NHS Bolton NHS Foundation Trust

# BOARD OF DIRECTORS' AGENDA

## *MEETING HELD IN PUBLIC*

**To be held at 1pm on Thursday 30 July 2026**
**In the Boardroom, Royal Bolton Hospital, Minerva Road**

| Ref No. | Agenda Item | Process | Lead | Time |
|---|---|---|---|---|
| **PRELIMINARY BUSINESS** | | | | |
| TB06726 | **Chair's welcome and note of apologies**<br>***Purpose:*** *To record apologies for absence and confirm the meeting is quorate.* | *Verbal* | Chair | |
| TB068/26 | **Patient and Staff Story**<br>***Purpose:*** *To **receive** the patient and staff story* | *Presentation* | Chair | |
| TB069/26 | **Declaration of Interests concerning agenda items**<br>***Purpose:*** *To record any interests relating to agenda items* | *Verbal* | Chair | **13:00** (20 mins) |
| TB070/26 | **Minutes of the previous meeting held on 26 March 2026**<br>***Purpose:*** *To **approve** the minutes of the previous meetings.* | *Report* | Chair | |
| TB071/26 | **Matters Arising and Action Logs**<br>***Purpose:*** *To consider matters arising not included on the agenda, review outstanding and approve completed actions.* | *Report* | Chair | |
| **WELL LED FRAMEWORK** | | | | |
| TB072/26 | **Chair's Update**<br>***Purpose:*** *To **receive** the Chair's Update* | *Verbal* | *Chair* | **13:20** (05 mins) |
| TB073/26 | **Chief Executive's Report**<br>***Purpose:*** *To **receive** the Chief Executive's Report.* | *Report* | *CEO* | **13:25** (05 mins) |
| TB074/26 | **Board Assurance Framework**<br>***Purpose:*** *To **approve** the Board Assurance Framework.* | *Report* | *DCG* | **13:30** (10 mins) |
| **AN ORGANISATION THAT'S FIT FOR THE FUTURE** | | | | |
| TB075/26 | **Sustainability Board AAA Report**<br>***a)*** **Integrated Performance Report** | *Report* | *CEO + Exec Directors* | **13:40** (30 mins) |

***Purpose:*** *To* ***receive*** *the Sustainability Board AAA and Integrated Performance Reports.*

| | | | | |
|---|---|---|---|---|
| | **COMFORT BREAK (10 mins)** | | | **14:10** |
| | **IMPROVING CARE, TRANSFORMING LIVES** | | | |
| **TB076/26** | **Quality Assurance Committee Chair's Report**<br>***Purpose:*** *To* ***receive*** *assurance on the work delegated to the Committee.* | *Report* | *QAC Chair* | **14:20** (05 mins) |
| **TB077/26** | **Maternity Review: Post-Death Care and Fuller Inquiry Board Assurance Statement**<br>***Purpose:*** *To* ***approve*** *the Maternity Review: Post-Death Care and Fuller Inquiry Board Assurance Statement.* | *Report* | *CNO* | **14:25** (10 mins) |
| **TB078/26** | **Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Report**<br>***Purpose:*** *To* ***receive*** *the CNST Maternity Incentive Scheme Report.* | *Report* | *CNO + Director of Midwifery* | **14:35** (05 mins) |
| | **A GREAT PLACE TO WORK** | | | |
| **TB079/26** | **People Committee Chair's Report**<br>***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.* | *Report* | *PC Chair* | **14:40** (05 mins) |
| **TB080/26** | **Freedom to Speak Up Annual Report**<br>***Purpose:*** *To* ***receive*** *the Freedom to Speak Up Annual Report.* | *Report* | *CPO* | **14:45** (10 mins) |
| **TB081/26** | **Leadership Development Programme**<br>***Purpose:*** *To* ***receive*** *the Leadership Development Programme Update.* | *Report* | *CPO* | **14:55** (10 mins) |
| | **A HIGH PERFORMING PRODUCTIVE ORGANISATION** | | | |
| **TB082/26** | **Finance and Investment Committee Chair's Report**<br>***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.* | *Report* | *F&I Chair* | **15:05** (10 mins) |
| **TB083/26** | **Audit and Risk Committee Chair's Report**<br>***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.* | *Report* | *ARC Chair* | **15:15** (10 mins) |

| | | | | |
|---|---|---|---|---|
| **TB084/26** | **Audit and Risk Committee Annual Report**<br>***Purpose:*** *To* ***receive*** *the Audit and Risk Committee Annual Report* | *Report* | *ARC Chair* | **15:25** (10 mins) |
| **TB085/26** | **Green Plan Annual Report**<br>***Purpose:*** *To* ***approve*** *the Green Plan Annual Report.* | *Report* | *CFO* | **15:35** (10 mins) |

## A POSITIVE PARTNER

| | | | | |
|---|---|---|---|---|
| **TB086/26** | **Questions to the Board**<br>***Purpose:*** *To discuss and respond to any questions received from the members of the public.* | *Verbal* | *Chair* | **15:45** (02 mins) |
| **TB087/26** | **Feedback from Board Walkabouts**<br>***Purpose:*** *To* ***receive*** *feedback following walkabouts.* | *Verbal* | *Members* | **15:47** (08 mins) |

## CONCLUDING BUSINESS

| | | | | |
|---|---|---|---|---|
| **TB088/26** | **Messages from the Board**<br>***Purpose****: To agree messages to be shared with all staff.* | *Verbal* | *Chair* | **15:55** (03 mins) |
| **TB089/26** | **Any Other Business**<br>***Purpose:*** *To* ***receive*** *any urgent business not included on the agenda* | *Report* | *Chair* | **15:58** (02 mins) |
| | **Date and time of next meeting:**<br>• Thursday 24 September 2026 | | | ***16:00***<br>***Close*** |

**Chair Dr Niruban Ratnarajah**

| Name: | Position: | Interest Declared | Type of Interest |
|---|---|---|---|
| Tony **Allen** | Non-Executive Director | Locala Community Partnership | Financial Interest |
| | | Inclusion Group | Financial Interest |
| | | YMCA Together Liverpool | Non-Financial Professional Interest |
| | | Kiklees ICB Finance Committee member | Financial Interest |
| Gita **Bhutani** | Associate Non-Executive Director | Employment at Lancashire and South Cumbria NHS FT | Financial Interest |
| | | Director, Bhutani Consultancy Ltd | Financial Interest |
| | | Independent Chair, NICE Guidelines Programme | Financial Interest |
| | | Director, G&J Property (Mcr) Ltd | Financial Interest |
| | | University of Manchester Honorary Research Fellow | Non-Financial Professional interest |
| | | Co-chair Psychological Professions Network North-West (NHS England funded) | Non-Financial Professional interest |
| | | Director, Healthwatch Bury CIC | Non-Financial Professional interest |
| | | Site lead on NIHR funded research hosted through LSCFT | Non-Financial Professional interest |
| Sean **Harriss** | Non-Executive Director | Trustee at Age Exchange | Non-Financial Professional Interest |
| | | Senior Advisor, Private Public Limited | Financial Interest |
| | | Director, Harriss Interim and Advisory | Financial Interest |
| | | Family member works for Astra Zeneca | Non-Financial Personal Interest |
| | | Non-Executive Director Borough Care | Financial Interest |

| Name: | Position: | Interest Declared | Type of Interest |
|---|---|---|---|
| Janat **Hulston** | Non-Executive Director | Non-Executive Director Chorley Building Society | Financial Interest |
| | | Vice Chair/Trustee Manchester Care and Repair Charity | Non-Financial Professional Interest |
| Sharon **Katema** | Director of Corporate Governance | Nil Declaration | |
| James **Mawrey** | Chief People Officer / Deputy CEO | Partner employed at a neighbouring NHS Trust within Greater Manchester. | Non-Financial Personal Interest |
| | | Family member works on administration bank for NHSP | Loyalty Interest |
| Rauf **Munshi** | Medical Director | Spouse employed at an NHS Trust within Lancashire | Non-Financial Personal Interest |
| Tiri **Mutambasere** | Associate Non-Executive Director | Trustee GoChurch | Non-Financial Personal Interest |
| | | Director SubmitFox Limited | Financial Interest |
| Fiona **Noden** | Chief Executive | Trustee Bolton Community and Voluntary Services | Non-Financial Professional Interest |
| | | Bolton Locality Place Based Lead | Non-Financial Professional Interest |
| | | Chair of Greater Manchester Maternity and Neonatal System Board GMEC Local Maternity & Neonatal System (LMNS). | Non-Financial Professional Interest |
| Niruban **Ratnarajah** | Chair | GP Partner: Stonehill Medical Centre | Financial Interest |
| | | Lead for GP Strategy and Placements at the University of Bolton | Financial Interest |
| | | Director of Ratnarajah Holdings Limited | Financial Interest |
| | | Director of Ratnarajah Medical Services Limited | Financial Interest |
| Tyrone **Roberts** | Chief Nurse | Personal Trainer | Non-Financial Personal Interest |

| Name: | Position: | Interest Declared | Type of Interest |
|---|---|---|---|
| | | | |
| Fiona **Taylor** | Non-Executive Director | Chair of Governors St Georges CE Primary & Nursery School | Non-Financial Personal Interest |
| | | Trustee Moya Cole Hospice | Non-Financial Personal Interest |
| | | Trustee Women for Well Women (Leigh) | Non-Financial Personal Interest |
| | | Chair of North West Non-Executive Director Network | Non-Financial Professional Interest |
| Annette **Walker** | Chief Finance Officer | Chief Finance Officer of both Bolton Foundation Trusts and GM ICP Bolton | Non-Financial Professional Interest |
| Rae **Wheatcroft** | Chief Operating Officer | Nothing to declare | |
| Sharon **White** | Chief of Strategy and Partnerships | Trustee George House Trust | Non-Financial Professional Interest |
| | | Board Member of Bolton College | Non-Financial Professional Interest |
| | | Partner employed by Trust | Non-Financial Personal Interest |
| Ian **Williamson** | Non-Executive Director | Interim Chair The Gaddum Charity | Non-Financial Professional Interest |
| | | Trustee Connect Academy | Non-Financial Professional Interest |
| | | Director Primary Care Commissioning | Financial Professional Interest |
| | | Spouse is Chair of Manchester Carers Forum | Indirect Interest |

## GUIDANCE NOTES ON DECLARING INTERESTS

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

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

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

Types of Interests:

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

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

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

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

# *Draft* Minutes of the Board of Directors Meeting

**Held in the Boardroom**

**Thursday 28 May 2026**

*Subject to the approval of the Board of Directors Meeting on Thursday 30 July 2026*

## Present

| Name | | Initials | Title |
|---|---|---|---|
| Ratnarajah | Niruban | NR | Chair |
| Allen | Tony | TA | Non-Executive Director |
| Bhutani | Gita | GB | Associate Non-Executive Director |
| Crofts | Seth | SC | Non-Executive Director |
| Harriss | Sean | SH | Non-Executive Director |
| Hulston | Janat | JH | Non-Executive Director |
| Katema | Sharon | SK | Director of Corporate Governance |
| Mawrey | James | JM | Chief of People/Deputy Chief Executive |
| Munshi | Rauf | RM | Medical Director |
| Mutambasere | Tiri | TM | Associate Non-Executive Director |
| Noble | Rachel | RN | Interim Director of Strategy |
| Noden | Fiona | FN | Chief Executive |
| North | Martin | MN | Non-Executive Director and Deputy Chair |
| Roberts | Tyrone | TR | Chief Nursing Officer |
| Walker | Annette | AW | Chief Finance Officer |
| Wheatcroft | Rae | RW | Chief Operating Officer |
| Williamson | Ian | IW | Non-Executive Director |

## In Attendance

| | | | |
|---|---|---|---|
| Arcamo | Ulida | UA | Trainee Advanced Clinical Practitioner (for agenda item 044) |
| Blackburn | Amy | AB | Head of Communications |
| Chadwick | Faye | FC | Divisional Nurse Director (DND) Community Care (for agenda item 044) |
| Crompton | Victoria | VC | Corporate Governance Manager |
| Luhar | Nicola | NL | Advanced Clinical Practitioner (for agenda item 044) |

## Apologies

| | | | |
|---|---|---|---|
| Taylor | Fiona | FLT | Non-Executive Director |
| White | Sharon | SW | Chief of Strategy and Partnerships |

There were two observers in attendance

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

**TB043/26 Chair's Welcome and Note of Apologies**

The Chair welcomed everyone to the meeting and apologies for absence were as noted above.

**TB044/26 Patient and Staff Story**

The Chief Nurse introduced Faye Chadwick, Divisional Nurse Director for the Community Care Division, who presented a patient story relating to the Admission Avoidance Team. The story centred on a patient who had experienced multiple hospital admissions prior to referral. It was noted that the team provided sustained support through regular home visits and comprehensive multidisciplinary input, including geriatricians, advanced clinical practitioners, pharmacists and wider Multi-Disciplinary Team (MDT) colleagues. Following the interventions, the patient did not require further hospital admissions and remained safely managed at home, reporting improved wellbeing, reduced stress and increased confidence in managing medication, supported by access to ongoing care.

**Staff Story**

The Board received a staff story from Ulida Arcamo, Trainee Advanced Clinical Practitioner outlining her career progression within the Trust. It was noted that she joined the Trust in 2017 as an international recruit and credited internal development pathways, strong mentorship, and a supportive organisational culture with enabling her progression from ward-based practice to a Trainee Advanced Clinical Practitioner role.

The story highlighted cross-service experience, including acute, intermediate care and community services, and reflected positively on staff development, retention, and patient care. Areas for improvement include more consistent communication of development opportunities and strengthening cross-service understanding.

SC queried the impact of the Advanced Clinical Practitioner programme. UA advised that university study had enhanced her knowledge and understanding, enabling greater autonomy in clinical decision-making. In response to a follow-up question regarding patient benefit, UA noted that this experience supported more timely and independent decision-making, improving patient care.

In response to a query from IW, FC confirmed that readmission avoidance was a core function of the team and that forthcoming innovations such as wearable

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

devices would present further opportunities to strengthen admission avoidance. It was also noted that the team had expanded significantly.

RN welcomed the vision for the future of nursing and queried factors contributing to the team's growth. It was noted that the integration of former care home advanced practitioners into the team had driven expansion, with staff now working across hospital and community settings as part of the wider MDT.

NR asked how the nursing workforce of the future would be developed. UA advised that a hybrid training model would support cross-sector experience, and TR noted that Greater Manchester was piloting a vanguard approach for student nurses. It was acknowledged that further work was required to enable delivery at scale.

Board members thanked the team for presenting the patient and staff story.

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

**TB045/26 Declaration of Interests Concerning Agenda Items**

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

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

**TB046/26 Minutes of the previous meetings**

The Board received and approved the minutes of the meeting held on 26 March 2026, as a correct and accurate record of proceedings.

**RESOLVED:**
The Board of Directors ***approved*** the minutes from the meeting held on 26 March 2026.

**TB047/26 Matters Arising and Action Logs**

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

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

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

**TB048/26 Chair's Update**

The Chair extended best wishes to all those who had celebrated Eid al-Adha the previous day.

NR also noted that this would be Martin North's final Board meeting, having joined the Trust in 2018 as a Non-Executive Director. Over this period, he had served as Deputy Chair for the past two years and made a significant contribution in his role as Maternity Safety Champion. The Board thanked Martin for his contribution during his tenure and wished him well for the future.

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

**TB049/26 Chief Executive's Report**

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

- The Integrated Transfer of Care Hub was due to open on the Royal Bolton Hospital site, operating seven days a week to improve patient flow, reduce length of stay, and support timely discharge through coordinated hospital and community working, aligned to the Government's 10 Year Health Plan.
- The Trust was participating in the national Triceps trial (one of 19 NHS organisations), which had recruited over 200 participants and was evaluating a £2m stroke rehabilitation treatment using transcutaneous vagus nerve stimulation, with potential for wider rollout at scale.
- The 2025 NHS Staff Survey results reflected the impact of sustained operational, workforce and financial pressures, with a decline across all People Promise themes in line with national trends; findings had informed five Trust-wide people and culture priorities.
- The former Mayor of Bolton visited the Trust to view Our Bolton NHS Charity-funded initiatives, highlighting the positive impact on patient care and experience following his own treatment within Critical Care.

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

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

**TB050/26** **Annual Governance Declarations**

**A.** **Modern Slavery Statement**

The Director of Corporate Governance presented the Modern Slavery Statement, noting the Trust's statutory requirement under the Modern Slavery Act 2015 and its commitment to preventing modern slavery across its operations and supply chains. The 2025/26 statement aligned with NHS England guidance and reflected established controls providing assurance on due diligence, risk assessment, training and reporting.

The statement had been reviewed by the Audit and Risk Committee and was presented for Board approval, with publication to follow on the Trust website and within the Annual Report.

**B.** **Compliance with Fit and Proper Person's Test Compliance Report**

The Director of Corporate Governance presented the Fit and Proper Person Test (FPPT) Compliance Report, confirming alignment with NHS England's framework and that appropriate systems were in place to ensure and monitor director suitability.

The Chair would confirm compliance for all directors, with outcomes reported via the NHS England Annual Review and updates provided to the Remuneration and Nominations Committee.

SK noted that the Fit and Proper Person Test report for Non-Executive Directors would also be presented to the Council of Governors.

**C.** **Compliance with NHS Providers' Licence Self-Certification**

The Director of Corporate Governance presented the NHS Provider Licence self-certification, noting the Trust's statutory requirement to confirm compliance with licence conditions and relevant legislation. The Board was required to approve the annual self-certification by 31 May 2026, with any areas of non-compliance supported by a proportionate action plan.

The report set out the outcome of the annual assessment and sources of assurance to support the Board in confirming compliance.

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

**D.** **Code of Governance Compliance**

The Director of Corporate Governance presented the Code of Governance compliance report, noting the requirement to include an annual statement confirming compliance with the FT Code and explaining any exceptions. The report and appendices provided assurance of the Trust's compliance, including confirmation of compliance with mandatory provisions as set out in Appendix 3.

**E.** **Register of Interests**

The Director of Corporate Governance presented the Register of Interests, noting that comprehensive and publicly available registers were maintained in line with the Managing Conflicts of Interest Policy and national NHS guidance.

The report provided assurance on compliance monitoring, with year-on-year trends and remaining declaration gaps identified and confirmed that appropriate systems and controls were in place during 2025/26, with further actions identified to improve completeness.

Although governors' interests were not directly covered by the national policy, a register of Governors' Interests was held in accordance with the Trust's Standing Orders for the Council of Governors.

**RESOLVED:**
The Board of Directors ***received*** the Annual Governance Declarations.

**TB051/26** **Bolton Sustainability Plan**

The Interim Director of Strategy presented the Bolton Sustainability Plan, noting it had been submitted to NHS England on 18 March 2026. NHS England had subsequently requested a revised narrative and a detailed three-year delivery plan, with work underway to be completed by the end of Quarter 2.

**RESOLVED:**
The Board of Directors ***received*** the Bolton Sustainability Plan.

**TB052/26** **Sustainability Plan (Medium Term Plan) EQIA**

The Interim Director of Strategy presented the Sustainability Plan (Medium Term Plan) QEIA, noting that it had been revised in response to Executive and Board

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

feedback. The revised QEIA provided clear articulation of delivery risks, strengthened mitigations and controls, and improved alignment with Board assurance processes.
Enhanced monitoring and escalation arrangements were embedded within existing governance, providing clearer lines of oversight and assurance.

**RESOLVED:**
The Board of Directors ***received*** the Sustainability Plan (Medium Term Plan) EQIA.

**TB053/26 Sustainability Board AAA Chair's Report**

The Chief Executive presented the Chair's Report from the inaugural Sustainability Board meeting held on 27 April 2026 advising that governance arrangements were established, challenge had strengthened, and a clearer programme of actions was in place to address identified gaps.

FN also provided a verbal update from the meeting held on 27 May 2026, highlighting that there was improved grip and delivery across programmes. Most programmes were rated amber, but challenges had been identified in terms of capacity and pace, data visibility (particularly within workforce), and the need for further progress in digital enablement.

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

**A. Integrated Performance Report**

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

- The Elective Improvement Programme had entered its second year, with refreshed workstreams across six pillars: Did Not Attend (DNA) reduction, outpatient slot utilisation, clinic template standardisation, Patient Initiated Follow Up (PIFU) implementation, theatre utilisation, and demand reduction, aimed at improving capacity, reducing variation and enhancing patient experience.
- RTT Performance was slightly below plan due to industrial action and waiting list pressures, with recovery expected from May. The waiting list had reduced but remained above plan. Validation activity and an operational sprint were planned to support recovery.

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

- There had been 440 52-week performance breaches at the end of April, an increase driven by industrial action, with recovery expected by June.
- Diagnostics Waiting Times and Activity (DM01) performance for April was 10.8%, better than plan, with deterioration attributed to the inclusion of Audiology patients.
- Ambulance handover performance was below plan at 50.6%. Type 3 Emergency Department (ED) performance exceeded plan at 96.79%. Overall, four-hour ED performance improved to 72.4%, exceeding plan, although admitted performance remained a challenge.
- There had been a slight increase in length of stay with improvement work ongoing through targeted actions including discharge processes and benchmarking.
- No Criteria to Reside (NCTR) performance and lost bed days were above plan, although improvement actions are in place, including enhanced system escalation and strengthened partnership working.

**Quality and Safety**

The Chief Nursing Officer presented the Quality and Safety Update, advising that harm-free care indicators, including pressure ulcers and falls, remained stable within common cause variation. There were no category 4 pressure ulcers reported, and prevention practices were well embedded. Falls performance remained below threshold, with one moderate harm incident reviewed and no care concerns identified.

There were six C. difficile cases in April, and the Trust was in common cause variation, with a sustained reduction in average monthly rates. There were no Methicillin-resistant Staphylococcus aureus (MRSA) or Klebsiella bacteraemia cases reported, marking the first month in 12 months with no Klebsiella cases.

It was noted that C. auris, a multi-drug-resistant fungal infection, had recently emerged, with the Trust identifying its first case. Appropriate infection prevention and control measures were implemented, including enhanced precautions, routine and weekly screening of critical care patients, and a deep clean of the affected area.

Maternity indicators remained within common cause variation. No cases of Hypoxic-ischemic encephalopathy (HIE) were reported, although this remained a new metric requiring continued monitoring. Improvements were noted in 1:1 care in labour, timely booking and induction delays, alongside progress in breastfeeding initiation and advancement towards Stage 2 Baby Friendly Initiative accreditation.

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

Patient experience reflected a mixed position with ED response rates and satisfaction remaining below target but within common cause variation, with Friends and Family Test (FFT) compliance a key focus. Inpatient response rates remained stable, with satisfaction consistently above the 90% target.

The Medical Director reported that inpatient clinical correspondence completed within one working day remained below the 95% target, with a reported position of 77.4% for April 2026 and year-to-date performance remaining static. Outpatient clinical correspondence completed within five working days showed a deteriorating trend, with performance at 57.9% against the 95% target for April 2026.

In relation to the Summary Hospital-level Mortality Indicator (SHMI), performance was within the expected range and identified as common cause.

Compliance with preventative measures for venous thromboembolism (VTE) had fallen below the 95% target, with performance at 94.8% for April 2026. The metric demonstrated a deteriorating trend and variability, with performance not consistently meeting the expected standard.

**Finance**

The Chief Finance Officer presented the Month 1 financial position, noting a year-to-date deficit of £3.1m, which was favourable to plan. It was acknowledged that the Trust remained forecast to deliver a £7m deficit in line with plan, with key risks relating to industrial action and delivery of the Cost Improvement Programme (CIP). CIP delivery was slightly behind plan, with identified opportunities subject to risk adjustment. Variable pay had reduced in month one, although full-year targets were yet to be confirmed. Capital spend was marginally above plan, with a reduction in total assets driven by the in-month deficit and a higher-than-planned cash position, with anticipated reliance on cash support from August.

**Workforce**

The Chief People Officer provided an update on the sickness and workforce position, noting a continued reduction in sickness absence over the preceding months, with in-month performance slightly below forecast and a sustained downward trajectory projected.

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

It was further noted that total Whole Time Equivalents (WTE) had reduced in month one compared to both the previous month and the medium-term plan, reflecting reductions in substantive and temporary staffing. Board members acknowledged that improvements were supported by reduced sickness, controls on rosters, and closure of escalation areas, with agency usage remaining low and within NHSE targets.

MN queried whether increased theatre utilisation would result in increased income. AW explained that this would depend on the Trust's contract and would require discussion with commissioners. RW added that a 2% increase in theatre utilisation had already been built into the productivity plan.

MN queried the impact on No Criteria to Reside (NCTR) performance without continued focus. RW advised that further scrutiny could always be applied but highlighted ongoing system pressures, including the potential withdrawal of local authority provision of an intermediate care facility, which would remove capacity and increase pressure on NCTR. NR queried whether utilisation of vacant wards could mitigate this risk; RW confirmed that a number of mitigation options were being explored.

NR queried whether bringing forward the planned October launch of the Single Point of Access (SPOA) would deliver benefit to the Trust. RW advised that options were being explored to introduce some specialties earlier, potentially from July.

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

**TB054/26** **Quality Assurance Committee Chair's Report**

Seth Crofts presented the Chair's Report from the Quality Assurance Committee meeting held on 27 May 2026, advising that overall quality and safety performance remained stable, with improvement evident in key areas including mortality indicators, maternity CNST compliance and venous thromboembolism (VTE) performance. Progress was also noted in theatre utilisation, reflecting improved efficiency and reduced cancellations, with a sustained positive trajectory.

Ongoing risks were highlighted in clinical correspondence, where performance remained below the 24-hour discharge summary standard, and in cancer follow-up processes, where assurance remained limited despite an established action plan.

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

Assurance was received on the development of the Quality Account, health inequalities work aligned to national priorities, and operational delivery programmes through the Performance and Transformation Group.

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

**TB055/26** **Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Report**

The Chief Nursing Officer presented the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Report, advising that formal notification had been received from NHS Resolution on 26 March 2026 confirming the Trust had met all ten CNST Year 7 safety actions and successfully passed external verification; confirmation of the associated financial payment remained awaited.

The CNST Year 8 scheme was launched on 23 April 2026 in a revised, outcomes-focused format comprising six safety actions with increased emphasis on Board accountability, with associated workstreams in development. The report also presented Quarter 4 2025/26 data, providing assurance on implementation of the Perinatal Quality Oversight Model and progress against delivery of the national maternity care bundle, alongside continued submissions to the Maternity Outcomes Signal System dashboard.

AW advised that she had met with NHS Resolution to discuss the Trust's contribution and was informed that the premium was determined by historic claims, reflecting a cash-based member contribution scheme whereby payments fund previous liabilities.

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

**TB056/26** **Learning from Deaths/Mortality Report**

The Medical Director presented the Learning from Deaths/Mortality Report, advising that SHMI (109.11) and HSMR (106.65) were both within the expected range, with a reduction in alerting diagnostic groups and improvement in comorbidity recording and coding compliance. Revised Mortality Steering Group

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

reporting had strengthened oversight of deteriorating patient workstreams, including sepsis and NEWS compliance.

Neonatal reviews confirmed no cases where care contributed to death; of nine stillbirths, two identified learning, including one where care contributed, with actions being tracked. Of five paediatric deaths, four occurred in the ED and one highlighted a gap in palliative care provision for young adults. 10% of cases were subject to SJR, with one case identified where care contributed to the outcome. Thematic analysis highlighted issues relating to timing, ownership and communication, particularly at transitions of care, with governance processes under review to strengthen organisational learning.

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

**TB057/26 People Committee Chair's Report**

Martin North presented the Chair's Report from the People Committee held on 19 May 2026, advising that workforce numbers had reduced, sickness absence had decreased to 5.34% and turnover remained stable at 12.1%. The Committee had requested further triangulation with the sustainability plan to strengthen assurance.

Assurance was provided that nurse staffing governance remained effective with no increase in harm, although a workforce planning risk which related to vacancy and supply visibility was noted. Maternity staffing challenges continued, with mitigating actions in place to maintain safety. The Committee also noted a decline in NHS Staff Survey results and supported actions to strengthen engagement and progress the People and Culture Plan.

Updates were also received on wellbeing, Freedom to Speak Up (FTSU), Guardian of Safe Working and employee relations, providing assurance on organisational culture and workforce management.

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

**TB058/26 NHS Staff Survey 2025/26 Results and Response**

The Chief People Officer presented the NHS Staff Survey 2025/26 Results and Response Report, advising that the results showed a decline consistent with the

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

national position, with a more pronounced reduction locally. The survey identified key strengths and informed five Trust-wide people and culture priorities underpinning the People and Culture Plan.

The Board noted that Our Way, underpinned by VOICE values, would be expanded to further embed behaviours across the organisation, with staff engagement remaining a key priority. A structured engagement and planning programme was underway to support finalisation of the Plan by July 2026.

SH queried whether the response to the staff survey would be revised in light of the Sustainability Plan. JM advised that the engagement plan had been developed over a number of months, and RN confirmed that the Assistant Director of Organisational Development was a member of the Sustainability Delivery Group.

**RESOLVED:**
The Board of Directors ***received*** the NHS Staff Survey 2025/26 Results and Response Report.

**TB059/26** **Nursing and Midwifery Staffing Reports**

The Chief Nursing Officer presented the Nurse Staffing Report, advising that the bi-annual review confirmed effective systems and governance for safe staffing. Establishment changes across Medicine and Surgery had been embedded, with triangulated metrics providing assurance that these had supported safe care without increased harm. Enhanced care processes, including the POST assessment tool, had improved alignment of observation to patient need and reduced demand, supported by ongoing Safe Care reviews, escalation processes and Red Flag reporting.

The Board also noted a workforce planning risk, as nursing waterfall modelling could not be updated pending upload of the funded establishment to Electronic Service Record (ESR) following finalisation of the 2026/27 budgets, limiting visibility of vacancies and future supply risk.

**Maternity Staffing Report**

The Chief Nursing Officer presented the Maternity Staffing Report, advising that the bi-annual review provided assurance on maternity staffing, with the funded establishment aligned to Birthrate Plus recommendations and recruitment ongoing.

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

An updated Birthrate Plus review had commenced in September 2025, with no breaches of CNST Year 7 standards reported.

The Board noted that one-to-one care in labour remained below the required standard due to vacancies, with an action plan in place. Survey results were largely in line with other providers, with lower performance noted for partner experience. The report highlighted ongoing workforce pressures, with mitigating actions in place to maintain safe staffing and clinical safety.

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

**TB060/26 Guardian of Safe Working Hours Annual Report**

The Medical Director presented the Guardian of Safe Working Hours Annual Report, advising that exception reporting enabled resident doctors to raise variations from contractual and educational requirements, with issues addressed in real time. The report set out exception report activity by department, grade and type for the period 01 April 2025 to 31 March 2026, including outcomes and key themes arising.

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

**TB061/26 Finance and Investment Committee Chair's Report**

Sean Harriss presented the Chair's Reports from the Finance and Investment Committee meetings held on 22 April and 20 May 2026. CIP delivery was reported at £28.71m against a £38m target, with risk-adjusted savings of £19.2m; however, the full target remained unidentified and further work was required to accelerate scheme development and progression through governance.

The Month 1 financial position showed a £3.1m deficit, £17k favourable to plan, with emerging cost pressures of £18m for 2026/27 and an underlying requirement for cash support later in the year.

The Digital Programme update highlighted a complex delivery environment, with an external review planned to support prioritisation, strengthen governance and

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

address delays, alongside ongoing work to confirm the Maternity Electronic Patient record (EPR) go-live date.

The Committee had considered a Sustainability Partner Update, noting the preferred hybrid delivery model to support CIP and long-term transformation, with further work underway to define a phased plan in line with NHS England expectations.

The Committee also approved the award of a three-year contract for the provision of Delivered Ready Prepared Meals, with any extension to be subject to future Committee approval.

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

**TB062/26** **Audit and Risk Committee Chair's Report**

Tony Allen presented the Chair's Report from the Audit and Risk Committee held on 06 May 2026, advising that substantial assurance was received for Risk Management Core Controls and Key Financial Controls, with moderate assurance for Finance Systems (Agency Costs). The Committee raised concerns regarding the volume and timeliness of high-risk internal audit actions, particularly within digital and IT, and highlighted issues relating to long-standing risks, residual risk clarity, and Declarations of Interest compliance, with further assurance sought on supply chain compliance within the Modern Slavery Statement.

The Committee also received assurance across governance and statutory reporting, including the External Audit Strategy, Counter Fraud arrangements, and Board Assurance Framework. Compliance was confirmed in relation to the Trust Seal, Fit and Proper Person Test, and NHS Provider Licence self-certification. Draft statutory reports, including the Annual Governance Statement and Annual Report and Accounts, were noted as progressing to schedule, with no new risks identified.

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

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

**TB063/26 Questions to the Board**

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

**TB064/26 Feedback from Walkabouts**

SC and AW reported on their visit to the Sexual Health Service, noting a highly committed multidisciplinary team and positive examples of service innovation, including the use of social media to improve accessibility. Opportunities for further service transformation were also identified.

MN and JM reported on their visit to the Emergency Department, noting that despite being busy, the environment was calm and staff engagement was positive.

JH and TR reported positively on ward operations, highlighting a strong improvement focus, effective discharge support arrangements and consistent messaging to patients and visitors. Observations from the Emergency Department also reflected staff commitment to delivering high-quality care.

SH and JM reported a positive visit to Ophthalmology, and AS, in their role as FTSU Guardian, noted improvements within the Breast Unit as recognised by staff.
SH and RM reported a visit to G4, commending the ward leadership.

NR and SK reported on Outpatients, noting effective use of capacity and demonstrable service improvements.

FLT and RW reported a positive visit to B1, highlighting strong ward leadership and engagement with new discharge facilitator roles.
FN and TA reported on their visit to Bolton One Paediatric Outpatients, noting opportunities to optimise use of estate and clinical space.

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

**TB065/26 Messages from the Board**

The key messages from the meeting were noted for communication through appropriate Trust channels.

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|

**TB066/26** **Any Other Business**

There being no further business, the Chair thanked everyone for attending and brought the meeting to a close at 15:40.

The next Board of Directors meeting would be held on Thursday 30 July 2026 at 1pm in the Boardroom.

| Meeting Attendance 2026 | | | | | | |
|---|---|---|---|---|---|---|
| **Members** | **Jan** | **March** | **May** | **July** | **Sept** | **Nov** |
| Niruban Ratnarajah | ✓ | ✓ | ✓ | | | |
| Annette Walker | ✓ | ✓ | ✓ | | | |
| Fiona Noden | ✓ | ✓ | ✓ | | | |
| Fiona Taylor | ✓ | ✓ | A | | | |
| Gita Bhutani | ✓ | ✓ | ✓ | | | |
| Ian Williamson | ✓ | ✓ | ✓ | | | |
| James Mawrey | ✓ | ✓ | ✓ | | | |
| Janat Hulston | ✓ | ✓ | ✓ | | | |
| Martin North | ✓ | ✓ | ✓ | | | |
| Rae Wheatcroft | ✓ | ✓ | ✓ | | | |
| Rauf Munshi | ✓ | ✓ | ✓ | | | |
| Sean Harriss | ✓ | ✓ | ✓ | | | |
| Seth Crofts | ✓ | ✓ | ✓ | | | |
| Sharon Katema | ✓ | ✓ | ✓ | | | |
| Sharon White | ✓ | ✓ | A | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Tiri Mutambasere | ✓ | ✓ | ✓ | | | |
| Tony Allen | ✓ | ✓ | ✓ | | | |
| Tyrone Roberts | ✓ | ✓ | ✓ | | | |
| ✓ = In attendance A = Apologies | | | | | | |

**Status**

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

# Board of Directors

## Matters Arising Action Log

Action Log updated May 2026

NHS Bolton NHS Foundation Trust

## ONGOING ACTIONS

| Agenda Ref | Meeting Date | Agenda Item | Agreed Action | Lead | Original Deadline | Forecast Completion | Status Outcomes | BRAG Status |
|---|---|---|---|---|---|---|---|---|
| TB088/25 | 31/07/2025 | Our Leaders Programme and Culture Update | HS and RK to return to a Board of Directors meeting in 12 months' time to provide a progress update. | LR | Jul-26 | Jul-26 | A progress update will be presented at the September 2026 Board of Directors meeting. | Amber |

## COMPLETED ACTIONS

| Agenda Ref | Meeting Date | Agenda Item | Agreed Action | Lead | Original Deadline | Forecast Completion | Status Outcomes | Status |
|---|---|---|---|---|---|---|---|---|
| TB038/26 | 26-Mar-26 | Charitable Funds Committee Chair's Report | A letter of thanks from the Board of Directors to be sent to Betty Swyer's family | SW | May-26 | May-26 | Letter sent 15/04/26 | Complete |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Chief Executive's Report | | | |
| **Meeting:** | Board of Directors | **Action Required** | Assurance | ✓ |
| **Date:** | 30 July 2026 | | Discussion | |
| **Executive Sponsor** | Chief Executive | | Decision | |

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

| | |
|---|---|
| **Previously considered by:** | Not Applicable. |

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

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

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

| **Summary of key elements / Implications** | | |
|---|---|---|
| **Implications** | **Yes / No** | **If Yes, State Impact/Implications and Mitigation** |
| **Finance** | **No** | |
| **Legal/ Regulatory** | **Yes** | |

| | | |
|---|---|---|
| **Health Inequalities** | **Yes** | |
| **Equality, Diversity and Inclusion** | **Yes** | |
| **Is a Quality Impact Assessment required** | **No** | |

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

## Ambition 1:
## Improving care, transforming lives

Sunday 05 July marked an incredible 78 years of the National Health Service and to celebrate this milestone, colleagues and their families were invited to explore the hidden history of our hospital site, thanks to Transport for Greater Manchester. A historian led three guided tours throughout the day, offering a fascinating insight into the stories and heritage behind our hospital.

Healthcare has changed enormously over the last 78 years, and we continue to innovate and improve the care we provide today. One example is our opt-out testing scheme for blood-borne viruses in the Emergency Department, which recently reached its first anniversary. The initiative makes sure even more people are being told about undiagnosed conditions and are being offered support and treatment, which can ultimately save lives. The one year milestone was marked with an event at the University Medical School, bringing together colleagues and local and national partners to reflect on the success of the testing programme and set out plans to strengthen it in the future.

We continued our focus on high-quality record keeping through another successful *Know Your Patient Week.* The initiative encouraged colleagues to review and validate patient information, helping to ensure records are accurate, complete and up-to-date. Reliable patient records are essential for safe and effective care, supporting timely clinical decision-making and helping healthcare professionals provide the right care at the right time. High-quality documentation also enables the effective monitoring of outcomes and service performance. The campaign highlights our ongoing commitment to patient safety, quality improvement and excellence in care.

Two of our community nursing teams provided a behind-the-scenes insight into the vital role community nurses play in supporting people across Bolton. Each week, hundreds of residents receive care in their own homes from nurses working across the borough, from Westhoughton and Horwich to Breightmet and Farnworth. Community nurses deliver a wide range of essential services, including palliative care, wound management, catheter and continence care, and medication support for patients who are unable to leave their homes. With each nurse carrying out up to 12 patient visits per day, the service enables people to access high-quality care and treatment in the comfort of their own homes, helping them maintain their independence and avoid unnecessary hospital admissions.

More than 300 newborn babies have participated in the Generation Study, a national research programme aimed at accelerating the diagnosis of more than 200 rare genetic conditions. The study uses genomic screening to identify conditions such as Spinal Muscular Atrophy (SMA), with the potential to enable earlier diagnosis, faster access to treatment, and improved outcomes for babies and families. To mark six months of participation, two of our midwives shared their experiences of supporting families to take part in the study and contributing to research that could help shape the future of neonatal care.

As part of plans to improve and develop care in our Paediatric Emergency Department, families were invited to participate in a patient forum to share their experiences of care. The sessions provided valuable insight into what matters most to patients and families, highlighting both positive aspects of care and opportunities for improvement. The feedback will be used to help shape future service developments, ensuring that the department continues to deliver high-quality, family-centred care that meets the needs of our local communities.

Our services remain committed to supporting research and innovation that can improve care, outcomes and experiences for local families. This has included participation in a trail for maternity patients who have been offered access to an innovative digital tool which is evaluating the Tommy's Pathway Clinical Decision Support Tool, helping clinicians identify individual risk factors early in pregnancy and supports informed decision-making about care. The national study will involve more than 62,000 women and pregnant people receiving NHS maternity care across England and will assess whether the tool can improve pregnancy outcomes and reduce complications such as pre-eclampsia, stillbirth and preterm birth.

## Ambition 2: A great place to work

On 13 July colleagues participated in a regional conference focused on advancing racial equity across the NHS and wider health and care system. The event brought together leaders, partners and community representatives from across the North West to share learning, strengthen collaboration and promote fair, inclusive and equitable care. Reflecting our commitment to tackling health inequalities and fostering an inclusive culture, our Chair, Niruban Ratnarajah, contributed to the discussion through a personal blog, highlighting the importance of courageous leadership, partnership working and sustained action to drive meaningful and lasting change.

We were particularly proud to see one of our consultants, Dr Jeff Kwartz, featured in the Greater Manchester Integrated Care Partnership's *No Space for Racism* campaign. The campaign shines a light on the experiences of health and care staff who have faced racism in the workplace, using powerful real-life stories to raise awareness and encourage meaningful action across the sector. Dr Kwartz's involvement demonstrated both personal courage and leadership, helping to reinforce the importance of creating workplaces where everyone feels valued, respected and safe. The campaign strongly reflects our ongoing commitment to challenging discrimination, tackling inequalities and fostering a culture of dignity, inclusion and belonging for all colleagues.

We marked the 78th anniversary of the NHS by celebrating colleagues whose dedication has helped shape healthcare services in Bolton over many years. More than 30 members of staff were honoured at the Trust's Annual Long Service Awards, celebrating 25 and 40 years of service to Bolton NHS Foundation Trust and the NHS, and recognising their exceptional commitment to patients, communities and colleagues.

Nominations for the For a Better Bolton (FABB) Awards 2026 have now closed, with hundreds of entries received recognising the exceptional work and dedication of colleagues across the Trust over the past year. In addition, patients, families and members of the public have been invited to nominate NHS and healthcare workers who have made a difference to their lives, in the People's Choice Category helping to recognise outstanding care and compassion. The longlist will be announced at the end of July, with nominations then reviewed by our diverse judging panels. Winners will be announced at the awards ceremony on 9th October at the Toughsheet Community Stadium.

Respiratory nurse Rebecca Worswick has been shortlisted in the Nursing Times Awards 2026 in the Nurse Leader of the Year category. Rebecca has been recognised for her longstanding commitment to supporting people living with respiratory diseases and for her strong partnership with the Bolton Pulmonary Fibrosis Support Group, helping patients access the care and support they needed.

During Volunteers' Week, we recognised the significant contribution made by volunteers across Bolton NHS Foundation Trust and promoted opportunities for greater community involvement. More than 500 volunteers contribute over 20,000 hours each year, supporting patients, visitors and staff across hospital and community services. Their contribution enhances the quality and experience of care, strengthens community engagement and delivers added value across the organisation.

On 10th June, we were delighted to welcome Dr Mumtaz Patel, President of the Royal College of Physicians (RCP), and colleagues to Bolton. The visit provided an important opportunity to showcase our organisation, highlight the experiences of our medical workforce, and share the strengths and challenges of delivering care in Bolton. Discussions will help inform the RCP's future policy development and national workforce priorities, while also ensuring that the voice and experience of Bolton colleagues contribute to shaping the future of medicine and patient care across the NHS.

## Ambition 3:
## A high performing, productive organisation

We held our annual Service Review Day where representatives from our clinical divisions and corporate services shared their achievements from the last twelve months, as well as their plans for the future. Achievements demonstrated the delivery of outstanding care and operational improvements across all divisions including:

- Community Services teams delivered more than 608,000 patient contacts, over 42,800 home appointments, avoided 4,457 hospital admissions and achieved 100% Friends and Family recommendations for children's services.

- Families and Diagnostics teams supported 4,784 births, performed more than 172,000 diagnostic scans and x-rays, delivered 8.7 million laboratory tests and dispensed 443,125 pharmacy items.

- Medicine teams managed 144,260 Emergency Department attendances and 94,844 elective care attendances, while reducing corridor care, improving ambulance handovers and reducing length of stay.

- Our Surgery teams delivered 193 joint replacements, 626 paediatric surgeries, 2,304 emergency surgeries and 106 robotic-assisted procedures, while providing 164,628 outpatient appointments, improving referral-to-treatment times and achieving top national performance for cancer standards.

- Corporate Services underpinned this success through major digital upgrades, leadership development, data and financial management, a 17% reduction in cardiac arrests as a result of the Deteriorating Patient Collaborative, a social media reach of more than 10.7 million users and securing £1.5 million in Green Plan funding.

Our teams have responded to a number of significant business continuity incidents, including challenges relating to medical gases, the pod system, fire alarms and bleeps, an electronic patient record (EPR) outage, an unplanned steam outage, and more recently the impact of extreme weather conditions including high temperatures. Despite the frequency and complexity of these incidents, the commitment, adaptability and teamwork demonstrated by colleagues across clinical and corporate services have

been exceptional. Through a coordinated organisational response, staff have worked together to maintain safe services and minimise disruption to patient care wherever possible, ensuring that the impact on patients and their experience remained limited. These incidents have highlighted both the resilience of our workforce and the strength of our partnership working across teams and departments.

A key priority during June has been the implementation of Patient Initiated Follow-Up (PIFU) as the standard model of care across all specialties. PIFU enables patients, where clinically appropriate, to initiate follow-up appointments when they need them, rather than attending routine pre-scheduled appointments, giving patients greater flexibility while ensuring clinical support remains available when required. This represents an important change for both patients and the way outpatient capacity is utilised, and the focus is now on moving from planning and discussion to consistent delivery across the organisation. PIFU is already live in more than 30 specialties, providing a strong foundation for further expansion. Plans are in place to increase this to ensure we can realise the full benefits in terms of patient experience, flexibility and productivity.

NHS England has written to all Integrated Care Boards and providers setting out the requirement to have a robust, clinically led and deliverable winter plan. As a result of early planning and strong collaboration across health and care organisations, last winter delivered the strongest national performance in three years for four-hour emergency care and ambulance response times. This was achieved despite significant pressures, including an early flu season, a peak in norovirus cases in January and periods of industrial action. Our winter planning has already begun to ensure that we are working together as one Bolton team to ensure our services are sustainable and efficient throughout the winter period.

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

To ensure we continue to meet the needs of local people, a temporary 16-bed nursing Intermediate Care ward has relocated to F6 at Royal Bolton Hospital, complemented by a further eight residential intermediate care beds at Laburnum Lodge, managed by Bolton Council. These arrangements will maintain intermediate care capacity while preparations continue for the opening of a new 24-bed nursing Intermediate Care Unit in N Block this September.

The new unit, currently under development on the first floor of N Block, will provide high-quality short-term care focused on recovery, rehabilitation and restoring independence, helping people return to the place they call home. As with our existing provision, the service will bring together health and social care colleagues to deliver integrated, person-centred support that maximises independence and promotes recovery.

We have submitted a further planning application to support our ambition to develop a modern main entrance at Royal Bolton Hospital. Following approval of the initial plans in May, the development will create a welcoming, accessible and intuitive arrival experience, improving navigation and helping to create a more positive first impression for patients, visitors and staff.

The second phase of the redevelopment will further enhance the accessibility and functionality of the hospital's main entrance through the creation of a new patient drop-off area and dedicated wheelchair store. The proposals have been designed to improve the overall patient and visitor experience by

providing safe, convenient and inclusive access to services. By maintaining a drop-off point close to the main entrance and ensuring mobility aids are readily available on arrival, the development supports our wider ambition to create an environment that is welcoming, accessible and centred on the needs of patients, visitors and carers.

In June, we temporarily paused treatment room clinics at Winifred Kettle due to staffing pressures. This enabled services to be safely maintained across Bolton, with patients continuing to access essential care, including wound management, dressings, leg ulcer treatment and catheter support, at alternative treatment room locations.

As our staffing pressures have begun to ease, treatment room clinics have been reintroduced two days a week. This phased reopening will provide an opportunity to review how the service is used and better understand patient needs and experiences. Patient feedback is being sought to help inform future service planning, including how easy it is to access appointments, the factors that influence where patients choose to attend, and the impact of any service changes.

## Ambition 5: A positive partner

Our Bolton NHS Charity funded a simple but meaningful gesture to help our patients and staff stay cool during the recent heatwave. The charity provided ice-creams across hospital wards, bringing a little comfort and cheer to those spending time in hospital and the teams caring for them during the exceptionally warm weather. Working closely with ward teams, ice creams were offered where clinically appropriate, giving patients a welcome opportunity to cool down and enjoy a small act of kindness. While an ice cream may seem like a small gesture, it reflects Our Bolton NHS Charity's ongoing commitment to making hospital experiences more positive. Thank you to everyone who supports Our Bolton NHS Charity and helps us continue making a difference for patients, families and staff across Bolton.

A leading breast cancer charity that has long supported Royal Bolton Hospital's Breast Unit has raised thousands of pounds to help fund vital new equipment to help with the diagnosis of cancer. Boot Out Breast Cancer has donated more than £10,000 to the Unit after hosting a Ladies Lunch at Rivington Hall Barn in Bolton earlier this year. The donation will go towards specialist equipment that will allow people to receive a same-day diagnosis, reducing anxiety around waiting for results and speeding up access to life-saving treatment. The charity has supported the unit for more than a decade, raising more than £220,000 to help fund a range of items to improve patient experience and support staff with their life-saving work, which includes state-of-the-art equipment to support breast surgery, mammography chairs and ultrasound equipment.

We and Bolton Deaf Society have been shortlisted for a prestigious HSJ Patient Safety Award in recognition of their collaborative work to make Martha's Rule more accessible for Deaf patients. Martha's Rule is a national initiative that enables patients and families to raise concerns about a patient's condition. Working closely with members of the deaf community, clinical and operational teams co-designed improvements to reduce reliance on verbal communication and remove barriers to access. The project demonstrates how partnership working can support safer, more equitable care and ensure all patients can escalate concerns effectively when needed.

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Board Assurance Framework Q1 Update | | | |
| **Meeting:** | Board of Directors | **Action Required** | Assurance | ✓ |
| **Date:** | 30 July 2026 | | Discussion | ✓ |
| **Executive Sponsor** | Director of Corporate Governance | | Decision | ✓ |

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

| | |
|---|---|
| **Previously considered by:** | The Q1 BAF update has been reviewed with the relevant Executive Director leads and discussed through the lead Committees and Executive Director reviews which have informed the updated risk descriptions, controls, assurances, gaps and actions now presented to the Board. |

| | |
|---|---|
| **Executive Summary** | This report presents the Quarter 1 update of the Board Assurance Framework (BAF), the Board's primary mechanism for overseeing the principal strategic risks to delivery of the Trust's Ambitions. The Q1 review confirms that strategic risks have been reviewed with Executive Director leads and through the relevant lead committees, with updated risk descriptions, controls, assurances, gaps and actions reflected in the revised BAF.<br><br>The update strengthens alignment between the BAF, the Trust Strategy, 2026/27 Trust priorities and the Sustainability Plan 2026–29. It also reflects committee challenge on the adequacy of controls, the effectiveness of assurance and the actions required to address remaining gaps. Key areas updated include productivity improvement, workforce sustainability, digital and data maturity, transformation governance, benefits realisation, quality and patient safety, health inequalities and financial sustainability.<br><br>A key Q1 change is the reprofiling of Strategic Risk 12 within Ambition 4 to reflect the delivery risk associated with the Sustainability Plan. The inherent risk has been rebased to 25, with a current residual risk of 20 and a target score of 8, reflecting exposure across financial sustainability, recurrent CIP delivery, productivity, benefits realisation and transformation delivery. |

| | |
|---|---|
| **Proposed Resolution** | The Board of Directors is asked to **receive and approve** the Q1 update of the Board Assurance Framework, noting the changes made following Executive Director review and lead committee discussion, and the reprofiling of Strategic Risk 12 to reflect the delivery risk associated with the Sustainability Plan. |

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

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

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

# Board Assurance Framework Explanatory Notes

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

## 1. INTRODUCTION

1.1. The Board Assurance Framework (BAF) is the Board's primary tool for overseeing the principal strategic risks that may affect delivery of the Trust's Ambitions. It brings together the strategic risks, controls, sources of assurance, gaps and actions required to support effective Board oversight.

1.2. This Q1 update has been reviewed with Executive Director leads and through the relevant lead committees. It reflects the Trust's current strategic risk profile, including the Sustainability Plan 2026–29, 2026/27 Trust priorities, refreshed corporate objectives, updated controls and assurances, and revised actions to address remaining gaps.

1.3. The report provides the Board with a clear line of sight between strategic risks, Trust priorities, committee assurance and the actions required to strengthen controls or close assurance gaps.

## 2. Strategic Alignment

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

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

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

- **Defined Controls:** Measures in place to reduce the likelihood and/or impact of the risk.
- **Sources of Assurance:** Internal and external mechanisms that provide evidence of control effectiveness.
- **Risk Appetite Statements:** Reflecting the level of risk the Trust is willing to accept in pursuit of its objectives.
- **SMART Actions:** Updated actions, owners and target dates to address identified gaps in controls and assurance, with ongoing monitoring through Executive Director review, lead committees and Board reporting.

## 3. EXECUTIVE OVERSIGHT

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

- Regular Review of Strategic Risks, ensuring that emerging threats, operational challenges, and external influences are identified and assessed in a timely manner.

- Evaluation of the potential impact and likelihood of each risk materialising, ensuring that risk scores remain current and reflective of the operating environment.
- Controls in place to mitigate them
- Assurance mechanisms that demonstrate control effectiveness
- Where gaps in control or assurance are identified, SMART actions are developed with clear deadlines. These actions are monitored and updated regularly.

## 4. RISK MANAGEMENT

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

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

**Severity (Consequence) x Likelihood = Risk Score**.

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

### Risk Categorisation Matrix

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

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

4.1. **Principal Risks**

All Principal Risks within the BAF are disaggregated into individual Strategic Risks. Each Strategic Risk is aligned to a Corporate Objective and has been reviewed in Q1 to ensure the wording, controls, assurances, gaps and actions remain current. This supports clearer accountability, improved oversight and a more direct line of sight between risk exposure, organisational priorities and committee assurance.

The Q1 update strengthens alignment with the Sustainability Plan 2026–29 and the 2026/27 Trust priorities. It reflects committee challenge on the adequacy of controls, the quality of assurance, benefits realisation, productivity improvement and the need for actions to be specific, time-bound and linked to the gaps they are intended to address.

## 5. RISK APPETITE

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

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

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

Each Risk Appetite Statement is categorised as follows:

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

6. **Recommendation:**

The Board of Directors is asked to **receive and approve** the Q1 update of the Board Assurance Framework. In doing so, the Board is asked to note the changes made following Executive Director review and lead committee discussion, the continued alignment with the Sustainability Plan and 2026/27 Trust priorities, and the reprofiling of Strategic Risk 12.

The Board is also asked to consider whether the controls remain robust, whether the assurances demonstrate effective operation of those controls, and whether the revised actions are sufficient to address the remaining gaps in control and assurance.

## Q1 2026/27 - Board Assurance Framework Dashboard

| 16 | 8 | 8 | 5 |
|---|---|---|---|
| **Strategic risks** Across five ambitions | **Red risks** Highest attention required | **Amber risks** Active oversight required | **Assurance routes** Board and committees |

## Risk Heat Map

| Impact ↓ Likelihood → | 1 Rare | 2 Unlikely | 3 Possible | 4 Likely | 5 Almost certain |
|---|---|---|---|---|---|
| **5 Catastrophic** | 5 | 10 | 15 | **20** SR7, SR9, SR10b, SR11, SR12 | 25 |
| **4 Major** | 4 | 8 | 12 | **16** SR4, SR5, SR6, SR8 | 20 |
| **3 Moderate** | 3 | 6 | 9 | **12** SR1, SR2, SR3, SR10a, SR13, SR14, SR15 | 15 |
| **2 Minor** | 2 | 4 | 6 | 8 | 10 |
| **1 Insignificant** | 1 | 2 | 3 | 4 | 5 |

**Heat map interpretation:** The heat map shows the current BAF risk distribution by likelihood and impact. Red cells indicate the highest levels of residual risk requiring continued Board and committee oversight; amber cells indicate active management and monitoring; green cells indicate lower-rated risks within tolerance.

## Q1 2026/27 - Board Assurance Framework Dashboard

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

## Ambition 1: Improving care, transforming lives

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

## CO.1: Improving access to our services

## EXECUTIVE LEAD: CHIEF NURSING OFFICER

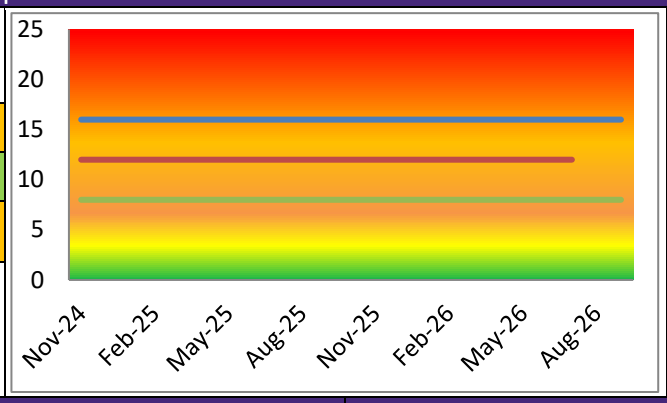
**26/27 Improvement Priority:** ~~**We communicate in ways people understand, and we will find better ways of working that releases more time to care**~~**.**
We will improve access, experience and outcomes by communicating in ways people understand, reducing unwarranted variation, using digital and data more effectively, and finding better ways of working that release more time to care**.**

**Risk Appetite:** **OPEN**

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

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

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




### Link to Risks on Corporate Risk Register

1595 (15) Critical care delayed discharges & mixed sex accommodation breaches
3330 (15) Waiting time for Glaucoma new patient appointments and follow-up
5425 (16) Delivery of Urgent Care Performance Standards
6491 (15) Failure of ambulatory cardiac monitoring analysis software
2836 (16) CYP with mental health and behavioural difficulties being cared for within the acute setting
**Catastrophic for Impact**
6145 (15) Maternity Theatres ventilation failure
2937 (15) Orthopaedic Interface Service (OIS) waiting times
6344 (16) Unavailability of Abatacept

### Issues impacting achievements of our objective including Sustainability Plan Risks

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

### KPIs / Measures

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

### Controls

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

### Assurances

**1st line of Defence (Operational management)**

- Risk registers reviewed at Risk Management Group
- Real-time patient experience with addition of key questions for all in-patients and community long term caseloads
- Monthly reports including Quality and Equality Quarterly reviews
- Quarterly reports to PSE from Very Important Person Group
- Refreshed Clinical Governance & Quality Governance Group through separation between Patient safety and experience (PSE) and Clinical Effectiveness (CeC) chaired by CNO & CMO respectively
- NHS IMPACT self-assessment
- Nurse and Midwife sensitive clinical outcomes dashboard (heatmap)
- Digital accreditation system (Genome) launched 1.4.26 - provides increasing summary of best practice and opportunities for improvement
- Monthly CQC KLOE using Genome spot checks

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

**Reports to Quality Assurance Committee and Board, namely:**

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

### Actions (Chief Nursing Officer)

1. ~~Scoping procurement of a digital solution to support with provision of aggregated data / thematic analysis. Expected (business case) presentation March 2025). July 25 Update: Revised Target Date Q3 2025~~ ~~**Update Nov 25: Target Date of Q3 25/26 remains.**~~
~~Procurement completed – business case to CRIG Dec 2025 (agreed in principle as linked to CIP)~~
~~**Update Feb 2026**: Genome procured and implementation and roll out underway~~. **Revised Target date: Sep 26**
**Action Completed and went live on 1 April.**

2. Development of Risk Management Framework with stakeholder engagement **Target Completion Date** ~~**30.12.2023.**~~
Risk Management Framework has been drafted with wider discussions with Executive Team to discuss new approach planned.
**Mar 26 Update 26**: To be presented at Board Development Day in April 2026 and then for wider engagement/roll out.
**July 26 Update**: Revised completion date Sep 26

3. ~~Introduction of shared decision-making councils. TOR developed, further engagement planned in April with Divisional teams, first leadership council meeting in June~~ ~~**Target Completion Date –** revised date to **Q2 25/26**~~ ~~Divisional restructure necessitated changes in Divisional Governance.~~
**Target Completion Date: 30 June 2026.** Shared decision-making councils have been rolled out and were used in April discussions on Trust priorities, supporting stronger engagement, local ownership and culture development.
**Action Completed**

4. ~~Improvement plan to attain full compliance with NHSE workforce safeguards: Target Completion Date 31.3.2026 March 26 Update – On track and expected to be completed in line with target date~~.

| | | |
|---|---|---|
| • NMAHP clinical outcomes for stratification by ethnicity and deprivation<br>• Holistic annual planning to support the Quality Planning aspect of QMS<br>• Improvement plan to attain full compliance with NHSE workforce safeguards<br>• Genome digital solution used to provide aggregated data and thematic analysis<br>• Decision making Councils | **3rd Line of Defence (Independent or external assurance)**<br>• GMICB Bolton Locality Quality Spot Checks<br>• Internal audit reviews<br>• CQC inspection reports, visits, Insight reports, and engagement meetings<br>• Peer reviews and accreditation.<br>• Quality governance review via Good Governance institute 2023<br>• National patient surveys<br>• Maternity specific outcomes benchmarked against peers using available data (and new national datasets). Introduction of MOSS – Maternity national dashboard quality performance.<br>• National Oversight Framework quality dashboard / league table. | **July 26 Update:**the Trust is compliant with all the required standards, this is monitored on a quarterly basis to ensure compliance is maintained. Action Completed<br>5. Provision of inclusive patient experience / service user feedback that represents all users; **Target Completion Date 31.3.26**<br>**Mar 26 Update:** All FFT areas are set to deliver at least 30 returns per team in March 2026; activity likely to continue after April. **Revised Target Date: Sep 26**<br>**July 26 Update:** Action ongoing – new FFT provider procured and will go live in July 2026. This will allow ability to build in local questions to capture alongside mandated questions.<br>6. ~~Very Important Person (VIP) group established and initial overview of compliance with various standards and key performance indicators presented to Quality and Clinical Governance October 2025. Action plan agreed. Review progress 6 monthly. **Update Feb 26:** Initial meeting held. ToR agreed. For review 31.03.2026.~~<br>~~**Revised Target Date: July 26**~~<br>**Jul 26 Updates:** Reports through to PSE quarterly reports and included in AAA to QAC. Action Completed<br>7. Completed self-assessment against NHSE Experience of Care standards. **Target Completion Date**: 31.08.2026 **July 26 Update**: Gap analysis in progress, on track to completing self-assessment by target date<br>8. Procure new FFT provider with increased ability to generate questions and ability to translate responses from other languages other than English. **Target Completion Date:** 31.08.2026 **July 26 Update**: Completed and gone live with new provider. Action Completed<br>9. Quality Management Service Roadmap (*to be presented to execs) provision for leadership for improvement training (via IHI*) with a view to partnering with IHI as a strategic partner. (Q.2 2026)<br>10. Annual focus on Quality Control (areas include CEO led Improvement Wall **July 26 Update:** Target Completion Date Q.2 2026)<br>11. Revised and focussed approach to Exec Buddy walkabouts and Board walkabouts linked to annual priorities with rollout expected August 2026<br>12. Maternity (Ockenden/Amos) Gap Analysis and Action Plan (Q.2 2026) |
| **Gaps in Control** | **Gaps in Assurance** | **Notable Changes since previous iteration** |
| • Development of a Risk management framework/strategy<br>• Lack of robust non-medical research plan<br>• Quality Management Service Roadmap now in place<br>• | • Lack of robust, co-ordinated & consistent intelligence on patient experience / service user feedback from those without / with limited, mental capacity and / or those for whom English is not first language<br>• Real-time access to Quality KPIs and access to automated triangulation (to be addressed by roll out o genome)<br>• Ability to benchmark data in real time | This BAF section has been reviewed and updated by the Chief Nursing Officer to reflect alignment with the 2026/27 improvement priority and the Trust's Sustainability Plan. There is no change is proposed to the current risk score, which remains 12, with the target score remaining 8.<br>Controls and assurances have been refreshed to reflect the launch of Genome, the new FFT provider, strengthened patient experience reporting, refreshed clinical and quality governance arrangements, and the Quality Management Service Roadmap.<br>Several actions have been completed and have now been added to the Controls. Ongoing actions remain focused on completion of the Risk Management Framework, inclusive patient experience feedback, NHSE Experience of Care self-assessment, Quality Management Service Roadmap implementation, Quality Control priorities, revised walkabout arrangements, and Maternity Ockenden/Amos gap analysis.<br>Residual gaps remain in relation to real-time triangulation and benchmarking of quality intelligence, and inclusive feedback from patients and service users who may be under-represented in standard feedback mechanisms. |

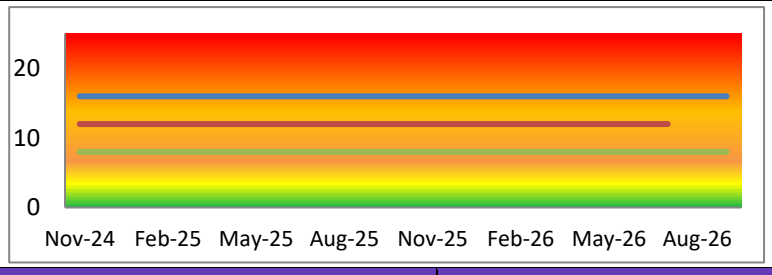
| CO.2 - Create a culture where staff can innovate and collaborate to improve care and reduce harm | EXECUTIVE LEAD: MEDICAL DIRECTOR |
|---|---|

**26/27 Improvement priority : To find better ways of working that releases more time for care, guided by what matters most to our patients and aligned to the Sustainability Plan through productivity improvement, digital enablement and refreshed research and innovation.**

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

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

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




## Link to Risks on Corporate Risk Register

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

### Issues impacting achievements of our objective

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

### KPIs / Measures

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

### Controls

- Quality Improvement collaboratives for recognising and responding to deteriorating patients incorporating Martha's Rule (NHSE pilot)
- A strengthened Quality, Control, Improvement and Assurance framework
- Quality Improvement (QI) strategy
- Quality Management System (QMS)
- Bolton Locality Plan and Outcomes Framework
- Bolton Borough wide Patient engagement and collaboration strategy
- Clinical strategy
- Job planning policy
- Benchmarking through Model Health Systems
- NHSE Improving Patient Care Together (IMPACT) self-assessment Maturity Matrix level
- Advanced Care Planning (ACP) to support Admission Avoidance with monitoring at End of Life Steering Group
- Increased attendance at the OUR LEADERS programme with the development of medic specific blended learning bundles and Action Learning Sets
- Improvement portfolio oversight through the Sustainability Board ensuring schemes are aligned to Trust priorities, productivity, quality, safety and benefits realisation.
- Digital, data and analytics enabling programme, supporting improved data quality and decision-support for clinical and operational improvement.
- Partnership and system collaboration arrangements, including work with primary care, GM partners, academic partners and voluntary/community sector organisations where relevant.
-

### Assurances

**1st line of Defence (Operational management)**

- Quarterly Quality Account updates to CG&QA committee
- Quarterly mortality reports, including Learning from Deaths, neonatal, stillbirth and child deaths, to CGQA
- Clinical audits
- Alignment and monitoring of actions within the Research Plan
- Divisional and corporate oversight of Trust Level priorities through Quality Planning, IPM and local performance review arrangements.
- Operational delivery of improvement schemes through clinical teams, QI collaboratives,
- Transformation and Improvement SMT and programme workstreams.

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

- Sustainability Board and Improvement Board oversight of the Sustainability Plan, Improvement Portfolio, benefits, risks and dependencies.
- Quality Assurance Committee and Board reporting on quality, safety, research, innovation, clinical effectiveness and improvement outcomes.
- Research Committee, Clinical Effectiveness Group, CG&QC, AI Steering Group
- Integrated Performance Reports to QAC and Board
- Reports on IPC, transfusion, Medicines Safety, Safeguarding
- Quarterly Mortality Steering Group and LfD reports to QAC
- Mortality reports to QAC and Board

**3rd Line of Defence (Independent or external assurance)**

- NIHR and GM research benchmarking
- National reporting and benchmarking
- AQuA audits of care
- GIRFT reviews into care provision

### Actions

1. Implementing artificial intelligence (AI) and robotic process automation to deliver trust wide clinical data and decision support programme that improves the improves timeliness and reliability of data for decision making aligned to patient safety, flow and productivity.
   **Revised Target Date: Q4 2027**
   **July 2026 Update**: Action progressing**.**

2. Expanding research trial access to benefit more people with innovative therapies. . Deliver the trust research plan, increasing patient access to research and integrating research delivery with clinical improvement priorities. Revised Target Date: Q3 2026/27
   **July 2026 Update**: Action progressing. RM to present an updated positioning paper to Executive Directors before onward submission to QAC.

3. Rolling out of Quality Improvement training to Medical staff. Establish QI faculty with job planned time ensuring > 75% of medical staff are QI-capable and actively contributing to priority improvement programmes aligned to trust priorities addressed through objective setting within job plans.
   **Target Completion Date: Q4 2026**
   **July 26 Update:** Action progressing. An updated plan with QI training and wider training for medical staff currently under review this will support and development of clinical leads regarding wider governance.

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

| | | |
|---|---|---|
| | • External assessments and accreditation<br>• Report to Bolton University Joint Delivery Board | improvements in access, experience and outcomes for patients. **Revised Target Date: Q3 2026**<br>**July 26 Update: A**ction progressing to with a view to increase ACP in community.<br><br>**5.** Outcomes based focus with greater oversight of data. Improve outcomes for non-elective patients through better responses to deteriorating patients, cancer pathways, elective list and complications related to procedures and surgery with board level visibility of data disaggregated to allow oversight of impact on different population groups**.**<br>**Target Completion date Q.4 2026-27**<br>**July 26 Update:** Action progressing<br><br>6. ~~Recruitment to the role of Chief Clinical Information Officer (CCIO**). Target Completion Date of August 26**~~<br>July 26 Update: Action completed<br><br>7. Ambition and action plan relating to University Hospital Status**. Target Completion Date: Q2 2027**<br>**July 26 Update:** Action progressing |
| **Gaps in Control** | **Gaps in Assurance** | **Notable Changes since last iteration of the BAF** |
| • Development of a Research Plan<br>• Capacity in consultant job planning to support delivery of Ambitions.<br>• Protected job planning and structured support for medical staff to lead and participate in Quality Improvement (QI)<br>• Central oversight of innovation, research and QI<br>• Resident Doctor listening events<br>• Lack of consistent EPR solution<br>• Development of medic specific blended learning bundles and Action Learning Sets<br>• Lack of strategic alignment between system partners<br>• Lack of resource/know how and support for transformation<br>• Lack of bi support for data<br>• Borough wide patient engagement and collaboration strategy<br>• Research and innovation committee<br>• ~~Vacant CCIO to deliver~~<br>• Authorisation as a University Hospital<br>• Trust-wide improvement and innovation governance framework to provide a clear route for identifying, prioritising, innovation and research opportunities | • Reporting and oversight of innovation and collaboration<br>• Regular reporting and oversight through QAC to provides assurance of staff participation, impact of QI programmes, and learning from QI collaboratives, demonstrating sustained improvement and alignment with organisational priorities. | The BAF has been reviewed by the Medical Director and updated to align with the Trust's Sustainability Plan and priorities.<br><br>No change is proposed to the current or target risk score, or to risk appetite.<br><br>Controls, assurance routes and all actions have been refreshed to reflect current progress, with gaps updated to highlight central oversight, protected improvement capacity, BI support, system alignment and the need for a Trust-wide improvement and innovation governance framework. |

## Ambition 1: Improving care, transforming lives

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

**EXECUTIVE LEAD: MEDICAL DIRECTORS**

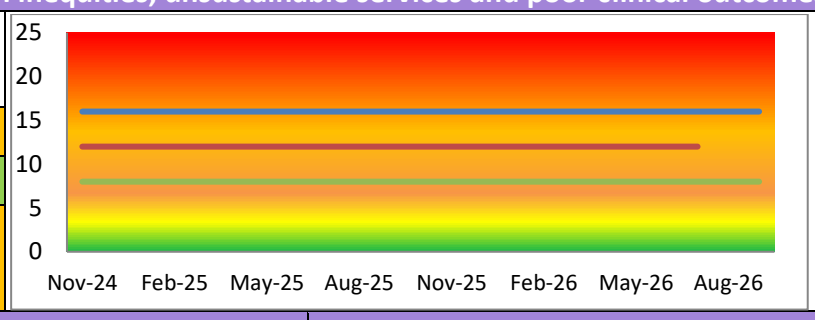
**26/27 Improvement Priorities: Develop high quality demographic and outcome/effectiveness metrics that help us understand how care is delivered and identify opportunities to improve**

**Risk Appetite:** CAUTIOUS

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

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

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




### Link to Risks on Corporate Risk Register

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

### Issues impacting achievements of our objective

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

### KPIs / Measures

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

### Controls

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

### Assurances

**1st line of Defence (Operational management)**

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

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

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

**3rd Line of Defence (Independent or external assurance)**

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

### Actions

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

2. Board level discussion on our Socio-Economic Duty and Action Plan. Target Completion Date: March 2026
   **Update Mar 26**: Date provisionally planned for Feb 26 and deferred to April 2026
   **Revised Completion Date**: ~~May 26~~ Sep 26
   **July 26 Update:** To be discussed in Part 2 September Board

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

### Gaps in Control

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

### Gaps in Assurance

- Increasing focus on prevention and equitable access, experience and outcomes through community engagement and neighbourhood groups.

### Notable changes since last iteration of the BAF

This element of the BAF has been reviewed by the Medical Director.

All controls, assurances and actions to support any gaps have been reviewed and updated. All actions are progressing as planned, with new target dates requested and specified alongside each action.

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

## AMBITION 2: A GREAT PLACE TO WORK

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

**Lead Committee:** People Committee

**Lead Directors:** Chief People Officer

| Our Objectives | 26/27 Improvement Priorities | 2026-27 Trust Level Outcome aims | ENABLING PLANS |
|---|---|---|---|
| **CO.4 Improve the experience of our staff and make our organisation a great place to work.** | Improve staff wellbeing and attendance so that **All** staff feel supported, healthy, and able to deliver great care | • Sickness absence no greater than 4.8% by 31/03/27 (baseline Jan 26 6.5%)<br>• Significant Improvement against comparators in NHS Staff Survey for recommend as a place work / care by 31/03/27 | • Operational Plan<br>• Our People Plan<br>• Equality, Diversity and Inclusion Plan 2022-26 |
| **CO.5 Help all staff to unlock their potential** | Ensure the right people are in the right place at the right time | • WWTE reduction by 300 by 31/03/27<br>• Achieve >85% appraisal compliance by 31/03/27<br>• Achieve >92% mandatory and statutory training by 31/03/27 | |
| **CO.6 Ensure that our workforce reflects the population we serve** | Build a representative and inclusive workforce where "we all belong | • Staff disability declaration rates in line with the NHS national average (baseline 5.2%)<br>• >80% of staff with a declared disability receiving adequate workplace adjustments (baseline of 73.2%)<br>• Improvement in staff declaration rates for: religion 85% and sexual orientation 87%<br>• Reduction in any disparity in appointment rates between White / non disabled and BME / disabled applicants by 50% within 12 months<br>• Reduction in any disparity of BME/disabled staff experiencing bullying, harassment or discrimination from any source by 50% within 12 months<br>• Achievement of 90% Oliver McGowan (LD & autism) e-learning by 30/09/26<br>• With Tier 1 and Tier 2 delivery programme approved by 30/06/26 | |

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

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

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

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

## Ambition 2: A great place to work

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

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

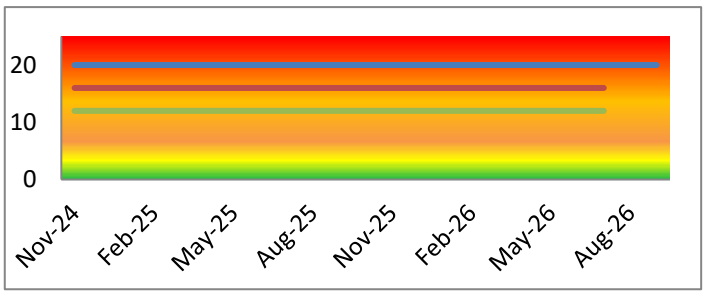
**26/27 Trust Priority: Improve staff wellbeing and attendance so that all staff feel supported, healthy, and able to deliver great care.**

**Risk Appetite:** CAUTIOUS

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

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

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




Link to Risks on Corporate Risk Register

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

### Issues impacting achievements of our objective

- Worked Whole Time Equivalents not reducing in line with our plan due to the operational / quality pressures impacting our organisation.
- Poor management and provision of health and wellbeing support to staff, leading to an increase in sickness absence rates.
- Low staff engagement and satisfaction experienced due to the high number organisational change.
- Failure to deliver workforce productivity and establishment control measures within the Sustainability Plan may reduce available resources to invest in staff wellbeing, development and workforce initiatives.
- Continued operational pressures and organisational change associated with delivery of the Sustainability Plan may adversely affect staff engagement, morale and attendance

### KPIs / Measures

- Reduction in Worked Whole Time Equivalents in line with our Sustainability Plan
- Year-on-year improvement in % staff reporting that they would recommend BFT as a place to work and receive care
- Sickness absence no greater than 4.8% by 31/03/27 (baseline Jan 26 6.5%)
- Significant Improvement against comparators in NHS Staff Survey for recommend as a place work / care by 31/03/27
- Delivery of workforce savings target within the Sustainability Plan.
- Reduction in variable pay expenditure.
- Reduction in agency expenditure.
- Improvement in productive hours.
- Achievement of planned establishment levels

### Controls

Experience

- Operational Plan
- Executive Vacancy Panel (monthly)
- Executive Variable Pay Panels (daily/weekly)
- Refreshed Flexible Working Policy
- Our People Plan
  - People
    - Resourcing Plan
    - Staff Health and Wellbeing Plan
    - Occupational Health Provision
    - Job Planning
    - Rostering
  - Culture
    - Equality, Diversity and Inclusion Plan
    - Great Place to Work Plan
    - Our VOICE Reset Programme
    - Our Leaders Programme
    - Staff Networks
    - FTSU
    - Appraisal
- Sustainability Board oversight of workforce programmes.
- Workforce Productivity Plan.
- Vacancy Management and Approval Framework.
- Agency and Variable Pay Reduction Programme.
- Workforce Efficiency Dashboard

### Assurances

**1st line of Defence (Operational management)**

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

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

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

**3rd Line of Defence (Independent or external assurance)**

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

### Actions

1. Medical E Rostering roll out plan to commence in Oct 2025
   Update Mar 26: Expected to progress into 2026 with a new project plan. Timescale extended to allow for MD to review with support from CPO. Revised Action Date: July 2026
   **Jul 26 Update: Revised target date Dec 26**

2. Establishment Controls to be put in place with a view to align the Ledger and information on Electronic Staff Record (ESR) **Target Completion Date Q3 2026.**

3. Quarterly Pulse check reports to Executive Directors meeting. **Target Completion Date Q2 2026**

### Gaps in Control

- Establishment Controls to be put in place with a view to align the Ledger and information on Electronic Staff Record (ESR) timescale Q3 target for completion.
- Workforce productivity measures and benefits realisation framework require further maturity to demonstrate sustainable delivery of Improvement & Sustainability Plan workforce targets.
- Further work is required to align establishment, ESR and ledger data to provide a single source of workforce information.
- Refreshed People Plan with a view to complete in Q3.2026 (action

### Gaps in Assurance

Quarterly Pulse check reports to Executive Directors meeting.

### Notable changes since previous iteration

The BAF was reviewed by the Chief People Officer to ensure it was aligned with the Executive Director themes from the Sustainability Plan and the Strategic Priorities for the Trust.

