efficiently as possible. The programme works with an ethos of continuous improvement and is clinically led. Key initiatives for delivery include continuation of the newly established capacity and demand management, development of internal professional standards for specialities and the booking team, implementation of monitoring and check and challenge for procedures of limited clinical value and working with primary care to ensure that shared decision-making is in play and supports demand reduction.

- **Community Care Improvement Plan Summary**

The intention of the Community Services Division Improvement programme is to operationalise a new and innovative model of working, built on existing good practice, to shift patient level activity from the hospital into the community. The intention is that this will deliver better patient experience, shift activity from already pressured acute services and be more financially efficient. The focus in 2025/26 should be supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations. The cohort has been estimated at around 7% of the population and associated with around 46% of hospital costs. Priority for 25/26: NHS and Social care working together to prevent people from spending unnecessary time in hospital or care homes.

Benefits overview for all 3 programmes of work are;

- Delivery of performance standards
- Delivery of the operational plan
- Delivery of productivity aspirations
- Delivery of longer-term cost reduction
- Reduced harm related delays (which cost more)
- Improved patient experience and outcomes
- Improved staff moral (reduced turnover, sickness)

All 3 programmes focus on clinically led, operationally driven improvement to utilise our capacity and resource as efficiently and effectively as possible, for the benefit of our patients with an ethos of getting patients to the right team as swiftly and directly as possible.

3. Aims of the Winter plan 25/26

Bolton NHS Foundation Trust winter plan for 25/26 sets out to:

- Ensure the best possible care, safety and experience for patients and service users
- Safely manage and protect patients from infections such as Flu, COVID-19, RSV and Norovirus etc. across all settings
- Deliver care in the right setting, making a shift of patient activity from hospital to community and treatment to prevention (as set out in the NHS 10 year plan) through initiatives set out in the community operational improvement plans such enhanced palliative care services at home, 7 day integrated transfer of care hub (ITOCH), expansion of hospital at home (virtual wards,) and the establishment of a proactive care team (PACT.)
- Continue to progress our elective, cancer and diagnostics recovery in line with the 25/26 national operating plan
- Protect and support our staff, looking after staff wellbeing and protecting staff from flu and other winter viruses.

4. Review of Winter 2024/25

The plan has been informed by a series of organisational and locality winter reviews and planning workshops. It reflects collaborative working across teams and takes account of lessons learnt from last winter.

A review of last winter has been carried out including achievement against 2024/25 transformational plans, any improvements and lessons learnt from winter. The impact of flu and COVID 19 on the trust plans and reflection on the accuracy of our bed modelling forecast capacity against demand.

The review of winter 24/25 identified several positive elements of our plans that we wish to continue and build on. This included positive feedback on the following schemes:

Winter action 24/26	Impact
Acute Medicine Re-Design	Increasing Acute Medicine assessment bed capacity
Increasing Acute Medicine assessment bed capacity	Supporting early flow through increasing 12:00 & 16:00 discharges - Special cause improvement observed for 16:00 discharges (+66%) - Continue to drive utilisation, particularly at weekends
Weekly LOS Review	Clinically led review of top 20 patients with and without criteria to reside - LOS in October 24 reduced to 9.77 (circa 1 day reduction since Aug)
Increasing Alternative Speciality Pathways	Expanded pathways through SDEC, Hot Clinics, CDC & Virtual Ward to target seasonal disease profiles
Digital Autopsy	First location in Greater Manchester to carry out digital autopsies that reduce the need for invasive postmortems and release bodies to families and loved ones sooner.

N Block	Redesign and delivery of N Block ward to create 22 beds for NCTR patients on ward N3 and support winter pressure, allowing B4 to be used as winter escalation beds.

Overall feedback from 24/25 was positive highlighting strong cross divisional plans last year which will be carried forward into this year. The Trust also received praise from the System, as they felt last year was the best year they had witnessed, for planning and sharing within the system. ICB colleagues continue to be invited to all planning events for 25/26 to continue to build on this supportive approach.

