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NHS
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Bolton NHS Foundation Trust

Quality Account
2025/2026

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

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PART 1

Statement on the quality of services from the Chief Executive

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Statement on Quality from our Chief Executive

I am pleased to introduce our Quality Account for 2025/26. This year's report showcases the meaningful improvements we have made to the quality of our care, achieved against an increasingly challenging backdrop for the NHS. Despite the pressures facing the health and care system, our commitment to delivering safe, effective and compassionate care has remained unwavering.

Throughout this document, we outline the strides we have taken over the past year to strengthen the services we provide, along with the priority areas we will concentrate on in the months ahead. It also reflects how we continue to learn from the insights and experiences of patients, carers, colleagues and partners across our local system.

Part two of this report summarises our progress against all the Quality Account improvement priorities we set for 2025/26. I would like to extend my sincere thanks to every member of staff for their dedication and resilience. Your contributions, often made under significant pressure are central to advancing our quality and safety agenda. Together, we continue to make a real and lasting difference for patients, their families and carers.

Looking ahead, next year will no doubt bring further challenges for the NHS, with a renewed national focus on essential priorities and the need for organisations like ours to meet standards while operating more efficiently. We remain committed to rising to these challenges, delivering high- quality care and ensuring we provide the best possible value for taxpayers.

Quality and safety will continue to be our focus and our improvement priorities for 2026/27 are as follows:

- **Priority 1 -** Understanding health inequalities – new for 26/27
- **Priority 2 -** Releasing time to care – continuation from 25/26
- **Priority 3 -** Improving patient communication and shared decision making - continuation from 25/26

To the best of my knowledge, the information we have provided in this Quality Report is accurate. I hope that this report provides you with an understanding of the focus we place and how important quality improvement, patient safety and experience are to us at Bolton NHS Foundation Trust.

Fiona Noden,
Chief Executive

Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

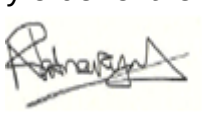
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation *trust annual reporting manual 2025/26* and supporting guidance *Detailed requirements for Quality Reports 2023/24*
- the content of the Quality Report is consistent with internal and external sources of information including:
    - board minutes and papers for the period April 2025 to the date of this statement
    - papers relating to quality reported to the board over the period April 2025 to the date of this statement
    - feedback from commissioners
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009,
    - the 2025 national patient survey
    - the 2025 national staff survey
    - latest CQC inspection report
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board



Chairman Chief Executive

25th June 2026

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PART 2

How quality initiatives are prioritised at the Trust

Improving care,
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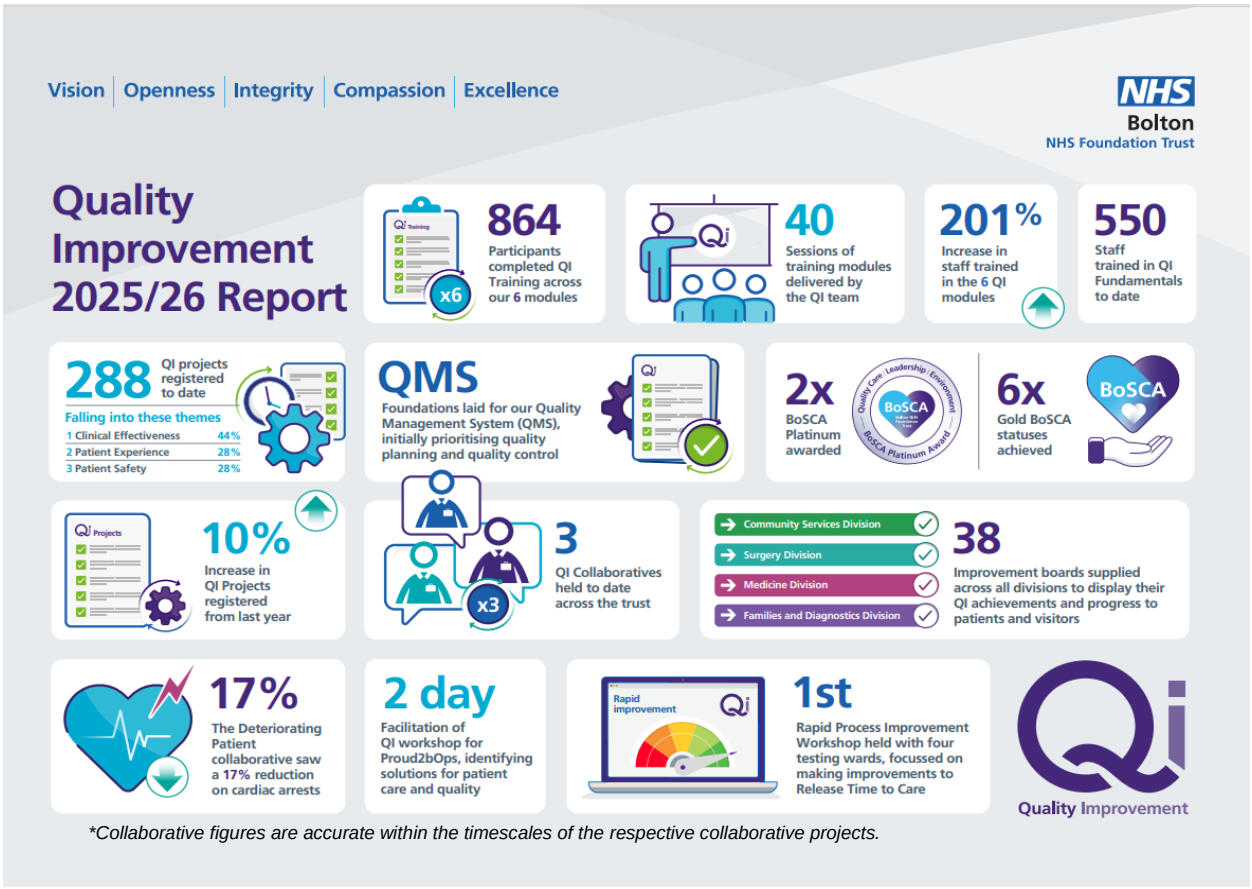
Establishing a Quality Management System

A Quality Management System (QMS) is a simple way of making sure we consistently provide safe, effective, and high-quality care by using clear processes, good information, and regular learning. It brings together feedback from patients, staff, and partners, along with performance data and national standards, to help us understand what is working well and where we need to improve. This in turn helps us prioritise our quality improvement initiatives so we focus our time and resources on the areas that will make the biggest difference to people using our services.

Over the past year, we have been exploring what it means to have a Quality Management System and how we start to develop and embed it at Bolton. With an initial focus on strengthening Quality Planning to ensure we have clear priorities, goals, and therefore quality improvement plans in place and that these are understood, owned and contributed to by all staff members in our organisation.

In the coming year, our focus will shift towards Quality Control to strengthen how we monitor performance, check that standards are being met, and take timely action to maintain and improve the quality and safety of our care.

Quality Improvement (QI) science is a cornerstone of a Quality Management System and therefore a key enabler of our organisational vision and strategy. This Quality Account report demonstrates how QI has supported progress towards the achievement of our strategic ambitions in 2025/26, a summary of which is shown below:



How quality initiatives are prioritised in the Trust

This Quality Account identifies the progress made against the quality and safety agendas in 2025/26 and outlines the quality improvement priorities for 2026/27. Quality initiatives are chosen and prioritised based on quality, safety and experience data to ensure we focus improvement activities on greatest need and decisions are made based on robust data.

Key quality improvement priorities for 2026/27 –
Following consultation with our stakeholders we would like to highlight the following as our quality account improvement priorities for 2026/27:

- **Priority 1 -** Understanding health inequalities – new for 26/27
- **Priority 2 -** Releasing time to care – continuation from 25/26
- **Priority 3 -** Improving patient communication and shared decision making - continuation from 25/26

Outline of aims and plans for the 2026/27 priorities are summarised on the following pages.

Quality Performance in 2025/26:
In our Quality Account for 2024/25 we set ourselves a series of key priorities for improvement for 2025/26, these were:

- **Priority 1 -** Recognition and response to the deteriorating patient
- **Priority 2 -** Releasing time to care – phase one – a focus on documentation
- **Priority 3 –** Communication – Involving our patients in their care

Progress against each priority is outlined on the pages below.

Quality Account Improvement Priorities 2025/26

Priority 1 – Recognition and response to the deteriorating patient

A deteriorating patient refers to an individual whose medical condition is worsening or declining. This can occur in a variety of health care settings and manifests through worsening symptoms, increased hospital stays, a decline in overall health or even cardiac arrest and in some cases death. Timely recognition and appropriate intervention are crucial to prevent further deterioration and ensure that the patient receives appropriate care.

Over the past few years there has been a great deal of work focussing on recognition and response to deterioration in patients with conditions such as sepsis, acute kidney injury (AKI). However, there are commonalities in the ability to detect and respond to deterioration across these conditions and so work has been brought together to understand these and share learning.

AIM:

To reduce the number of cardiac arrests across inpatient and community sites by 20% by 28th February 2026 and by a further 30% by 31st March 2028.*

Cardiac arrests are measured by:

- **Avoidable*
- *Should not have been for resuscitation (DNACPR)*
- *Non-avoidable*

OUTCOMES:

- 17% reduction in number of cardiac arrests across the Trust.
- 11% reduction in the number of 2222 calls (alerting potential cardiac arrest)

Progress to date

Deteriorating Patient Quality Improvement (QI) Collaborative

February 2025 saw the launch of an Improvement Collaborative to test improvement ideas on the identification and escalation of deterioration across various specialties, acute and community settings, different identification pathways and patient groups and demographics. The collaborative teams worked on ideas across four primary drivers:

- Reliable recognition and response,
- Communication,
- Knowledge and skills
- Leadership.

There have been four learning sessions to date whereby an educational element and/or feedback on team progress with their improvement ideas were delivered, a summary of which is below:

- Implementation of a screening tool to identify chest relating deterioration in patients with a learning disability.
- Implementation of new Maternity Early Warning Score (MEWS) for more accurate identification of deterioration and therefore more timely response in pregnant women
- Embedding of Martha's Rule in all inpatient areas, which includes the following:
  - Patients Wellness trajectory - a structured way of assessing how are patients are feeling about their health from one day to the next – to spot early signs of deterioration
  - An escalation route for patients, families should feel their concerns regarding a patient's condition are not being addressed.
  - An escalation route for staff - a clinical review from another team if they are concerned about deterioration that is not being addressed.
- Early adoption of Martha's Rule principles in a community setting – with the Admission Avoidance Team

Staff awareness and education

- Foundation doctors training programme -
- Acute Illness Management (AIM) training programme
- Sepsis Study Days
- Sepsis E-learning Sepsis Link Nurses

Technology and policy

- Redevelopment of EPR (Electronic Patient Record) - to ensure easier workflows and visual triggers for responding to deterioration
- Data dashboard – knowing our performance at a glance
- Revision of trust policy in line with new NICE Sepsis guidelines

Next Steps:

- Continuous collection and analysis of data to drive improvement e.g. the use of patient track to analyse response times to deterioration
- The first phase of the Deteriorating Patient Collaborative is now complete. All improvement interventions will be reviewed and analysed for trust-wide learning and sharing in Q2 26/27

- The focus and structure of phase two will be dependent on the outcome of the above and latest deteriorating patient data.

Reporting our progress:
All our improvement projects and workstreams follow an established governance structure which monitors and measures performance and progress. The forums and governance committees that provide progress, oversight and accountability for recognising and response to the deteriorating patient are summarised below:

- Mortality Steering Group
- Patient Safety and Experience Group
- Quality Assurance Committee

Priority 2 - Releasing Time to Care

In healthcare, there are often many layers beyond the patient's own journey through care. These can include communication processes, administrative tasks, and paperwork. They may involve several different teams, departments, or even organisations. When these parts do not work together smoothly or as intended, it can lead to confusion, delays, or a poorer overall experience for patients and staff.

Healthcare staff are spending more time away from patients due to a combination of factors, including increasing administrative burdens. These pressures lead to reduced time for patient care, which could impact patient outcomes and staff well-being.

This improvement priority is concerned with the reduction of this additional pressure and duplicate tasks, initially focusing on improving processes around clinical documentation to release that time back to spend with our patients and other service users.

This is a multi-year improvement priority and learning from this first phase will be applied to other ward/departmental processes and environmental design, throughout 26/27 and beyond.

AIM:
Reduce staff time spent on documentation by 20% by 31/05/26
***OUTCOMES**:*

• By 31/03/2026:
  • 9% reduction in documents entered into the electronic patient record across pilot wards, reducing administrative workload on clinical staff
  • 14% reduction in the number of unnecessary assessments on pilot wards

Progress to date:

- Scoping, stakeholder engagement and data analysis around reasons and time away from direct patient care
- First Rapid Process Improvement Workshop (RPIW) held in February focussed on documentation and processes to reduce waste and duplication, key areas of improvement were:
  - Standardisation of nursing Shift Evaluation Template – a co-ordinated central document – reducing duplicate care plans
  - HCA Bundle Template to collate tasks required by HCAs into one document

- Discussions around frequency of documentation – ward to ward transfer, risk assessments etc.
- Quantifying baseline number of documents to assess a percentage reduction in documentation and time saving

.

Next Steps: Quality Account Priority 2 2026/27 – Releasing Time to Care

Releasing Time to Care remains a key improvement priority for the organization throughout 2026/27 and beyond. Below is a summary of work planned in 2026/27.

- Development of workplan to focus on 32 separate issues identified as part of the first RPIW above
- RPIW Model applied to other process related improvements and multiple disciplines of staff across the trust e.g. virtual wards
- 30, 60, 90-day check-ins and local support
- Measurable outcomes to demonstrate improvements and the links to 26/27 priorities

Reporting our progress:

All our improvement projects and workstreams follow an established governance structure which monitors and measures performance and progress. The forums and governance committees which will provide progress, oversight and accountability for Releasing Time to Care are summarised below:

- Divisional Governance
- Patient Safety and Experience Group
- Quality Assurance Committee

Priority 3 - Communication – Involving our patient in their care and decision making

Communication is not just a matter of conveying information; it's a fundamental aspect of patient care and a key factor in building trust, promoting safety, and ensuring a positive patient experience. However, communication failures are a prominent reason for NHS complaints, and a theme replicated at Bolton. Not only can poor communication create a negative overall experience for patients and their families, it can also make it difficult for patients to fully participate in their care and recovery.

Moreover, certain groups of patients, such as those with language barriers or cognitive impairments, may be particularly vulnerable to the effects of poor communication. This can further exacerbate existing inequalities in healthcare access and outcomes.

Involving patients is vital to ensure equal access, experience and health outcomes and the first step to doing this is to be as inclusive as possible and listen to many voices when gathering and using feedback to improve how we communicate with our patients and service users and how we work with our patients in their care, treatment and decision making.

AIM:

- Minimum of 30 responses per month per team / department / ward by 31/03/26 – source FFT
- Evidence inclusivity in feedback from service users that reflect the local Bolton population such as patients who are/have; non-English as first language, no/reduced capacity, learning disability etc.