The action log has been updated.

There is no proposed change in risk score or appetite.

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

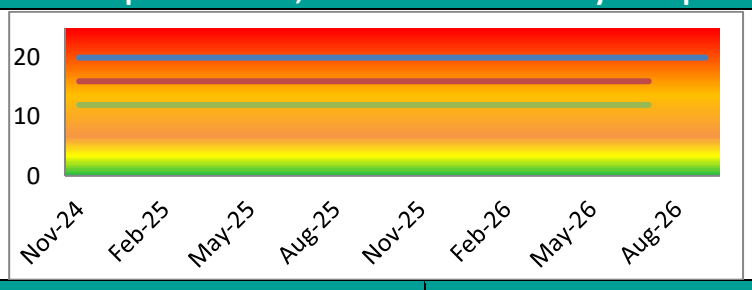
**26/27 Sustainability Plan Priority: Ensure the right people are in the right place at the right time.**

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

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

**If the Trust does not support staff to reach their potential through effective workforce planning, leadership development, skills optimisation and productivity improvement, there is a risk that organisational performance, financial sustainability and quality of care will be adversely affected**

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




**Link to Risks on Corporate Risk Register**

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

## Issues impacting achievements of our objective

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

## KPIs / Measures

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

## Controls

**Our People Plan**

- People
  - Staff Health and Wellbeing Plan
  - Occupational Health Provision
- Culture
  - Equality, Diversity and Inclusion Plan 2022-26
  - Great Place to Work Plan
  - Our VOICE Reset Programme
  - Our Leaders Programme
  - Staff Networks
  - FTSU
  - Appraisal
- L2 Divisional Priorities for delivery
- Workforce Productivity Programme.
- Skills and Role Redesign Programme.
- Medical E-Rostering Programme.
- Leadership Development linked to Improvement & Sustainability Plan priorities.
- Workforce Transformation Programme

## Assurances

**1st line of Defence (Operational management)**

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

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

- Integrated Performance Report to People Committee and Board.
- Staff Story included as a standing item in Board
- People Plan actions overseen by People Committee (People and Culture)
- Reports to People Committee from the EDI Assurance Group
- Improvement & Sustainability Board reports.
- Workforce productivity reporting.
- Benefits realisation reports for transformation schemes.

**3rd Line of Defence (Independent or external assurance)**

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

## Actions (CPO)

1. Develop and implement a workforce productivity framework, including divisional productivity measures and benefit realisation reporting.
   **Jul 26 Update:** To be completed through the alignment of the Establishment roster. Q3 2026

2. Complete alignment of establishment, roster and financial workforce information to support effective workforce planning and decision-making.
   **Target Completion Date: Q3 2026**

## Gaps in Control

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

## Gaps in Assurance

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

## Notable changes since previous iteration

The BAF was reviewed by the Chief People Officer to ensure it was aligned with the Executive Director themes from the Sustainability Plan and the Strategic Priorities for the Trust.

The action log has been updated.

There is no proposed change in risk score or appetite.

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

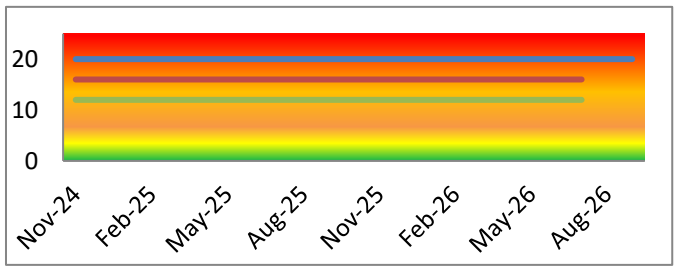
**26/27 Sustainability Plan Priority: Build a representative and inclusive workforce where "we all belong".**

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

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

**There is a risk that workforce reduction and recruitment control measures associated with the Sustainability Plan could unintentionally impact workforce diversity objectives if equality impacts are not fully considered**

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




**Link to Risks on Corporate Risk Register**

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

## Issues impacting achievements of our objective

- Failure to have an inclusive and diverse workforce representative of the population.
- Widening health inequalities impacting care provision, reputation, recruitment and retention

## 26/27 Trust Level Outcome Aims

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

## Controls

- Our People Plan
  - People
  - Resourcing Plan
- Culture
  - Equality, Diversity and Inclusion Plan 2022-26
- Attendance and membership of Bolton wide People and culture group.
- Equality Diversity and Inclusion Strategy
- Equality Impact Assessments / Equality analysis
- Health Inequalities Enabling group
- Staff networks and fora representing diverse groups
- Equality Impact Assessments for all significant workforce change programmes.
- EDI oversight of workforce redesign initiatives.
- Monitoring of recruitment controls through an equality lens.

## Assurances

**1st line of Defence (Operational management)**

- Staff Survey (quarterly and annually)
- WRES and WDES (quarterly and annually)
- Reports to EDI Assurance Committee which reports to People Committee
- Staff Experience Inclusion Steering Group
-

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

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

**3rd Line of Defence (Independent or external assurance)**

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

## Actions (CPO)

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

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

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

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

## Gaps in Control

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

## Gaps in Assurance

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

## Notable changes since previous iteration

The BAF was reviewed by the Chief People Officer to ensure it was aligned with the Executive Director themes from the Sustainability Plan and the Strategic Priorities for the Trust.
The Committee is asked to consider the proposed wording of the STRATEGIC RISK 6*: If our workforce does not reflect the diversity of the population we serve, then we risk reduced cultural competence and inequitable service delivery, to be revised as follows:*:
There is a risk that workforce reduction and recruitment control measures associated with the Sustainability Plan could unintentionally impact workforce diversity objectives if equality impacts are not fully considered
The action log has been updated. There is no proposed change in risk score or appetite.

## AMBITION 3: A HIGH PERFORMING, PRODUCTIVE ORGANISATION

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

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

| Corporate Objective | | Principal Risk | Risk Appetite | Risk Rating | Exec Lead | Lead Commitee | Trend Analysis |
|---|---|---|---|---|---|---|---|
| **Ambition 4: An organisation that's fit for the future** | | | | | | | |
| CO7 | Improving Access to our services | If the trust does not optimise processes or adhere to standards then this may harm service productivity and efficiency, leading to regulatory action and financial instability | Minimal | 20<br>4x5 | COO | Quality Assurance Committee | ⇔ |
| CO8 | Being Efficient and Productive | If the Trust does not optimise its processes, this could negatively impact productivity and efficiency, resulting in unsustainable services | Cautious | 16<br>4x4 | CFO/ COO | Finance and Investment Committee | ⇔ |
| CO9 | Delivering Financial Sustainability | If the Trust does not deliver its Financial Plan, then it will fail to meet its financial objectives, which could negatively affect the Trust's long-term financial sustainability. | Minimal | 20<br>4x5 | CFO | Finance and Investment Committee | ⇔ |

| Severity<br>Likelihood | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 1 | 1 | 2 | 3 | 4 | 5 |
| 2 | 2 | 4 | 8 | 8 | 10 |
| 3 | 3 | 6 | 9 | 12 | 15 |
| 4 | 4 | 8 | 12 | 16 | 20 |
| 5 | 5 | 10 | 15 | 20 | 25 |

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

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

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

## AMBITION 3: A HIGH PERFORMING, PRODUCTIVE ORGANISATION

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

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

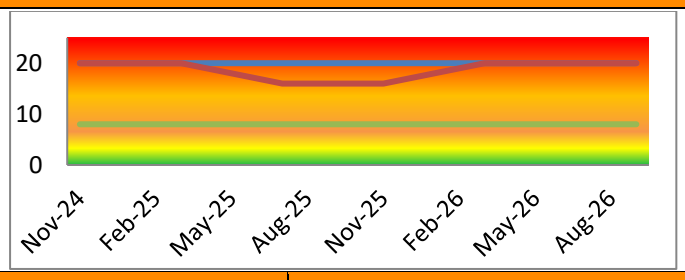
**26/27 Trust Priority: People have improved timely access to care and are seen, in the right place at the right time by right person.**

**Risk Appetite:** MINIMAL

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

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

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




### Link to Risks on Corporate Risk Register

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

### Issues impacting achievements of our objective

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

### KPIs / Measures

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

### Controls

- Trust policies including (Escalation, Access, Discharge)
- Joint system working with NWAS, Bolton Council and GMICB and Locality partners to admission avoidance, streaming from ED and discharge and delivery of care closer to home
- System Cell and System Co-ordination Centre Meetings previously (SCC) linked to operational delivery escalation Joint working with GM on cancer pathways to ensure equality of access across GM
- Regular validation of waiting lists strengthened by Internal audit review ~~and completion of~~ recommendations and ongoing compliance monitoring
- Escalation Policy, Revised Access Policy and Discharge Policy now refreshed and implemented
- Urgent and Elective care assurance meeting with GM
- Support from the Emergency Care Intensive Support Team (ECIST) when requested
- Capacity & Demand planning cycle embedded within annual operational planning and aligned to the Medium term plan submitted for 2026-27
- Sustainability Plan 26-29 and associated transformation portfolio including
  - elective care, urgent care improvement
  - booking/admin transformation
  - productivity diagnostics
  - benchmarking
  - digitally enabled pathway redesigns
  - Community and neighbourhood improvement
- Benefit realisation and productivity controls including
  - divisional performance reviews
  - Model Hospital / GIRFT benchmarking
  - Transformation programme milestones monitoring and operational Grip through Sustainability Board oversight

### Assurances

**1st line of Defence (Operational management)**

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

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

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

**3rd Line of Defence (Independent or external assurance)**

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

### Actions

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

2. Introduce routine exception reporting for schemes that are off track, including impact on constitutional standards, delivery milestones, benefits, dependencies and required executive intervention.
   **Target: Q3 2026/27**

### Gaps in Control

- Weak monitoring of the implementation of ward SAFER principles
- Refreshed ED Improvement Plan supported by a continuous improvement plan (phase 3)
- Further maturity through linking Sustainability Plan schemes to operational controls, including productivity, capacity utilisation, booking/admin transformation and pathway redesign.
- Divisional ownership of benefits, milestones and dependencies requires further strengthening to ensure delivery risks are identified and escalated promptly

### Gaps in Assurance

- Further assurance is required on the delivery of Sustainability Plan access and productivity schemes, including measurable benefits, recurrent impact and alignment to 2026/27 Trust priorities.
- Benefits-realisation reporting is developing and needs to demonstrate whether transformation schemes are improving waiting times, ED performance, diagnostics, discharge flow, productivity and patient outcomes.
- Independent assurance over programme governance, productivity metrics and scheme delivery should be built into the 2026/27 assurance cycle.

### Notable change from previous iteration of the BAF

Strategic Risk 7 has been updated to reflect the Sustainability Plan 2026-29 and Trust priorities for 2026/27 to 2028/29, particularly improved timely access to care in the right place, at the right time, by the right person.
Controls and assurances now reflect Sustainability Plan delivery, including productivity, care closer to home, digital transformation, benchmarking and benefits realisation. Gaps and actions have been refreshed to evidence whether transformation schemes are improving access, flow, productivity, quality and recurrent financial benefit.

No change is proposed to the current risk score or appetite, pending further maturity of benefits-realisation and delivery assurance during 2026/27.

## CO.8 - Being efficient and productive

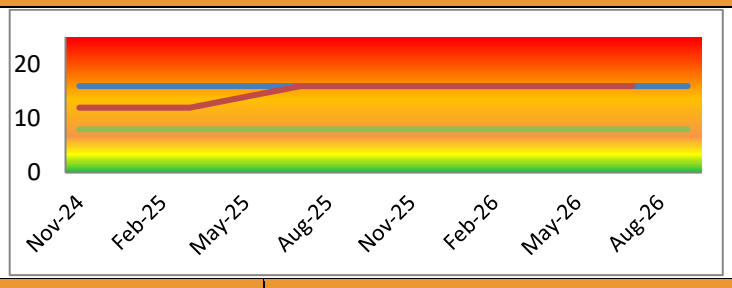
## EXECUTIVE LEAD: CHIEF FINANCE OFFICER AND CHIEF OPERATING OFFICER

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

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

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

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




**Link to Risks on Corporate Risk Register**

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

### Issues impacting achievements of our objective

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

### KPIs / Measures

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

### Controls

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

Use of patient-level costing and income reporting at Divisional level benchmarking.

### Assurances

**1st line of Defence (Operational management)**

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

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

- Integrated Performance Reports to F&I and Board
- Operational Update to Board
- Monthly Finance Report to F&I
- Monthly report to F&I detailing activity levels and performance along with regular updates on service profitability
- Finance Report to Board from CFO
- Annual Report on reference costs to F&I with action plans around each specialty level (particularly those with loss making position)

**3rd Line of Defence (Independent or external assurance)**

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

### Actions

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

2. Understand impact of contract reconciliation work and implications of the 10 year plan. Action Progressing and will become clearer as part of the national workstream and planning round. Expected to progress into Q4 as part of Medium-Term Planning
   Update Mar 26: This will become part of BAU processes now as the national work has completed and will be updated routinely to F&I and as part of annual planning. Revised Target Date: Q3 26
   **July 26 Update: Ongoing process supported by the national (block deconstruction) Whilst it will continue year on year the process has BAU. Action Completed**

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

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

5. Data capture and improved data recording for activity to be addressed by the Income Group**. Target Completion Q3 2026**

6. Implement productivity dashboard and real-time analytics and establish routine reporting to F&I Committee **Target Completion Q4 2026**

| | | |
|---|---|---|
| | | 7. **Develop and embed a long-term financial model**<br>Use the model to support medium-term financial planning, scenario testing and recurrent sustainability. **Target Completion Q4 2026**<br><br>8. **Strengthen evidence of Drivers of Deficit delivery**<br>Track implementation of the Drivers of Deficit action plan, including milestones, recurrent impact and assurance reporting. **Target Completion Q3 2026**<br><br>9. **Maintain oversight of annual plan and deficit support assumptions**<br>Track delivery risks, external dependencies and mitigations through F&I Committee and Board reporting. |
| **Gaps in Control** | **Gaps in Assurance** | **Notable change from previous iteration of the BAF** |
| • Productivity tracking reports to be presented to F&I Committee to ensure better control and oversight<br><br>• Need for enhanced real-time data analytics to support decision-making<br>• Long term financial model<br>• Productivity Dashboard under development with real-time analytics | • Model Hospital benchmarking reporting to F&I Committee<br>• Visibility of activity and income reporting at Board level<br>• Activity Management Plans developed with the GM ICB<br>• Establish routine reporting to F&I Committee | The Chief Finance Officer has reviewed Strategic Risk 8, *Being Efficient and Productive*, within the BAF. The Risk Score and Risk Appetite remain unchanged. |

## CO.9: Delivering Financial Sustainability

## EXECUTIVE LEAD: CHIEF FINANCE OFFICER

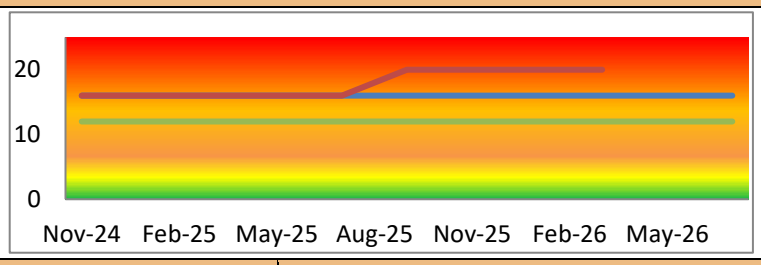
**26/27 Improvement Priorities: Provide the right care, in the right place, at the right time, while using our resources efficiently and effectively so everyone can stay within budget and income is maximised**

**Risk Appetite:** MINIMAL

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

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

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




**Link to Risks on Corporate Risk Register**

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

### Issues impacting achievements of our objective

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

### KPIs / Measures

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

### Controls

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

### Assurances

**1st line of Defence (Operational management)**

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

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

Reports to F&I including

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

**3rd Line of Defence (Independent or external assurance)**

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

### Actions

1. Understand cost and income at budget level **Target Completion Q3 2025 revised to Q1 2026**
   **Update Nov 25:** Action Progressing with Trust working at getting income at Divisional level. Due to restructure, new ledger work expected to progress into Q1 .2026
   **Revised Target Date: Q3 2026**
   **July 26 Update: to check with Juliet expect Q2**

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

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

4. Complete implementation of agreed actions from the Drivers of Deficit reviews and evidence sustainable improvement in the Trust's underlying financial position through delivery of the Financial Improvement Action Plan. **Target Date: Q3 2026.**

5. Ongoing action around CIP identification, validation and delivery, ensuring the achievement of recurrent savings and sustainable improvements in the Trust's underlying financial position. **Target Date: Q3 2026**

### Gaps in Control

- ~~GM ICB overarching strategy~~
- PSC Drivers of Deficit Report and implementation of outcome (understand the main drivers of the Trust's recurrent action and the actions to be undertaken whether income or expenditure)

### Gaps in Assurance

- Model Hospital benchmarking reporting to F&I Committee

### Notable change from previous iteration of the BAF

The Chief Finance Officer has reviewed and updated all actions relating to Strategic Risk 9, *Delivering Financial Sustainability*, within the BAF.
The Risk Score and Risk Appetite remain unchanged.

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

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

| Corporate Objective | | Principal Risk | Risk Appetite | Risk Rating | Exec Lead | Lead Committee | Trend Analysis |
|---|---|---|---|---|---|---|---|
| **Ambition 4: An organisation that's fit for the future** | | | | | | | |
| **CO10a** | Being digitally enabled and inclusive | If the Trust is not digitally enabled and inclusive, then it can face significant challenges, including barriers to essential services, widening health inequalities, missed economic and educational opportunities | Minimal | **12**<br>4x3 | CSP | Finance & Investment Committee | ⇔ |
| **CO10b** | Cyber Security | If the Trust experiences a cyber-attack and lacks effective defences and recovery plans,<br>Then it may face serious disruption to patient care, data security, and regulatory compliance, with prolonged downtime and delayed recovery. | Avoid | **20**<br>4 x 5 | CSP | Finance & Investment Committee | ⇔ |
| **CO11** | Improving our estate | If the Trust does not provide compliant and reliable premises and supporting infrastructure then personal safety and business effectiveness will be compromised resulting in potential harm, service disruption and potential statutory breach. | Avoid | **20**<br>4 x 5 | CFO | Finance & Investment Committee | ⇔ |
| **CO12** | Proactively planning for the future | If the Trust fails to proactively plan for the future, it will negatively affect service provision and hinder the overall achievement of the Strategy | Minimal | **16**<br>4 x 4 | CFO | Finance & Investment Committee | ⇔ |

| Severity<br>Likelihood | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 1 | 1 | 2 | 3 | 4 | 5 |
| 2 | 2 | 4 | 8 | 8 | 10 |
| 3 | 3 | 6 | 9 | 12 | 15 |
| 4 | 4 | 8 | 12 | 16 | 20 |
| 5 | 5 | 10 | 15 | 20 | 25 |

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

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

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

## CO.10a - Being digitally enabled and inclusive

## EXECUTIVE LEAD: CHIEF PEOPLE OFFICER

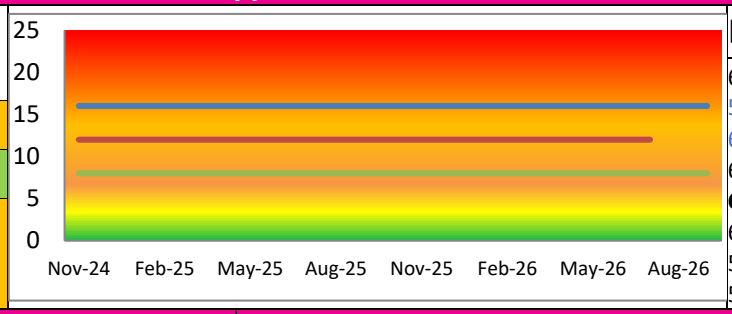
**26/27 Improvement Priorities: Improving care and experience by strengthening our digital foundations and using innovation to support and empower staff and patients**

**Risk Appetite:** MINIMAL

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

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

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




### Link to Risks on Corporate Risk Register

6491 (15) Failure of ambulatory cardiac monitoring analysis software
5406 (15) ENT Cancer Patients being lost to follow up
6731 (16) Endobase end of life.
6428 (15) ICE Upgrade / End of Life
**Catastrophic for Impact**
6009 (15) Blick Stanley Paging System
5720 (10) Digital Infrastructure and Resources
5422 (5) Windows 1909 Out of Support

### Issues impacting achievements of our objective

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

### KPIs / Measures

- Improve Digital Maturity Matrix score and maintain regular, updated capacity and demand
- Complete full EPR rollout during 2026.
  - Implement Maternity into the Trust-wide EPR by 31/03/27.
  - Deploy eight Pyxis cabinets across the Maternity new build by 31/03/27.
  - Rebuild the EPR medicines catalogue to support community prescribing by 31/03/27.
  - Implement electronic blood transfusion workflows to strengthen the clinical safety of blood administration by 30/09/26.
- Increase the number of specialties where patients can access digital self-help information and procedure guidance.
- Implement Patient Knows Best (PKB) in applicable services by 30/06/26.
- Quantified productivity benefits realised from EPR implementation.
- Reduction in administrative effort through digital workflows.
- Improvement in outpatient productivity through digital solutions.
- Delivery of Digital Transformation Programme savings target (£2m).

### Controls

- Board approved Digital Plan
- Lead Bolton Borough wider Partnership
- Digital Performance and Transformation Board
- Digital Maturity Matrix
- Data Protection Toolkit Annual assessment
- External and Internal Audit reports
- Digital Teams manage delivery of programme based on good practice project methodology
- Divisions included in the Digital Performance and Transformation Board to ensure they have oversight of the Digital program
- Community and OPD rollout of the Electronic Patient Record (EPR)
- Laboratory Information Management System software system used to manage and track laboratory samples, associated data, and laboratory workflows
- Sustainability Plan 2026-29.
- Monitoring of 12 Executive Themes at Sustainability Board.

### Assurances

**1st line of Defence (Operational management)**

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

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

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

**3rd Line of Defence (Independent or external assurance)**

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

### Actions (Chief of Strategy and Partnerships)

1. Refresh Digital Strategy – **Target Update Date: July 2026** Action progressing
   Update Mar 26: Strategy development in progress and in line with completion date.
   **Update Jul 26:** The strategy refresh is being progressed alongside the MFT Digital Review, with a first draft due by the end of July 2026. **Target Completion Date:** Q3 2026.

2. System for staff feedback on service provision – **Target Completion Date: March 2025**
   Update Nov 25: Quarterly survey in place. Action plan and *you said we did* to be put in place
   Update Mar 26: Continue to obtain quarterly feedback and action plan in place to resolve staff feedback.
   **Update Jun 26:** A plan is in place to recommence the audit. Service desk performance has been reported to the CPO, with responses to be considered by DTG and escalated to F&I Committee through the established reporting route. **Action closed.**

3. Maternity EPR Rollout – **Target Completion Date: March 2026**
   Action progressing risk to the February implementation due to complexities of configuration. Working with Clinical and Digital Teams to understand this risk
   Update Mar 26: February 2026 go-live was deferred in agreement with F&I. Programme replanning has been undertaken and revised go live date to be presented to F&I committee in March 2026.
   **Update Jul 26:** The plan is still in development, but the EPR Board confirmed that there would be elements of the Maternity EPR available by March 2027. It may be delivered in a phased approach.
   **Revised target date: Phase 1 completion expected Feb 27.**

4. Recruitment and onboarding of Digital Business Partners (starting in Oct 26)

| | | |
|---|---|---|
| | | 5. Development and output from Digital Review by MFT Jul 26 Update: To be undertaken and supported through a Board session by Q.3 26 |
| **Gaps in Control** | **Gaps in Assurance** | **Notable changes from previous iteration of the BAF** |
| • Require system to understand and respond to staff feedback on Digital support<br>• Digital and Cyber Strategy to be refreshed 2026<br>• Implementation and ongoing optimisation of the Electronic Patient Record (EPR) in Maternity (supports safer, more efficient, and more reliable patient care by improving data accuracy, accessibility, and security).<br>• QI project to look at transitional support between implementation and business as usual, with a project checklist to be completed ahead of go live, minimum requirements for engagement and feedback during implementation.<br>• Digital Transformation Programme as part of the Trust's transformation portfolio.<br>• Benefits realisation framework for EPR and digital programmes.<br>• Strategic Sustainability Partner support for digital productivity diagnostics<br>• | • Requirement for key Digital roles within Service Delivery, integration and configuration teams currently undergoing recruitment ~~and increase in substantive capacity in the digital programme - still working with agencies and Procurement for the remainder of the programmes to fill posts.~~<br>• Capacity within wider trust teams for digital system implementations.<br>• NHS Benchmarking for digital workforce is difficult to compare for Digital Teams so a different system of assurance is required<br>• Limited assurance regarding realisation of productivity and efficiency benefits from digital investment and transformation programme<br>• External Digital Review by Manchester FT colleagues | Strategic Risk 10a *Being digitally enabled and inclusive* has been reviewed by the Chief People Officer.<br><br>Actions continue to progress, and the BAF has been revised to strengthen alignment with the Sustainability Plan. Gaps in controls and assurance have been updated, with corresponding actions now included within the actions section.<br><br>No change is proposed to the current risk score or risk appetite. |

## CO.10b - Being resilient against Cyber Threats

**EXECUTIVE LEAD: CHIEF PEOPLE OFFICER**

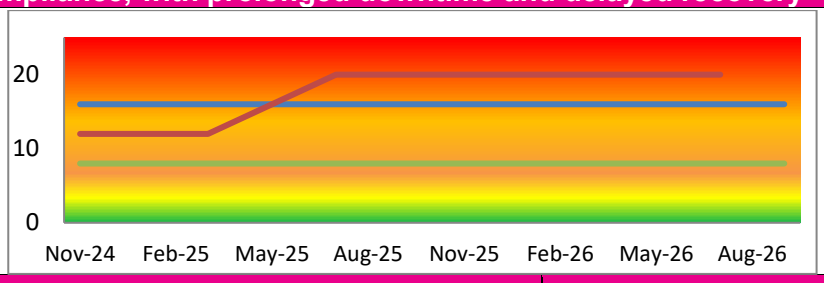
**26/27 Improvement Priority: Improving care and experience by strengthening our digital foundations and using innovation to support and empower staff and patients**

**Risk Appetite:** AVOID

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

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

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




Link to Risks on Corporate Risk Register

5869 (20) – Cyber attack

### Issues impacting achievements of our objective

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

### KPIs / Measures

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

### Controls

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

**Emergency planning**

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

### Assurances

**1st line of Defence (Operational management)**

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

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

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

**3rd Line of Defence (Independent or external assurance)**

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

### Actions (Chief of Strategy and Partnerships)

1. Review of digital team responsibilities to put a dedicated Cyber security role in place.
   Mar 26 Update: Role continues to be undertaken by the level three technical team. Job description and business case is under developments to be submitted to CRIG April 2026.
   **Update Jul26**: Job description has been completed, business case going through the approval process. Revised completion date: **Revised Target Date Oct26**

2. Complete the recommendations from the Toolkit submission and MIAA report Target Completion Dec 2025 Action progressing. Some progress has been made; however, we are currently dependent on the divisions to provide key information, including details about contracts and business continuity plans, etc. due to this the deadline has been extended to December. 13/42 recommendations have been closed. Mar 26 Update: The Improvement Plan was completed and submitted to NHSE in December 2025.
   **July 26 Update:** New improvement has been put in place for the DSPT for 2025-26, this is as part of MIAA external audit, with a deadline of Sep26.

3. Penetration test recommendation to be prioritised and actioned by Digital Services. For the recommendations provided by the external company there has been a progress of 59% of completed task as part of the report. Update Mar 26: Penetration testing completed action in place being reported through DPTB and via the new Cyber Group. Development of Business continuity plans for all Essential Functions on track. Revised Completion Date: July 2026
   **Update Jun26:** 74% of the finding has been completed, we have only the mediums findings left, these are 26 in total. Some of the delays is because some of these have a 3rd party and clinical dependency. **Revised Completion Date: Oct 2026**

4. Completion of IT Disaster Documentation covering all Essential Function. **Revised Completion Date: Sep2026**

5. Development and submission of a business case to deploy immutable backups across all Essential Functions.
   ITDR to completed by IT and approved by the Cyber Security Group. **Target Completion Date: Q4 2026**

### Gaps in Control

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

### Gaps in Assurance

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

### Notable changes since previous iteration of the BAF.

Strategic Risk 10b Being *resilient against Cyber Threats* of the BAF was reviewed by the Chief People Officer. Actions continue to progress, and the BAF has been revised to strengthen alignment with the Sustainability Plan. Gaps in controls and assurance have been updated, with corresponding actions now included within the actions section. No change is proposed to the current risk score or risk appetite.

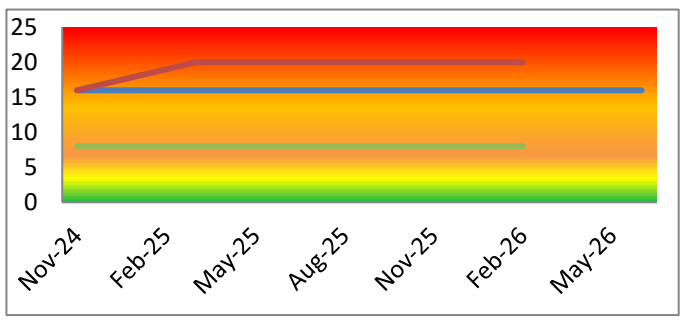
| CO.11 – Improving our estate and deliver against Net Zero targets and infrastructure compliance | EXECUTIVE LEAD: CHIEF FINANCE OFFICER |
|---|---|

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

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

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

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




## Link to Risks on Corporate Risk Register

5747 (15) Substation 10 Air circuit breaker replacements
6145 (15) Maternity Theatres ventilation failures
5929 (15) Site wide roofing repairs

## Issues impacting achievements of our objective

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

## KPIs / Outcome measures

- Achievement of our Green Plan targets with a focus on annual improvement towards net zero,
- Year on Year improvement in estates utilisation
- Improved safety and compliance through a year-on-year reduction in backlog maintenance
- IMC (N Block) – delivered 30/06/26
- Ophthalmology Theatres – delivered by 30/09/26
- Labs – delivered by 31/03/27
- Electrical Substations – delivered by 31/03/27
- Phase 2 - Ward refurbishment, 4 wards complete 31/03/27
- Estates and Facilities Programme delivery against £1.5m savings target.
- Estate utilisation improvements.
- Reduction in backlog maintenance risk.
- Delivery of capital schemes supporting operational productivity.

## Controls

- Estates Strategy and supporting Business Cases to make the case for external capital to CRIG, F&I, Board
- Established links to GM and NHSE
- Capital processes to ensure correct prioritisation
- Links with local partners including LA, University
- Membership of Bolton Strategic Estates Group
- Premises Assurance Model
- Enterprise Asset Management CAFM
- Agile Working Programme
- Our Green Plan
- Demolition and Disposal Strategy
- IFM asset management
- Digital Plan that maps back to the Trust strategy
- Clinical Strategy
- National RAAC team support
- Estates utilisation group
- Improvement Board oversight of Estates and Facilities transformation programme.
- Estates and Facilities transformation workstream within the Improvement and Sustainability Plan.
- Business case and gateway review process for major infrastructure schemes.
- Benefits realisation framework for estate utilisation and rationalisation scheme

## Assurances

**1st line of Defence (Operational management)**

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

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

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

**3rd Line of Defence (Independent or external assurance)**

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

## Actions

1. Production of a shared vision for the site and neighbouring land.
   Support the Partners of Health Innovation Board to develop a shared vision via monthly delivery board meetings. **Target Completion Date**: ~~**December 2025**~~ **Revised to Q3 26**
   **Update Jul 26**: Vision document has been reviewed by Strategic Estates Group and work is ongoing. Business cases will come to Board as needed for approval.

2. Monitor and manage the aging estate and escalate urgent issues with the estates. - Additional PDC bids submitted to support critical infrastructure works**.**
   **Target Completion Date: ~~Dec 2025~~ Revised to Q3 26**
   **Update Jul 26**: This is an ongoing action with a three-year rolling capital programme aimed at reducing backlog maintenance.

3. Review and formalisation of Strategic Estates Group to F&I. Continue to meet monthly to track progress with business cases and updates to the Executive and Board**.**
   **Target Completion Date: ~~Q3 2025~~ revised to Q2 2026**
   **Update Jul 26**: A review of the ToR for the Strategic Estates Group and Our Green Group is underway with a view to prepare a AAA Report the Executive Committee for escalations.

## Gaps in Control

- Achievement of our Green Plan targets with a focus on annual improvement towards net zero
- Delivery of the Estates and Facilities transformation programme and associated recurrent productivity and efficiency improvements remains dependent on successful implementation of planned schemes and capital investment
- Estates Strategy

## Gaps in Assurance

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

## Notable changes since previous iteration of the BAF

Strategic Risk 11 *Improving our estate and deliver against Net Zero targets and infrastructure compliance* of the BAF has been reviewed by the Chief Finance Officer prior to presentation at F&I and Board.

The Board took assurance that the framework continues to reflect the organisation's current risk posture and mitigation efforts. All actions are progressing as planned, with new target dates requested and specified alongside each action.

There was no change to the Risk Score or Risk Appetite

| CO.12 – PROACTIVELY PLANNING FOR THE FUTURE | EXECUTIVE LEAD: CHIEF STRATEGY AND PARTNERSHIPS |
|---|---|

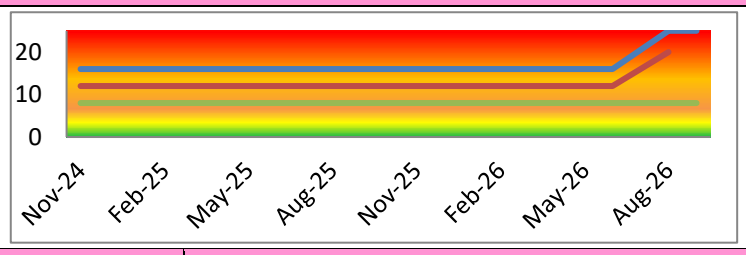
**26/27 Trust Priorities: Establish an Improvement Board that oversees a joined-up approach to strategy, planning and transformation, ensuring priorities are aligned and progress is delivered consistently across the organisation**

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

**STRATEGIC RISK 12: If the Trust fails to effectively deliver its Sustainability Plan, transformation programmes and productivity improvement initiatives, this may compromise financial sustainability, operational performance, delivery of strategic objectives and achievement of a sustainable operating model.**

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

| **Risk Assessment** | **Inherent** | **Current** | **Target** |
|---|---|---|---|
| Severity | 5 | 4 | 4 |
| Likelihood | 5 | ~~3~~ 5 | 2 |
| Risk Score | **25** | ~~**12**~~ **20** | 8 |




Link to Risks on Corporate Risk Register

6245 (16) Elective Care microscope obsolescence issued

## Issues impacting achievements of our objective

- The Greater Manchester (GM) financial position is a significant factor
- Shortage of revenue and capital funding.
- Meeting NHS England Productivity requirements.
- Working within GM ICB (jointly responsible and reliant on others results)
- Inability to deliver high levels of cost improvement
- Failure to identify and convert productivity opportunities into recurrent savings.
- Inadequate maturity of CIP schemes.
- Workforce, digital and estates dependencies delaying transformation.
- Failure to redesign pathways and deliver left-shift opportunities.
- Limited analytical capacity to understand drivers of productivity underperformance.
- Delivery risk associated with transformation programmes

## KPIs / Measures

- Improved accuracy and timeliness in forecasting service demand, leading to optimised resource allocation, strategic planning and enhanced decision making
- Comprehensive understanding of long-term healthcare trends, their impact on our services and plans in place to address
- Estates and capital planning based on data and intelligence on demographic and demand changes
- % of clinical services that have access to demographic data and disease prevalence and use this to inform planning
- Sub-KPI: Approach to workforce planning and service design informed by population health changes
- Sub-KPI: Succession planning effectiveness measured by the percentage of key positions with identified successors
- Delivery of £26m recurrent CIP programme.
- Percentage of CIP schemes fully developed and approved.
- Productivity KPI suite established and reported.
- Transformation programme milestones achieved.
- Executive theme savings delivered against target.
- Improvement Board effectiveness and reporting compliance.
- Recurrent versus non-recurrent savings ratio.
- Delivery against medium-term sustainability trajectory.
- Year 2 and 3 Transformation plan in development

## Controls

- PMO oversight of transformation and improvement programmes ~~coordination of CIP~~
- *Annual budget setting and planning processes*
- *Finance department annual business planning process*
- *Finance and Intelligence Group reviews of productivity and actions to improve*
- *Financial Improvement Group*
- *Executive Pay Panel*
- *Discretionary Non-Pay Panel*
- *Variable / agency pay panel*
- *Training panel*
- Sustainability Board chaired by the Chief Executive
- Benefit realisation reporting.
- Productivity and efficiency tracking.
- Alignment between the Improvement Board, transformation programme and financial recovery programme.
- Executive-led transformation programme governance with support from a Strategic Sustainability Partner.
- Productivity diagnostic programme.
- Trust-wide KPI framework.
- Benefits realisation framework.
- Gateway review process for transformation schemes.
- Twelve executive-led transformation workstreams.

## Assurances

### 1st line of Defence (Operational management)

- Annual Planning Process
- Reports to Finance Improvement Group (FIG)
- Review of Cost Improvement Programme at Finance Improvement Group
- Monthly Strategic Improvement Board reviews of milestones, benefits, risks and dependencies.
- CIP Check and Challenge meetings between Divisional Triumvirates and CEO and execs
- Productivity diagnostics and performance reviews.
- Executive-led transformation programme reviews

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

- Reports to F&I
- Improvement Board reports to Executive Committee.
- Quarterly reporting to F&I and Board on Sustainability Plan delivery.
- Transformation portfolio reporting
- Sustainability Board report as standing agenda item at Board

### 3rd Line of Defence (Independent or external assurance)

- Internal and External audit reports
- System Reports to Greater
- NHSE Operating Plan and Guidance
- GM Operating Plan
- Model Hospital benchmarking
- Independent review of transformation programme delivery.
- External benchmarking of productivity performance.
- Independent assurance of benefits realisation arrangements

## Actions

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

2. *Closer / joint local working in Bolton System.* Ongoing through Locality Board meetings.
   **Update Mar 26**: Board meetings are becoming less frequent and changes due to the ICB reorganisation are affecting this trend. **Revised Target Date Q3 26**.
   **Update July 26**: Locality Board meeting is back in place, and a partnership agreement is being developed by GM to support system working. **Revised Target Date Q3 26**.

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

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

5. Develop Sustainability Plan that is signed off by NHSE. **Completion Date Q3 26:** Update work is ongoing to develop the final plan to provide further assurance for years 2&3 regarding benefits realisation, productivity improvement, financial sustainability and the

| | | |
|---|---|---|
| | | effectiveness of transformation programmes in achieving intended outcome |
| **Gaps in Control** | **Gaps in Assurance** | **Notable changes since previous iteration of the BAF** |
| • Pay and non-pay controls require further enhancement The Trust's improvement and transformation arrangements are maturing and require further development of productivity measures, benefits realisation processes, programme management capability and transformation delivery infrastructure to support successful delivery of the Improvement and Sustainability Plan.<br>• Sustainability Plan 2026-29 measures<br>• Monthly productivity dashboard reported to Executive Committee, Sustainability Board and F&I.<br>• NOF improvement programme (where relevant).<br>• Service transformation programme governance.<br>• Productivity metrics embedded within divisional performance reviews. | • Model Hospital benchmarking programme and action plans<br>• Further assurance is required regarding delivery of the Sustainability Plan, including:<br>○ benefits realisation,<br>○ productivity improvement,<br>○ financial sustainability and<br>○ the effectiveness of transformation programmes in achieving intended outcome | Strategic Risk 12 *Proactively planning for the future* has been reviewed in the context of the Trust's Sustainability Plan and the associated requirement to deliver sustained productivity, transformation and financial recovery.<br><br>The inherent risk has been reprofiled to 25, reflecting a maximum severity and likelihood assessment before the application of controls. This recognises that non-delivery of the Sustainability Plan could have a material impact on financial sustainability, operational performance, productivity improvement, delivery of strategic objectives and the Trust's ability to achieve a sustainable operating model.<br><br>The revised inherent score is justified by the scale of the Trust's financial challenge, the dependency on recurrent CIP delivery and transformation benefits, the need to meet NHS England productivity expectations, and the reliance on system-wide decisions and partner contributions across Greater Manchester. The current and target scores remain subject to continued assurance through Sustainability Board oversight, Improvement Board reporting, productivity dashboards, benefits realisation tracking and escalation through F&I and Board. |

| AMBITION 5: A POSITIVE PARTNER |
|---|
| **PRINCIPAL RISK:** IF THE TRUST DOES NOT MAINTAIN TRANSPARENT AND COLLABORATIVE COMMUNICATION WITH STAKEHOLDERS, THEN TRUST AND ENGAGEMENT MAY DECLINE, POTENTIALLY UNDERMINING THE EFFECTIVENESS OF PARTNERSHIP INITIATIVES. |
| **Lead Committee:** Executive Committee through Trust Management Committee |
| **Lead Director:** Chief of Strategy and Partnerships |

| Our Objectives | OUR IN-YEAR PRIORITIES | ENABLING PLANS |
|---|---|---|
| Corporate Objective 13- Developing our neighbourhoods<br>Corporate Objective 14– Working as one team<br>Corporate Objective 15- Partnership for local benefit | • Provide care to as many people as possible in the community.<br>• Use every opportunity to improve the health of our patients.<br>• Increase services delivered in partnership with other providers and system partners to reduce costs, hand-offs and duplication. | • Clinical Strategy<br>• Financial Plan<br>• Green Plan |

| Corporate Objective | | Principal Risk | Risk Appetite | Risk Rating | Exec Lead | Lead Committee | Trend Analysis |
|---|---|---|---|---|---|---|---|
| **Ambition 4: An organisation that's fit for the future** | | | | | | | |
| CO13 | Developing our neighbourhoods | If the Trust fails to integrate care, opportunities to improve the health and wellbeing of the population of Bolton will be missed | Minimal | **12** 4x3 | CSP | Executive Committee | ⟷ |
| CO14 | Working as one team | If the Trust does not optimise its processes, this could negatively impact productivity and efficiency, resulting in unsustainable . | SEEK | **12** 4x3 | CSP | Executive Committee | ⟷ |
| CO15 | Partnership for local benefit | If the Trust does not establish partnerships that align with its Ambitions then this could negatively affect the services on offer, infrastructure, and financial stability | Minimal | **12** 4x3 | CFO | Executive Committee | ⟷ |

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

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

Current risks rating 15+ aligned with Ambition 5: **A POSITIVE PARTNER**

| Severity / Likelihood | | 1.Rare | 2. Minor | 3. Moderate | 4. Major | 5. Catastrophic |
|---|---|---|---|---|---|---|
| 1 | Rare | | | | | |
| 2 | Unlikely | | | | | |
| 3 | Possible | | | | | |
| 4 | Likely | | | | | |
| 5 | Certain | | | | | |

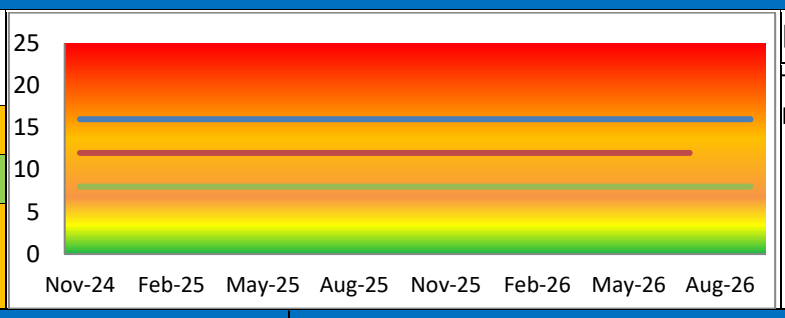
| CO13: Developing our neighbourhoods | EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS |
|---|---|

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

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

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

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




## Link to Risks on Corporate Risk Register

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

## Issues impacting achievements of our objective

- If BFT and other system partners have a financial deficit, there is a risk this may fragment integration and slow development
- Lack of collaboration with system partners to understand and respond to the wider determinants of health
- Changes in the wider health economy may destabilise our organisation
- the people of Bolton will experience poorer outcomes, and demand for acute and community services will remain high in future potential fragment integration and slow development
- Developing system transformation and finance plans may delay or weaken alignment of neighbourhood integration and Sustainability Plan priorities across partners.

## Outcome Measures

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

## Controls

- Community engagement plan developed for Bolton Locality
- Accountability for delivery of through the Place Based Lead
- Bolton Alliance Agreement to support the governance of the partnership
- Representation at Locality Board and System Finance Board on use of the of the Bolton £ .
- ICB Locality Delegation agreement with GM in place with Governance model for delivery in place.
- GM Sustainability Plan alignment embedded through neighbourhood, locality and system transformation priorities.
- Bolton Locality Plan and Outcomes Framework provide the delivery framework for partnership priorities and measurable locality outcomes.
- Regular stakeholder engagement fora embedded through neighbourhood working, including the use of patient stories to support ongoing communication, engagement and feedback.

## Assurances

**1st line of Defence (Operational management)**

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

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

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

**3rd Line of Defence (Independent or external assurance)**

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

## Actions

1. Refresh and embed the Locality Plan and ensure delivery. Delivery of the Locality Plan continues and the Neighbourhood Plan has been refreshed. **Revised Target Date: Q3 2026**
   **July 26 update:** Continue to refresh and embed the Locality Plan, ensuring delivery remains aligned to neighbourhood integration, the Sustainability Plan and agreed locality outcomes. Action remains ongoing in line with the target date.
2. Ensure timely and clear communication of decisions and developments. **Revised Target Date: Q3 2026**
   **Update Jul 26**: Ongoing with regular reviews
3. Monitor stakeholder feedback and adjust communication strategies accordingly.
   Ongoing reviews at Voice and Influence Group.
   Live Well project Breightmet piloting different ways of engaging with and communicating with communities with good outcomes. **Revised Target Date: Q3 2026**
   **July 26 update:** Action ongoing in line with target date
4. Develop Provider Collaborative Board to further develop the Neighbourhood offer and support the roll out of the Proactive Care model. Workshops in place with partners to scope Provider Collaborative
   Update Mar 26: Neighbourhood Plan has been refreshed work continues with the ICB to develop provider collaborative. BFT continue to roll out the Business Cases for Proactive Care. **Revised Target Date: Q3 2026**
   **July 26 update:** Action ongoing in line with target date
5. Deliver against the Bolton Outcomes Framework
   Ongoing with Quarterly monitoring through the Locality Board. Target Completion Date: Q4: 2026/27
   **July 26 update:** Action ongoing in line with target date
   :

## Gaps in Control

- ~~System transformation plan to transform services and drive integration being developed~~
- ~~System finance plan in development~~
- System transformation and finance plans remain in development, creating a risk that delivery of neighbourhood integration and Sustainability Plan priorities may be delayed or insufficiently aligned across partners.

## Gaps in Assurance

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

## Notable changes from previous iteration of the BAF

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

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

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

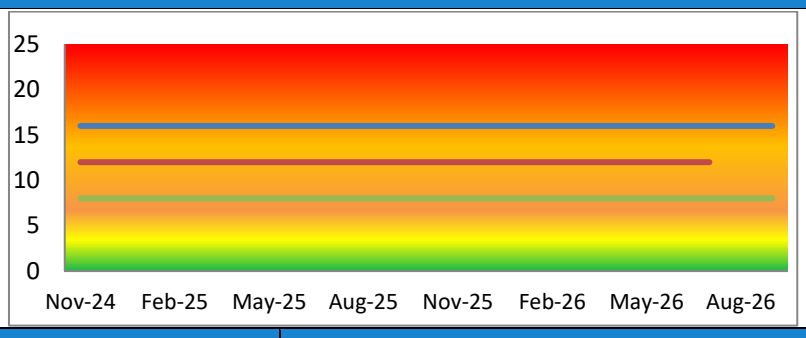
| CO.14 - Working as one team | EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS |
|---|---|

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

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

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

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




**Link to Risks on Corporate Risk Register**

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

**Issues impacting achievements of our objective**

- Workforce capacity and capability may limit delivery of safe, effective care and the Trust's ability to support shared system priorities.
- Strategic partnership opportunities may be missed if priorities, decision-making and delivery plans are not aligned across system partners.
- Limited integration with partners could affect access, experience and outcomes for the people of Bolton and weaken delivery of Sustainability Plan priorities.
-

**Outcome Measures**

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

**Controls**

- Bolton Joint Strategic Needs Assessment (JSNA)
- Membership of Bolton Strategic Development and Partnership Meetings
- Bolton Locality Governance Structure
- Joint governance routes with locality and GM partners to support shared decision-making, reduce duplication and align delivery with the Sustainability Plan.
- Bolton Partner Communication Update
- Community engagement plan and meetings with partners at Locality
- Bolton Alliance Agreement to support the governance of the partnership
- Governors Monthly Update
- Membership Newsletter
- Quarterly update to Locality following BFT Board meetings
- Active Connected and Prosperous (ACP)
- Local pathology, radiology and pharmacy clinical service strategies.
- GM PACs and LIMS procurements.
- Finalisation of GM network agreements
- Development of Local pathology, radiology and pharmacy clinical service strategies

**Assurances**

**1st line of Defence (Operational management)**

Deputy Place Based Lead attendance monthly at Executive Directors

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

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

**3rd Line of Defence (Independent or external assurance)**

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

**Actions**

1. Continued participation in GM working group to shape and influence the developing programme. Update Mar 26: GM work program in place with TPC priorities developed - ongoing progress updates, with regular reviews in place**.**
   **Revised Target Date: Q3 26**
   **July 26 update:** Action ongoing in line with target date

2. Develop Provider Collaborative Board workshops in place with partners to scope Provider Collaborative.
   **Revised Target Date: Q4 26**
   **July 26 update:** Continue to progress the Provider Collaborative as a key mechanism for closer system working, shared delivery and alignment with Sustainability Plan priorities. Delivery remains a priority but has been delayed due to NHS reforms; action remains ongoing in line with the revised target date.

3. Work with the ICB on developing the Place Based Partnership Team. ICB led workshops in place with partners to scope structure of the team
   **Update Mar 26**: work on the structure of the partnership team continues within the ICBs consultation.
   **Revised Target Date: Q3 26**
   **July 26 update:** Continue to work with the ICB on the structure of the Place Based Partnership Team to strengthen shared decision-making, clarify delivery arrangements and support alignment with Sustainability Plan and Bolton Locality priorities. Action remains ongoing in line with the revised target date.

**Gaps in Control**

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

**Gaps in Assurance**

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

*Further assurance will be strengthened as system partnership arrangements mature and clearer reporting routes are established for Provider Collaborative, Place Based Partnership and Sustainability Plan delivery.*

**Notable changes from previous iteration of the BAF**

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

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

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

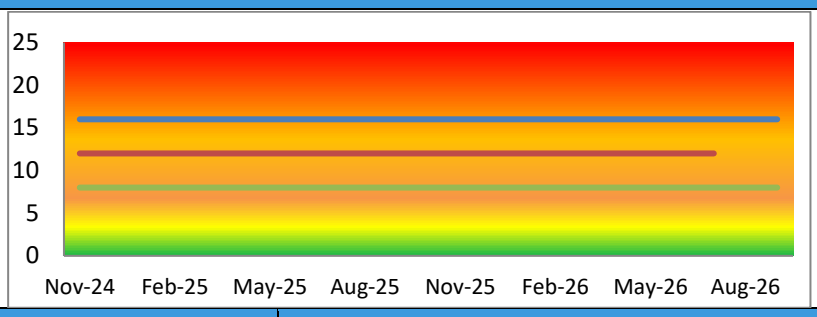
| CO.15: Partnering for local benefit | EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS |
|---|---|

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

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

**STRATEGIC RISK 15: If the Trust does not establish effective partnerships aligned to its ambitions and the Sustainability Plan, then opportunities to deliver sustainable services, reduce duplication, improve infrastructure and strengthen financial stability may be missed.**

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




**Link to Risks on Corporate Risk Register**

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

**Issues impacting achievements of our objective**

- Resilience of GM clinical services
- Increasing demand for services
- Resilience of sector and GM Radiology, Pharmacy and Pathology to support reconfigured services
- Provider Collaborative arrangements across GM remain in development, creating a risk to timely delivery of shared sustainability and service transformation priorities.
- Sustainable Workforce Pipeline
- Lack of relationships with neighbouring landowners and developers.
- Missed opportunity to use strategic partnerships to reduce duplication, improve productivity and deliver local benefit.

**Outcome Measures**

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

**Controls**

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

**Assurances**

**1st line of Defence (Operational management)**

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

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

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

**3rd Line of Defence (Independent or external assurance)**

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

**Actions**

1. Development of a stronger partnerships with local academic providers to develop a workforce pipeline. Library has moved into the Bolton Medical School Building, and first cohort of medical students start September 2025. Revised Target Date: Q3 2026.
   **July 26 update:** Action ongoing in line with target date

2. Expansion of clinical courses and programmes mapped to workforce demand—**Target Completion Date: March 2026**
   **Revised Target Date: Q4 2026**
   **July 26 update:** A refreshed approach to collaboration with the University is underway to support and influence clinical course provision in line with workforce demand. Action ongoing in line with target date

3. Development of new programmes to fulfil recruitment issues e.g. health informatics.
   **Revised Target Date: Q3 2026**
   **July 26 update:** Action ongoing in line with target date

4. Production of a shared vision for the site and neighbouring land**.** Action ongoing and expected to progress into Q3 2026. **Revised Target Date: Q3 2026**
   **July 26 update:** Action ongoing in line with target date

**Gaps in Control**

Substantive membership and participation in service transformation programmes within GM.

Development of Local pathology, radiology and pharmacy clinical service strategies

**Gaps in Assurance**

- GM Sustainable Services and Provider Collaborative assurance arrangements are still developing, with further work required to demonstrate clear alignment between system plans, local delivery priorities and Sustainability Plan outcomes.
- Finalisation of GM network agreements

**Notable changes from previous iteration of the BAF**

Strategic Risk 15: Partnering *for local benefit* of the BAF has been reviewed by the Chief of Strategy and Partnerships and updated to strengthen alignment with the Sustainability Plan, Provider Collaborative development and wider system partnership priorities. The framework continues to reflect the organisation's current risk posture and mitigation efforts.

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

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

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Sustainability Board Chair Report | | | |
| **Meeting:** | Board of Directors | **Action Required** | Assurance | ✓ |
| **Date:** | 30 July 2026 | | Discussion | |
| **Executive Sponsor** | Sharon White | | Decision | |

| | |
|---|---|
| **Purpose of the report** | This report provides an update and assurance to the Board of Directors on the work delegated to the Sustainability Board. |

| | |
|---|---|
| **Previously considered by:** | N/A |

| | |
|---|---|
| **Executive Summary** | The attached report from the Chair of the Sustainability Board provides an overview of matters discussed at the meeting held on 13 July 2026.<br><br>The report also sets out the assurances received by the Sustainability Board and identifies the specific concerns that require the attention of the Board of Directors. |

| | |
|---|---|
| **Proposed Resolution** | The Board of Directors is asked to ***receive*** the Sustainability Board Chair Report. |

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

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Sharon White<br>Chief of Strategy and Partnerships | **Presented by:** | Fiona Noden<br>Chief Executive |

| ALERT \| ADVISE \| ASSURE (AAA)<br>Key Issues Highlight Report | | | |
|---|---|---|---|
| **Name of Committee /Group:** | Sustainability Board | **Reports to:** | Board of Directors |
| **Date of Meeting:** | 13 July 2026 | **Date of next meeting:** | 30 July 2026 |
| **Chair** | Fiona Noden | **Meeting Quoracy** | Yes |

**AGENDA ITEMS DISCUSSED AT THE MEETING:**

- Terms of Reference
- Current position and update on Sustainability Themes
- Cost of Change Update
- Transformation Delivery SMT AAA Report
- Data and Intelligence Dashboard

## ALERT

**Current position and update on Sustainability Themes**

Limited movement in the overall CIP position, with Part-year effect (PYE) savings of £29.58m and risk-adjusted savings of £23.07m against the revised £38m target. The Chair highlighted that the position had not materially moved for six to seven weeks and that a significant change in pace was required and a continued focus on identifying additional opportunities to close the gap against the revised £38m target and progressing existing opportunities through the governance process to improve the risk-adjusted position and delivery assurance.

Action:

## ADVISE

**Terms of Reference**

The Terms of Reference were approved subject to the development of a practical checklist/oversight mechanism to support QMS assurance, stage-gate oversight and prioritisation/resource alignment.

**Cost of Change Update**

The Board received the update noting that a £1.5m allocation had been established to support delivery of the Sustainability Plan, with funding already committed to the Drivers of the Deficit programme, additional PMO capacity and senior PwC support. Further resource requirements were identified, including clinical leadership, operational improvement support, benefits management, analytical capacity and IHI support. The Board advised that the paper should clearly distinguish confirmed commitments from potential further investment, including digital requirements, so that Executive Directors can assess the link between investment decisions, expected benefits and delivery of the Sustainability Plan.

## ASSURE

**Data and Intelligence Dashboard**

The Board welcomed the clarity of the updated dashboard which provided a near-time view of activity, performance and validation issues, with agreement that it should support executive and operational

| |
|---|
| efficiency discussions and feed into EPR sprint priorities.<br><br>**Transformation Delivery SMT**<br>The Transformation SMT AAA report provided assurance that work is underway to establish a single organisational improvement portfolio, prioritisation methodology, resource framework and refreshed benefits realisation approach for Years 2 and 3 of the Sustainability Plan. |
| **New Risks identified at the meeting: N/A** |
| **Review of the Risk Register:** The Board should consider whether existing financial sustainability, transformation delivery, digital delivery and data quality risks adequately reflect the current level of delivery risk, enabling capacity constraints and benefits realisation concerns. Any gaps should be reviewed through the relevant executive governance route. |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Integrated Performance Report | | | |
| **Meeting:** | Board of Directors | **Action Required** | Assurance | ✓ |
| **Date:** | 30 July 2026 | | Discussion | ✓ |
| **Executive Sponsor** | Deputy Chief Executive/Chief People Officer | | Decision | |

| | |
|---|---|
| **Purpose of the report** | To present the Month 03 Integrated Performance Report |

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

| | |
|---|---|
| **Executive Summary** | The Integrated Performance Report provides an overview of the Trust's performance against the reported metrics during June 2026. This report is intended to offer a transparent and accessible account of the Trust's outcomes for both patients and staff. The narrative included describes issues that are affecting performance and any mitigating actions to improve performance and meet key standards.<br><br>Each of the relevant Executive Directors will provide a short overview of the key critical areas outlined in the report. |

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

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

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

| | | | |
|---|---|---|---|
| **Prepared by:** | **Emma Cunliffe (BI)** | **Presented by:** | **Executive Directors** |

Bolton NHS Foundation Trust

# Integrated Performance Report

June 2026

# Guide to Statistical Process Control

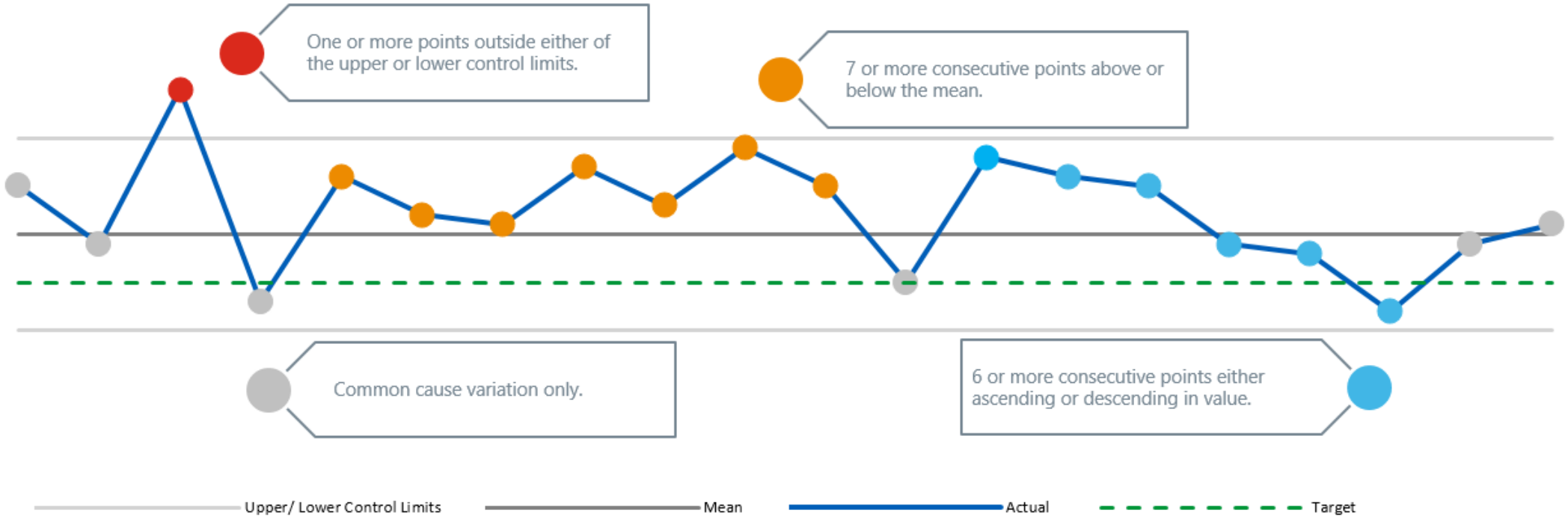
NHS Bolton NHS Foundation Trust

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

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

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

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



# Integrated Performance Report Summary Matrix – July 2026 edition

NHS Bolton NHS Foundation Trust

| | | |
|---|---|---|
| **No action**: *improving and consistently passing.* | **Monitor**: *Improving but can be inconsistent*<br>• Diagnostic Waits >6 weeks %<br>• 2 Hour Urgent Community Response % | **Monitor**: *Improving but consistently not achieving target.* |
| **No action**: *No change and consistently passing.* | **Consider action**: *No change and can be inconsistent with target.*<br>• A&E 4-hour target<br>• 31 Day General Treatment Standard<br>• 62 Day General Standard<br>• Cancer: 28 day faster diagnosis<br>• Summary Hospital-level Mortality Indicator (SHMI)<br>• A&E Friends and Family Satisfaction Rates %<br>• Maternity Friends and Family Test - Satisfaction %<br>• Total Healthcare Associated C. difficile Cases<br>• Total Healthcare Associated MRSA Bacteraemia (days between cases)<br>• Total Healthcare Associated E. coli Bacteraemia<br>• RTT Incomplete pathways within 18 weeks % | **Take action:** *No change and consistently not achieving target.*<br>• A&E 12 hour waits<br>• Sickness absence level - Trust |
| **Caution**: *Declining but still consistently passing.*<br>• Friends and Family Test (Inpatients) - Satisfaction % | **Take action**: *Declining and inconsistent with target.*<br>• Our staff tell us they would recommend the Trust as a place to work | **Take action:** *Declining and consistently not achieving target.*<br>• Our staff tell us they would recommend the Trust for treatment |

The indicators on the matrix are taken from the Integrated Performance Report and arranged according to their current Statistical Process Control (SPC) alert status. The indicators have been selected to cover the NHS Constitutional targets plus the NHS Oversight Framework (2025/26 current indicators). The Matrix is intended to help summarise performance across key metrics.

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

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

# Executive Summary

Bolton NHS Foundation Trust

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

## Variation

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

## Assurance

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

## Performance

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

# Quality and Safety - Harm Free Care

Bolton NHS Foundation Trust

Pressure Ulcers

Hospital-acquired pressure ulcer performance remains within common cause variation. There were no category 3 or category 4 hospital-acquired pressure ulcers reported during the month, demonstrating a continued reduction in month.

The measures implemented through the Pressure Ulcer Change Package continue to demonstrate improvement, with the Trust now achieving five consecutive months below the historical mean for inpatient category 3 and above pressure ulcers, including unstageable pressure ulcers. If this position is maintained for one further month, the Trust will achieve special cause variation, providing evidence that the improvement is sustained rather than attributable to normal variation.

The Patient Safety Review Panel continues to support an open culture of learning and improvement. Themes remain consistent, with learning focused on documentation, care planning, registered nurse oversight and the management of moisture-associated skin damage, which can increase skin vulnerability and contribute to pressure damage. The Tissue Viability Service continues to support the Releasing Time to Care programme, ensuring documentation remains safe and appropriate whilst maximising time available for direct patient care.

Community-acquired pressure ulcers remain within common cause variation across all categories, although a recent increase in category 3 pressure ulcers will continue to be monitored. Historically, warmer weather can contribute to an increase in pressure ulcer development through reduced mobility, dehydration and lower nutritional intake. Whilst this pattern has been observed within community-acquired pressure ulcers, review of inpatient data has not identified a similar trend. No significant learning events have been identified, with Divisional Safety Senates continuing to provide opportunities for shared learning and dissemination of good practice.

Falls

Inpatient falls per 1,000 bed days remain within common cause variation, although performance has marginally exceeded the Trust stretch threshold at 5.58. There were two falls resulting in moderate harm during the month. Both incidents involved patients who were independently mobile and occurred in bathrooms, making them unwitnessed events. One fall resulted in a fractured neck of femur and the other in a head injury.

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 6 - Compliance with preventative measure for VTE | >= 95% | 95.8% | Jun-26 |  | >= 95% | 96.1% | May-26 | >= 95% | 95.6% |  |
| 9 - Never Events | = 0 | 0 | Jun-26 |  | = 0 | 0 | May-26 | = 0 | 0 |  |
| 13 - All Inpatient Falls (Safeguard Per 1000 bed days) | <= 5.30 | 5.58 | Jun-26 |  | <= 5.30 | 4.87 | May-26 | <= 5.30 | |  |
| 14 - Inpatient falls resulting in Harm (Moderate +) | <= 1.6 | 2 | Jun-26 |  | <= 1.6 | 4 | May-26 | <= 4.8 | 7 |  |
| 15 - Number of Acute Inpatient incidences - pressure damage (category 2) | <= 6.0 | 13.0 | Jun-26 |  | <= 6.0 | 5.0 | May-26 | <= 18.0 | 25.0 |  |

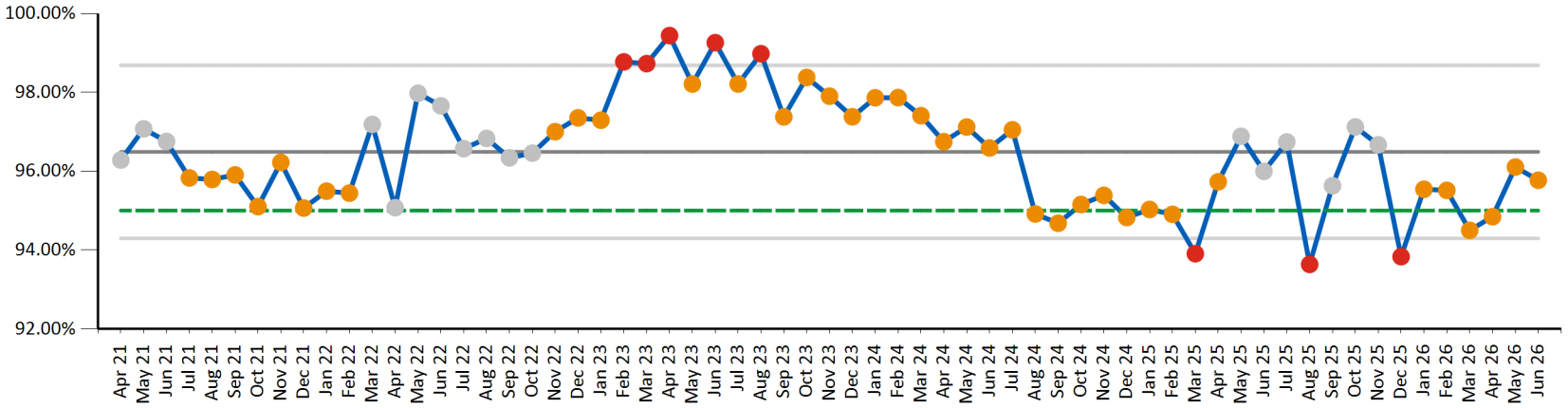
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 620 - Number of Acute Inpatient incidences - pressure damage (category 3 plus unstageables) | <= 1 | 0 | Jun-26 | | <= 1 | 0 | May-26 | <= 2 | 2 | |
| 17 - Number of Acute Inpatient incidences - pressure damage (category 4) | = 0.0 | 0.0 | Jun-26 | | = 0.0 | 0.0 | May-26 | = 0.0 | 0.0 | |
| 18 - Number of Community incidences - pressure damage (category 2) | <= 7.0 | 10.0 | Jun-26 | | <= 7.0 | 9.0 | May-26 | <= 21.0 | 30.0 | |
| 621 - Number of Community incidences - pressure damage (category 3 plus unstageables) | <= 4 | 15 | Jun-26 | | <= 4 | 8 | May-26 | <= 12 | 26 | |
| 20 - Number of Community incidences - pressure damage (category 4) | <= 1.0 | 2.0 | Jun-26 | | <= 1.0 | 2.0 | May-26 | <= 3.0 | 7.0 | |
| 535 - Community patients acquiring pressure damage - significant learning category 2 | | 0 | Jun-26 | L | | 0 | May-26 | | 0 | |
| 536 - Community patients acquiring pressure damage - significant learning category 3 plus unstageables | | 0 | Jun-26 | | | 0 | May-26 | | 0 | |
| 537 - Community patients acquiring pressure damage - significant learning category 4 | | 0 | Jun-26 | L | | 0 | May-26 | | 0 | |
| 30 - Clinical Correspondence - Inpatients %<1 working day | >= 95% | 79.6% | Jun-26 | H | >= 95% | 78.0% | May-26 | >= 95% | 78.3% | F |
| 31 - Clinical Correspondence - Outpatients %<5 working days | >= 95.0% | 56.1% | Jun-26 | L | >= 95.0% | 56.9% | May-26 | >= 95.0% | 56.9% | F |
| 86 - Patient Safety Alerts - Trust position | = 100% | 100.0% | Jun-26 | H | = 100% | 100.0% | May-26 | = 100% | 100.0% | |
| 88 - Nursing KPI Audits | >= 85% | 96.8% | Jun-26 | H | >= 85% | 95.8% | May-26 | >= 85% | 96.2% | P |
| 91 - Patient Safety Incident Investigation turnaround performance by agreed deadline | = 100% | 100.0% | Jun-26 | H | = 100% | 100.0% | May-26 | = 100% | | |
| 8 - Same sex accommodation breaches | = 0 | 44 | Jun-26 | H | = 0 | 25 | May-26 | = 0 | 95 | F |

## 6 - Compliance with preventative measure for VTE

Special cause variation with deteriorating performance

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

4/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 95% | 95.8% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 95% | 96.1% | May-26 |

### Year to Date

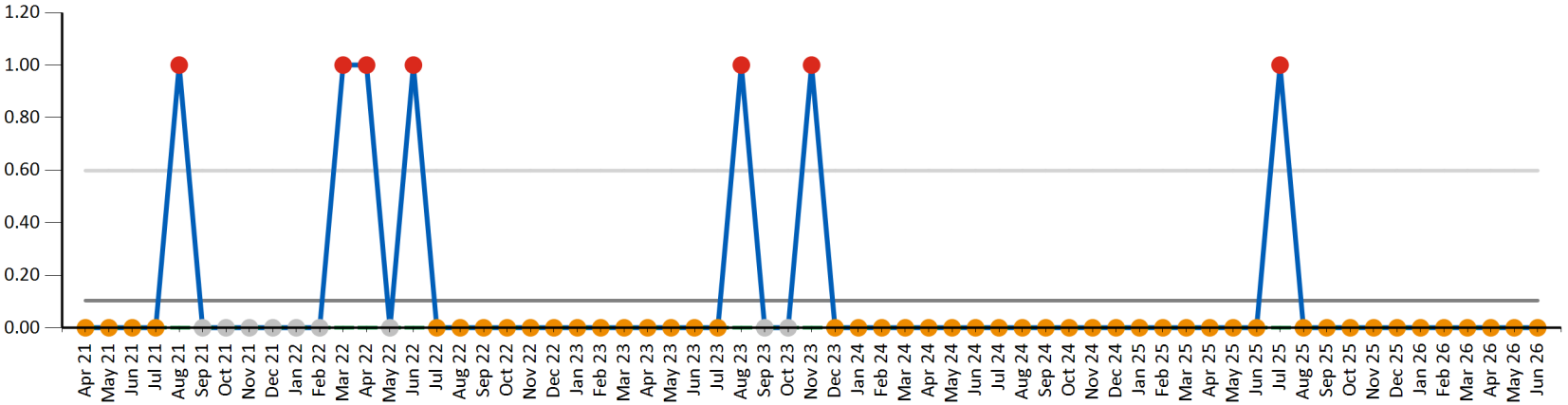
| Plan | Actual |
|---|---|
| >= 95% | 95.6% |

## 9 - Never Events

Special cause variation with improving performance

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

6/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| = 0 | 0 | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| = 0 | 0 | May-26 |

### Year to Date

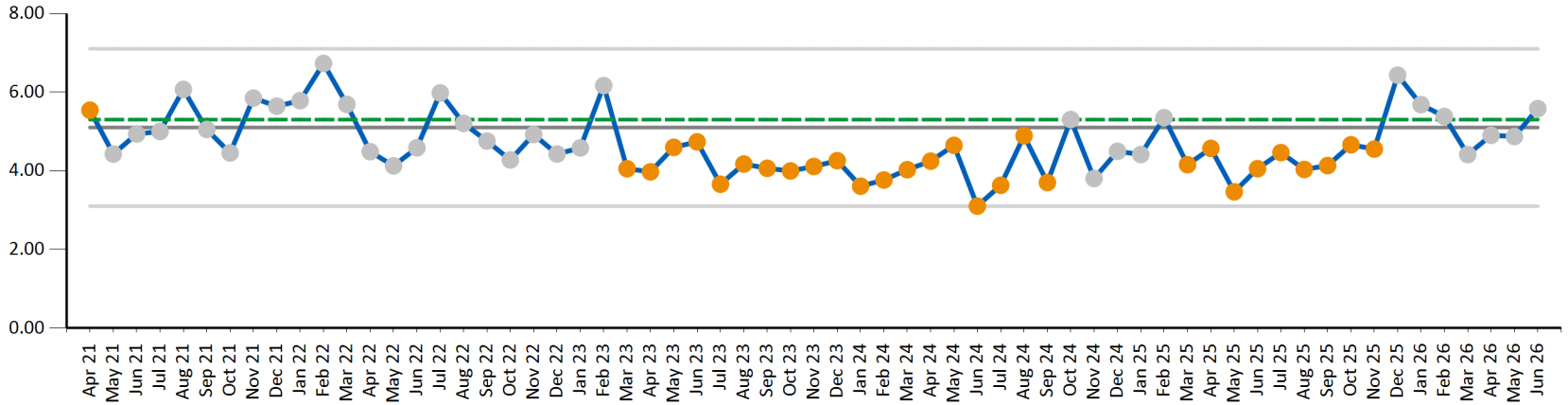
| Plan | Actual |
|---|---|
| = 0 | 0 |

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

Common cause variation.

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

3/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 5.30 | 5.58 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 5.30 | 4.87 | May-26 |

**Year to Date**

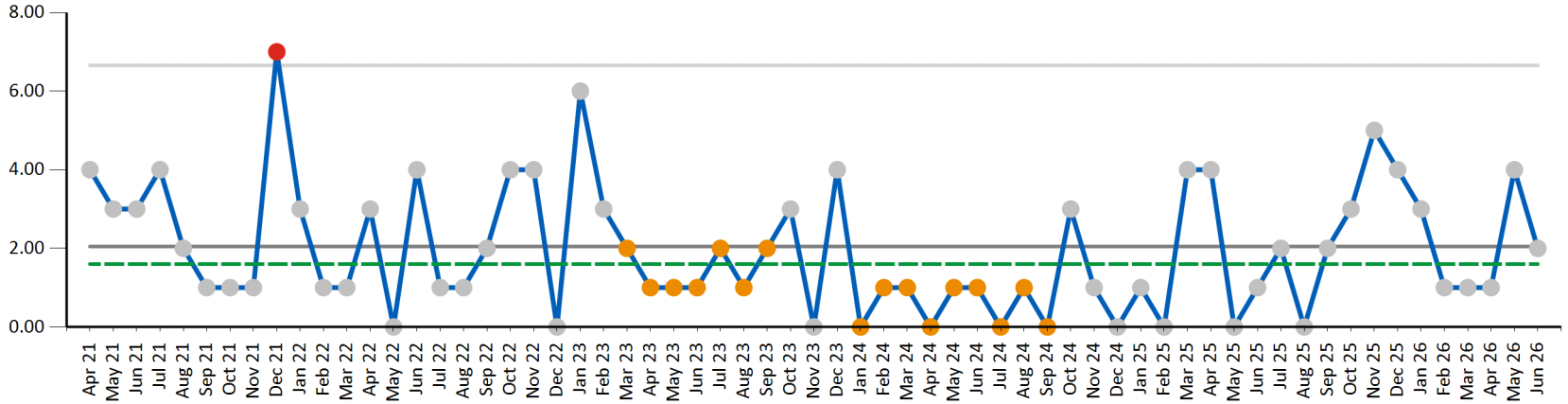
| Plan | Actual |
|---|---|
| <= 5.30 | |

## 14 - Inpatient falls resulting in Harm (Moderate +)

Common cause variation.

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

3/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 1.6 | 2 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 1.6 | 4 | May-26 |

**Year to Date**

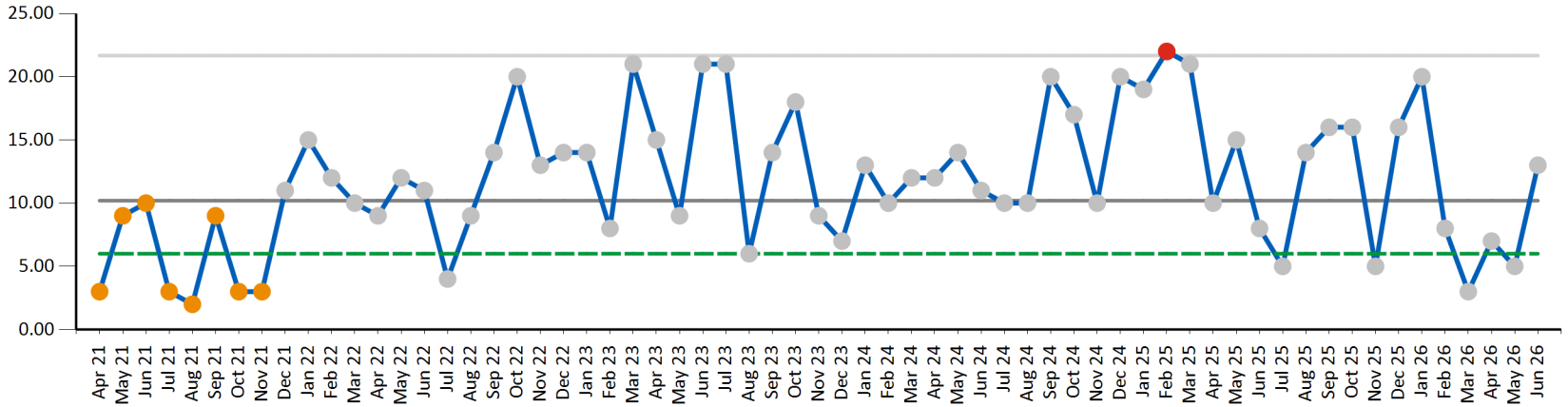
| Plan | Actual |
|---|---|
| <= 4.8 | 7 |

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

Common cause variation.