Part of the reflection and discussion on 24/25 by the divisional teams described some challenges. It was noted that there was a direct correlation between high bed occupancy and waits in the ED. As part of winter planning for 24/25 the bed model highlighted a high forecasted deficit position and at that point of the winter planning process all G&A beds available on the hospital spine were being utilised and no ward closures occurred during summer 24/25, resulting in no winter escalation space available for winter 24/25. N block was identified as an area for which additional winter beds could be created and planning from August to November occurred to open 22 (NCTR patient) beds in December 24 for winter escalation. Reflections on the opening of the N block ward demonstrated highly effective collaborative working between: clinicians, operations, IFM, IT, BI and many others all working together to open this ward ahead of winter.

5. **Winter Bed Modelling and Intelligence**

Winter bed modelling enables the Trust to understand whether our predicted urgent care demand will match our available capacity. It also allows us to understand and to plan for scenarios related to winter infectious diseases such as flu. This year, as in all years, we anticipate that demand for beds will not match available capacity. This year specifically we are experiencing compounding factors including;

An overall planned reduction in available beds across the Trust, a number of planned changes to wards over 24/25 will results in a net reduction of open G&A beds during winter 25/26. The trust continues to hold the net impact of RAAC on available bed numbers. R1 will become maternity triage to ensure a safe and effective space and to create co-located maternity triage and ANDU to allow RAAC building works. SCare Unit 2 will change 16 General & Acute (G&A) beds to a trolleyed Surgical SDEC which is aimed to reduce the number of patients admitted to a surgical ward and enable timely assessment and treatment. At present 2 G&A wards are closed and plans are in place to open 1 ward for winter capacity for 4 months (December '25 – March '26) in line with operational improvement and ICIP plans to balance the pressures of safety, delivery and finances.

A reduced ability to accommodate medical outliers within our surgical bed base. This is due to the surgical bed base being proportionately more affected by the overall reduction in beds and changes to G&A capacity to enable surgical SDEC. This is combined with a need to maintain the elective programme throughout the year to achieve

the elective recovery milestones this year; in pre-pandemic years we have been able to tolerate a ramp down of elective work to support UEC demand.

Possible impact from the redesign of N Block – The Trust has been allocated £1.8 million 'Recovery to Assessment' monies to renovate wards N3 and N4 to allow for closure of Laburnum Lodge (16 beds) and Farnworth Care Home (10beds) to create a 24 single bay Intermediate Care Unit on the Bolton Hospital Site from April 2026. N3 is currently a 22 bedded ward for patients with no criteria to reside and N4 is currently used for Haematology care. A new location for Haematology care needs to be identified and works to N block will commence around November 2025. High level plans are currently being worked through with an aspiration to have minimal impact on the running of N3 ward, but there remains a risk that refurbishment works could require changes.

The bespoke bed model used within the Trust was updated winter 24/25 and the same model has been used for winter 25/26. This model includes all changes to the core capacity resulting from bed moves / changes including the changes to the usage of R1, N3 and SCU2 as described above and the planned use of 1 winter escalation ward for four months (December 25 to March 26.) The model also includes assumptions based on the delivery of phase 1 of the community health and care business case being in place and benefits being released preventing avoidable admissions to the hospital.

The annual bed modeling suggests that the likely scenario is that we will need 21 (compared with 29 forecast 24/25) additional beds, with the worst-case scenario being 56 additional beds (compared with 57 forecast 24/25).

Following a review by the senior operational and Business Intelligence teams, it was felt that the forecast above was tolerable and that a flexible approach to the opening of any additional unplanned capacity would be considered if required. Review of key metrics linked to the bed model will be reviewed at monthly performance and transformation group meetings and any statistically relevant changes to the model will result in a reforecasting exercise. During winter 25/26 there will be 1 ward which through the planned approach will remain closed but if required due to safety concerns and higher demand than forecasted can be open as an unplanned approach.