***OUTCOMES**:*

- Minimum of 30 responses per month per team / department / ward by 31/03/26 – not yet achieved – due to issues with existing data extraction. Aim extended

- FFT questionnaire translated into the top 11 local languages used by the Bolton community
- A focus on qualitative feedback, from patients and service users of different demographics; highlighting areas for quality improvement

Progress to date:

- Exploration and procurement of new FFT provider to enhance quality and reliability of data and improved data analysis across the range of services alongside identification of patient's protective characteristics for deeper thematic scrutiny.
- Addition of questions and field for comments to Friends and Family Test (FFT) questionnaires:
  1. Dignity and respect - Can you share your thoughts on how we treated you during your experience with us?
  2. Involvement in decisions about care and treatment - Can you describe how you feel about the level of involvement you had in decisions regarding your care?
- The FFT questionnaire was translated into the 11 most frequently used languages in Bolton and work has commenced on the translation of the responses for learning and improvement purposes
- A Lived Experience Panel has been established within the community division and further developments regarding training, ongoing mentorship and peer support

Next Steps: Quality Account Priority 3 2026/27 - Improving patient communication and shared decision making

Improving communication and involving our patients in their care and decision making remains a key improvement priority for the organisation and work will continue for many years. Below is a summary of work planned for 2026/27.

- Go-live and embedding of new FFT provider software to enhance FFT data collection, a clear, systematic process to interpret and understand service user feedback with improved reporting and analytics to provide a deeper thematic review, strengthen insight and improvement activity across the Trust
- Further development of the translation of FFT responses to understand any variation in experience for patients whose first language is not English
- Patient Experience Improvement Framework self-assessment, to understand how patient experience feeds into and shapes:
  - Leadership
  - Organisational culture
  - Collecting feedback
  - Analysing feedback
  - Learning for improvement
- Learning from the above will guide the workplan of the Quality Patient Experience Reporting Group and assist in the development of a comprehensive Patient Experience Strategy.
- Expansion of the existing Patient Experience Panel into a Trust-wide model, supported by strengthened corporate oversight to ensure consistency and alignment across all divisions.

Reporting our progress:

All our improvement projects and workstreams follow an established governance structure which monitors and measures performance and progress. The forums and governance committees which will provide progress, oversight and accountability for Communication – 'involvement in decision making' as rated by our patients / service users are summarised below:

- Divisional Governance
- Quality Patient Experience Reporting Group

- Patient Safety and Experience Group
- Quality Assurance Committee

Quality Account Improvement Priorities 2026/27

Due to their ongoing strategic importance, the following two Quality Account Improvement Priorities for 2026/2027 are continuation from 2025/26 and focus for 26/27 is covered above in the next steps section.

- Releasing time to care
- Improving patient communication and shared decision making

The new Quality Account improvement priority for 2026/27 is focused on understanding the health inequalities within our patient population and a summary of our focus is below:

Priority 1 – Understanding health inequalities

Health inequalities are unfair and avoidable differences in health outcomes, access, and experience that arise from wider social, economic, and environmental factors. Reducing health inequalities is both a core responsibility of the NHS and central to the delivery of high-quality, patient centric care. Local intelligence from Bolton's Joint Strategic Needs Assessment (JSNA) and population health data shows that our borough experiences higher than average levels of deprivation, with significant variation in health outcomes between communities.

In Bolton, people living in more deprived areas experience poorer health outcomes, have a lower life expectancy, and spend more years living in ill health compared with those in less deprived areas. Certain groups, including people from global majority backgrounds, people with disabilities, carers, and those experiencing digital or social exclusion, face additional barriers to accessing timely and effective care.

Listening to local communities and involving under-represented groups is essential to addressing these inequalities, but first we must understand what these health inequalities are and how they manifest in access to and receipt of care we provide. Once we understand this, we can use this local insight, patient feedback, and lived experience to shape services, to improve access, experience, and outcomes and deliver more equitable care for the population we serve.

AIM:

- Identify and monitor health inequalities by improving our demographic recording and reporting visibility across all specialties
- Inequalities insight and thematic analysis – to understand where inequity exists through initiatives such as organisational Experts by Experience panel
- QI methodology to reduce inequalities and test targeted interventions such as exploring new and innovative translation and interpretation solutions, including video translation

Drivers for change:
The key drivers for change for 2026/27 are summarised below:

Monitoring and identification of health inequalities
- Baseline analysis of access, experience and outcomes by ethnicity, deprivation, disability,

age, sex, and other inclusion characteristics
- Use local Bolton population health data (e.g. JSNA, IMD deciles) to identify priority cohorts and services with the greatest inequalities for focused interventions where appropriate
- Identify services or pathways with poorer outcomes or lower access for Core20PLUS5 and locally defined underserved groups
- Monitor key indicators (e.g. DNA rates, waiting times, outcomes, patient experience) by demographic group for learning and targeted improvement
- Use digital exclusion, language need, and reasonable adjustment data to identify inequitable access to services and plan for improvements

Inequalities insight and thematic analysis – understanding through data and feedback where inequity exists
- Thematic analysis of patient experience, complaints, and feedback data by demographic group to identify differential experience
- Comparison of outcomes and access across population groups to identify unwarranted variation
- Review qualitative insight from community engagement, patient stories, and VCSE partners to understand lived experience
- Analyse where barriers exist across the patient journey (e.g. referral, access, treatment, discharge) for specific groups
- Triangulate quantitative data with qualitative insight to confirm priority inequality themes

QI methodology to reduce inequalities and test targeted interventions
- Use inequality insight to prioritise areas for focused improvement activity
- Co-design improvement ideas with patients and communities from underserved groups
- Test targeted actions using Plan, Do, Study, Act (PDSA) cycles (e.g. tailored communications including translation and interpretation services, outreach clinics, reasonable adjustments)
- Measure impact by comparing outcomes and experience before and after interventions for priority groups
- Share learning, scale successful interventions, and embed equity-focused practice and culture across services

Reporting our progress:
Our improvement projects and workstreams follow established organisational governance structures, some of which report to Board level to monitor performance and progress. These forums and governance committees help us through providing multiple level support and challenge which range from acting as a critical friend with improvement priorities, monitoring progress on commitments up to providing oversight on accountability for statutory and legal requirements. These forums include:
- Health Inequity Reduction Group
- Equality, Diversity and Inclusion Group
- Know your Patient Group
- Lived Experience Panels
- Patient Safety and Experience Group
- Quality Assurance Committee
- Board of Directors

Statement of assurance from the board

Review of services

During 2025/26 Bolton NHS Foundation Trust provided and/or sub-contracted 10 relevant health services (as defined by the CQC) across 40 specialties.

Bolton NHS Foundation Trust has reviewed all the data available to them on the quality of care in all these relevant health services.

The income generated by the relevant health services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant health services by the Bolton NHS Foundation Trust 2025/26

Participation in Clinical Audits and Research Activity

The NHS published a list of 88 Quality Accounts (*of which several fall under the same programme of work) in 2025-2026.

During that period Bolton NHS Foundation Trust participated in 58 out of 88 national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The Trust did not participate in the following 30 audits:

1. British Spine Registry
2. Cleft Registry and Audit NEtwork (CRANE) Database
3. RCEM Adolescent Mental Health
4. Fracture Liaison Service Database (FLS-DB)
5. Mental Health Clinical Outcome Review Programme
6. Diabetes Prevention Programme (DPP) Audit
7. National Audit of Cardiovascular Disease Prevention in Primary Care (CVD Prevent)
8. National Audit of Eating Disorders (NAED)
9. National Bariatric Surgery Registry
10. National Adult Cardiac Surgery Audit (NACSA)
11. National Congenital Heart Disease Audit (NCHDA)
12. National Audit of Percutaneous Coronary Intervention (NAPCI)
13. UK Transcatheter Aortic Valve Implantation (TAVI)Registry
14. Left Atrial Appendage Occlusion (LAAO) Registry
15. Patent Foramen vale Closure (PFOC)Registry
16. National Audit of Mitral Valve Leaflet Repairs (MVLR)
17. Transcatheter Mitral and Tricuspid Valve (TMTV) Registry
18. National Clinical Audit of Psychosis (NCAP)
19. National Obesity Audit (NOA)
20. National Pulmonary Hypertension Audit
21. Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Bolton does send data to NWAS regarding outcomes of OOH cardiac arrests that were admitted to Bolton's A&E; however, the data is then entered by NWAS onto OHCAO's database.
22. Paediatric Intensive Care Audit Network (PICANet)
23. Prescribing Observatory for Mental Health (POMH): Improving the quality of valproate prescribing in adult mental health services
24. Prescribing Observatory for Mental Health (POMH): Use of clozapine
25. Prescribing Observatory for Mental Health (POMH): Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services
26. UK Cystic Fibrosis Registry – Adults
27. UK Cystic Fibrosis Registry – Children
28. BTS Interstitial Lung Disease (ILD) Registry

29. UK Renal Registry Chronic Kidney Disease Audit
30. Transition (Adolescents and Young Adults) and Young Type 2 Audit

The national clinical audits and national confidential enquiries that Bolton NHS Foundation Trust did participate in during 2025/2026 are as follows:

	Project Name	Additional Information/Individual Studies/Data Range	No. of cases submitted
1	BAUS Data & Audit Programme	Evaluating the Management Pathway for Suspected Testicular Cancer (EMPAST) Audit	8
2		British Audit of the Investigation and referral of Women with Recurrent Urinary Tract Infection using recent Guidance (BOOMERANG)	5
3	Breast and Cosmetic Implant Registry		11
4	Case Mix Programme (CMP) - Critical Care		317
5	Child Health Clinical Outcome Review Programme		See NCEPOD page 17
6	Emergency Medicine QIPs:	a) Mental Health (Self-Harm)	148
7		b) Care of Older People	179
8		c) Time Critical Medications *TCM form data:* *TCM doses:*	 187 230
9	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People		20
10	Falls and Fragility Fracture Audit Programme (FFFAP):	National Audit of Inpatient Falls (NAIF)	26
11		National Hip Fracture Database (NHFD)	432
12	Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)		See LeDer page 21
13	Maternal, Newborn and Infant Clinical Outcome Review Programme		27
14	Medical and Surgical Clinical Outcome Review Programme		See NCEPOD page 17
15	National Adult Diabetes Audit (NDA):	a) National Diabetes Core Audit. Includes: - Care Processes and Treatment Targets - Complications & Mortality - Type 1 Diabetes - Learning Disability and Mental Health - Structured Education -	823
16		c) National Diabetes Foot care Audit (NDFA)	*2025/2026 Data set closes 16/07/26
17		d) National Diabetes Inpatient Safety Audit (NDISA)	46
18		e) National Pregnancy in Diabetes Audit (NPID)	34
19		f) Gestational Diabetes Audit	649
20	National Audit of Cardiac Rehabilitation		193
21	National Audit of Care at the End of Life (NACEL)		80
22	National Audit of Dementia (NAD) *2025-26 was for diagnostic services only, done by GMMH, not Bolton FT.*		N/A
23	National Cancer Audit Collaborating Centre (NATCAN):	National Audit of Metastatic Breast Cancer (NAoMe)	98
24		National Audit of Primary Breast Cancer	543

		(NAoPri)	
25		National Bowel Cancer Audit (NBOCA)	262
26		National Kidney Cancer Audit (NKCA)	77
27		National Lung Cancer Audit (NLCA)	73
28		National Non-Hodgkin Lymphoma Audit (NNHLA)	81
29		National Oesophago-Gastric Cancer Audit (NOGCA)	58
30		National Ovarian Cancer Audit(NOCA)	30
31		National Pancreatic Cancer Audit (NPaCA)	40
32		National Prostate Cancer Audit (NPCA)	328
33	National Cardiac Arrest Audit (NCAA)		52
34		c) National Heart Failure Audit (NHFA)	179
35		d)National Audit of Cardiac Rhythm Management (CRM)	370
36		e) Myocardial Ischaemia National Audit Project (MINAP)	233
37	National Child Mortality Database (NCMD) **This is not a National Audit, therefore no submission total**		N/A
38	National Comparative Audit of Blood Transfusion	2025 Major Haemorrhage Audit	30
39	National Early Inflammatory Arthritis Audit (NEIAA)		25
40	National Emergency Laparotomy Audit (NELA) Laparotomy/No Laparotomy		126
41	National Joint Registry		818
42	National Major Trauma Registry		159
43	National Maternity and Perinatal Audit (NMPA)		4510 bookings 3910 deliveries 3970 babies
44	National Neonatal Audit Programme (NNAP)		730
45	National Ophthalmology Database (NOD):	a) Age-related Macular Degeneration Audit	386
46		b) Cataract Audit	1542
47	National Paediatric Diabetes Audit (NPDA)		151
48	National Perinatal Mortality Review Tool		18
49	National Respiratory Audit Programme (NRAP):	a) COPD Secondary Care	205
50		b) Pulmonary Rehabilitation	72
51		c) Adult Asthma Secondary Care	48
52		d) Children and Young People's Asthma Secondary Care	221
53	National Vascular Registry (NVR) - Angioplasty Procedure		10
54	Perioperative Quality Improvement Programme (PQIP)		5
55	Sentinel Stroke National Audit Programme (SSNAP)		240
56	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme		21
57	UK Parkinson Disease Audit		20
58	UK Renal Registry National Acute Kidney Injury Audit		2623

National Confidential Enquiry into Patient Outcome and Death (NCEPOD):
Data submission 2025/2026

Acute illness in people with Learning Disability Publication: Summer 2026

	Requested	Submitted
Case notes	6	6
Organisation Proforma	1	1
Clinical Questionnaire	6	6

Stabilisation of the critically ill child Publication: December 2026

	Requested	Submitted
Case notes	5	5
Organisation Proforma	1	2
Clinical Questionnaire	5	1

Stabilisation of the critically ill child (critical care) Publication: December 2026

	Requested	Submitted
Case notes	-	-
Organisation Proforma	-	-
Clinical Questionnaire	3	0

Pleural Procedures Publication: November 2026

	Requested	Submitted
Case notes	8	8
Organisation Proforma	1	1
Clinical Questionnaire	8	6

Rib Fractures Publication: Spring 2027

	Requested	Submitted
Case notes	6	6
Organisation Proforma	1	1
Clinical Questionnaire	6	6

Maternal, New-born and Infant Programme (Managed by MBRRACE-UK)
The Perinatal Mortality rates by trust/health board are taken from the perinatal mortality data viewer, which includes data up to 2024. It is a supplementary tool to the MBRRACE-UK State of the Nation Report published in May 2025.

The results concern stillbirths and neonatal deaths among the 5,067 babies born within Bolton Hospital NHS Foundation Trust in 2024, EXCLUDING births before 24 weeks' gestational age and all terminations of pregnancy. Neonatal deaths are reported by place of birth irrespective of where death occurred.

Type of death	Number	Crude rate	Stabilised and adjusted rate	Comparison to average for similar Trusts/Health Boards
Stillbirth	20	3.95	3.51	3.50
Neonatal death	16	1.39	1.72	1.52
Extended perinatal	36	5.33	5.22	5.42

For the purposes of the MBRRACE-UK section, extended perinatal death refers to all stillbirths and neonatal deaths. Of the 16 neonatal deaths, 14 were early neonatal deaths and

2 were late neonatal deaths. There were 0 postnatal deaths reported. There were also 4 late fetal losses, bringing the total number of deaths in 2024 to 40.

During the 2025-26 Quality Account period, MBRRACE-UK published the State of the Nation Report: Perinatal Mortality Surveillance on UK perinatal deaths of babies born in 2023. The report was published 8 May 2025. A review of the report found that there were no new recommendations included with the publication. It did, however, reiterate previous recommendations in the executive summary.

The Trust had one action from a previous publication that remained open. The action was from an existing recommendation from messages for the care of women with general medical and surgical conditions. The specific recommendation from the publication was as follows:
"Services providing care to pregnant women should be able to offer all appropriate methods of contraception, including Long-Acting Reversible Contraception (LARC), to women before they are discharged from the service"

At the time of the previous report, it was noted that funding was required to support this and discussion with the FCD SLT. In June 2025, this action was closed following discussion with clinical lead. Depovera is given on the postnatal ward and the team can arrange LARC implants or an IUS at the sexual health clinic prior to discharge. There is currently no funding for a ward base service for implants or IUS.