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

2/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 6.0 | 13.0 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 6.0 | 5.0 | May-26 |

**Year to Date**

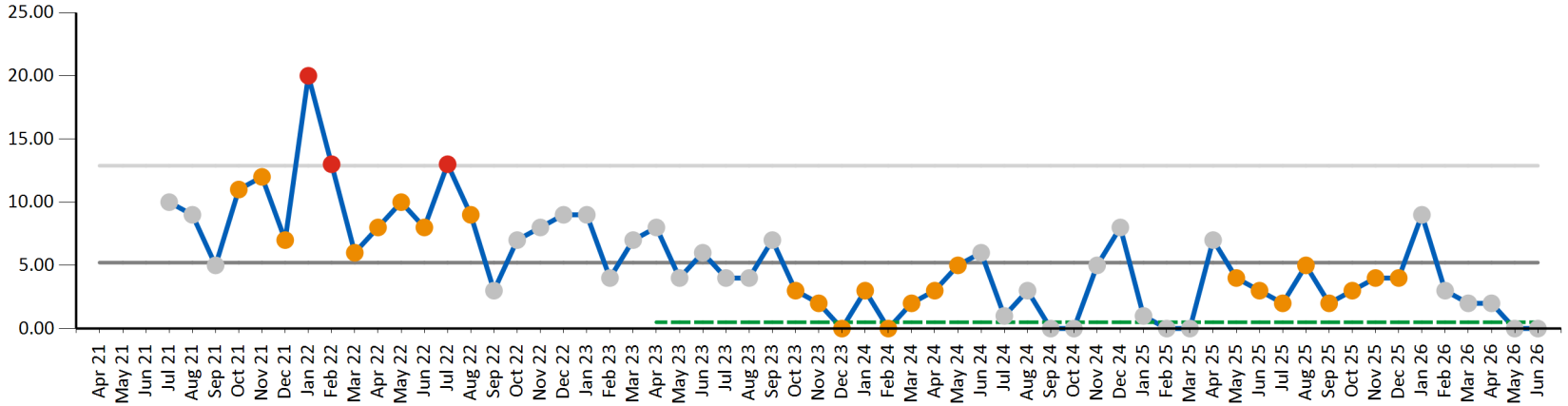
| Plan | Actual |
|---|---|
| <= 18.0 | 25.0 |

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

Common cause variation.

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

2/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 1 | 0 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 1 | 0 | May-26 |

**Year to Date**

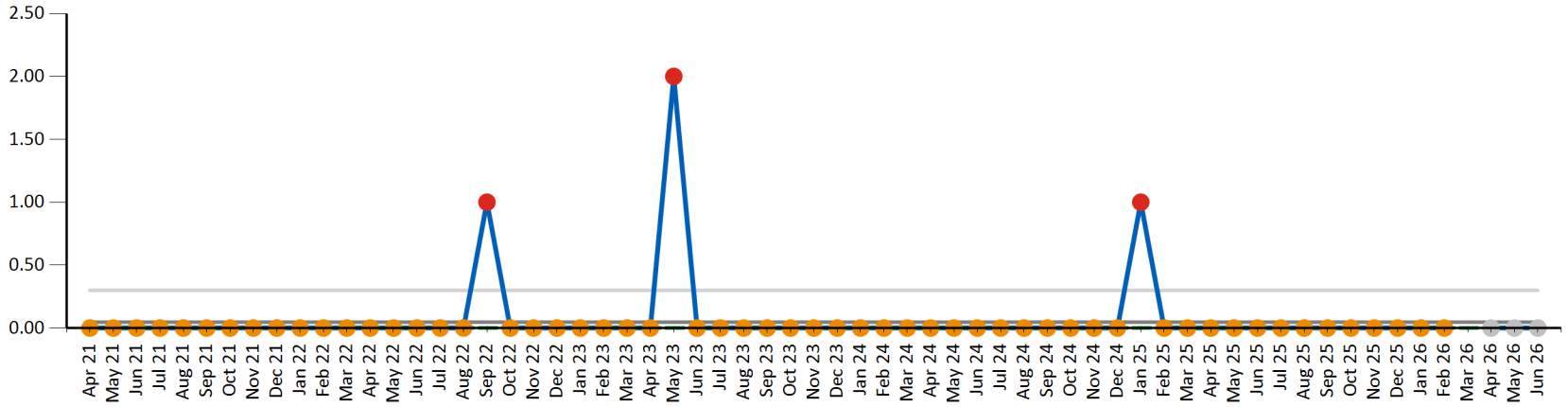
| Plan | Actual |
|---|---|
| <= 2 | 2 |

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

Common cause variation.

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

5/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| = 0.0 | 0.0 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| = 0.0 | 0.0 | May-26 |

**Year to Date**

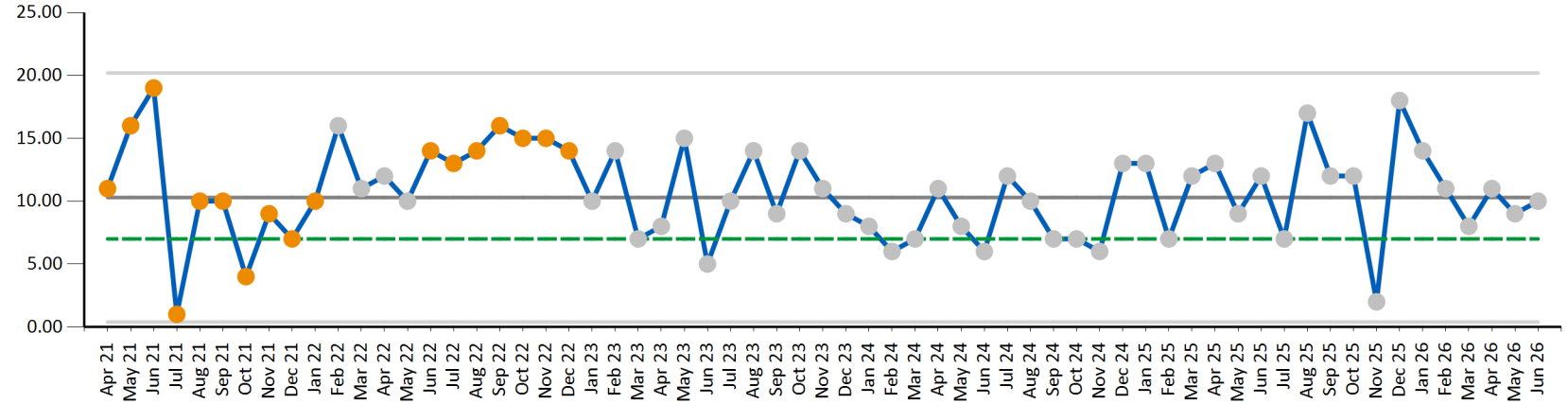
| Plan | Actual |
|---|---|
| = 0.0 | 0.0 |

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

Common cause variation.

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

0/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 7.0 | 10.0 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 7.0 | 9.0 | May-26 |

**Year to Date**

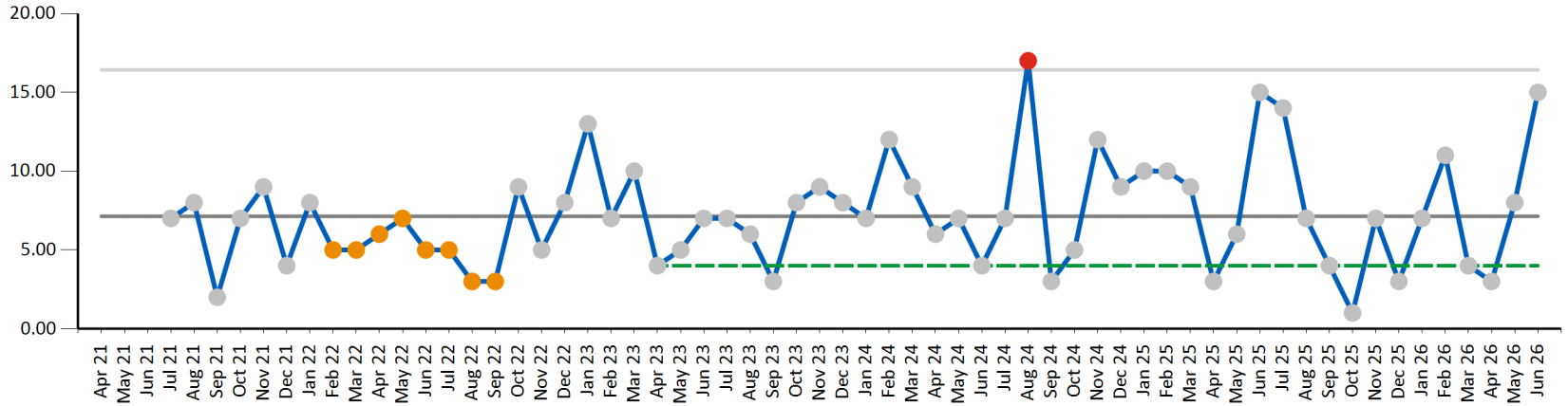
| Plan | Actual |
|---|---|
| <= 21.0 | 30.0 |

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

Common cause variation.

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

2/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 4 | 15 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 4 | 8 | May-26 |

**Year to Date**

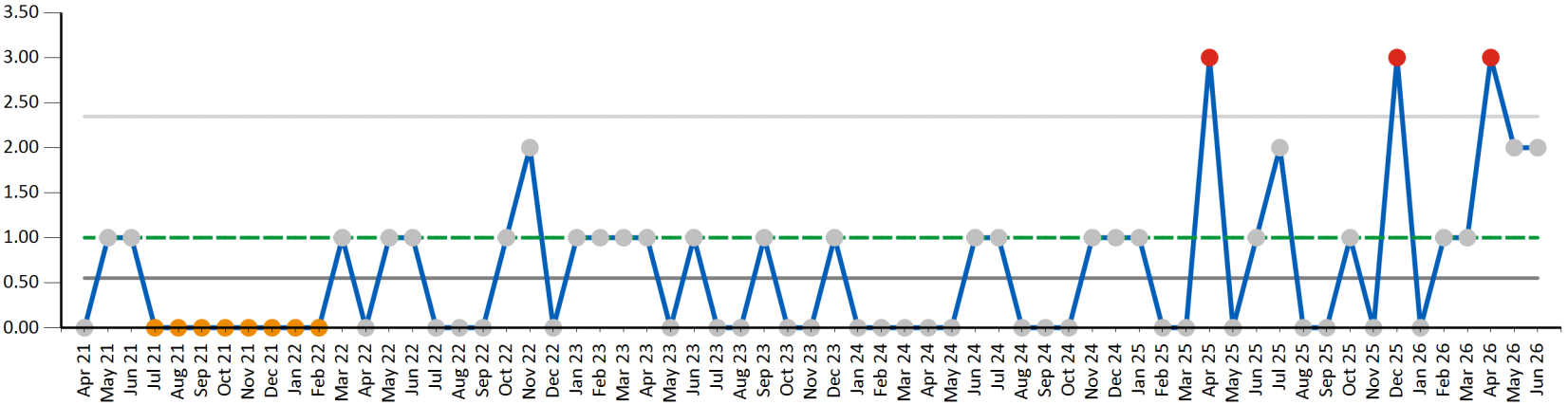
| Plan | Actual |
|---|---|
| <= 12 | 26 |

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

Common cause variation.

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

3/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 1.0 | 2.0 | Jun-26 |

**Previous**

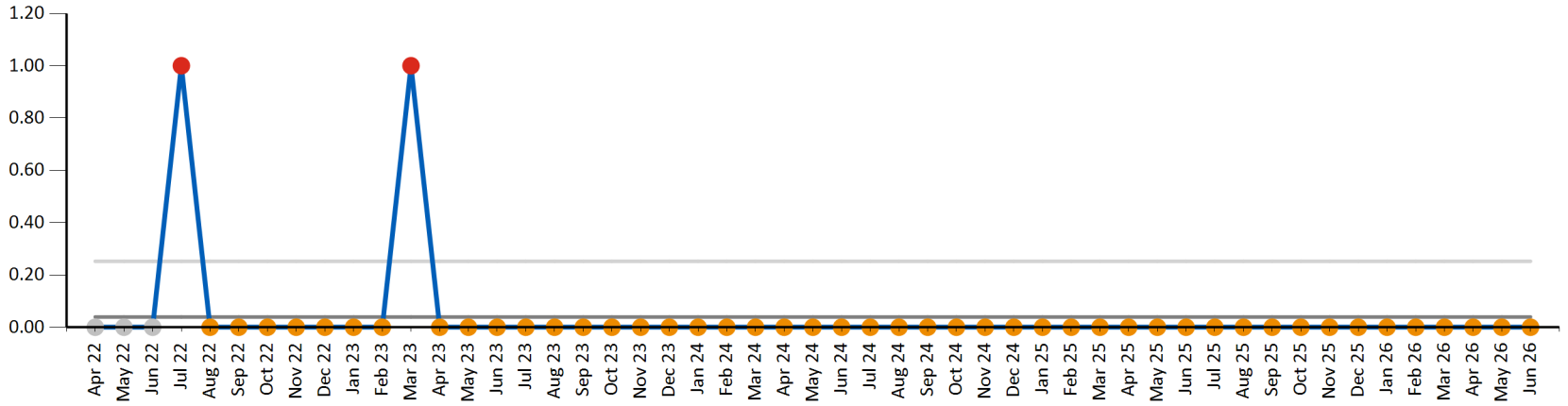
| Plan | Actual | Period |
|---|---|---|
| <= 1.0 | 2.0 | May-26 |

**Year to Date**

| Plan | Actual |
|---|---|
| <= 3.0 | 7.0 |

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

Special cause variation with improving performance




Latest

| Plan | Actual | Period |
|---|---|---|
| | 0 | Jun-26 |

Previous

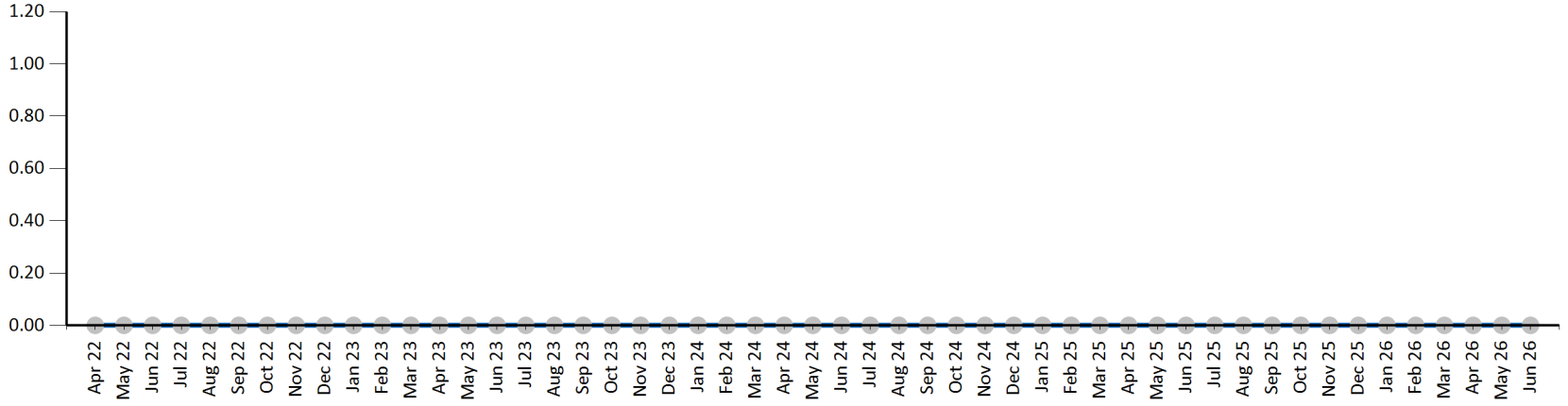
| Plan | Actual | Period |
|---|---|---|
| | 0 | May-26 |

Year to Date

| Plan | Actual |
|---|---|
| | 0 |

## 536 - Community patients acquiring pressure damage - significant learning category 3 plus unstageables

Common cause variation.




Latest

| Plan | Actual | Period |
|---|---|---|
| | 0 | Jun-26 |

Previous

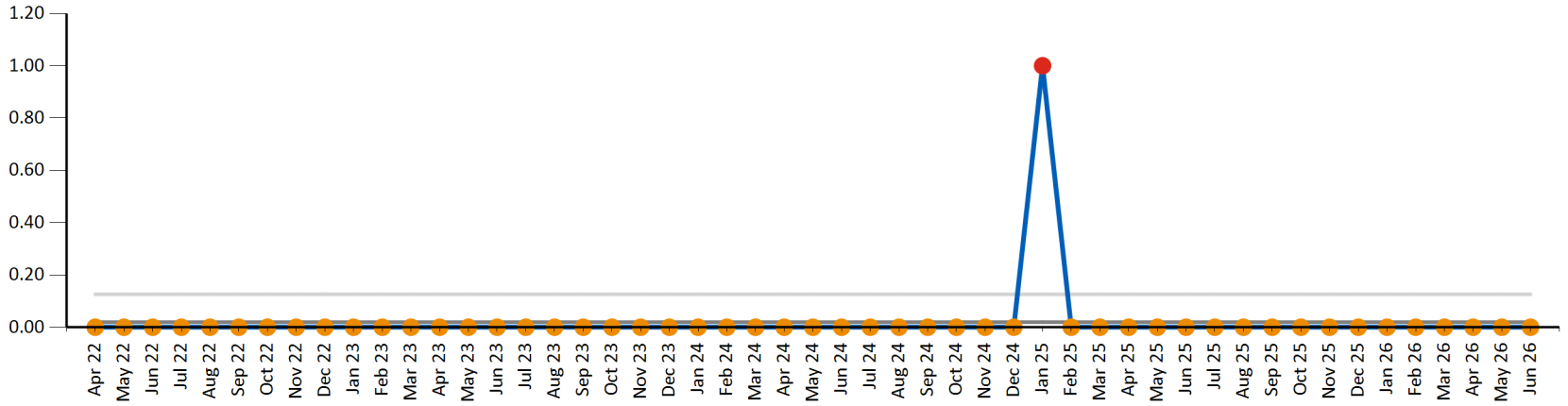
| Plan | Actual | Period |
|---|---|---|
| | 0 | May-26 |

Year to Date

| Plan | Actual |
|---|---|
| | 0 |

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

Special cause variation with improving performance




**Latest**

| Plan | Actual | Period |
|---|---|---|
| | 0 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| | 0 | May-26 |

**Year to Date**

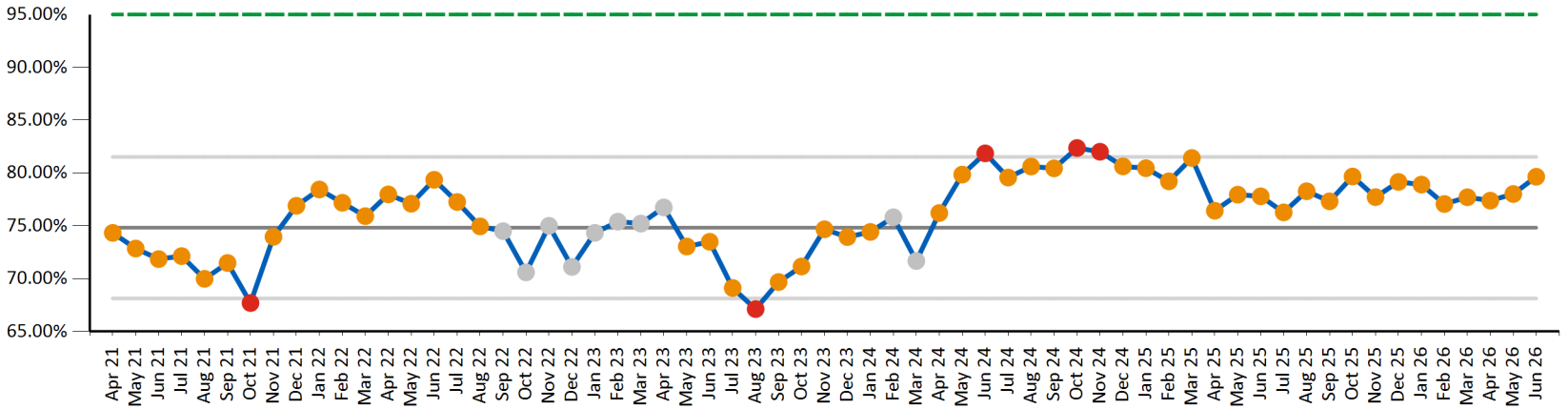
| Plan | Actual |
|---|---|
| | 0 |

## 30 - Clinical Correspondence - Inpatients %<1 working day

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 95% | 79.6% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 95% | 78.0% | May-26 |

**Year to Date**

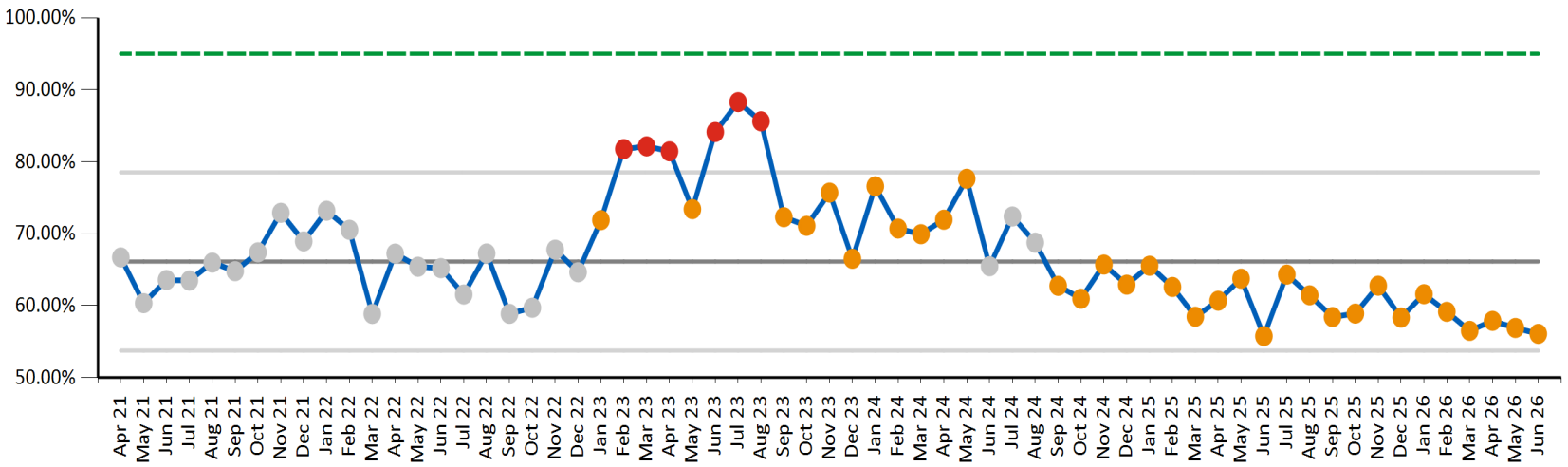
| Plan | Actual |
|---|---|
| >= 95% | 78.3% |

## 31 - Clinical Correspondence - Outpatients %<5 working days

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 95.0% | 56.1% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 95.0% | 56.9% | May-26 |

**Year to Date**

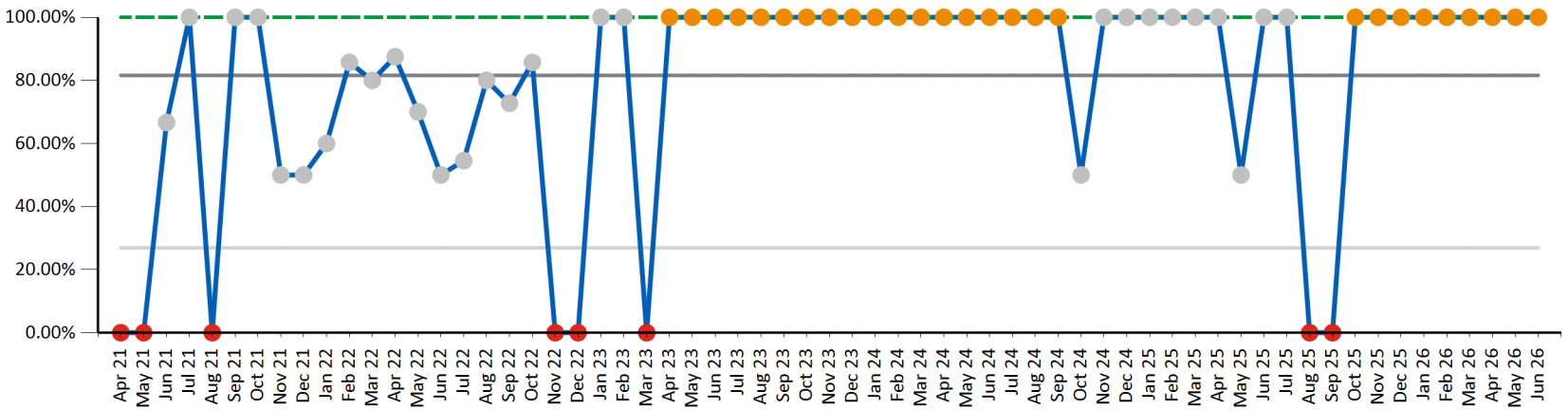
| Plan | Actual |
|---|---|
| >= 95.0% | 56.9% |

## 86 - Patient Safety Alerts - Trust position

Special cause variation with improving performance

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

6/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| = 100% | 100.0% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| = 100% | 100.0% | May-26 |

**Year to Date**

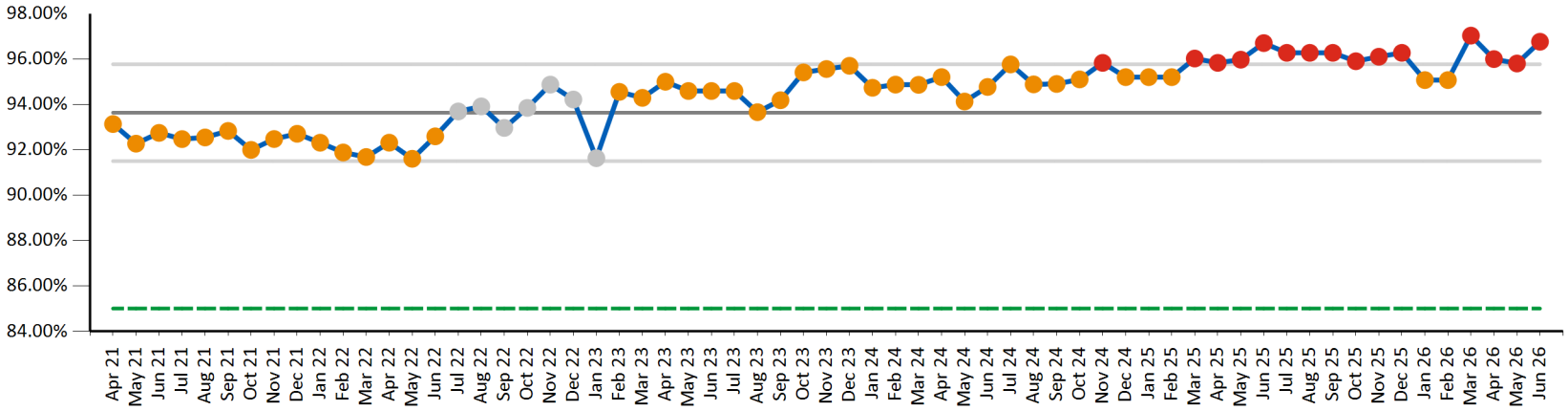
| Plan | Actual |
|---|---|
| = 100% | 100.0% |

## 88 - Nursing KPI Audits

Special cause variation with improving performance

Target will be regularly met.

6/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 85% | 96.8% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 85% | 95.8% | May-26 |

### Year to Date

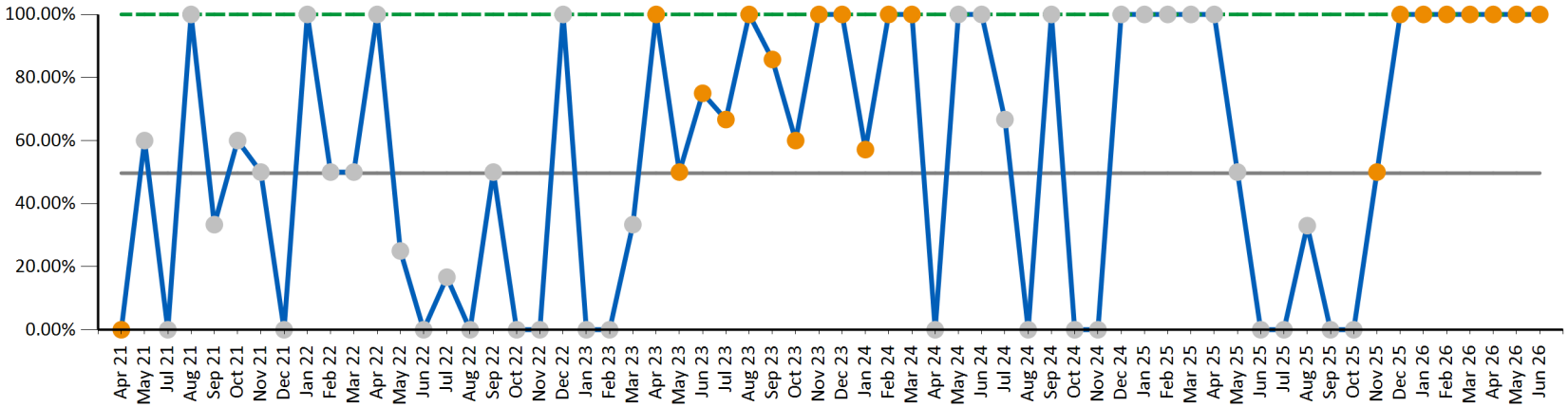
| Plan | Actual |
|---|---|
| >= 85% | 96.2% |

## 91 - Patient Safety Incident Investigation turnaround performance by agreed deadline

Special cause variation with improving performance

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

6/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| = 100% | 100.0% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| = 100% | 100.0% | May-26 |

### Year to Date

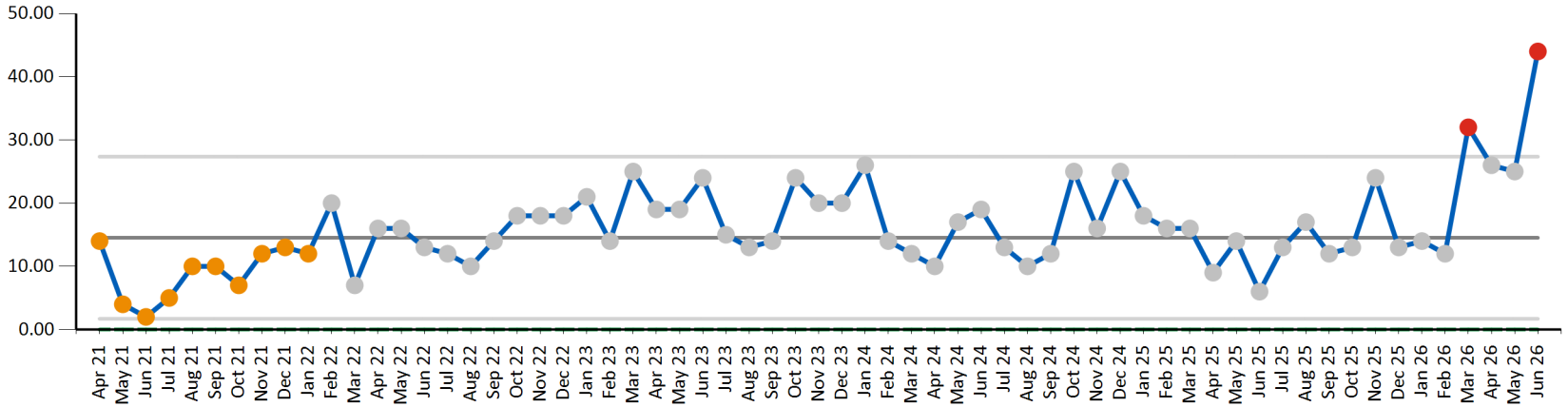
| Plan | Actual |
|---|---|
| = 100% | |

## 8 - Same sex accommodation breaches

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| = 0 | 44 | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| = 0 | 25 | May-26 |

### Year to Date

| Plan | Actual |
|---|---|
| = 0 | 95 |

# Quality and Safety - Infection Prevention and Control

NHS Bolton NHS Foundation Trust

For the second month in a row there have been 12 healthcare associated CDT cases, leaving the Trust more than two cases over trajectory. This includes a confirmed cluster of cases connected to one ward which the division are addressing with support from the Infection Prevention Control Team.

It is likely that the ongoing pressures caused by the norovirus outbreaks have contributed to the number of CDT cases, as isolation compliance reduces when patients are cohorted, and more stool samples are tested. From time to time this results in a CDT positive result secondary to the viral gastroenteritis causing the diarrhoea. However, there has also been a reduction in compliance with isolation and, from WC 20/07/26, there will be a period of increased focus and scrutiny on patient isolation.

As part of the review of the impact of norovirus on the Trust during this 'winter' period, the key question addressed has been 'what has changed since last year?' Two changes have been a physical revision of the ED footprint and changes to NWAS handover policy, creating an environment where there are surges of patients in the Initial Assessment area, some of whom may have symptoms of viral gastroenteritis. This has increased opportunities for cross-transmission. Consequently, additional air scrubbers have been acquired to reduce risk. Air scrubbers draw in air and pass it through an ultraviolet (UV) matrix and High-Efficiency Particulate Air (HEPA) filter, improving air quality within the environment.

There has been one healthcare associated MSSA bacteraemia in June related to a long-term condition of the patient and unrelated to healthcare interventions. The average number of cases over the past six months has reduced to two cases per month compared to three cases per month in the preceding six months. It is too soon to be confident that this is a sustained reduction.

There have been three E. coli bacteraemias, maintaining common cause variation.

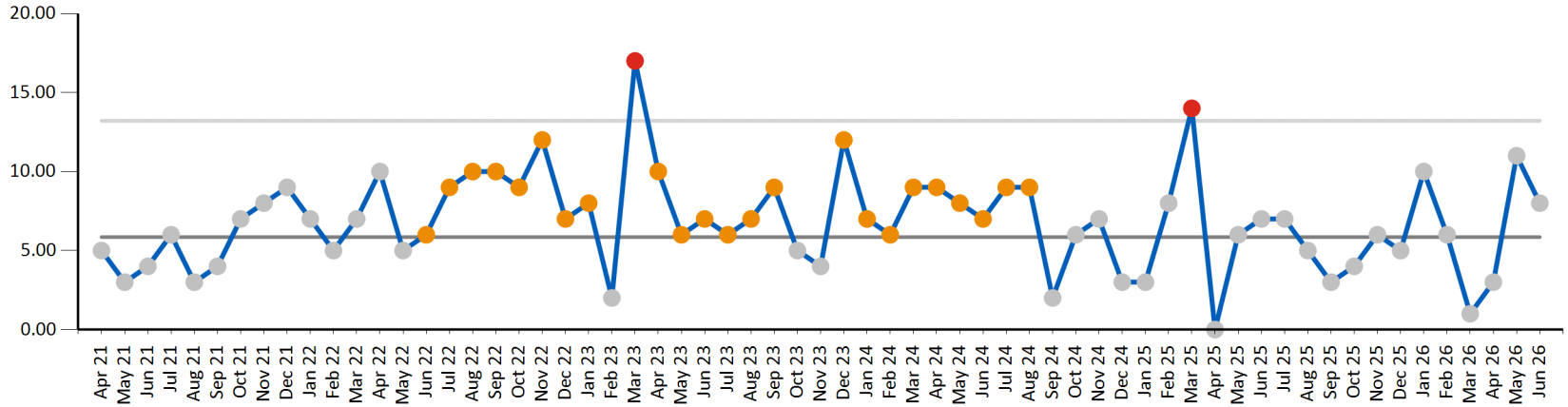
There have been no MRSA, Klebsiella spp. or Pseudomonas aeruginosa bacteraemias in June. By the end of June, there had been more than 117 days since the last healthcare associated MRSA bacteraemia and more than 76 days since the last healthcare associated Pseudomonas aeruginosa bacteraemia

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 215 - Total Hospital Onset, Healthcare-Associated C. difficile Cases | | 8 | Jun-26 | | | 11 | May-26 | | 22 | |
| 346 - Total Community Onset, Healthcare-Associated C. difficile Cases | | 4 | Jun-26 | | | 1 | May-26 | | 8 | |
| 347 - Total Healthcare Associated C. difficile Cases | <= 10 | 12 | Jun-26 | | <= 10 | 12 | May-26 | <= 30 | 30 | |
| 217 - Total Healthcare Associated MRSA Bacteraemia (days between cases) | = 0 | 0 | Jun-26 | | = 0 | 0 | May-26 | = 0 | | |
| 218 - Total Healthcare Associated E. coli Bacteraemia | <= 5 | 3 | Jun-26 | | <= 5 | 4 | May-26 | <= 16 | 10 | |

| Outcome Measure | Latest Plan | Latest Actual | Latest Period | Latest Variation | Previous Plan | Previous Actual | Previous Period | Year to Date Plan | Year to Date Actual | Target Assurance |
|---|---|---|---|---|---|---|---|---|---|---|
| 219 - Blood Culture Contaminants (rate) | <= 3% | 2.9% | Jun-26 | | <= 3% | 2.9% | May-26 | <= 3% | | |
| 304 - Total Healthcare Associated MSSA Bacteraemia | <= 1.0 | 1.0 | Jun-26 | | <= 1.0 | 0.0 | May-26 | <= 3.0 | 4.0 | |
| 305 - Total Healthcare Associated Klebsiella spp. Bacteraemia | <= 1 | 0 | Jun-26 | | <= 1 | 1 | May-26 | <= 2 | 1 | |
| 306 - Total Healthcare Associated Pseudomonas aeruginosa Bacteraemia (days between cases) | = 0 | 0 | Jun-26 | | = 0 | 1 | May-26 | = 0 | | |
| 637 - Healthcare Associated Pseudomonas Aeruginosa Cases (12 month rolling average) | | 0 | Jun-26 | | | | | | 0 | |

## 215 - Total Hospital Onset, Healthcare-Associated C. difficile Cases

Common cause variation.




**Latest**

| Plan | Actual | Period |
|---|---|---|
| | 8 | Jun-26 |

**Previous**

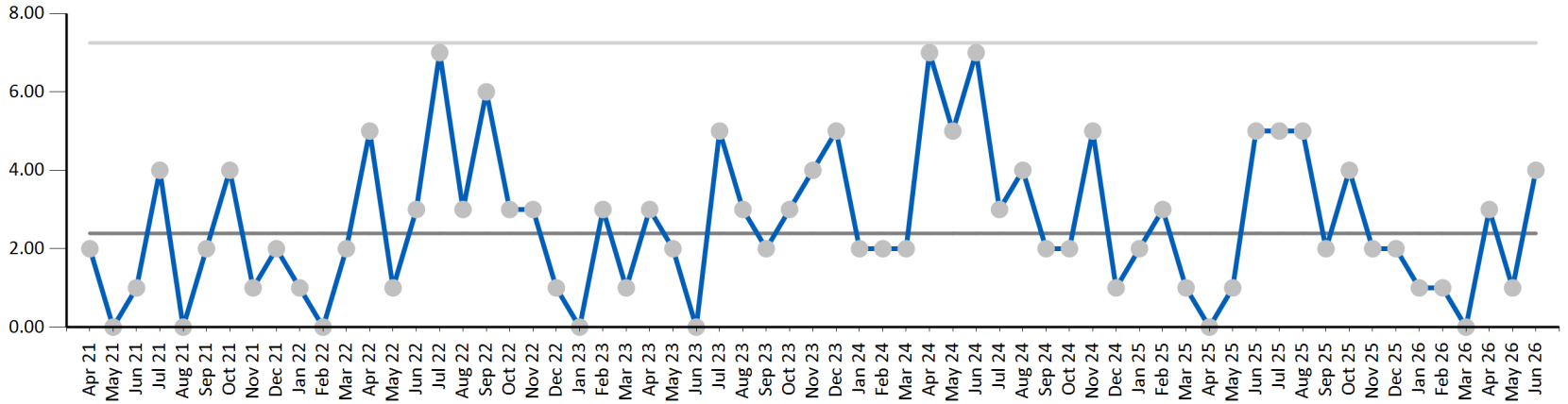
| Plan | Actual | Period |
|---|---|---|
| | 11 | May-26 |

**Year to Date**

| Plan | Actual |
|---|---|
| | 22 |

## 346 - Total Community Onset, Healthcare-Associated C. difficile Cases

Common cause variation.




Latest

| Plan | Actual | Period |
|---|---|---|
| | 4 | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| | 1 | May-26 |

Year to Date

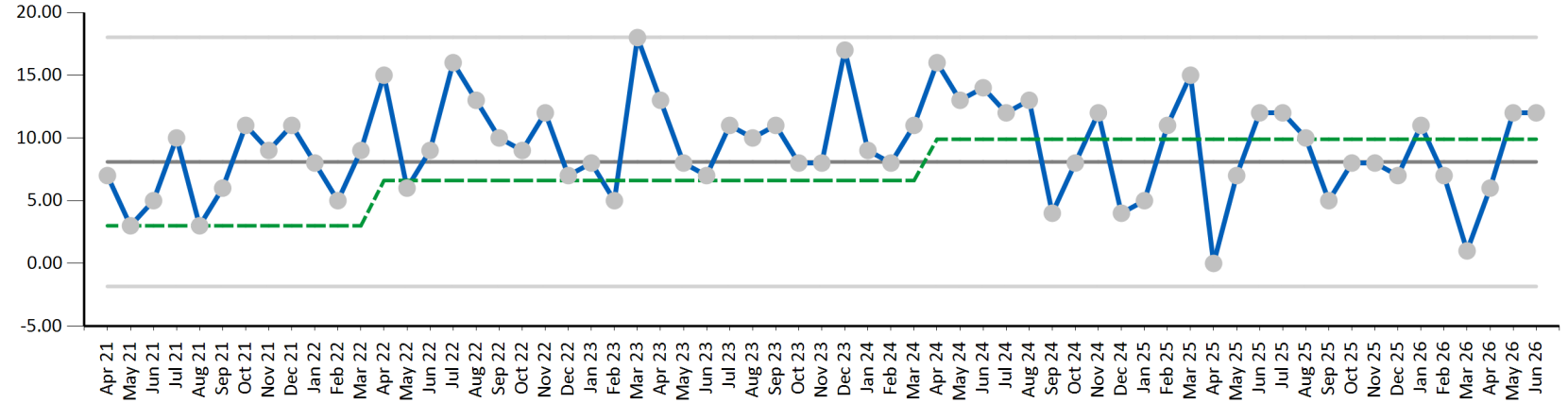
| Plan | Actual |
|---|---|
| | 8 |

## 347 - Total Healthcare Associated C. difficile Cases

Common cause variation.

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

3/6




Latest

| Plan | Actual | Period |
|---|---|---|
| <= 10 | 12 | Jun-26 |

Previous

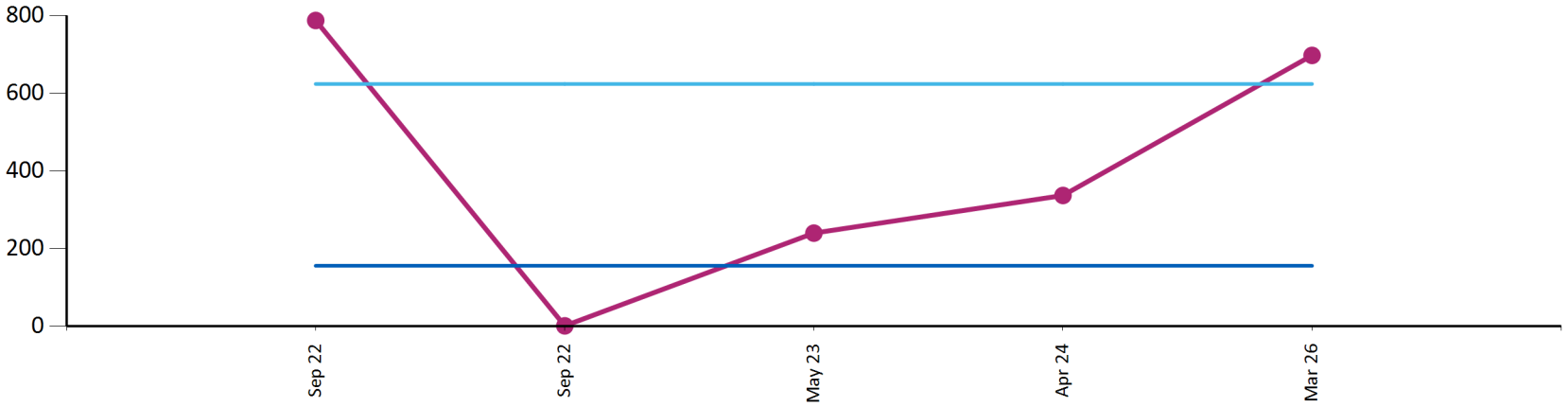
| Plan | Actual | Period |
|---|---|---|
| <= 10 | 12 | May-26 |

Year to Date

| Plan | Actual |
|---|---|
| <= 30 | 30 |

## 217 - Total Healthcare Associated MRSA Bacteraemia (days between cases)

0/6




Latest

| Plan | Actual | Period |
|---|---|---|
| | 0 | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| | 0 | May-26 |

Year to Date

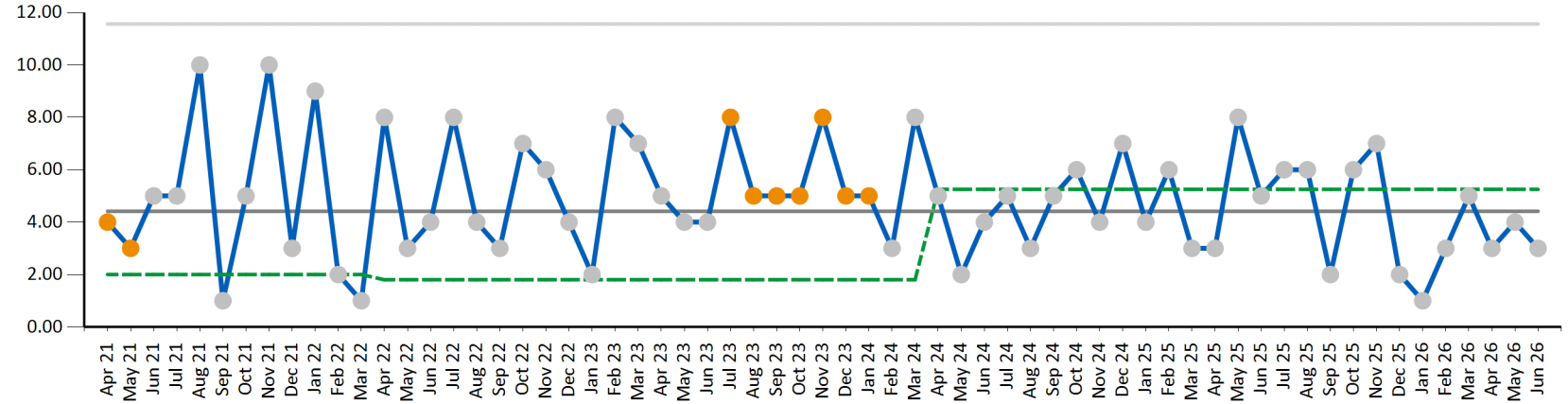
| Plan | Actual |
|---|---|
| | |

## 218 - Total Healthcare Associated E. coli Bacteraemia

Common cause variation.

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

6/6




Latest

| Plan | Actual | Period |
|---|---|---|
| <= 5 | 3 | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| <= 5 | 4 | May-26 |

Year to Date

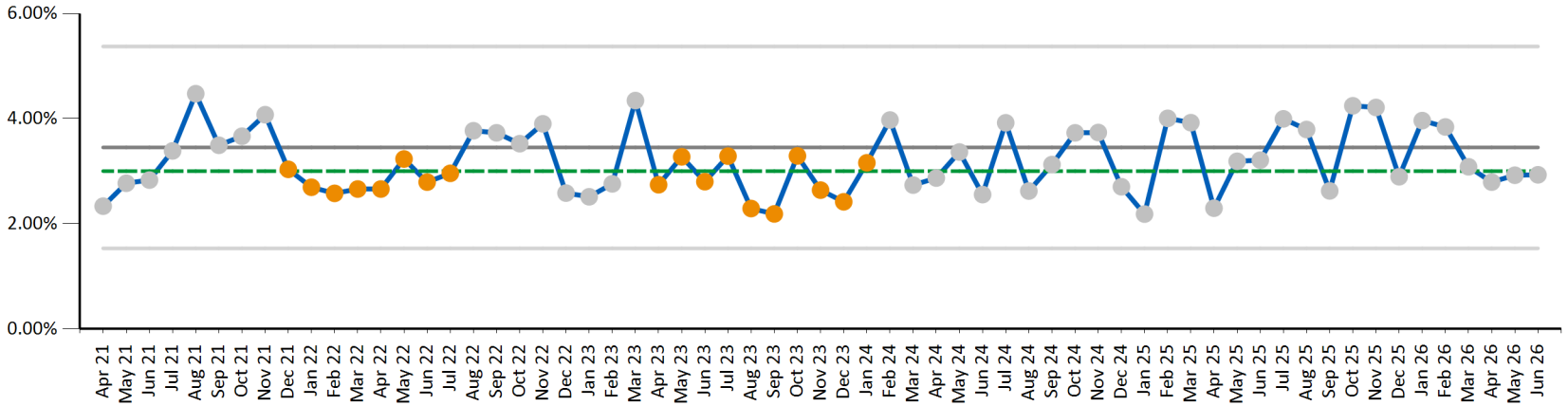
| Plan | Actual |
|---|---|
| <= 16 | 10 |

## 219 - Blood Culture Contaminants (rate)

Common cause variation.

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

3/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| <= 3% | 2.9% | Jun-26 |

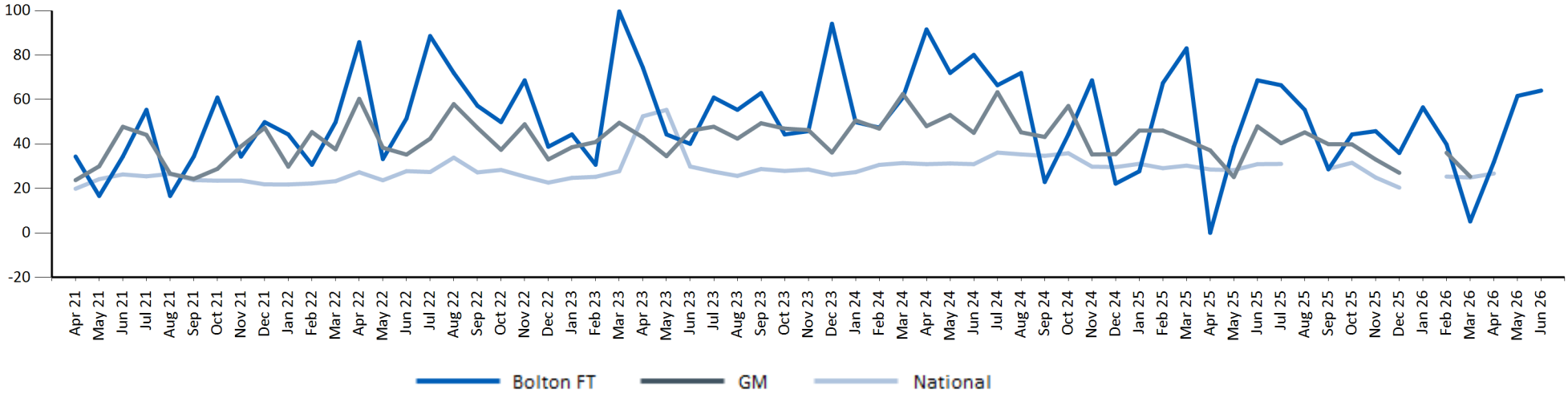
### Previous

| Plan | Actual | Period |
|---|---|---|
| <= 3% | 2.9% | May-26 |

### Year to Date

| Plan | Actual |
|---|---|
| <= 3% | |

## 549 - C Diff Rate Comparison

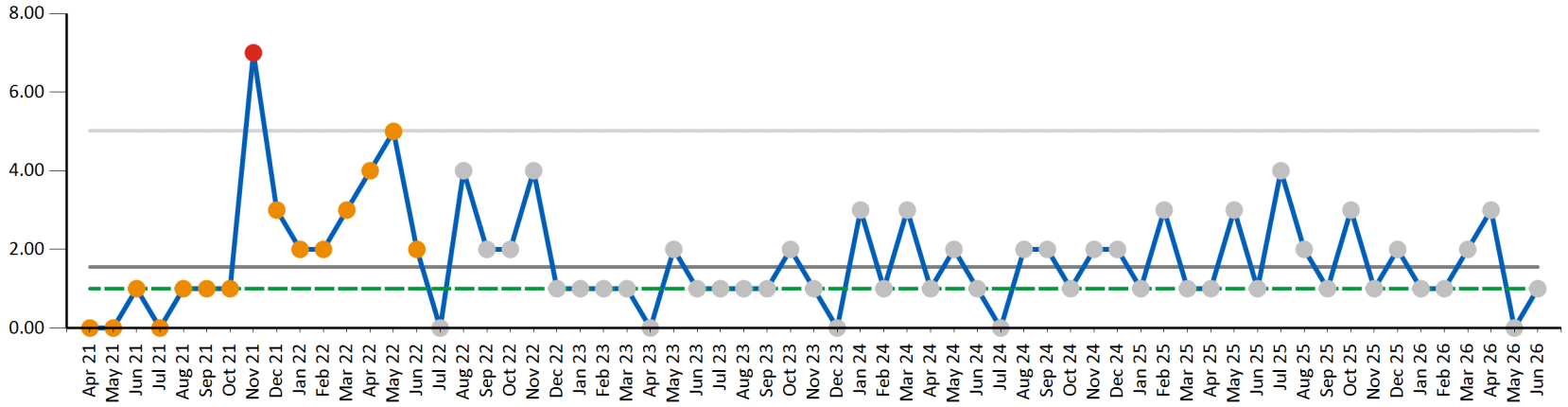


## 304 - Total Healthcare Associated MSSA Bacteraemia

Common cause variation.

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

4/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 1.0 | 1.0 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 1.0 | 0.0 | May-26 |

**Year to Date**

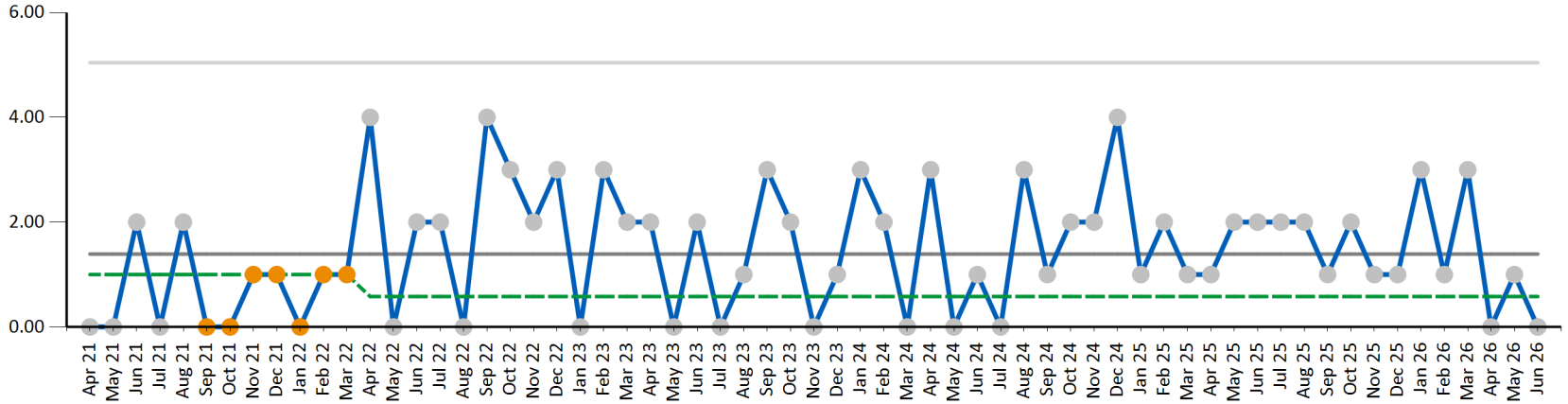
| Plan | Actual |
|---|---|
| <= 3.0 | 4.0 |

## 305 - Total Healthcare Associated Klebsiella spp. Bacteraemia

Common cause variation.

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

2/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 1 | 0 | Jun-26 |

**Previous**

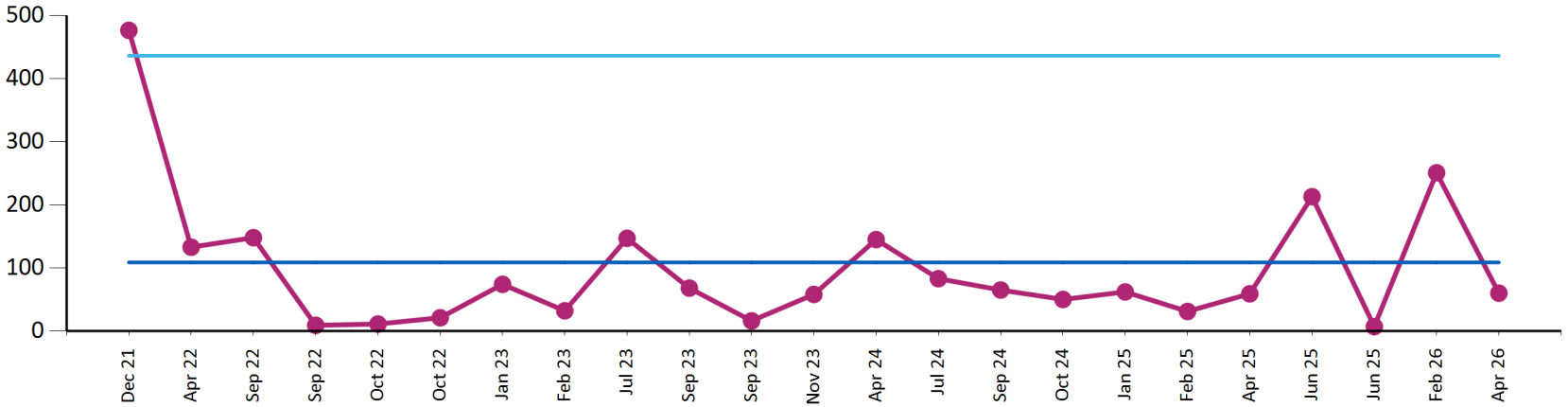
| Plan | Actual | Period |
|---|---|---|
| <= 1 | 1 | May-26 |

**Year to Date**

| Plan | Actual |
|---|---|
| <= 2 | 1 |

## 306 - Total Healthcare Associated Pseudomonas aeruginosa Bacteraemia (days between cases)

0/6




Latest

| Plan | Actual | Period |
|---|---|---|
| | 0 | Jun-26 |

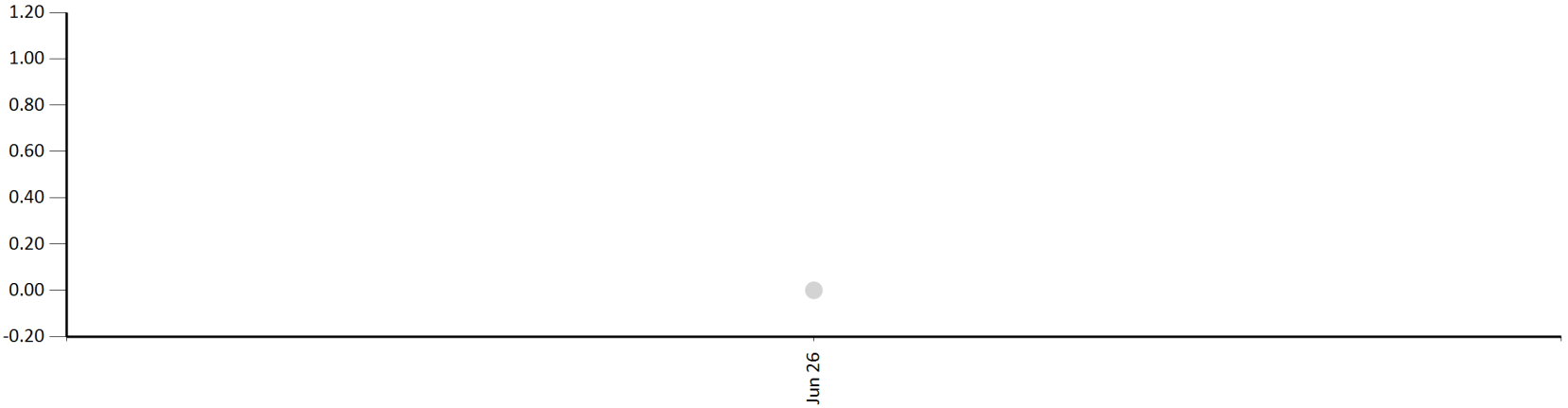
Previous

| Plan | Actual | Period |
|---|---|---|
| | 0 | May-26 |

Year to Date

| Plan | Actual |
|---|---|

## 637 - Healthcare Associated Pseudomonas Aeruginosa Cases (12 month rolling average) - SPC data available after 20 data points




Latest

| Plan | Actual | Period |
|---|---|---|
| | 0 | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|

Year to Date

| Plan | Actual |
|---|---|
| | 0 |

# Quality and Safety - Mortality

Bolton NHS Foundation Trust

Crude – in month rate is below Trust target and average for the timeframe and is showing 25 points below the mean showing improved special cause. It has now remained in control for more than three years.

HSMR – in month figure is slightly below average for the period and remains in control. The 12 month rolling average to February 2026 is 106.42, this is 'Green' when compared to other Trusts.

SHMI – in month figure is at average for the time period and remains in control. The published rolling average for the period March 2025 to February 2026 is 111.5 which is 'as expected'.

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

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

The early neonatal mortality rate is in control, but is higher than the average for the time period.

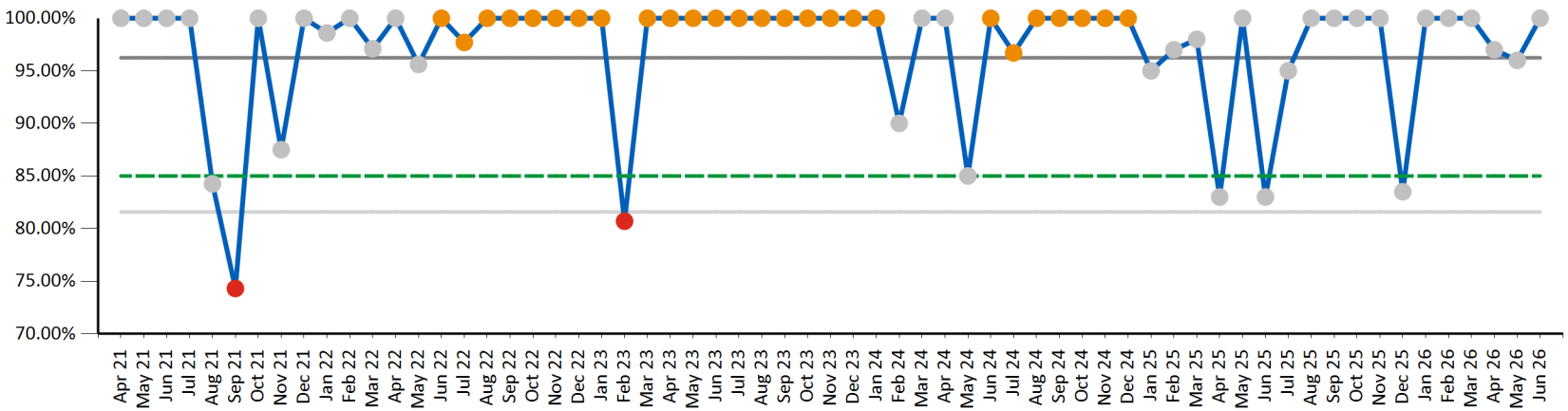
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 3 - National Early Warning Scores to Gold standard | >= 85% | 100.0% | Jun-26 | | >= 85% | 96.0% | May-26 | >= 85% | 97.7% | |
| 495 - HSMR | | 105.60 | Feb-26 | | | 115.56 | Jan-26 | | | |
| 11 - Summary Hospital-level Mortality Indicator (SHMI) | <= 100.00 | 116.94 | Feb-26 | | <= 100.00 | 119.58 | Jan-26 | <= 100.00 | | |
| 12 - Crude Mortality % | <= 2.9% | 2.1% | Jun-26 | L | <= 2.9% | 1.6% | May-26 | <= 2.9% | 1.9% | |
| 519 - Average Charlson comorbidity Score (First episode of care) | | 5 | Mar-26 | H | | 4 | Feb-26 | | | |
| 520 - Depth of recording (First episode of care) | | 6 | Mar-26 | | | 6 | Feb-26 | | | |
| 521 - Proportion of fully coded records (Inpatients) | | 99.1% | Feb-26 | H | | 99.7% | Jan-26 | | | |
| 604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS) | | 10.20 | Jun-26 | | | 5.00 | May-26 | | | |

## 3 - National Early Warning Scores to Gold standard

Common cause variation.

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

6/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 85% | 100.0% | Jun-26 |

### Previous

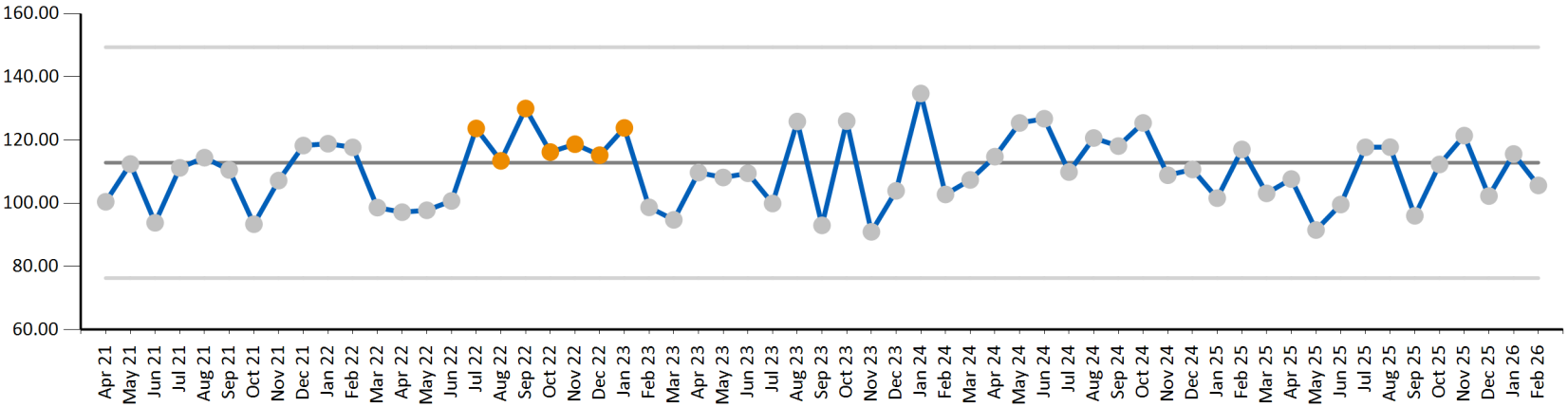
| Plan | Actual | Period |
|---|---|---|
| >= 85% | 96.0% | May-26 |

### Year to Date

| Plan | Actual |
|---|---|
| >= 85% | 97.7% |

## 495 - HSMR

Common cause variation.




### Latest

| Plan | Actual | Period |
|---|---|---|
| | 105.60 | Feb-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| | 115.56 | Jan-26 |

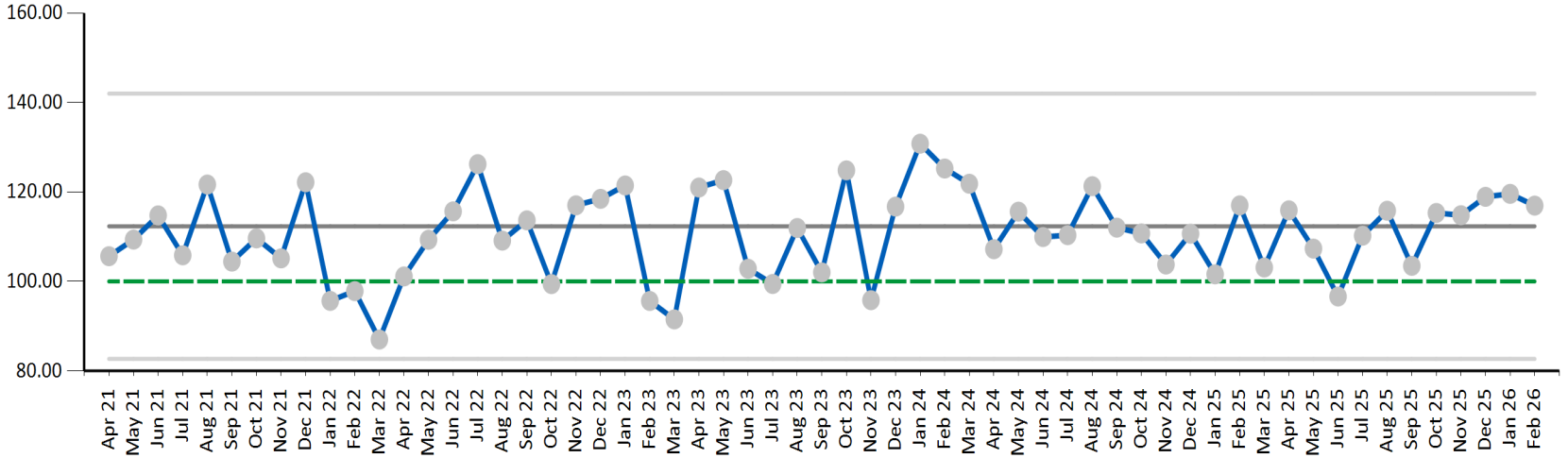
### Year to Date

| Plan | Actual |
|---|---|
| | 105.60 |

## 11 - Summary Hospital-level Mortality Indicator (SHMI)

Common cause variation.

We will not regularly meet the target due to normal variation. 0/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 100.00 | 116.94 | Feb-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 100.00 | 119.58 | Jan-26 |

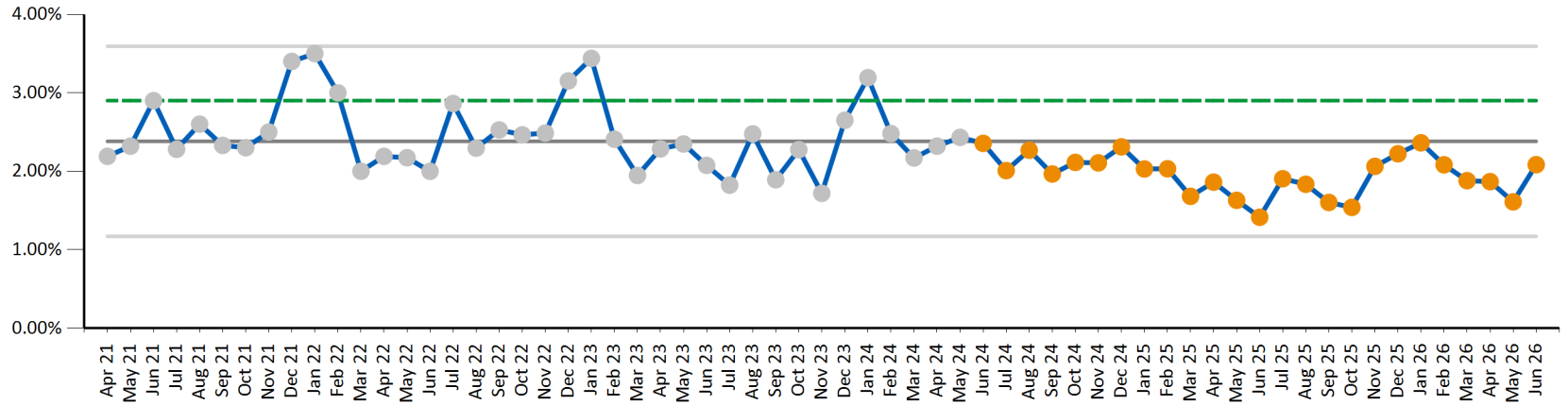
**Year to Date**

| Plan | Actual |
|---|---|
| <= 100.00 | 116.94 |

## 12 - Crude Mortality %

Special cause variation with improving performance

We will not regularly meet the target due to normal variation. 6/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 2.9% | 2.1% | Jun-26 |

**Previous**

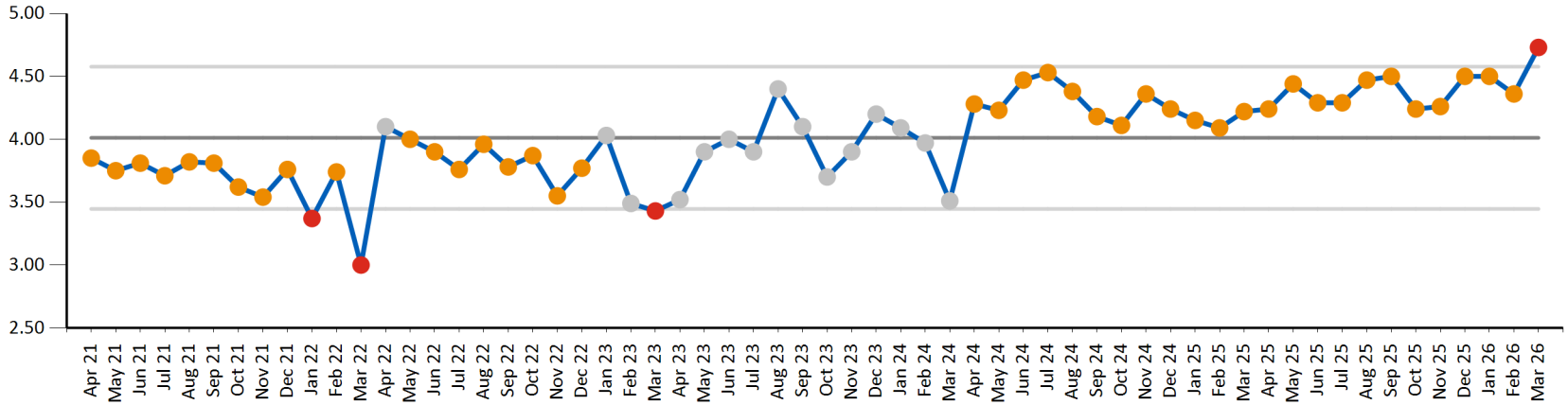
| Plan | Actual | Period |
|---|---|---|
| <= 2.9% | 1.6% | May-26 |

**Year to Date**

| Plan | Actual |
|---|---|
| <= 2.9% | 1.9% |

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

Special cause variation with improving performance




Latest

| Plan | Actual | Period |
|---|---|---|
| | 5 | Mar-26 |

Previous

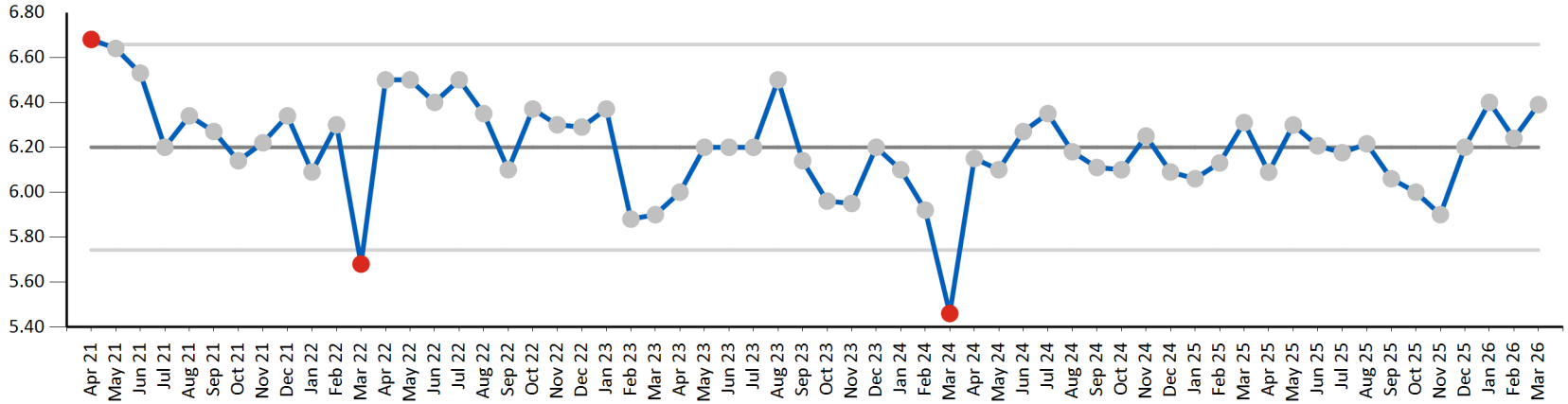
| Plan | Actual | Period |
|---|---|---|
| | 4 | Feb-26 |

Year to Date

| Plan | Actual |
|---|---|
| | 53 |

## 520 - Depth of recording (First episode of care)

Common cause variation.




Latest

| Plan | Actual | Period |
|---|---|---|
| | 6 | Mar-26 |

Previous

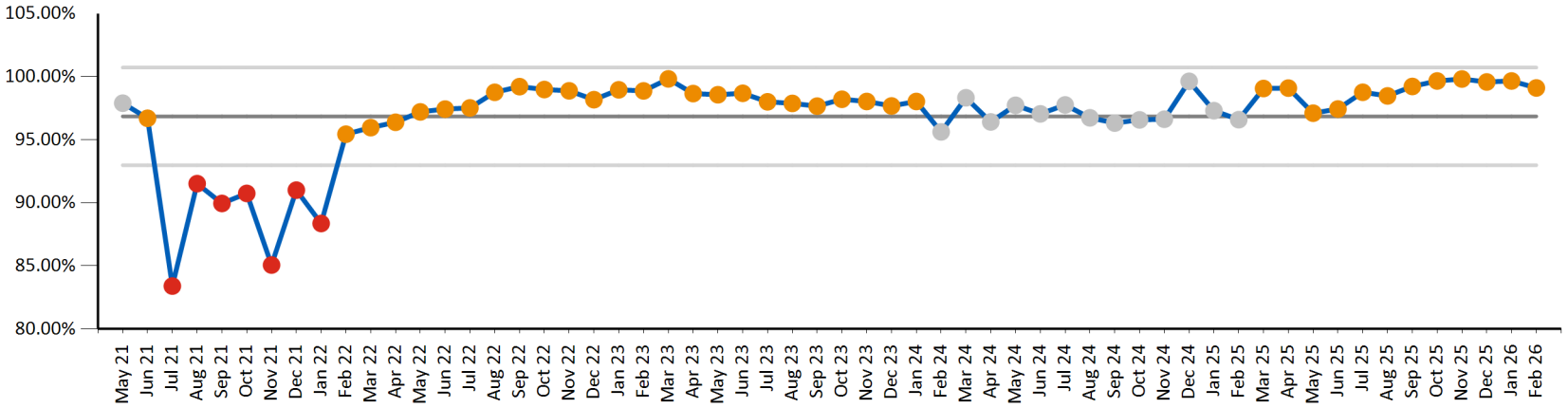
| Plan | Actual | Period |
|---|---|---|
| | 6 | Feb-26 |

Year to Date

| Plan | Actual |
|---|---|
| | 74 |

## 521 - Proportion of fully coded records (Inpatients)

Special cause variation with improving performance




**Latest**

| Plan | Actual | Period |
|---|---|---|
| | 99.1% | Feb-26 |

**Previous**

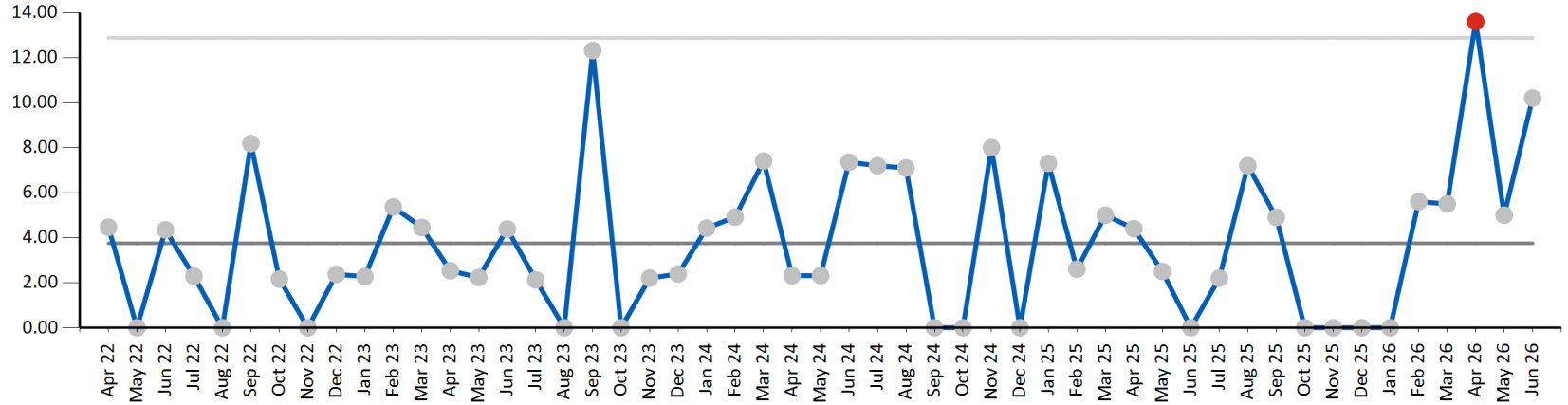
| Plan | Actual | Period |
|---|---|---|
| | 99.7% | Jan-26 |

**Year to Date**

| Plan | Actual |
|---|---|
| | 98.9% |

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

Common cause variation.