6. **Divisional Capacity Planning**

As part of the winter planning process all divisions have a transactional capacity plan that supports their business-as-usual activities during the winter period. The trust winter plan has oversight and checks on the progress of these plans. The check and challenge session planned for September and November will ensure that progress is being made in the corresponding workstreams. The Community services division works closely with Bolton Council colleagues to ensure sufficient capacity in integrated services.

The capacity plans identified by Divisions include;

Alternatives to admission / avoidance

- Enhanced palliative care services at home,
- 7 - day integrated transfer of care hub (ITOCH)
- Expansion of hospital at home (virtual wards)
- Establishment of a proactive care team (PACT)
- Creation of a Surgical SDEC area
- Completing and/or updating Bolton FT Internal directory of services
- Revised initial assessment model (enhanced RAT) for all ED arrivals to expedite senior decision making and streaming to appropriate clinical setting. Align with ED estates improvement.

Reducing Length of Stay

- Creation of a medical Patient Investigation Unit
- Development of Criteria Led Discharge pathways to be deployed across Medicine and Surgery
- Expand Long Length of Stay reviews & education to remaining Medical wards including N3.
  - Extended Cover on acute pain and oncology pathways
- Roll out of Ward based dispensing hubs to reduce time to dispense discharges

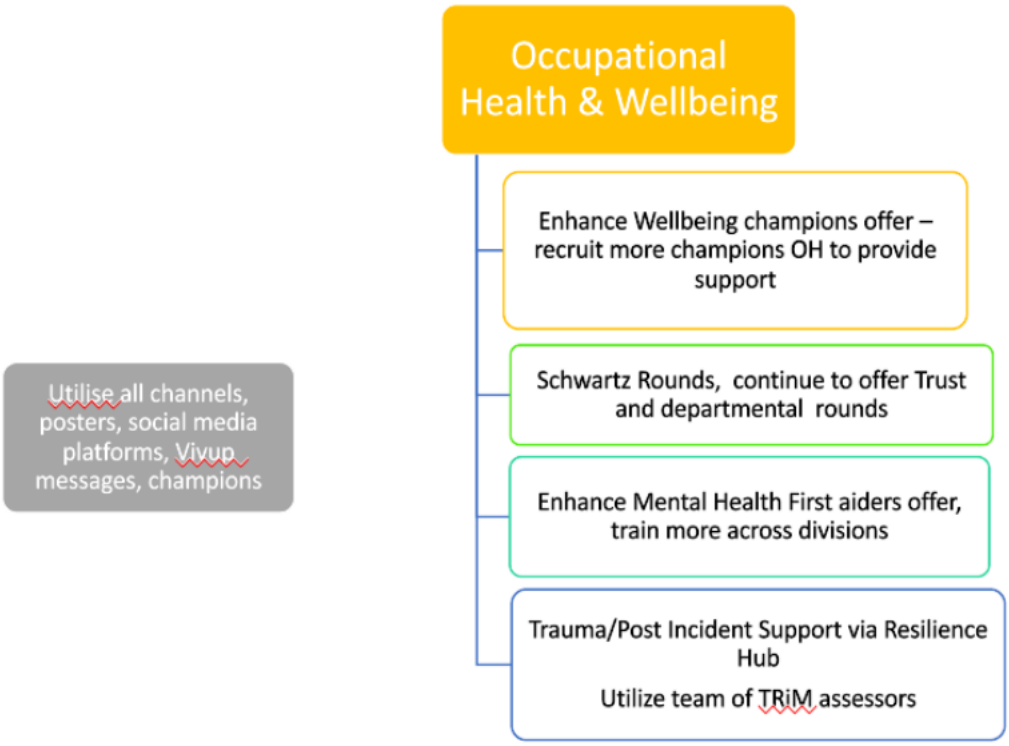
Additional capacity

- Planned reopening of 24 beds from December 25 till the end of March 26 to provide additional winter bed capacity
- Increased capacity within the mortuary for storage in winter months. Will allow for post mortem activity to be uninterrupted and provide resilience for the service. Will also provide some regional resilience via Digital Autopsy/Coronial Services

Colleague Wellbeing Offer

As part of the winter planning process the occupational health and wellbeing team have been invited to the winter planning sessions, enabling them to listen to the workstreams and challenges the divisional teams face.