The total number perinatal deaths reported to the MBRRACE-UK perinatal mortality surveillance for QA 2025-26 was 27**.**

Note that 'perinatal deaths' refers to late fetal losses, stillbirths and neonatal deaths, but does not include post-neonatal deaths, as these are not eligible for MBRRACE-UK surveillance, nor are terminations of pregnancy included.

Learning Disability Mortality Review (LeDeR)
The LeDeR mortality review process is firmly embedded within the Bolton locality, maintaining strong links with the Greater Manchester Local Area Contact to ensure learning from Bolton reviews is shared appropriately across organisations. We continue to have robust locality representation at the Greater Manchester panel meeting, helping to identify themes from completed reviews and ensuring locality involvement in agreeing any required actions to address ongoing health inequalities for people with learning disabilities and/or autism. Since January 2022, the programme has received death notifications for those aged 4+ who have a learning disability and/or autism. As in recent years, reviews are completed by an external review team, hosted by NHS Cheshire and Merseyside under a memorandum of understanding agreement. Once learning is agreed from the completed reviews this is shared via appropriate locality forums, including the Learning Disability and Autism Strategic Improvement Group, the Learning Disability Partnership Board and the Learning from Deaths Committee. A Greater Manchester report is published annually, this the Bolton locality data. From 1 April 2024 to 31 March 2025, there have been 13 completed LeDeR reviews for Bolton residents, 7 were standard, initial reviews and 6 required a more detailed focused review. 12 of the individuals had a primary diagnosis of learning disability with one person having an autism diagnosis without a learning disability. The leading cause of death for adults with a learning disability continues to be respiratory conditions, with 38.4% of Bolton LD deaths being attributed to pneumonia or other respiratory causes.

The Greater Manchester leading cause of death for adults with learning disabilities is also respiratory (34%) whilst the national leading cause is circulatory conditions, suggesting an ongoing need for a Greater Manchester focus on respiratory health. All completed reviews indicate some health complexity, with all individuals being diagnosed with at least one long

term health condition (multimorbidity). Both the Greater Manchester and Bolton locality reports evidence that the average age of death is still significantly lower for adults with learning disabilities, with this population dying, on average, over 20 years earlier than the non-learning-disabled peers. The average age of death for adults with learning disabilities in Greater Manchester has increased slightly, from 61.8 years to 62.5 years, however, this is still much younger than the mainstream population. There is also a notable disparity in the average age of death for people with learning disabilities from ethnic minority groups, the average age of death being 56.9 years, in some cases up to 19.8 years younger than learning disabled adults from a white British background. There has been a slight reduction in the number of people who died in hospital, 69.2% of learning disability deaths were in hospital in 2024/25, a reduction from 81% in 2023/24, however, we need to be cautious interpreting this as a trend due to the small numbers of deaths reported. Advanced care planning has been identified as a priority area for focus for the coming year.

National information gathered for adults with an autism only diagnosis is based on a small number of death notifications so may not be representative of the whole population of autistic people. The data indicates that for autism only reviews, over 53% had a diagnosis of depression and over 42% had a diagnosis of anxiety disorder. The national leading cause of death for adults with autism is suicide, accident or misadventure, again, the caveat regarding the numbers reported should be a factor when considering this statistic. The Bolton community learning disability team have contributed to the Trust deteriorating patient collaborative and have developed a quality improvement project focused on respiratory health. The project aims to ensure carers have essential baseline information to help identify early indications of health deterioration and have a clear framework for discussing health concerns with health professionals. The project has helped to introduce a robust respiratory screening process which can lead to comprehensive respiratory assessments and results in an individualised bespoke chest health care plan where required. There is a locality action plan aimed at addressing learning from deaths and a Greater Manchester work plan, outlining several workstreams aimed at addressing identified health inequalities. We also contribute to the Greater Manchester learning disability strategy which aims to share good practice across Greater Manchester with focus on service improvement. There is a need to continue to encourage mainstream services to report deaths of people with learning disabilities and/or autism to the LeDeR platform; the majority of current notifications are made by specialist learning disability services, therefore highlighting a missed opportunity to learn from the deaths of those who do not access specialist services or who have an autism only diagnosis.

National Clinical Audits: Actions to Improve

The reports of 46 national clinical audits were reviewed by the provider in 2025-26 and Bolton NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. Please note: This is not an exhaustive list of all audit outcomes for 2025/2026, as some results and reports have not yet been published

<table>
<tr><th></th><th>Audit Title</th><th>Status/Learning/Actions</th></tr>
<tr><td>1</td><td>RCEM QIP Mental Health (Self-Harm)</td><td>Total number of records entered for QA 25-26: 148
Mental Health (self-harm) will be replaced by a new Quality Account, focusing specifically on Adolescent Mental Health. This will run from 2026. It has been registered on Safeguard. MH-SH will remain open on Safeguard, awaiting final national publication.

<table>
<tr><th>Standards</th><th>Is the Trust compliant?</th></tr>
<tr><td>Standard 1a - Proportion of patients who had a complete mental health triage with risk assessment by ED nurses/clinician ≤ 15 minutes of arrival</td><td>Local mean 18%, national mean 31%
See below narrative</td></tr>
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Standard 1b - Proportion of patients who had a complete mental health triage with risk assessment by ED nurses/clinician ≤ 30 minutes of arrival	Local mean 30%, national 45% See below narrative
Percentage of Patients that Underwent a Mental Health Triage	Local 79%, national 82%
Time to Mental Health Triage (Minutes)	Local 25 minutes, national mean 42 minutes
Percentage of Patients that Underwent a Parallel Assessment	Local 68%, national 56%
Time to ED Clinician Review After Triage (Minutes)	Local mean 232, national mean 167 See below narrative
Time to Adult Psychiatric Liaison Service patient review in the ED following referral (Minutes)	Local mean 153, national mean 141
Total time spent in ED before either Discharged / Admitted / Transferred off site (Hours)	Local mean 8 hours, national mean 11 hours
Standard 2 - Proportion of medium or high-risk patients who had an appropriate level of observation (Good evidence of continuous or intermittent observation, interaction or care)	Local mean 21%, national mean 43% See below narrative
Standard 3 - Proportion of patients who had a brief risk assessment by ED clinician of suicide and further self- harm and met the standard (4 out of 4)	Local mean 16%, national mean 31% Trainee QIP on this project
Evidence of Compassionate and Practical Care	Yes - 25% (38% national) Partial – 44% (26% national) No – 31% (36% national)
Evidence of appropriate physical health assessment, relevant investigation and treatment been carried out by the ED clinician appropriate to patient presentation	Yes – 98% (93% national) No – 2% (7% national)
Safeguarding Concerns	Concerns both considered and addressed: 68% (45% national) Concerns considered but not addressed: 2% (4% national) Concerns not considered: 30% (51% national)
Drug and Alcohol Concerns	Concerns both considered and addressed: 50% (41% national) Concerns considered but not addressed: 13% (10% national) Concerns not considered: 37% (49% national)
If not seen by Adult Psychiatry liaison services and discharged by ED: Was this documented and an acceptable safe discharge plan made?	Yes: 63% (88% national) No: 37% (12% national) Trainee QIP on this project
If patient left before ED clinician review, was this acted on?	Yes: 100% (63% national) No: 0% (8% national) Not Recorded: 0% (29% national)
If patient left before ED clinician review, was a capacity assessment documented?	Yes: 17% (45% national) No: 83% (55% national) Trainee QIP on this project
If patient left before Adult Psychiatric Liaison Services review, was this acted on?	Yes: 59% (66% national) No: 8% (7% national) Not Recorded: 33% (27% national)
If patient left before Adult Psychiatric Liaison Services review, was a capacity assessment documented?	Yes: 58% (59% national) No: 42% (41% national)

It is important to acknowledge this data is from 2023-2024, published in 2025. Since then, ED has made significant changes in the processes (e.g. new initial assessment process, increased consultant presence 11am-7pm midweek) and next year's data should reflect that lots of patients have their medical review within the first hour

RCEM does not dictate a target figure for all these metrics, but the gold standard for all mental health patients presenting to ED. Of 19 metrics, we

<table>
<tr><td></td><td></td><td>meet or exceed national averages in 12 (63%). This is partly because our ED mental health lead has made several improvements to help patients get better support while they are in ED, from a robust triage process, SOPs relating to RAG rating and observation, and how to manage the agitated patient.

The triage element (standard 1a and 1b) is going to be a balancing measure for the ED department. Since ED have introduced initial assessment, we are expecting an increase in the time to “triage” or “initial assessment”; however, that is in preference of continuing doing more for all the patients as they pass through their initial assessment (e.g. frontloading pertinent investigations and treatment) for overall departmental safety. This process started April 2024.

ED areas of focus will be to increase documentation of capacity assessments for patients, and for those patients who are discharged by the ED team, a safe discharge plan is made and documented.</td></tr>
<tr><td>2</td><td>RCEM
QIP Care of Older People</td><td>Total number of submissions for QA 2025-26: 179.
Care of Older People will run for another year in 2026. Awaiting national publication for 2025 data.

Care of Older People interim report gap analysis received confirming partial compliance with recommendations. Dr Newport has got a working group to do the delirium management plan QIP. Overall, we are in line or above national performance. Changes will be cascaded via ED Newsletter and governance

<table>
<tr><th>Standards</th><th>Is the Trust compliant?</th></tr>
<tr><td>Delirium Screening using 4AT:
• Continue the drive to screen all patients over 75 years old, irrespective of presenting complaint, for delirium using 4AT
• Training in the 4AT should be rolled out to all clinical staff in ED</td><td>82 of 207 (40%)
Nationally 16%</td></tr>
<tr><td>Falls risk assessment</td><td>120 of 207 (58%)
Nationally 48%</td></tr>
<tr><td>Frailty Screening:
• Perform a frailty screening to all patients over 75 years old at the front door of ED
• Provide EDs with the training to incorporate screening in all presentations from patients over 75 years old.</td><td>182 of 207 (88%)
Nationally 56%</td></tr>
<tr><td>Delirium Management Plan Initiated for Patients with Delirium:
• All patients presenting with delirium risk factors, or suspicion of delirium should have a management plan implemented.
• Management plans should be implemented as soon as possible within the patient journey.</td><td>Complete 7% (37% national)
Partial 68% (46% national)
No 25% (7% national)</td></tr>
<tr><td>Complete Delirium Management Plan Initiated for Patients with Delirium:
• Use of 4AT and risk assessment tools to highlight risk.
• Encourage early mobilisation, reduce invasive procedure use such as catheters, and monitor hydration/nutritional needs.
• Include specialty help where needed, medication reviews, early physio/OT input, use of frailty services/teams to reduce likelihood of adverse outcomes.</td><td>2 of 28 (7%)
Nationally 36%</td></tr>
<tr><td>Component Breakdown of Delirium Management Plan Initiated for Patients with Delirium:
• Encourage urinary retention and constipation assessment within ED assessment bundles</td><td>Constipation: 12% (nationally 34%)
Urinary Retention: 27% (nationally 41%)
Bloods: 49% (nationally 66%)
ECG: 22% (nationally 59%)
Medication Review: 27% (nationally 46%)
Pain Assessment: 29%</td></tr>
</table>
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		(nationally 54%)
Post-fall assessments for patients presenting after a fall: • All patients over 75 years presenting to type 1 EDs should have a dedicated falls risk assessment documented. These patients should be identified from the triage process. • There should be a standardised form, proforma, or similar way to document the risk of further falls, and staff performing these assessments should receive training in how to complete the assessments.	21 of 59 (36%) Nationally 35%
Complete Post-Fall Assessment Documented: • Patients over 75 presenting with a fall should have ECG, postural blood pressure and if appropriate, blood tests and assessment for major trauma, as a minimum. • There should be a form, proforma or similar standardised way of documenting these investigations, and staff should receive training on how to complete these elements of the post-fall assessment.	Complete: 36% (nationally 36%) Partial: 49% (nationally 50%) No: 15% (nationally 14%)
Post fall assessment breakdown	Bloods: 92% (nationally 92%) ECG: 58% (nationally 84%) PBP: 34% (nationally 34%) Major Trauma: 34% (nationally 45%)
Falls mitigation plan. (Cotsides up, Non-Slip Socks On, Observation Documented, Risk Flagged Up, Walking Aids)	Complete: 68% (nationally 37%) Partial: 15% (43%) No: 17% (nationally 20%)
Comprehensive geriatric assessment done? (triggered by CFS >4)	30% (nationally 34%)
Safety round documented. (Medications Charted, Observations Documented, Offered Food and Drink, On Hospital Bed, Pressure Areas Checked)	Complete: 72% (nationally 32%) Partial: 21% (nationally 43%) No: 7% (nationally 25%)

2025's publication covers data from October 2023- October 2024, for adult patients aged 75 and above.

Most of our care for older patients meets or exceeds the national average; RCEM does not set a target for each care component so comparisons with other type 1 EDs is our benchmark.

Since this data was published, the 4AT delirium screening tool has been embedded and clinical frailty scores into the ED Adult Cas Card.

Delirium management plan instigation requires improvement. E.g. increasing the use of ED TIME (Triggers, investigate, manage and engage) bundle document.

It is felt that most doctors are aware of the potential contributing factors to delirium encapsulated in the PINCHME acronym – pain (including urinary retention), infection, nutrition, constipation, hydration, medication, and electrolytes, but there are barriers to implementing including time pressures, environment restrictions and delays to review.

An ED Quality Improvement project on instigating delirium management plans to involve liaising with the Geriatricians is in progress.