**Latest**

| Plan | Actual | Period |
|---|---|---|
| | 10.20 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| | 5.00 | May-26 |

**Year to Date**

| Plan | Actual |
|---|---|

# Quality and Safety - Patient Experience

Bolton NHS Foundation Trust

Complaint response rates

Across the four core divisions there was a total of 6 overdue responses, Medicine (0), Surgery (5), Community (0) and Family Diagnostics (1).

Of the 6 overdue complaint responses in June, 2 have subsequently been completed and 4 remain overdue and outstanding. The outstanding overdue responses are all within the Surgery Division.

FFT Response and Satisfaction rates

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

ED response and satisfaction rates are below target. The ED team have undertaken analysis of FFT data and have identified a number of common themes. Actions and projects are underway to respond to the themes across both Adult ED and Paediatric ED:

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 200 - A&E Friends and Family Response Rate | >= 20% | 13.8% | Jun-26 | L | >= 20% | 13.6% | May-26 | >= 20% | 13.8% | ? |
| 294 - A&E Friends and Family Satisfaction Rates % | >= 90% | 80.9% | Jun-26 | | >= 90% | 82.1% | May-26 | >= 90% | 83.2% | ? |
| 80 - Inpatient Friends and Family Response Rate | >= 30% | 23.4% | Jun-26 | L | >= 30% | 21.1% | May-26 | >= 30% | 22.4% | ? |
| 240 - Friends and Family Test (Inpatients) - Satisfaction % | >= 90% | 91.9% | Jun-26 | L | >= 90% | 91.6% | May-26 | >= 90% | 93.1% | P |
| 81 - Maternity Friends and Family Response Rate | >= 15% | 18.3% | Jun-26 | | >= 15% | 19.2% | May-26 | >= 15% | 21.3% | ? |
| 241 - Maternity Friends and Family Test - Satisfaction % | >= 90% | 92.1% | Jun-26 | | >= 90% | 92.5% | May-26 | >= 90% | 93.5% | ? |
| 82 - Antenatal - Friends and Family Response Rate | >= 15% | 8.7% | Jun-26 | | >= 15% | 4.0% | May-26 | >= 15% | 13.7% | ? |
| 242 - Antenatal Friends and Family Test - Satisfaction % | >= 90% | 94.9% | Jun-26 | | >= 90% | 100.0% | May-26 | >= 90% | 97.8% | ? |
| 83 - Birth - Friends and Family Response Rate | >= 15% | 31.0% | Jun-26 | | >= 15% | 34.6% | May-26 | >= 15% | 34.3% | P |

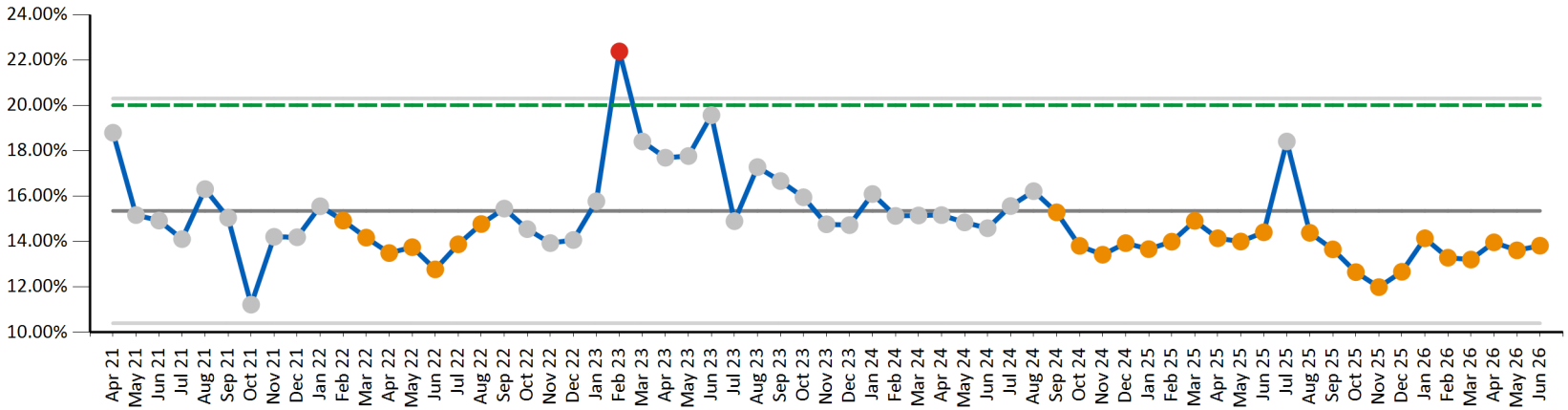
| Outcome Measure | Latest Plan | Latest Actual | Latest Period | Latest Variation | Previous Plan | Previous Actual | Previous Period | Year to Date Plan | Year to Date Actual | Target Assurance |
|---|---|---|---|---|---|---|---|---|---|---|
| 243 - Birth Friends and Family Test - Satisfaction % | >= 90% | 88.9% | Jun-26 | | >= 90% | 92.7% | May-26 | >= 90% | 92.5% | |
| 84 - Hospital Postnatal - Friends and Family Response Rate | >= 15% | 13.8% | Jun-26 | | >= 15% | 18.8% | May-26 | >= 15% | 16.8% | |
| 244 - Hospital Postnatal Friends and Family Test - Satisfaction % | >= 90% | 88.9% | Jun-26 | | >= 90% | 88.9% | May-26 | >= 90% | 87.8% | |
| 85 - Community Postnatal - Friend and Family Response Rate | >= 15% | 19.8% | Jun-26 | | >= 15% | 21.1% | May-26 | >= 15% | 20.4% | |
| 245 - Community Postnatal Friends and Family Test - Satisfaction % | >= 90% | 96.5% | Jun-26 | | >= 90% | 92.6% | May-26 | >= 90% | 94.7% | |
| 89 - Formal complaints acknowledged within 3 working days | = 100% | 100.0% | Jun-26 | | = 100% | 100.0% | May-26 | = 100% | 100.0% | |
| 90 - Complaints responded to within the period | >= 95% | 79.3% | Jun-26 | | >= 95% | 62.5% | May-26 | >= 95% | 60.2% | |

## 200 - A&E Friends and Family Response Rate

Special cause variation with deteriorating performance

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

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 20% | 13.8% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 20% | 13.6% | May-26 |

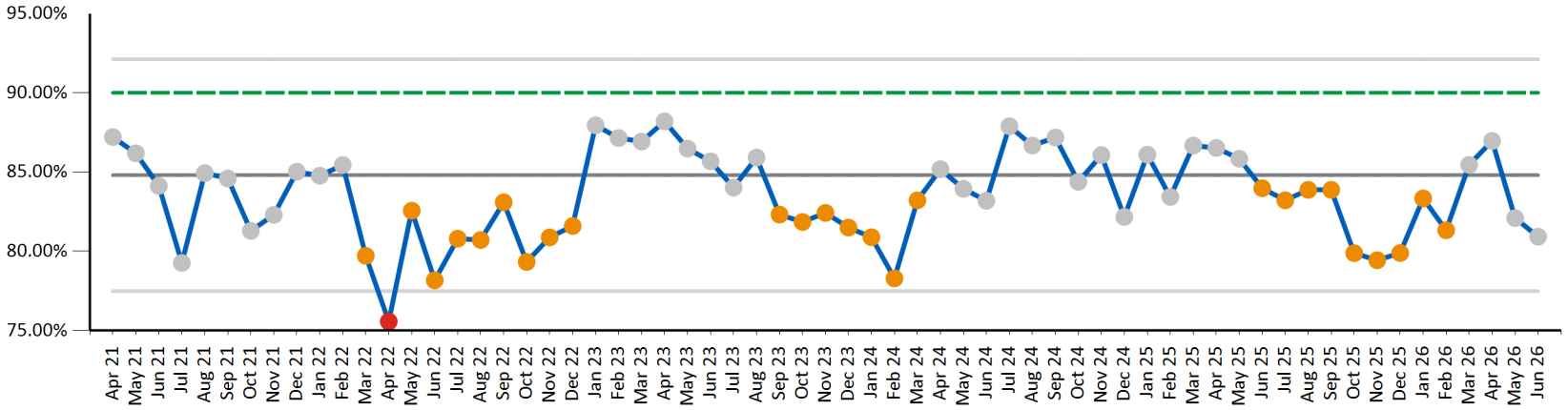
### Year to Date

| Plan | Actual |
|---|---|
| >= 20% | 13.8% |

## 294 - A&E Friends and Family Satisfaction Rates %

Common cause variation.

We will not regularly meet the target due to normal variation. 0/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 90% | 80.9% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 90% | 82.1% | May-26 |

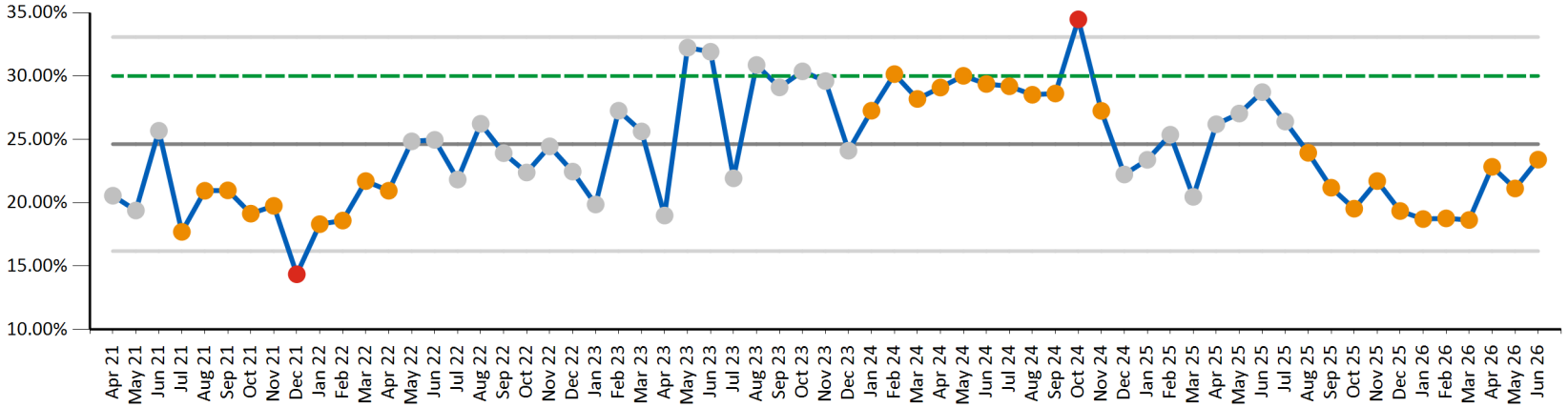
**Year to Date**

| Plan | Actual |
|---|---|
| >= 90% | 83.2% |

## 80 - Inpatient Friends and Family Response Rate

Special cause variation with deteriorating performance

We will not regularly meet the target due to normal variation. 0/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 30% | 23.4% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 30% | 21.1% | May-26 |

**Year to Date**

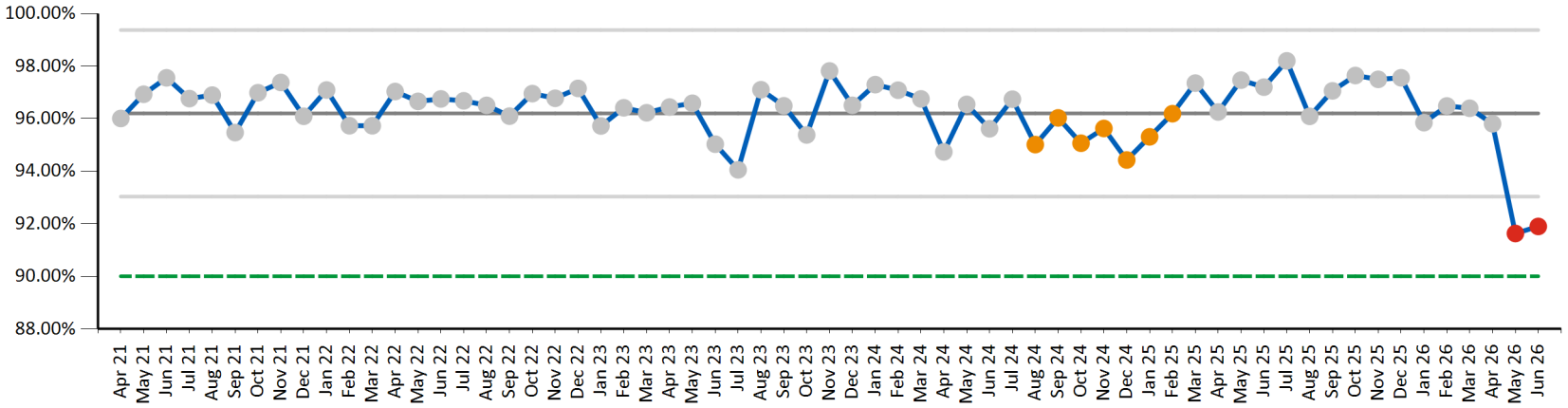
| Plan | Actual |
|---|---|
| >= 30% | 22.4% |

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

Special cause variation with deteriorating performance

Target will be regularly met.

6/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 90% | 91.9% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 90% | 91.6% | May-26 |

**Year to Date**

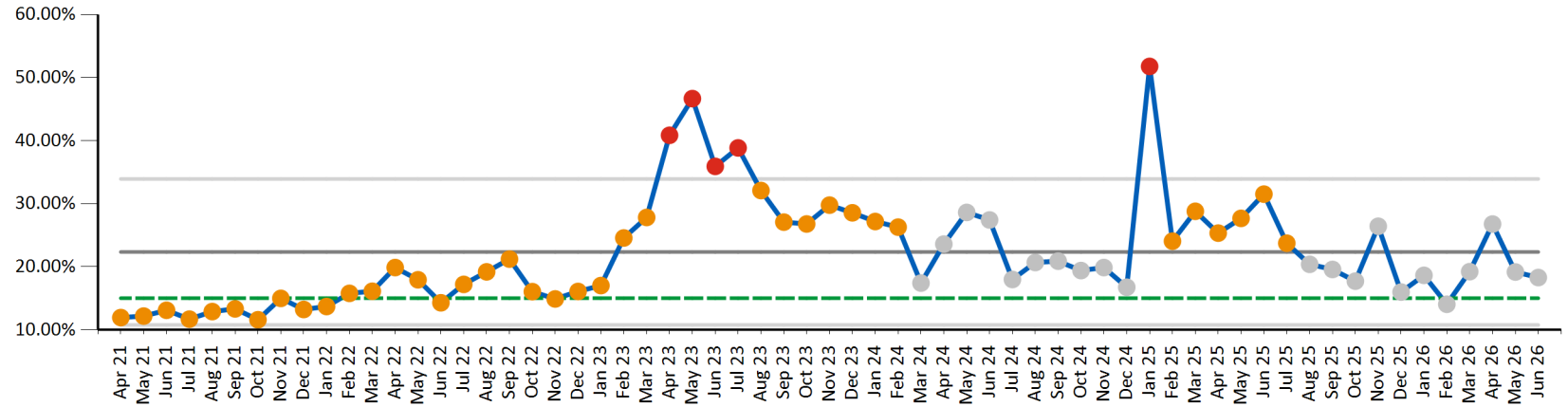
| Plan | Actual |
|---|---|
| >= 90% | 93.1% |

## 81 - Maternity Friends and Family Response Rate

Common cause variation.

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

5/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 15% | 18.3% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 15% | 19.2% | May-26 |

**Year to Date**

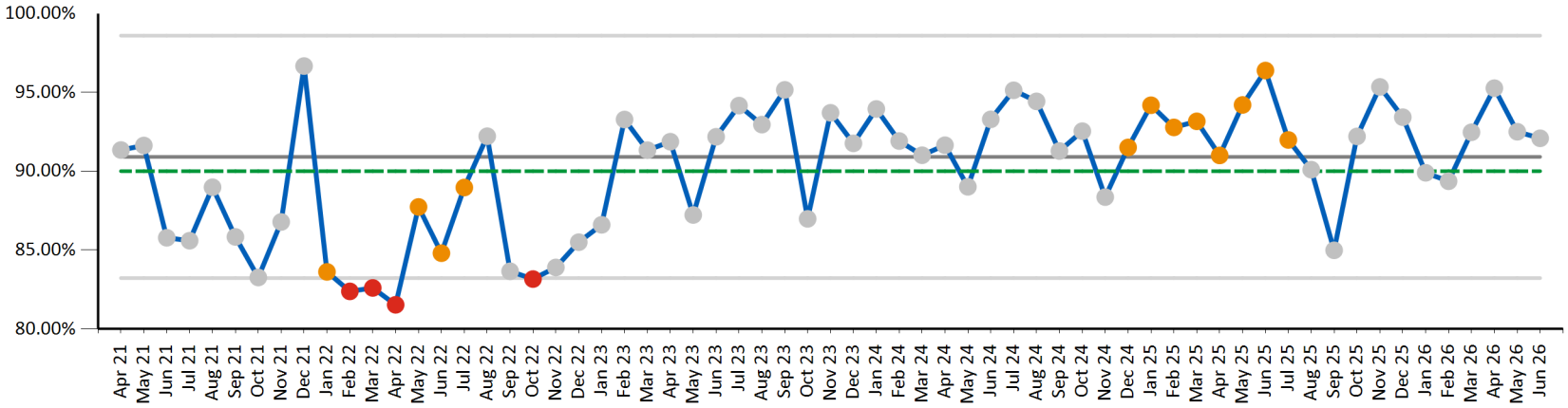
| Plan | Actual |
|---|---|
| >= 15% | 21.3% |

## 241 - Maternity Friends and Family Test - Satisfaction %

Common cause variation.

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

4/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 90% | 92.1% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 90% | 92.5% | May-26 |

**Year to Date**

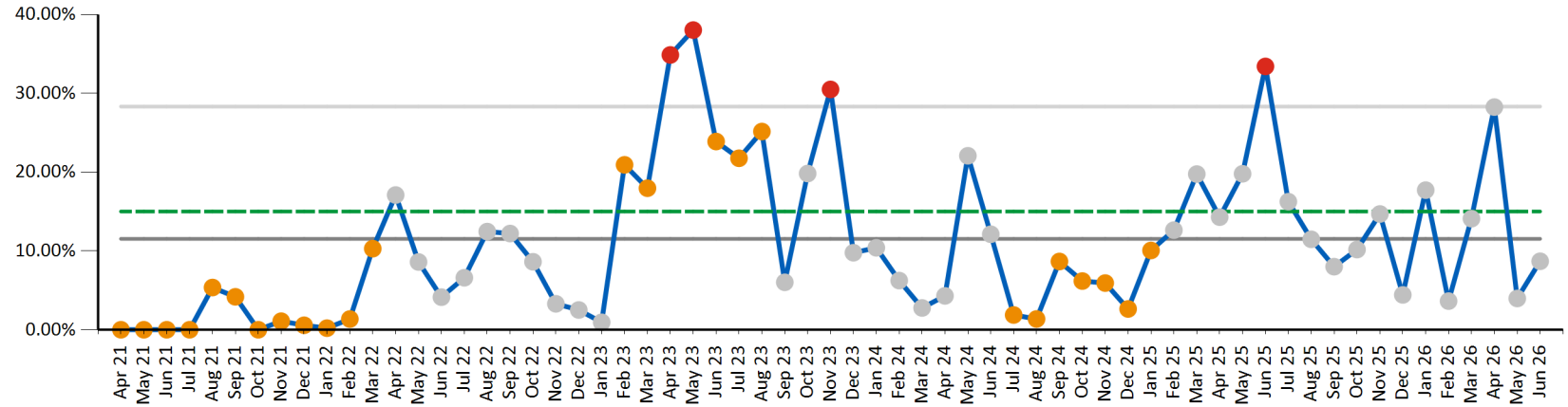
| Plan | Actual |
|---|---|
| >= 90% | 93.5% |

## 82 - Antenatal - Friends and Family Response Rate

Common cause variation.

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

2/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 15% | 8.7% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 15% | 4.0% | May-26 |

**Year to Date**

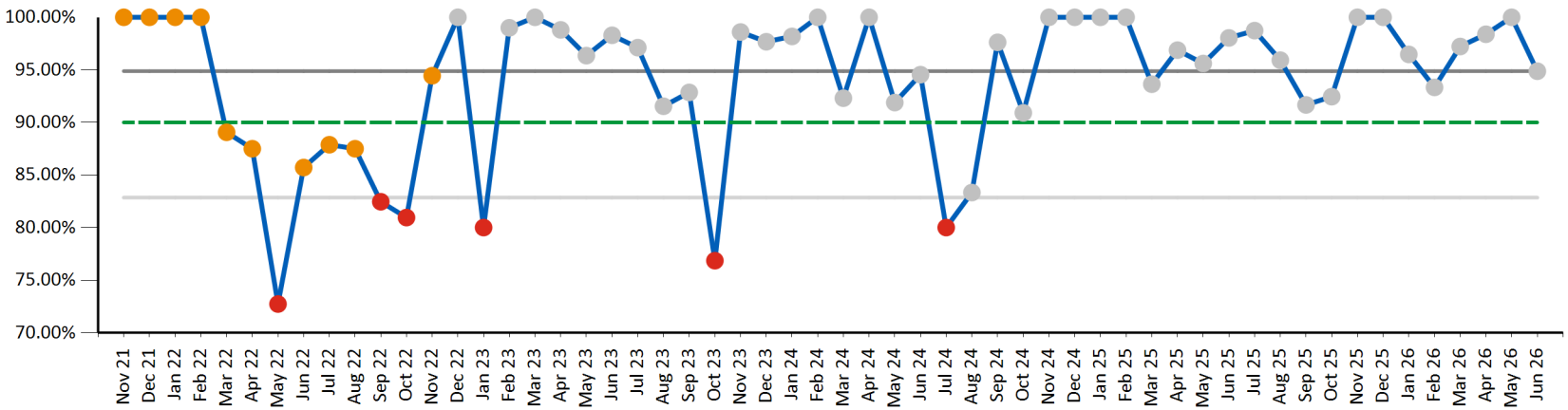
| Plan | Actual |
|---|---|
| >= 15% | 13.7% |

## 242 - Antenatal Friends and Family Test - Satisfation %

Common cause variation.

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

6/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 90% | 94.9% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 90% | 100.0% | May-26 |

### Year to Date

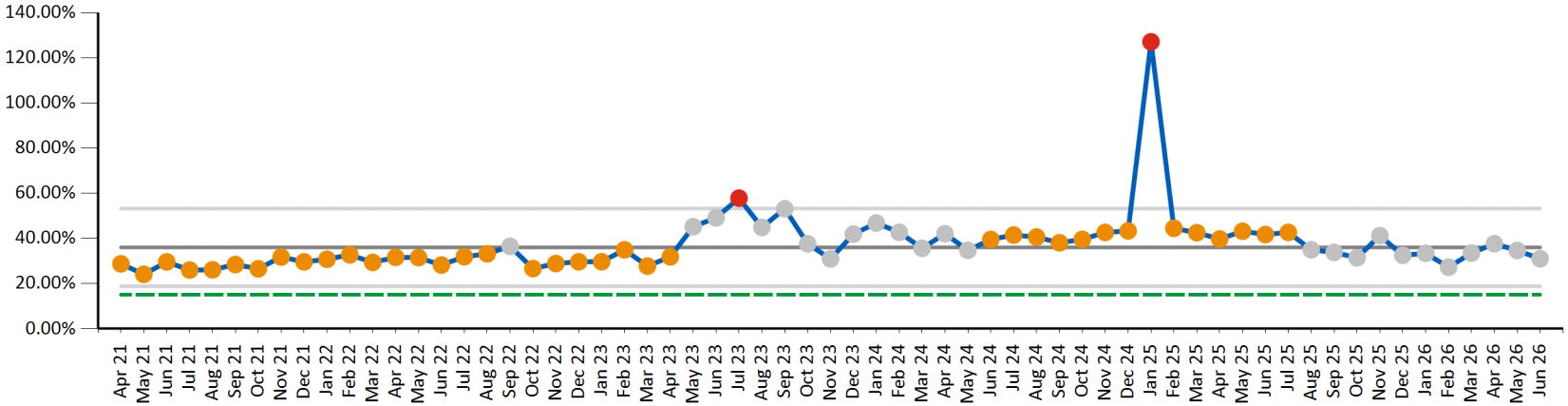
| Plan | Actual |
|---|---|
| >= 90% | 97.8% |

## 83 - Birth - Friends and Family Response Rate

Common cause variation.

Target will be regularly met.

6/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 15% | 31.0% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 15% | 34.6% | May-26 |

### Year to Date

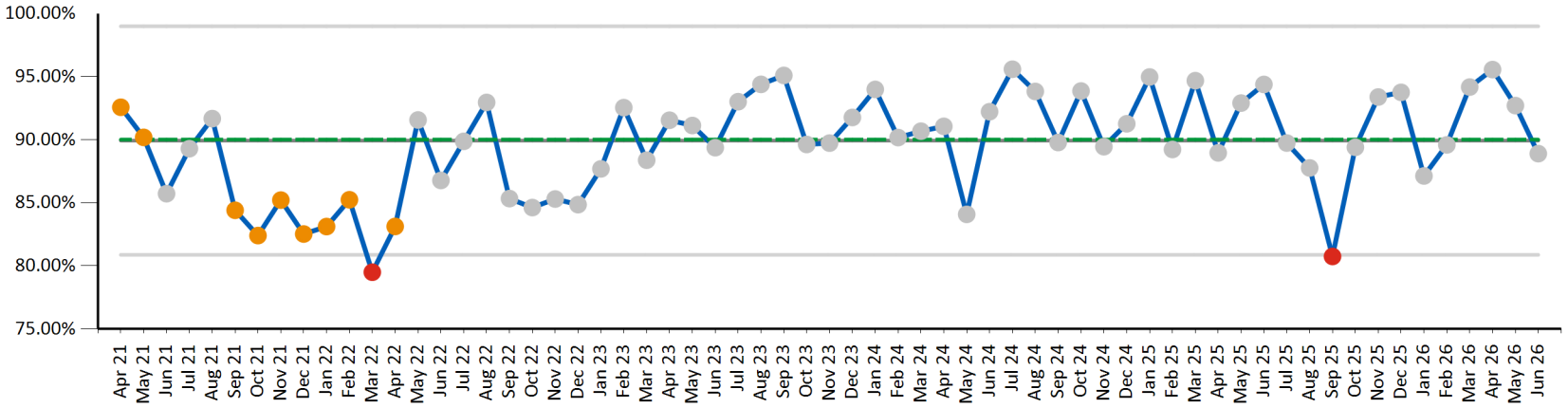
| Plan | Actual |
|---|---|
| >= 15% | 34.3% |

## 243 - Birth Friends and Family Test - Satisfaction %

Common cause variation.

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

3/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 90% | 88.9% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 90% | 92.7% | May-26 |

### Year to Date

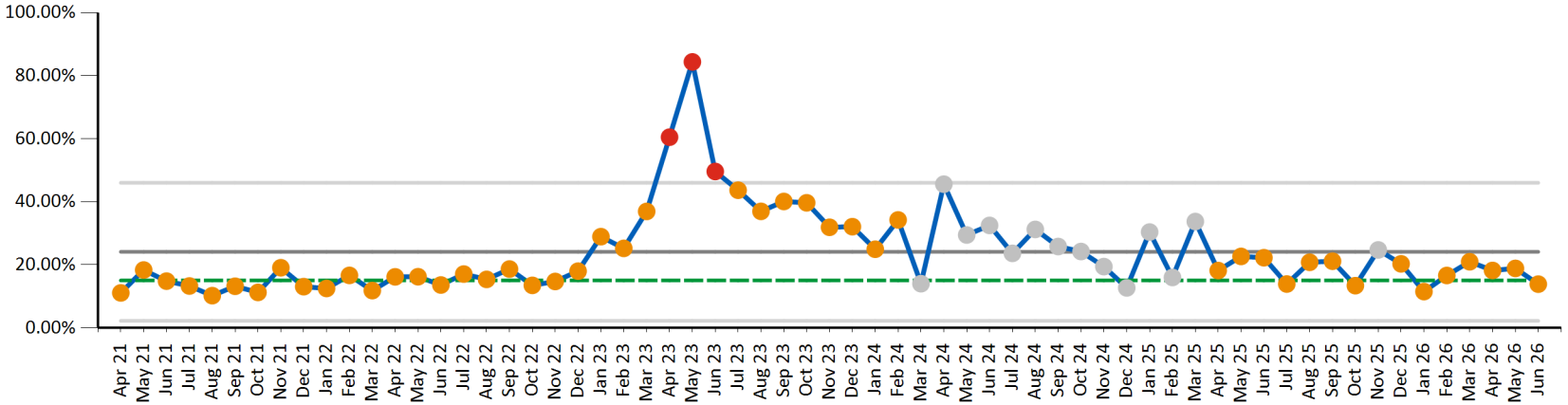
| Plan | Actual |
|---|---|
| >= 90% | 92.5% |

## 84 - Hospital Postnatal - Friends and Family Response Rate

Special cause variation with deteriorating performance

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

4/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 15% | 13.8% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 15% | 18.8% | May-26 |

### Year to Date

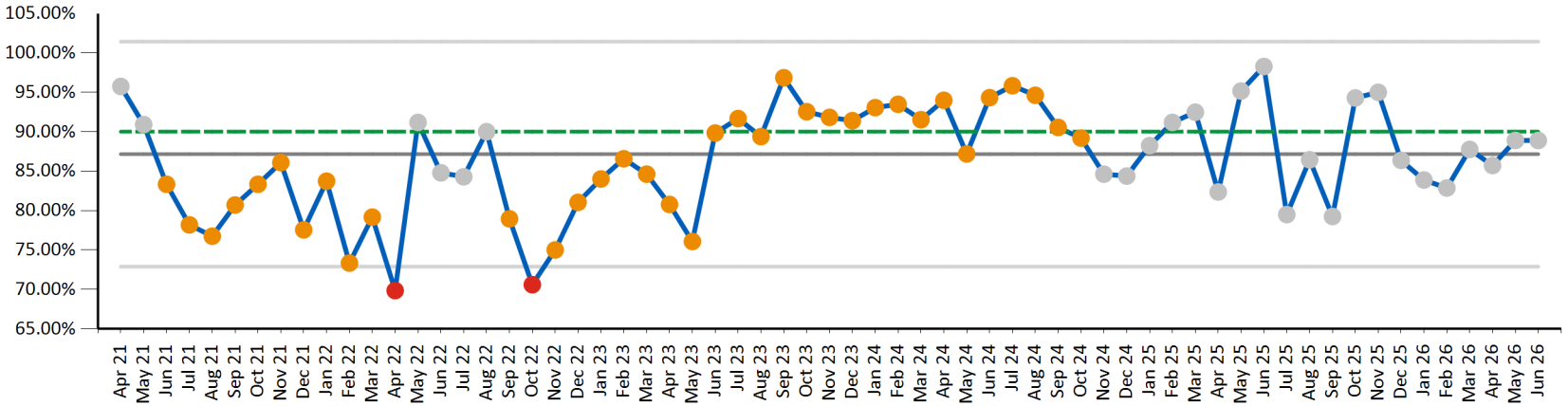
| Plan | Actual |
|---|---|
| >= 15% | 16.8% |

## 244 - Hospital Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

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

0/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 90% | 88.9% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 90% | 88.9% | May-26 |

**Year to Date**

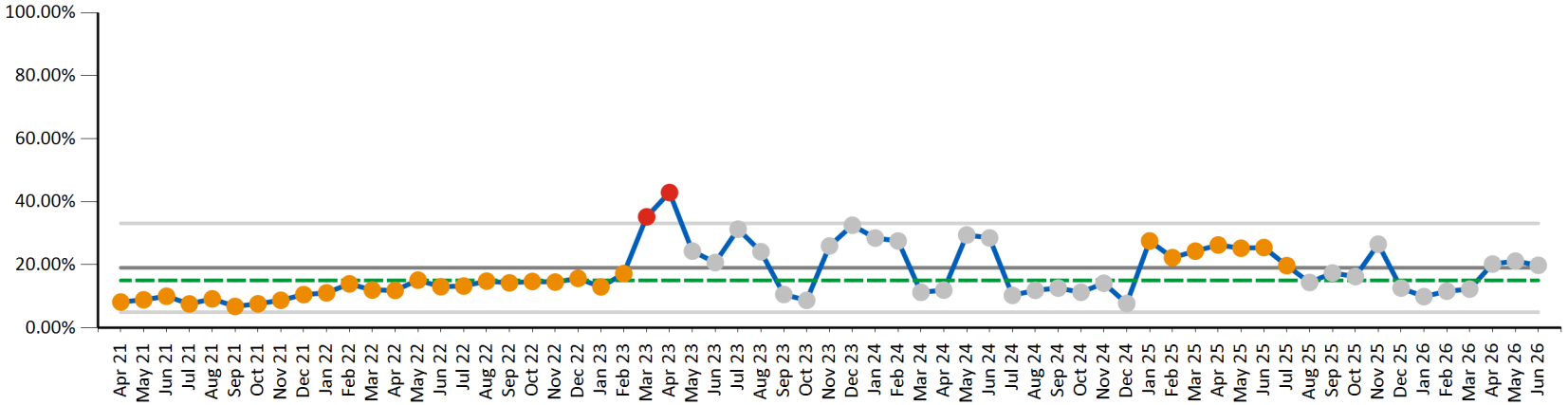
| Plan | Actual |
|---|---|
| >= 90% | 87.8% |

## 85 - Community Postnatal - Friend and Family Response Rate

Common cause variation.

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

3/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 15% | 19.8% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 15% | 21.1% | May-26 |

**Year to Date**

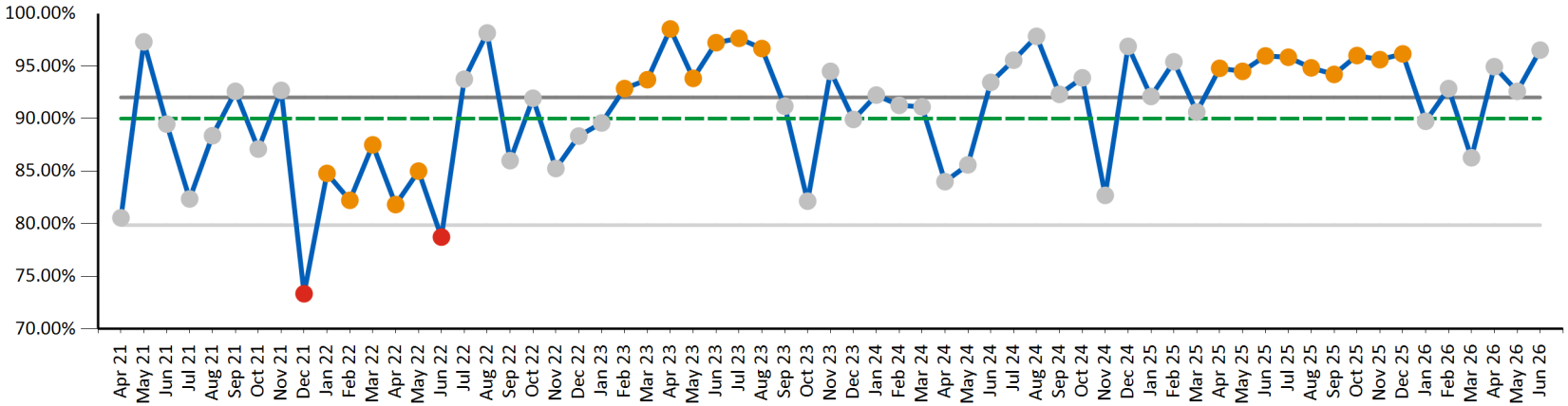
| Plan | Actual |
|---|---|
| >= 15% | 20.4% |

## 245 - Community Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

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

4/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 90% | 96.5% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 90% | 92.6% | May-26 |

### Year to Date

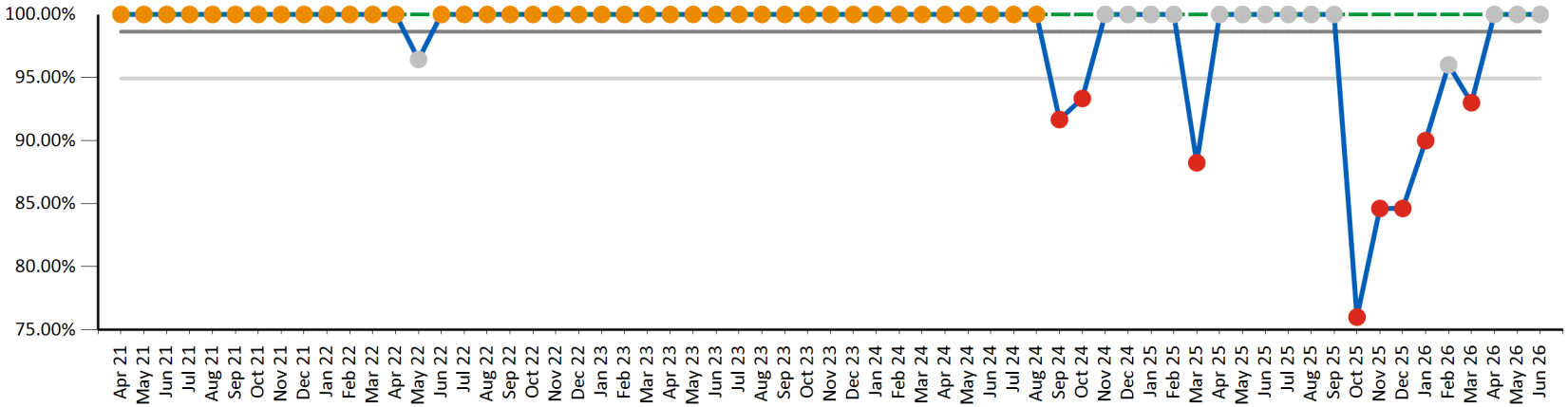
| Plan | Actual |
|---|---|
| >= 90% | 94.7% |

## 89 - Formal complaints acknowledged within 3 working days

Common cause variation.

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

3/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| = 100% | 100.0% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| = 100% | 100.0% | May-26 |

### Year to Date

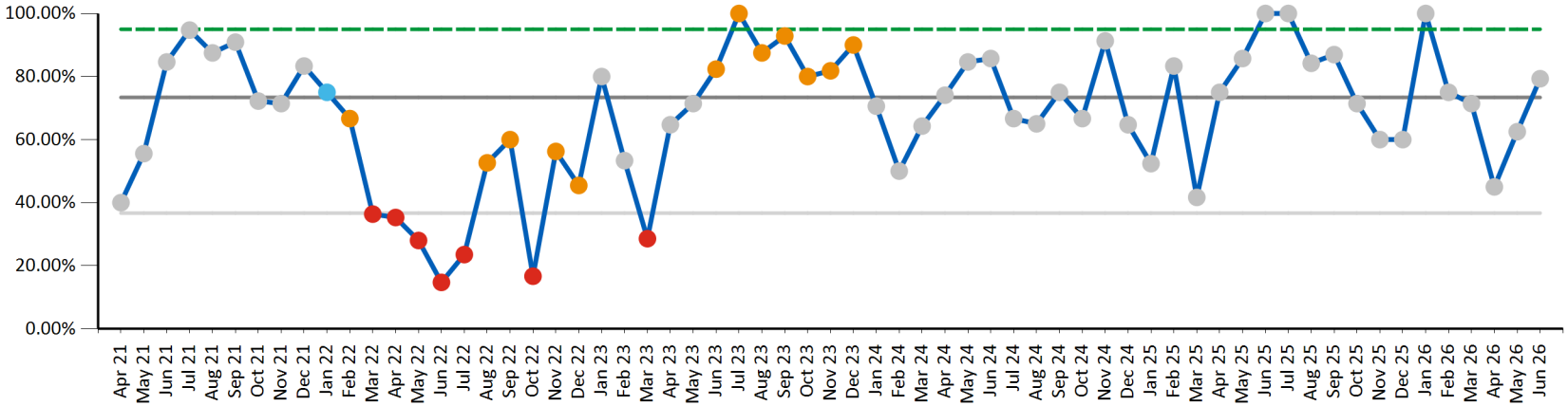
| Plan | Actual |
|---|---|
| = 100% | 100.0% |

## 90 - Complaints responded to within the period

Common cause variation.

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

1/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 95% | 79.3% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 95% | 62.5% | May-26 |

### Year to Date

| Plan | Actual |
|---|---|
| >= 95% | 60.2% |

# Quality and Safety - Maternity

Bolton NHS Foundation Trust

Friends and Family response rate – low response rate noted in June 2026 – 18.4%. Service planning in progress to transition to text messaging following the introduction of the new Trust service in August 2026. New national maternity specific patient experience reported metric (PREM) awaited.

Friends and Family satisfaction rate – Common cause variation noted in satisfaction rate with 92.1% reported in June 2026.

Maternity Stillbirth Rate (excluding termination of pregnancy (TOP) – 1 case reported in June 2026, initial review undertaken and no attributable causes identified. Perinatal mortality reviews (PMRT) with external peers awaited.

3rd & 4th Degree tears – Low incidence rate continued with 2.5% in June 2026 with target of <=3.5%. Perinatal pelvic health service implementation continues.

1:1 care in labour - Current performance has shown a sustained improvement to 99.0%. Improvement seen as a result of recruitment, retention, and strengthened roster management, and improved flow with Matron oversite. Ongoing oversight continued by recruitment and retention lead.

Booked by 12+6 - This clinical indicator relates to the timing of the initial antenatal booking visit, ensuring women access maternity care in a timely manner and remain eligible for early pregnancy scans and antenatal screening blood tests. Current performance has shown common cause variation with 90.8% reported in June 2026. Early Pregnancy Information Clinics (EPIC) continued and plan to roll out a further team.

Booked by 10 weeks (target reflects bookings by 10+0 gestation as per national standard which removes the impact of ultrasound booking scan date changes made and associated impact). Trust performance has seen further improvement this month with 68% compliance reported following the introduction of the Early Pregnancy Information Clinics (EPIC) ( as above).

Inductions of labour delayed by > 6hrs – This is a new NHS England metric that aligns with the national reporting measures. This metric tracks the number of women where induction of labour commencement is delayed more than 6hrs from their planned admission time. No cases of delay were reported in the month of June 2026.

Breastfeeding initiation – A special cause variation improvement sustained with 73.32% reported in June 2026. The service has booked the external assessment for Stage 2 Baby Friendly Initiative accreditation to be undertaken at the end of January 2027.

Preterm birth (less than 37 weeks gestation) – A common cause variation in incidence was noted during the month, with a preterm birth rate of 8.9% reported in June 2026. The PregnAncy Risk assessmenT aNd dEcision suppoRt tool (Partner trial - which is a risk assessment and clinical decision support tool) implementation is now underway and will support improved screening to reduce placental disorders and preterm birth in pregnancy. Bolton is also ranked as the 23rd most deprived local authority in England out of 296, which is recognised as a contributory factor to higher rates of preterm birth.

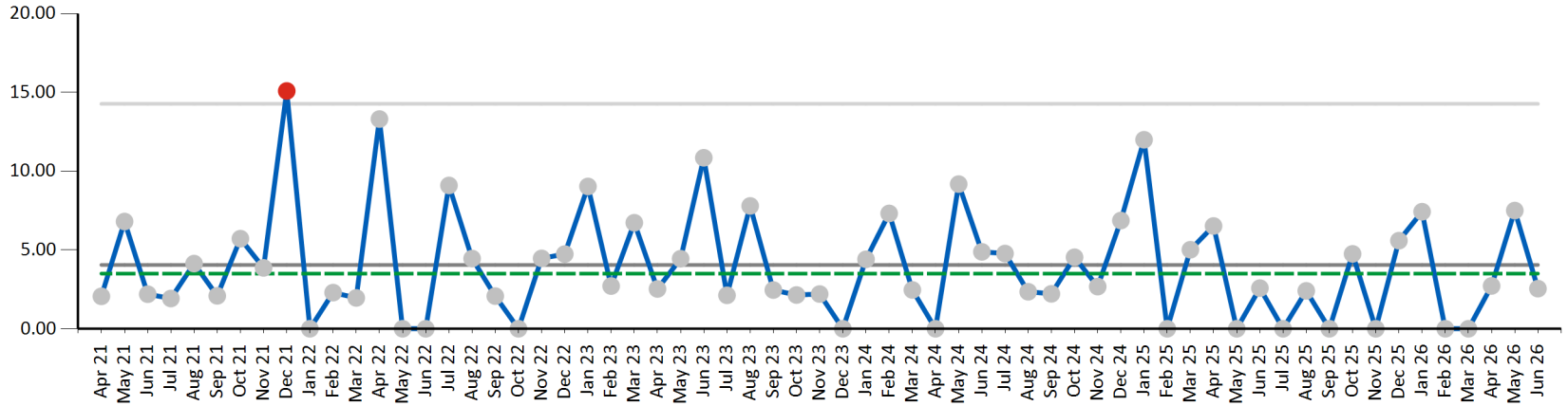
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 322 - Maternity - Stillbirths per 1000 births (excludes termination of pregnancy) | <= 3.50 | 2.54 | Jun-26 | | <= 3.50 | 7.50 | May-26 | <= 3.50 | 4.31 | |
| 23 - Maternity -3rd/4th degree tears | <= 3.5% | 2.5% | Jun-26 | | <= 3.5% | 4.6% | May-26 | <= 3.5% | 3.3% | |
| 202 - 1:1 Midwifery care in labour | >= 95.0% | 99.0% | Jun-26 | H | >= 95.0% | 100.0% | May-26 | >= 95.0% | 99.5% | P |
| 203 - Booked 12+6 | >= 90.0% | 90.8% | Jun-26 | | >= 90.0% | 91.6% | May-26 | >= 90.0% | 91.5% | |
| 586 - Booked 10+0 | | 68.0% | Jun-26 | | | 68.6% | May-26 | | 67.4% | |
| 204 - Percentage of women induced | <= 40% | 25.6% | Jun-26 | L | <= 40% | 34.2% | May-26 | <= 40% | 31.9% | |
| 210 - Initiation breast feeding | >= 65% | 73.32% | Jun-26 | H | >= 65% | 75.77% | May-26 | >= 65% | 72.98% | |
| 213 - Maternity complaints | <= 5 | 3 | Jun-26 | | <= 5 | 0 | May-26 | <= 15 | 6 | |
| 319 - Maternal deaths (direct) | = 0 | 0 | Jun-26 | L | = 0 | 0 | May-26 | = 0 | 0 | |
| 320 - Rate of Preterm births (rate <37 weeks as a percentage of all births) | <= 6% | 8.9% | Jun-26 | | <= 6% | 8.5% | May-26 | <= 6% | 9.2% | |
| 631 - Number of Neonates with suspected HIE Grade 2 and 3, = 37 Weeks (Bolton Babies only) | | 1 | Jun-26 | | | 0 | May-26 | | 1 | |
| 665 - Inductions of Labour >6 hours | | 0 | Jun-26 | | | 11 | May-26 | | 13 | |

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

Common cause variation.

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

4/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 3.50 | 2.54 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 3.50 | 7.50 | May-26 |

**Year to Date**

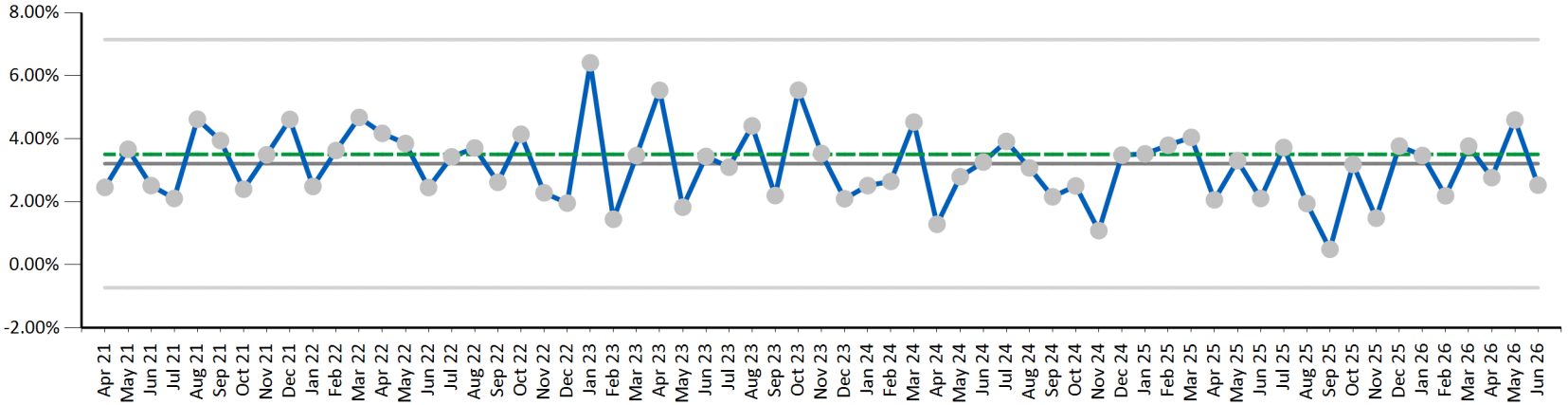
| Plan | Actual |
|---|---|
| <= 3.50 | 4.31 |

## 23 - Maternity -3rd/4th degree tears

Common cause variation.

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

4/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 3.5% | 2.5% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 3.5% | 4.6% | May-26 |

**Year to Date**

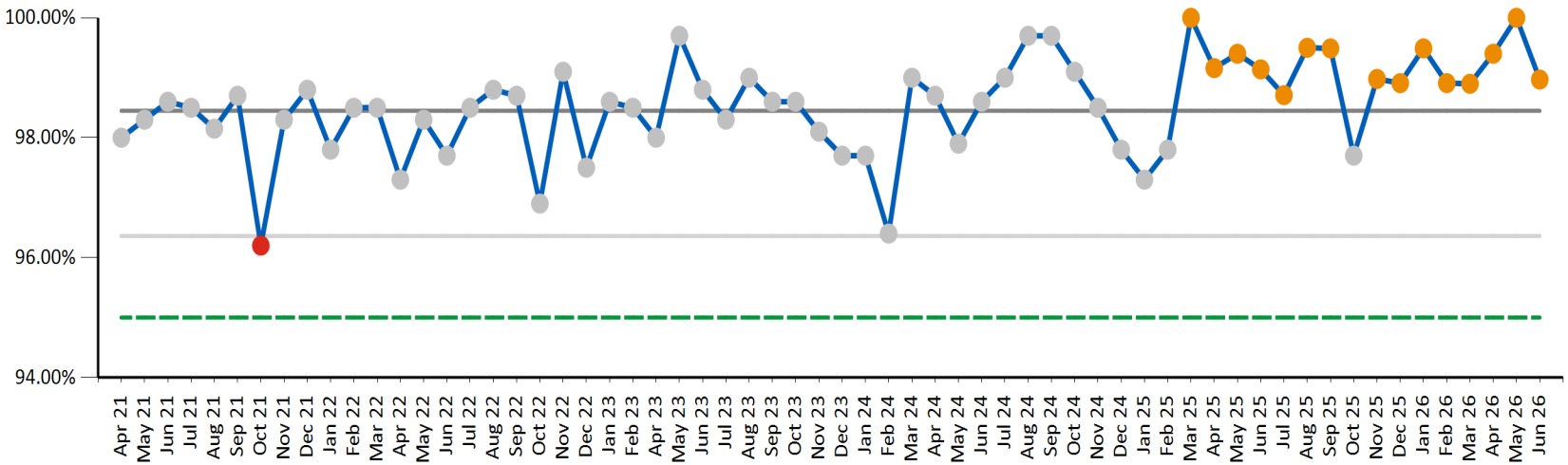
| Plan | Actual |
|---|---|
| <= 3.5% | 3.3% |

## 202 - 1:1 Midwifery care in labour

Special cause variation with improving performance

Target will be regularly met.

6/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 95.0% | 99.0% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 95.0% | 100.0% | May-26 |

### Year to Date

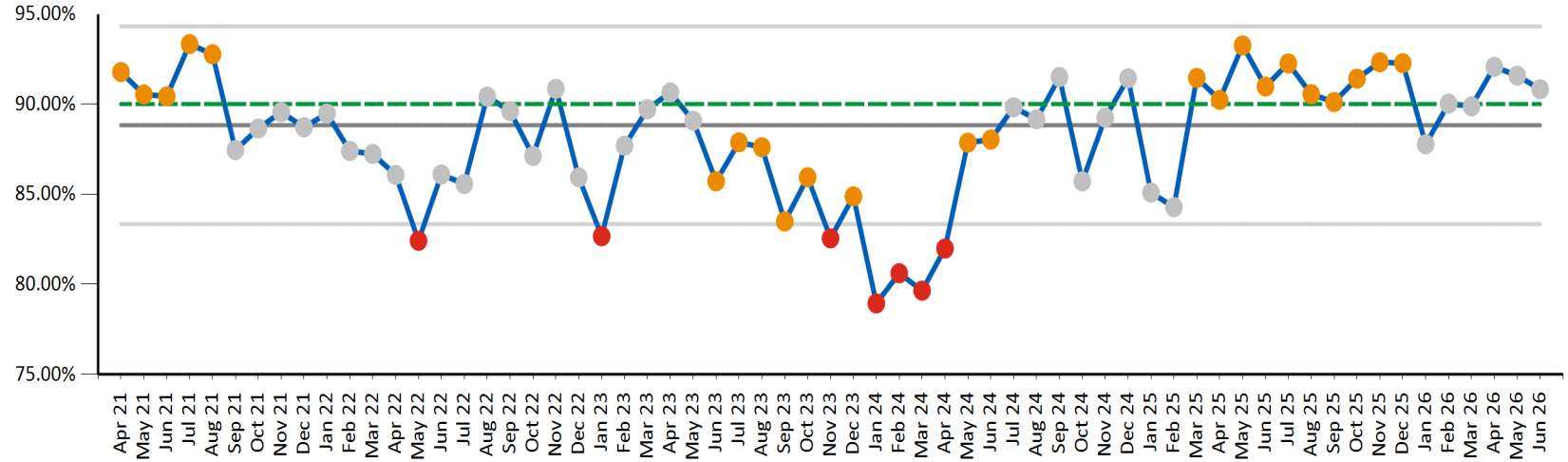
| Plan | Actual |
|---|---|
| >= 95.0% | 99.5% |

## 203 - Booked 12+6

Common cause variation.

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

4/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 90.0% | 90.8% | Jun-26 |

### Previous

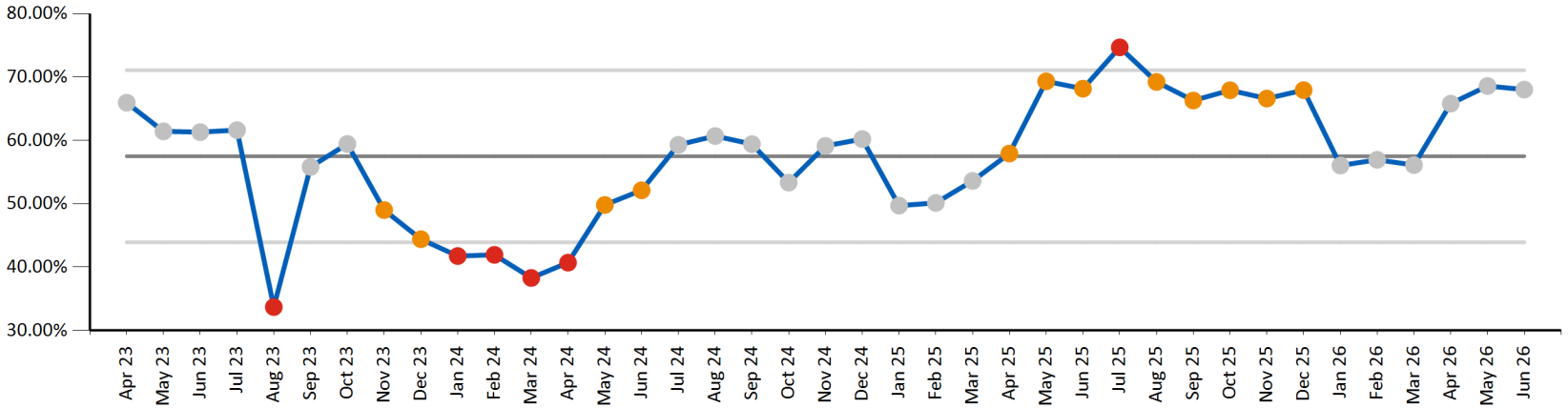
| Plan | Actual | Period |
|---|---|---|
| >= 90.0% | 91.6% | May-26 |

### Year to Date

| Plan | Actual |
|---|---|
| >= 90.0% | 91.5% |

## 586 - Booked 10+0

Common cause variation.




Latest

| Plan | Actual | Period |
|---|---|---|
| | 68.0% | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| | 68.6% | May-26 |

Year to Date

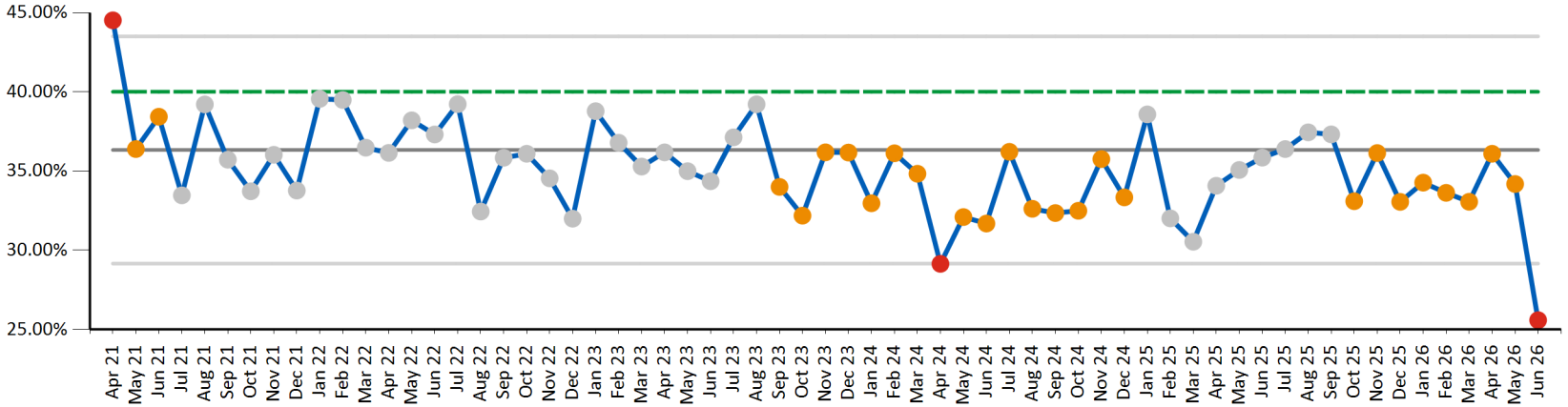
| Plan | Actual |
|---|---|
| | 67.4% |

## 204 - Percentage of women induced

Special cause variation with improving performance

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

6/6




Latest

| Plan | Actual | Period |
|---|---|---|
| <= 40% | 25.6% | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| <= 40% | 34.2% | May-26 |

Year to Date

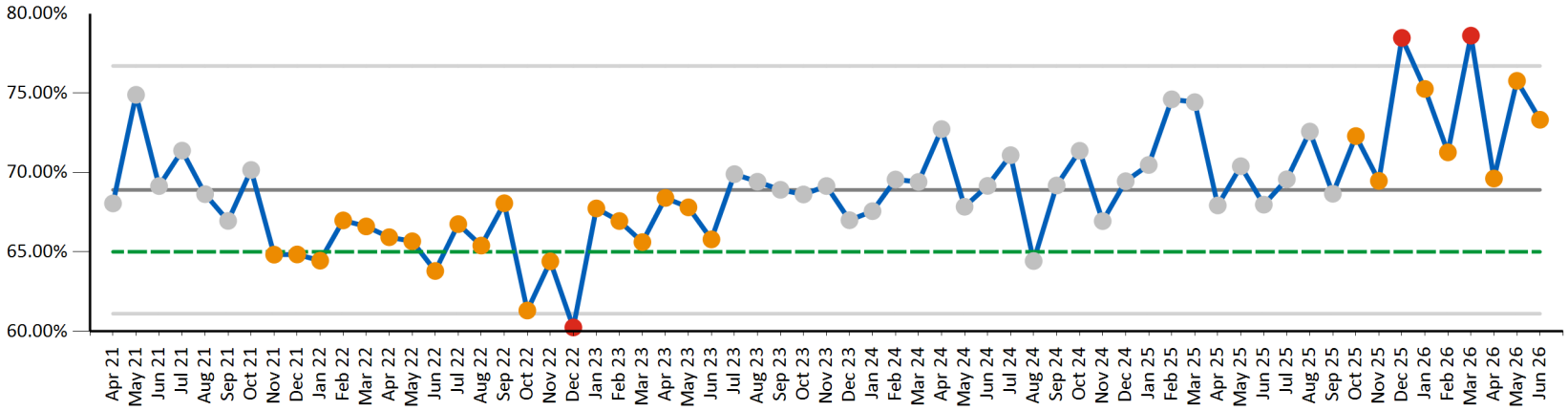
| Plan | Actual |
|---|---|
| <= 40% | 31.9% |

## 210 - Initiation breast feeding

Special cause variation with improving performance

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

6/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 65% | 73.32% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 65% | 75.77% | May-26 |

### Year to Date

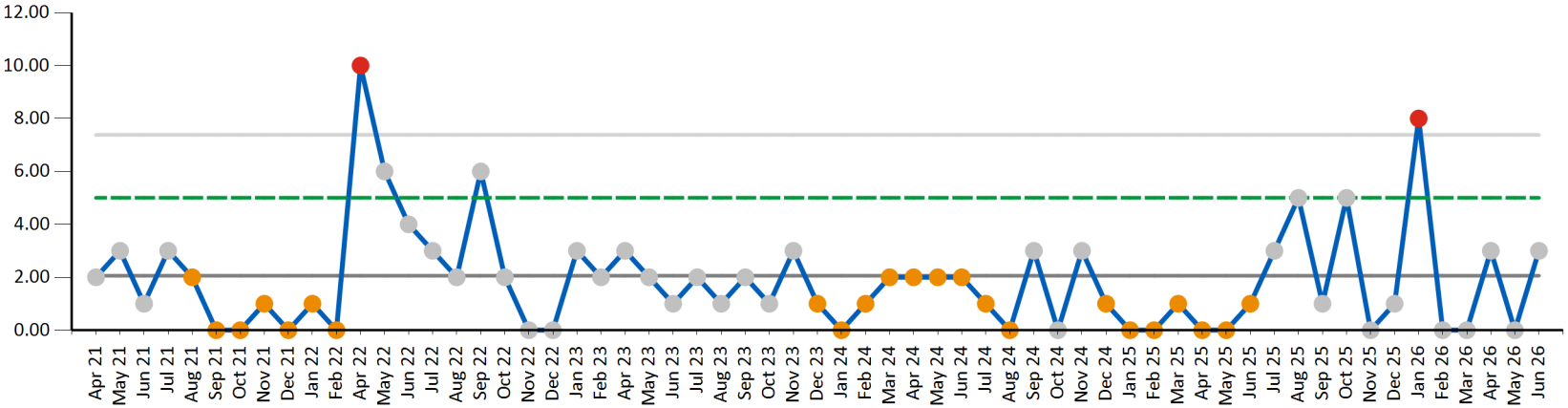
| Plan | Actual |
|---|---|
| >= 65% | 72.98% |

## 213 - Maternity complaints

Common cause variation.

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

5/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| <= 5 | 3 | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| <= 5 | 0 | May-26 |

### Year to Date

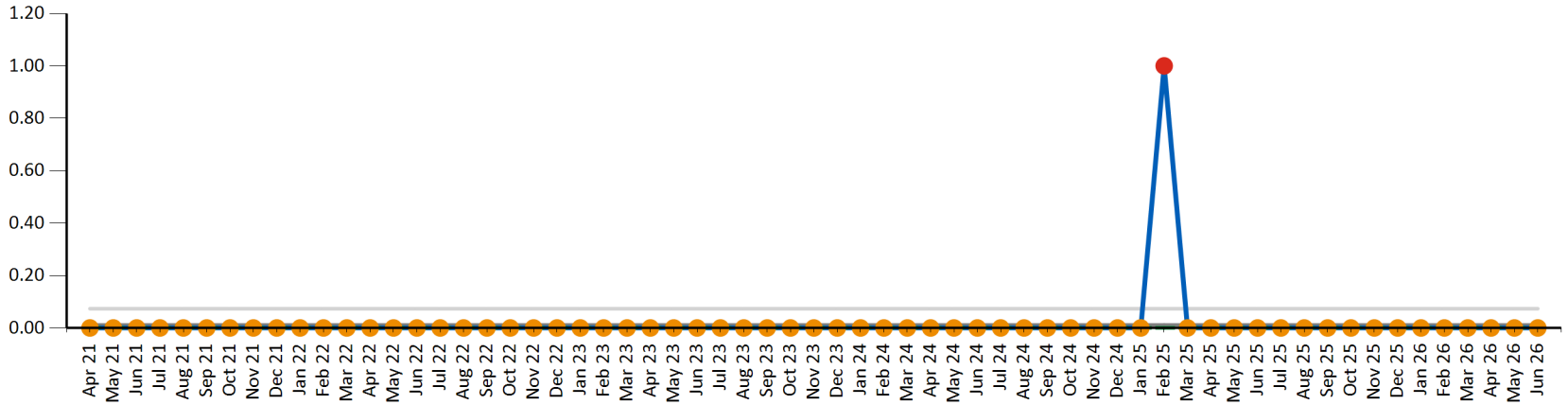
| Plan | Actual |
|---|---|
| <= 15 | 6 |

## 319 - Maternal deaths (direct)

Special cause variation with improving performance

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

6/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| = 0 | 0 | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| = 0 | 0 | May-26 |

### Year to Date

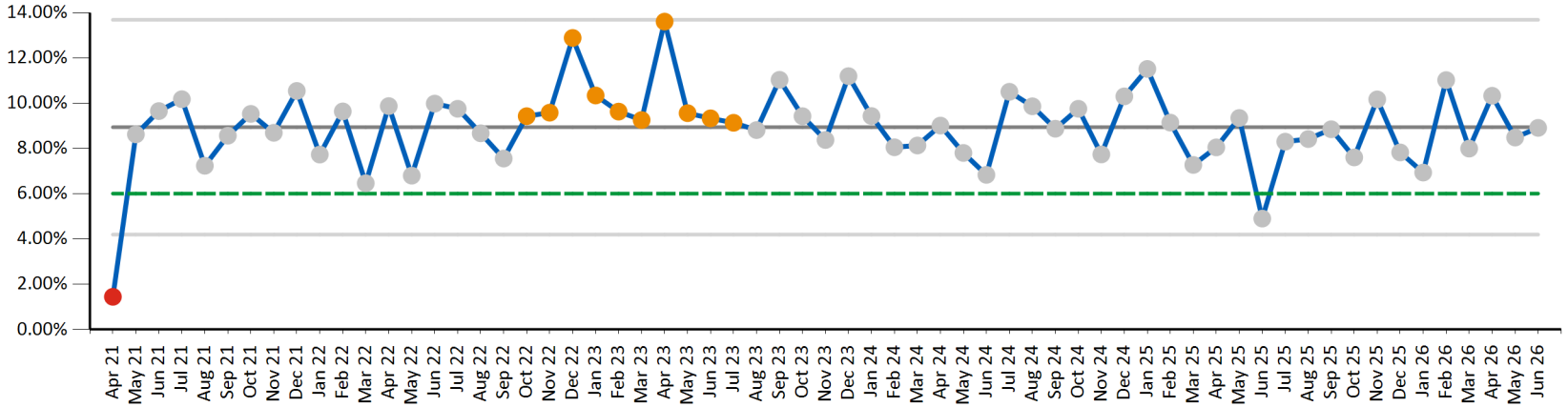
| Plan | Actual |
|---|---|
| = 0 | 0 |

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

Common cause variation.

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

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| <= 6% | 8.9% | Jun-26 |

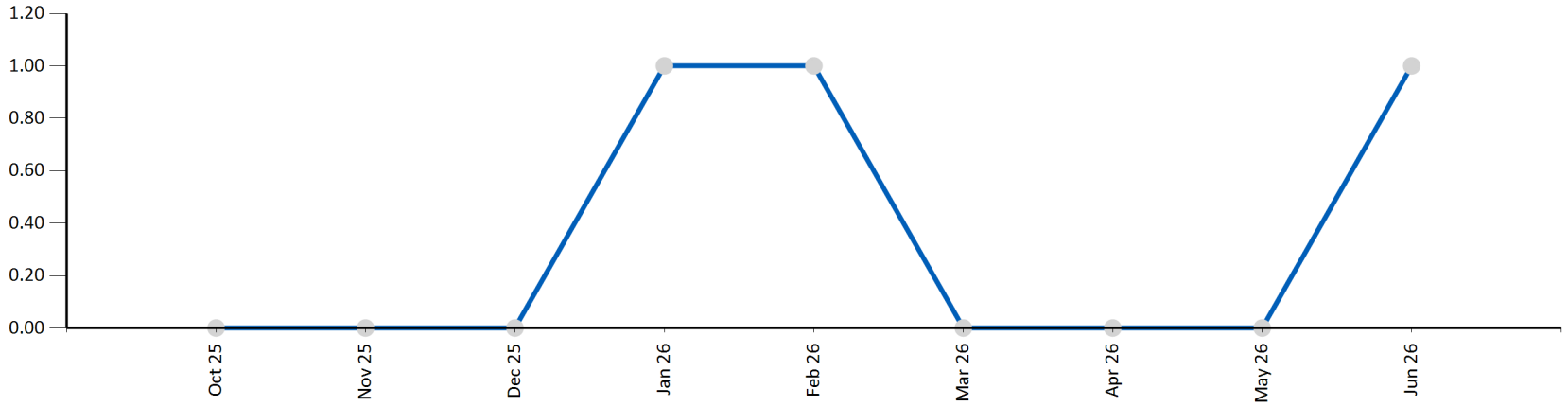
### Previous

| Plan | Actual | Period |
|---|---|---|
| <= 6% | 8.5% | May-26 |

### Year to Date

| Plan | Actual |
|---|---|
| <= 6% | 9.2% |

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




Latest

| Plan | Actual | Period |
|---|---|---|
| | 1 | Jun-26 |

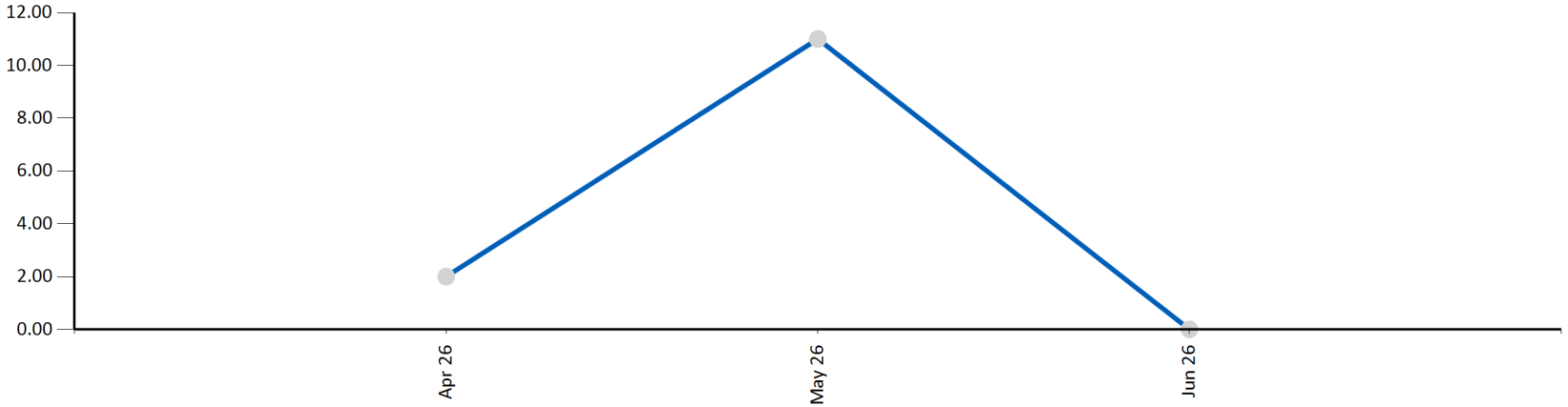
Previous

| Plan | Actual | Period |
|---|---|---|
| | 0 | May-26 |

Year to Date

| Plan | Actual |
|---|---|
| | 1 |

## 665 - Inductions of Labour >6 hours - SPC data available after 20 data points




Latest

| Plan | Actual | Period |
|---|---|---|
| | 0 | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| | 11 | May-26 |

Year to Date

| Plan | Actual |
|---|---|
| | 13 |

# Operational Performance - Urgent Care

NHS Bolton NHS Foundation Trust

Urgent Care

In June 2026, performance against the all types 4 hour standard was 66.52%, a deterioration compared to May 2026 (68.73%). Ambulance handovers within 15 minutes worsened to 51.73% (52.54 % in May), handovers above 30 minutes improved to 8.32% (9.94% in May), while those completed above 60 minutes worsened at 1.26% (0.77% in May). Whilst some metrics demonstrate challenges versus May performance, many demonstrate a trend of improving performance, in particular 4-hour performance, which for context was 64.91% in June 2025.

The percentage number of over 12 hour waits improved to 8.29% in June compared to 8.37% in May.

Trust non elective length of stay worsened, increasing to 5.1 days in June from 4.7 days in May, however in month length of stay which presents a more accurate representation of live performance indicates an improvement to 2.8 days from 2.9 days over the same period.

Adult G&A bed occupancy improved to 88.99% in June from 90.08% in May.

NOF

For June, our fractured neck of femur performance increased to 67.6%, which signifies the highest performance for over two years. 22 of the 33 eligible patients got to theatre within the 36 hour window. Of the 11x patients who breached the target, 6x related to delays awaiting a plan and optimisation of patients, including delays for patients taking anticoagulants and patients awaiting complex equipment prior to surgery, while 2x patients were delayed in the Emergency Department. The remaining 3x patients were due to delays to theatre capacity – 2x of these patients were delayed due to only having a half-day list on a Sunday.
For the first time since May 2024, average hours to theatre is below the national average position, and mortality remains under the national average when adjusted for casemix.

Emergency Department Deflections & 2 Hour UCR

AAT/Home First ED deflections increased from 683 from 655 and this well above plan (400) due to proactive screening and early identification by Home first and an overall increase in UCR referrals into AAT.  2 hour UCR performance remained high at 82.3% (target 70%), however it is 6% lower on the previous month, this is expected to improve with further data validation in M4. Referral numbers increased to 487 from 459 and this exceeds the national target of 457. Expansion and promotion of clinical pathways continues including acute urinary retention pathway and IV antibiotic pathway. CSD directory of services is currently in development and will be accessible on the trust intranet to enable quick access to clinical pathway information to support deflection from ED and earlier discharge.

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 53 - A&E 4 hour target | >= 72% | 66.5% | Jun-26 | | >= 72% | 68.7% | May-26 | >= 72% | 69.2% | |
| 538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes | >= 65.0% | 51.7% | Jun-26 | | >= 65.0% | 52.5% | May-26 | >= 65.0% | 51.7% | |

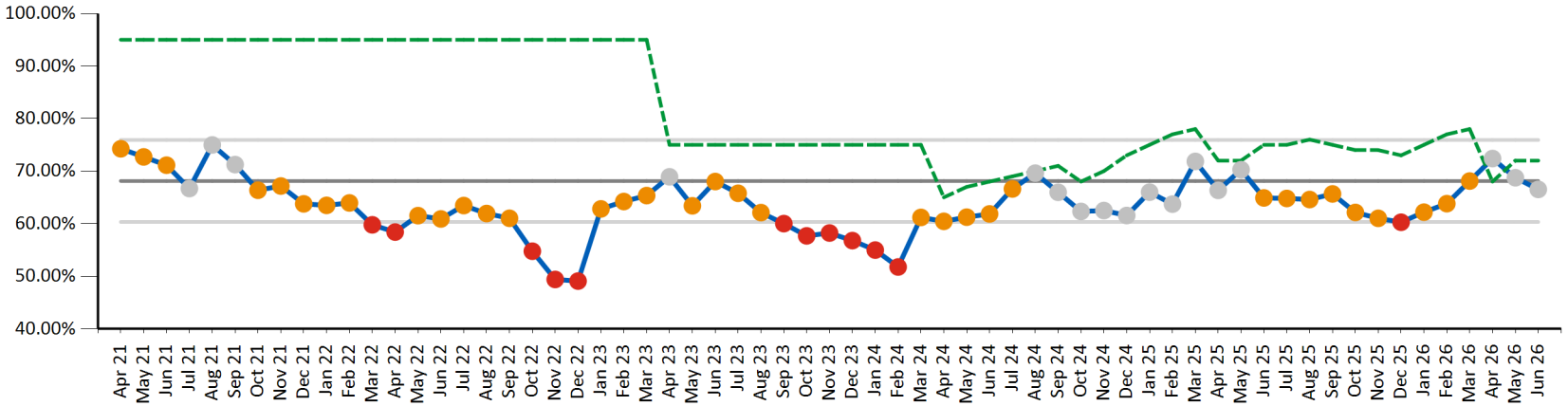
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins | >= 95.0% | 91.7% | Jun-26 | | >= 95.0% | 90.1% | May-26 | >= 95.0% | 88.4% | F |
| 71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes | = 100% | 98.74% | Jun-26 | | = 100% | 99.23% | May-26 | = 100% | 97.86% | ? |
| 539 - A&E 12 hour waits | = 0 | 1,005 | Jun-26 | | = 0 | 1,026 | May-26 | = 0 | 2,945 | F |
| 26 - Patients going to theatre within 36 hours of a fractured Neck of Femur | >= 75% | 67.6% | Jun-26 | | >= 75% | 45.5% | May-26 | >= 75% | 50.8% | ? |
| 56 - Stranded patients - over 7 days | <= 200 | 241 | Jun-26 | | <= 200 | 231 | May-26 | <= 200 | 241 | F |
| 307 - Stranded Patients - LOS 21 days and over | <= 69 | 83 | Jun-26 | | <= 69 | 84 | May-26 | <= 69 | 83 | ? |
| 541 - Adult G&A bed occupancy | <= 92.0% | 86.8% | Jun-26 | | <= 92.0% | 85.4% | May-26 | <= 92.0% | 85.4% | P |
| 66 - Non Elective Length of Stay (Discharges in month) | <= 3.70 | 5.09 | Jun-26 | L | <= 3.70 | 4.78 | May-26 | <= 3.70 | 5.07 | F |
| 59 - Re-admission within 30 days of discharge (1 mth in arrears) | <= 13.5% | 11.1% | May-26 | | <= 13.5% | 9.8% | Apr-26 | <= 13.5% | 10.5% | P |
| 554 - 2 Hour Urgent Community Response % | <= 70.0% | 82.3% | Jun-26 | H | <= 70.0% | 88.0% | May-26 | <= 70.0% | 87.7% | ? |
| 555 - 2 Hour Urgent Community Response Referrals | <= 358 | 294 | Jun-26 | H | <= 358 | 241 | May-26 | <= 1,074 | 826 | P |
| 664 - Urgent Community Response Referrals | >= 428 | 487 | Jun-26 | H | >= 432 | 459 | May-26 | >= 1,297 | 1,444 | ? |

## 53 - A&E 4 hour target

Common cause variation.