The well-being offer for 25/26 has been described using a 4-pronged approach:



This approach will be supported by:

- Creation of new staff wellbeing roles for high need areas e.g. Urgent care and maternity services – dedicated shift pattern
- Creation of a centre for staff wellbeing where coaches, counsellors and trauma response staff can be based

The flu campaign for 25/26 will be led by the occupational health and wellbeing team in the form of a roving model. Members of staff will be asked to support the delivery of the flu campaign from 01 October 2025.

Governance

The Urgent Care Transformation Board will oversee and monitor progress against the plans which will be a standard agenda item. The Urgent Care Programme Manager will monitor the winter plan and will escalate issues through to the Director of Operations.

The winter plan will be submitted to the Board of Directors in September 2025 for approval following review at Performance and Transformation Group and Quality Assurance Committee.

Bolton system's winter plan will also be tested through Exercise Aegis, which aims to:

- Test winter response plans against three demand scenarios for a base case, moderate and extreme winter surge.
- Ensure that individual organisations have tested internal arrangements to respond to increasing levels of pressure from winter virus outbreaks, with effective measures to maintain patient safety and minimise risk.
- Assess system leadership arrangements. Ensure that organisations will collaborate under pressure, with a shared understanding of the relative risk and impact of individual actions on partners.
- Use lessons learned during the exercise to finalise and sign off winter plans through Board assurance.

In addition, a winter planning 25/26 board assurance statement (BAS) requires submission to NHS England (see appendix A for completed submission for approval.)

7. Financial Implications

No additional funding has been allocated to the Trust via Greater Manchester Integrated Care Board (ICB.) Our winter plans have been based on assumptions that funding is within their existing budgets and the plans also take into account any identified ICIP plans such as ward closures.

8. Recommendations

The Board of Directors is asked to:

- Note and agree the actions within the proposed winter plan
- Note the monitoring and escalation process for the winter plan
- Note the bed modelling out put and plans for a flexible approach
- Review and approve appendix 1 'Board assurance statement' for approval of submission

Appendix 1: Board assurance statement – for approval of submission

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Section A: Board Assurance Statement

Assurance statement	**Confirmed (Yes / No)**	**Additional comments or qualifications (optional)**
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	Approval gained at September 2025 Trust Board
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Appendix to board paper
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	System testing in September 25
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	System testing in September 25
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Exec lead – Rae Wheatcroft (Chief Operating Officer and Trust EPRR lead) SRO – Michelle Cox (Director Operations)
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any	Yes	These metrics are reviewed monthly, and winter pressure was built into the annual planning

risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.		process (as demonstrated in the Trust Operating plan submission)

Provider CEO name	Date	Provider Chair name	Date
Fiona Noden		Niruban Ratnarajah	

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Covered in the Trust winter plan
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Annual bed modelling is undertaken Monthly changes in demand monitored against last years known demand.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Partial	Pathway 0 – Yes Pathways 1-3 – Partially, We predict based upon current numbers but any stretch targets need agreement with local authority as they rely upon social work and IMC capacity. These conversations will commence at our joint ICP SLT meeting
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the	Yes	Winter pressure was built into the annual planning process (as

	impacts of likely winter demand – including on diagnostic services.		demonstrated in the Trust Operating plan submission)
Infection Prevention and Control (IPC)			
6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	Deputy DIPC approved and part of planning process
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Trust have an all year round fit testing team with sufficient capacity and equipment
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	Included in Families and Diagnostics winter plan
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	This is in place 365 days of the year and frequently tested as part of EPRR
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	This is in place 365 days of the year and frequently tested as part of EPRR
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	N/A	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	N/A	