3	RCEM QIP Time Critical Medications	RCEM Time Critical Medications is on the Quality Account list for QA 2025-26. Number of records entered for QA 25-26 below: • TCM form data: 187 • TCM doses: 230

		• TCM QIP will run for another year in 2026. Time Critical Medications will continue for a third year in 2026, with plans to continue through 2026 and 2027. Awaiting national publication for the 2025 data. From Bolton's interim report Y1, see below: **STANDARD 1a –** Patient identified to be on TCM within 30 minutes of arrival • National mean: 47.37% • Bolton mean: 14.10% • Weekly average of Time to identify TCM (from arrival) • National average: 116 minutes • Bolton average: 235 minutes **STANDARD 1b –** Patient identified to be on TCM within 30 minutes of arrival (Levodopa only) • National mean: 48.36% • Bolton mean: 9.89% • Weekly average of Time to identify TCM (from arrival) - Patients exclusively on Levodopa • National average:106 minutes • Bolton average: 218 minutes **STANDARD 1c –** Patient identified to be on TCM within 30 minutes of arrival (Insulin only) • National mean: 44.44% • Bolton mean: 14.11% • Weekly average of Time to identify TCM (from arrival) - Patients exclusively on Insulin • National average:124 minutes • Bolton average: 258 minutes **STANDARD 2a -** TCM dose administered within 30 minutes of expected time • National mean: 32.62% • Bolton mean: 28.29% • Average time difference to administer TCM • National average: 125 minutes • Bolton average: 96 minutes **STANDARD 2b -** TCM dose self-administered within 30 minutes of expected time • National mean: 64.92% • Bolton mean: 60.00% • Average time difference to administer TCM (self-administered doses) • National average: 75 minutes • Bolton average: 24 minutes **STANDARD 2c -** TCM dose administered within 30 minutes of expected time (All Levodopa doses) • National mean: 39.39% • Bolton mean: 31.61%

		• Average time difference to administer TCM (All Levodopa doses) • National average: 107 minutes • Bolton average: 92 minutes **STANDARD 2d - TCM** dose administered within 30 minutes of expected time (Self-administered Levodopa doses) • National mean: 71.87% • Bolton mean: 50.00% • Average time difference to administer TCM (Self-administered Levodopa doses) • National average: 56 minutes • Bolton average: 16 minutes **STANDARD 2e -** TCM dose administered within 30 minutes of expected time (All Insulin doses) • National mean: 22.77% • Bolton mean: 26.18% • Average time difference to administer TCM (All Insulin doses) • National average: 153 minutes • Bolton average: 75 minutes **STANDARD 2f -** TCM dose administered within 30 minutes of expected time (Self-administered Insulin doses) • National mean: 51.72% • Bolton mean: 66.67% • Average time difference to administer TCM (Self-administered Insulin doses) • National average: 113 minutes • Bolton average: 30 minutes **STANDARD 3a -** Patients did not miss any ED administered TCM whilst in ED • National mean: 55.44% • Bolton mean: 38.26% • Breakdown of Standard 3 eligible doses (Expected to be administered by ED staff) • Missed dose: 152 (47.8%) • Not missed: 166 (52.2%) **STANDARD 3b -** Patients did not miss any ED administered TCM whilst in ED (Patients identified to be exclusively on Levodopa) • National mean: 58.14% • Bolton mean: 35.00% • Breakdown of Standard 3 eligible doses (Expected to be administered by ED staff) Levodopa • Missed dose: 93 (52.54%) • Not missed: 84 (47.46%) **STANDARD 3c -** Patients did not miss any ED administered TCM whilst in ED (Patients identified to be exclusively on Insulin) • National mean: 52.45% • Bolton mean: 45.92%

		• Breakdown of Standard 3 eligible doses (Expected to be administered by ED staff) Insulin • Missed dose: 59 (41.84%) • Not missed: 82 (58.16%)
4	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	The Trust is fully compliant with all recommendations from the national Epilepsy12 report – published July 2025 • Audit participation and workforce capacity • Stronger community and digital infrastructure • Faster access to specialist and surgical care • Integrated mental health support • Reducing unwarranted variation and inequality Data collection for Cohort 6 is complete, 20 eligible patients entered. Within the clinical audit there are 12 'Performance Indicator' measures which are derived from national guidelines and recommendations.
5	National Audit of Inpatient Falls (NAIF)	The Trust completed the NAIF Clinical dataset and facilities audit which is a yearly requirement, which was the first recommendation of the 2025 annual report.
6	National Hip Fracture Database (NHFD)	Annualised values based on 28 cases averaged over 12 months to the end of January 2026. Masa quality score 18% (NAIF overall: 26%), Cases where patients were checked for injury before being moved 50% (NAIF overall: 79%), Cases where safe manual handling method was used to move a patient from floor 50% (NAIF overall: 37%), Cases that received within 30 minutes of a fall 82% (NAIF overall: 65%)
7	National Diabetes Foot care Audit (NDFA)	National dashboard reviewed which had confirmed Bolton is above the National average with 85.7% of patients being seen between 0-13 days. The specialist foot service is accessible to all diabetes patients with an ulcer either at the Diabetes Centre or with domiciliary visit.
8	National Diabetes Inpatient Safety Audit (NDISA)	1. Episodes of hypoglycaemia by month - The target being 3.9% - non-compliant 2. Foot checks on admission - The target being 100% - Compliant 3. Compliance and monitoring by division of mandatory diabetes training in hypoglycaemia, insulin safety and foot assessment. Target 85 % - Compliant 4. Those eligible to self-administer insulin whilst in hospital – audited every three months. Target 80% - Non- Compliant *5.* GIM 15 Behind Bed Board Compliance Audit - Target 80% - Non-Compliant
9	National Pregnancy in Diabetes Audit (NPID)	Pregnancy end dates from April 2025 to end of March 2026, demographics, preparation and outcome below. **Bolton Patient demographics-** Type 1: 9 Type 2: 25 Maturity-Onset Diabetes of the Young (MODY): 0 Other: 0 Not Specified: 0 Total pregnancies: 34. **Diabetes Type 1 Summary-** Bolton BMI-Mean Average: 27.02 National BMI-Mean Average: 26.7 Bolton Age-Mean Average: 29 National Age-Mean Average: 30

		Bolton average for HBA1c >= 48mmol/mol: 62.0% National average for HBA1c >= 48mmol/mol: 25.3% Total pregnancies for Type 1 diabetes: 9 **Diabetes Type 2 Summary-** Bolton BMI-Mean Average: 32.45 National BMI-Mean Average: 33.1 Bolton Age-Mean Average: 33 National BMI-Mean Average: 35 Bolton average for HBA1c >= 48mmol/mol: 50.0% National average for HBA1c >= 48mmol/mol: 35.4% Total pregnancies for Type 2 diabetes: 25 **Bolton's Pregnancy Outcomes by Diabetes Types-** Type 1: 9 Live births, 0 Stillbirths, 0 Terminations and 0 Miscarriages. Type 2: 24 Live births, 0 Stillbirths, 0 Terminations and 1 Miscarriage. Total Pregnancy Outcomes: 33 Live births and 1 Miscarriage.
10	National Gestational Diabetes Audit	National Gestational Diabetes Mellitus (GDM) Audit, 2024-25 data published in November 2025. This is the first publication of National Gestational Diabetes Mellitus (GDM) data taken from the National Diabetes Audit. Please note, most of this audit is undertaken by GPs in Primary Care. The total number of women who have booked or delivered between April 2025 to March 2026 who were coded as having Gestational Diabetes as an endocrine problem: 649.
11	National Audit of Cardiac Rehabilitation	The Trust is fully compliant with all below recommendations from the latest national publication, NACR Quality and Outcomes Report 2025 (Jan-Dec 2024 data), published December 2025 Recommendation 1: Where required, increase pharmacology related support as part of the CR service. NACR suggests: Enable appropriate CR staff to upskill to become nonmedical prescribers Recommendation 2: Ensure that assessment 1 (pre-CR) is inclusive of all three core areas of risk factors, exercise test and psychosocial wellbeing. NACR suggests: Work alongside NACR to identify missing components within assessment 1 (pre-CR) to target measurement and recording. Recommendation 3: Increase CR completion rates across all modes with a primary focus on Home-based/Self-managed CR. NACR suggests: Planned “Definition of Completion” due to be published in late 2025 in collaboration with the BACPR and the NCP_CR Steering Group. Recommendation 4: Review service provision in light of incorporating more digital components into the CR pathway. NACR suggests: Using the findings from this report to highlight barriers in utilisation of digital modes/content and support solutions e.g. staff training, patient literacy and funding. Where modern technologies are being introduced refer to NICE Early Value Assessment • Patients Starting CR with Mode Recorded: 69%

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Patients Starting Group-based CR: 83%
Patients Completing Group-based CR: 90%
Patients Starting Home-based/Self-managed CR: 17%
Patients Completing Home-based/Self-managed CR: 69%
Patients Starting Hybrid CR: 0%
Patients Completing Hybrid CR: 0%

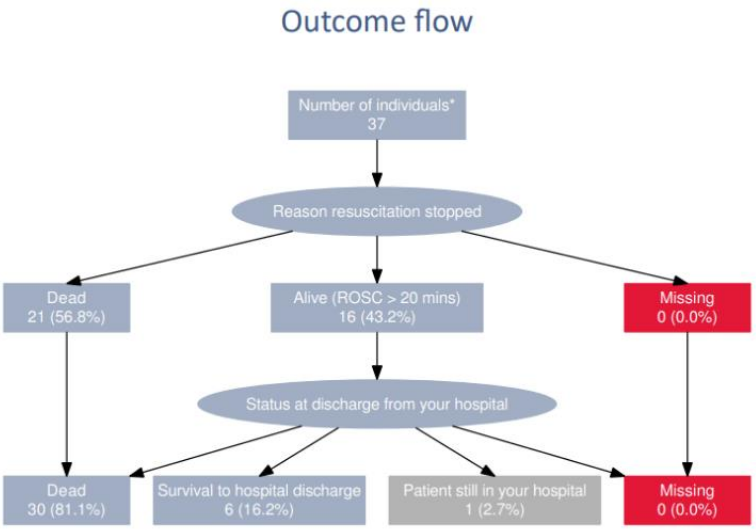
<table>
<tr><th>Trust Name</th><th>Region/Network</th><th>% Starting CR with Mode Recorded</th><th>% of Patients Starting Group-based CR</th><th>% of Patients Completing Group-based CR</th><th>% of Patients Starting Home-based/Self-managed</th><th>% of Patients Completing Home-based/Self-managed CR</th><th>% of Patients Starting Hybrid* CR</th><th>% of Patients Completing Hybrid* CR</th></tr>
<tr><td>Bolton Hospitals NHS Trust (Royal Bolton Hospital and Royal Bolton Heart Failure Rehab)</td><td>Greater Manchester</td><td>69%</td><td>83%</td><td>90%</td><td>17%</td><td>69%</td><td>0%</td><td>0%</td></tr>
<tr><td>Manchester University NHS Foundation Trust (Manchester Heart Centre / Manchester Royal Infirmary)</td><td>Greater Manchester</td><td>34%</td><td>6%</td><td>0%</td><td>82%</td><td>0%</td><td>12%</td><td>0%</td></tr>
<tr><td>Manchester University NHS Foundation Trust (North Manchester General Hospital)</td><td>Greater Manchester</td><td>53%</td><td>47%</td><td>88%</td><td>50%</td><td>65%</td><td>3%</td><td>100%</td></tr>
<tr><td>Manchester University NHS Foundation Trust (Trafford General Hospital)</td><td>Greater Manchester</td><td>100%</td><td>83%</td><td>52%</td><td>0%</td><td>0%</td><td>17%</td><td>11%</td></tr>
<tr><td>Manchester University NHS Foundation Trust (Wythenshawe Hospital & South Manchester Community)</td><td>Greater Manchester</td><td>96%</td><td>82%</td><td>78%</td><td>18%</td><td>25%</td><td>0%</td><td>0%</td></tr>
<tr><td>Northern Care Alliance NHS Foundation Trust (Bury Care Organisation)</td><td>Greater Manchester</td><td>94%</td><td>45%</td><td>92%</td><td>35%</td><td>93%</td><td>20%</td><td>94%</td></tr>
<tr><td>Northern Care Alliance NHS Foundation Trust (Oldham Care Organisation)</td><td>Greater Manchester</td><td>99%</td><td>46%</td><td>55%</td><td>15%</td><td>60%</td><td>40%</td><td>76%</td></tr>
<tr><td>Northern Care Alliance NHS Foundation Trust (Salford Royal Hospital)</td><td>Greater Manchester</td><td>100%</td><td>0%</td><td>0%</td><td>100%</td><td>54%</td><td>0%</td><td>0%</td></tr>
<tr><td>Stockport NHS Foundation Trust (Stepping Hill Hospital)</td><td>Greater Manchester</td><td colspan="7">Insufficient Number of Core Records for Valid Data Reporting (<10)</td></tr>
<tr><td>Tameside and Glossop Integrated Care NHS Foundation Trust (Tameside General Hospital)</td><td>Greater Manchester</td><td>93%</td><td>74%</td><td>28%</td><td>26%</td><td>36%</td><td>0%</td><td>0%</td></tr>
<tr><td>Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (Community Cardiac Rehabilitation)</td><td>Greater Manchester</td><td>97%</td><td>0%</td><td>0%</td><td>82%</td><td>80%</td><td>18%</td><td>88%</td></tr>
</table>
</td></tr>
<tr><td>12</td><td>National Audit of Dementia (NAD)</td><td>In 2025, the National Audit of Dementia ran the community-based Memory Assessment Services Audit and the Dementia Diagnostics Services survey; however, these are not applicable to the Trust. Bolton NHS Foundation Trust does not have dementia diagnostic services; dementia is diagnosed by the mental health liaison team from Greater Manchester Mental Health Trust. Therefore, this was not applicable

The next data collection period for acute hospitals will be June 2026. The Royal College of Psychiatrists will roll out the new audits in 2026 and 2027, with one State of the Nation report in each year. The main activities for acute general hospitals include the voluntary Annual Census Day spot audit and the voluntary patient and carer data collection pilot.</td></tr>
<tr><td>13</td><td>National Audit of Metastatic Breast Cancer (NAoMe)</td><td>State of the Nation Report published September 2025. One recommendation for Trusts and two for Cancer Alliances working with breast care teams and clinical management to action.
The national guidance is based on NICE guidance, and the Trust is compliant against all applicable NICE guidance.

Number of patients with de novo diagnosis of metastatic breast cancer 46
Data items on which data completeness target is met:
• Performance status 72% (58%)
• Clinical nurse specialist 74% (64%)
• Tumour grade 91% (85%)
• Overall stage 89% (83%)
• Oestrogen receptor (ER) status 87% (78%)
• HER2 status 85% (73%)
• Progesterone receptor (PR) status 87% (64%)
Percentage shown in brackets are for the whole of England</td></tr>
<tr><td>14</td><td>National Audit of Primary Breast Cancer (NAoPri)</td><td>State of the Nation Report published December 2025. These recommendations are for Cancer Alliances to action. Therefore, no gap analysis was required. However, performance shown below:
• Number of patients with breast cancer 1130</td></tr>
</table>

		• Data items covering all people diagnosed with breast cancer • Performance status 95% (65%) • Clinical nurse specialist 90% (78%) • Tumour grade 98% (97%) • Overall stage 98% (88%) • Oestrogen receptor (ER) status 98% (86%) • HER2 status 96% (78%) • Progesterone receptor (PR) status 95% (68%) • Data items covering people with invasive disease • T Stage 98% (94%) • N Stage 98% (93%) • Three-year breast cancer specific survival 97.5% (97.3%) *Percentage shown in brackets are for the whole of England*
15	National Bowel Cancer Audit (NBOCA)	State of the Nation Report published October 2025. The recommendations made are for the Cancer Alliances working with NHS Trusts to action. • Number of patients of diagnoses 238, recorded as undergoing major surgery 113. • Major resection • Number of procedures: 137 • Observed 2-year survival rate - 87% (84.9%) • Adjusted 2-year survival rate – 83% (84.9%) • Observed Cancer Specific 2-year survival rate – 88% (88%) • Adjusted Cancer Specific 2-year survival rate – 84% (88%) *Percentage shown in brackets are the overall figure*
16	National Kidney Cancer Audit (NKCA)	State of the Nation Report published September 2025. The recommendations made are for the Cancer Alliances working with NHS Trusts to action. • Number of people new diagnosis of kidney cancer – 88 • Percentage of people with tumour size recorded – 59% • Percentage of people with TNM (all complete) recorded – 83% • Percentage of people with TNM (all complete) recorded (including full T stage) - 67%
17	National Lung Cancer Audit (NLCA)	State of the Nation Report 2026 report (2024 care data) published on 04/03/2026. These recommendations are for Cancer Alliances to action. Therefore, no gap analysis was required, and the report was sent for information/review only. However, Bolton FT's lung cancer data April 2025 - March 2026 shown below: • Primary and non-primary diagnoses: 227 new primaries (97.01%), 4 non-primary (1.71%). 3 progressions (1.28%). 0 transformations. • Diagnoses discussed at MDT: 226. Not discussed: 1. Percentage discussed: 99.56%. • CNS Contact: 117 (77.92%). No CNS Contact: 50 (22.03%). • Children, Teenagers & Young Adults (CTYA): All 227 diagnoses were patients who were aged 25+ (100%). • Basis of diagnosis: 134 histological (59.03%), 92 other (40.53%), 1 not recorded (0.44%).
18	Non-Hodgkin Lymphoma Audit (NNHLA)	The National Non-Hodgkin Lymphoma Audit State of the Nation Report 2025 was published. Recommendations for action by Cancer Alliances and NHS England, rather than for NHS Trusts. Therefore, no gap analysis was required, and the recommendations were sent for information only. However, Bolton FT's NHL data April 2025 - March 2026 shown below: • Primary and non-primary diagnoses: 60 new primaries (86.96%), 5 non-primary (7.25%). 4 progression (5.80%). 0 transformations.