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

1/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 72% | 66.5% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 72% | 68.7% | May-26 |

### Year to Date

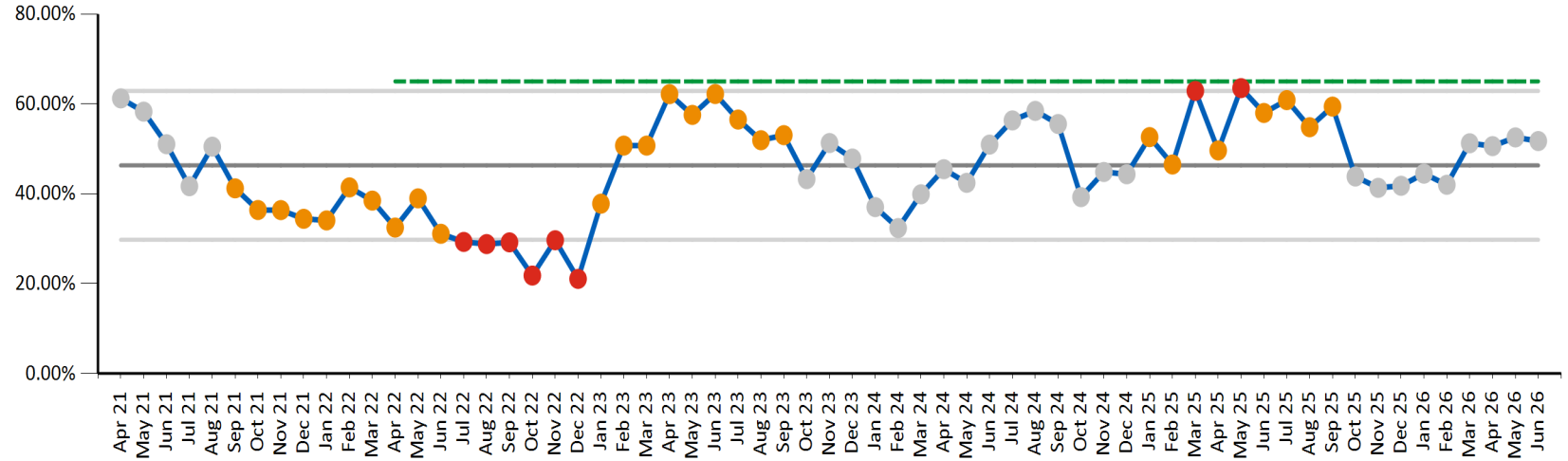
| Plan | Actual |
|---|---|
| >= 72% | 69.2% |

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

Common cause variation.

We will regularly fail to meet the target.

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 65.0% | 51.7% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 65.0% | 52.5% | May-26 |

### Year to Date

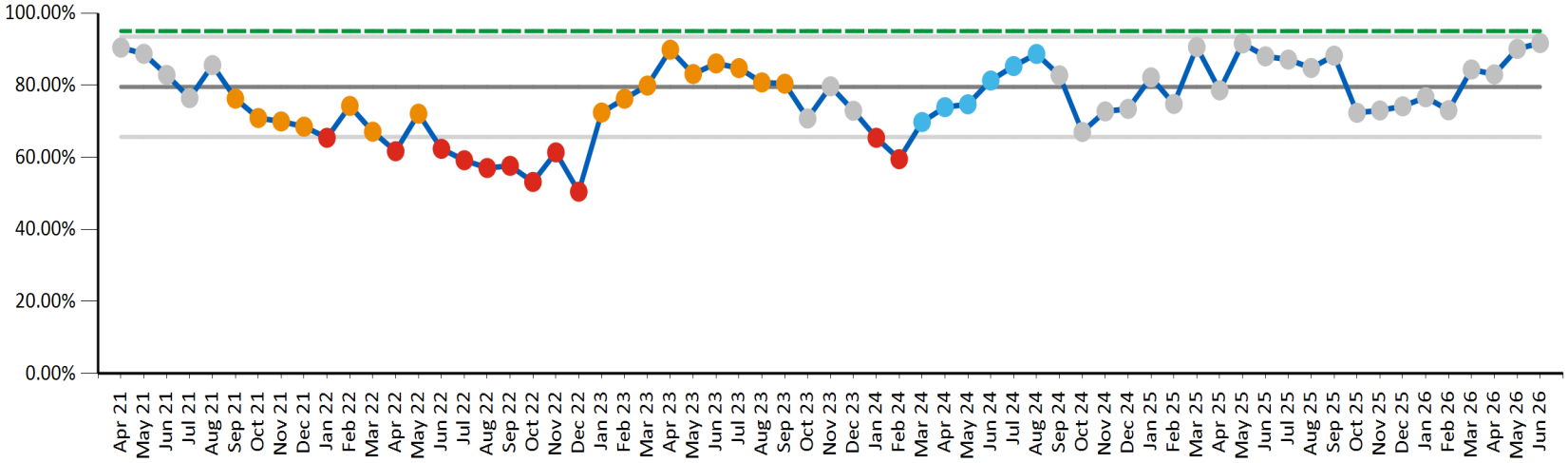
| Plan | Actual |
|---|---|
| >= 65.0% | 51.7% |

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

Common cause variation.

We will regularly fail to meet the target.

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 95.0% | 91.7% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 95.0% | 90.1% | May-26 |

### Year to Date

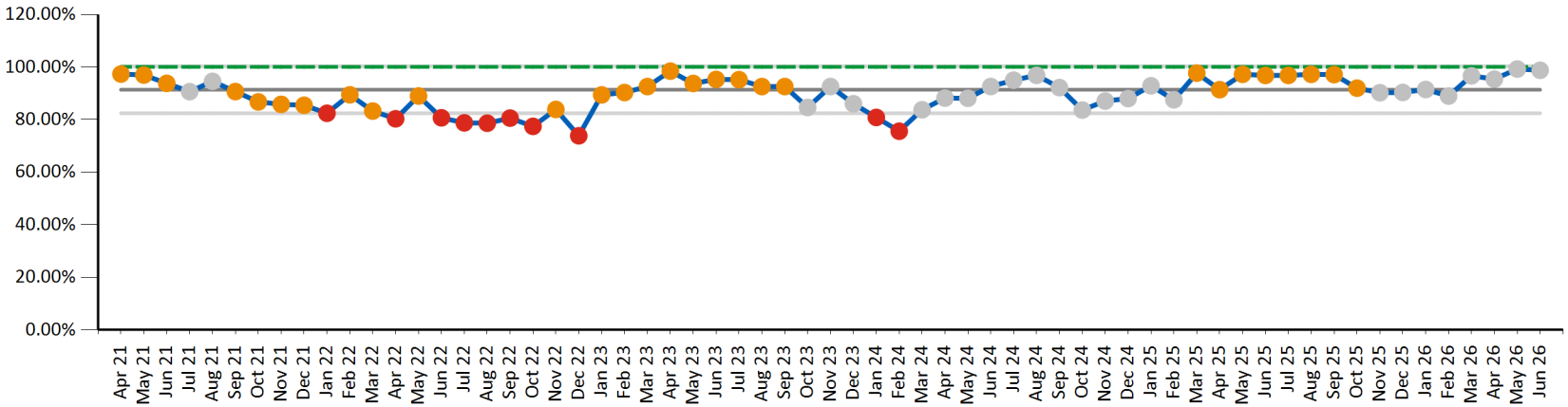
| Plan | Actual |
|---|---|
| >= 95.0% | 88.4% |

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

Common cause variation.

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

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| = 100% | 98.74% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| = 100% | 99.23% | May-26 |

### Year to Date

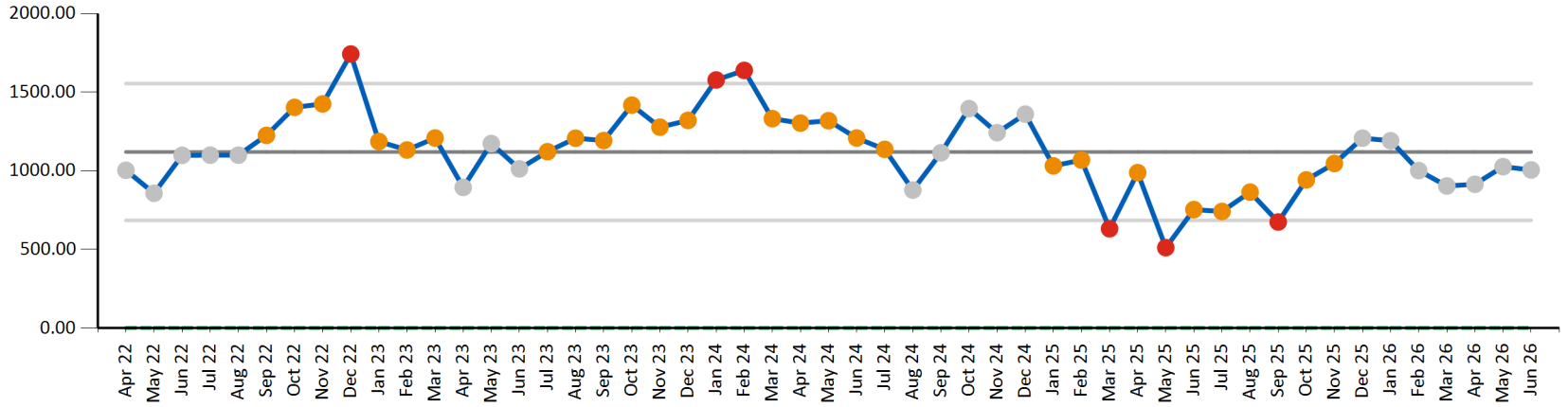
| Plan | Actual |
|---|---|
| = 100% | 97.86% |

## 539 - A&E 12 hour waits

Common cause variation.

We will regularly fail to meet the target.

0/6




Latest

| Plan | Actual | Period |
|---|---|---|
| = 0 | 1,005 | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| = 0 | 1,026 | May-26 |

Year to Date

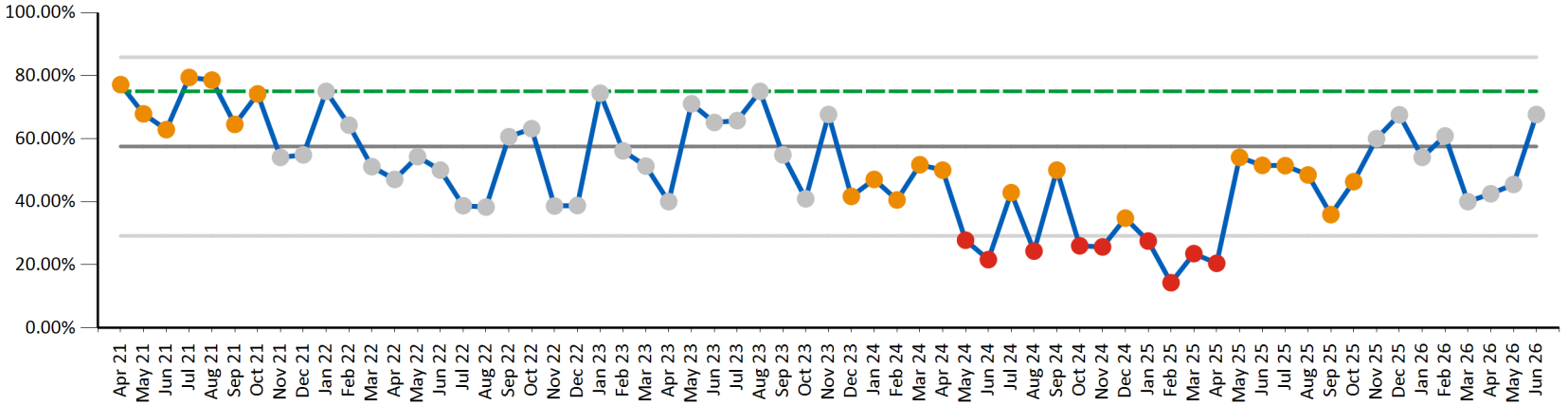
| Plan | Actual |
|---|---|
| = 0 | 2,945 |

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

Common cause variation.

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

0/6




Latest

| Plan | Actual | Period |
|---|---|---|
| >= 75% | 67.6% | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| >= 75% | 45.5% | May-26 |

Year to Date

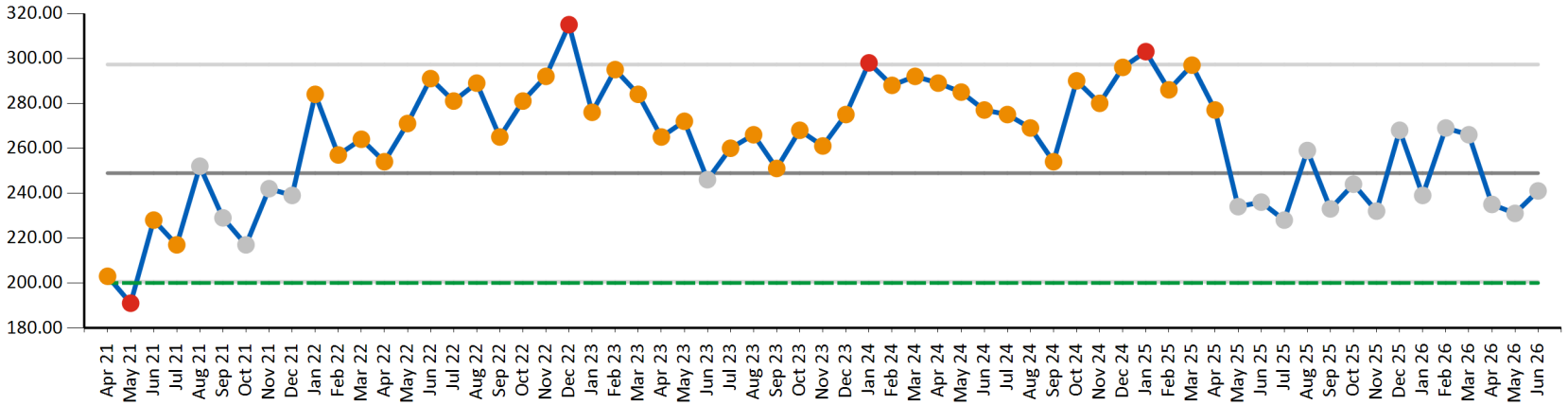
| Plan | Actual |
|---|---|
| >= 75% | 50.8% |

## 56 - Stranded patients - over 7 days

Common cause variation.

We will regularly fail to meet the target.

0/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 200 | 241 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 200 | 231 | May-26 |

**Year to Date**

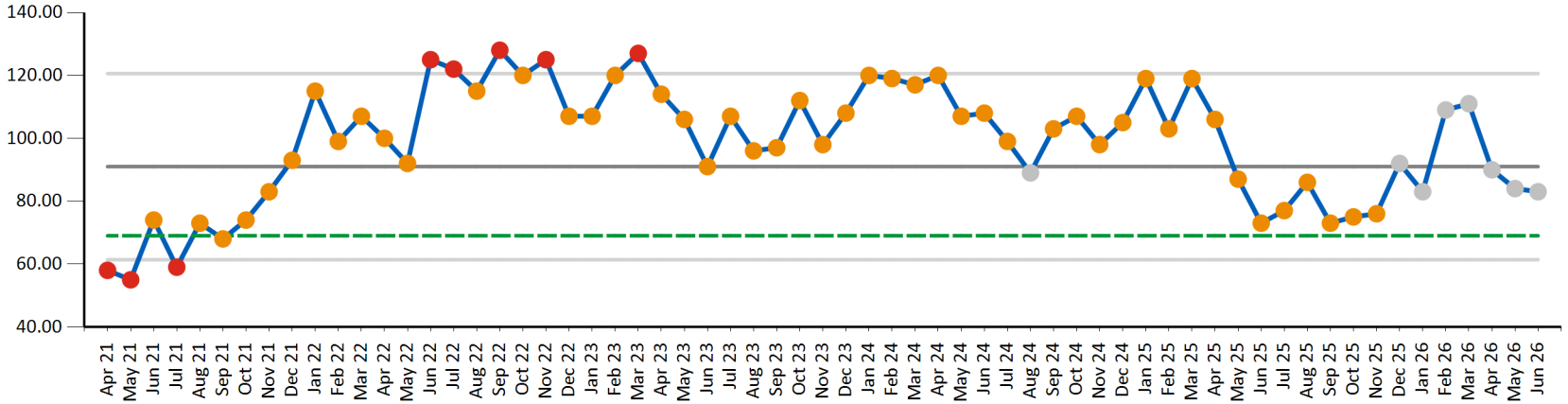
| Plan | Actual |
|---|---|
| <= 200 | 241 |

## 307 - Stranded Patients - LOS 21 days and over

Common cause variation.

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

0/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 69 | 83 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 69 | 84 | May-26 |

**Year to Date**

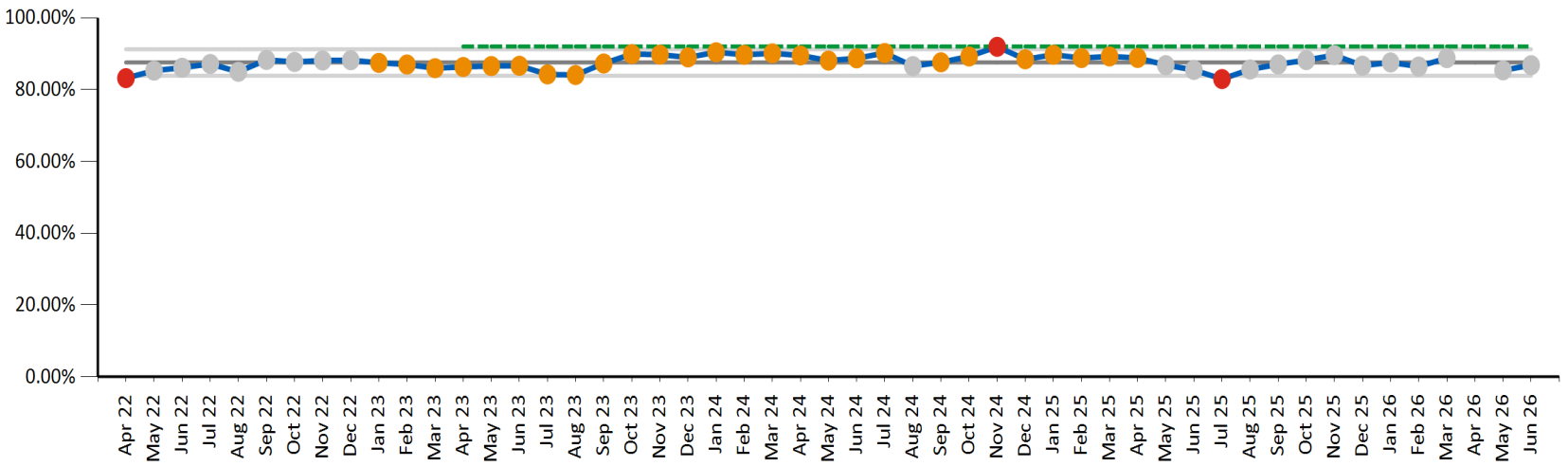
| Plan | Actual |
|---|---|
| <= 69 | 83 |

## 541 - Adult G&A bed occupancy

Common cause variation.

Target will be regularly met.

5/6




Latest

| Plan | Actual | Period |
|---|---|---|
| <= 92.0% | 86.8% | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| <= 92.0% | 85.4% | May-26 |

Year to Date

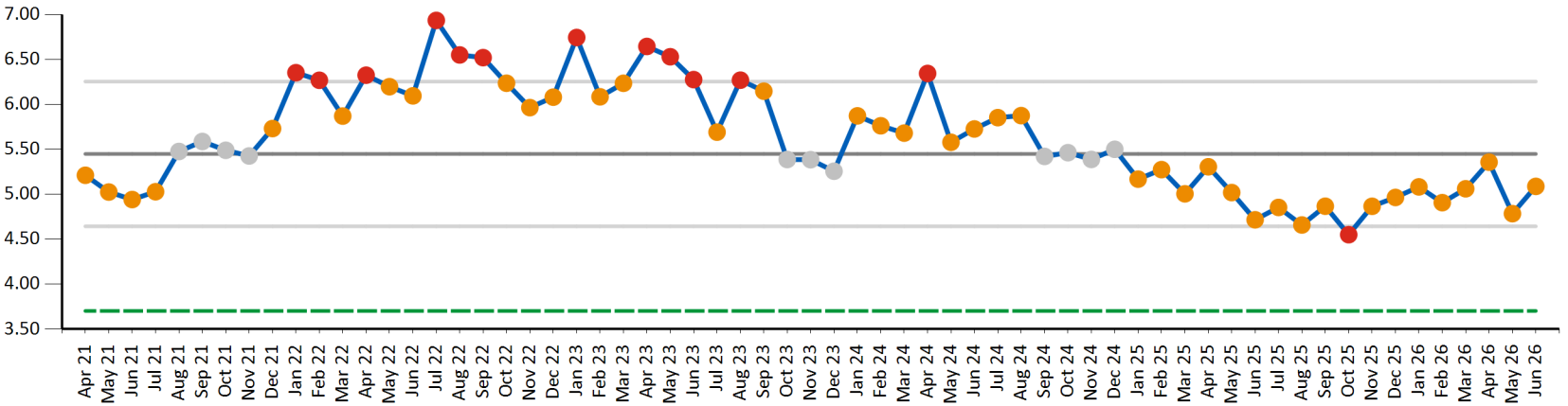
| Plan | Actual |
|---|---|
| <= 92.0% | 85.4% |

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

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6




Latest

| Plan | Actual | Period |
|---|---|---|
| <= 3.70 | 5.09 | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| <= 3.70 | 4.78 | May-26 |

Year to Date

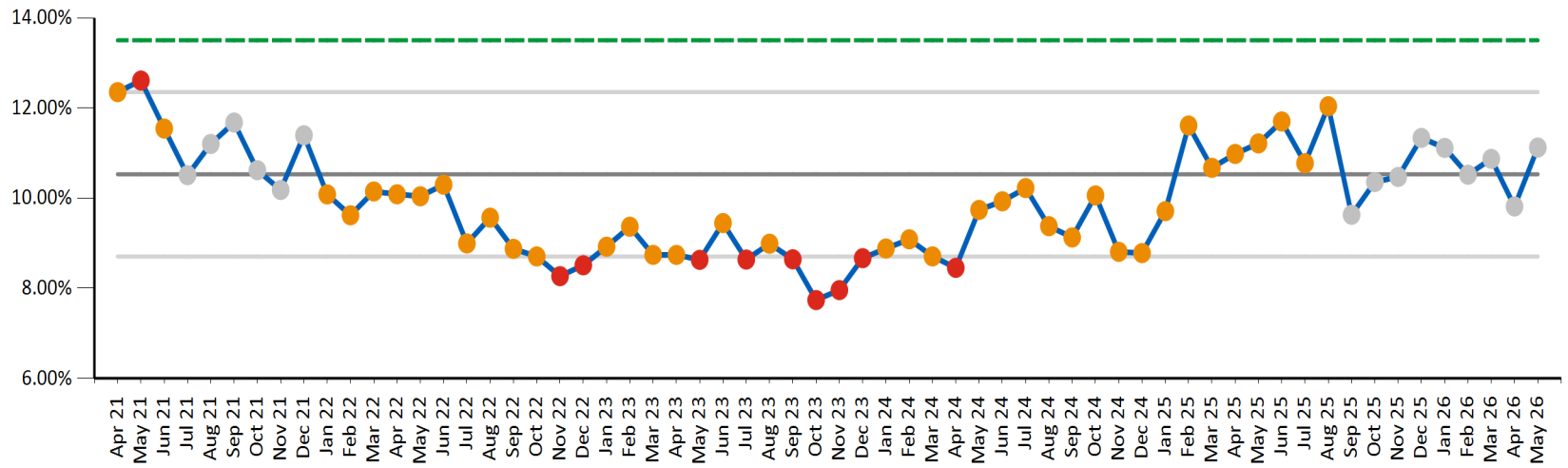
| Plan | Actual |
|---|---|
| <= 3.70 | 5.07 |

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

Common cause variation.

Target will be regularly met.

6/6




Latest

| Plan | Actual | Period |
|---|---|---|
| <= 13.5% | 11.1% | May-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| <= 13.5% | 9.8% | Apr-26 |

Year to Date

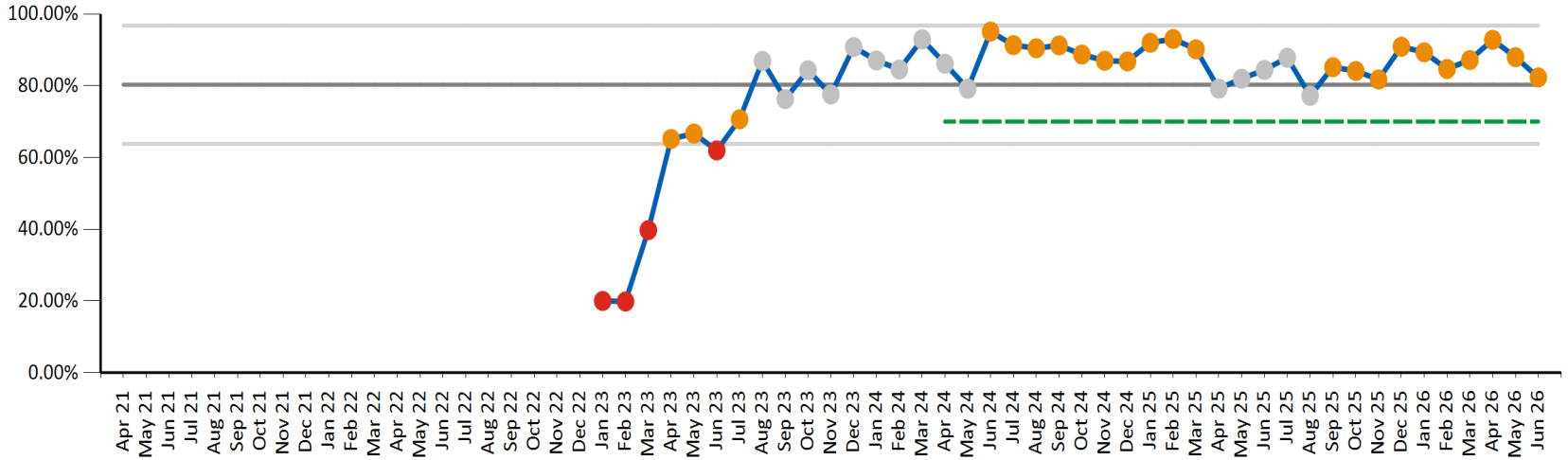
| Plan | Actual |
|---|---|
| <= 13.5% | 10.5% |

## 554 - 2 Hour Urgent Community Response %

Special cause variation with deteriorating performance

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

0/6




Latest

| Plan | Actual | Period |
|---|---|---|
| <= 70.0% | 82.3% | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| <= 70.0% | 88.0% | May-26 |

Year to Date

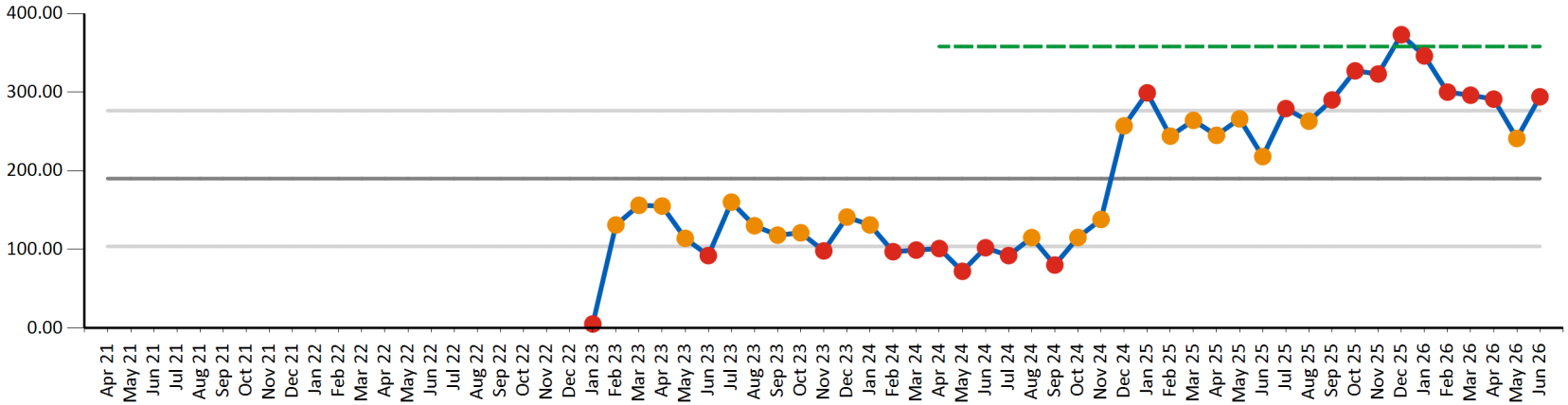
| Plan | Actual |
|---|---|
| <= 70.0% | 87.7% |

## 555 - 2 Hour Urgent Community Response Referrals

Special cause variation with deteriorating performance

Target will be regularly met.

6/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| <= 358 | 294 | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| <= 358 | 241 | May-26 |

### Year to Date

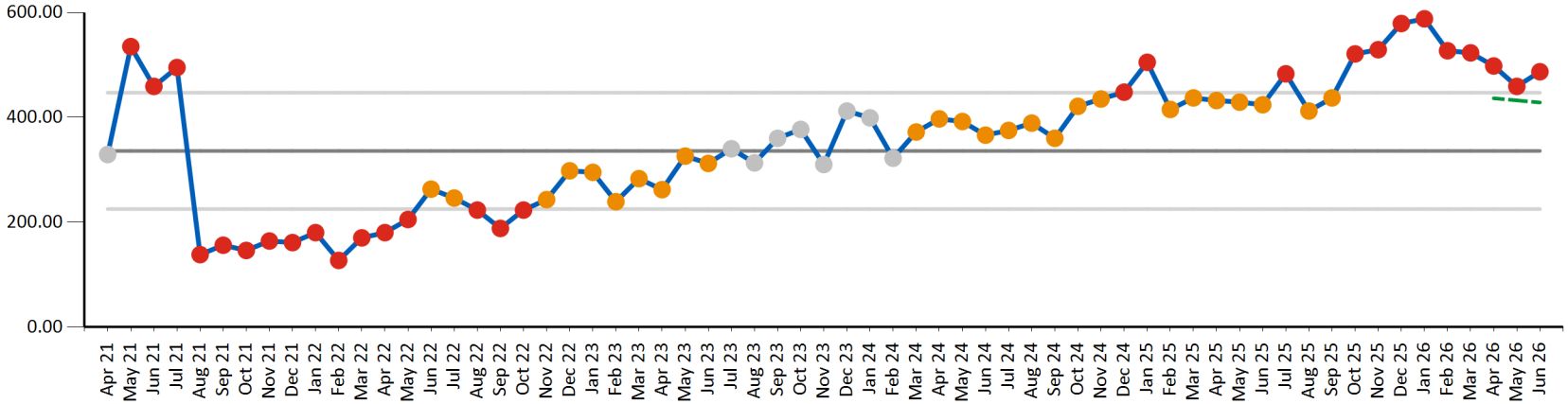
| Plan | Actual |
|---|---|
| <= 1,074 | 826 |

## 664 - Urgent Community Response Referrals

Special cause variation with improving performance

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

3/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 428 | 487 | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 432 | 459 | May-26 |

### Year to Date

| Plan | Actual |
|---|---|
| >= 1,297 | 1,444 |

# Operational Performance - Elective Care

RTT

Latest data currently available is May 26 due to the national deadline for June being extended.  A verbal update will be provided by the Chief Operating Officer.

DM01

DM01 performance deteriorated in M3 to 15.07% against a plan of 11.59%, a variance of 3.48% above plan.

The deterioration in performance was primarily driven by challenges within CT, Audiology and Cystoscopy services. CT reported 109 breaches (17.6%), reflecting the continued prioritisation of cancer pathways alongside increased demand for Cardiac CT activity. Audiology accounted for 521 breaches (46.8%), largely due to a cohort of paediatric review patients remaining within the backlog position.

Recovery actions are underway to address this. Cystoscopy reported 93 breaches (33.7%), with capacity constrained pending confirmation of additional estate; however, breaches for July are forecasted and tracking a reduction. Audiology and CT have recovery plans in place, as well as additional activity. For Cystoscopy, a detailed recovery plan and trajectory have been requested by 31 July 2026, aligned to the proposed estate developments that will increase service capacity.

Performance is forecast to improve marginally for M4 but is expected to remain above plan until at least M5 whilst recovery activity is implemented and additional capacity is delivered.

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 41 - RTT Incomplete pathways within 18 weeks % | >= 62% | 60.7% | May-26 | | >= 62% | 60.8% | Apr-26 | >= 62% | 60.7% | ? |
| 314 - RTT 18 week waiting list | <= 35,113 | 37,294 | May-26 | H | <= 36,415 | 36,779 | Apr-26 | <= 35,113 | 37,294 | ? |
| 42 - RTT 52 week waits (incomplete pathways) | <= 324 | 395 | May-26 | L | <= 345 | 440 | Apr-26 | <= 669 | 835 | F |
| 667 - Percentage of cases where a patient is waiting more than 52 weeks for elective treatment | >= 0.90% | | Jun-26 | | >= 0.90% | | May-26 | >= 0.90% | 1.20% | P |
| 540 - RTT 65 week waits (incomplete pathways) | = 0 | 0 | May-26 | L | = 0 | 0 | Apr-26 | = 0 | 0 | F |
| 526 - RTT 78 week waits (incomplete pathways) | = 0 | 0 | May-26 | L | = 0 | 0 | Apr-26 | = 0 | 0 | F |
| 527 - RTT 104 week waits (incomplete pathways) | = 0 | 0 | May-26 | L | = 0 | 0 | Apr-26 | = 0 | 0 | F |

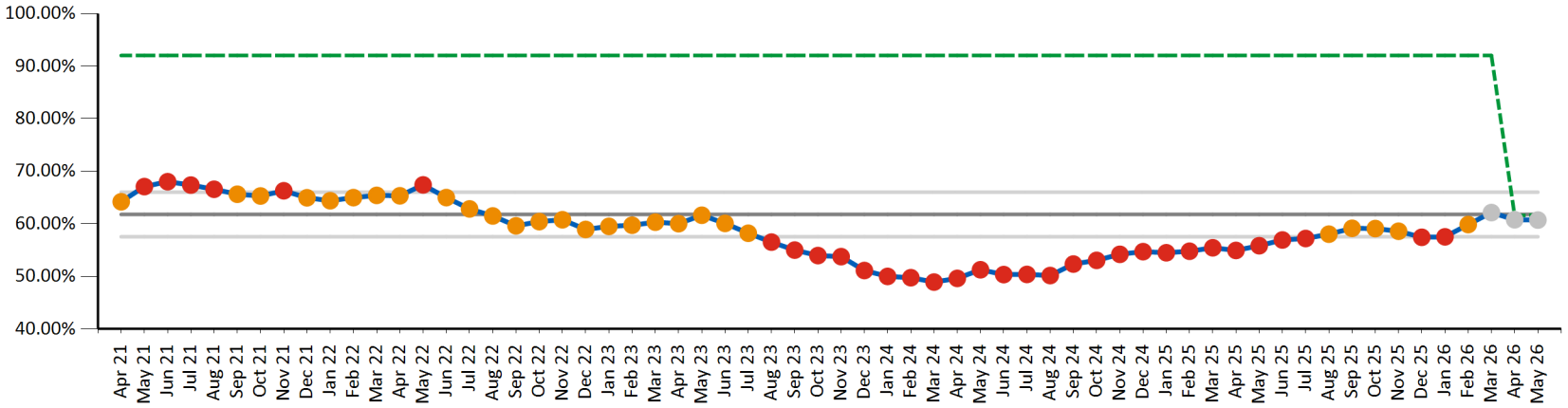
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 72 - Diagnostic Waits >6 weeks % | <= 12% | 15.7% | Jun-26 |  | <= 12% | 11.9% | May-26 | <= 12% | 12.8% |  |
| 489 - Daycase Rates | >= 85% | 84.9% | Jun-26 |  | >= 85% | 80.5% | May-26 | >= 85% | 82.0% |  |
| 582 - Theatre Utilisation - Capped | | 79.8% | Jun-26 |  | | 77.7% | May-26 | | 79.0% | |
| 583 - Theatre Utilisation - Uncapped | | 89.1% | Jun-26 |  | | 81.9% | May-26 | | 85.1% | |
| 61 - Operations cancelled on the day for non-clinical reasons | <= 1% | | Jun-26 |  | <= 1% | 2.0% | May-26 | <= 1% | 1.8% |  |
| 62 - Cancelled operations re-booked within 28 days | = 100% | 36.2% | May-26 |  | = 100% | 26.9% | Apr-26 | = 100% | 32.9% |  |
| 65 - Elective Length of Stay (Discharges in month) | <= 2.00 | 3.73 | Jun-26 |  | <= 2.00 | 2.93 | May-26 | <= 2.00 | 3.46 |  |
| 309 - DNA Rate - New | <= 6.3% | 9.7% | Jun-26 |  | <= 6.3% | 9.5% | May-26 | <= 6.3% | 9.3% |  |
| 310 - DNA Rate - Follow up | <= 5.0% | 9.0% | Jun-26 |  | <= 5.0% | 8.9% | May-26 | <= 5.0% | 9.0% |  |

## 41 - RTT Incomplete pathways within 18 weeks %

Common cause variation.

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

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 62% | 60.7% | May-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 62% | 60.8% | Apr-26 |

### Year to Date

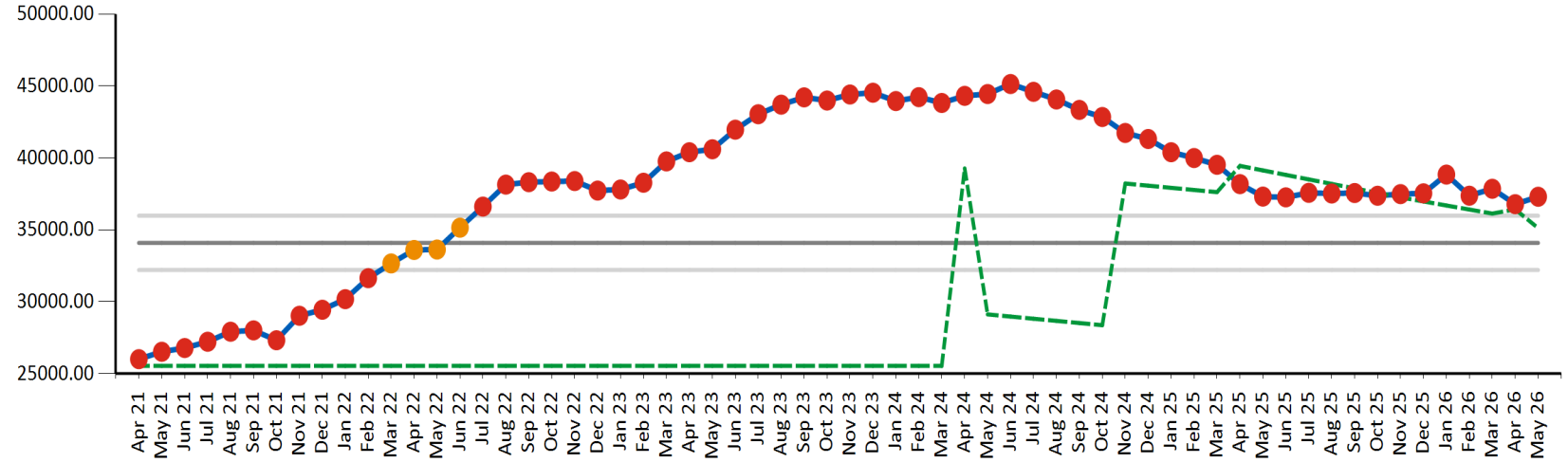
| Plan | Actual |
|---|---|
| >= 62% | 60.7% |

## 314 - RTT 18 week waiting list

Special cause variation with deteriorating performance

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

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| <= 35,113 | 37,294 | May-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| <= 36,415 | 36,779 | Apr-26 |

### Year to Date

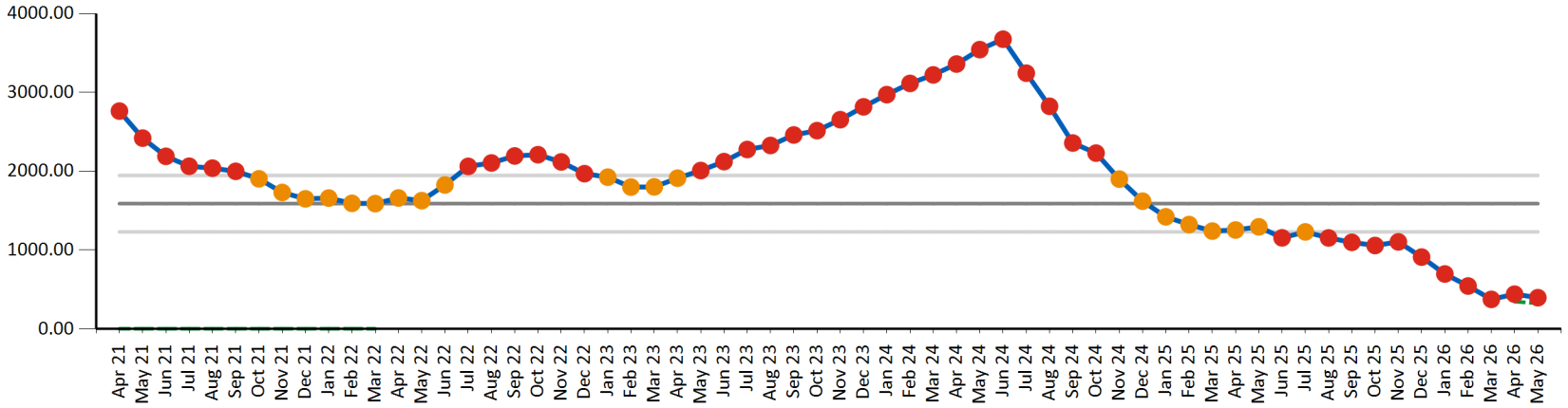
| Plan | Actual |
|---|---|
| <= 35,113 | 37,294 |

## 42 - RTT 52 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 324 | 395 | May-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 345 | 440 | Apr-26 |

**Year to Date**

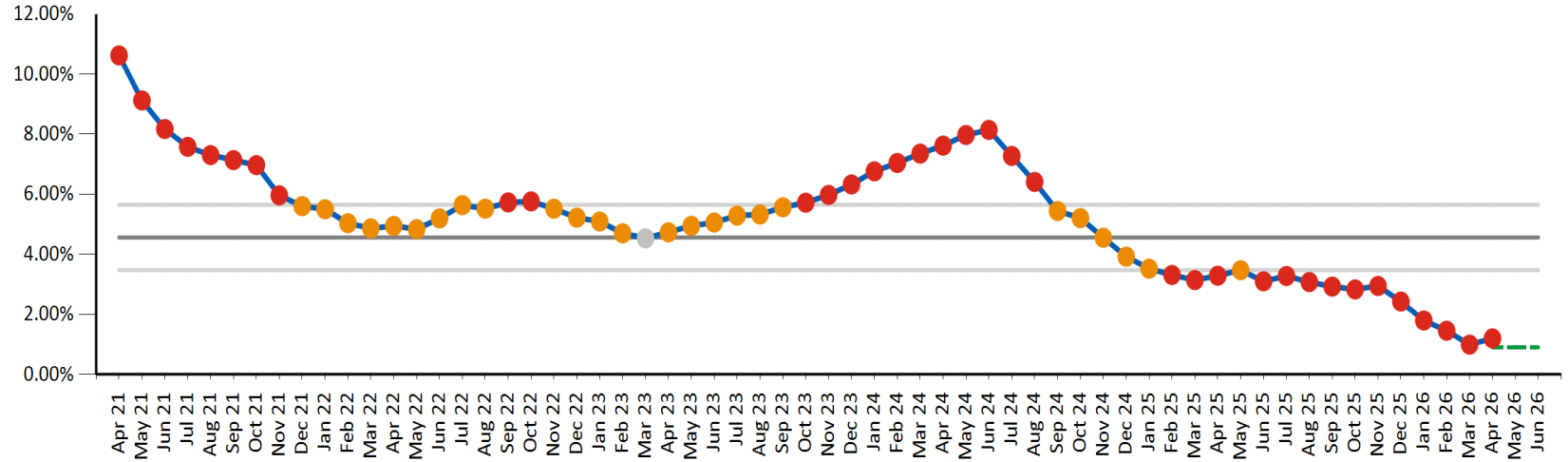
| Plan | Actual |
|---|---|
| <= 669 | 835 |

## 667 - Percentage of cases where a patient is waiting more than 52 weeks for elective treatment

Common cause variation.

Target will be regularly met.

1/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 0.90% | | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 0.90% | | May-26 |

**Year to Date**

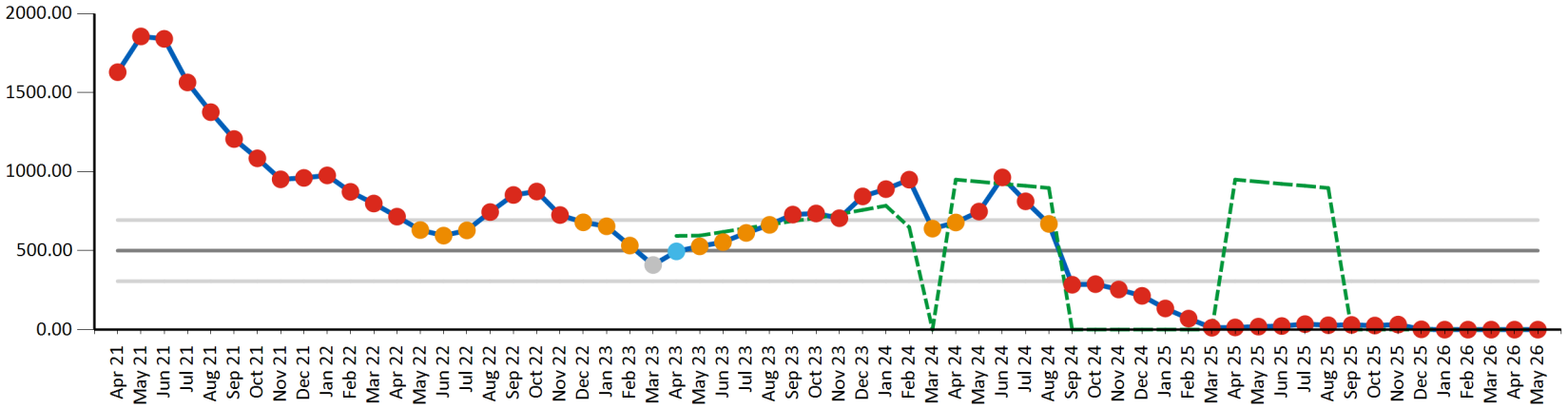
| Plan | Actual |
|---|---|
| >= 0.90% | 1.20% |

## 540 - RTT 65 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

5/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| = 0 | 0 | May-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| = 0 | 0 | Apr-26 |

**Year to Date**

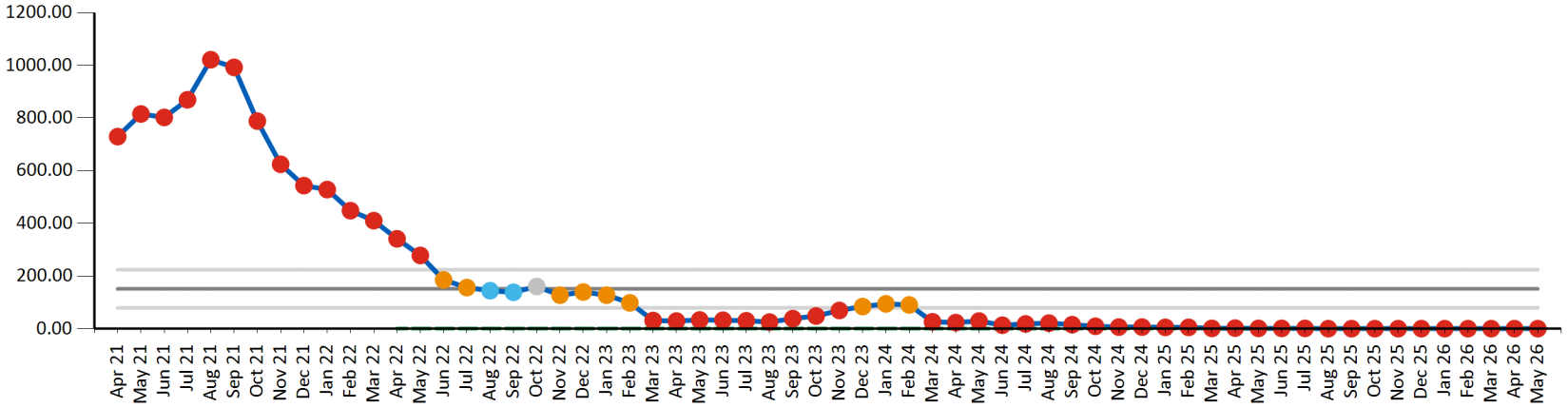
| Plan | Actual |
|---|---|
| = 0 | 0 |

## 526 - RTT 78 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

6/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| = 0 | 0 | May-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| = 0 | 0 | Apr-26 |

**Year to Date**

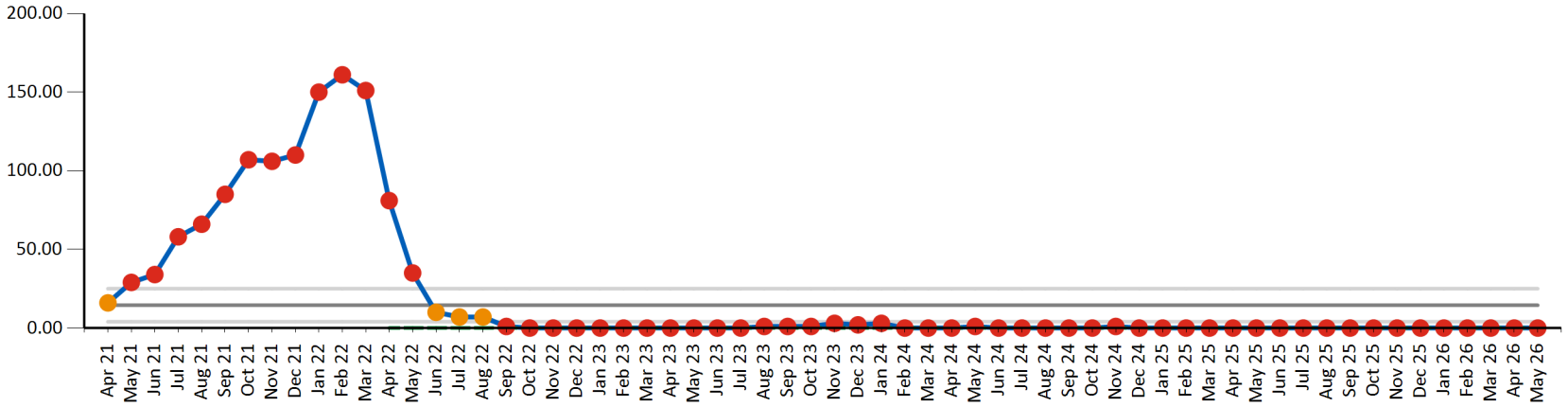
| Plan | Actual |
|---|---|
| = 0 | 0 |

## 527 - RTT 104 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

6/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| = 0 | 0 | May-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| = 0 | 0 | Apr-26 |

**Year to Date**

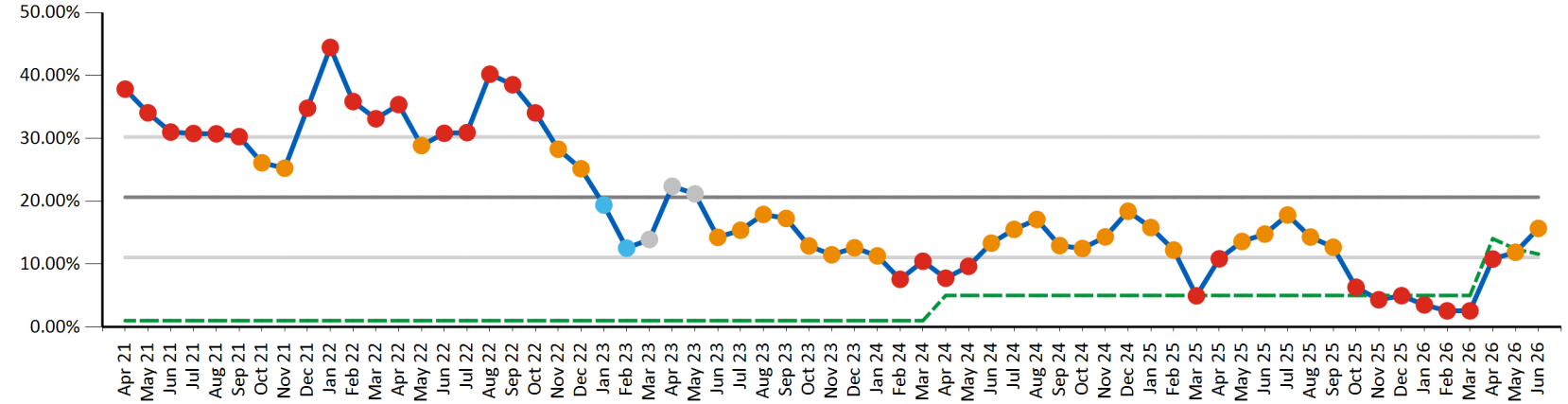
| Plan | Actual |
|---|---|
| = 0 | 0 |

## 72 - Diagnostic Waits >6 weeks %

Special cause variation with improving performance

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

5/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 12% | 15.7% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 12% | 11.9% | May-26 |

**Year to Date**

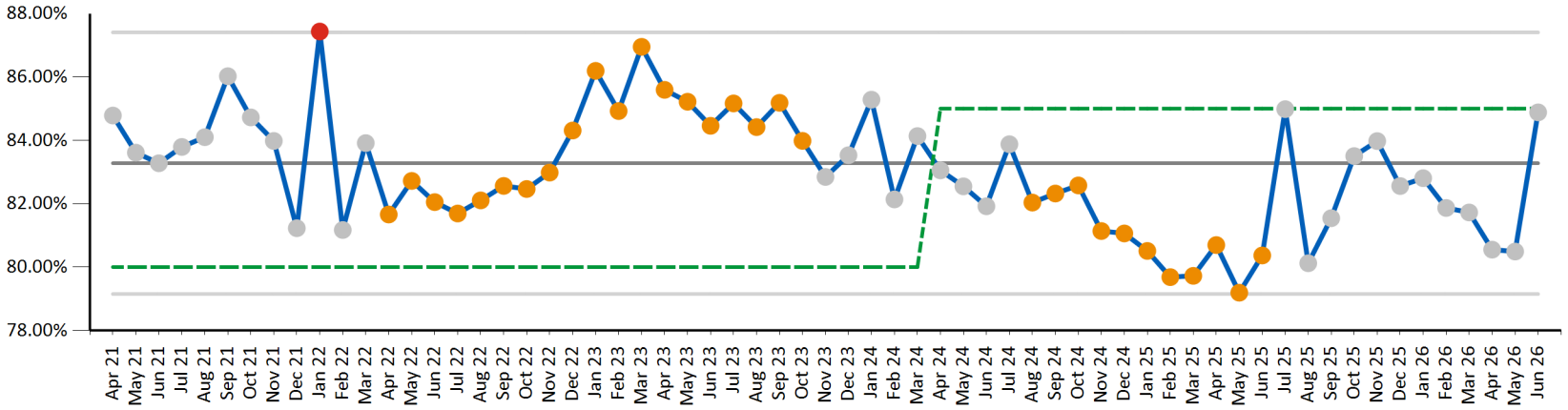
| Plan | Actual |
|---|---|
| <= 12% | 12.8% |

## 489 - Daycase Rates

Common cause variation.

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

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 85% | 84.9% | Jun-26 |

### Previous

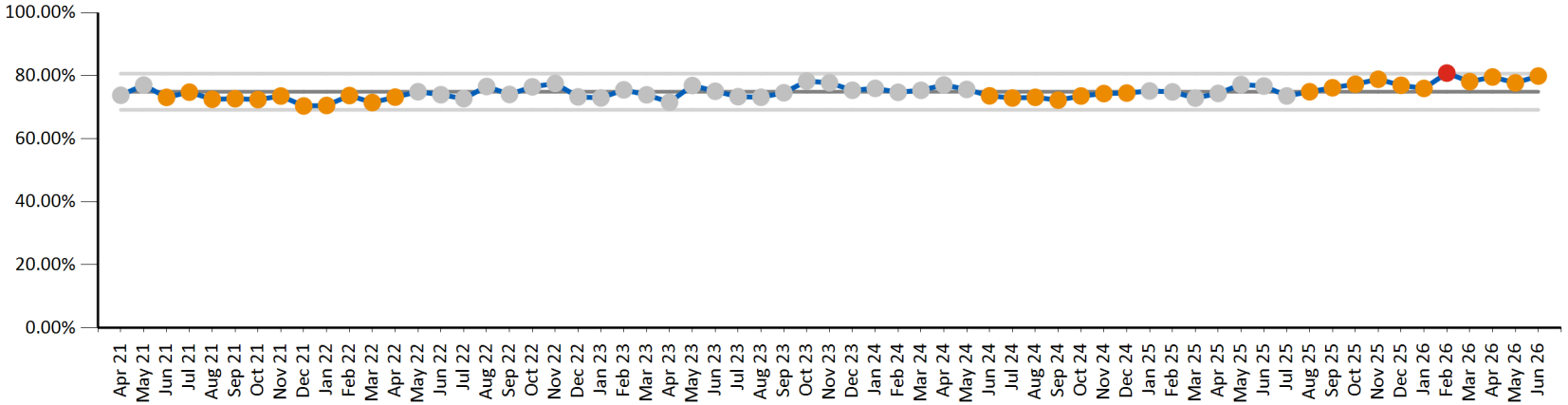
| Plan | Actual | Period |
|---|---|---|
| >= 85% | 80.5% | May-26 |

### Year to Date

| Plan | Actual |
|---|---|
| >= 85% | 82.0% |

## 582 - Theatre Utilisation - Capped

Special cause variation with improving performance




### Latest

| Plan | Actual | Period |
|---|---|---|
| | 79.8% | Jun-26 |

### Previous

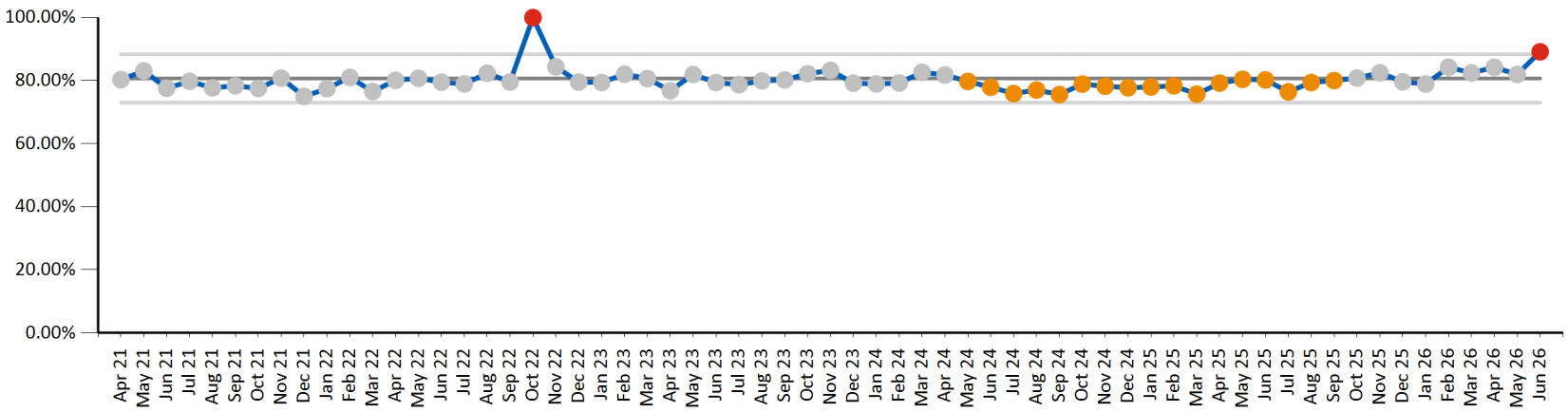
| Plan | Actual | Period |
|---|---|---|
| | 77.7% | May-26 |

### Year to Date

| Plan | Actual |
|---|---|
| | 79.0% |

## 583 - Theatre Utilisation - Uncapped

Special cause variation with improving performance




### Latest

| Plan | Actual | Period |
|---|---|---|
| | 89.1% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| | 81.9% | May-26 |

### Year to Date

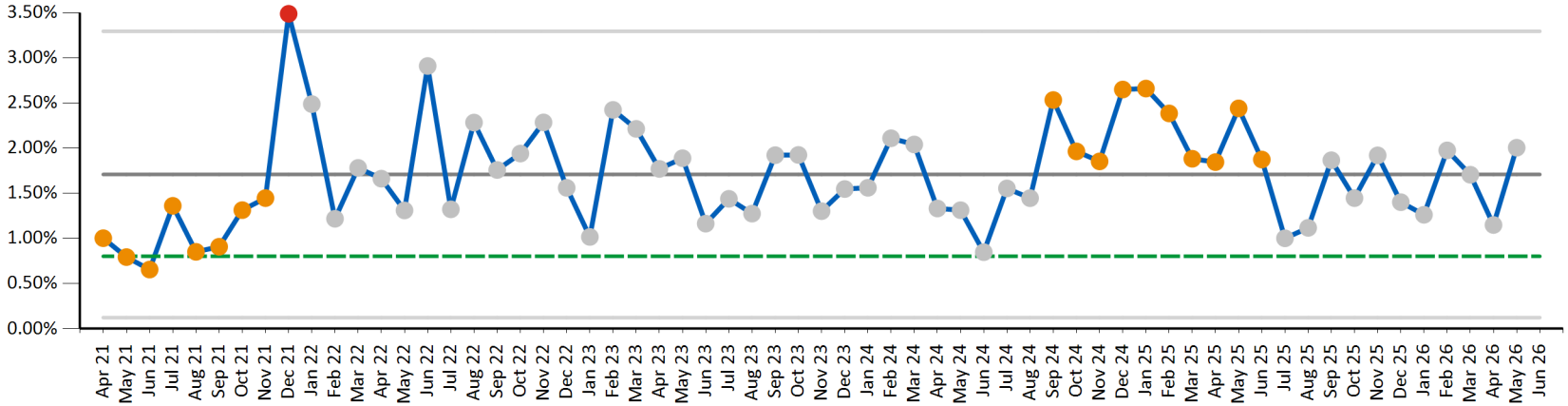
| Plan | Actual |
|---|---|
| | 85.1% |

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

Common cause variation.

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

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| <= 1% | | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| <= 1% | 2.0% | May-26 |

### Year to Date

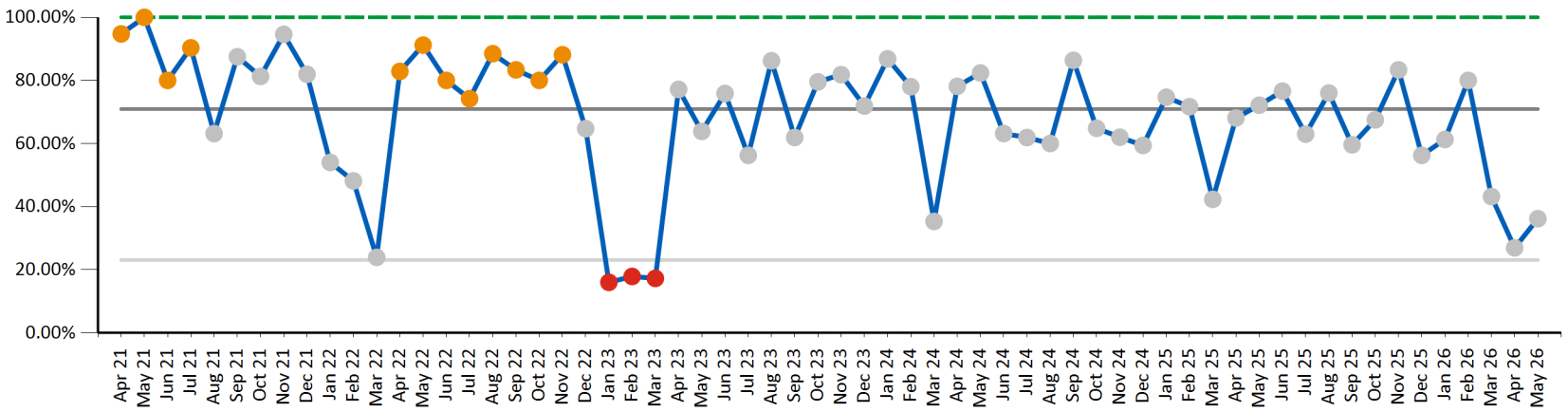
| Plan | Actual |
|---|---|
| <= 1% | 1.8% |

## 62 - Cancelled operations re-booked within 28 days

Common cause variation.

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

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| = 100% | 36.2% | May-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| = 100% | 26.9% | Apr-26 |

### Year to Date

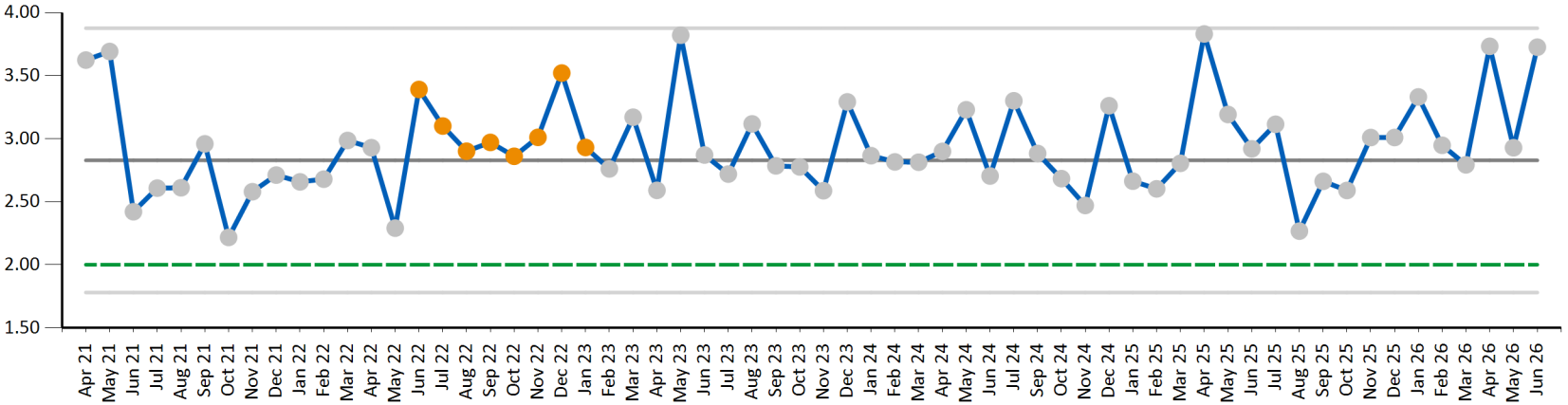
| Plan | Actual |
|---|---|
| = 100% | 32.9% |

## 65 - Elective Length of Stay (Discharges in month)

Common cause variation.

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

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| <= 2.00 | 3.73 | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| <= 2.00 | 2.93 | May-26 |

### Year to Date

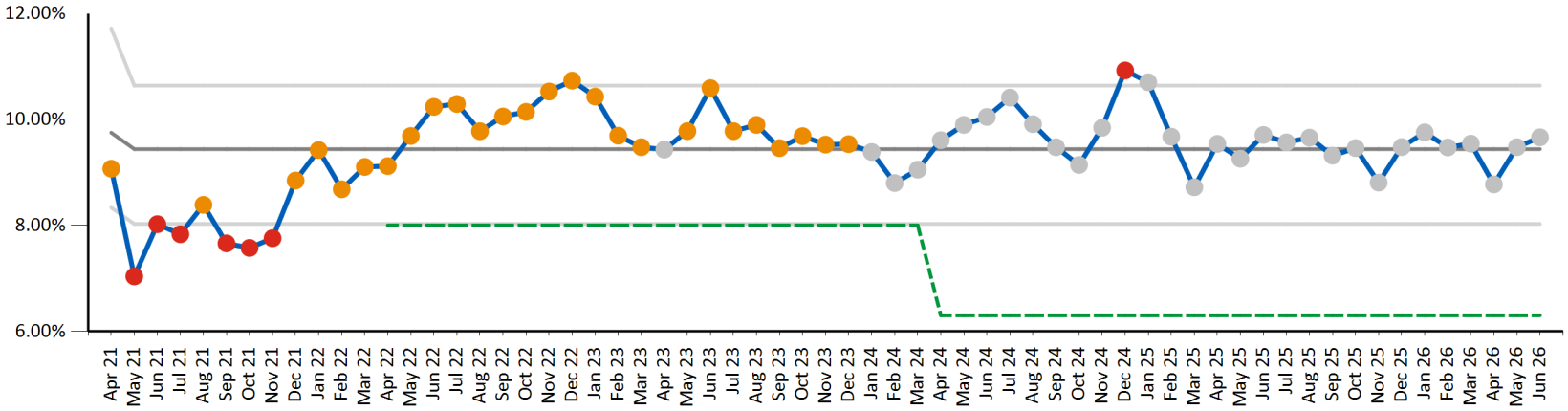
| Plan | Actual |
|---|---|
| <= 2.00 | 3.46 |

## 309 - DNA Rate - New

Common cause variation.

We will regularly fail to meet the target.

0/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 6.3% | 9.7% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 6.3% | 9.5% | May-26 |

**Year to Date**

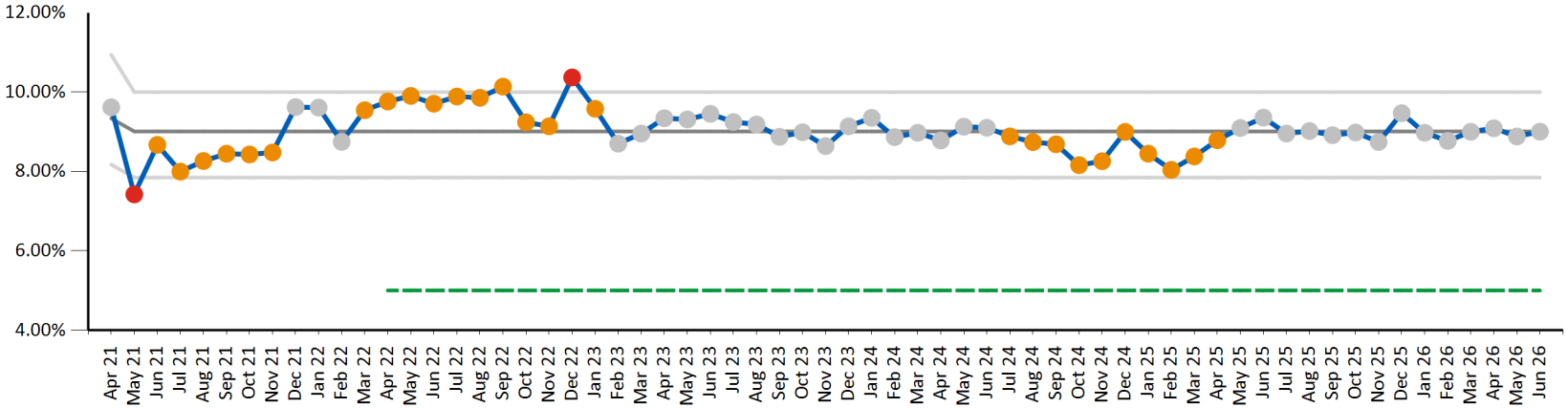
| Plan | Actual |
|---|---|
| <= 6.3% | 9.3% |

## 310 - DNA Rate - Follow up

Common cause variation.

We will regularly fail to meet the target.

0/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 5.0% | 9.0% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 5.0% | 8.9% | May-26 |

**Year to Date**

| Plan | Actual |
|---|---|
| <= 5.0% | 9.0% |

# Operational Performance - Cancer

Bolton NHS Foundation Trust

For May, we achieved the faster diagnosis standard, and the 31-day treatment standard. Of note, from April the target for the Faster Diagnosis Standard has increased from 75% to 80%.

We failed to achieve the 62-day standard for May, with performance of 73.75% which was a deteriorated position against April's performance. Performance remains challenged across multiple tumour groups and is impacted by Radiology delays along various modalities as well as specialty-specific capacity issues including Plastic Surgery, Colorectal, and Gynaecology. A cancer recovery plan is in place and will be monitored monthly through Trust governance routes. It is not expected that we will achieve the 62-day standard before August as pressures remain in the system and will impact waiting times for the patients currently on their 62-day pathway.

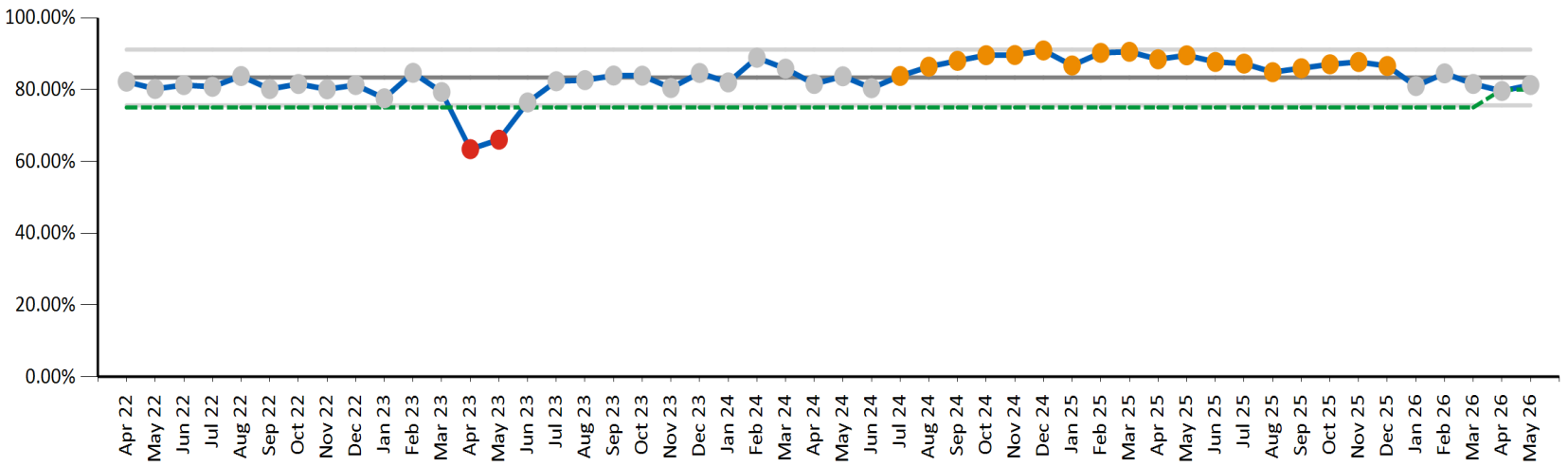
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 542 - Cancer: 28 day faster diagnosis | >= 80.0% | 81.3% | May-26 | | >= 80.0% | 79.6% | Apr-26 | >= 80.0% | 80.4% | |
| 584 - 31 Day General Treatment Standard | >= 96% | 99.2% | May-26 | | >= 96% | 97.6% | Apr-26 | >= 96% | 98.4% | |
| 585 - 62 Day General Standard | >= 85% | 73.8% | May-26 | | >= 85% | 83.8% | Apr-26 | >= 85% | 78.5% | |

## 542 - Cancer: 28 day faster diagnosis

Common cause variation.

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

5/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 80.0% | 81.3% | May-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 80.0% | 79.6% | Apr-26 |

### Year to Date

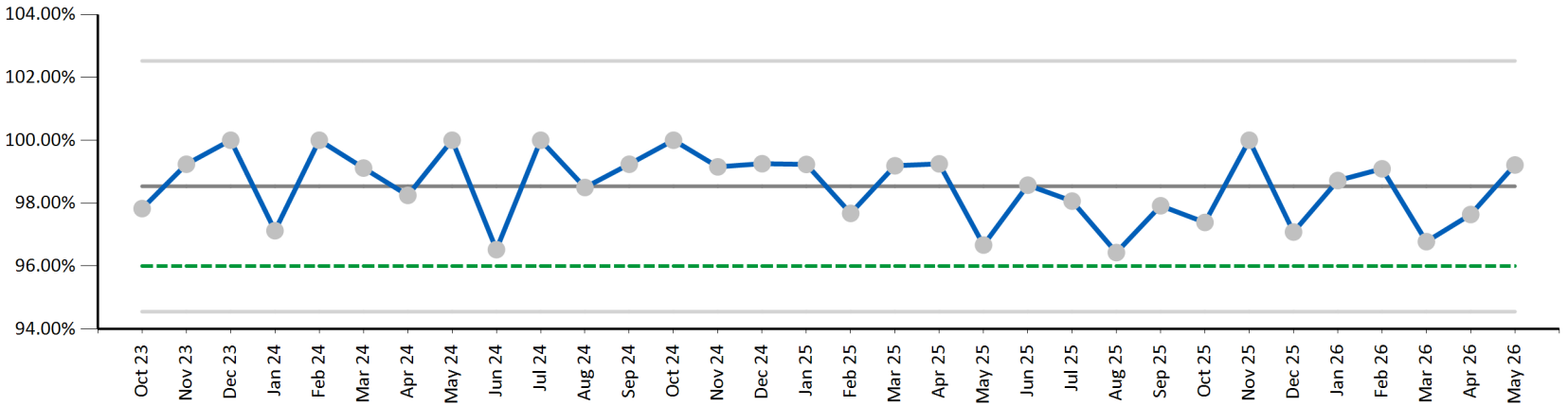
| Plan | Actual |
|---|---|
| >= 80.0% | 80.4% |

## 584 - 31 Day General Treatment Standard

Common cause variation.

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

6/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 96% | 99.2% | May-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 96% | 97.6% | Apr-26 |

### Year to Date

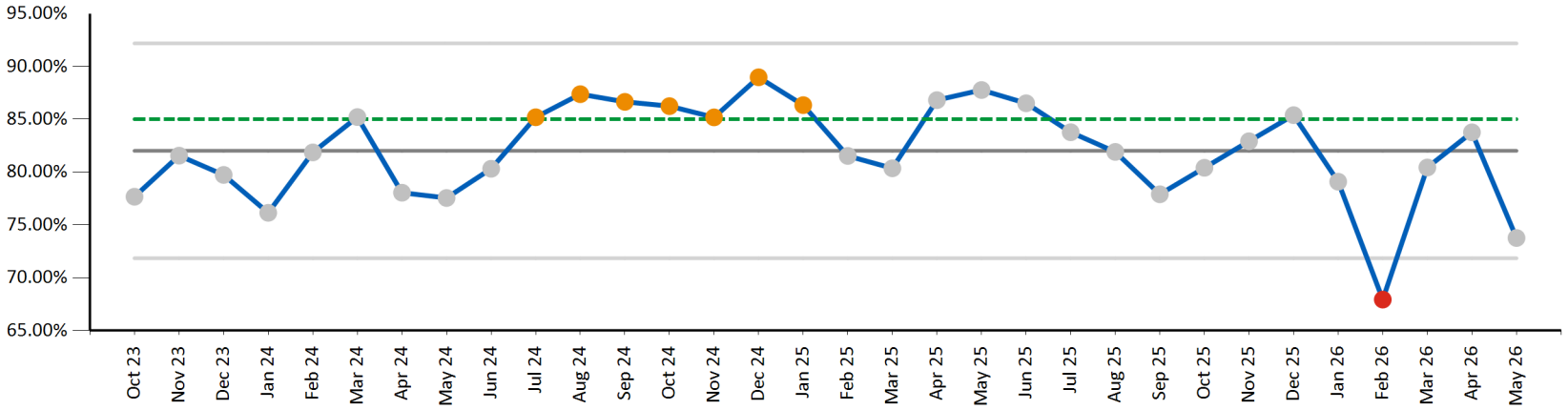
| Plan | Actual |
|---|---|
| >= 96% | 98.4% |

## 585 - 62 Day General Standard

Common cause variation.

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

1/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 85% | 73.8% | May-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 85% | 83.8% | Apr-26 |

### Year to Date

| Plan | Actual |
|---|---|
| >= 85% | 78.5% |

# Operational Performance - Community Care

NCTR

Month 3 NCTR numbers increased slightly to 88 from 84, meeting the operational target of 90. Lost bed days equated to 511, decreasing from 584 in the previous month. NCTR lost bed days performance was above plan for June of 634. The establishment of discharge facilitators across all wards and the ITOCH pathway 1 triage function has supported this recovery from M1.

System escalation continues to unblock delays, and additional focus has been implemented for patients with a LOS over 30 days which has supported a further reduction in NCTR lost bed days. Longer term improvement work continues across community services (N block IMC and ITOCH). Open of F6 nursing IMC unit in M3 offset the impact of Dove unit closing and daily monitoring is taking place to monitor the impact of the overall reduction in community beds.

0-5 Years Mandated Contacts

Performance remains below target (85% vs 95%). Following a period of sustained improvement this has settled in the last few months in the Mid 80%s. This is linked to levels of sickness and subsequent vacancy within the service with posts actively being recruited into. Despite this the performance sustaining at Mid 80s highlights a sustained pattern of improvement and consistency throughout the last 12 months

EHCP compliance

Compliance was 95% in M3, achieving the 95% target. This maintenance is very positive considering staff sickness and vacancies – particularly within the consultant cohort (2 vacancies + 1LTS). Recruitment is ongoing and reviews of workload took place to support this recovery, with reallocation of ACP capacity proving fruitful. Robust processes remained in place to monitor and escalate delays.

Looked after Children

Has achieved 95% against the of 90%, initial Health Assessments, showing an improvement on May, which was expected following school holidays. Review Health Assessments in Special Schools remained 100%, continuing to exceed target.

Community Waits – 52+ Weeks

Community 52+ week waits have reduced significantly over recent months following validation of waiting lists and the introduction of the Community Wait programme, including PTL oversight and strengthened governance arrangements. Performance is currently ahead of plan. Initial trajectories based a reduction of 52 week waits to 230 by the end of June, with the actuals resulting in 165 (65 ahead of plan). This includes the completed "re-validation" following some data quality issues in M2

Although there is no national target for community 52+ week waits, a local trajectory had been set to reduce the position to 100 by the end of 2026/27. With the improvement seen so far, the local stretch target has bene adjusted to 70.

Community Waits 18 week % Combined (as of 17.7 reflecting on 30.6 validation)

Performance against the 18-week community wait standard is currently above plan at 84.39%. Previously it was highlighted some re-validation was required after some errors within a couple of waiting lists, that have now been completed. Audiology and ICPS remain the main areas of concern over the medium term as current capacity does not meet demand, Audiology will slowly recover however is fragile based on specific staffing required but this is being worked through. ICPS is limited based on commissioning arrangements. As a result, the 18-week position is expected to deteriorate. However, the 52+ week position is expected to remain minimal, with ongoing discussions taking place with ICB colleagues.

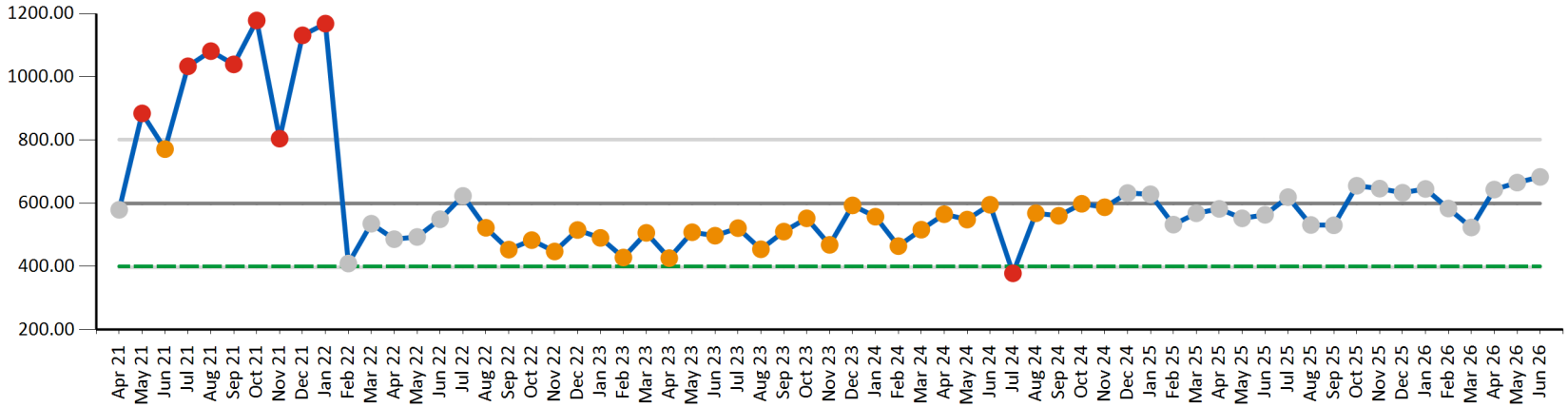
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 334 - Total Deflections from ED | >= 400 | 683 | Jun-26 | | >= 400 | 665 | May-26 | >= 1,200 | 1,991 | |
| 641 - Community Service Waits - 52 weeks + | | 156 | Jun-26 | | | 226 | May-26 | | 451 | |
| 644 - Community Service Waits - 18 weeks % (Combined) | >= 78.0% | 84.8% | Jun-26 | | >= 78.0% | 85.1% | May-26 | >= 78.0% | 85.2% | |
| 493 - Average Number of Patients: with no Criteria to Reside | <= 91 | 88 | Jun-26 | | <= 90 | 84 | May-26 | <= 91 | 88 | |
| 494 - Average Occupied Days - for no Criteria to Reside | <= 360 | 511 | Jun-26 | | <= 360 | 558 | May-26 | <= 1,080 | 1,875 | |
| 267 - 0-5 Health Visitor mandated contacts | >= 95% | 85% | Jun-26 | | >= 95% | 85% | May-26 | >= 95% | 85% | |
| 269 - Education, health and care plan (EHC) compliance | >= 95% | 95% | Jun-26 | | >= 95% | 94% | May-26 | >= 95% | 96% | |
| 550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse | >= 90.0% | 95.0% | Jun-26 | | >= 90.0% | 90.0% | May-26 | >= 90.0% | | |
| 551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales | >= 90.0% | 89.5% | Jun-26 | | >= 90.0% | 91.0% | May-26 | >= 90.0% | | |
| 552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools | >= 90.0% | 100.0% | Jun-26 | | >= 90.0% | 100.0% | May-26 | >= 90.0% | | |

## 334 - Total Deflections from ED

Common cause variation.

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

6/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 400 | 683 | Jun-26 |

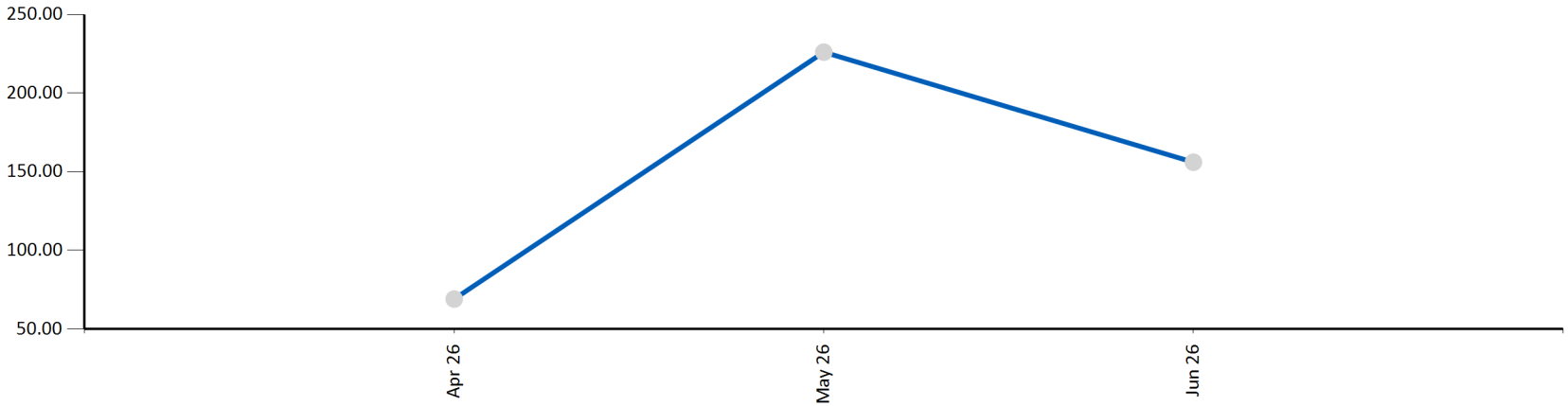
**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 400 | 665 | May-26 |

**Year to Date**

| Plan | Actual |
|---|---|
| >= 1,200 | 1,991 |

## 641 - Community Service Waits - 52 weeks + - SPC data available after 20 data points




**Latest**

| Plan | Actual | Period |
|---|---|---|
| | 156 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| | 226 | May-26 |

**Year to Date**

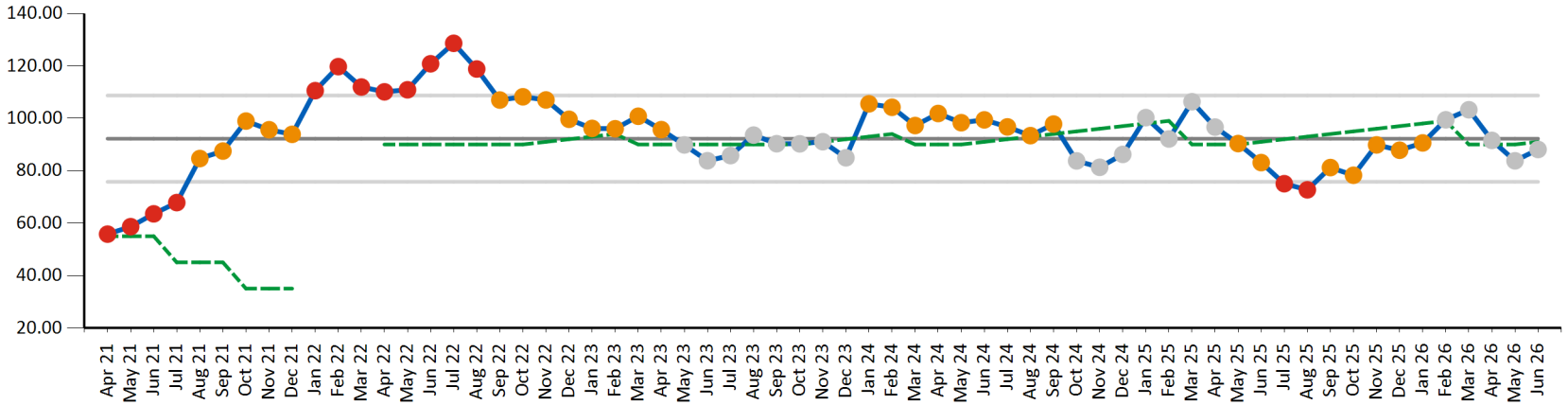
| Plan | Actual |
|---|---|
| | 451 |

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

Common cause variation.

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

3/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| <= 91 | 88 | Jun-26 |

### Previous

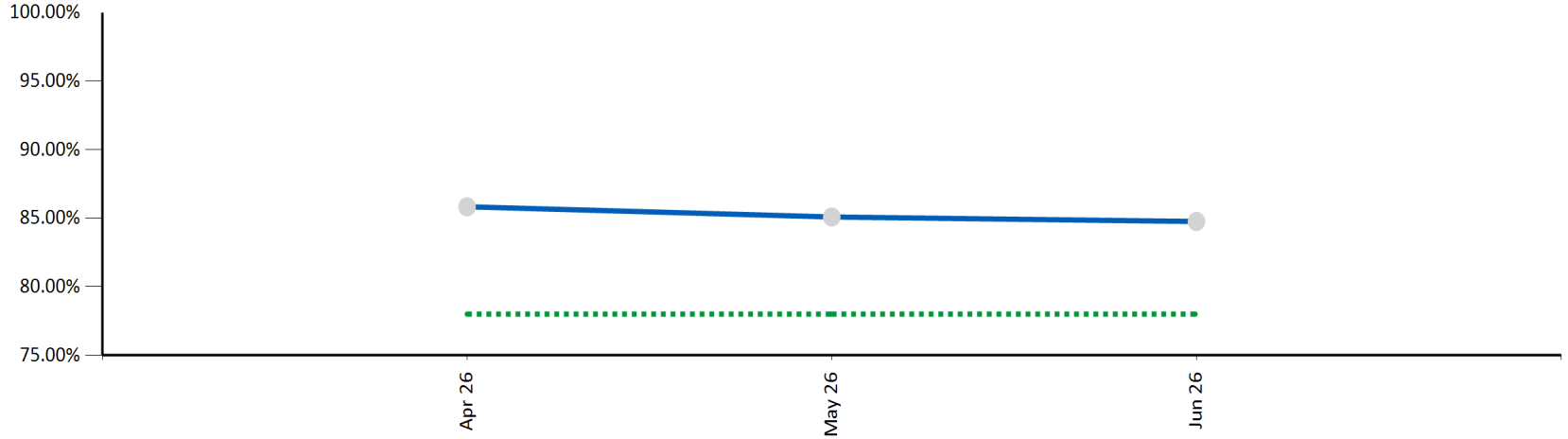
| Plan | Actual | Period |
|---|---|---|
| <= 90 | 84 | May-26 |

### Year to Date

| Plan | Actual |
|---|---|
| <= 91 | 88 |

## 644 - Community Service Waits - 18 weeks % (Combined) - SPC data available after 20 data points

3/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 78.0% | 84.8% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 78.0% | 85.1% | May-26 |

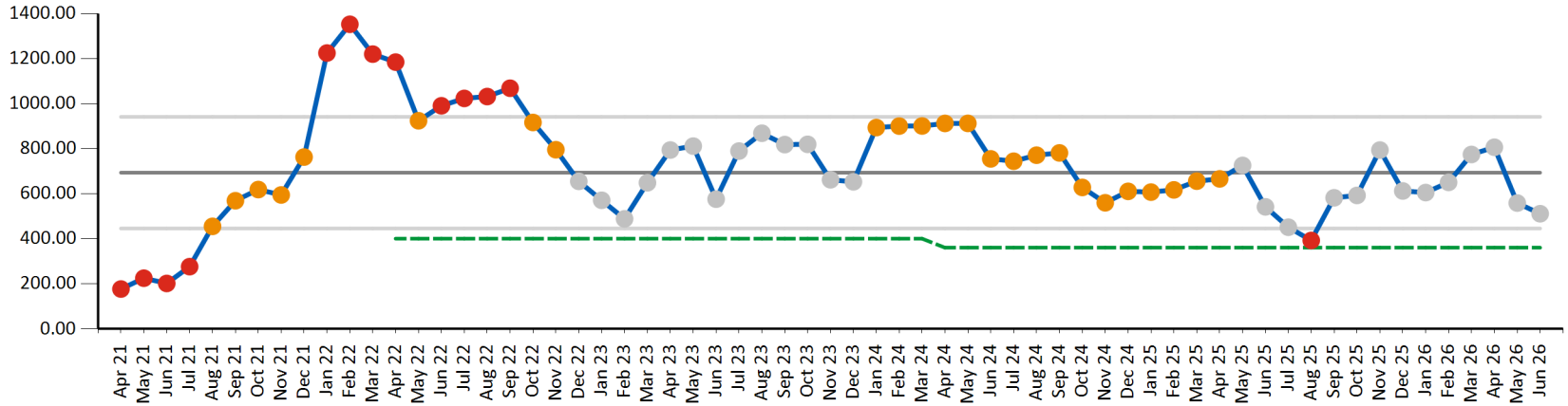
### Year to Date

| Plan | Actual |
|---|---|
| 0.78 | 85.2% |

## 494 - Average Occupied Days - for no Criteria to Reside

Common cause variation.

We will regularly fail to meet the target. 0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| <= 360 | 511 | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| <= 360 | 558 | May-26 |

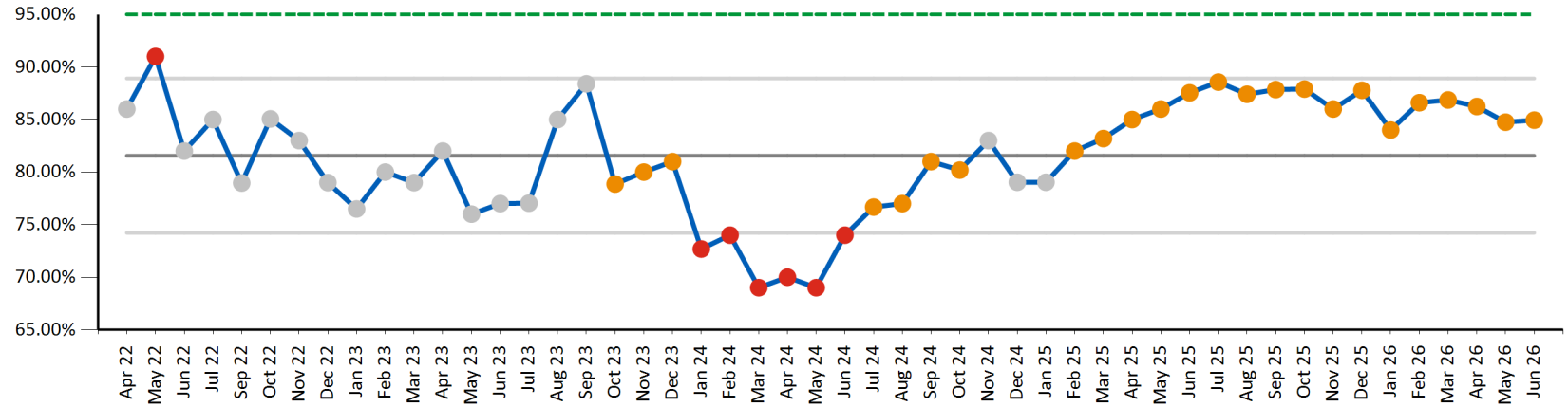
### Year to Date

| Plan | Actual |
|---|---|
| <= 1,080 | 1,875 |

## 267 - 0-5 Health Visitor mandated contacts

Special cause variation with improving performance

We will regularly fail to meet the target. 0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 95% | 85% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 95% | 85% | May-26 |

### Year to Date

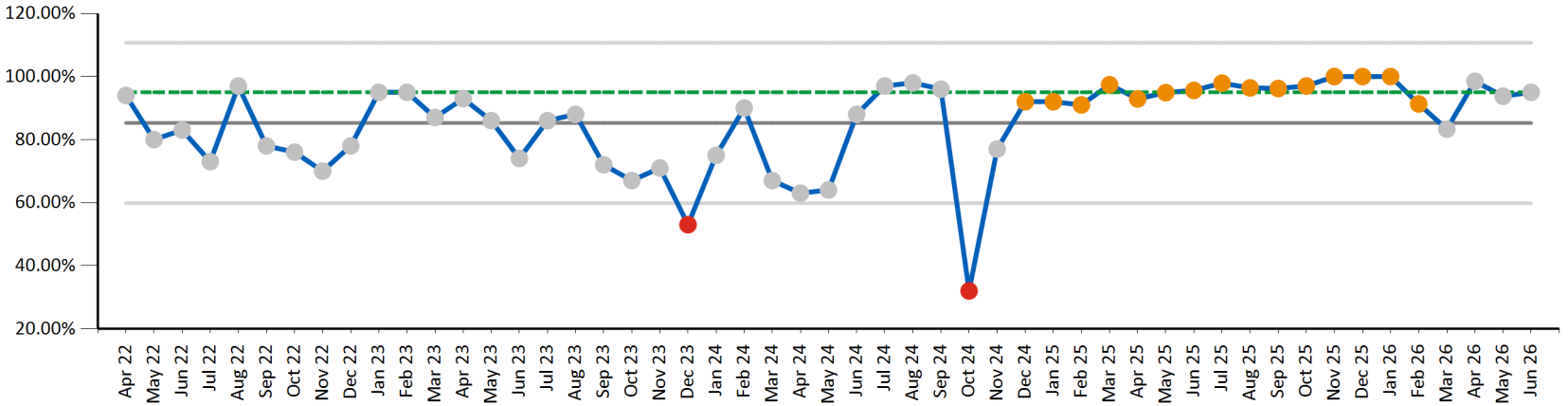
| Plan | Actual |
|---|---|
| >= 95% | 85% |

## 269 - Education, health and care plan (EHC) compliance

Common cause variation.

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

3/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 95% | 95% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 95% | 94% | May-26 |

**Year to Date**

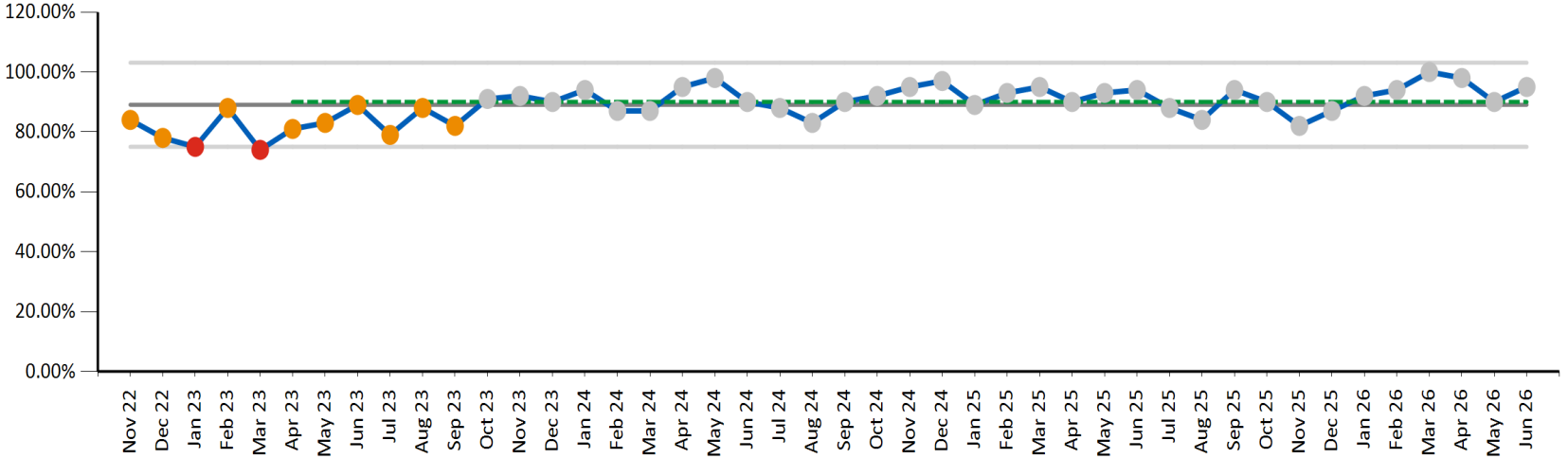
| Plan | Actual |
|---|---|
| >= 95% | 96% |

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

Common cause variation.

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

6/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 90.0% | 95.0% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 90.0% | 90.0% | May-26 |

**Year to Date**

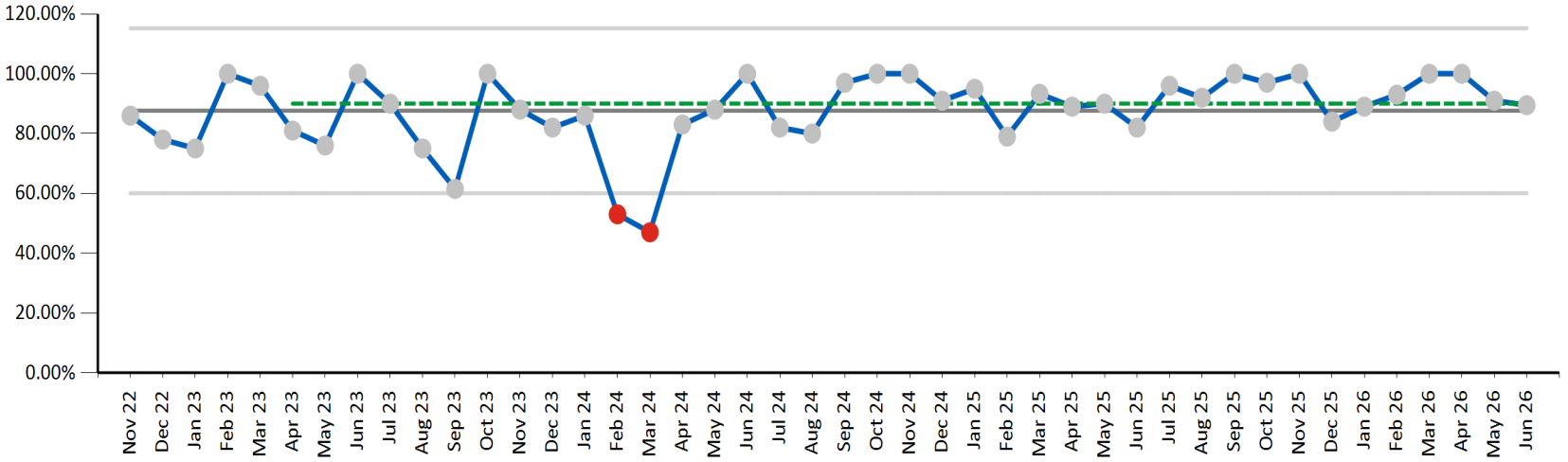
| Plan | Actual |
|---|---|
| >= 90.0% | |

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

Common cause variation.

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

4/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| > = 90.0% | 89.5% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| > = 90.0% | 91.0% | May-26 |

**Year to Date**

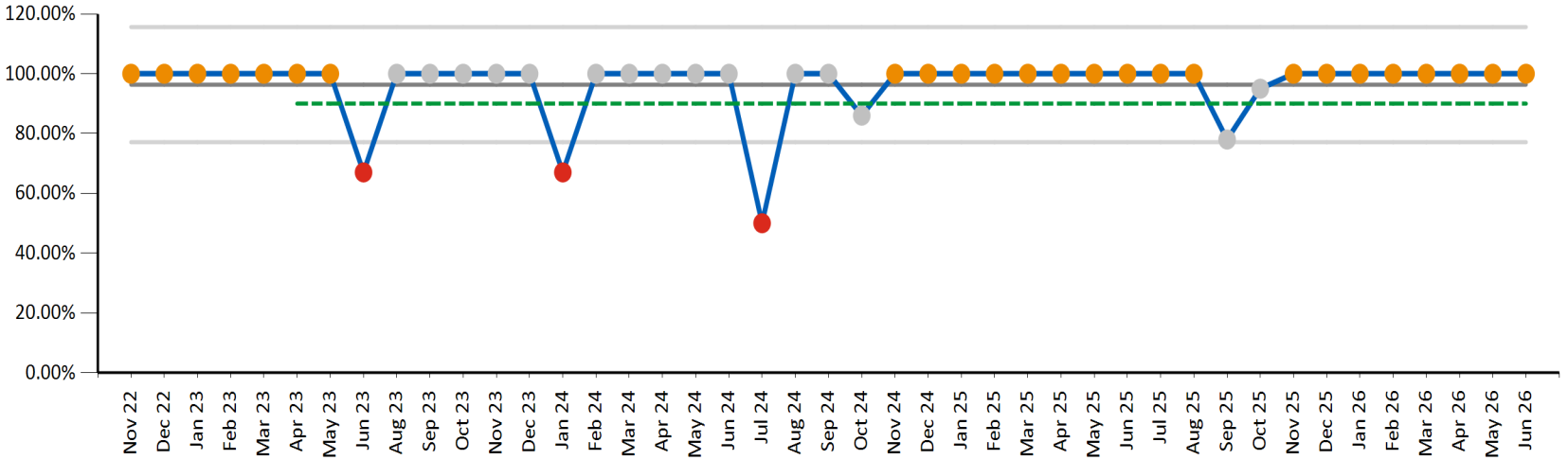
| Plan | Actual |
|---|---|
| > = 90.0% | |

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

Special cause variation with improving performance

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

6/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| > = 90.0% | 100.0% | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| > = 90.0% | 100.0% | May-26 |

**Year to Date**

| Plan | Actual |
|---|---|
| > = 90.0% | |

# Workforce - Sickness, Vacancy and Turnover

NHS Bolton NHS Foundation Trust

Sickness:
Sickness has increased slightly in June 26 to 5.54%, compared to 5.22% in May 2026, following five consecutive months of reducing sickness absence. The Trust continues to provide additional support through the Trust's Employee Assistance Programme (EAP) and early intervention support through Occupational Health.

Each Division and corporate function continues to undertake a review of sickness, with an increased focus on providing wellbeing support through Occupational Health and wider wellbeing initiatives. The Divisional and Workforce teams continue to work together to closely monitor sickness and provide a range of health and well-being support to our staff. Additional oversight meetings are ongoing to further review current rates of sickness absence and identify any further actions and support.

Turnover:
Showing a relatively static trend with a small reduction to 12.14% noted in-month and behaving in line with our submitted Medium-Term Plan expectations. Highest turnover is in Additional Clinical Services, and Admin & Clerical, staff groups.

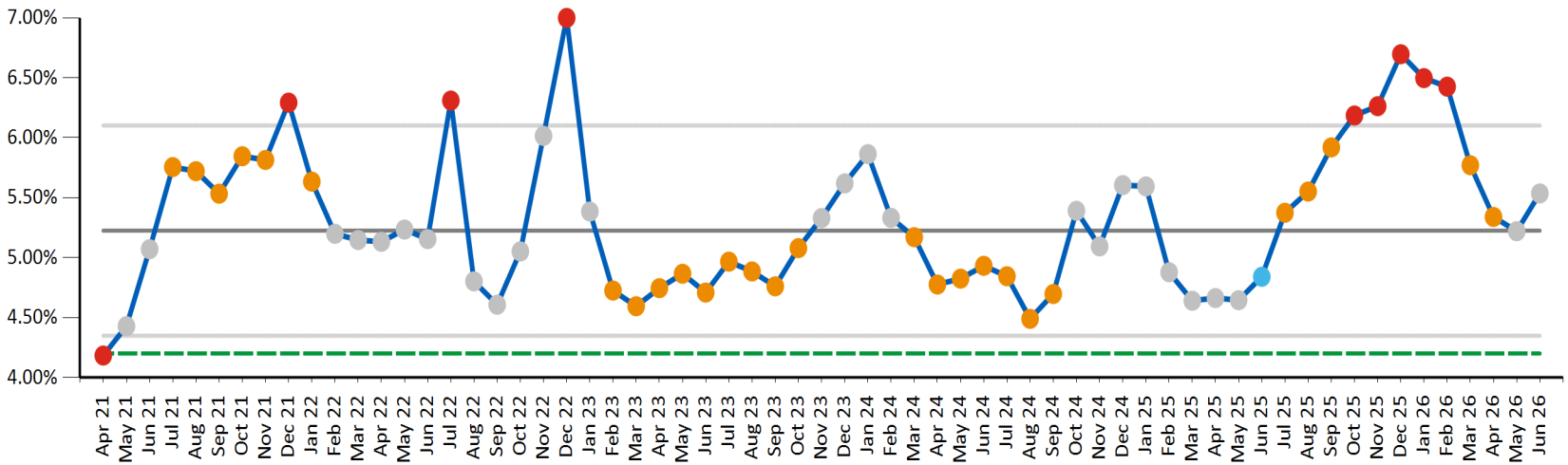
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 117 - Sickness absence level - Trust | <= 4.20% | 5.54% | Jun-26 | | <= 4.20% | 5.22% | May-26 | <= 4.20% | 5.36% | F |
| 120 - Vacancy level - Trust | <= 6% | 4.62% | Mar-25 | | <= 6% | 5.08% | Feb-25 | <= 6% | | ? |
| 121 - Turnover | <= 9.90% | 12.14% | Jun-26 | | <= 9.90% | 12.27% | May-26 | <= 9.90% | 12.17% | F |
| 366 - Ongoing formal investigation cases over 8 weeks | | 0 | May-26 | L | | 0 | Apr-26 | | 0 | |

## 117 - Sickness absence level - Trust

Common cause variation.

We will regularly fail to meet the target.

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| <= 4.20% | 5.54% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| <= 4.20% | 5.22% | May-26 |

### Year to Date

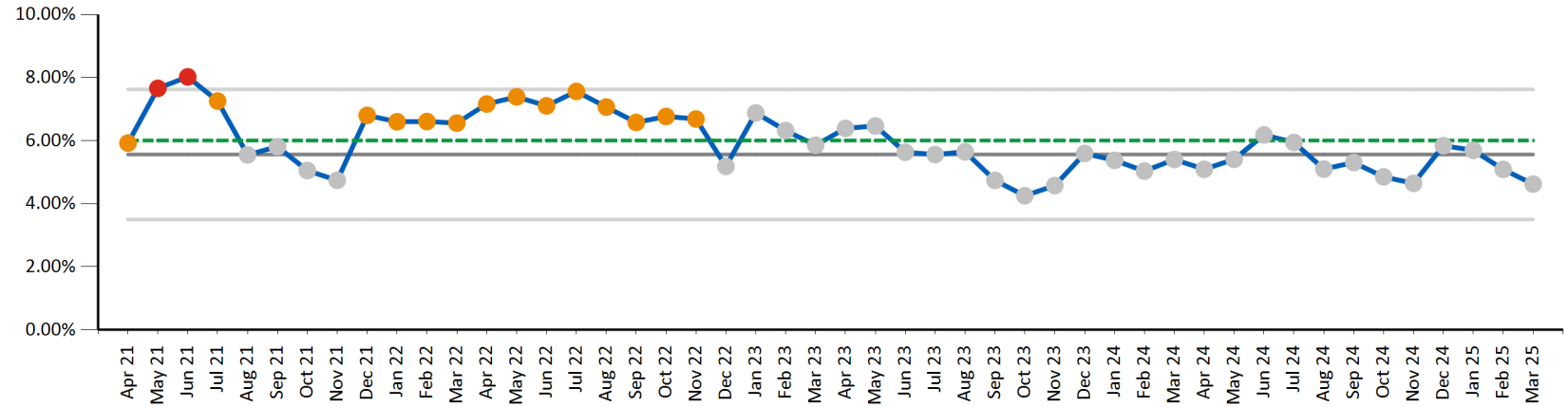
| Plan | Actual |
|---|---|
| <= 4.20% | 5.36% |

## 120 - Vacancy level - Trust

Common cause variation.

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

6/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| <= 6% | 4.62% | Mar-25 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| <= 6% | 5.08% | Feb-25 |

### Year to Date

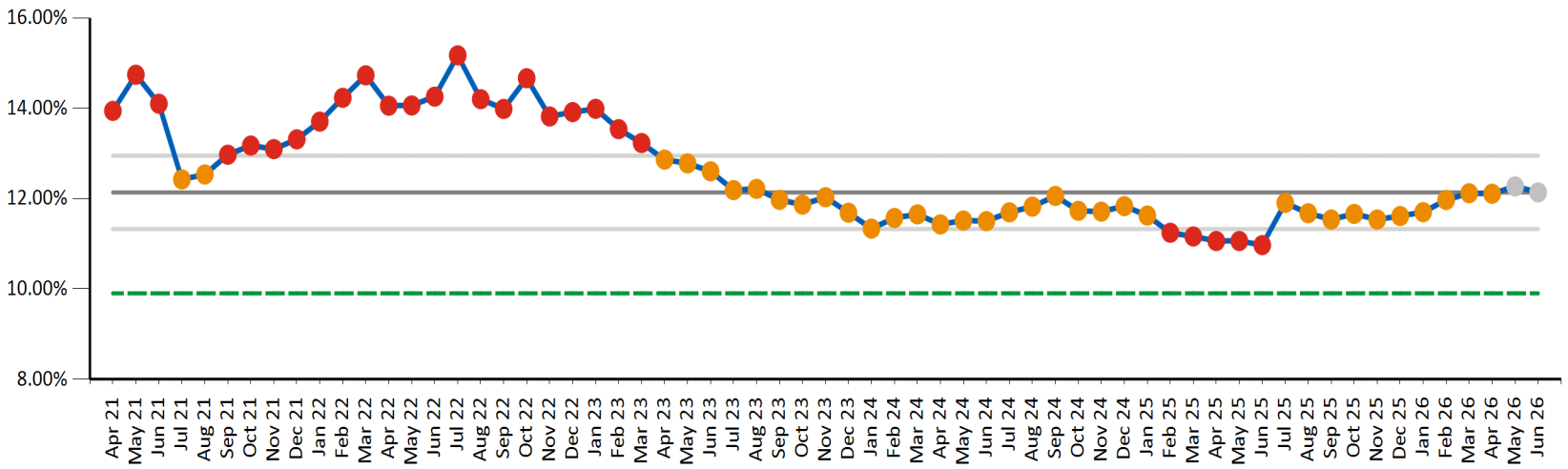
| Plan | Actual |
|---|---|
| <= 6% | 5.31% |

## 121 - Turnover

Common cause variation.

We will regularly fail to meet the target.

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| <= 9.90% | 12.14% | Jun-26 |

### Previous

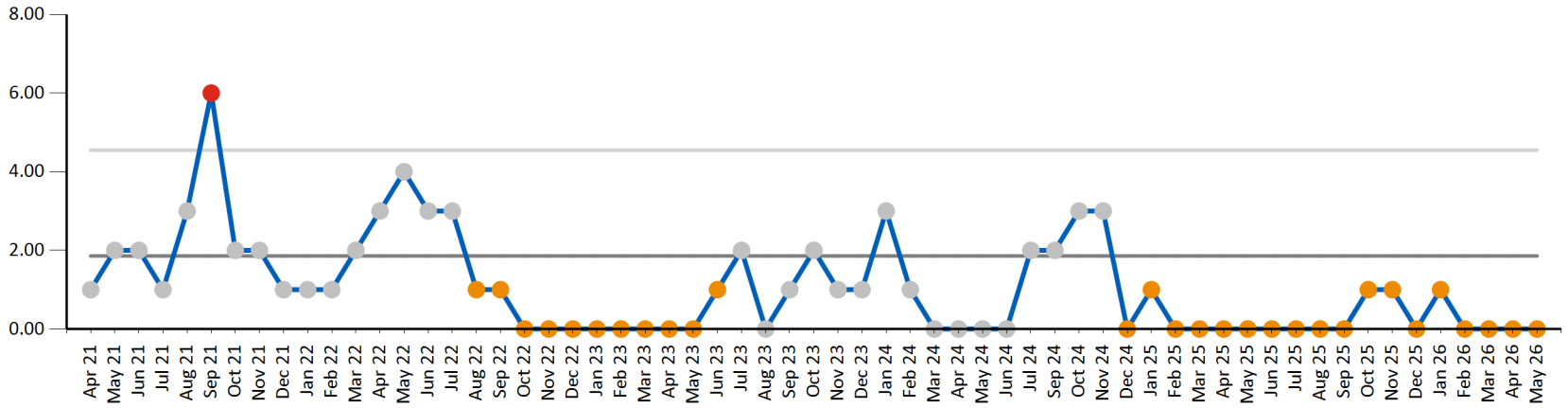
| Plan | Actual | Period |
|---|---|---|
| <= 9.90% | 12.27% | May-26 |

### Year to Date

| Plan | Actual |
|---|---|
| <= 9.90% | 12.17% |

## 366 - Ongoing formal investigation cases over 8 weeks

Special cause variation with improving performance




### Latest

| Plan | Actual | Period |
|---|---|---|
| | 0 | May-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| | 0 | Apr-26 |

### Year to Date

| Plan | Actual |
|---|---|
| | 0 |

# Workforce - Organisational Development

Bolton NHS Foundation Trust

Compulsory training
A positive month, with staff continuing to prioritise compulsory training compliance, increasing slightly from 94.1% to 94.2%. Bespoke Basic Life Support (BLS) sessions, targeted at staff overdue their annual assessment, have contributed to a 0.8% in month improvement (86.65%). These sessions will continue on a monthly basis alongside bookable sessions.
Moving and Handling Level 2 (two-year refresher) remains a challenge. From September 2026, the requirement to complete the e-learning module prior to attending the face-to-face assessment will be removed, with theory incorporated into the assessment session. This change will simplify the booking process for relevant staff. All other compulsory subjects are above 90% compliance.

Trust Mandated training
A marginal in month reduction from 90.4% to 90.3% is noted; however, performance remains well above the 85% compliance target. Targeted focus on ANTT (aseptic non-touch technique) and Falls Prevention e-learning within relevant clinical teams has mitigated further decline.

Appraisal
Performance has improved from 82.4% to 83.1%, supported by improvements in Medical Education and Patient Safety & Experience Directorates. Ongoing support and guidance are provided by the Organisational Development team to achieve the Trust compliance target of 85%, with a particular focus on the two areas currently below 80%. Compulsory and Trust Mandated Training and Appraisals both feature as focus areas in the draft People & Culture Priorities.

Staff Survey Data
No further survey results since the information provided in the April 2026 update.

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 37 - Staff completing Compulsory Training | >= 95% | 94.2% | Jun-26 |  | >= 95% | 94.1% | May-26 | >= 95% | 94.1% |  |
| 38 - Staff completing Trust Mandated Training | >= 85% | 90.3% | Jun-26 |  | >= 85% | 90.4% | May-26 | >= 85% | 90.3% |  |
| 39 - Staff completing Safeguarding Training | >= 95% | 94.38% | Jun-26 |  | >= 95% | 94.05% | May-26 | >= 95% | 94.06% |  |
| 101 - Increased numbers of staff undertaking an appraisal | >= 85% | 83.2% | Jun-26 |  | >= 85% | 82.4% | May-26 | >= 85% | 82.5% |  |
| 78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears) | >= 66% | 36.5% | Q1 2026/27 |  | >= 66% | 35.0% | Q4 2025/26 | >= 66% | |  |

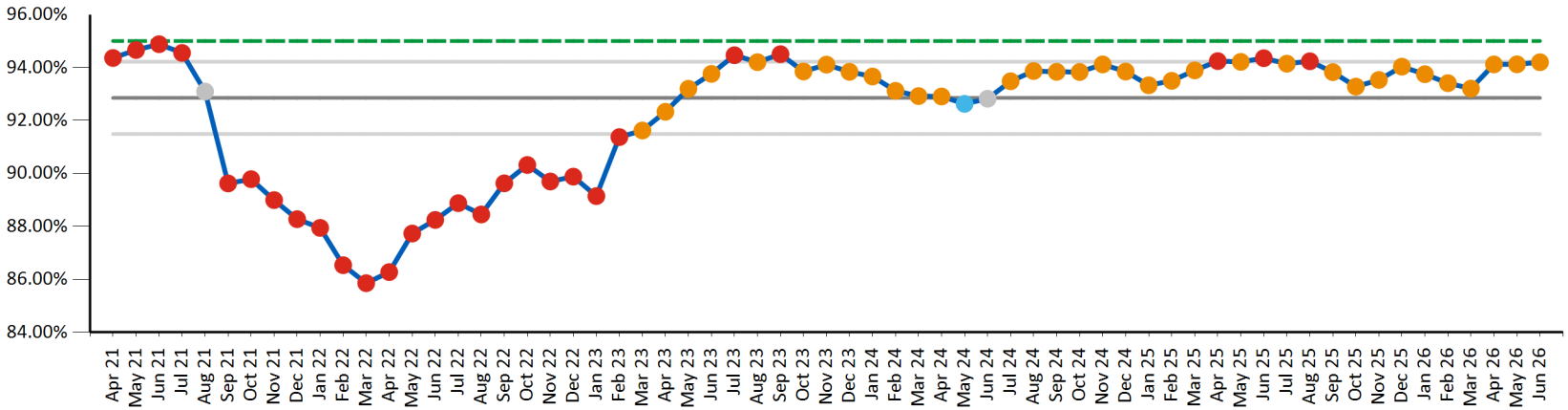
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears) | >= 80% | 45.9% | Q1 2026/27 | L | >= 80% | 41.3% | Q4 2025/26 | >= 80% | | F |

## 37 - Staff completing Compulsory Training

H Special cause variation with improving performance

F We will regularly fail to meet the target.

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 95% | 94.2% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 95% | 94.1% | May-26 |

### Year to Date

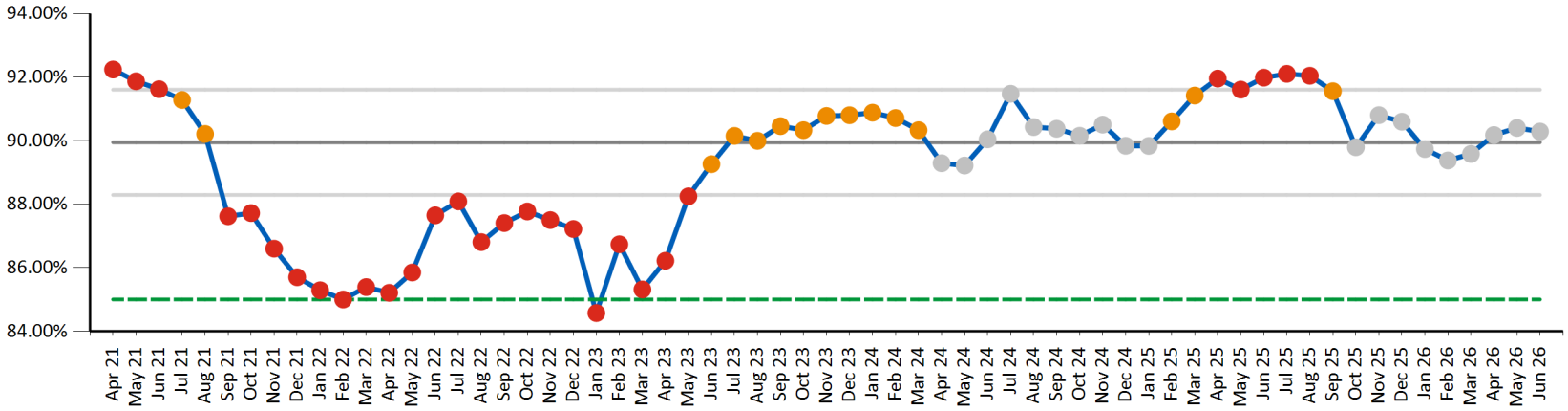
| Plan | Actual |
|---|---|
| >= 95% | 94.1% |

## 38 - Staff completing Trust Mandated Training

Common cause variation.

Target will be regularly met.

6/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 85% | 90.3% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 85% | 90.4% | May-26 |

### Year to Date

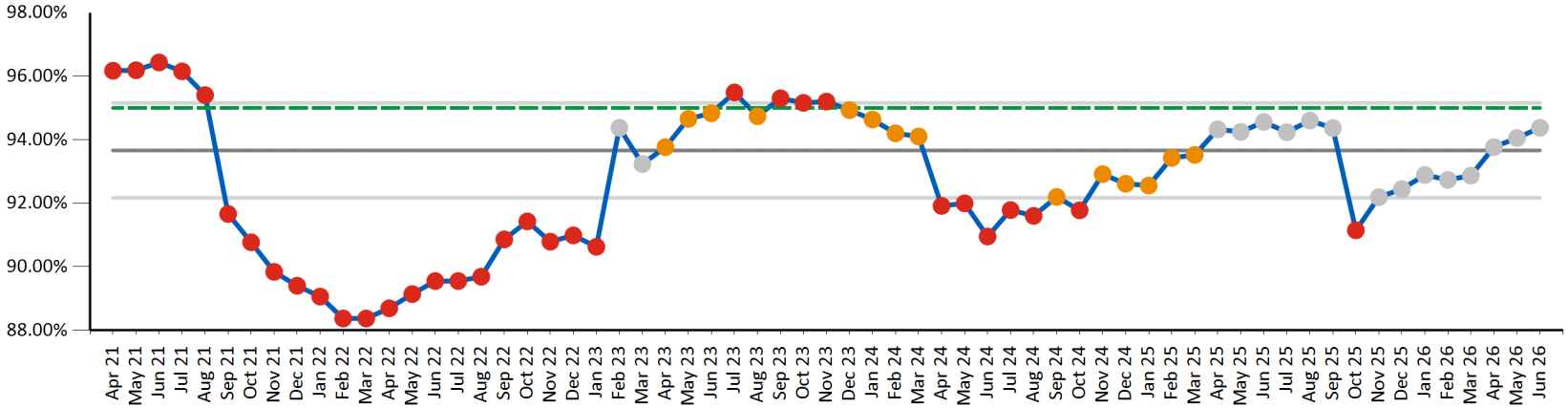
| Plan | Actual |
|---|---|
| >= 85% | 90.3% |

## 39 - Staff completing Safeguarding Training

Common cause variation.

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

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 95% | 94.38% | Jun-26 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 95% | 94.05% | May-26 |

### Year to Date

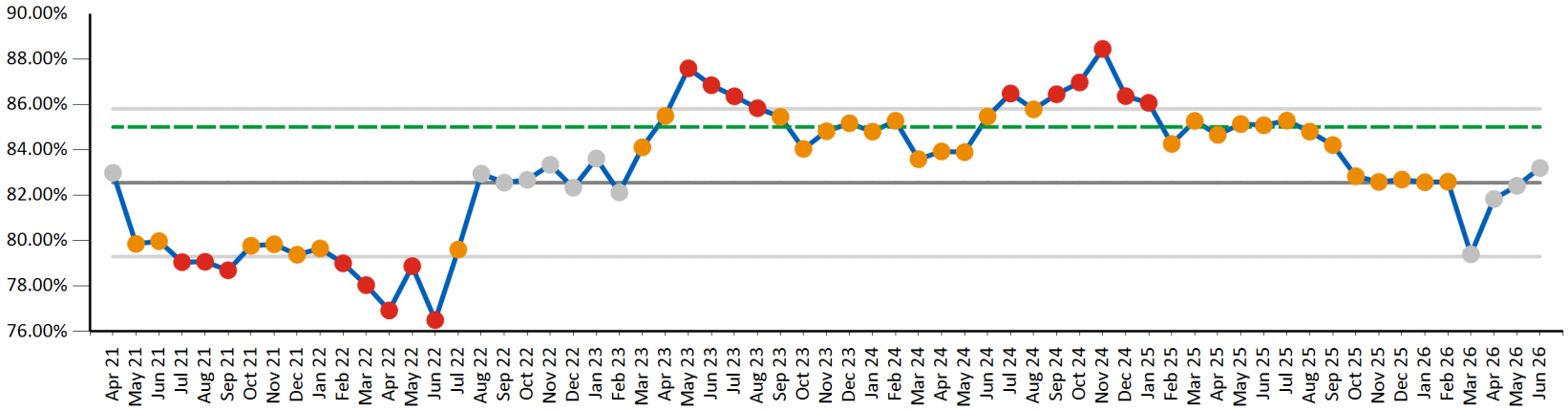
| Plan | Actual |
|---|---|
| >= 95% | 94.06% |

## 101 - Increased numbers of staff undertaking an appraisal

Common cause variation.

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

0/6




Latest

| Plan | Actual | Period |
|---|---|---|
| >= 85% | 83.2% | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| >= 85% | 82.4% | May-26 |

Year to Date

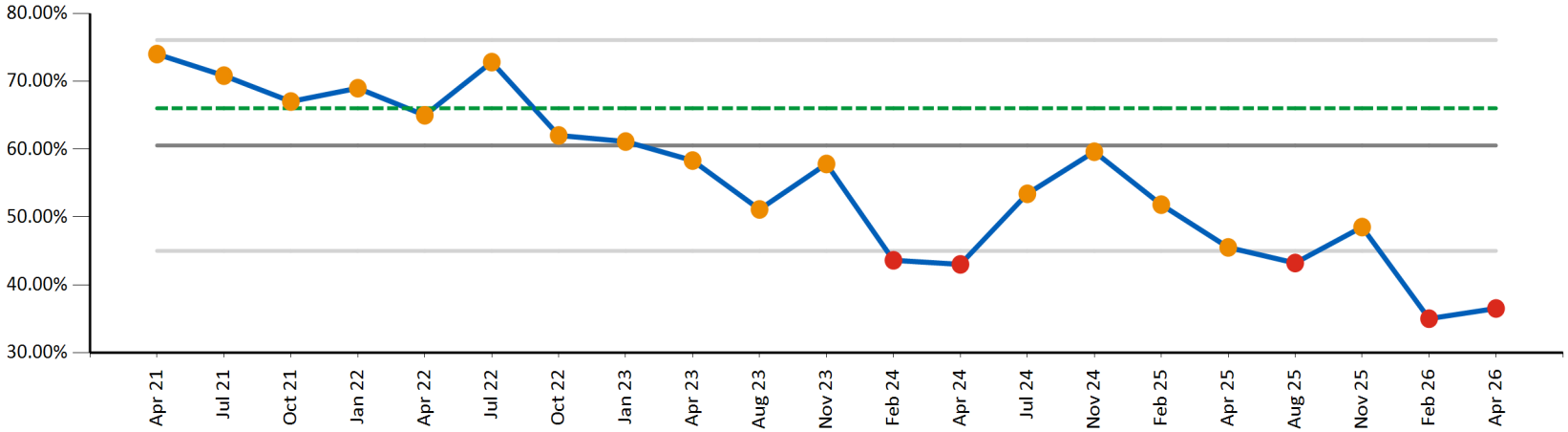
| Plan | Actual |
|---|---|
| >= 85% | 82.5% |

## 78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)

Special cause variation with deteriorating performance

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

0/6




Latest

| Plan | Actual | Period |
|---|---|---|
| >= 66% | 36.5% | Q1 2026/27 |

Previous

| Plan | Actual | Period |
|---|---|---|
| >= 66% | 35.0% | Q4 2025/26 |

Year to Date

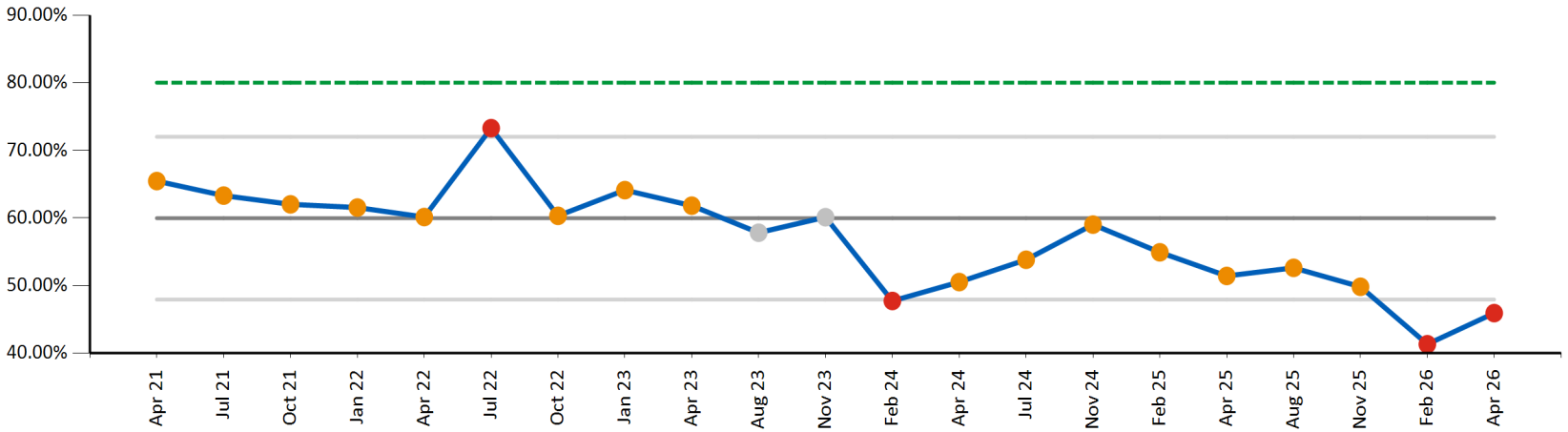
| Plan | Actual |
|---|---|
| >= 66% | |

## 79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6




### Latest

| Plan | Actual | Period |
|---|---|---|
| >= 80% | 45.9% | Q1 2026/27 |

### Previous

| Plan | Actual | Period |
|---|---|---|
| >= 80% | 41.3% | Q4 2025/26 |

### Year to Date

| Plan | Actual |
|---|---|
| >= 80% | |

# Workforce - Agency

Bolton NHS Foundation Trust

Agency usage levels remain low and we are only using agency workers in medical (almost all usage is in this staffing group), and Allied Health Professions, staff groups. Most usage is driven by nationally recognised hard-to-recruit roles.

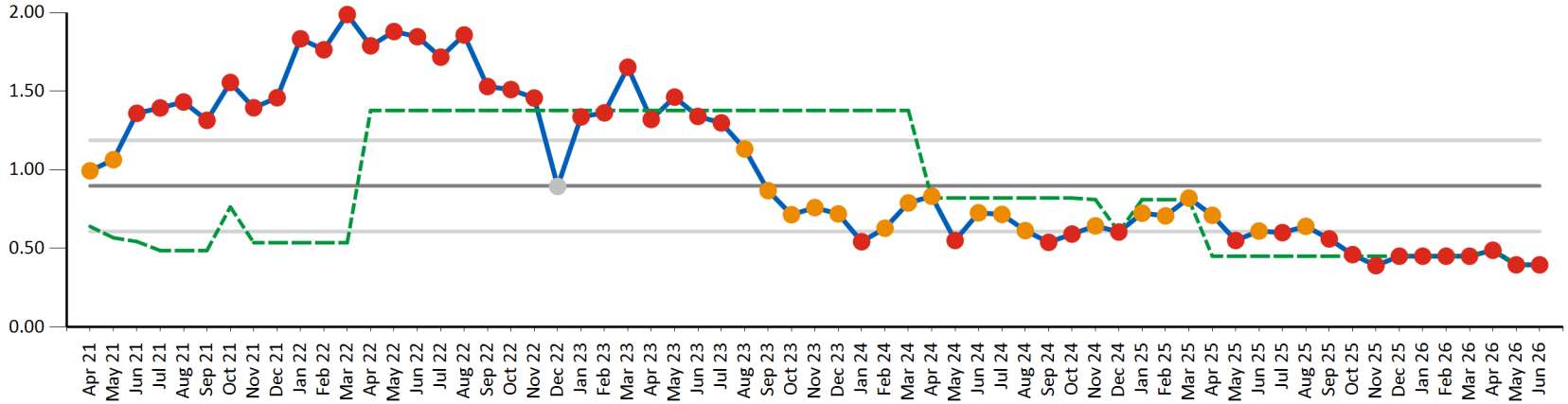
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 198 - Trust Annual ceiling for agency spend (£m) | <= 0.40 | 0.40 | Jun-26 | L | <= 0.40 | 0.40 | May-26 | <= 1.29 | 1.28 | F |
| 111 - Annual ceiling for Nursing Staff agency spend (£m) | <= 0.01 | 0.01 | Jun-26 | L | <= 0.01 | 0.01 | May-26 | <= 0.03 | 0.03 | F |
| 112 - Annual ceiling for Medical Staff agency spend (£m) | <= 0.38 | 0.29 | Jun-26 | | <= 0.38 | 0.50 | May-26 | <= 1.14 | 1.20 | ? |

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

L Special cause variation with improving performance

F We will regularly fail to meet the target.

6/6




Latest

| Plan | Actual | Period |
|---|---|---|
| <= 0.40 | 0.40 | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| <= 0.40 | 0.40 | May-26 |

Year to Date

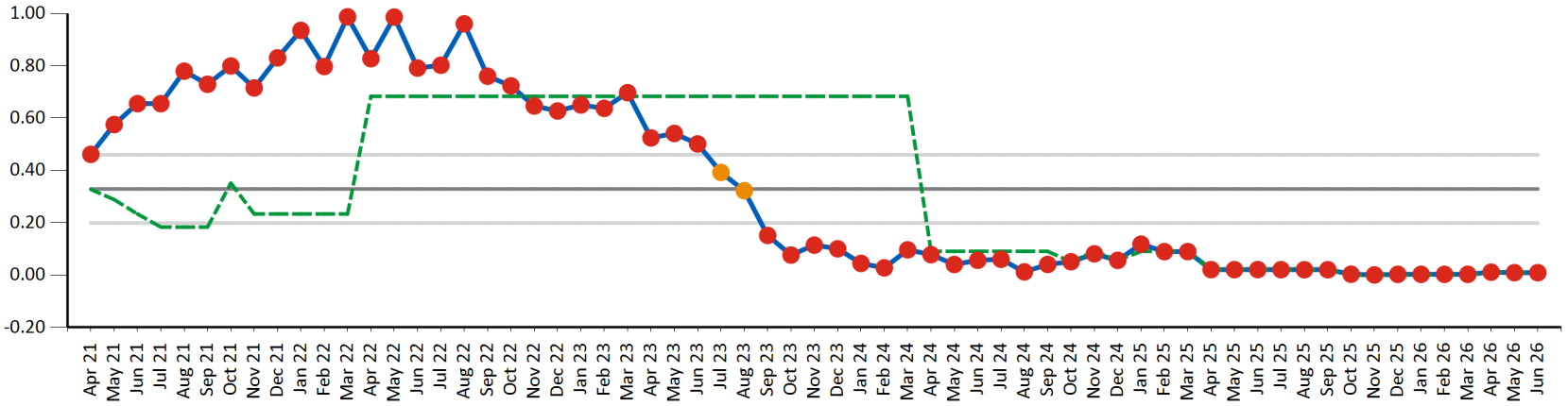
| Plan | Actual |
|---|---|
| <= 1.29 | 1.28 |

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

Special cause variation with improving performance

We will regularly fail to meet the target.

2/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 0.01 | 0.01 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 0.01 | 0.01 | May-26 |

**Year to Date**

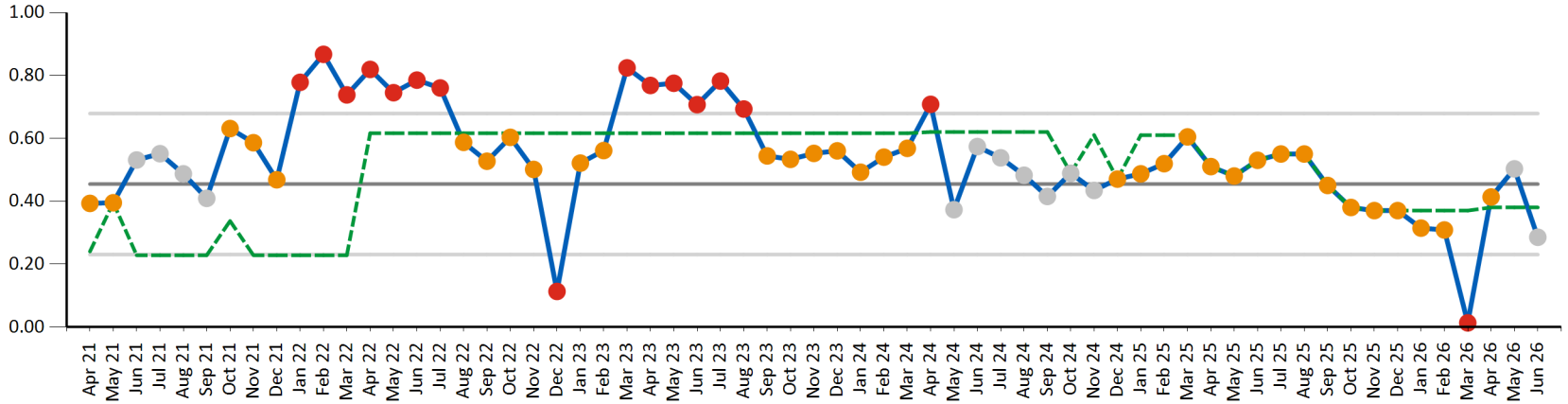
| Plan | Actual |
|---|---|
| <= 0.03 | 0.03 |

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

Common cause variation.

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

4/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| <= 0.38 | 0.29 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| <= 0.38 | 0.50 | May-26 |

**Year to Date**

| Plan | Actual |
|---|---|
| <= 1.14 | 1.20 |

# Finance - Finance

Surplus / (Deficit)
The in-month position is a deficit of £2.9m, which is £8k favourable to plan. The cumulative deficit is £8.9m, which is £30k favourable to plan. However, this is in context of a full year planned deficit of £7m. This means that, in order to hit plan, Months 4-12 need to average a surplus of £0.2m, which is a run-rate improvement of £3.1m vs the Month 3 position (7%), which needs to be delivered by CIP schemes and other cost control measures.

Income
Commissioner variable activity income is being reported £0.4m below plan, reflecting activity 'lost' due to industrial action and the June heatwave. Actual performance is calculated in arrears using coded activity information, initial estimates at Month 3 show that this is £1.9m lower than plan. For Month 3, it is assumed that £1.5m of the under-performance can be recovered in-year, or the income will not be clawed back, therefore the downside is not reflected in the Month 3 position, which is a risk. Other variances in month relate to CDC income and excluded Drugs/Devices, which is offset in Non Pay.

Deficit Support Funding (DSF)
Q1 Deficit Support funding is anticipated to be paid at £0.5m per quarter, up to £2m for the full year. Q2-4 DSF will need to be achieved through delivery of financial and CIP targets.

Pay
Underlying pay costs have reduced significantly from March to April/May, when allowing for the 2026/27 Pay Award, and are cumulatively favourable to the Trust Plan. This is driven by reductions in WTEs and MARS costs in the Month 12 position. Pay costs have increased from M2 to M3, due to the Medical Staff Pay Award, which is offset by additional income. The cumulative Pay position includes £140k of costs of cover for Industrial Action, net of the pay reductions for those who were on strike.

Worked WTEs
Worked WTEs reduced from 6,288 at Month 12 to 6,147 at Month 1, with a further reduction of 54 to Month 3.

Non Pay
Non Pay costs have increased slightly from M2, including the costs of PWC supporting the 2026/27 CIP plan and the benefit of a VAT rebate for Q4 of 2025/26. Month 3 includes a cumulative £0.2m adjustment to Amortisation, which relates to a change agreed during the audit of the annual accounts.

Non Operating
Interest received has been slightly higher than planned due to the cash balance

Cash
The Trust was above plan by £9.1m in Month 3, largely due to PDC capital monies and cash paid received in advance of being paid out, e.g. education income. The underlying cash is a balance of £8.8m, although £5.0m of this is required to pay creditor invoices which are due or overdue. It is expected that cash support will be needed by November.

CIP Delivery
Year to date achievement is ahead of plan, although the plan is significantly end-loaded, with only 4.2% of the £39.3m target (£38.0m for 2026/27 plus £1.3m full-year effect of 2025/26 schemes) in the cumulative plan at Month 3. Over-achievement is therefore needed in earlier months to reduce risk in later months.

Capital

Capital plan of £37.0m including £17.8m of RAAC. Cumulative expenditure of £1.9m is £3.7m behind plan.

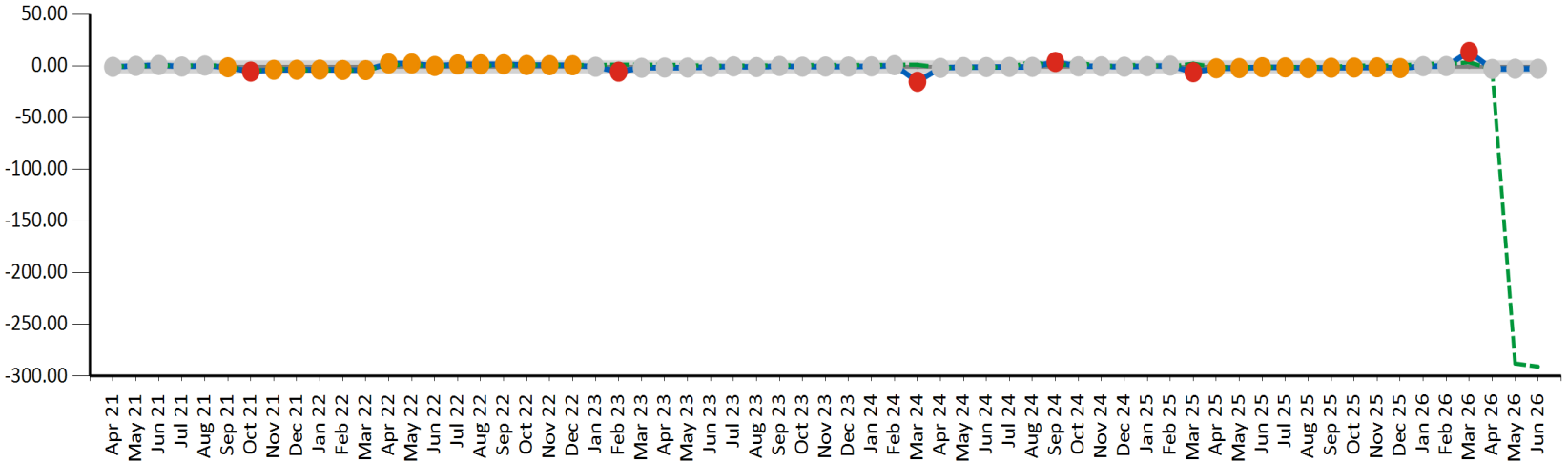
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 220 - Control Total (£ millions) | >= -291.0 | -2.9 | Jun-26 | | >= -288.0 | -2.9 | May-26 | >= -582.2 | -8.9 | |
| 222 - Capital (£ millions) | >= 3.1 | 0.1 | Jun-26 | | >= 1.4 | 0.5 | May-26 | >= 5.6 | 2.0 | |
| 223 - Cash (£ millions) | >= 2.7 | 11.8 | Jun-26 | | >= 2.7 | 12.5 | May-26 | >= 2.7 | 11.8 | |

## 220 - Control Total (£ millions)

Common cause variation.

Target will be regularly met.

4/6




Latest

| Plan | Actual | Period |
|---|---|---|
| >= -291.0 | -2.9 | Jun-26 |

Previous

| Plan | Actual | Period |
|---|---|---|
| >= -288.0 | -2.9 | May-26 |

Year to Date

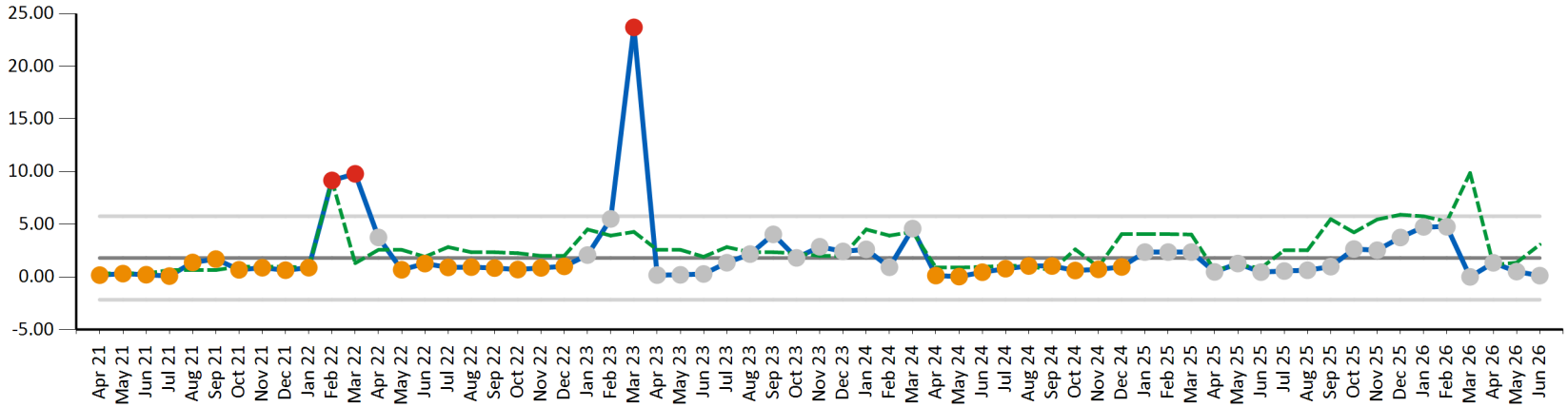
| Plan | Actual |
|---|---|
| >= -582.2 | -8.9 |

## 222 - Capital (£ millions)

Common cause variation.

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

1/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 3.1 | 0.1 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 1.4 | 0.5 | May-26 |

**Year to Date**

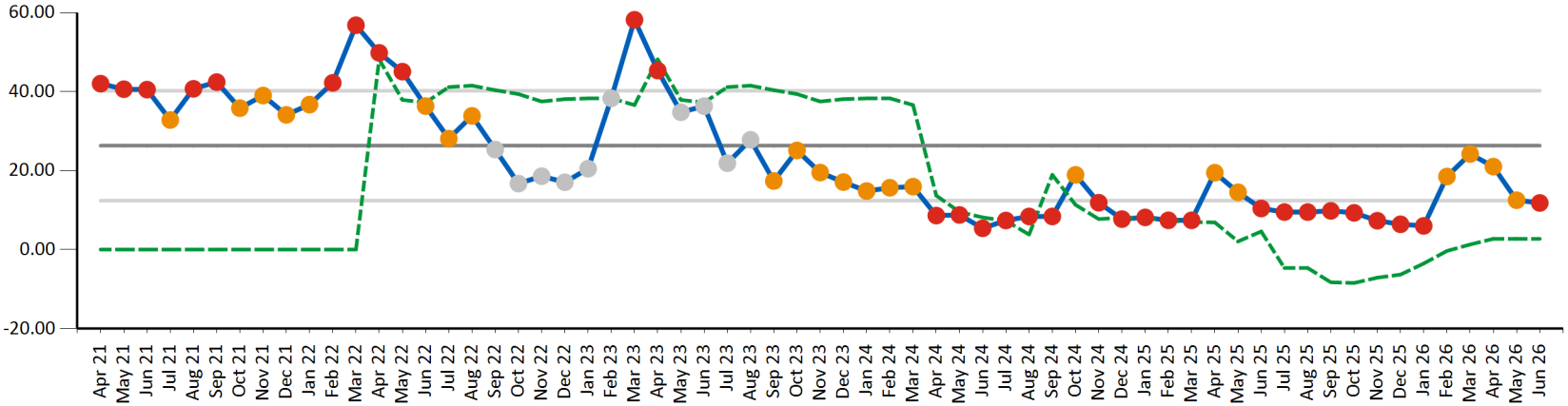
| Plan | Actual |
|---|---|
| >= 5.6 | 2.0 |

## 223 - Cash (£ millions)

Special cause variation with deteriorating performance

Target will be regularly met.

6/6




**Latest**

| Plan | Actual | Period |
|---|---|---|
| >= 2.7 | 11.8 | Jun-26 |

**Previous**

| Plan | Actual | Period |
|---|---|---|
| >= 2.7 | 12.5 | May-26 |

**Year to Date**

| Plan | Actual |
|---|---|
| >= 2.7 | 11.8 |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Quality Assurance Committee Chair's Report | | | |
| **Meeting:** | Board of Directors | **Action Required** | Assurance | ✓ |
| **Date:** | 30 July 2026 | | Discussion | ✓ |
| **Executive Sponsor** | Quality Assurance Committee Chair | | Decision | |

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

| | |
|---|---|
| **Previously considered by:** | N/A |

| | |
|---|---|
| **Executive Summary** | This report provides an overview of the key topics scheduled for discussion at the Quality Assurance Committee meeting on 29 July 2026. It highlights the areas where the Committee expects to receive assurance relating to the Trust's operational performance, quality governance, patient safety, and clinical effectiveness.<br><br>As the July Board meeting takes place before the QAC convenes, this Chair's Report is submitted in advance and therefore summarises the main items planned for consideration, rather than presenting detailed outcomes. Any urgent or significant issues arising from the QAC meeting will be escalated verbally to the Board by the Committee Chair at the meeting.<br><br>The report aims to ensure the Board remains sighted on forthcoming areas of focus within the QAC agenda and is aware of any potential matters that may require attention or future discussion. |

| | |
|---|---|
| **Proposed Resolution** | The Board of Directors is asked to ***receive*** the Quality Assurance Committee Chair's Report. |

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

| Summary of Key Elements / Implications | | |
|---|---|---|
| **Implications** | **Yes/No** | **If Yes, State Impact/Implications and Mitigation** |
| **Finance** | No | |
| **Legal/ Regulatory** | No | |
| **Health Inequalities** | No | |
| **Equality, Diversity and Inclusion** | No | |
| **Is a Quality impact assessment Required** | No | |

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

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

| | | | |
|---|---|---|---|
| **Name of Committee /Group:** | Quality Assurance Committee | **Reports to:** | Board of Directors |
| **Date of Meeting:** | 29 July 2026 | **Date of next meeting:** | 30 July 2026 |
| **Chair** | Fiona Taylor | **Meeting Quoracy** | Yes |

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

- Board Assurance Framework
- Integrated Performance Report
- Trust Heatmap
- Maternity Incentive Scheme Year 7 Progress Update (CNST Update)
- Quality Account Q1 26/27 Update
- Community Business Case Benefits Realisation Report
- Maternity Review: Post-Death Care and the Fuller Inquiry Board Assurance Statement
- Patient Safety Incident Investigation
- Clinical Effectiveness Group Report
- Patient Safety and Experience Group
- Performance and Transformation Group Report
- Health Inequities Reduction Group Chairs Report

## ALERT

| Agenda items | Action Required |
|---|---|
| Any alerts following from discussions held at the meeting will be provided verbally by the Committee Chair. | |

## ADVISE

**Board Assurance**
The Q1 BAF has been refreshed to align with the Sustainability Plan and 2026/27 Trust priorities, strengthening risk wording, controls, assurance routes, actions and target dates. QAC is asked to review the updated entries, consider whether risk scores and assurance arrangements remain appropriate, and confirm any further escalation or action before onward reporting to the Board.

**Trust Heatmap**
The heatmap illustrates Month 3 (June 2026) workforce data specific to staffing and workforce metrics. All areas are subject to detailed review and are narrated within the six-monthly Safe Staffing reports to Board of Directors, as well as within individual performance reports.

## ASSURE

**Maternity Incentive Scheme Year 7 Progress Update (CNST Update)**
The report provides assurance that CNST Year 8 delivery is progressing, with all 27 actions allocated and governance arrangements in place. Key risks relating to training compliance and workforce capacity remain under oversight, with mitigations underway. Progress continues across maternity and neonatal safety improvement programmes, with no significant external concerns identified in Q1 2026/27.

**Health Inequities Chairs Report**

The Health Inequity Reduction Group received assurance on progress in reducing health inequalities, including improved interpretation services, demographic data quality, evidence resources, EDS2022 reviews, and community engagement. A key risk remains the delayed approval and implementation of Video on Demand interpretation, which may affect timely access and patient experience.