		• Diagnoses discussed at MDT: 54. Not discussed: 6. Percentage discussed: 90.00%. • CNS Contact: 27 (45.00%). No CNS Contact: 33 (55.00%). • Children, Teenagers & Young Adults (CTYA): Under 15: 0 (0%). 15-24: 4 (5.88%). 25+: 64 (94.12%) • Basis of diagnosis: 56 histological (93.33%), 1 other (1.67%), 3 not recorded (5.00%).
19	National Oesophago-Gastric Cancer Audit (NOGCA)	State of the Nation Report September 2025 the recommendations are to be actions by NHS England, Cancer Alliances working with NHS trusts, Cancer Alliances working with NHS trusts and Integrated Care Boards (ICBs) working with NHS trusts. • No. diagnosed with oesophago-gastric cancer – 146 • Stage at diagnosis (% complete) - 84 (84) • Performance status (% complete) - 98 (80) • Clinical nurse specialist (CNS) (% complete) - 67 (68) *Figure shown in brackets are for England*
20	National Ovarian Cancer Audit (NOCA)	One recommendation from the 2024 Ovarian Cancer State of the Nation Report that the Trust was following up on during QA 2025-26. Recommendation: "Improve the completeness and quality of data items recorded in the national cancer datasets (e.g. percentage of women with recorded diagnosis based on histology or cytology in the national cancer registration data and percentage of women with recorded staging information)" This is a general recommendation from NOCA, and we have a variety of systems in place to ensure the most accurate staging information is recorded: • Contemporaneous documentation of local and sector MDT discussions and outcomes during meetings by the MDT Coordinator • Outcomes printed, checked and verified by chairing clinician, which includes staging information, where known • New Gynaecology Cancer Navigator position, which facilitates the diagnostic and staging process Bolton FT's gynaecological cancer data April 2025 - March 2026: • Primary and non-primary diagnoses: 115 new primaries (91.27%), 8 non-primary (6.35%). 3 progressions (2.38%), 0 transformations. • Diagnoses discussed at MDT: 113. Not discussed: 2. Percentage discussed: 98.26%. • CNS Contact: 77 (66.96%). No CNS Contact: 38 (33.04%). • Children, Teenagers & Young Adults (CTYA): All 126 diagnoses were patients who were aged 25+ (100%). • Basis of diagnosis: 107 histological (93.04%), 3 other (2.61%), 5 not recorded (4.35%).
21	National Pancreatic Cancer Audit (NPaCA)	The National Pancreatic Cancer Audit State of the Nation Report 2025 was published with a set of recommendations. Recommendations for action by Cancer Alliances and NHS England. Therefore, no gap analysis required, and the recommendations were sent for information only. However, Bolton FT's pancreatic cancer data April 2025 - March 2026 shown below: • Primary and non-primary diagnoses: 38 new primaries (100%), 0 non-primary. 0 progressions. 0 transformations. • Diagnoses discussed at MDT: 38 (100%) • CNS Contact: 29 (76.32%). No CNS Contact: 9 (23.68%) • Children, Teenagers & Young Adults (CTYA): All 38 diagnoses were

		patients who were aged 25+ (100%). • Basis of diagnosis: 13 histological (34.21%), 24 other (63.16%), 1 not recorded (2.63%).
22	National Prostate Cancer Audit (NPCA)	State of the Nation Report published October 2025. Recommendations for Cancer Alliances working with NHS trusts to action. • Number of men diagnosed – 269 • Data completeness for performance status – 94 • Data completeness for PSA – 79 • Data completeness for Gleason Score – 91 • Data completeness for TNM – 94
23	National Cardiac Arrest Audit (NCAA)	Please see breakdown of monthly denominator data (team visits recorded - true cardiac arrests) for QA 2025-26 below: • April 2025: 5 • May 2025: 8 • June 2025: 1 • July 2025: 4 • August 2025: 2 • September 2025: 5. • October 2025: 3 • November 2025: 7 • December 2025: 4 • January 2026: 5 • February 2026: 4 • March 2026: 4 • Current total of cardiac arrests entered: 52 The latest NCAA publication - February 2026, looks at care between April 2025-December 2025. Please see outcomes of these cardiac arrests below: 
24	National Heart Failure Audit (NHFA)	The Trust is fully compliant with all recommendations from the latest national report, NHFA 2025 2nd Edition Annual Summary Report except for one recommendation. Recommendation: "Follow-up arrangements should be improved: Cardiology follow-up needs to improve. Patients should be referred for Cardiology and Specialist HF Nurse follow-up irrespective of their cardiac function. This should include leaving hospital with their first appointment

		already arranged to happen within two weeks. The benefits of cardiac rehabilitation across all age groups and HF types should not be neglected, and patients referred accordingly." Current Trust compliance: The Heart Failure service is not commissioned and therefore cannot support Specialist Nurse follow-up for patients with HFpEf. Work ongoing with Virtual frailty team and training of lead HF nurse as ACP with a long-term objective to deliver follow up for patients irrespective of ejection fraction. Review again in 6-12 months regarding training of lead HF nurse to advanced care practitioner.
25	National Audit of Cardiac Rhythm Management (CRM)	The Trust is fully compliant with the relevant recommendations from the latest NACRM publication, the Annual 2025 2nd edition (24-25 data) Recommendations for Clinical Practice: • Device therapy: As pacemaker and ICD implantation rates remain lower than comparable countries, regional services should review waiting lists and local practice against guidelines. (Compliant) • AF Ablation: Given variation across regions, local services should review patient selection and re-intervention rates for AF ablation. (Undertaken by Tertiary Centre Service) • Re-intervention rates: Hospitals should review accessory pathway ablation practice given high re-intervention rates. (Undertaken by Tertiary Centre Service) • Emerging technologies: Regional services should review appropriate clinical use and access to emerging technologies (such as leadless pacing, conduction system pacing or pulsed field ablation). (Compliant) Recommendations for data collection: • Implant records: There is an increasing obligation to monitor medical implants, and all operators should ensure implant identifiers and relevant clinical fields are completed and submitted to the NACRM within agreed timelines (see background for more details on captured fields). (Compliant) • Emerging technologies: There is a growth of emerging heart rhythm technologies, and all operators should ensure correct submissions are made to facilitate monitoring of procedures and outcomes of changing practice. (Compliant)
26	Myocardial Ischaemia National Audit Project (MINAP)	The Trust is fully compliant with all recommendations from the latest national report, MINAP 2025 2nd Edition Annual Summary Report • Recommendation: Patients should receive high-quality pre-hospital care and timely reperfusion treatment in hospital. • Recommendation: To improve the care of the increasing proportion of patients who self-present with higher-risk STEMI heart attacks to hospitals that do not have primary. • Recommendation: Hospitals should submit accurate and timely data to the MINAP audit.
27	National Child Mortality Database (NCMD)	The report recommended ensuring that reasonable adjustments are routinely discussed with and provided for all children with a learning disability, autistic children, and, where appropriate, their families and carers. Details of agreed reasonable adjustments should be accurately recorded and maintained within the Reasonable Adjustments Digital Flag in the child's clinical record. At present, children are not routinely digitally flagged for reasonable adjustments within the Electronic Patient Record (EPR)

		• For paediatric patients, a Hospital Passport is uploaded for some children, primarily those with a learning disability, which may include details of reasonable adjustments. • There is no consistent digital flag within EPR for children with a learning disability, and autism is not currently flagged. • The process for flagging autism following a BSCIP diagnosis remains unclear and requires further discussion, including whether this could be actioned by administrative staff at the point of diagnosis. Leadership for this work has been identified within integrated community paediatric services and working group will develop and agree a consistent approach for paediatric services, using learning from adults
28	National Early Inflammatory Arthritis Audit (NEIAA)	Outlier metric is NICE QS 2 – Treatment within 6 weeks of referral. Bolton Rheumatology consultants do not initiate medications during the Early Inflammatory Arthritis (EIA) clinic appointment. The consultant assesses the patient, requests the necessary investigations, and refers the patient to pharmacy for medication initiation. Patients are then placed on a waiting list for drug starts. Due to capacity restrictions the service is currently unable to consistently meet the six-week standard to medication initiation from referral
29	National Emergency Laparotomy Audit (NELA)	Tenth Patient Report of the National Emergency Laparotomy Audit published October 2025. The recommendations are for Royal College of Anaesthetists, Royal College of Emergency Medicine, Royal College of Radiologists, Royal College of Surgeons of England and NHS England, Integrated Care Boards to action. • Number of cases – 172 • Case ascertainment – 100% • Data completeness – 100% • Consultant surgeon and anaesthetist present in theatre when risk of death >=5% - 94% • Consultant surgeon present in theatre when risk of death >=5% - 94% • Consultant anaesthetist present in theatre when risk of death >=5% - 100% • Admitted to critical care post op when risk of death >=5% - 74% • Frailty assessment of patients >= 65 years – 87% • Assessment and management by a member of a perioperative team with expertise in CGA in patients > 65 years frail and 80+ - 59% • Proportion returning to theatre after emergency laparotomy - 5%
30	National Joint Registry	Annual Report 2024/25 - no recommendations made. However, efforts made to understand the reasons behind the hospital consent rate and make improvements. Consequently in 25/26 the consent rate is 97% and above national at 90%. • Total procedures - 819 • Indicator 1 - Trust compliance rate – Better than expected • Indicator 2 – Hospital consent rate – Worse than expected • Indicator 3 – Hospital data linkability – Better than expected • Indicator 4 – Hospital SRR hips (latest 10 years) - 99.8% • Indicator 5 – Hospital SRR knees (latest 10 years) - 99.8% • Indicator 6 – Hospital SMR hips (latest 5 years) - 99.8% • Indicator 7 – Hospital SMR knees (latest 5 years) - 99.8%.
31	National Major	The NMTR replaced Trauma Audit & Research Network (TARN) in

	Trauma Registry	2024.To date there has been no publication and therefor, no recommendations • ED admissions for trauma entered onto the NMTR Outcome registry: 159 (25/26) Hospital Trauma indicator: • Median length of stay in hospital for cases submitted • Bolton: 10.0 (days) National average: 10.0 (days) • Time to CT- Bolton: 243 mins National median: 136 mins • Time to provisional CT report- Bolton: 59 mins National median:48 mins • Time to final CT report- Bolton: 67 mins National median:146 mins • Time to first operation- Bolton: 1228 mins National median: 942 mins
32	National Maternity and Perinatal Audit (NMPA)	The NMPA made two publications during the QA period 2025-26: State of the Nation 2023 Report and NMPA Induction of Labour Snapshot Audit Report, recommendations were not applicable to Bolton; The next NMPA State of the Nation Summary report for 2024 data is expected by Q2 26/27 Data completeness overview from the 2023 data published in 2025 compared to the national standards: • Parity – Bolton: 100. National: 100 • Blood loss – Bolton: 98. National: 76 • Gestation length at birth – Bolton: 100. National: 100. • Birthweight – Bolton: 100. National: 100. • Delivery method – Bolton: 100. National: 100. • Delivery date – Bolton: 100. National: 100. • Labour onset – Bolton: 98. National: 95. • Episiotomy – Bolton: 99. National: 96. • Delivery presentation – Bolton: 99. National: 95. • Previous caesarean birth – Bolton: 100. National: 100. • Number of infants – Bolton: 100. National: 100. • 3rd and 4th degree perineal tears – Bolton: 100. National: 100 • Foetus outcome – Bolton: 100. National: 100. • Apgar score at 5 min – Bolton: 91. National: 95. • Skin-to-skin – Bolton: 0. National: 90. • Breast milk at 1st feed – Bolton: 99. National: 91. • Breast milk at discharge – Bolton: 0. National: 12. • Readmission within 42 d – Bolton: 99. National: 96. • Gestation length at booking – Bolton: 99. National: 98. • BMI – Bolton: 82. National: 68. • Ethnicity – Bolton: 82. National: 97. • IMD – Bolton: 100. National: 99. • Smoking at delivery – Bolton: 98. National: 50. • Smoking at booking – Bolton: 84. National: 86. Bolton's maternity data from between April 2025 - March 2026: • April 2025: 430 bookings, 445 deliveries, 450 babies. • May 2025: 455 bookings, 380 deliveries, 395 babies. • June 2025: 450 bookings, 380 deliveries, 385 babies • July 2025: 475 bookings, 425 deliveries, 430 babies • August 2025: 415 bookings, 390 deliveries, 395 babies • September 2025: 435 bookings, 400 deliveries, 405 babies • October 2025: 510 bookings, 405 deliveries, 410 babies • November 2025: 420 bookings, 355 deliveries, 360 babies • December 2025: 445 bookings, 350 deliveries, 355 babies • January 2026: 475 bookings, 380 deliveries, 385 babies

		• February 2026: Not yet published. • Current total: 4510 bookings, 3910 deliveries, 3970 babies.

33	National Neonatal Audit Programme (NNAP)	NNAP Summary Report (2024 data), the Trust is compliant with all recommendations.
		
		• Recommendation 1a. Review their mortality data and where rates are higher than expected, develop locally prioritised improvement plans. Quality improvement activity should focus on best practices identified from Neonatal Networks exhibiting low mortality, with particular attention given to differences in network structure, staffing, clinical governance, and clinical practices.
		• Recommendation 1b. With their constituent units, undertake reviews of deaths in accordance with the BAPM Framework for Practice: Neonatal Mortality Governance (expected to be published in the second part of 2025) and engage with other statutory death review processes. Shared learning from these reviews should inform network governance and unit level clinical practice.
		• Recommendation 2a. Issue clear guidance to neonatal services around the correct reporting of preterm brain injury including PHVD, so that robust data collection can support the achievement of the national ambition for neonatal brain injury.
		• Recommendation 2b. Develop a mandatory NHS neonatal information standard to ensure that clinical reporting systems are interoperable, ensuring robust data collection to support effective measurement and reporting of all neonatal processes and outcomes.
		• Recommendation 3: Neonatal Networks should ensure that their constituent units are using the NNAP restricted access dashboard to regularly review their rates of optimal perinatal care delivery, identifying instances of non-adherence, and implementing quality improvement activities in response to them.
		• Recommendation 4: Neonatal networks and local maternity and neonatal systems should ask their constituent units with below average rates of breastmilk feeding by day 2 to:
		  • investigate reasons for variation in uptake locally, and
		  • with families, co-design targeted, quality improvement programmes
		• Recommendation 5: should work with the perinatal teams in their constituent neonatal units to:
		  • ensure that staff receive appropriate and consistent training to confidently ask families about their ethnicity and that of their baby, and to accurately record demographic information,
		  • use the NNAP dashboard to review how well NNAP process measures are delivered locally, and whether this differs by ethnicity
		  • where differences exist, seek to understand the underlying causes
		  • with families, co-design quality improvement programme that directly address those causes.
		