**Quality Account Q1 26/27 Update**
The Q1 2026/27 Quality Improvement update provided assurance on progress across Trust improvement priorities, including reductions in clinical documentation, unnecessary assessments and cardiac arrests, alongside continued development of patient experience, health inequalities and QI capability. Progress also continues in embedding the Quality Management System to support safer, more efficient and patient-centred care.

**Performance and Transformation Group Chair's Report**
The June and July Chairs' reports provided assurance on progress across urgent, elective and community care, including improvements in community waiting times, neighbourhood health, CDC and urgent care performance. Key risks remain under oversight, including elective income delivery, EPR delays, data quality, RTT performance, digital dependencies and capacity constraints, with continued focus on recovery, productivity and assurance.

**Community Business Case Benefits Realisation Report**
Assurance was provided on the continued progress in the Neighbourhood Health programme, with early benefits across Integrated Transfer of Care, Enhanced Palliative Care and Proactive Care, including improved performance, reduced lost bed days and benefits delivered ahead of plan in some areas.

**Patient Safety Incident Investigation**
The Committee received two completed Maternity and Neonatal Safety Investigation reports, with associated action plans previously approved through the Patient Safety Incident Investigation Executive Sign-Off Panels. The reports provided assurance on the investigations, learning and actions to reduce recurrence, and the Committee were asked to note the findings and ongoing actions.

**Clinical Effectiveness Group Report**
The Clinical Effectiveness Group received assurance on progress across sepsis, clinical effectiveness, GIRFT and Audiology recovery, with improvements in governance, waiting lists and accreditation. Key concerns remain around Radiology capacity, Surgical mortality governance, NICE and GIRFT compliance, and digital pressures, with actions agreed to strengthen oversight.

**Patient Safety and Experience Group**
The Patient Safety and Experience Group received assurance on positive quality and patient safety performance, including improvements in investigations, complaints, pressure ulcers and QI initiatives. Key focus areas included maternity review learning, vulnerable patient oversight and corridor care actions, with no new risks or alerts identified.

**New Risks identified at the meeting: None**

**Review of Risk Register:** The Committee received the Q1 iteration of the Board Assurance Framework, accompanied by the Corporate Risk Register entries aligned and relevant to its remit.

| Meeting Attendance 2026 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Members** | | **Jan** | **Mar** | **May** | **Jul** | **Sep** | **Nov** |
| Fiona **Taylor** | Committee Chair | ✓ | ✓ | A | | | |
| Seth **Crofts** | NED | ✓ | ✓ | ✓ | | | |
| Sharon **Katema** | Director of Corporate Governance | ✓ | ✓ | ✓ | | | |
| Dr Rauf **Munshi** | Medical Director | ✓ | ✓ | A | | | |
| Tiri **Mutambasere** | Associate NED | | | ✓ | | | |
| Fiona **Noden** | Chief Executive | ✓ | ✓ | ✓ | | | |
| Martin **North** | NED | ✓ | ✓ | ✓ | | | |
| Tyrone **Roberts** | Chief Nursing Officer | ✓ | ✓ | ✓ | | | |
| Rae **Wheatcroft** | Chief Operating Officer | ✓ | ✓ | ✓ | | | |
| Sharon **White** | Chief of Strategy and Partnerships | ✓ | ✓ | A | | | |
| ✓ = In attendance A = Apologies | | | | | | | |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Maternity Review: Post-Death Care and the Fuller Inquiry Board Assurance Statement | | | |
| **Meeting:** | Board of Directors | **Action Required** | Assurance | ✓ |
| **Date:** | 30 July 2026 | | Discussion | ✓ |
| **Executive Sponsor** | Chief Nurse and Quality Officer | | Decision | ✓ |

| | |
|---|---|
| **Purpose of the report** | To provide the Board of Directors with the current position in relation to the assurance statements required to be submitted to NHS England following publication of the Nottingham review of maternity and the issues identified in relation to post-death care. The issues have been linked to the recommendations that were set following Phase 2 of the Fuller Inquiry. |

| | |
|---|---|
| **Previously considered by:** | Executive Directors – 27 July 2026<br>Quality Assurance Committee – 29 July 2026 |

| | |
|---|---|
| **Executive Summary** | Following publication of the findings from the Nottingham maternity review and the issues identified in relation to post-death care and following publication of the Fuller Phase 2 recommendations, NHS England has emphasised that every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.<br><br>On the basis that all NHS providers may be involved in caring for people after they die, NHS England have requested assurance that each Board has robustly tested its position. **All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, have been asked to complete and return a Board Assurance Statement (see Appendix 2 and 3) by 31 July 2026. The Trust is confirming compliance with all statements.**<br><br>**The self-assessment has identified that the Trust is meeting 15 out of 18 applicable recommendations.** An action plan (see Appendix 1) has been established to address the recommendations applicable to the Trust that the Trust is not fully meeting but are in progress. |

| | |
|---|---|
| | Oversight of progress of the action plan and ongoing oversight has been built into existing governance mechanisms via Patient Safety & Experience Group. |

| | |
|---|---|
| **Proposed Resolution** | The Board is asked to ***approve*** the submission of the assurance statement to NHS England; ***note*** the current position in relation to the Fuller Phase 2 recommendations; ***be assured*** that oversight of the actions to respond to all recommendations has been built into existing governance forums which will ensure visibility by the Board; and ***note*** further understanding of where the Fuller Phase 2 recommendations were received into the Trust and action is being undertaken. |

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

| **Summary of key elements / Implications** | | |
|---|---|---|
| **Implications** | **Yes/ No** | **If Yes, State Impact/Implications and Mitigation** |
| **Finance Implications** | **No** | |
| **Legal/ Regulatory** | **Yes** | Assurance statement to be returned to NHS England. |
| **Impact on Health Inequalities** | **No** | |
| **Impact on Equality, Diversity and Inclusion** | **No** | |
| **Is a Quality Impact Assessment required** | **No** | |

| | | | |
|---|---|---|---|
| **Prepared by:** | Stuart Bates, Director of Quality Governance and Richard Catlin, Divisional Nurse Director, Family & Diagnostic Division. | **Presented by:** | Tyrone Roberts, Chief Nurse |

| Assurance statement | Confirmed (yes/no) | Additional comments or qualifications (optional) |
|---|---|---|
| The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis. | Yes | |
| The Board has undertaken a review of progress against the 19 recommendations immediately relevant to the NHS as made by the Fuller Inquiry (Phase 2). Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps. | Yes | |
| In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die. | Yes | |
| The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency. | Yes | |
| For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission. | Yes | |

**Trust Name:** Bolton NHS Foundation Trust

**Trust CEO/AO Name:** Prof. Fiona Noden **Date:**

**Trust Chair Name:** Dr Niruban Ratnarajah **Date:**

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Clinical Negligence Scheme for Trusts (CNST) Year 8 & Perinatal Quality Oversight Update – Q1 2026/27 | | | |
| **Meeting:** | Board of Directors | **Action Required** | Assurance | ✓ |
| **Date:** | 30 July 2026 | | Discussion | ✓ |
| **Executive Sponsor** | Chief Nursing Officer | | Decision | |

| | |
|---|---|
| **Purpose of the report** | This report provides assurance regarding progress against the NHS Resolution Maternity Incentive Scheme (CNST Year 8), implementation of the Perinatal Quality Oversight Model (PQOM), and key maternity and neonatal safety, quality and workforce programmes within Bolton NHS Foundation Trust |

| | |
|---|---|
| **Previously considered by:** | Quality Assurance Committee – 29 July 2026 |

| | |
|---|---|
| **Executive Summary** | Key highlights:<br>• The CNST year 8 maternity scheme launched on the 23 April 2026 in a revised format with a greater focus on outcomes, flexibility for local implementation with six safety actions.<br>• This report provides assurance that all 27 sub-actions within the CNST year 8 scheme have been allocated, 2 have not yet commenced as within date and 3 have been identified as compliance risks relating to attainment of training metrics at the two defined checkpoints. Weekly oversight of training performance and compliance is being undertaken to mitigate this risk.<br>• Business cases relating to the 4.6WTE neonatal nursing and 7.2PA's neonatal medical staffing gaps to align with British Association of Perinatal Medicine (BAPM) requirements and the 18.52WTE midwifery staffing gap to align with the Birthrate plus 2025 report recommendations are due to be presented at Capital Revenue and Investment Group (CRIG) in August 2026 with a combined value of circa £1.3m. A fully funded position for the midwifery staffing deficit must be reported by the end of 31 March.2027. |

| | |
|---|---|
| | • Work remains ongoing to benchmark compliance in accordance with the maternity care bundle national requirements following the launch of the implementation tool on the 1 June 2026. |

| | |
|---|---|
| **Proposed Resolution** | The Board are asked to ***receive*** the Clinical Negligence Scheme for Trusts (CNST) Year 8 & Perinatal Quality Oversight Update – Q1 2026/27. |

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

| **Summary of key elements / Implications** | | |
|---|---|---|
| **Implications** | **Yes / No** | **If Yes, State Impact/Implications and Mitigation** |
| **Finance Implications** | **Yes** | Potential impact upon maternity incentive scheme fund reimbursement if all requirements of the scheme not fulfilled. |
| **Legal/ Regulatory** | **No** | |
| **Impact on Health Inequalities** | **No** | |
| **Impact on Equality, Diversity and Inclusion** | **No** | |
| **Is a Quality Impact Assessment required** | **No** | |

| | | | |
|---|---|---|---|
| **Prepared by:** | Janet Cotton, Director of Midwifery and Tyrone Roberts, Chief Nurse | **Presented by:** | Janet Cotton, Director of Midwifery<br>Tyrone Roberts, Chief Nurse |

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

| | |
|---|---|
| ATAIN | Avoiding Term Admissions into Neonatal Units |
| BAPM | British Association of Perinatal Medicine |
| CNST | Clinical Negligence Scheme for Trusts |
| GMEC | Greater Manchester and East Cheshire |
| ICB | Integrated Care Board |
| MIS | Maternity Incentive Scheme |
| NIPE | Newborn and Infant Physical Examination |
| NWNODN | North West Neonatal Operational Delivery Network |
| NHSR | NHS Resolution |
| PMRT | Perinatal Mortality Review Tool |
| PQOM | Perinatal Quality Oversight Model |
| PROMPT | Practical Obstetric Multi-Professional Training |
| LMNS | Local Maternity and Neonatal System |
| MBRRACE | Mothers and babies; reducing risk through audit and confidential enquiries |
| RCOG | Royal College of Obstetricians and Gynaecologists |

**Purpose**

This report provides assurance regarding progress against the NHS Resolution Maternity Incentive Scheme (CNST Year 8), implementation of the Perinatal Quality Oversight Model (PQOM), and key maternity and neonatal safety, quality and workforce programmes within Bolton NHS Foundation Trust.

**Executive Assurance**

The CNST Year 8 scheme launched in April 2026 with a revised structure focused on outcomes, local flexibility, and strengthened Board accountability across six safety actions.

The Trust has established workstreams and is progressing implementation of all 27 required actions. Currently no actions have yet reached full compliance due to the early stage of the reporting year.

Current progress across the six safety actions indicates:

- 22 sub-actions are progressing and on track.
- Three sub-actions have been identified as compliance risks. All risks relate to the attainment of the CNST training metrics to the required standard across all defined staff groups at two checkpoints namely 30 September 2026 and 30 November 2026.
- Two sub-actions have not yet commenced.
- No actions have yet achieved full compliance to date.

**Key Areas of Assurance**

**1. Workforce and Capacity**

**Positives**

- 100% compliance achieved with Royal College of Obstetricians and Gynaecologists consultant attendance standards as demonstrated in the Q1 RCOG 2026/2027 audit report that confirms compliance with attendance of the obstetric team at defined clinical situations.
- Midwifery funded establishment is aligned with the 2023 Birthrate Plus recommendation and vacancy rates remain low at 2%.

- Full assurance received regarding 24/7 obstetric anaesthetic cover with no roster gaps identified.

**Risks and Actions**

- Neonatal medical staffing remains below British Association of Perinatal Medicine standards, with a gap of 7.2 programmed activities (PA) within Tier 3 consultant provision. A business case is scheduled for presentation at CRIG in August 2026.
- Neonatal nursing workforce remains below recommended establishment by 4.69 WTE and requires investment. A business case is being prepared for presentation at CRIG in August 2026.
- The 2025 Birthrate Plus review published in April 2026 identified the need for additional midwifery investment. of an additional 18.52WTE Registered Midwives. NHS Resolution has confirmed that organisations have up to one year to implement revised recommendations where recent assessments have been completed, and progress needs to be demonstrated towards attainment during the interim period.
- All three business cases due to be presented to CRIG in August 2026 have a combined value of circa £1.3m.
- A fully funded position for the midwifery staffing deficit must be reported by the end of 31 March.2027.

**Board Assurance:** Workforce oversight arrangements are robust; however, neonatal medical, neonatal nursing and midwifery establishment deficits remain the principal workforce risks.

**2. Training and Competency**

**Positives**

- CNST training governance arrangements have been strengthened through establishment of a dedicated CNST Training Board.
- Neonatal Life Support compliance currently exceeds 95% across most professional groups and has attained 100% in several areas. Further sessions have been scheduled to maintain this compliance at the upcoming training checkpoints.
- Multi-professional simulation training within the hospital setting has been undertaken and community-based scenarios have been scheduled for autumn 2026.

- Approval was sought for the second training compliance checkpoint to be agreed as the 30 September 2026 from the Quality Assurance Committee – approval at a Committee / Board level is a CNST requirement.

**Risks**

- PROMPT training compliance remains below the required 90% threshold for some anaesthetic and support staff groups.
- Achievement of Year 8 training standards remains dependent on staff attendance and release from operational duties, which has been identified as a compliance risk. The service is required to attain 90% compliance at two checkpoints during the April – November 2026 period.

**Board Assurance:** Training performance is improving, but maintaining compliance through September and November checkpoints will require continued operational focus.

**3. Learning from Reviews and Investigations**

The Trust has met all Q1 requirements relating to notification, review and governance of perinatal mortality events.

**Key Learning Themes Identified**

1. Delayed recognition of deterioration.
2. Inconsistent adherence to clinical pathways.
3. Delays in escalation and intervention.

A strength identified through review processes was effective multidisciplinary team working, with evidence of consideration of ethnicity and deprivation factors throughout investigations.

**Board Assurance:** Thematic learning is embedded and translated into specialty action plans with ongoing oversight. The Q1 report is due to be presented to Safety Champions in September 2026 and will be submitted to Quality Assurance Committee thereafter.

### 4. Service User Voice and Health Equity

Targeted engagement activity undertaken by the Maternity and Neonatal Voice Partnership has been undertaken with a focus on groups at greater risk of poorer maternity outcomes or reduced engagement.

Key themes identified from the engagement events held included:

- Need for improved communication regarding postnatal care.
- Clearer explanation of induction pathways.
- Improved communication regarding plans of care and discharge arrangements.

The service has demonstrated responsive action, including culturally sensitive improvements to bereavement facilities following family feedback.

**Board Assurance:** Service-user feedback is actively shaping service improvement and culturally responsive care.

### 5. Care Bundles and Quality Improvement

#### Saving Babies' Lives Care Bundle

All process indicators have been implemented and previously achieved CNST sign-off during the year 7 period.

#### Positive Outcomes

- Smoking at Time of Delivery rate reduced to 3.1%, the lowest level recorded within the service.
- Compliance achieved with national requirements regarding fetal growth surveillance following review of growth-chart guidance.

#### Areas Requiring Further Work

- Fetal growth restriction pathway requires strengthening.
- Neonatal pulse oximetry testing implementation is progressing; equipment has been ordered and the standard operating procedure is awaiting ratification.

**Board Assurance:** Strong progress continues against national care bundle requirements, with targeted improvement work underway where gaps remain.

**Maternity Care Bundle**

The service is currently utilising the national implementation tool released in June 2026 to benchmark progress of the service in relation to the required standards.

**6. Governance, Oversight and Culture**

**Maternity Outcomes Signal System (MOSS)**

The Trust has commenced mandatory MOSS submission and has received no safety alerts or outlier notifications to date. A simulation exercise is being planned as per CNST requirements.

**Culture and Leadership**

An Our Ways Team Tool survey of band 7 and above midwifery and neonatal leaders involving maternity and neonatal leaders highlighted:

**Strengths**

- Strongly supportive culture.
- Psychological safety.
- Compassionate and respectful working relationships.
- Increased openness and trust reported by colleagues within the service.

**Improvement Themes**

- More consistent communication.
- Greater opportunities for connection and collaboration.
- Stronger alignment around service priorities and shared vision.

These findings have informed a formal perinatal cultural improvement action plan. One of the actions is to develop a digital communication teams channel to improve the sharing of key service level messages.

**Board Assurance:** Governance arrangements continue to strengthen, with culture improvement remaining a key strategic priority.

## Quality and Safety Intelligence

### Perinatal Mortality

During Q1 2026/27:

- Five stillbirths were reported.
- One late foetal loss was reported.
- 11 neonatal deaths were reported.
- Six neonatal deaths related to babies born at less than 24 weeks gestation occurred during the Q1 2026/2027 period – all were reported in accordance with national requirements.

No Maternity and Newborn Safety Investigations reports were concluded during the period, and no external assurance requests were received.

## Principal Risks Requiring Board Oversight

1. Neonatal medical staffing remains below British Association of Perinatal Medicine (BAPM) standards.
2. Neonatal nursing establishment remains below recommended levels.
3. The midwifery funded establishment does not currently align with the 2025 Birthrate Plus recommendations.
4. Training compliance requires sustained improvement to achieve the two CNST checkpoints scheduled for September and November 2026.
5. Communication remains a recurring theme across incidents, complaints and staff feedback and steps to improve channels of communication are being strengthened in response.
6. Further work benchmarking continues regarding the implementation of the maternity care bundle.

**Conclusion**

The report provides assurance that maternity and neonatal services continue to make progress towards compliance with CNST Year 8 requirements and implementation of the Perinatal Quality Oversight Model.

A detailed breakdown of progress to date and the inclusion of all actions plans has been reviewed in a written report by the Quality Assurance Committee prior to presentation of this report to the Board of Directors.

Significant strengths are evident in consultant obstetric compliance, maternity workforce planning, service-user engagement, care bundle implementation, cultural development and governance oversight.

Key risks relate to neonatal and midwifery workforce capacity, achievement of training compliance standards and communication improvement within the service. Action plans are in place, and progress will be subject to ongoing oversight of the Quality Assurance Committee.

| | | | | |
|---|---|---|---|---|
| **Report Title:** | People Committee AAA Chair Report | | | |
| **Meeting:** | Board of Directors | **Action Required** | Assurance | ✓ |
| **Date:** | 30 July 2026 | | Discussion | |
| **Executive Sponsor** | Deputy Chief Executive/Chief People Officer | | Decision | |

| | |
|---|---|
| **Purpose of the report** | The purpose of this report is to provide an update and assurance to the Board of Directors on the work delegated to the People Committee. |

| | |
|---|---|
| **Previously considered by:** | The matters included in the Chair's report were discussed and agreed at the People Committee. |

| | |
|---|---|
| **Executive Summary** | The attached report from the Chair of the People Committee provides an overview of matters discussed at the meeting held on 21 July 2026.<br>The report also sets out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors. |

| | |
|---|---|
| **Proposed Resolution** | The Board of Directors are asked to ***receive*** the People Committee Chair's Report. |

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

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

| | | | |
|---|---|---|---|
| **Prepared by:** | **Ian Williamson, People Committee Chair** | **Presented by:** | **Ian Williamson, People Committee Chair** |

| ALERT \| ADVISE \| ASSURE (AAA)<br>Key Issues Highlight Report | | | |
|---|---|---|---|
| **Name of Committee:** | People Committee | **Reports to:** | Board of Directors |
| **Date of Meeting:** | 21 July 2026 | **Date of next meeting:** | 16 September 2026 |
| **Chair** | Ian Williamson | **Meeting Quoracy** | Yes |

**AGENDA ITEMS DISCUSSED AT THE MEETING**

- Board Assurance Framework
- Corporate Risk Register
- Workforce Delivery
- OD & Culture Update
- Our Leaders Update
- Adoption of IHRA Definition of Antisemitism
- Steering Group Chair Reports
- Divisional People Committee Chair Reports

## ALERT

| **Workforce Delivery** | **Action** |
|---|---|
| Overall workforce performance remains strong, contributing to a significantly better and more positive position than planned in the Medium-Term Plan for May and June 2026, driven by lower than planned substantive staffing usage. However, further work is needed to deliver CIP-related WTE reductions, particularly in relation to planned bank staffing reductions.<br><br>Sickness absence increased in June 2026 and remains above expectation, while turnover was stable and vacancy rates remain low across most staffing groups. | The Committee requested an update at the next meeting on the enabling actions that are taking place to support a reduction in sickness absence. |

## ADVISE

**Board Assurance Framework**

The Committee received the revised Board Assurance Framework (BAF), which has been updated to align with the Trust's Sustainability Plan and Level 1 Trust Priorities for 2026.

**OD & Culture Update**

The Committee received an update on the national launch of the NHS Staff Standards and Leadership and Management Framework, noting its emphasis on culture, leadership and staff experience, and the strong alignment with the Trust's existing *Our Way* and *Our Leaders* approaches. Members noted that the Trust's People and Culture Priorities had been informed by the 2025 NHS Staff Survey, subsequent people and culture intelligence, and extensive stakeholder engagement.

Staff experience measures were reported to have declined between the November 2025 Staff Survey and January 2026 Pulse Survey, with modest improvement in April 2026; however, performance remained below baseline. The Committee noted the development of a Trust-wide People and Culture Plan, due for completion in September 2026, which would provide a single improvement framework with clear priorities, accountability, enhanced assurance and compliance with national requirements. Members also recognised

the ongoing Trust-wide staff engagement programme supporting staff voice and involvement in improvement activity.

**Our Leaders Update**

The Committee received an update on the Our Leaders programme, launched in January 2025 to strengthen leadership and management capability in response to staff feedback and people and culture intelligence. Aligned to Our Way, the programme supports the Trust's leadership and culture ambitions by setting clear expectations for leaders.

By June 2026, 967 colleagues had attended, with the 1,000th participant expected in August 2026. This included 479 Band 7 and above leaders and managers, representing 36% of the target cohort, with increased engagement from this group remaining a priority.The programme exceeded EDI participation targets and continues to attract strong engagement from aspiring, frontline and mid-level leaders, with increasing participation from senior leaders. Alignment with the national NHS Leadership and Management Framework provides further assurance.

At the midpoint of the three-year culture improvement programme, progress is evident in leadership capability, team development and cultural consistency. Priorities for the next phase include increasing participation, strengthening people management and change leadership capability, evaluating impact, and considering alternative accredited leadership development routes in light of potential Apprenticeship Levy funding changes.

**ASSURE**

**Adoption of the IHRA Definition of Antisemitism**

The Committee was advised that since the paper had been drafted further detailed legal advice had been received. It was proposed that a full paper including the analysis of the Lord Mann recommendations, tackling racism, National Staff Standards and the Government's anti-Muslim hostility statement, as well as the IHRA considerations be brought to the September meeting. In the meantime any concerns raised by staff would continue to be addressed in line with our commitment to anti-racism.

**Steering Group Chair Reports**

The Committee received the Chair reports from the Steering Group meetings which had taken place since the last People Committee.

**Divisional People Committee Chair reports**

The Committee received the Chair reports from the Divisional People Committee meetings which have taken place since the last People Committee.

**New Risks identified at the meeting: None**

**Review of the Risk Register:**

The Committee received the Q1 iteration of the Board Assurance Framework, accompanied by the Corporate Risk Register detailing all risks scoring 15 or above that are assigned to the People Committee.

| Meeting Attendance 2026/27 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Members** | **Role** | **Jan** | **Mar** | **May** | **Jul** | **Sep** | **Nov** |
| **Ian Williamson** | Committee Chair | ✓ | ✓ | ✓ | ✓ | | |
| Gita **Bhutani** | Associate NED | **-** | ✓ | ✓ | **A** | | |
| Janet **Hulston** | NED | ✓ | A | ✓ | ✓ | | |
| Sharon **Katema** | Director of Corporate Governance | ✓ | ✓ | ✓ | ✓ | | |
| James **Mawrey** | Chief People Officer / Deputy CEO | ✓ | ✓ | ✓ | ✓ | | |
| Rauf **Munshi** | Medical Director | ✓ | **A** | **A** | ✓ | | |
| Tyrone **Roberts** | Chief Nursing Officer | ✓ | **A** | **A** | ✓ | | |
| Fiona **Taylor** | NED | ✓ | **A** | **A** | ✓ | | |
| Annette **Walker** | Chief Finance Officer | ✓ | ✓ | **A** | A | | |
| Sharon **White** | Chief of Strategy and Partnerships | ✓ | - | **A** | **A** | | |
| Martin **North** | NED | ✓ | ✓ | ✓ | | | |
| ✓ = In attendance A = Apologies - = left the Trust | | | | | | | |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Freedom to Speak Annual Report 2025/26 | | | |
| **Meeting:** | Board of Directors | **Action Required** | Assurance | ✓ |
| **Date:** | 30 July 2026 | | Discussion | |
| **Executive Sponsor** | Chief People Officer | | Decision | |

| | |
|---|---|
| **Purpose of the report** | This report provides the Board with annual assurance on the effectiveness of the Trust's Freedom to Speak Up (FTSU) arrangements for 2025/26, covering the period 1 April 2025 to 31 March 2026. |

---

| | |
|---|---|
| **Executive Summary** | During 2025/26, 198 Freedom to Speak Up cases were raised across the Trust. The report provides assurance on speaking up activity, key themes, learning and improvement actions, demonstrating continued support for a culture of speaking up, listening and following up.<br><br>Activity reflected strong engagement with speaking up routes, with a Quarter 2 increase linked to targeted listening events before returning to baseline. Key themes included inappropriate attitudes and behaviours, with worker safety and wellbeing becoming more prominent in the latter half of the year.<br><br>Responsiveness remained strong, with almost all staff acknowledged within 48 hours.<br><br>**Key issues:**<br>• Workforce morale impacted by financial and structural pressures and ongoing organisational change<br>• Increasing complexity of culture-related cases<br>• National uncertainty following the closure of the National Guardian's Office |

| | |
|---|---|
| **Proposed Resolution** | The Board of Directors are asked to ***receive*** the Freedom to Speak Up Annual Report |

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

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Tracey Garde/ Louise Cartin FTSU Guardians | **Presented by:** | Tracey Garde FTSU Guardian |

## 1.0 Introduction

**1.1** Freedom to Speak Up enables staff to raise concerns about patient safety, quality, behaviors, culture or ideas for improvement without fear of reprisal. A positive speaking up culture supports early identification of risk, learning and staff wellbeing and is central to the NHS People Promise commitment that “we each have a voice that counts”.

Listening to the concerns of our workers helps us to identify areas for improvement and creates a culture of safety and support for both our workers, our patients and the community we serve. However, relying on workers ‘being brave’ enough to speak up isn’t enough. We also need to ensure, as an organisation, we are listening and acting on the information we are hearing and sharing the feedback and learning as per- Speak Up, Listen Up and Follow Up- they are all crucial elements to create a positive environment for workers and for patients to receive safe, high quality care.

This report gives an update from the Trusts FTSU Guardians of the reporting period 01 April 2025 to 31 March 2026.

**1.2** The organisation currently employs 2 part-time FTSU Guardians Tracey Garde (0.53 WTE) and Louise Cartin (0.6 WTE). These hours equate to a total of 1.13 WTE and cover the service Monday - Friday. Unlike some organisations that work solely with 1 FT Guardian, Bolton is in a preferred position in its ability to have Guardian cover for AL, sickness etc.

In February 2026, the North-West FTSU Guardian Network, which is co-chaired by Bolton Guardian Tracey Garde, agreed to complete a NW survey of Guardian ringfenced time. The intention was to provide benchmark data for colleagues to use as they wish, to support discussions within their organisations to provide assurance on the level of FTSU provision, or as a basis for efforts to increase that provision.

The trendline in the graph below (Fig 1) represents with moderate strength the “average” provision of ringfenced time by organisational size. This shows that Boltons Guardian capacity is in line with its Northwest peers.

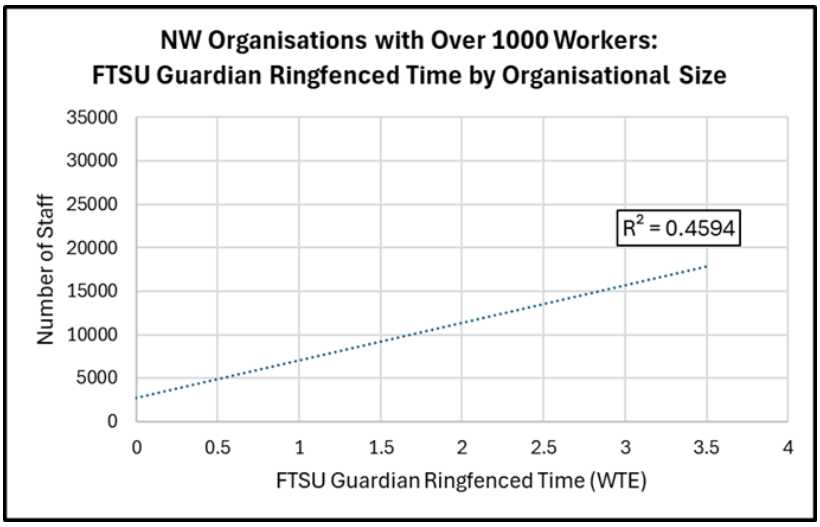



Figure 1: Benchmark- No. of Guardians per organisation size

**1.3** The FTSU Guardians in Bolton NHS FT are supported by a Network of 88 FTSU Champions from all areas across the organisation (Appendix one and Figure 2 below).

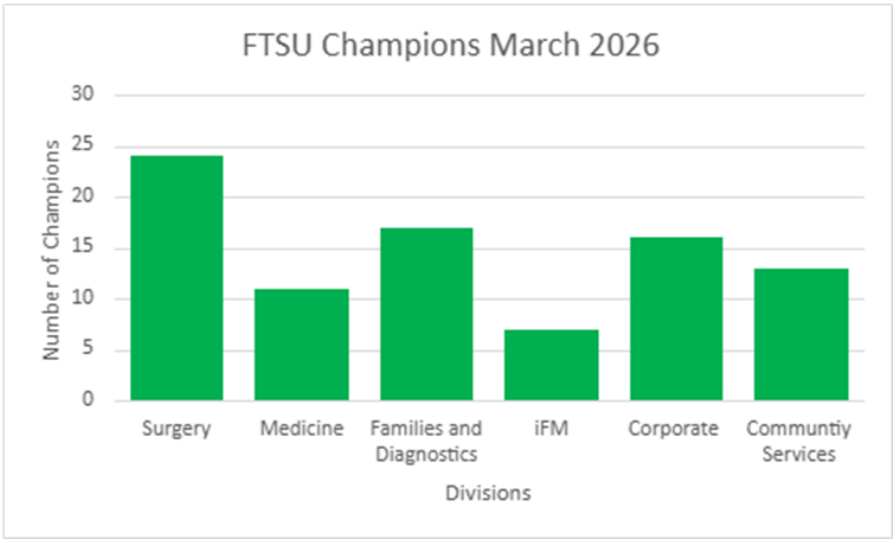



Figure 2: FTSU Champion Network

Several new FTSU Champion training events took place throughout the year due to the increasing demand for workers wanting to be part of the FTSU Champion Network. The Guardians are aiming to develop the diverse FTSU Network even further by having FTSU Champions across all disciplines and in all areas where possible.

The Guardians meet with the Champion Network quarterly to share the reports and support them in their roles. The Guardians hosted the Annual FTSU Champion Conference on Thursday 2nd October 2025 at the Education Centre. Topics included Psychological Safety,

Introduction to Coaching Skills, and Sexual Safety. The day also provided an opportunity to recognise and celebrate the contributions of those Champions who have really embraced the role.

The National Guardian's Office (NGO) recommends 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 organisation's FTSU Policy.

• Promoting a positive speaking up culture- Supporting the organisation to welcome and celebrate speaking up.

The Guardians recognise the commitment of the FTSU Champions but also recognise the difficulties of balancing the voluntary role with their own substantive roles. Going forward, the Guardians are aiming to reduce the number of meetings with the Champions but will have a short 10-15 minutes 1:1 meeting annually and 2 Network meetings which includes the annual conference. The Champions have the ability to contact the Guardians for any ongoing support whenever needed and do reach out as required.

**2.0 Overview of FTSU Activity 2025/26**

**2.1** From 1 April 2025- 31 March 2026 198 cases were reported via the FTSU Guardian route. This is an increase on the previous year (Figure 3)

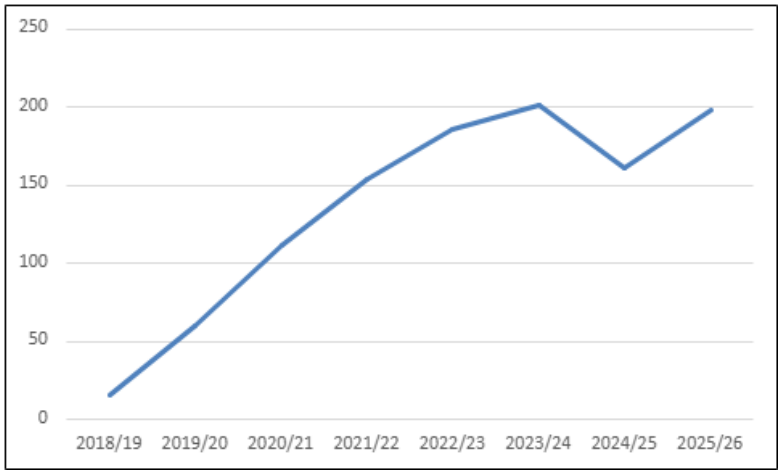



Figure 3: Annual number of FTSU Cases from 2018-2026

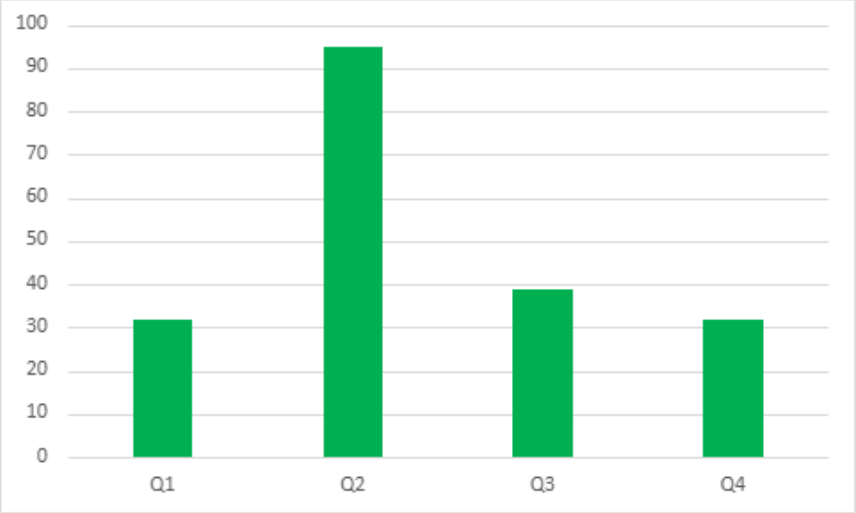



Figure 4: Breakdown of concerns by Quarter in 2025/26

**2.2** In June 2025, the Clinical Divisions reduced from 5 to 4. The Quarter 2 increase reflected targeted listening events within the Family and Diagnostic Division and was interpreted as increased confidence in the FTSU service supporting workers to raise their concerns safely. There was an increase seen overall, in concerns relating to organisational change and workers feeling unsettled with processes particularly in admin and clerical staff. (Figure 5-9).

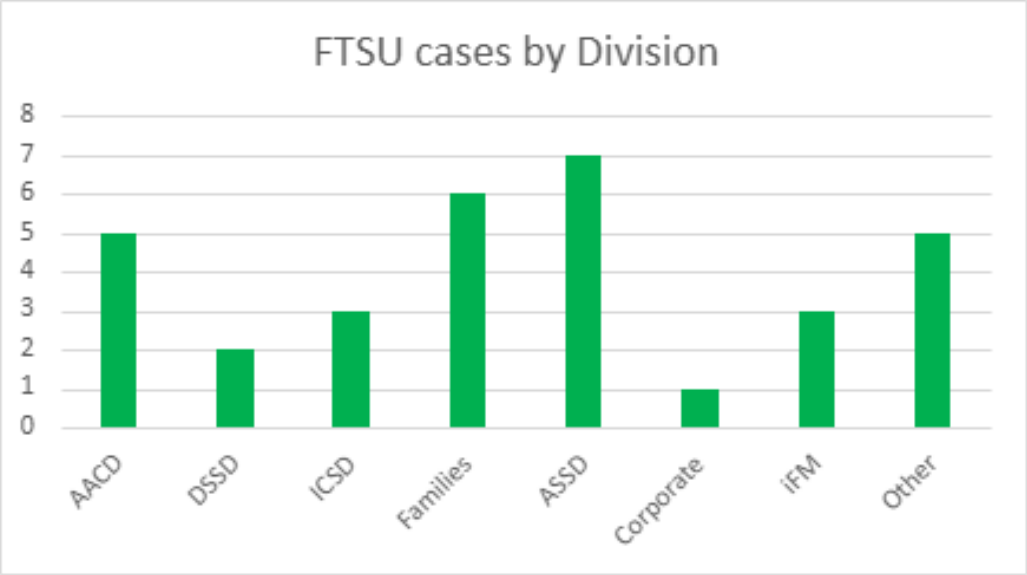



Figure 5: Breakdown in Q1 per Division

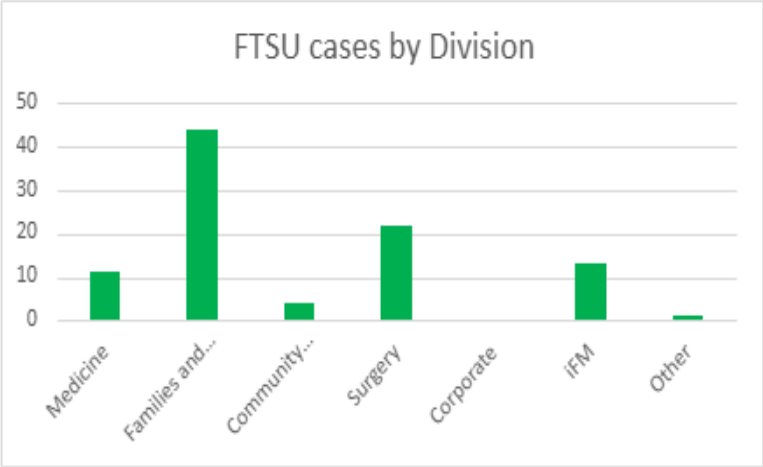



Figure 6: Breakdown in Q2 per Division

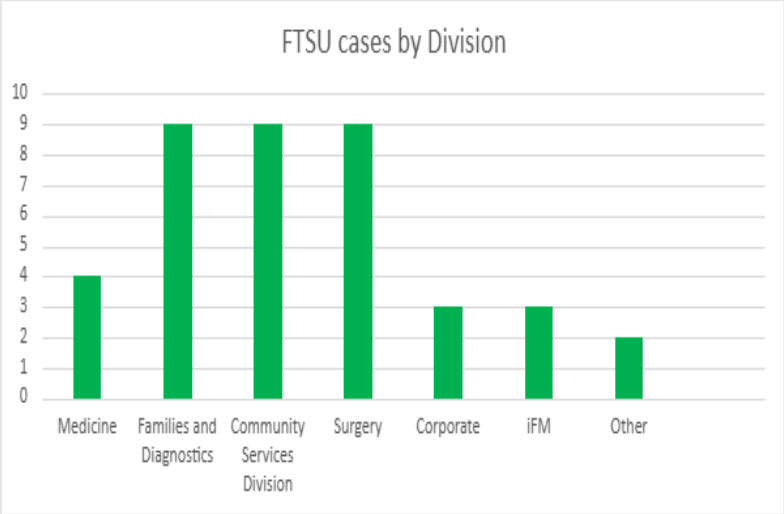



Figure 7: Breakdown in Q3 per Division

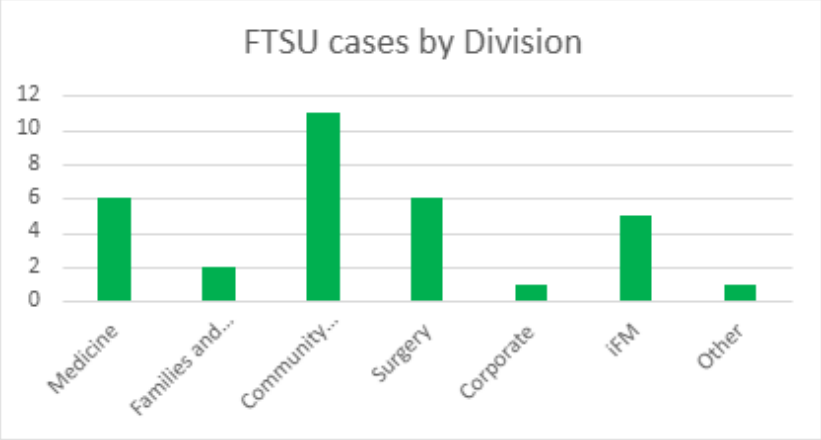



Figure 8: Breakdown in Q4 per Division

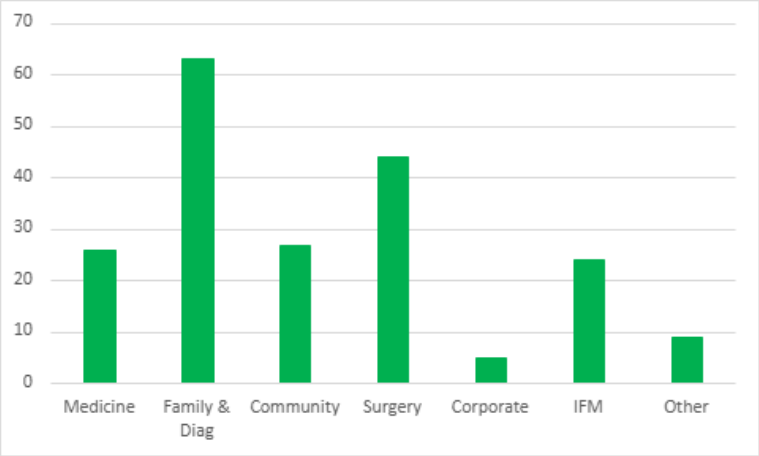



Figure 9: Total number of cases per Division in 2025/26

**2.3** For national reporting, everyone that speaks up must be recorded separately. Therefore, whilst some concerns are collectively conveyed, each worker is captured within the data individually.

All the FTSU concerns raised have been discussed with the relevant divisional senior leadership teams/managers/HRBM and have been or are being dealt with accordingly. Workers who speak up are not discussed by name with senior management unless the Guardians have the individuals express consent to do so. The Guardians also ask that the concerns are then only discussed with individuals with the consent of the original person who has spoken up as protecting the individual's confidentiality is extremely important to the Guardians.

The Guardians take appropriate steps to ensure that workers are well supported and that they are thanked for speaking up. The Guardians ensure that concerns are addressed appropriately and in a timely manner and ensure that workers receive feedback either directly or indirectly.

Once the Guardians receive the necessary assurance that the individual case has been dealt with, any lessons that have been learned/actions taken and the individual who has spoken up is satisfied their concern has been listened to and they have received feedback, then the case is then closed. Sometimes the outcome may not always be what the worker was hoping for, but if they feel they have been listened to and their concerns acted on appropriately, following policy and due process, the Guardians will look to close the case. Of the 198 cases seen in 2025/26 94 were resolved and 70 remain open – some of these cases are in HR processes or the Guardians are awaiting feedback and learning prior to closure.

The Guardians follow the National Guardian Office guidance on recording and reporting data regarding the closing of cases:

"A case should not be closed until you are satisfied that all possible routes have been reasonably pursued, including all avenues of dispute. In some circumstances, someone

speaking up may decide to 'drop out' of the process – however, you will want to make sure any action taken in response to a case reaches an appropriate conclusion before it is closed."

The Guardians therefore keep a case open until the individual and the Guardian is satisfied that all avenues have been addressed and feedback and learning has been received from the manager or individual dealing with the case/

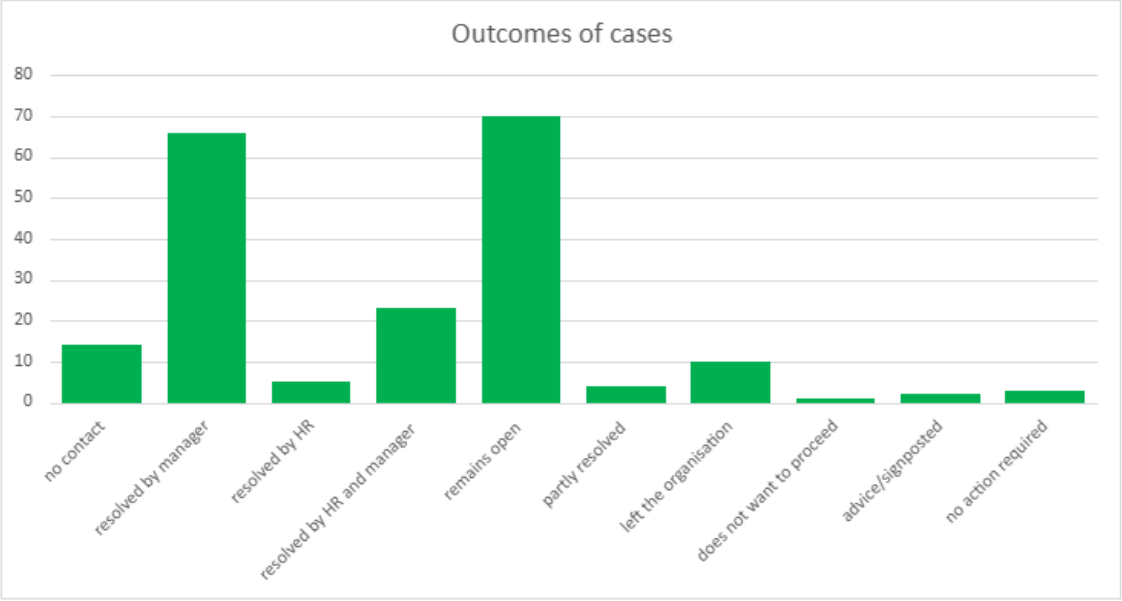



Figure 10: Outcomes of cases 2025/26

A link to a confidential feedback survey is sent to the individual about their speaking up experience within 3 months of their case being closed. The results of surveys from 2025/26 are displayed below (Figures 11-19):

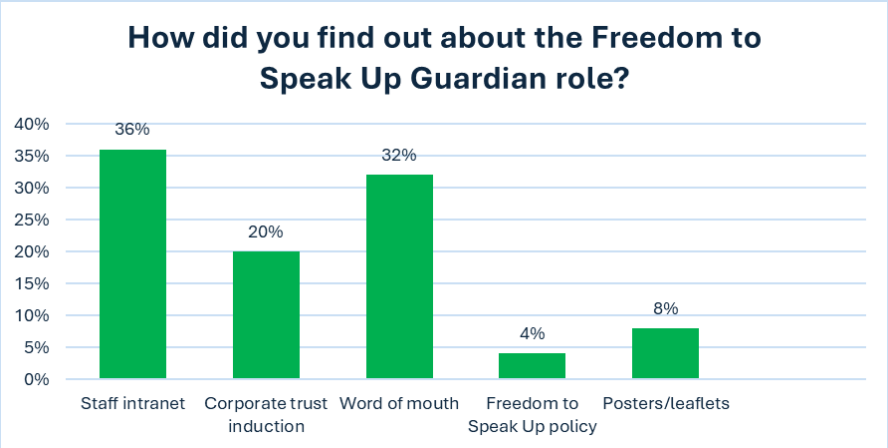



Figure 11




Figure 12

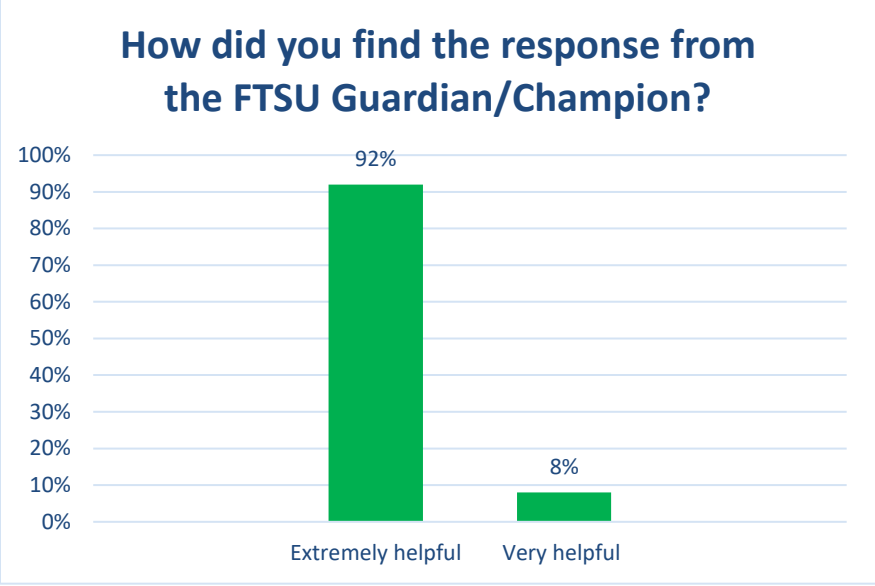



Figure 13

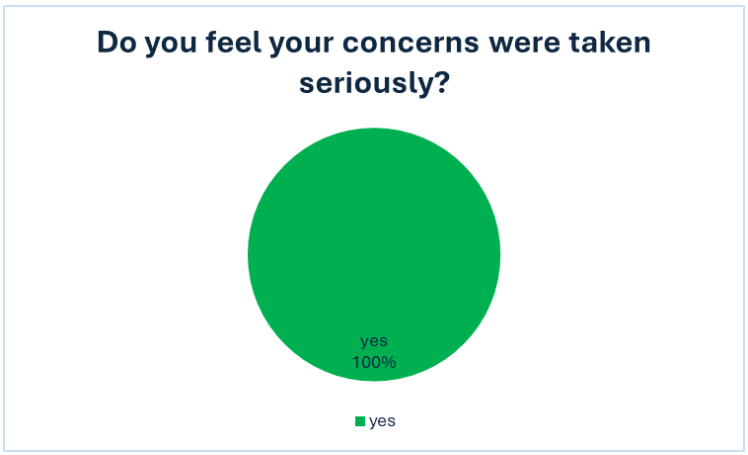



Figure 14

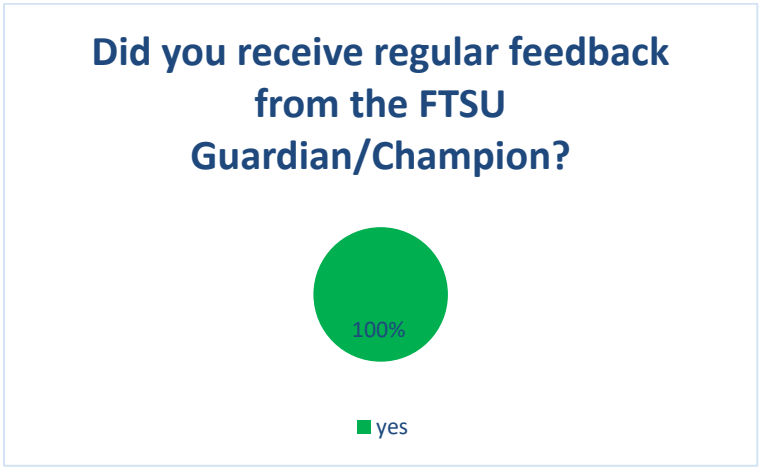



Figure 15

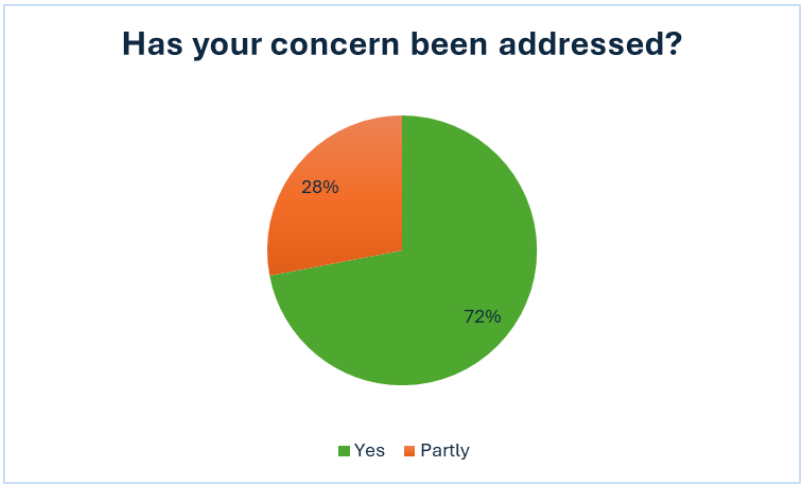



Figure 16

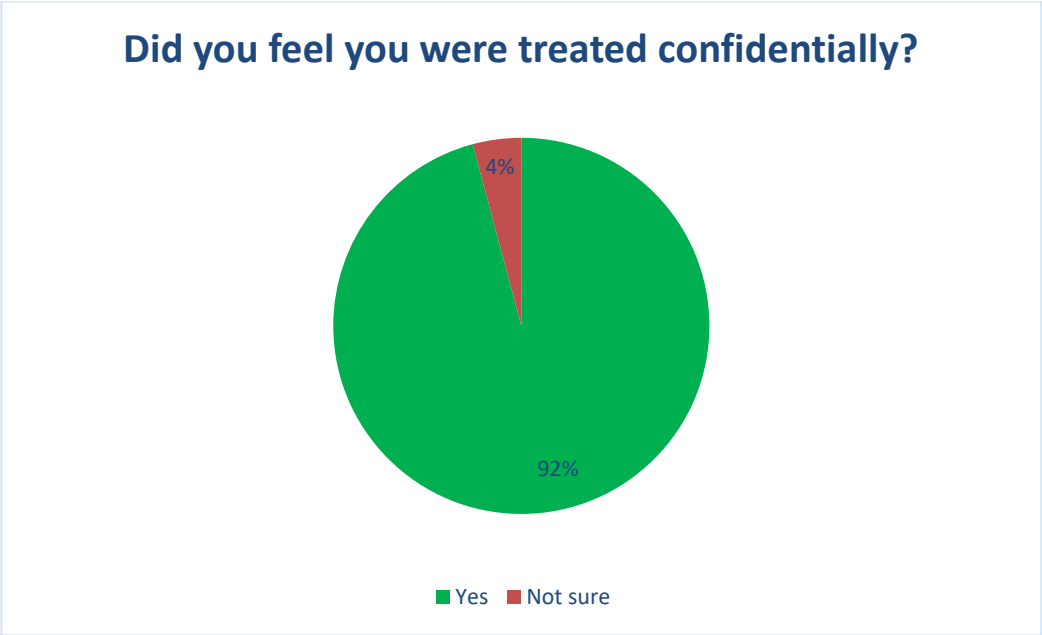



Figure 17

1 x did not answer

1x not sure said “I need my information to be shared to get the issue fixed”

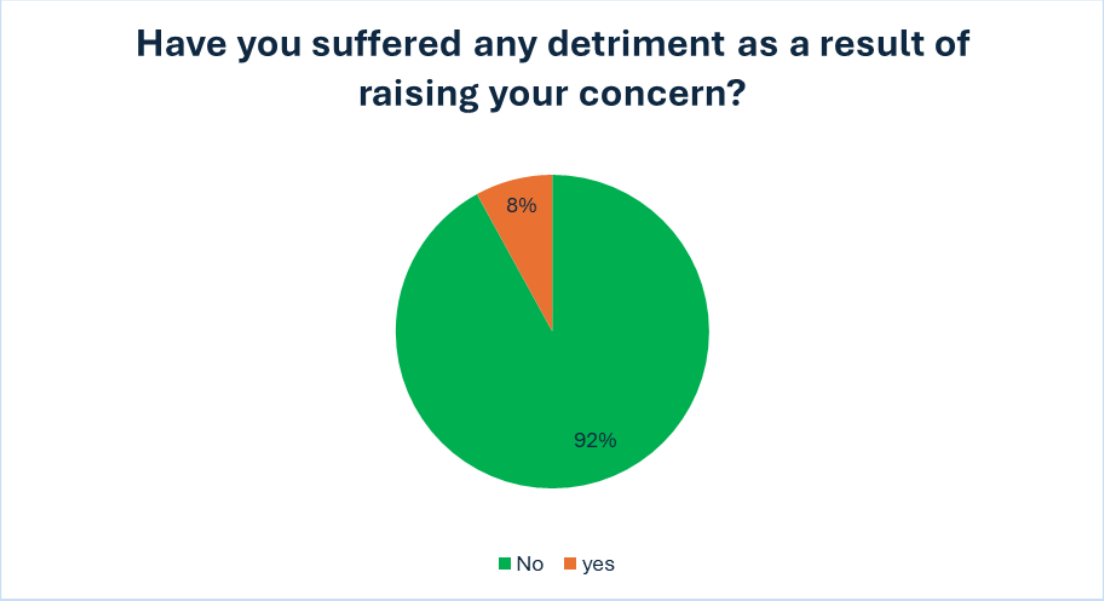



Figure 18

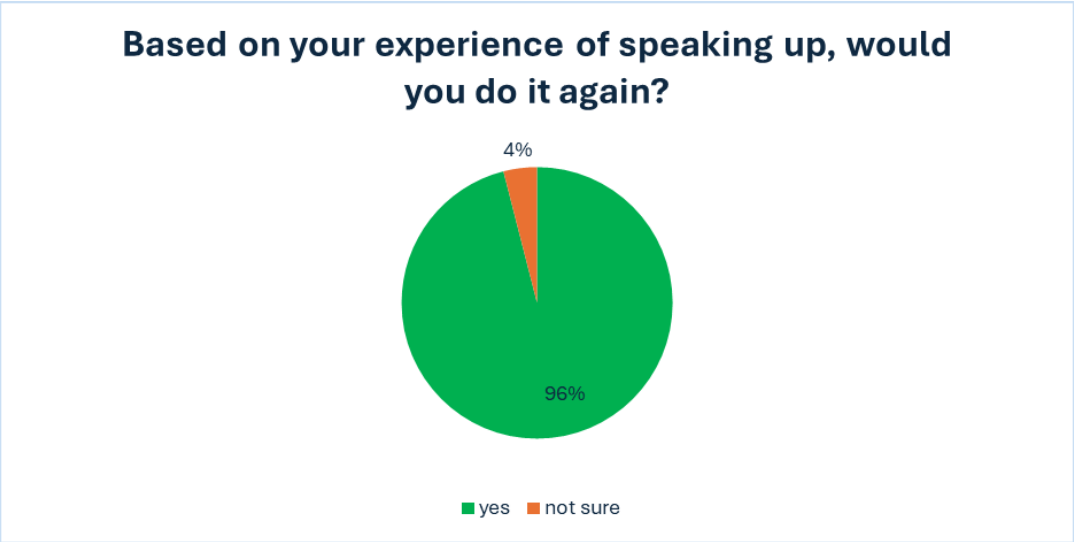



Figure 19

Some of the free text comments from survey

- I felt listened to and my concerns were taken seriously
- Once again, I am grateful for the amazing support and encouragement that has positively impacted my traumatised physical and mental health. Thank you Tracey.
- I thought that Louise was amazing. She reassured me and kept me up to date. I do think that there could have been more from the other persons Hr or whoever it was who was involved.
- Tracey was lovely every step of the journey
- Tracey was very knowledgeable and extremely helpful when it came to any concerns I had raised. She pointed me in the right direction and followed up throughout the process. I want to thank Tracey and her team for a very pleasant and professional experience.
- Very helpful, thank you
- She is a credit to the service and the trust
- Louise in FTSU did help was listening and always did a follow up on me
- Always helpful and supportive
- I met Tracey and she was extremely attentive, helpful and compassionate regarding my situation.
- Tracey was quick to deal with my case; she explained every element of my situation in great detail to resolve my issue. She was always quick to respond to my emails, and she never left me hanging.

- I felt Tracey to be warm hearted and easy to share my problems with and the positivity card I picked out at the end of our face-to-face session was a fantastic touch.
- Tracey is a credit to your team at Royal Bolton Hospital.
- I did initially have concerns re confidentiality but was given reassurance regularly.
- Tracey was absolutely amazing. I was so scared to initially approach the team, but she was nothing but helpful. I would happily go to her again if I had to in the future.
- Tracey was easy to talk to and helped me feel relaxed and less worried. She explained the process clearly and kept me updated throughout.
- I feel without the FSTU team my story/ concerns would not have been raised and heard at the level it has been.

**2.4** The Guardians are always keen to hear from leaders regarding any learning or changes that take place as a result of workers speaking up as there is a national and local requirement to report both the learning that takes place as well as the themes.

The Guardians explain to workers that the FTSU Guardian is not the fixer of the concern but acts as a conduit for a resolution elsewhere. Realistic options and possible outcomes for those options are discussed with the individual(s). During the meetings where concerns are raised, the welfare of the worker(s) is of paramount importance to the Guardians, and the individual will be supported throughout any formal processes. Occupational health support or Vivup support are regularly signposted to, as are on-going follow-up discussions and support should they be required.

**2.5** The themes are nationally set by the National Guardian Office and are reported both locally and nationally although the Guardians have broken Inappropriate behavior down into management behavior and peer behavior (see figures 20-24)

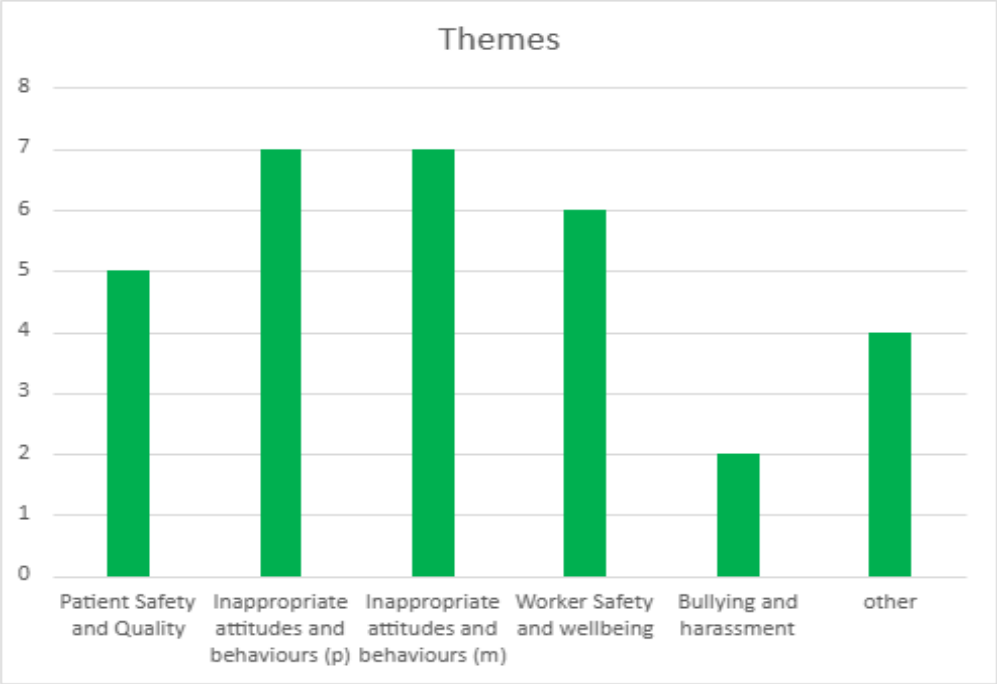



Figure 20: Themes in Q1 2025/26




Figure 21: Themes in Q2 2025/26

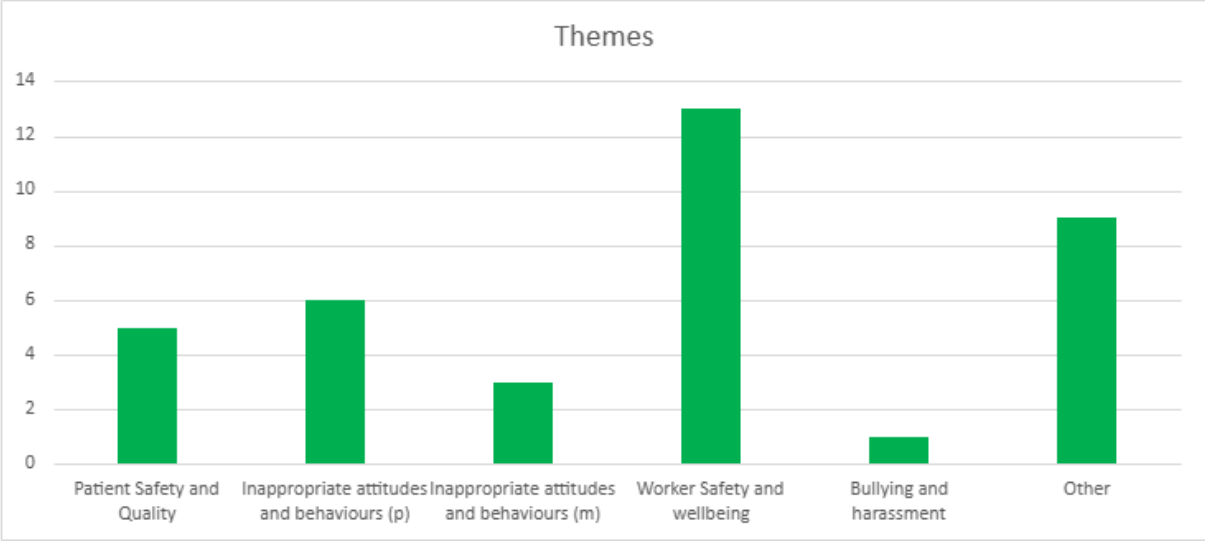



Figure 22: Themes in Q3 2025/26

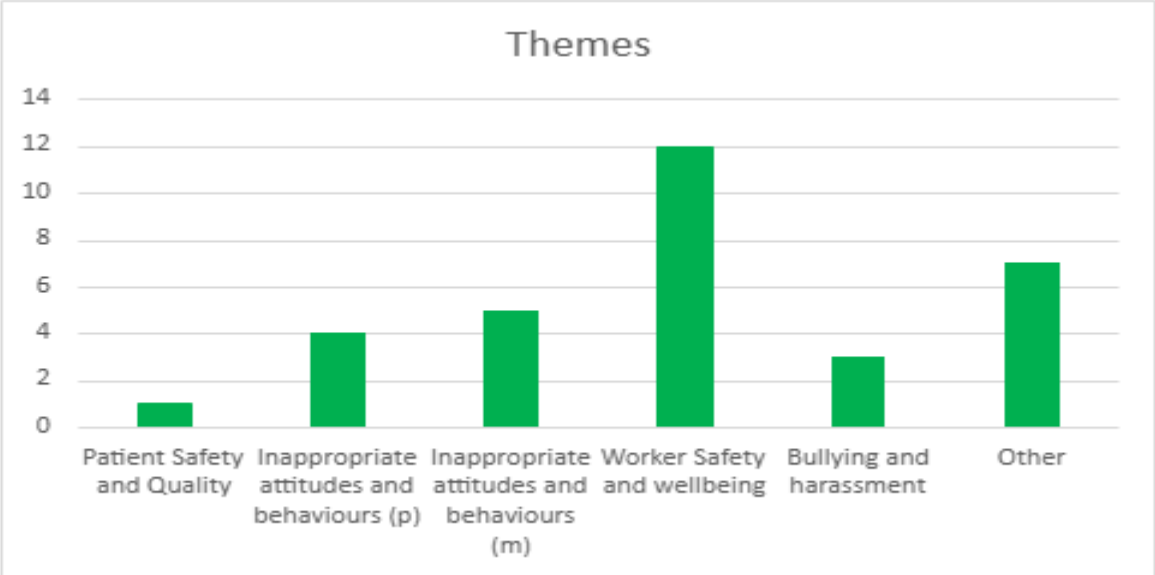



Figure 23: Themes in Q4 2025/26

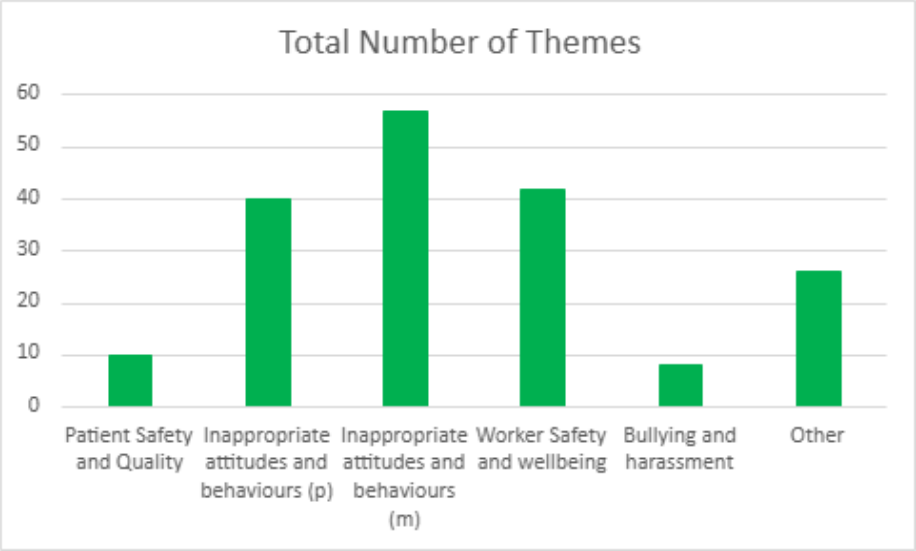



Figure 24 Total number of Themes 2025/26

**2.6** Dominant themes in 2025/26 were inappropriate attitudes and behaviours and worker safety and wellbeing relating to organisational change and communication.

There was a reduction in concerns relating to line managers early in the year although this increased towards the end of the year

Worker safety and wellbeing emerged as the top themes in Q3 and Q4 for the first time. This was mainly linked to:

- Culture and a lack of psychological safety
- HR processes and organisational change
- Communication and engagement

Themes align with national FTSU intelligence and are triangulated locally through regular meetings with HR, EDI, and People Committees.

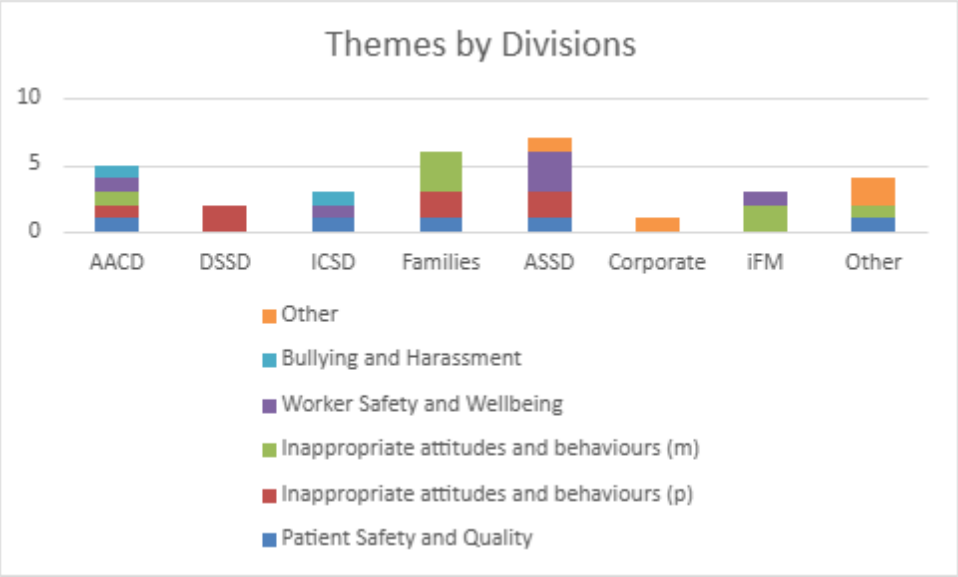



Figure 25: Themes by Division in Q1

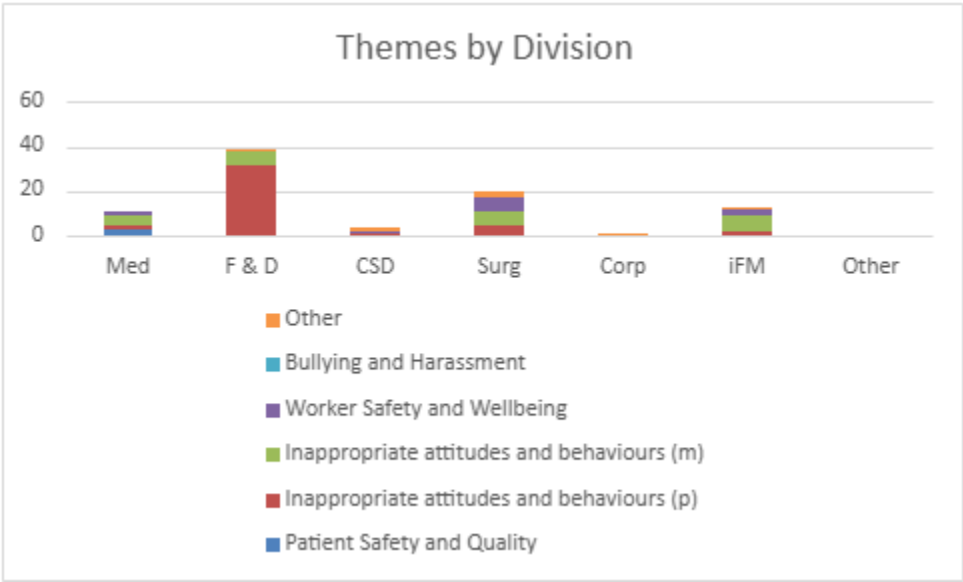



Figure 26: Themes by Division in Q2

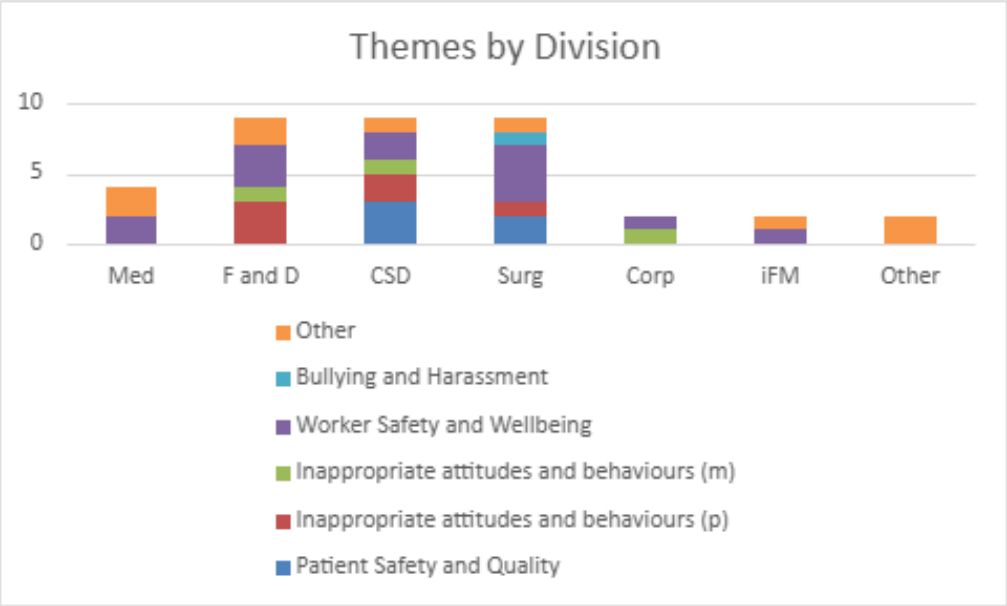



Figure 27: Themes by Division in Q3

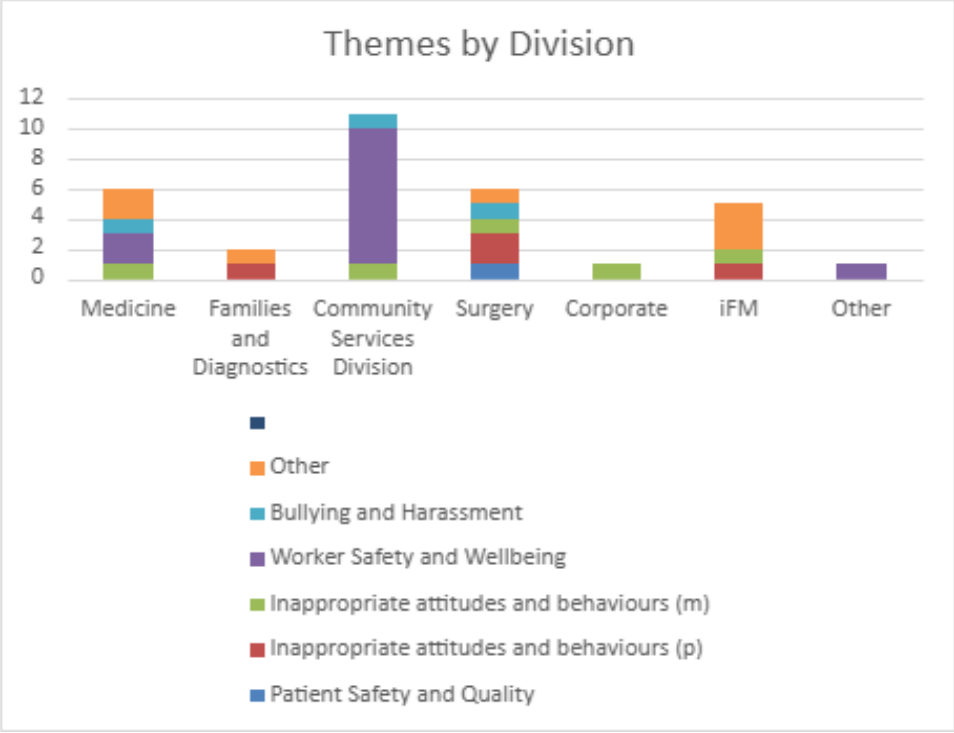



Figure 28: Themes by Division in Q4

**2.7** The graphs below (Figures 29-33) show a breakdown of concerns raised by the staffing group. Registered Nurses/Midwives were the largest group of staff who use the FTSU route to speak up. This is not surprising as they are the largest staff group and a staff group that the Guardians do face-to-face training during induction and preceptorship. The second largest group was the admin and clerical staff. These teams have been facing a lot of uncertainty with job roles during 2025/26 with the reduction in Clinical Divisions resulting in consultation and reorganisation as well as the reduction in headcount due to financial issues. In 2025/2026, 20 concerns were recorded anonymously. 3 of these were via the QR code and 17 were from an area where the Guardians were supporting a listening event and although the Guardians knew the area the individuals worked, they were unaware of the individual roles of the staff from the area. 3 other concerns used the QR code and although they wanted to remain anonymous, the individuals were happy to share their role. Listening events were held in 2 other areas, and 21 staff were seen from these areas. Although the Guardians maintained anonymity of the staff members, their roles were known.

Guardians promote speaking up in the 3 ways- Openly, Confidentially or Anonymously – whichever they feel is right for the individual worker. Speaking up can be difficult and workers may be worried about facing detriment so often choose confidentially or in some cases anonymously. The Guardians have introduced a QR code to support workers to speak up if they feel this is the only way they feel confident to raise their concern. However, the Guardians are aware that this has its limitations as you are unable to thank the individual for speaking up, unable to obtain all the relevant information or unable to provide feedback. The Guardians have been exploring systems that allow workers to speak up but that allow dialogue with the individual with an aim to build up a dialogue of trust in the hope that the individual will meet with the Guardian- but failing this will enable the Guardian to work with the individual to help to resolve their concern.