		Bolton's performance benchmarked against the national average for standards for 2025:
		• Perinatal Optimisaton - Bolton FT: 55.6% National: 55.2%
		• Perinatal Optimisaton - Bolton FT: 32.6% National: 23.3%
		• Antenatal Steroid - Bolton FT: 57.3% National: 50.6%

		• Antenatal magnesium sulphate - Bolton FT: 96.2% National: 88.3% • DCC (deferred cord clamping) - Bolton FT: 79.1% National: 75.8% • Temperature - Bolton FT: 92.2% National: 77.4% • Breastmilk D2 (feeding in the first 2 days of life) - Bolton FT: 80.6% National: 72.3% • Bloodstream infection - Bolton FT: 2.1% National: 3.1% • BPD (bronchopulmonary dysplasia) or death - Bolton FT: 46.3% National: 40.8% • NEC (necrotising enterocolitis) - Bolton FT: 1.2% National: 5.0% • Brain inj. IVH - Bolton FT: 17.5% National: 13.0% • Brain inj. Cpl - Bolton FT: 12.8% National: 9.2% • Brain inj. PHVD - Bolton FT: 12.8% National: 10.6% • Parent Consultation - Bolton FT: 97.8% National: 91.8% • Parents on Ward Rounds - Bolton FT: 29.3% National: 38.1% • Breastmilk D14 (receiving their mother's own milk on day 14) - Bolton FT: 74.0% National: 81.8% • Breastmilk Disch - Bolton FT: 60.0% National: 70.8% • Follow-up (at two years gestationally corrected age) - Bolton FT: 93.6% National: 68.6% • ROP (retinopathy of prematurity) screening - Bolton FT: 92.6% National: 83.2% • Nurse staffing - Bolton FT: 81.1% National: 84.2% • Respiratory Support (non-invasive) - Bolton FT: 50.0% National: 52.9%
34	Cataract Audit	Eighth Annual Report of the National Cataract Audit, there were no recommendations made within the report. • Number of operations – 1542 • Case ascertainment – 99.7% • % with any ocular co-pathology – 50.5% • Unadjusted PCR rate – 1.43 • Expected PCR rate – 1.53 • Case complexity adjusted PCR rate – 0.65 • % with preoperative VA data – 95.4% • % with postoperative VA data – 79.9% • % with both preoperative and postoperative VA data – 76.9%
35	National Paediatric Diabetes Audit (NPDA)	Two new national reports published, Paediatric diabetes: care and outcomes 2023/2 and Type 2 diabetes – spotlight audit 2023/24 The recommendations are not for NHS Trusts to action.
36	National Perinatal Mortality Review Tool	One outstanding action from the latest Perinatal Mortality Review Tool annual report (October 2025), • Recommendation: "Ensure that PMRT review teams are adequately resourced so that all appropriate staff are able to attend and contribute to PMRT review meetings" • Current compliance: Administration support is required. The funding for the admin post has now been held as part of the financial recovery plan; this applies to all admin posts across the trust. • To be reviewed again by 30/06/2026. Perinatal mortality reviews completed for deaths which occurred since April 2025 - March 2026 • Total perinatal deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: 27 • Number of stillbirths and late fetal losses reported: 16 • Number of neonatal and post-neonatal deaths reported: 11

37	COPD Secondary Care	The Trust is not fully compliant with recommendations 3 and 4 of NRAP's 'Breathing Well' National Report. Target review date is May 2026-
		• R3: All people with asthma and COPD discharged from hospital after an acute event should have a current self-management plan. Where this is not achieved, services should work towards a target of 75% by May 2026. Services should prioritise patient-centred approaches and explore the role of clinically approved digitally supported self-management. In England, integrated care boards should work with providers to ensure that there is adequate resource to support frontline clinicians in the delivery of patient's discharge bundles.
		• Current practice: Education and training on-going with respiratory staff regarding safe management of patients admitted with AE asthma/COPD and promote the use of discharge care bundles
		• R4: All patients requiring pulmonary rehabilitation should have timely access to the intervention, in line with recommendations from NICE and the British Thoracic Society's clinical statement on pulmonary rehabilitation.8 Where that's not achieved, services should work towards a target of 70% of patients starting a PR programme within 90 days of referral, and 70% of patients with acute exacerbation of COPD starting within 30 days of referral, by May 2026. In England, integrated care boards should be resourced to create increased pulmonary rehabilitation capacity.
		• Current practice: see below-
		  • Review of assessment process to increase capacity and implement additional walk test.
		  • Introduction of an opt-in letter for all referred patients prior to placing on waiting list
		  • Review of demand vs capacity

38	Pulmonary Rehabilitation	NRAP opened a pulmonary rehabilitation case ascertainment survey for the period of 2024-25. The survey was completed Trust is currently awaiting feedback from NRAP. Eligible with COPD: 124. Eligible total: 192. Figures from SQL.
39	Adult Asthma Secondary Care	NRAP's State of the Nation Report 'Catching our breath: Time for change in respiratory care" was published in 2025, and a gap analysis was undertaken confirming full compliance with all recommendations. • Recommendation 1: Integrated care boards and local health boards should mandate for all eligible services to participate in NRAP to achieve 100% service participation and a minimum of 50% case ascertainment. • Recommendation 2: The British Thoracic Society, as the expert body, should lead the development of a standardised acute care bundle for patients with asthma and COPD on arrival to hospital. • Recommendation 3: All people with COPD and asthma who smoke, and smokers who are parents of children and young people with asthma, should be offered evidence-based treatment and referral for tobacco dependency.
40	Children and Young People's Asthma Secondary Care	Compliant with all relevant recommendations from the latest Children and YP Asthma Report, updated September 2025. • Recommendation: All people with COPD and asthma who smoke, and smokers who are parents of children and young people with asthma, should be offered evidence-based treatment and referral for tobacco dependency. In England, the Department of Health and Social Care, NHS England and integrated care boards should work together to provide increased resource to all acute, mental health and maternity

		services in England, so that every provider develops and implements a comprehensive inpatient tobacco dependency service. • Most recent benchmarking shows 34.6% carer tobacco dependency addressed (compared to 29.3% previous year). However, we remain below the national average (46 %). • Recommendation: All people with asthma and COPD discharged from hospital after an acute event should have a current self-management plan. Where this is not achieved, services should work towards a target of 75% by May 2026. Services should prioritise patient-centred approaches and explore the role of clinically approved digitally supported self-management. In England, integrated care boards should work with providers to ensure that there is adequate resource to support frontline clinicians in the delivery of patient's discharge bundles. • Update Aug/Sep 25: PAAP now recorded as 69.2% of patients (national average 52.6)
41	National Vascular Registry (NVR)	2025 NVR State of the Nation Report made five recommendations for Integrated Care Boards (ICBs) (working with Trusts), Local Health Boards, Vascular Networks to action. Work will begin to audit against the NICE guidelines within the recommendations
42	Perioperative Quality Improvement Programme (PQIP)	Report 6 was published July 2025. The report included 5 improvement priorities; these are discussed within speciality meeting.
43	Sentinel Stroke National Audit Programme (SSNAP)	Sentinel Stroke National Audit Programme is on the NHS England Quality Accounts List 2025-26. Total submissions between April 2025 - March 2026 for the inpatient dataset: 240 records. Bolton's case ascertainment compared to national average- • B1.1: Average patient-centred case ascertainment: Bolton- 90%+ National-90%+ • B2.1: Case ascertainment for all patients seen by your team with a clock start: Bolton- 90%+ National-90%+ • B3.1: Case ascertainment for all patients seen by your team who were discharged from inpatient care: Bolton- 90%+ National-90%+ • Overall Audit Compliance Score: Bolton 97.2 National 92.8 • Overall Audit Compliance Band: Bolton A National A Band is determined by the following key indicator scores and score assigned – Band A = over 80 A separate Organisational Audit also took place in 2025. The results of the 2025 Organisational SSNAP Audit are below: • Key Indicator 1: Minimum establishment of band 6 and 7 nurses per 10 beds: Achieved if sum of band 6 and 7 (WTE) nurses per 10 stroke unit beds is equal to/above 2.375 per 10 beds for ALL stroke beds [NOT ACHIEVED] • Key Indicator 2: Presence of a clinical psychologist (qualified): Achieved if presence of at least one (WTE) qualified clinical psychologist per 30 stroke unit beds [NOT ACHIEVED] • Key Indicator 3: Out of hours presence of stroke specialist nurse: Achieved if there is out of hours presence of a stroke specialist nurse

		to undertake assessments of suspected stroke patients in ED [ACHIEVED] • Key Indicator 3a: At site treating your patients in first 72hrs [NOT ACHIEVED] • Key Indicator 4: Minimum number of nurses on duty at 10am weekends: Achieved if have 3.0 WTE nurses per 10 type 1 and 3 beds (average number of nurses on duty on type 1 and type 3 beds) [NOT ACHIEVED] • Key Indicator 4a: At site treating your patients in first 72hrs [NOT ACHIEVED] • Key Indicator 5: At least two types of therapy available 7 days a week: Achieved if 7-day working for at least two types of qualified therapy. Includes occupational therapy, physiotherapy and speech and language therapy [NOT ACHIEVED] • Key Indicator 6: Stroke team receives a pre-alert for suspected stroke patients: Achieved if a pre-alert is received for all types of strokes AND the call is made to stroke specialist nurse, stroke consultant on call or stroke junior doctor on call [NOT ACHIEVED] • Key Indicator 6a: At site treating your patients in first 72hrs [NOT ACHIEVED] • Key Indicator 7: Formal survey undertaken seeking patient/carer views on stroke services: Achieved if at least one a year [NOT ACHIEVED] • Key Indicator 8: First line of brain imaging for TIA patients is MRI: Achieved if MRI is first line brain imaging for suspected TIA AND investigations are completed within 2 days for outpatients [NOT ACHIEVED] • Key Indicator 9: Responsibility for governance and quality improvement: Achieved if Executive on the Board, Non-executive on the Board, or Chair of Clinical Governance takes responsibility for the follow-up of stroke audit results AND there is a strategic group with responsibility for stroke [NOT ACHIEVED] The national percentage (out of 145 participating sites showing a total number of key indicators achieved (Max = 9) • 0: 2.1% (3/145) • 1: 9.0% (13/145) – Bolton FT's performance included in this total. • 2: 18.0% (26/145) • 3: 22.8% (33/145) • 4: 20.0% (29/145) • 5: 13.8% (20/145) • 6: 9.7% (14/145) • 7: 3.5% (5/145) • 8: 1.4% (2/145) • 9: 0% (0/145) An internal review found these results were just slightly below the national average and results did not include the Community Stroke Team.
44	Society for Acute Medicine Benchmarking Audit (SAMBA)	The Trust did not participate in SAMBA 25 due to resource issues. SAMBA26 will commence Thursday 18th June 2026.
45	Serious Hazards of Transfusion (SHOT): UK	The Annual SHOT 2024 Report was published in 2025, and a gap analysis completed confirming full compliance with the relevant recommendations. • Recommendation 1: All healthcare organisations should systematically identify gaps in transfusion safety by benchmarking practices against

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<td>National Haemovigilance Scheme</td>
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the SHOT Transfusion Safety Standards, implement targeted corrective measures and actively monitor compliance through structured audits and performance indicators

Recommendation 2: Blood Services must ensure that donors are aware of the importance of reporting all adverse events of donation, especially those that occur after the donor has left the donation session - not applicable to the Trust.
Recommendation 3: All United Kingdom (UK) Blood Services should continue to work collaboratively to ensure best practice in the prevention and management of donor complications is developed and shared. Measures such as the development of standard questions for donor adverse event follow up and guidance documents will facilitate harmonisation of practices - not applicable to the Trust.
Recommendation 4: Hospital Trusts/Health Boards must improve all areas relating to the quality and safety of blood and blood component storage and the investigation of such storage errors
Recommendation 5: All reporters must continue to thoroughly investigate all SAE, even those with no actual harm to patients. It is through thorough investigations that improvements can be identified to reduce risks to the quality and safety of blood and blood components and reduce the risk of harm to patients
Recommendation 6: When investigating an incident, reporters must have taken care to ensure that process, procedural or system-based errors or problems have not been overlooked. For example, if distractions have been identified then these distractions must be addressed in the CAPA to avoid reoccurrence
Recommendation 7: CAPA must correct the error made and not just rely of making error checking more robust
Recommendation 8: Engagement from staff in clinical areas must be improved. It is the responsibility of the Trust to ensure all SAE are investigated and reported in a timely manner as per the requirements of the BSQR
Recommendation 9: Reporters are reminded to report ‘as soon as known’. You are required only to submit a confirmation report with RC and ‘proposed’ CAPA. Changes to CAPA following review can be added to SABRE reports as footnotes

SHOT provides benchmarking data - not individual organisational data. The 2025 data will be available in November 2026. The latest available participation benchmarking SHOT data is from 2024, is below:
<table>
<tr><th></th><th>Serious Adverse Reaction</th><th>Serious Adverse Event</th><th>Near Miss WBIT</th><th>Near Miss Other</th><th>Anti-D</th><th>Withdrawn Reports</th><th>Other Reports (Cell Salvage / TTI)</th><th>Anti-D Immunisation Reports</th><th>Total Reports</th></tr>
<tr><td>2024 No. of Reports</td><td>0</td><td>8</td><td>7</td><td>1</td><td>3</td><td>2</td><td>0</td><td>0</td><td>21</td></tr>
<tr><td>Increase/Decrease from 2023</td><td>-7</td><td>-12</td><td>+3</td><td>0</td><td>-4</td><td>0</td><td>0</td><td>-1</td><td>-21</td></tr>
<tr><td>Area Average</td><td>3.42</td><td>7.54</td><td>4.08</td><td>1.83</td><td>1.46</td><td>2.75</td><td>0.04</td><td>0.17</td><td>21.29</td></tr>
<tr><td>Low Usage Cluster Average</td><td>1.98</td><td>4.37</td><td>2.29</td><td>1.12</td><td>1.17</td><td>3.13</td><td>0.02</td><td>0.19</td><td>14.31</td></tr>
<tr><td>2024 Reports per 1000 components</td><td>0.00</td><td>1.71</td><td>1.49</td><td>0.21</td><td>0.24</td><td>0.43</td><td>0.00</td><td></td><td>4.48</td></tr>
<tr><td>Increase/Decrease from 2023</td><td>-1.50</td><td>-2.57</td><td>+0.64</td><td>0.00</td><td>-0.29</td><td>0.00</td><td>0.00</td><td></td><td>-4.51</td></tr>
<tr><td>Area Average</td><td>0.27</td><td>0.98</td><td>0.65</td><td>0.18</td><td>0.11</td><td>0.41</td><td>0.08</td><td></td><td>2.96</td></tr>
<tr><td>Low Usage Cluster Average</td><td>0.49</td><td>0.99</td><td>0.50</td><td>0.27</td><td>0.19</td><td>0.71</td><td>0.00</td><td></td><td>3.26</td></tr>
</table>
</td>
</tr>
<tr>
<td>46</td>
<td>NCABT: Major Haemorrhage Audit</td>
<td>Bolton NHS Foundation Trust contributed 30 cases to the management of major haemorrhage audit - 100% of the sample size required.
Awaiting publication and subsequent recommendations</td>
</tr>
</table>

Local Clinical Audits

210 Local clinical audits were registered and reviewed by the provider in 2025/26 and Bolton NHS Foundation. The breakdown is as follows:

Audit Driver	n
Clinical Interest	24
Clinical Outcome / NCEPOD	2
CNST	10
Complaint	1
CQC	4
Existing Reporting Systems	1
External Audit	3
Incident (Divisional Review)	4
Incident (SI Review)	6
Local Standard	30
Monitoring	13
National Regulations	41
NICE Clinical Guidelines (CG)	3
NICE Guidance (NG)	25
NICE Quality Standards (QS)	1
Patient Satisfaction	2
Quality Account Requirement	10
Record Keeping/Documentation/L	2
Royal College	17
Trust Policy	5
Trust SOP	6
Grand Total	**210**

Local Clinical Audits, examples of learning and actions to improve

Below are some examples of the Trusts completed Local Audits which have taken place throughout the year with identified learning and actions.

Project Name	Actions
Readmission following Gynaecology procedure	This retrospective annual audit reviewed all gynaecology surgical readmissions (excluding early pregnancy) within 30 days between January–December 2024. Out of 3,731 total procedures, 49 cases were initially identified; after exclusions, 33 were analysed. Recommendations: • Refine classification criteria for readmission vs reattendance. • Work with BI and IT teams to improve EPR data capture, including antibiotic documentation. • Standardise operative notes for consistency and auditability. • Explore learning from other trusts with lower readmission rates. • Consider prophylactic antibiotics in patients with multiple infection risk factors.
Audit all admissions to the NNU of babies equal to or greater than 37 weeks	1. 73% of babies were admitted to NNU for RDS, 59% of these babies had a length of stay less than 48 hours on NNU. 2. 62% of caesarean section babies that were admitted to NNU had a length of stay less than 2 days. 356 babies were reviewed in ATAIN, 2 were found to be avoidable admissions to NNU, due to human factors when making clinical

	decisions. Actions to be agreed by Maternity and Neonatal Leads. • Audit babies admitted to NNU for RDS, with a LOS <48 hours, to review themes that could reduce these admissions.30.09.2025 • QI project in secondary drivers in relation to management of elective C/S, working collaboratively with ELCS team.31.12.2025 • Ensure staff NLS training across Family Care Division is compliant. 31.08.2025
Are radiographers' complaint in using Pre exposing chest markers?	Slight improvement from previous audit • Further training required to all the newly qualified radiographers and students, conduct CPD sessions to raise awareness of the importance of using pre-exposure anatomical markers • By training students, qualified radiographers can lead by example to always use markers where appropriate and teach them in their use • Re-audit annually to check the compliance. • Ensure all radiographers have their own markers and are training students in the same way. • Make notes/comments on CRIS while post processing as to why pre-exposing markers weren't used. • Random compliance checks through the day. • If markers visible in scatters, open collimators to include them.
Bowel Cancer Screening Program (BCSP) & CT Colonography (CTC) Annual Audit	Results: Cancer Detection and Outcome • 2 cancers detected based on histology: • C5a – T2/T3 N0 M0 early stage and patient had sigmoid resection. • C5b – T3 No M0 staging and patient had a sigmoid colectomy with no further spread. Results: Accuracy Polyps and Cancers • False positive: 1 (one unnecessary endoscopy (>80% Min std. Aspirational >90%) • False negative >5mm: unknown Results: Positive Predictive Value (PPV) • Definition: proportion of patients with polyps on CTC and subsequent polyp =4mm confirmed on endoscopy, surgery or imaging FU (regardless of segmental location) • 3/12 patients excluded due to no FU: • 2-No reason seen for why follow-up not performed • 1 for surveillance • PPV= 100% (>80% Min std. Aspirational >90%) Action Planning: • Standard: Percentage of scans rated with diagnostic quality of adequate or better • Segmental inadequacy has been added to the reporting template from start of 2024. • There has been an increase in the number triple positions performed when poor distension on dual position.
Improving NIV monitoring, prescription and documentation on the respiratory wards	• Out of the 53/66 who survived the admission, 8 patients died within 2 months post D/C. • Average mortality days after discharge: 31.625 days. • Proposed interventions to improve NIV monitoring, prescription and documentation on the respiratory wards: • Sharing posters of (BTS/ICS Guidelines for ventilatory management

	of AHRF in adults) in the respiratory wards amongst the medical and nursing staff. • Sending periodic emails to the medical staff highlighting the importance of NIV monitoring, prescription and documentation on patients' care and experience. • Teachings on NIV standard guidelines
Compliance with hyperkalaemia management in Acute Medicine	Recommendations: Update Hyperkalaemia guidance • Amend rate of administration of 10% Calcium Gluconate (30ml over 10 minutes IV) in line with the UKKA Hyperkalaemia guideline (2014), recent MHRA guidance and updated product information. • Suggest repeat ECG is done if there are ECG changes • Amend scope for the use of the novel oral K+ -binders (Sodium Zirconium Cyclosilicate and Patiromer) to include patients with moderate hyperkalaemia pending further evidence in the acute setting. • Patients to receive lokelma instead of insulin/dextrose infusions - avoiding harms associated with insulin dextrose. • Removal of Calcium Resonium in the treatment protocol for acute hyperkalaemia. • Amended blood glucose monitoring schedule to 6 hours (30, 60, 90, 120, 180, 240, 300, 360 minutes) post Insulin-Glucose treatment. • Ensure BMs are being monitored corrective. • Clarify for severe hyperkalaemia, a serum potassium should be done within 2 hours
NEWS scoring in Older Adults	A significant proportion of older adults who died in hospital had a last recorded NEWS 2 score that was deemed 'low clinical risk' and was more notable in patients who had a documented 'non-respiratory' cause of death than a 'respiratory' cause of death. This study highlights that low NEWS 2 scores are not necessarily reassuring in an older hospital population and would suggest that these scoring systems should not be solely relied upon to exclude deterioration, and the broader clinical picture remains crucial when making decisions regarding both escalation of care and advance care planning
Proper documentation of oxygen saturation during weaning periods on complex care ward	Key findings: Good practice: • Consistent documentation of oxygen saturation on Patient Track • Clear entries in shift evaluations and medical ward round notes Identified gaps: • Documentation of weaning intervals was often incomplete • 33% of patient records reflected accurate weaning period documentation Action taken: Staff education on documentation standards.
Consent Form 4	Training needs analysis regarding surgical procedures and consent, regarding the Mental Capacity Act for doctors at all levels, regardless of the surgical procedure. Actions • Determine the type of training required if identified from the TNA • Discussions regarding the present Consent Form 4, mental capacity assessment and best interest decision process on EPR and how to move forward, ensuring that as a Trust we are legally binding, ensuring we meet all five principles of the MCA.

Percentage of patients within Therapeutic Range (TIR)	To improve TIR outcomes, staff are advised to: • Increase frequency of monitoring for patients with higher or fluctuating INR ranges, as required. • Escalate concerns promptly to the clinical lead when INR stabilisation proves challenging. • Consistently reinforce patient education at each interaction, particularly for identified high-risk groups.
WHO Checklist – compliance of documenting local anaesthetic used within breast intervention	Improve layout of WHO safety checklist: • to prompt clinician to complete type and quantity of anaesthetic through tick box list of anaesthetic to simplify completion of checklist • adding highlighted prompt to ask and complete relevant allergies • adding a tick box of anaesthetic to be used and separate space for completion of anaesthetic batched number • adding highlighted prompt to complete anaesthetic expiry date.

Learning from Deaths
During, 2025/2026, a total of 1181 patients died in hospital. This comprises the following number of deaths which occurred in each quarter of that reporting period:

- 261 in Q1.
- 270 in Q2.
- 321 in Q3.
- 329 in Q4.

In 2025/26, 156 structured judgement case reviews and 48 cardiac arrest root cause analysis investigations have been carried out in relation to 1181 of the deaths included above.

Out of 156 structured judgement cases recorded, in 2 cases a death was subjected to both a case record review and a PSIRF investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 80 Case record reviews in Q1; Investigations = 1
- 50 Case record reviews in Q2; Investigations = 1
- 19 Case record reviews in Q3; Investigations = 0
- 7 Case records reviews in Q4; Investigations = 0

2 avoidable cardiac arrests audited during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been estimated using the data provided within the cardiac arrest root cause analysis reports and learning from deaths process.

Participation in Clinical Research
44 National Institute for Health Research (NIHR) Portfolio Research studies with Health Research Authority (HRA) / Research Ethics approval, were open to recruitment at Bolton NHS Foundation Trust in 2025/26. 6061 patients receiving relevant health services provided or sub-contracted by Bolton NHS Foundation Trust were recruited to participate in research during that period.

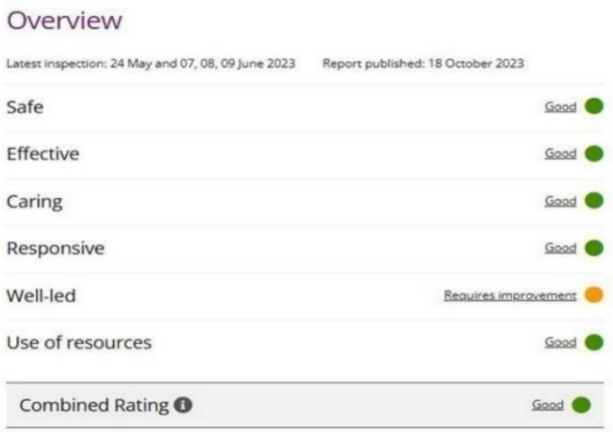
Goals agreed with Commissioners: use of the CQUIN payment framework
A proportion of Bolton NHS Foundation Trust's income in 2025/26 was not conditional on achieving quality improvement and innovation goals agreed between Bolton NHS Foundation Trust and any person or body they entered a contract, agreement or arrangement with for

the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. The mandatory CQUIN scheme has been paused.

Care Quality Commission Registration

Bolton NHS Foundation Trust is required to register with the Care Quality Commission, and its current registration status is "registered without conditions". The Care Quality Commission has not taken enforcement action against the Bolton NHS Foundation Trust during 2025/26. Bolton NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Bolton NHS Foundation Trust was last inspected by CQC on 24 May 2023 and 07, 08, 09 June 2023 and reported in October 2023 and achieved an overall rating of Good. The report included 28 recommendations to further improve the services provided by the Trust. All recommendations have been enacted.



Data Quality

Bolton NHS Foundation Trust submitted records during 2025/26, to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- **which included the patient's valid NHS number was:**
  - 99.9% for admitted patient care.
  - 99.9% for outpatient care; and
  - 99.7% for accident and emergency care

- **which included the patient's valid General Medical Practice Code was:**
  - 94.5% for admitted patient care.
  - 99.6% for outpatient care; and
  - 99.1% for accident and emergency care.

Action to Improve Data Quality

Bolton NHS Foundation Trust will be taking the following actions to improve data quality:

- Regular routine reporting via Executive performance meetings now includes a range of Data Quality Metrics
- There are several groups across the Trust which focus on Data Quality, including clinical data recording, specialist groups such as recording for Urgent and Emergency Care, and a general Trust wide Counting and Recording group which is operationally led and is supported by divisional groups, with a shared workplan.
- The Data Quality team continues to be proactive in promoting the importance of good quality data and the Clinical Coding team are now attending junior doctor induction to promote overall data quality and clinical data quality specifically.
- There is a wide range of management information available across key metrics including an overall data quality dashboard, to help identify areas of focus.
- Anomalies and issues are picked up as they arise, and users are made aware of errors to prevent further errors occurring.
- Data Quality training modules are available, focusing on RTT recording and one aimed at clinicians and focusing on the importance of good quality clinical data within the Electronic Patient Record.

- All training manuals for the Trust Patient Administration continue to be reviewed and updated as and when necessary
- RTT reports continue to be developed to support RTT validation, and the validation team are proactive in identifying themes for further education.
- Events such as Know your Patient continue to be run, which is a Trust wide 1 week education event.
- Face to face training and education to various targeted staff groups continues to be delivered to ensure the accuracy of data.

Information Governance
The Data Security and Protection toolkit which is mandated for all Trusts and measures organisations against the National Data Guardian measure. The Trust can evidence compliance against all mandated standards.

Clinical Coding Audit
Bolton NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2025/26 by the Audit Commission.

Seven-day Services
The Seven Day Hospital Services (7DS) Clinical Standards were developed to support providers of acute services to deliver high quality care and improve outcomes across all seven days for patients admitted to hospital in an emergency. Providers have worked to achieve all the four priorities identified in 2015, developed with the support of the Academy of Medical Royal Colleges. The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week. The importance of ensuring that patients receive the same level of high-quality care every day is reflected in the inclusion of these standards in the NHS Standard Contract as delivery of the 7DS clinical standards should also support better patient flow through acute hospitals. The revised standards were issued in February 2022, but the national programme around this including national data collection and comparison has been terminated. However, this remains a focus for Bolton NHS FT and throughout 24/26 we prioritised Standard 2 - Time to first Consultant review and Standard 8 - ongoing review by consultant.

A re-audit was undertaken in April 2026 which demonstrated for the associated standards: Standard 2 (review within 14 hours of admission): 18 out of 20 patients (90%) were seen by a consultant within 14 hours, representing a marked improvement compared to the previous two years. The remaining two patients were reviewed just one hour beyond the target timeframe.

Standard 8 (once or twice daily review): Of the 18 applicable patients, 15 (83%) had documentation of a once-daily review in their notes, and 1 patient had evidence of twice-daily reviews. One patient had no documentation available, and a further 2 patients were discharged. This is an increase on previous years.

The utilisation of the Board Assurance Framework to assess performance against these four priority 7DS continues to align the clinical standards on an annual basis. This audit and oversight of required improvement actions will continue throughout 2026.

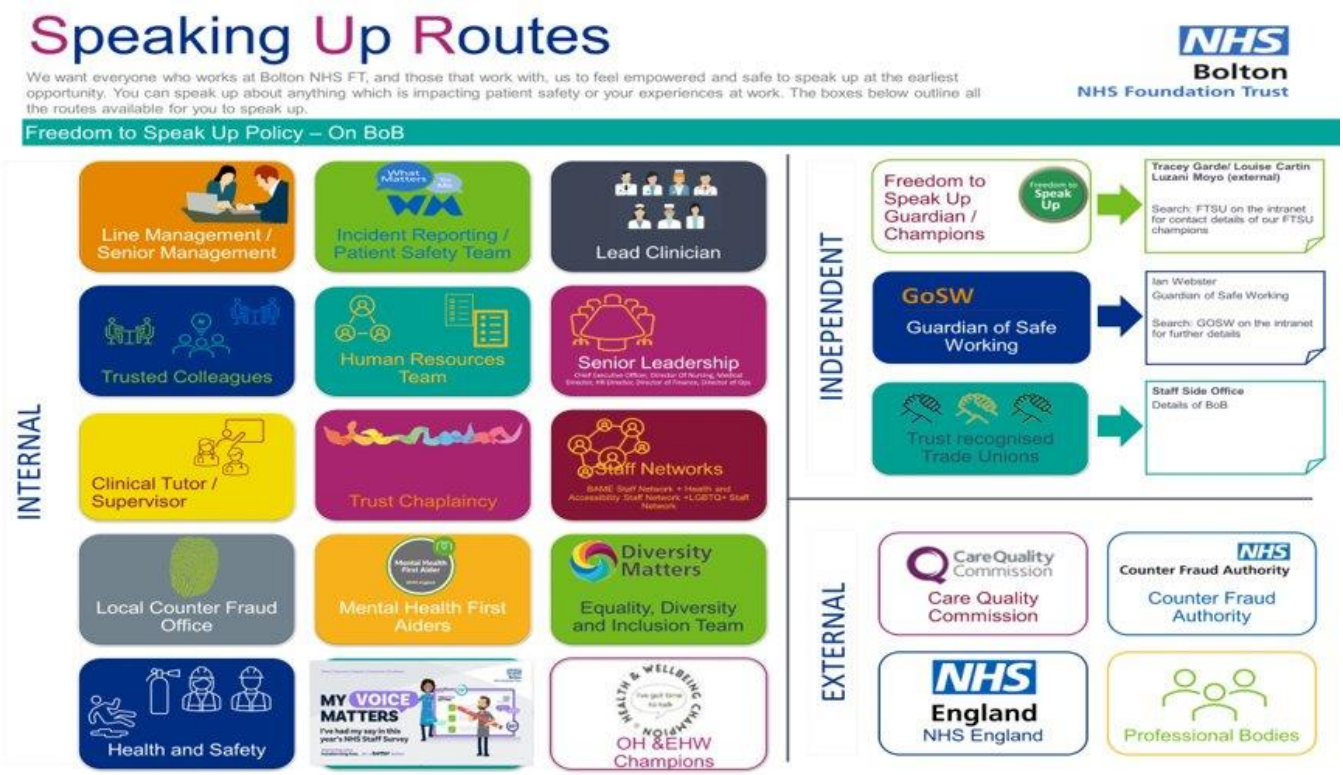
Raising Concerns
Freedom to Speak Up (FTSU) is about feeling able to speak up about anything that gets in the way of doing a great job. In healthcare that could be a concern about patient safety, a worry about behaviours or attitudes at work, or an idea which could improve processes or

make things better.

Speaking up may take many forms, including a discussion with a line manager, an idea for improvement submitted as part of a suggestion scheme, raising an issue with a Freedom to Speak Up Guardian, or bringing a matter to the attention of a regulator. If a healthcare worker thinks something might go wrong, it is important that they feel able to speak up so potential harm may be prevented. When things are good but could be better, workers should feel able to say something and expect their suggestions to be listened to and used as an opportunity for improvement.

Freedom to Speak Up Guardians provide an additional route to support workers to speak up. They work to ensure those who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken. They also work proactively to support the organisation to tackle barriers to speaking up. Freedom to Speak Up Guardians live the Guardian values of courage, impartiality, empathy and learning.

In Bolton we positively encourage workers to speak up and promote all the different available avenues to do so. It is up to the individual worker or team to decide which is best for them (see below).



We have tried to make speaking up anonymously much easier by the introduction of a QR code which staff can access using their smart phones. We are also encouraging senior managers to identify specific learning from speak up concerns raised.

The FTSU Guardians have developed a thriving Network of FTSU Champions from a diverse group of backgrounds and roles. There is a clear distinction between the roles of the FTSU Champion and the FTSU Guardian. Only FTSU Guardians, having received annual NGO training and registered on the NGO's public directory, should handle speaking up cases. This ensures quality and consistency in how workers are supported when speaking up.

FTSU Champions, however, have a vital role in:

- Awareness raising – Ensuring workers understand the importance of speaking up,

listening up and following up. Being visible and promoting speaking up and being a positive role model
- Signposting – Discussing concerns with workers and providing details of speaking up routes as stated in the organization's FTSU Policy.
- Promoting a positive speaking up culture- Supporting the organisation to welcome and celebrate speaking up.

The FTSU Guardians continue to meet with the Chief Executive, the Deputy Chief Executive/ Director of People and the Non-Executive Lead for FTSU monthly. An overview of the cases raised, actions that have been taken and themes identified are shared, whilst ensuring that all workers remain completely anonymous. The aim of these meetings is to allow the Chief Executive and Director of People to ensure that policies and procedures are being effectively implemented, help unblock any barriers that enable swift action to be taken to resolve cases and ensure that good practice and learning is shared across the organisation. The NED provides an avenue of support to the Guardians and ensures a positive challenge for the executives.

The Guardians meet monthly with the Head of Human Resources (HR) to discuss any themes that arise from the concerns specifically raised relating to HR policies or processes. The Guardians continue to meet with the leads for each division monthly to discuss cases in more detail and allow them to be followed up locally. The Guardians also attend the monthly Divisional People Committee meetings and present reports quarterly to the Divisional teams as well as to the Trust People Committee. The Guardians also present an Annual Report to the Board.

In 2025/26 198 concerns were raised via the FTSU route- this is an increase from the previous year when 161 concerns were raised. Main themes are in line with national trends – Inappropriate behaviours and worker safety and well-being. The Our Leaders Programme and the Our Way Tool and behaviour Framework have been developed to improve worker experience.

Guardian of Safeworking

The safety of our patients is the Trust's key priority, and it is widely acknowledged that staff fatigue is a hazard to both patients and the staff themselves. As such, there are safeguards in place for staff to ensure that working hours and rest periods are regulated and that these are adhered to. The Trust has appointed a Guardian of Safeworking to ensure that the Trust has an open and safe place for trainees to discuss, review and manage working conditions. These conditions are statutory as per the BMA guidance and working time directive and overseen by a BMA representative quarterly.

The conditions have also been widened to encompass a more holistic, wellbeing element to ensure our trainees get the best training experience they can from the Trust 39 Deviations from the working conditions are reported via DRS4 system, reviewed daily, and responded to. Such deviations reflect issues including missed educational opportunities, working outside contracted hours and intensity of work. Explanations for the exemptions reflect issues such as unpredictable sickness, short notice leave and rota gaps. The exemptions are collated into quarterly reports by medical education and GOSW and presented to the Trust quarterly and then an annual summary is prepared and presented to the Trust Board.

The 10 Point Plan to improve Resident Doctors' working lives is designed to address the fundamental factors that shape their professional experience, wellbeing, and capacity to deliver safe and effective patient care.

The plan provides a structured and targeted approach to improving working conditions, access to rest and facilities, educational supervision, flexible working opportunities, and

engagement with leadership. By addressing systemic challenges relating to workload, culture, and support, the plan seeks to enhance morale, retention, and productivity, while supporting a sustainable, inclusive, and high-quality clinical workforce that underpins patient safety and service excellence.

We have appointed a resident doctor peer lead to implement the delivery of the Resident Doctor 10 Point Plan, alongside the organisational support from the Medical Director and an appointed Non-Executive Director and continue to work through the delivery plan and the assurances Resident Doctor Board Assurance Framework

Reporting against core indicators – *latest published data to 29/04/26*

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by NHS Digital. An overview of the indicators is provided in the table. It is important to note that whilst these indicators must be included in the Quality Report the most recent national data available for the reporting period is not always for the most recent financial year. Where this is the case, the period used is noted underneath the indicator description. It is also not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

Indicator	2025/26	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2024/25	2023/24
Mortality: The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for (12/24 – 11/25) latest published data available	SHMI Value = 109.11 (12/24 – 11/25) Band 2 (as expected)	SHMI value = 100	SHMI Value = 71.94 (12/24 – 11/25) Band 3 (lower than expected) Imperial College Healthcare NHS Trust	SHMI Value = 131.83 (12/24 – 11/25) Band 1 (higher than expected) Blackpool Teaching Hospital NHS Foundation Trust	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from NHS Digital (NHSD) Bolton NHS Foundation Trust has taken the following actions to improve this indicator and to ensure the quality of its services by: • Monthly Mortality Reduction Group meetings to scrutinise the quality of care against the mortality metrics • Structured judgement review on patients who died, feeding into the learning from deaths process • Review of recording process across the trust	SHMI Value = 117.61 (01/24 – 12/24) Band 1 Higher than expected	SHMI Value = 107.64 (12/22-11/23) Band 2 (As expected)
The percentage patients' deaths with palliative care coded at either diagnosis or specialty level for the period (12/24 – 11/25) Latest published data	36%	44%	69% Hampshire Hospitals NHS Foundation Trust	17% Sherwood Forest Hospitals NHS Foundation Trust	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from NHS Digital (NHSD) Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • The Clinical Coding team receive weekly information on any patients who have had a palliative care or contact with the palliative care team, so that this can be reflected in the clinical coding	38%	37% (12/22 – 11/23)

Indicator	2025/26	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2024/25	2023/24
Patient reported outcome scores for hip replacement surgery (April 23 to March 24) latest data available	78.5%	78%	81.7% (24/25) Winfield hospital	52.5% (24/25) Blackpool Teaching Trust	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: Although some PROMS data was submitted for hip replacement and knee replacement – there were insufficient records to deem statistically viable and calculate any adjusted health gains, therefore not published nationally. However, national clinical audit section outlines findings from the records submitted, with actions to address	72.3% (2023/24)	67% April 22 to March 23 Measure EQ-5D Index
Patient reported outcome scores for knee replacement surgery April 23 to March 24 latest data available	72.1% (24/25)	74.0% (24/25)	91.0% (24/25) Winfield hospital	69.4% (24/25) Blackpool Teaching Trust		64.3% (2023/24)	76% April 22 to March 23 Measure EQ-5D Index
28-day readmission rate for patients aged 0 – 15 *	*The latest available published national data for 28-day readmission rate provided for these measures is for 2011/12. Local data for Bolton NHS Foundation Trust readmission rate is 10.5% for discharges in February 2026 *(based on Payment by Results national guidance, exclusions apply)*						
28-day readmission rate for patients aged 16 or over *							
The percentage of admitted patients' risk-assessed for Venous Thromboembolism	96.87 (04/25 to 03/26)	National submission paused since pandemic, therefore no comparative data available			Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from the Health & Social Care Information Centre (HSCIC) Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • VTE Nurse Champion • Nurse-led DVT Clinic • VTE database • Staff Awareness • RCA of patients developing clots for continuous learning and improvement	94.00 (04/24 to 03/25)	98.22 04/23 to 03/24

Indicator	2025/26	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2024/25	2023/24
Rate of C. difficile per 100,000 bed days (healthcare associated cases amongst patients 2 of over). Rate published by UK Health Security Agency (UKHSA), Source UKHSA healthcare associated infection (HCAI) Data Capture System (DCS) Mandatory Surveillance	38.36	25.57	Croydon Health Services NHS Trust (10.39)	Wirral University Teaching Hospital NHS Foundation Trust (52.72)	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: There has been a 30% reduction in cases year to year. Bolton NHS Foundation Trust has taken the following actions to continue improvements in this indicator and so the quality of its services by: • Continuation of an annual deep cleaning programme with high CDT incidence wards prioritised. • Embedding the safety checklists as part of the CDT QI Collaborative • Embedding the actions from the MIAA audit of CDT management • Increase use of antibiotics with a lower risk of C. difficile infection 50% of all antibiotics prescribed to 60% • Reduce IV-to-oral antimicrobial use by 10% • Evaluating how to create a hard stop in EPMA for IV antibiotics and review prescribing practice • Improve diagnostics to guide antibiotic use	55.36	52.94
Number/ Rate of patient safety incidents per 1000 bed days latest data available (NRLS)	The annual publishing of this data is paused while future publications are considered in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS. Most up to date data is April 2021/Mar 22				Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from the National Reporting and Learning System (NRLS) There is no patient safety data for 22/23 as the publishing of the annual data has been paused while it is considered how future publications are brought in line with the introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS. Bolton NHS Foundation Trust Risk & Assurance team have undertaken: • Implementation of new national Learning from Patient Safety Events Service, replacing NRLS • Implementation of new national Patient Safety Incident Response Framework (PSIRF)	Most up to date data is April 2021/Mar 22 61.5 per 1,000 bed days N = 12,420 Apr/21 to Mar/22	
Number of above patient safety incidents that resulted in severe harm or death latest data available (NRLS)	The annual publishing of this data is paused while future publications are considered in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS. Most up to date data is April 2021/Mar 22					Most up to date data is April 2021/Mar 22 N = 33 10 deaths 23 Severe harms Apr/21 to Mar/22	

Indicator	2025/26	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2024/25	2023/24
Inpatient Friends and Family Test (Feb/26)	96% (Feb/26)	95% (Feb/26)	100% (Feb/26) 10 Trusts gained 100	71% (Feb/26)) THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from the Health and Social Care Information Centre (HSCIC) Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • Increased use of Friends and Family Test – available in a variety of formats • Communicating the process to the public Implementation of the 'you said' we did' process for feedback	95% (Jan-25)	97.08% (Feb-24)
Accident and Emergency Friends and Family Test (Feb/26)	81% (Feb/26)	79% (Feb/26)	100% (Feb26) SOUTH WESTERN AMBULANCE SERVICE NHS FOUNDATION TRUST	60% (Feb26) BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST		86% (Jan-25)	

Vision | Openness | Integrity | Compassion | Excellence

NHS
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NHS Foundation Trust

PART 3

Performance against Trust selected metrics

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

Performance against Trust selected metrics – 2025/26

This section of the report gives an overview of care quality across a range of indicators covering patient safety, clinical effectiveness and patient experience. We have chosen to use the same indicators as used in previous years

	Indicator/Measure	2025/26		2024/25		2023/24
Patient Safety Outcomes	Mortality - SHMI	See page 49				
	C.*Diff* – number of cases	See page 51				
	Pressure ulcers by category: • Cat 2 • Cat 3 (category 3 plus unstageables) • Cat 4 *Data source – Bolton NHS Foundation Trust's incident reporting system*	Hospital 136 48 0	Community 135 82 12	Hospital 186 35 0	Community 112 99 5	256 3 7
Patient Experience	Friends and Family Test inpatients • Response rates • Recommendation rates *Data source – captured locally, submitted nationally, and published by NHS England*	18.63% 96.39% (Mar 26)		20% 97% (Mar 25)		28.2% 96.7% (Mar 24)
	Lessons Learnt	See below				
Effectiveness	Sickness rates *Data source – captured via local attendance management system (E-roster and ESR), submitted nationally, and published by NHS Digital*	5.77% (Mar 2026)		4.6% (Mar 2025)		5.2% (Mar 24)
	Appraisal rates *Data source – captured via local ESR and reported locally for Board report*	79.4% (Mar 2026)		85.3% (Mar 2025)		83.6% (Mar 24)
	Mandatory Training compliance *Data source – captured via local training and development system (Moodle and ESR)*	89.6% (Mar 2026)		91.4% (Mar 2025)		90.3% (Mar 24)

The above data is reflective of 2025/26 performance; national comparable benchmarking data for the same period was not available at time of Quality Account publication. Where applicable/available the above indicators are governed by national standard definitions.

Lessons Learnt:

The Trust has over the course of 2025/26 used a variety of methods to ensure that learning is captured, shared, and embedded in a timely manner.

Capture: Incidents, complaints, claims, audits, and Inquests provide us with the opportunity to reflect when our practice could have been better, the Governance Team are central to

ensuring that the intelligence gleaned from such events is accurate and focused on learning.

Shared: The Trust ensures that lessons learnt are shared with appropriate audiences across the organisation in formats that are engaging, helpful and easy to appreciate. The key example of this is the use of SBARS (Situation, Background, Recommendations, Situation) a single slide, covering an important topic that will improve patient safety

Embedded: SBARS, once published, are monitored in terms of demonstrating embeddedness via a measure in BoSCA (our in-house ward and departmental accreditation scheme) which ensures that staff in clinical settings have been made aware of the SBAR. Furthermore, the Governance Team meets divisions to discuss progress with the completion of actions associated with complaints and incidents on a regular basis, reporting if necessary to the Clinical Governance & Quality Committee.

Performance against the relevant indicators and performance thresholds (Risk Assessment Framework and Single Oversight Framework) 2025/26

Indicator for disclosure (limited to those that were included in both RAF and SOF for 2016/17)	**Apr 25-Mar 26**	**Target**	**Achieved**	**Apr 24-Mar 25**	**Apr 23-Mar 24**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway (as at 31/03/2026) **	62.13 %	92%	X	55.42%	48.9%
A&E: Maximum waiting time of four from arrival to admission, transfer, or discharge (average for the year)	64.51%	95%	X	64.5%	61.24%
All cancers: 62-day wait for first treatment from:					
• Urgent GP referral for suspected cancer (04/25 – 03/26)	78.92%	85%	X	82.66%	80.23%
• NHS Cancer Screening Service referral (04/25 – 03/26)	85.69%	90%	X	88.99%	84.73%
Clostridium difficile - meeting the C. difficile objective *National data is published in September each year. Therefore, latest available published data is 2024/25*	85 (2024/25)	N/A	N/A	85 (2024/25)	88 (2023/24)
Summary Hospital-level Mortality Indicator included in "**Reporting against core indicators" section**					
Maximum 6 weeks wait for diagnostic procedures *Definition – proportion of patients referred for diagnostic tests who have been waiting less than 6 weeks* (as at 31/03/2026)	97.4%	99%	X	95.05%	89.6%
Venous thromboembolism (VTE) risk assessment included in "**Reporting against core indicators section" page 50**					

Vision | Openness | Integrity | Compassion | Excellence

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