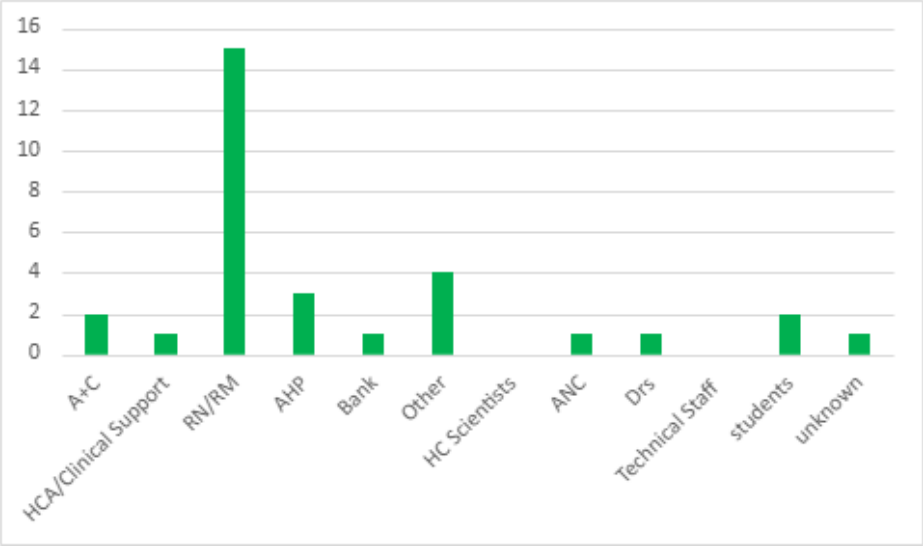



Figure 29: Job roles of staff speaking up in Q1

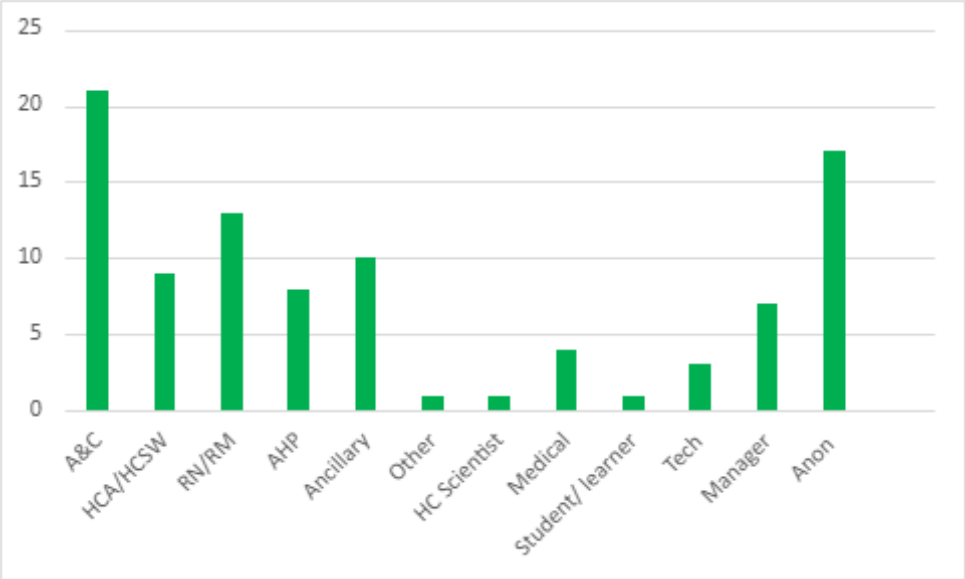



Figure 30: Job roles of staff speaking up in Q2

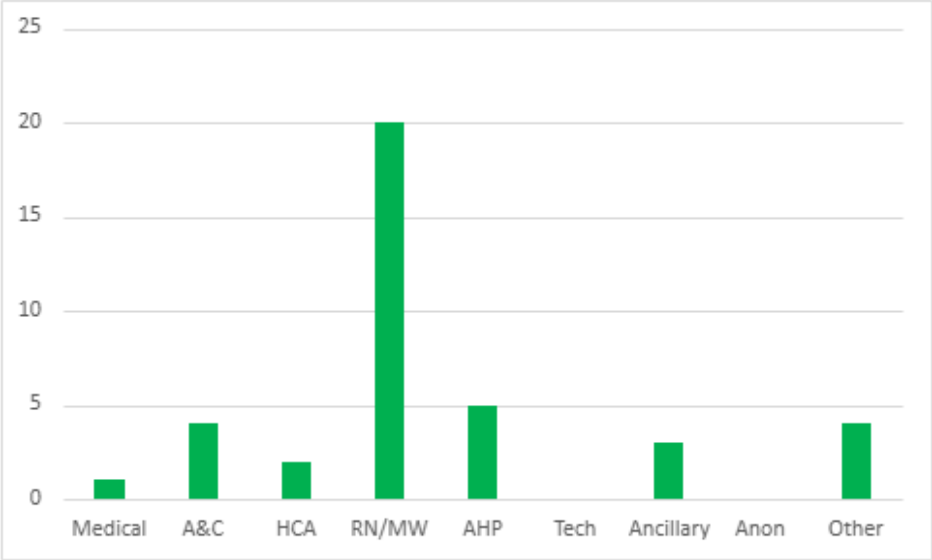



Figure 31: Job roles of staff speaking up in Q3

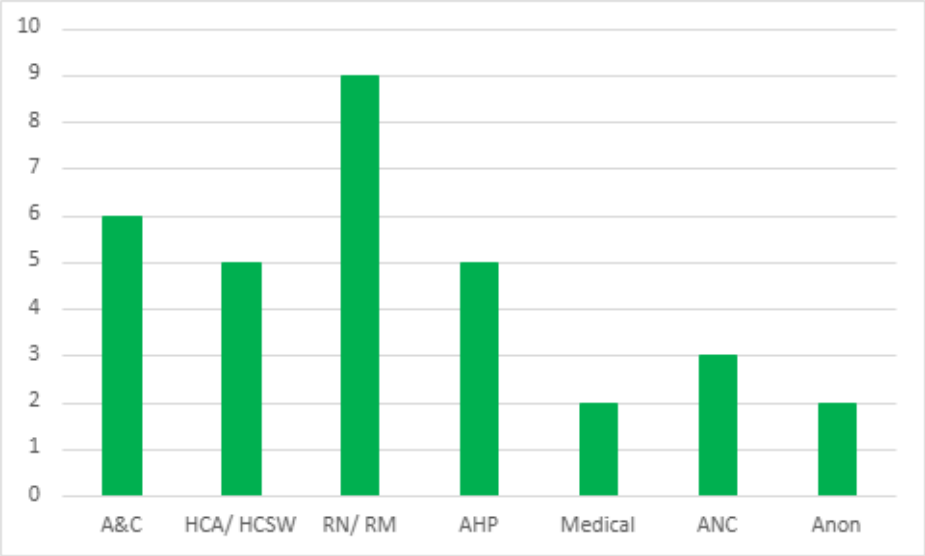



Figure 32: Job roles of staff speaking up in Q4

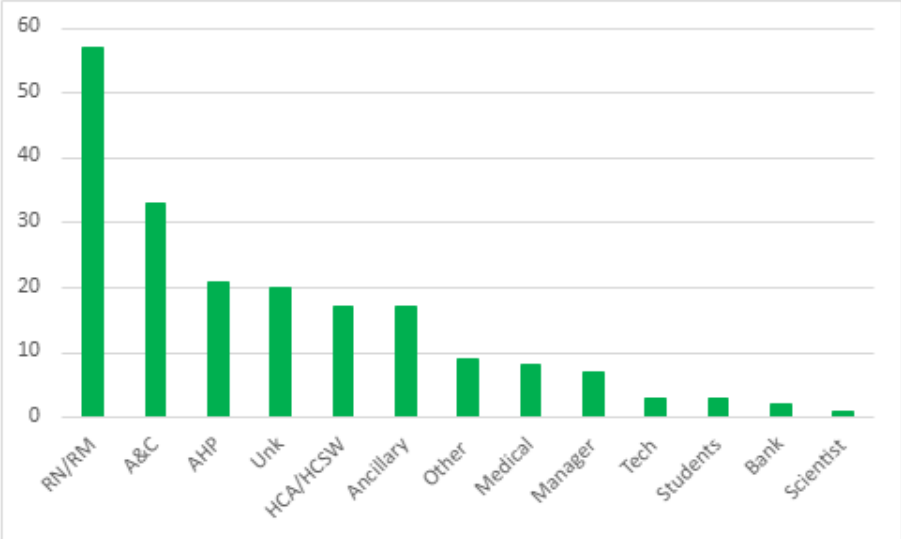



Figure 33: Job roles of staff speaking up in 2025-26

**2.9** In 2025/26 between 18-22% of workers from a Black, Asian and Minority Ethnic background used the FTSU route to raise their concern.

Staff from Black, Asian and Minority Ethnic backgrounds accounted for:

19% of Q1 cases

21% of Q2 cases

18% of Q3 cases

22% of Q4 cases

Guardians remain alert to:

- Bullying and harassment affecting BAME staff
- Barriers to speaking up for overseas trained workers
- Increased vulnerability linked to global events, antisemitism and islamophobia

The Guardians are planning some targeted listening events planned for BAME staff in conjunction with HR and senior nursing colleagues. The Guardians have also increased the diversity within the FTSU Champion Network to support colleagues and are working closely with the EDI Team to share intelligence.

**2.10** The Trust's Freedom to Speak Up arrangements remain effective, accessible and trusted. The Board can take assurance that concerns are handled appropriately, and learning is increasingly shared and embedded.

Speaking up takes great courage, and it is important that the Guardian and Champions respond to individuals in a timely manner. Whilst it is not an NGO metric, the Guardians aim, even outside of normal office hours or days of work, to ensure that all workers receive an initial acknowledgement of their concern within 48 hours.

Across all quarters nearly all staff received acknowledgement of raising a concern within 48 hours and 76% received contact within one hour.

A small number of concerns can be dealt with quite quickly such as signposting or providing information or coaching. However, with most concerns, it is necessary to meet with the worker either face to face or remotely to understand their issue and to ensure they receive the required support. These meetings usually take place within the same week, and some take place on the same day if there is a Guardian on site and available. The Guardians receive feedback that workers value this timely response as it clearly demonstrates that their concerns are important to the Guardians and the organisation.

Clear escalation and divisional oversight routes are in place via monthly meetings with senior Divisional Leaders and sharing quarterly reports at Divisional People Committees.

Confidentiality and consent are strictly maintained at all times

**2.11** Throughout the year the Guardians have:

- Delivered induction sessions, focused training and awareness events
- Conducted Non Executive Director walkabouts

- Supported targeted listening events where traditional routes had failed
- Produced videos and resources to demystify speaking up
- Hosted the annual FTSU Champion Conference
- Maintained strong regional and national leadership presence

**2.12** One of the main reasons that we encourage workers to speak up is that as an organisation, we can learn and do things better, both for our patients and our workers. Every speak up case will provide an opportunity to learn and improve. Guardians encourage leaders and managers to share their learning so that we are able to feedback to workers that they have made an impact by speaking up. Some of the learning that has been shared from cases in 2025/26 include:

- Improving communication/ relationships/ culture between staff and team lead's/managers
- Improved support and timely communication for staff going through consultation/ HR processes/ organisational change.
- Improved experiences for staff that change working area/ move during shift-local inductions
- Assurance for capabilities and clear communication for documentation linked to consent and rationale, knowledge and skills and perineal protection
- Learning from patient care case of bariatric stroke patient
- Use of reasonable adjustment passport to help staff return to work
- Improve awareness for leaders on neurodiversity and EDI
- Involving EDI expertise in dealing with difficult cases where protective characteristics are present
- Working with the team to improve the booking process when arranging temporary staffing shifts which are fair and equitable
- Improvements and fairness in recruitment processes

**3.0 Enhancing our Approach**

**3.1** In April, the Board engaged with a development session delivered by Beth Carter; National Lead Guardian for Support and Policy. It was an opportunity for members of the Board with the FTSU Guardians to reflect on speaking up within the organisation and how the Board can influence this in their roles as leaders, creating psychological safety and making speaking up business as usual. The Guardians are grateful for the continued support of the Board and their

committed investment in creating an organisation where staff know that they can speak up and they will be listened to.

**3.2** Following the Dash review of patient safety across health and social care, we received the news in 2025 that the National Guardians Office will be abolished at the end of June 2026 as part of the 10 Year Health Plan for England. The Government plans to align the functions of the National Guardian's Office with the other staff voice functions in NHS England and NHS England will take on the National Guardian's national functions. NHS England will transfer, in due course, to the Department of Health and Social Care. Employers will be required to take on greater responsibility and accountability for embedding effective FTSU arrangements.

NHS England will:

- Support existing guardian networks and individual Guardians, including managing general enquiries through the national contact centre and escalating specialist queries to the NHS England Freedom to Speak Up team
- Provide and maintain the platform for free online Guardian foundation training
- Collect Freedom to Speak Up data nationally and use both qualitative and quantitative insights to strengthen system learning. Insight will be shared routinely with Guardian networks
- Review national Freedom to Speak Up policy and guidance across all sectors, starting with primary care organisations

NHS healthcare providers and commissioners will:

- Have sole responsibility for ensuring that information about how to contact their Freedom to Speak Up Guardian is kept accurate, made publicly available and is accessible
- Routinely submit their Freedom to Speak Up data through NHS England's national data collection system (for 2026/27, this will be trusts and ICBs only)
- Ensure that any Guardian they appoint completes the mandatory guardian foundation training before starting their role and support their continuing professional development
- Ensure appropriate psychological support is available for their Guardians once the nationally sourced independent Employee Assistance Programme ends on 31 December 2026

While the future remains uncertain, the Guardians remain fully committed to supporting staff, promoting a culture of speaking up and breaking down barriers to ensure every voice is heard and valued. The Guardians are dedicated to continuing to foster an open and inclusive working environment and continue to play a vital part in organisational culture regardless of national level developments.

**3.3** October is traditionally National Speak Up Month. However, in 2025 the NGO, following national feedback, reduced this to a week due to the high number of other national campaigns in October. The theme in 2025 was Follow Up in Action which aimed to recognise the importance of learning and following up on information provided by workers. The FTSU Champions held events and displays in their workplace to promote speaking up, listening and following up with action. The Guardians also did a series of walkabouts and a stall on the main corridor to promote FTSU.

Key messages for Speak Up Week 2025 were**:**

**I'm Following Up:** How we must all take personal responsibility, by acting on what we've heard. Building on the psychologically safe culture we are creating means workers can see their voices translated into meaningful change. When we follow up with action, we prove that speaking up leads to real improvements without fear that concerns will be ignored.

**Follow Up:** Managers can turn listening into lasting change. There is power when managers act on concerns raised to drive continuous improvement. Last year we listened up – now is the time to follow up and act. Following up on what we hear creates the improvements workers need and deserve.

**Follow up with workers who don't speak up:** Be aware of seldom heard from workers, those who face barriers to speaking up. Follow up actively with groups of workers who face barriers to speaking up. Show them that when they raise concerns, you will take action.

**3.4** The Guardians attended the North-West Regional Conference in November 2025, which was co-organised by the Chair of the NW Regional Network and Bolton Guardian, Tracey Garde. This conference included a talk by Michelle Cox, a black senior nurse who recently won a landmark case for racial discrimination by colleagues at NHSE. The day also provided good face-to-face peer networking opportunities for Guardians from across the region.

**3.5** In Q3 FTSU Guardian Louise Cartin commenced her Professional Coaching Apprenticeship which will support her in the role by using a coaching approach when meeting with workers. Louise can also apply this to any wider culture work that may need support across the organisation.

**3.6** The Guardians have been looking to identify an improved IT system for collecting and collating data going forward. Guardians, as well as other professionals including HR colleagues, collect a great deal of information which needs to be stored confidentially whilst being able to run reports at divisional, trust and at a national level. The Guardians are also looking at how they could potentially improve access for people who want to speak up but wish to maintain their anonymity whilst also providing an avenue for direct communication.

The Guardians are exploring a two-way anonymous reporting channel which allows workers to share their thoughts and ideas without fear of retaliation or embarrassment. This type of communication channel could benefit us as an organisation by:

- Encouraging Candour: When workers can communicate anonymously, they are more likely to be candid and transparent about their thoughts and ideas. This can lead to more constructive feedback and better decision-making.
- Increases trust: A two-way anonymous communication channel can help build trust between workers and management as it shows that the organisation is committed to listening to feedback and addressing concerns.
- Fosters innovation: An anonymous communication channel can help generate new ideas and spur innovation, as workers feel more comfortable sharing their creative thoughts and suggestions.
- Gives the opportunity to hear otherwise silent voices: “The silence of missing voices costs careers, relationships and lives”
- Allows constructive criticism: When workers can provide anonymous feedback, they may be more likely to offer constructive criticism that can help improve processes and procedures within the organisation (misuse can be moderated).

**3.7** In 2025 the NGO published a report looking at the experience of overseas trained workers,

Summary of the findings include:

- Transitioning challenges- Overseas-trained workers faced significant hurdles in adapting to life and work in England. These included complex visa and immigration processes, cultural shock, language barriers, and a lack of recognition for their qualifications and prior experience.
- Systemic racism, limited training and integration support and practical issues such as housing and the cost of living added to these challenges. The responsibility for adapting, including its implications for speaking up, was often on overseas-trained workers. A lack of cultural intelligence was a repeated theme, highlighting the need for greater understanding and outreach by employers.
- Perceptions of speaking up- The perceptions of overseas-trained workers towards speaking up were often influenced by the cultural and societal norms of the places where they were raised and trained. Many shared how their experience of England’s speaking up culture and arrangements was significantly different from their home contexts.
- Cultural complexity. The overseas-trained workforce is diverse, encompassing people from cultures with varying norms around hierarchy and authority. For some, deference

and agreeability made speaking up feel uncomfortable, while others found the UK's speaking up culture restrictive.

Most overseas-trained workers are from ethnic minority backgrounds and experience systemic racism in similar ways to their ethnic minority UK-trained counterparts.

- Enablers and barriers to speaking up behaviours. Speaking up was hindered by fears of retaliation, including potential dismissal and jeopardising career progression, exacerbated by the link between visas and employment. Adaptation struggles, including communication difficulties, further impacted confidence in speaking up. While many overseas-trained workers share some of these barriers with their UK-trained colleagues, their unique circumstances intensified these challenges.
- Speaking up arrangements and support -Overseas-trained workers felt they lacked a meaningful voice within England's healthcare system. This was compounded by their under-representation in senior NHS roles, which reinforced feelings of invisibility and disempowerment. While almost three in four workers (72 per cent) were aware of the Freedom to Speak Up Guardian role, many did not understand its purpose, with some believing the role was for investigating concerns. Others saw it as primarily for nurses, and some, especially doctors, felt it lacked inclusivity. Many workers felt guardians might not fully understand their concerns, particularly those unique to overseas-trained workers. A lack of representation of overseas trained workers among Freedom to Speak Up Guardians and Champions further hindered confidence in seeking support.
- Importance of routes for anonymous speaking up- Concerns about repercussions and cultural norms highlighted the importance of providing routes for anonymous speaking up. Workers felt anonymity was often undervalued, with cases sometimes not treated as seriously. Some concerns were also raised about their perceptions of the independence of the guardian role.

In conclusion, the researchers did identify good practice examples of initiatives supporting overseas-trained workers, particularly in the North-East and Yorkshire and the Southwest. Encouragingly, they saw increasing recognition at local and national levels of the challenges faced by overseas-trained workers. However, these efforts often lacked consistent replication across the system, were reliant on limited funding sources, and were sometimes abandoned when resources were withdrawn. This inconsistency has hindered the development of sustainable, widespread change.

**3.8** The 2025 NHS Staff Survey indicates a national reduction in staff confidence that concerns raised will be addressed, reinforcing the ongoing importance of openness, transparency and visible learning from speaking up. Staff feedback highlights the need to clearly demonstrate how concerns lead to meaningful change to build trust and confidence in the speaking up processes. The survey also shows that staff are experiencing increasing levels of burn out and

work-related stress, which can contribute to incivility and breakdowns in working relationships. This is reflected in the Trust's FTSU data, where worker safety and wellbeing have been the most significant theme over the last two quarters. If not addressed, these issues present risks to patient safety, workforce risks such as disengagement and increased turnover, and a cultural risk where silence becomes normalised under pressure rather than constructive challenge and learning.

Learning from external assurance further reinforces these risks. A recent NHS England review of FTSU arrangements at another organisation found that staff feared raising concerns about attitudes, behaviours and sexual safety, particularly in relation to senior managers and senior medical staff. This was attributed to perceptions that concerns were not fully investigated, a lack of transparency, inconsistent application of policy, and staff not being kept informed of developments. As a result, staff reported low confidence that the organisation would act on their feedback, which was reflected in their staff survey results. This evidence emphasises that closing the feedback loop is central to maintaining an effective speaking up culture, and that Board assurance should include how staff are kept informed, how outcomes are communicated, and how learning is embedded and shared.

National analysis of acute trust and acute community data collated by a Guardian in the Northwest further supports the strategic importance of FTSU (see figures 34 and 35 below). Higher speaking up scores are strongly associated with more inclusive and respectful workplace cultures, greater staff willingness to recommend organisations as a place to work, increased confidence in standards and safety of care, and lower proportions of staff frequently thinking about leaving. Collectively, this provides assurance that effective FTSU arrangements are a critical enabler of positive culture, staff engagement, quality of care, and workforce retention. FTSU Guardians view concerns raised as a gift and will continue to support work that promotes openness, kindness and psychological safety, with a particular focus on strengthening feedback loops and visibly demonstrating how staff voices lead to positive change.

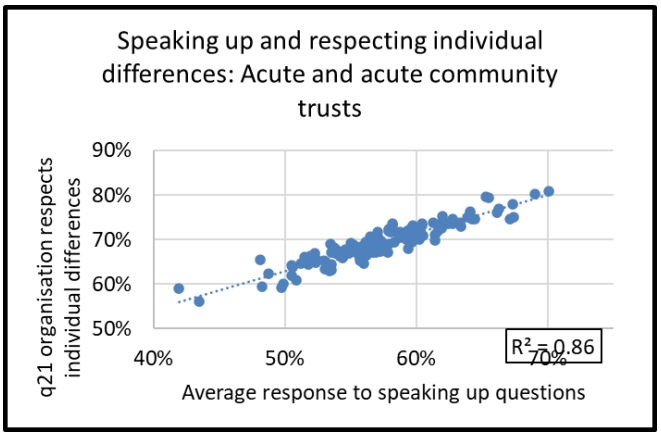



Figure 34: Correlation between Speaking Up and respecting individual differences

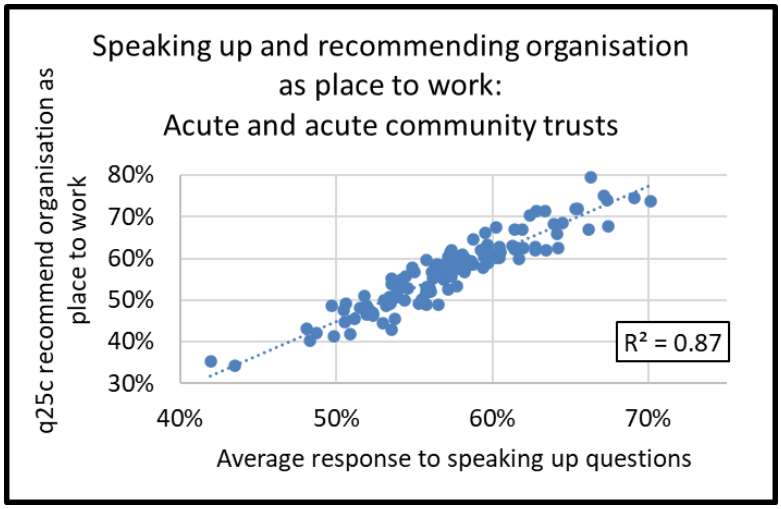



Figure 35: Correlation of Speaking up and recommending an organisation as a place to work

As an organisation, we need to recognise that our workers want to see demonstratable actions and outcomes when concerns are raised whether that via FTSU or any other route. The Guardians are working with colleagues in Organisational Development and Communications to look at ways to demonstrate as an organisation we are all listening and that everyone has a voice that counts and that their concerns will be listened to and appropriate actions and learning will take place as required.

**4.0 Conclusions and assurance**

**4.1** The Organisation continues to develop a strong commitment to speaking up, listening and following up despite the worsening NHS Staff Survey results. The Freedom to Speak Up service remains an essential cultural and safety mechanism, particularly during periods of organisational change. The Guardians have seen a number of teams across 2025/26 reporting issues relating to their team culture. More staff have been willing to speak up about issues they are having at work which is impacting their health and well-being and attendance which in turn impacts patient care and the financial recovery process. A number of anonymous 1:1 listening events held by the Guardians have supported teams to speak up about the culture in their team and helped to shape improvements.

The Guardians welcome the ongoing Our Leaders development programme and the introduction of the Our Way Team Tool which is an anonymous and free survey completed by all members within a team, providing insights into the team culture and dynamics. Results are then collated by the Organisational Development team and shared with the named team leader. Guardians have heard first-hand how the tool has helped teams in developing an improved psychologically safe space where they have started to see an improved culture.

**4.2** The Board is asked to:

Receive assurance on the effectiveness of FTSU arrangements

Note key themes, risks and learning

Continue to visibly support a culture of openness and psychological safety

Appendix 1

**Current FTSU Champions Network April 2026**

| | | |
|---|---|---|
| 1. Kirsty Buckley | Haematology Specialist Nurse | Medicine |
| 2. Dr Natalie Walker | Acute Physician | Medicine |
| 3. Shauna Barnes | Practice Development Lead Nurse | Medicine |
| 4. Alistair Soutar | Senior Charge Nurse A&E | Medicine |
| 5. Angela Hughes | Bed Management | Medicine |
| 6. Sonia Edwards | HCA B3 Ward | Medicine |
| 7. Jess Shields | Ward Manager C2 Ward | Medicine |
| 8. Dr Haider Abbas | Doctor in Training | Medicine |
| 9. Emma Lewin | ACP A&E (Mat Leave) | Medicine |
| 10. Kyle Turner | Registered Nurse | Medicine |
| 11. Adewunmi Obidele | SNA | Medicine |
| 12. Julie Pilkington | Assistant Divisional Nurse Director | Surgery |
| 13. Ruth Tyrer | Anaesthetics/Ops Support Manager | Surgery |
| 14. Dr Emma Wheatley | Consultant Anaesthetics/ Critical Care | Surgery |
| 15. Corinne Houghton | Health Care Assistant Recovery | Surgery |
| 16. Lisa Haughton | Health Care Assistant Critical Care | Surgery |
| 17. Dr Jenny Ruddlesdin | Consultant Orthopaedics/ Elderly Med | Surgery |
| 18. Vicky Jolley | RN Breast Unit | Surgery |
| 19. Georgina Withington | Registered Nurse Ophthalmology | Surgery |
| 20. Laly Joseph | RN Critical Care | Surgery |
| 21. Declan Haydock | RN Critical Care | Surgery |
| 22. Karen Roberts | RN Critical Care | Surgery |
| 23. Lauren Mayoh | Sister Critical Care | Surgery |
| 24. Cath Smith | Ward Clerk F6 | Surgery |
| 25. Zoe Geddes | Matron Critical Care | Surgery |
| 26. Kay Marshall | Acute Oncology Care Co-ordinator | Surgery |
| 27. Helene Jackson | Registered Nurse | Surgery |
| 28. Jody Peterson | Practice Educator | Surgery |
| 29. Sumera Motala | HCA | Surgery |
| 30. Oluchukwu Onaga | Registered Nurse | Surgery |
| 31. Zeb Boodhan | Personal Assistant | Surgery |
| 32. Simon Vanderlinden | ODP | Surgery |
| 33. Jenny Allen | Registered Nurse | Surgery |
| 34. Dawn Kelly | HCA Ophthalmology | Surgery |
| 35. Pam Walker | ODP | Surgery |

| | | |
|---|---|---|
| 36. Rahila Ahmed | Equality, Diversity & Inclusion Lead | Corporate |
| 37. Neville Markham | Chaplain | Corporate |
| 38. Sharon Lythgoe | EPR Project Manager | Corporate |
| 39. Nicola Caffrey | Corporate Business Manager for Medical Director | Corporate |
| 40. Robin Davis | TNA | Corporate |
| 41. Cherechi Ochemba | IT IGO | Corporate |
| 42. Nannette Gallagher-Ball | Senior Nurse Educator | Corporate |
| 43. Dawn Grundy | People Promise Manager | Corporate |
| 44. Toni Anderton | Senior Practitioner ECIST | Corporate |
| 45. Sylwia Desantis | Senior Management Accountant | Corporate |
| 46. Jonathan Benn | Clinical Information Assurasce Lead | Corporate |
| 47. Jack Ramsay | Public Governor | Corporate |
| 48. Micha Roberts | TNA | Corporate |
| 49. Lyndsey Westby | Clinical Educator | Corporate |
| 50. Sarah Richards | Head of People Development | Corporate |
| 51. Catherine Spruce | People Development Lead | Corporate |
| 52. Louise Quigley | Health Records Reception Coordinator | Family & Diagnostic |
| 53. Suzanne Lomax | Clinical Service Lead –Bereavement Services | Family & Diagnostic |
| 54. Dr Katy Edwards | Consultant Microbiologist | Family & Diagnostic |
| 55. Caroline Burke | Senior Clinical Pharmacist, | Family & Diagnostic |
| 56. Jodie Hughes | Administrator/ Personal Assistant Pharmacy | Family & Diagnostic |
| 57. Louise Smith | Admin Lab Services | Family & Diagnostic |
| 58. Jeanette Fielding | Midwife | Family & Diagnostic |
| 59. Vicky O'Dowd | Midwife | Family & Diagnostic |
| 60. Dr.Bim Williams | Obstetrics & Gynaecology Consultant | Family& Diagnostic |
| 61. Karen Keighley | ASST DND | Family& Diagnostic |
| 62. Anne-Marie Price | Medical Secretary | Family& Diagnostic |
| 63. Sharon Foster | Neonatal Nurse | Family & Diagnostic |
| 64. Hayley Fletcher | Transitional Care Lead | Family & Diagnostic |
| 65. Kayleigh Mills | Sonographer | Family & Diagnostic |
| 66. Katie Ryan | Radiology | Family & Diagnostic |
| 67. Elaine Holt | Housekeeper | Family & Diagnostic |
| 68. Waheeda Abbas | Specialist Cultural Liaison Midwife | Family & Diagnostic |
| 69. Jenni Makin | Specialist Physiotherapist Community Learning Disabilities Team | Community |
| 70. Firyal Atcha | SALT Paeds | Community |
| 71. Sam Carney | Divisional Director of Ops | Community |

| | | |
|---|---|---|
| 72. Michael Riordan | MSK Physio | Community |
| 73. Alison Brennan | DNs Evening/Night Service | Community |
| 74. Eleanor Speak | OT | Community |
| 75. Gareth Valentine | Registered Nurse | Community |
| 76. James Foster | Physiotherapist | Community |
| 77. Rachel Taylor | Matron | Community |
| 78. Lisa Brownlow | Divisional Governance Support Manager | Community |
| 79. Rachel Hemingway | Head of Therapies | Community |
| 80. Jennifer Harrison | Paediatric Practice Educator | Community |
| 81. Jennifer Semenuik | Junior Sister Laburnum Lodge | Community |
| 82. Keeley Barlow | Switchboard/ Uniforms Department | iFM |
| 83. Michelle Barber | Personal Secretary | iFM |
| 84. David Waite | Materials Management Assistant | iFM |
| 85. Lorraine Makinson | Recruitment/ Training Officer | iFM |
| 86. Kirstie Barlow Hart | Domestic Supervisor | iFM |
| 87. Charlotte Green | Catering Assistant | iFM |
| 88. William Robinson | Porter | iFM |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Leadership Development Programme Update | | | |
| **Meeting:** | Board of Directors | **Action Required** | Assurance | ✓ |
| **Date:** | 30 July 2026 | | Discussion | ✓ |
| **Executive Sponsor** | Chief People Officer/Deputy Chief Executive | | Decision | |

| | |
|---|---|
| **Purpose of the report** | To update on the Trust's Our Leaders leadership development and culture improvement programme |

| | |
|---|---|
| **Previously considered by:** | People Committee in July 2026. |

| | |
|---|---|
| **Executive Summary** | Our Leaders launched in January 2025 in response to staff feedback and people and culture intelligence, which highlighted the need to strengthen leadership and management capability across the Trust. Aligned to Our Way, the programme provides a clear framework for leadership expectations and supports the Trust's leadership development and culture ambitions.<br><br>By June 2026, 967 colleagues had attended the two-day event, with the 1000th attendee anticipated in August 2026. Of these, 479 leaders and managers are from the target audience of 1,335 Band 7+ leaders and managers, representing 36%; increasing attendance across this group remains an urgent priority.<br><br>Key successes include exceeding EDI participation targets, strong engagement from aspiring, frontline and mid-level leaders, and increased attendance among Band 8b+ leaders. Senior leader development for the Trust's top 100 leaders is also aligned to Our Leaders and runs alongside the main programme.<br><br>Bolton's participation in the national socialisation pilot for the NHS Leadership and Management Framework has provided assurance of strong alignment with national requirements. At the midpoint of this three-year programme, there are encouraging signs of progress in leadership capability, team development and cultural consistency. Ongoing focus is required on impact, attendance and |

| | |
|---|---|
| | alternative accredited development routes following Apprenticeship Levy changes. |

| | |
|---|---|
| **Proposed Resolution** | The Board of Directors are asked to ***receive*** the Leadership Development Programme Update |

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

| **Summary of key elements / Implications** | | |
|---|---|---|
| **Implications** | **Yes / No** | **If Yes, State Impact/Implications and Mitigation** |
| **Finance Implications** | **No** | |
| **Legal/ Regulatory** | **No** | |
| **Impact on Health Inequalities** | **No** | |
| **Impact on Equality, Diversity and Inclusion** | **Yes** | EDI principles and actions run throughout the Our Leaders framework and programme |
| **Is a Quality Impact Assessment required** | **No** | |

| | | | |
|---|---|---|---|
| **Prepared by:** | Catherine Spruce<br>People Development Lead<br><br>Sarah Richards<br>Head of People Development | **Presented by:** | Lisa Rigby<br>Associate Director of OD |

## 1. Introduction

The Trust's People Committee received an update on the Our Leaders programme and wider senior leadership development offer, providing very positive feedback and recognising Our Leaders as a strong foundation for embedding the Trust's culture and supporting continuous improvement.

People Committee encouraged continued focus on evidencing impact through staff stories and programme legacy, alongside quantitative measures. Members also discussed opportunities to strengthen sustainability and reach through recruitment and induction of new leaders, alongside targeted divisional engagement of existing leaders, informed by team level staff survey results.

To improve participation amongst the target audience, People Committee supported the use of stretch targets through Divisional IPMs rather than a Trust wide mandatory approach, while agreeing that further work should be undertaken to increase engagement from medical leaders.

## 2. Background

The Our Leaders programme was launched in January 2025 in response to staff feedback and people and culture intelligence, which highlighted the need to strengthen leadership and management capability across the organisation.

Through the Our Leaders Framework, aligned to Our Way cultural standards and expectations, the programme establishes a clear and consistent definition of effective leadership at Bolton, ensuring all leaders and managers are equipped to demonstrate these expectations in practice (Appendix 1).

While primarily a leadership development programme, Our Leaders is also a culture improvement initiative, recognising the vital role leaders and managers play in shaping staff experience and fostering high-performing team cultures at local, Trust-wide and system levels.

## 3. Engagement with the Our Leaders Programme

The programme is structured around three stages, Discover, Learn and Embed, with a two-day learning event at the core, bringing together leaders and managers from different roles, teams, locations and levels to learn as a mixed leadership community. (Appendix 2)

The programme launched with a target to engage with 1,500 leaders and managers in 18 months, across an audience consisting of all colleagues in Band 7+ roles, medical leaders and consultants.

In recognition that leadership and management responsibilities extend beyond these levels, and to support a culture of leadership by all, the programme has been made available more widely.

As of June 2026, encouragingly 967 colleagues have attended the 2-day event and we eagerly anticipate our 1000th attendee in August 2026.

From the total attendance, 479 attendees are from the target audience equating to 36% of target numbers, which is now 1,335 leaders in comparison to the start of the programme (Appendix 3).

Achieving our trajectory target has been hindered by not maximising the spaces available at the fortnightly 2-day events, equating to 500 spaces lost due to lack of bookings, cancellations or people

not attending on the day, in addition to limited access to larger venues with no cost due to financial pressures.

## 4. Senior Leader Development

Running alongside delivery of the 2-day Our Leaders events, over the past year OD have facilitated over 20 development events with Divisional and Senior Leadership teams from across the Clinical Divisions, providing ongoing, additional leadership development for the top 100 leaders in the Trust.

Consistency in design and content across these events, has ensured alignment with the core leadership principles of Our Leaders, also introducing Insights Discovery as a new self and team development tool, complimentary to MBTI and other self-awareness tools (Appendix 4).

| **Programme Strengths** |
|---|
| • Nearly half of attendees (458) are aspiring, frontline and mid-level leaders/managers, putting us in a strong position towards the 'line management' NHS Staff Standards requirements<br>• We have exceeded EDI attendance targets across BAME, disabled and female leaders and managers<br>• Divisional senior leadership development is aligned to Our Leaders expectations and messages, with targeted interventions for Band 8b+ leaders resulting in an increased attendance of 16%<br>• Performance reporting has been embedded within people and culture governance, supported by more regular, self-serve reporting and Divisional HRBP follow-up<br>• Collective leadership and Quality Management System (QMS) principles are embedded throughout Our Leaders shaped by QI, EDI and Strategy, providing a strong foundation for further leadership development<br>• Strong co-ownership approach, with leaders and managers co-facilitating alongside the OD team<br>• Consistently positive learner feedback and evaluation outcomes, leading to positive impact stories<br>• Clearer leadership expectations through FABB appraisals and check-ins, supporting ongoing performance<br>• Through avoiding external venues, and development and delivery entirely through internal expertise, delivery costs have been reduced from £43,500 to £8000, resulting in a £8.50 per person cost for everyone who has attended so far (excluding the costs of off the job time) |
| **Areas Requiring Further Improvement** |

- Ensure attendance across the target audience is an urgent priority, with the intention to communicate this as Trust mandated for everyone identified in a Band7+ role
- Enhance engagement across medical leaders and operational leaders, through bespoke leadership development, with Our Leaders at the core
- Strengthen development content which increases people management capability, particularly in attendance management, flexible working and reasonable adjustments
- Work collaboratively to rollout a next stage of Our Leaders which increases capability in leading system change and transformation, quality and model for improvement as part of a QMS approach
- Expand development opportunities, including reverse mentoring and access to external development
- Continue to embed and measure impact of learning on culture and staff experience at organisational and local levels, tracking progress of individuals and their teams
- Embed Our Leaders within recruitment, talent management and career development processes
- Ensure all leaders and managers have completed self-assessment and have clear development plans and actions through FABB appraisals and check-ins
- Increase promotion of Our Leaders across the Bolton locality, building on the current 11 attendees

## 5. National Requirements for Leadership

Over the last six months, Bolton has been actively involved in the national socialisation pilot for the NHS Leadership and Management (L&M) Framework, launched through the NHS College of Leadership and Management earlier this month (Appendix 5).

This has provided assurance that the principles and expectations of the NHS L&M framework are already embedded within Our Way and Our Leaders, demonstrating strong alignment with national best practice and supporting our ambition to foster a positive leadership culture.

Our Leaders reflects the key elements of the NHS L&M framework, including clear leadership standards, self-assessment, blended learning and 360-degree feedback (Appendix 6). Bolton was invited to showcase our approach through NHSE Community of Practice sessions.

We will continue to embed Our Leaders alongside the NHS L&M Framework as complementary to each other, meeting external requirements through a combined development pathway.

## 6. External Leadership Development

Alongside promoting the NHS L&M Framework development offer, we will continue to promote other external leadership development opportunities, including programmes through the Florence Nightingale Foundation and North West Leadership Academy.

We remain supportive of colleagues accessing externally funded leadership and management development, with the Trust's Training Panel providing oversight of opportunities and helping to maximise available NHS England funding.

The removal of Apprenticeship Levy funding for most leadership and management programmes from April 2026 onwards is not expected to have an immediate impact on the Trust, as existing learners can complete their programmes and recently approved cohorts remain funded.

However, the change is recognised nationally as reducing access to accredited leadership and management qualifications, potentially limiting future development pathways and requiring alternative approaches to building leadership capability.

## 7. Impact of Our Leaders on Culture and Staff Experience

The success of Our Leaders will ultimately be measured by improvements in organisational culture and staff experience. Evidence shows that sustainable culture change typically takes three years or more to become fully embedded and reflected in organisation wide measures. Culture and staff experience may dip before increasing whilst focus and attention is given to what needs improving.

As we reach the midpoint of this three-year programme, there are encouraging signs of progress at both leader and team level (Appendix 7). However, the full impact of Our Leaders is expected to be seen over time as leadership behaviours, team practices and organisational expectations become more consistently embedded across the Trust.

Although overall staff experience has reduced, reflecting the challenges faced by the Trust, teamwork and compassionate leadership remain strong. Feedback from Freedom to Speak Up themes also suggests that concerns are less frequently linked to leadership behaviours, indicating that the foundations of a positive leadership culture are strengthening.

To support implementation and measure impact, a range of tools and resources have been introduced. Whilst still early in the rollout, the Our Leaders 360-degree feedback tool has been used by 45 leaders, supporting self-awareness, targeted development and continuous improvement. In addition, 30 teams have used the Our Way Team Tool to assess and improve their local culture, promoting ownership, accountability and team effectiveness.

The impact of Our Leaders will continue to be monitored through staff experience measures, pulse surveys, team culture assessments and NHS Staff Survey results, alongside qualitative evidence including learner feedback, case studies and leadership stories.

Measurement will be strengthened through the introduction and measurement requirements of the NHS Staff Standards and reported progress against delivery of the People and Culture Priorities and Plan at both Trust and local levels. This will demonstrate how sustained investment in leadership development contributes to stronger team cultures, improved staff experience and better organisational outcomes.

## 8. Recommendations

*Board are asked to:*

- Endorse the continued implementation of Our Leaders as the Trust's leadership development and culture improvement programme, recognising that sustainable cultural improvements typically take three years or more to be fully realised

- Note the progress towards demonstrating the requirements of the NHS Leadership and Management Framework, with strong alignment between national expectations and our internal Our Leaders programme
- Support continued improvement of Our Leaders, with more focus on engagement of medical and operational leaders, and more emphasis on leading change and core people management
- Note the potential implications of Apprenticeship Levy funding changes and support exploration of alternative accredited options for leadership and management development
- Receive ongoing assurance regarding the impact of Our Leaders through staff experience, culture and leadership development measures.

# OUR LEADERS Framework

Vision | Openness | Integrity | Compassion | Excellence

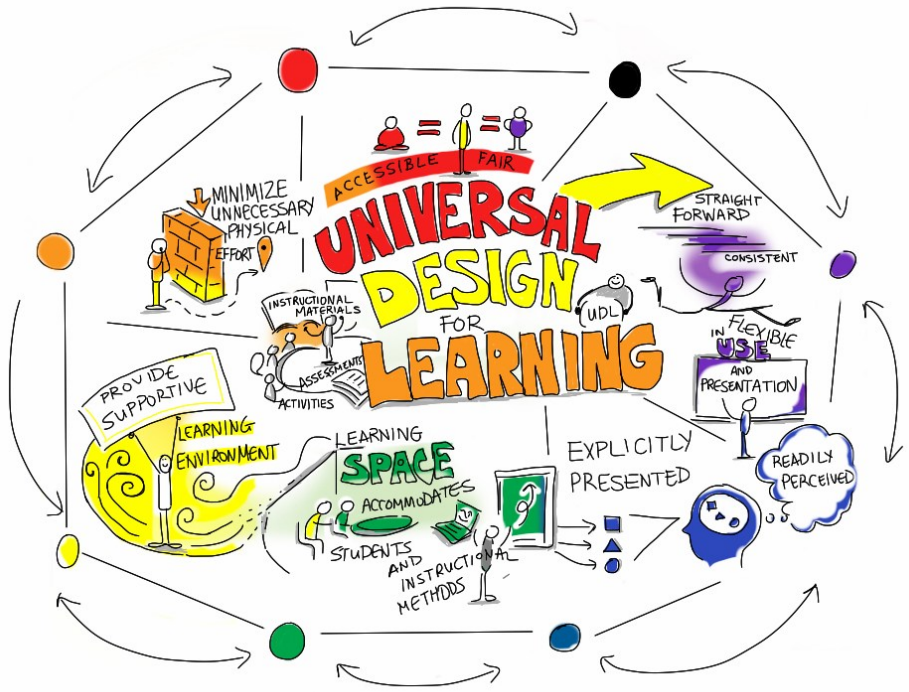
NHS Bolton NHS Foundation Trust

| OUR VOICE VALUES | OUR WAY BEHAVIOURS | CORE RESPONSIBILITIES OF ALL OUR LEADERS | | TOOLS & RESOURCES TO EMBED |
|---|---|---|---|---|
| VISION | We all LEAD by Example | 1. **Commit to our own leadership and management development and self-awareness** | Continually focusing on self-awareness and development that helps to improve our approach to leading and managing | Trust strategy 2024-2029 and ambitions<br>Health inequalities data<br>Multi-disciplinary team/triumvirate meetings<br>Locality/system meetings and networks<br>Equality, Diversity Inclusion action plans and resources<br>VOICE values and OUR WAY behaviours<br>VOICE change programme action plans<br>Staff survey/staff experience data linked to NHS People Promise<br>OUR LEADERS framework and leadership development<br>Apprenticeships, qualifications, external programmes, professional and clinical development, compulsory and trust mandated training<br>Self-awareness tools and 360 feedback<br>Personal development/talent conversations and plans<br>Shared communities of learning<br>Positive people management and performance development policies and guidance<br>Flexible working guidance<br>Wellbeing check ins and plans<br>Strengths-based coaching approach<br>Annual planning and team objective setting<br>Individual objective setting through FABB appraisals<br>Ongoing FABB conversations/check-ins/1:1s<br>Freedom to Speak Up guidelines and resources<br>Team culture assessment tool<br>Team charter<br>Team meetings, team communication, huddles |
| | | 2. **Value our people through our leadership and management approach** | Staying committed to positive, inclusive and compassionate leadership and management | |
| | | 3. **Achieve service standards using a performance-driven approach** | Using data, evidence and good governance to make effective decisions, maximising our collective resources to deliver results | |
| OPENNESS | | 4. **Empower others to develop and grow to realise their potential** | Coaching, sharing and learning with each other, so we can all be at our professional best | |
| | | 5. **Supportively hold ourselves and each other to account, celebrating individual and team success** | In achieving our team goals and in collectively shaping our organisational and team culture | |
| | | 6. **Collaborate with others for a collective purpose** | Through building effective relationships with each other and with partners across the wider locality and system | |
| INTEGRITY | We all BELONG | 7. **Involve, engage and communicate, being visible and present** | Both with our teams, patients and service users, helping us to understand and act on feedback | |
| | | 8. **Shape and maintain an inclusive and authentic culture** | Where we are kind and respect each other, valuing ideas and contributions | |
| | | 9. **Encourage others to speak up and listen to understand** | Creating the conditions for psychological safety and learning, sharing our concerns | |
| COMPASSION | | 10. **Care for our own and each other's health and wellbeing** | Coaching others to help manage work and life balance, accessing support that is needed | |
| EXCELLENCE | We are always IMPROVING | 11. **Play an active part in delivering our Trust strategy** | Working together to achieve our ambitions and objectives | |
| | | 12. **Shape service priorities and team goals together** | Collectively shaping and reviewing, celebrating team contribution and achievements along the way | |
| | | 13. **Reduce health inequalities through delivering inclusive services** | Understanding and committing to addressing and reducing health inequalities for our patients and service users | |
| | | 14. **Be curious and creative to enable future changes and improvements** | Using the voice of patients and service users to continually improve quality and safety and personalised care | |

# OUR LEADERS Programme

## Design Principles

- Accessible to **all leaders**, self-owned and digitally enabled, rolled out at scale and pace
- Building **consistency, confidence & competence** in all our leaders & managers as one Trust with many complementary styles and cultures
- Social movement of **leadership development** and **culture change** (through a community of leaders)
- **Co-created content**, taking a Trust wide collaborative approach across multiple teams
- **Alignment** with other development and corporate induction to help us all be on the same page
- **Not a one off** - before and after as important
- Mixed **learning communities** (tables) - learning from and with each other
- **Non-hierarchical/role bound** – focusing on our shared responsibilities as leaders, role modelling at every level




To ensure ALL our leaders and managers are capable, confident and supported in making this a **'great place to work'** for our people and in leading **'high performing, productive'** services, so together we are **'improving care, transforming lives….for a better Bolton'**

# OUR LEADERS Programme

## DISCOVER

Development conversation with your manager to self-assess against OUR LEADERS framework

+

Self-awareness tool/psychometrics

## LEARN

2-day Event

+

Development conversation with your manager to co-create a Personal Development Plan with development mapped to OUR LEADERS Framework, unique to your individual needs

⬇

Blended Learning Bundles

+

Apprenticeships, qualifications, External Programmes, Professional & Clinical Development & Revalidation

## EMBED

Embedding Activities and using the tools and resources with your teams

+

Ongoing development conversations with your manager supported through coaching conversations

## FABB APPRAISALS & CHECK-IN CONVERSATIONS

Personal Development, Realising Full Potential, Talent Management, Career Aspirations & Pathways

# OUR LEADERS Framework aligned to OUR WAY

| OUR VOICE VALUES | OUR WAY BEHAVIOURS | CORE RESPONSIBILITIES OF ALL OUR LEADERS | | TOOLS & RESOURCES TO EMBED |
|---|---|---|---|---|
| VISION | We all LEAD by Example | 1. Commit to our own leadership and management development and self-awareness | Continually focusing on self-awareness and development that helps to improve our approach to leading and managing | Trust strategy 2024-2029 and ambitions<br>Health inequalities data<br>Multi-disciplinary team/triumvirate meetings<br>Locality/system meetings and networks<br>Equality, Diversity Inclusion action plans and resources<br>VOICE values and OUR WAY behaviours<br>VOICE change programme action plans<br>Staff survey/staff experience data linked to NHS People Promise<br>OUR LEADERS framework and leadership development<br>Apprenticeships, qualifications, external programmes, professional and clinical development, compulsory and trust mandated training<br>Self-awareness tools and 360 feedback<br>Personal development/talent conversations and plans<br>Shared communities of learning<br>Positive people management and performance development policies and guidance<br>Flexible working guidance<br>Wellbeing check ins and plans<br>Strengths-based coaching approach<br>Annual planning and team objective setting<br>Individual objective setting through FABB appraisals<br>Ongoing FABB conversations/check-ins/1:1s<br>Freedom to Speak Up guidelines and resources<br>Team culture assessment tool<br>Team charter |
| | | 2. Value our people through our leadership and management approach | Staying committed to positive, inclusive and compassionate leadership and management | |
| | | 3. Achieve service standards using a performance-driven approach | Using data, evidence and good governance to make effective decisions, maximising our collective resources to deliver results | |
| OPENNESS | | 4. Empower others to develop and grow to realise their potential | Coaching, sharing and learning with each other, so we can all be at our professional best | |
| | | 5. Supportively hold ourselves and each other to account, celebrating individual and team success | In achieving our team goals and in collectively shaping our organisational and team culture | |
| | | 6. Collaborate with others for a collective purpose | Through building effective relationships with each other and with partners across the wider locality and system | |
| INTEGRITY | We all BELONG | 7. Involve, engage and communicate, being visible and present | Both with our teams, patients and service users, helping us to understand and act on feedback | |
| | | 8. Shape and maintain an inclusive and authentic culture | Where we are kind and respect each other, valuing ideas and contributions | |
| | | 9. Encourage others to speak up and listen to understand | Creating the conditions for psychological safety and learning, sharing our concerns | |
| COMPASSION | | 10. Care for our own and each other's health and wellbeing | Coaching others to help manage work and life balance, accessing support that is needed | |
| EXCELLENCE | We are always IMPROVING | 11. Play an active part in delivering our Trust strategy | Working together to achieve our ambitions and objectives | |
| | | 12. Shape service priorities and team goals together | Collectively shaping and reviewing, celebrating team contribution and achievements along the way | |
| | | 13. Reduce health inequalities through delivering inclusive services | Understanding and committing to addressing and reducing health inequalities for our patients and service users | |
| | | 14. Be curious and creative to enable future changes and improvements | Using the voice of patients and service users to continually improve quality and safety and personalised care | |

# Our Leaders Two-Day Event

## DAY ONE

Welcome to OUR LEADERS

Leadership & culture at Bolton

You as a Leader

**We all LEAD by example**

**We all BELONG**

## DAY TWO

Committing to Action

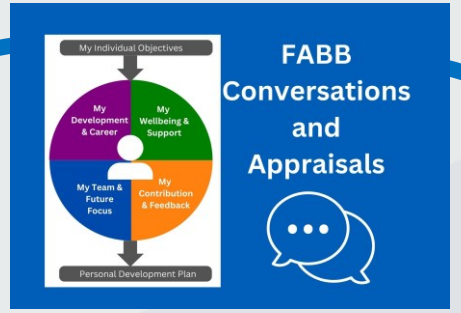
Embedding learning with our teams & people

Shaping Culture

**We are always IMPROVING**

# EMBED to Impact on Culture and Staff Experience



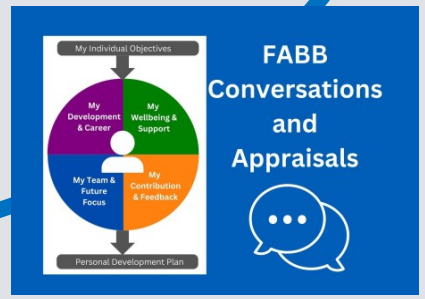





















# Your Commitment to Action – Our Way Team Tool & 360

Vision | Openness | Integrity | Excellence
Doing things... Our Way

NHS Bolton NHS Foundation Trust

## Our Way Team Tool TEST VERSION

Please take a few moments to complete this form, sharing your views openly and honestly. After all team members have provided their responses, we will be exploring the results as a team, then agreeing together where to focus first, to increase our teams effectiveness.

Responses will be collated by the Organisational Development Team and will be collated anonymously

When you submit this form, it will not automatically collect your details like name and email address unless you provide it yourself.

**1. We All LEAD by Example**

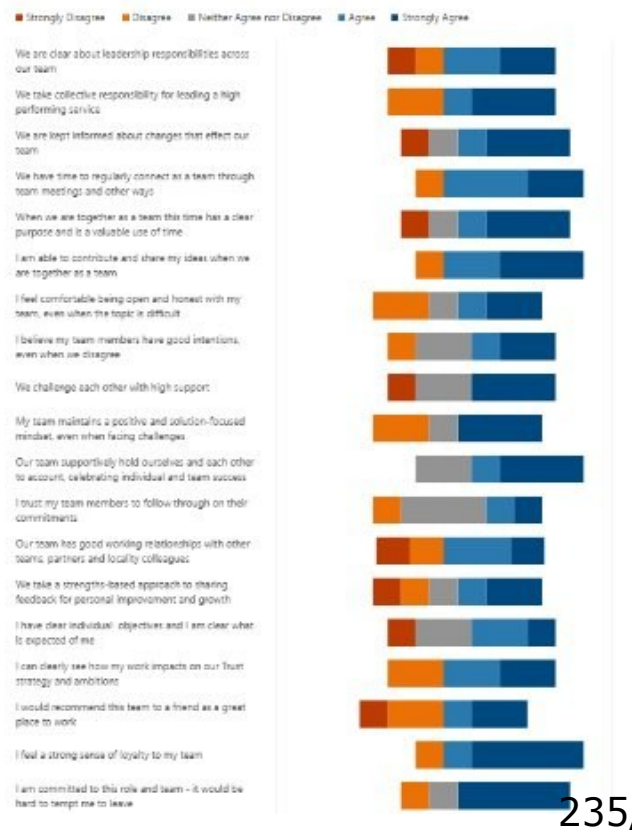
| | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| We are clear about leadership responsibilities across our team | ○ | ○ | ○ | ○ | ○ |
| We take collective responsibility for leading a high performing service | ○ | ○ | ○ | ○ | ○ |
| We are kept informed about changes that effect our team | ○ | ○ | ○ | ○ | ○ |
| We have time to regularly connect as a team through team meetings and other ways | ○ | ○ | ○ | ○ | ○ |
| When we are together as a team this time has a clear purpose and is a valuable use of time | ○ | ○ | ○ | ○ | ○ |
| I am able to contribute and share my ideas when we are together as a team | ○ | ○ | ○ | ○ | ○ |
| I feel comfortable being open and honest with my team, even when the topic is difficult | ○ | ○ | ○ | ○ | ○ |
| I believe my team members | | | | | |

Vision | Openness | Integrity | Compas

Our Way Team Tool TEST VERSION

6 Responses 06:10 Average time to complete Active Status

**1. We All LEAD by Example**



# Blended Learning Bundles



## Blended Learning Bundles

### Welcome to the Blended Learning Bundles Page

There are a number of Blended Learning Topics Below. Click on each button to discover the learning options within each topic.

Keep checking back to this page as we will continually be developing our topics.

The links under each topic will take you to ESR to enrol onto the learning. You might find it helpful to have a reflection template to hand as you access learning. This will help you think about any learning to intend to transfer back into your place of work. If it helps, use the document below.

Click here to view guidance on how to enrol and play the Blended Learning Bundles.

Click here to view guidance on how to save websites to your favourites, to access at a later date

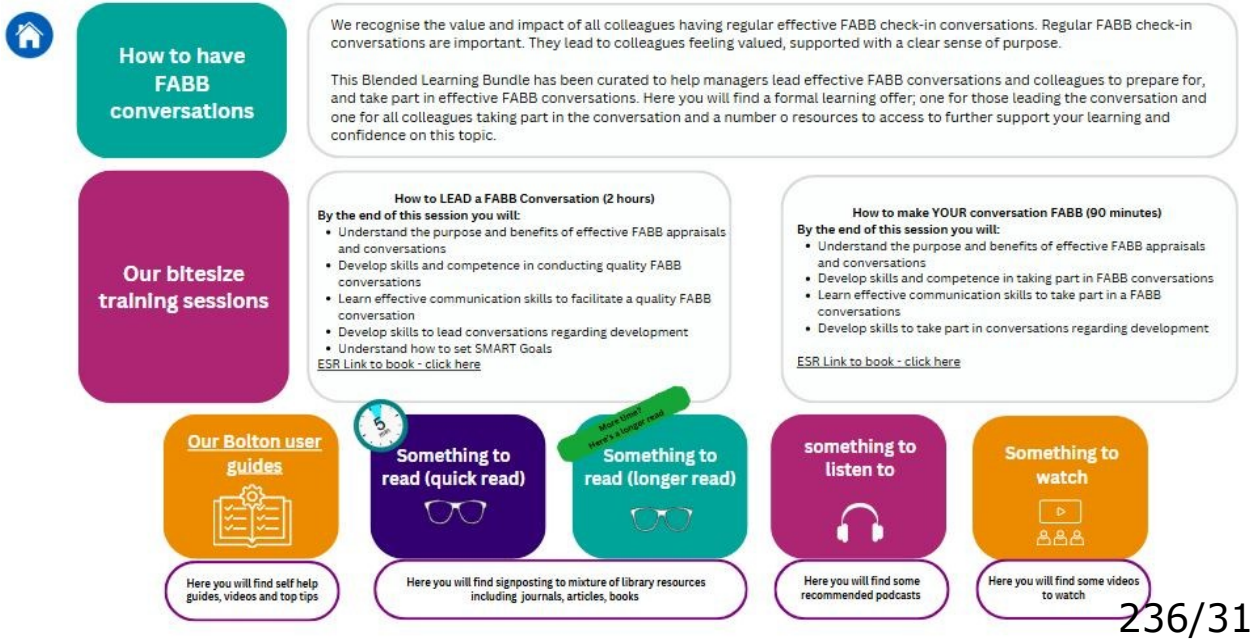
Coaching Blended Learning Bundle

Essential Conversations Blended Learning Bundle

FABB Conversations Blended Learning Bundle

Equality, Diversity & Inclusion Blended Learning Bundle

Quality Improvement Blended Learning Bundle



# External Leadership & Development

NHS Leadership Academy







aqua
Shape Change Inspire Quality Transform Care

FLORENCE NIGHTINGALE FOUNDATION

The Open University | OpenLearn

Welcome to ESR

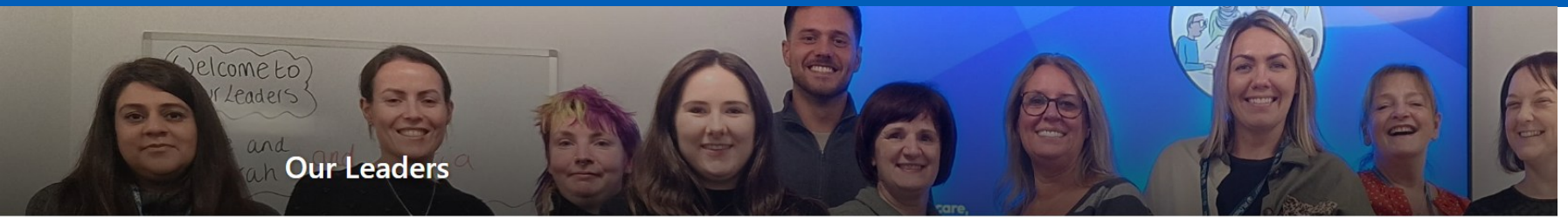
FutureNHS

NHS Elect

Free career development support open to all NHS staff

NHS North West Leadership Academy

# Digitalisation through BOB and ESR




Our Leaders

We know there are already many things that make Bolton a great place to work, and to help us further improve our culture, we have been listening to feedback to develop Our Leaders programme for all of our leaders and managers.





People Development

Spruce Catherine
People Development Lead

Fazackerley Lynne
Workforce Digitalisation Project

New dates announced for Our Leaders in 2025


Discover


Learn


Embed

# Our Leader Attendance – since January 2025

**937** Leaders and Managers have attended (898 remain in post)

**1335** Leaders and Managers are in our target audience (All Band 7+ colleagues, including Consultants and GPs)

**479** Leaders and Managers have attended from the target audience
A further **116** booked to attend

**458** Leaders and Managers have attended from outside of the target audience

**572** places booked and then cancelled

**20** Locality places offered

**11** Locality colleagues have attended

Since January 2026

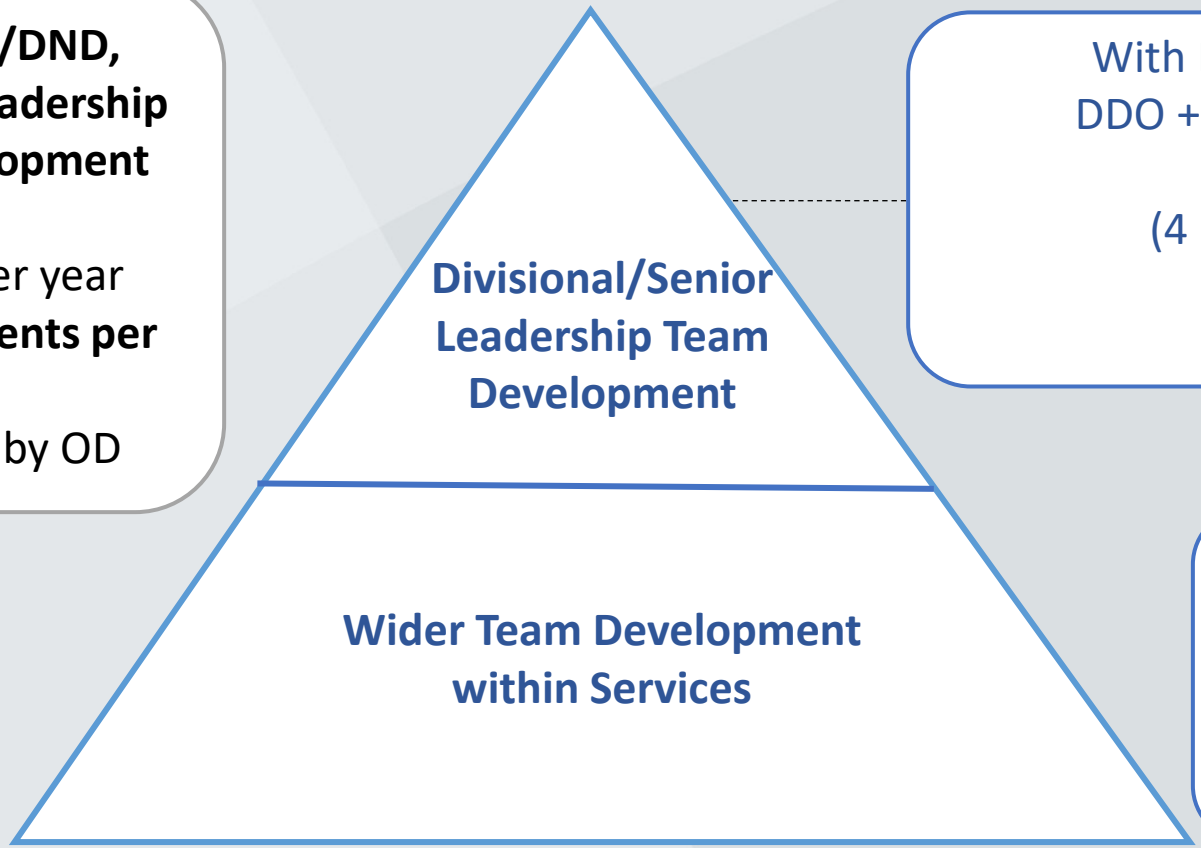
- An additional 20 Band 8b+ managers have attended
- Percentage of band 8b+ managers attended or booked has increased by 16.94%

| Target Group | Number in Target Group | Number Attended | Percentage Attended |
|---|---|---|---|
| Consultants and GPs | 306 | 16 | 0.52% |
| Band 7 | 616 | 281 | 45.62% |
| Band 8a | 289 | 127 | 43.94% |
| Band 8b | 80 | 42 | 52.5% |
| Band 8c | 32 | 13 | 40.63% |
| Band 8d | 11 | 4 | 36.36% |
| Band 9 | 18 | 8 | 44.44% |

# How OD Supports Leadership Team Development

**DDO, CNO/DND, MD/DMD Leadership Team Development**

4 Events per year
**TOTAL 12 events per year**
Facilitated by OD




With Divisional/Senior Leadership Team
DDO + Dep / DND + ADND / DMD + Leads
4 Events per year
(4 Divisions, plus corporate & IfM
**TOTAL 24 events per year**
Facilitated by OD

OD coach managers/leaders in Division to facilitate own team development
Access to High Performing Team Development Resources
Signpost from Our Leaders programme

# Our Way....to High Performing Teams

Our Way is our cultural standards and expectations for ‘HOW we do things’.

The VOICE values remain the core principles and beliefs that guide, influence inform WHAT we do and how we deliver care at Bolton

**Our Way Behaviours**
Guides us on how we interact and work together, aiding feedback conversations

**Our Way Team Tool**
Gathers feedback from team members

**Our Way to High Performing Teams**
Checklist/Audit and Resources for Leaders and Teams to use together

**Our Leaders Framework and Programme**
Defines expectations through leader responsibilities

**Our Leaders 360 tool**
Gathers feedback on leaders carrying out their leader responsibilities

# Medicine DLT & SLT Team Development Plan 2026

## DLT
## 6th July

Reflections on forming as a new DLT/Check In

Getting to know each other as a team

Working as a High Performing Team

L2 priority planning (including people and culture priorities)

## DLT & SLT
## 10th August

Getting to know each other as a team

Vision across Medicine/future state

L3 priority planning session (including people and culture priorities)

## DLT
## 14th September

Insights Discovery

Building on working as a High Performing Team




## DLT & SLT
## 5th October

Working as a High Performing Team

Leading under Pressure

NHS
College of Leadership and Management

To:
- NHS trust and ICB:
  - chairs
  - chief executives

cc.
- NHS trust and ICB:
  - chief people officers
  - communications leads

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

6 July 2026

Dear colleagues

Across the NHS, leaders and managers are being asked to deliver profound change: improving care, shifting services closer to home, embracing new technology and supporting the move from treatment to prevention.

The NHS already benefits from exceptional leadership and management talent. As we collectively deliver the 10 Year Health Plan, there is an opportunity to build on that strength by creating a more consistent, ambitious and profession-led approach to developing leaders and managers and helping establish NHS leadership and management as among the best in the world.

## NHS College of Leadership and Management

The NHS College of Leadership and Management will be the national home for NHS leadership, management and talent excellence.

Building on the foundations established through the NHS Leadership Academy, professional bodies and existing leadership communities, the college will help strengthen professional identity, support learning and career development, improve talent management, and provide a recognised quality mark for leadership and management excellence. The college exists to support the NHS by helping current and future NHS leaders and managers from all backgrounds to ‘step in, step onwards and step up’ – from aspiring first-time managers to executive leaders, in both clinical and non-clinical roles.

We are also pleased to announce that Steve McManus will join the college as interim chief executive from today. Steve joins the college after a decade as chief executive of Royal Berkshire NHS Foundation Trust and is passionate about supporting and developing strong leadership and management and staff engagement.

Publication reference: PRN02312_ii

The college is being launched with a clear purpose and vision, but its development will be shaped by the service. Over the summer, we will work closely with leaders and managers across trusts, systems, primary care, community services and neighbourhood health – alongside stakeholders and partners – to shape the college's future priorities, development offers and ways of working, with opportunities for organisations and individuals to contribute to its development.

During 2026/27, the college will introduce a range of development opportunities and support, including online learning aligned to the new Leadership and Management Framework, a new 360° feedback tool, a national development curriculum, strengthened talent management arrangements, and refreshed leadership and management programmes. These will be developed in partnership and will be accessible to leaders and managers working across all parts of the health service.

The college will also work with partners to support the development of diverse boards and executive teams, enabling organisations to create the conditions for sustained improvement. A new national attraction campaign, launching this week, will help build a strong and diverse pipeline of NHS non-executive directors, supporting effective governance across the service.

## NHS Leadership and Management Framework – for all leaders and managers

The Department of Health and Social Care has just published the new NHS Staff Standards, including the first national NHS staff standard on line management. We are also launching the new NHS Leadership and Management Framework, which sets clear expectations for all NHS leaders and managers, including line managers. This includes a code of practice and leadership and management standards for all NHS leaders and managers.

For the first time, the NHS has a single national framework describing what excellent leadership and management looks like across every setting, profession and level of responsibility. The framework provides a shared language for development, career progression and professional expectations. It will support stronger management capability, competent, compassionate and inclusive leaders, better staff experiences and, ultimately, improved care for patients.

The NHS Staff Standards have been shaped by broad engagement across the service, including with the Social Partnership Forum, trade unions, NHS chief executives, staff networks, professional groups and national partners. Similarly, the Leadership and Management Framework reflects the experiences and insight of thousands of NHS managers, leaders and patient representatives. Its development has been supported by NHS England, the Chartered Management Institute, the Faculty of Medical Leadership and Management, and the Florence Nightingale Foundation, among many others. More than 150

© NHS England 2026

organisations have helped refine it through local testing and communities of practice. We are grateful to everyone for their work and invaluable input.

## Implementing the framework

The framework and self-assessment tool are now available for you and your teams to use.

We ask organisations to begin embedding the framework within development, appraisal, recruitment and talent processes, and to support leaders and managers to use the self-assessment as part of their normal appraisal and development conversations during 2026/27.

NHS leaders and managers make a profound difference to patients, staff and communities on a daily basis. The establishment of the NHS College of Leadership and Management recognises the critical role played by leaders and managers at all levels, and the need for continued investment in their support and development. This becomes increasingly important in a more devolved NHS, where more decisions are taken closer to the communities we serve, and where leadership and management capability will be an important factor in determining whether we can deliver better outcomes for patients and the ambitions of the 10 Year Health Plan.

Together, the framework and the college provide an opportunity to build on existing excellence, strengthen leadership and management capability, and create a profession that is recognised as among the best in the world.

This work is central to improving care and supporting staff. We ask you to champion the staff standards and the framework in your organisation, engage with the college as its national offer develops, and help shape the next chapter of leadership and management development across the NHS.

For further information, please contact **england.leadershipandmanagement@nhs.net**

Yours sincerely,



**Daniel Mortimer**
Director General – People Group



**Ed Smith**
Chair
NHS College of Leadership and Management

© NHS England 2026

## Appendix: Further information about the NHS Leadership and Management Framework

### Actions for leaders and managers

- During 2026, all NHS leaders and managers should use the framework as a practical starting point for reflection, development and improvement.

- By the end of quarter 4, every manager and leader should self-assess against the framework stage that is relevant to their level, discuss the outcomes with their line manager, and agree a focused development plan. All senior managers should also use the 360-degree feedback tool to inform that conversation.

### Actions for organisations and boards

- We ask organisations and boards to begin implementation by embedding the framework into local people strategies, policies, training, appraisal and recruitment, and by aligning existing leadership and management development offers to the new standards. This should include mapping current provision and identifying gaps.

- The framework will also support delivery of the NHS Staff Standards which are reflected in the National Oversight Framework, and should therefore form part of local assurance of management quality, staff experience and improvement.

- Organisations should support all leaders and managers to complete the self-assessment and undertake development (including on-the-job learning) aimed at achieving their level's required competencies. Boards should monitor local completion and use the data to understand development needs across their organisation.

### The NHS leadership competency framework for board members

The NHS leadership competency framework for board members remains in place for 2026/27 for the purpose of Fit and Proper Persons Test assessment at board level. It will be updated from 2027/28 onwards, to ensure the 2 competency frameworks align.

© NHS England 2026

**NHS Leadership and Management Framework - Supporting Information**

Leadership and Management Framework

**Key Points:**

- For the first time, the NHS has a single national framework describing what excellent leadership and management looks like across every setting, profession and level of responsibility. The framework provides a shared language for development, career progression and professional expectations
- Builds on existing strengths of leaders and managers by creating a more consistent, ambitious and profession-led approach to developing leaders and managers, recognising the current context of leading through profound change to achieve the NHS 10-Year Plan
- The Framework is made up of several parts: code, standards and competencies, standards/competencies, self-assessment tool (national online development curriculum and 360 feedback tool to follow later in the year)
- A NHS College of Leadership and Management is being established to be the national home for NHS leadership, management and talent excellence, replacing the existing NHS Leadership Academy
- The NHS leadership competency framework for board members remains in place for 2026/27 for the purpose of Fit and Proper Persons Test assessment at board level. It will be updated from 2027/28 onwards, to ensure the 2 competency frameworks align.

Similarities and differences across the NHS Leadership and Management Framework and Our Leaders:

| **NHS L&M Framework** | **Our Leaders** |
|---|---|
| L&M code defining the principles and behaviours required of all leaders and managers | Our Way cultural standards and expectations of all leaders, managers, teams and staff |
| L&M standards and competencies set at different levels of leaders and managers | Our Leaders framework and responsibilities consistent across all leaders and managers, applied in the context of their role and level |
| Self-assessment tool enabling the evaluation against the expected L&M standards and competencies | Self-assessment tool enabling the evaluation against Our Leaders framework and responsibilities, linked with FABB appraisal and check-in conversations |
| Modular online learning, national appraisal template and guidance, 360° feedback tool *(not available yet)* | Blended learning bundles and bite-size sessions on range of L&M topics<br>Refreshed templates and guidance for FABB appraisal and check-in conversations<br>Our Leaders 360 tool |

# 2-Day Event Evaluation – Skills, Knowledge and Confidence

Leaders and Managers are asked a number of questions to understand their levels of knowledge and skill prior to attending, in relation to each of the three Our Way behaviours, as well as their confidence in putting into practice. They are then asked about their knowledge and skills after attending, as well as their confidence putting into practice



**We all LEAD by Example**

- 21.12% Skills and Knowledge
- 19.51% Confidence putting into practice



**We all BELONG**

- 22.16% Skills and Knowledge
- 20.66% Confidence putting into practice



**We are always IMPROVING**

- 19.06% Skills and Knowledge
- 18.53% Confidence putting into practice

# 2-Day Event Evaluation - Action Setting

Leaders and Managers are asked to identify three actions, one in relation to each of the three Our Way behaviours. Theming the actions that were committed to, the top three themes for each Our Way behaviour are below



## LEAD: Top 3 Action Themes

1. **Coaching, Mentoring & Empowerment** — 67 mentions (11.3%)
   Typical intent: adopt a coaching style, ask “why” questions, delegate, build ownership.

2. **Role Modelling Values & Positive Behaviour** — 62 (10.5%)
   Typical intent: “be the change”, model Trust values/civility, lead by example every day.

3. **Self-awareness & Reflection (incl. emotional intelligence)** — 61 (10.3%)
   Typical intent: use self-assessment tools, reflect on impact, increase self-awareness.



## BELONG: Top 3 Action Themes

1. **Communication & Feedback - 110 (19.0%)**
   Typical intent: Leaders commit to active listening and regular, inclusive feedback loops, asking team for feedback on changes and ideas. Share resources from the course widely; encourage colleagues to attend.

2. **Inclusive Decision-making & Empowerment - 70 (12.1%)**
   Typical intent: Actively involve the whole team in decision making.; giving ownership of work items. Empower colleagues to lead key pieces of work; reinforce accountability. Set team objectives, values & goals together; develop a team charter.

3. **Visibility, Presence & Regular Check-ins - 65 (11.2%)**
   Typical Intent: Being present, accessible; 1:1s, huddles, informal drop-ins. pen-door policy; be more visible in clinical areas. Regular FABB wellbeing check-ins; monthly drop-ins.



## IMPROVE: Top 3 Action Themes

1. **Change management & improvement mindset — 145 mentions (24.5% of actions)**
   Typical Intent: Asking how I can improve team dynamics and skill. Asking for feedback from partner teams often to improve work and relationships. Re-commence team meeting to discuss processes and changes needed

2. **Quality improvement (QI) projects & methods — 138 mentions (23.3%)**
   Typical Intent: Look at QI page on BOB. Research and start QI projects. Prioritise self care. Write up a QI project.

3. **Feedback (staff & patients) — 68 mentions (11.5%)**
   Typical Intent: Seek regular feedback. Create feedback forms for end users to capture ideas for areas of improvement. Continue to ask for feedback from patients and line manager

# 2-Day Event Evaluation – Learner Feedback

## What was most value / had the biggest impact?

1. EDI, privilege & inclusion — 210 mentions **(15.6%)**
2. Psychological safety & culture — 168 mentions **(12.5%)**
3. Interactive activities & videos — 136 mentions **(10.1%)**
4. Networking & peer connections — 135 mentions **(10.1%)**
5. Quality improvement (QI) & PDSA — 102 mentions **(7.6%)**
6. Executive Q&A / leader stories — 67 mentions **(5.0%)**
7. Coaching & leadership tools/models — 58 mentions **(4.3%)**
8. Facilitation & delivery quality — 47 mentions **(3.5%)**
9. Self-awareness & reflection — 46 mentions **(3.4%)**
10. Confidence & empowerment — 33 mentions **(2.5%)**
11. Learning resources & bundles — 22 mentions **(1.6%)**
12. Strategy & trust priorities — 20 mentions **(1.5%)**

## What could be improved?

1. Schedule & duration (length, pacing, 3 shorter days) — 100 mentions **(14.2%)**
2. Venue environment (room size, temperature, seating, facilities) — 93 mentions **(13.2%)**
3. EDI session – delivery, tone & localisation — 84 mentions **(11.9%)**
4. Breaks & movement (frequency, timing) — 61 mentions **(8.7%)**
5. More interaction, less PowerPoint — 60 mentions **(8.5%)**
6. Precourse info & daily agenda clarity — 34 mentions **(4.8%)**
7. Slides & AV (font size, mics, visibility) — 26 mentions **(3.7%)**
8. Practical leadership skills (conflict, conversations, tools) — 26 mentions **(3.7%)**
9. Catering & refreshments — 20 mentions **(2.8%)**
10. Executive Q&A – usefulness & style — 16 mentions **(2.3%)**
11. QI session – depth & relevance — 12 mentions **(1.7%)**
12. Follow-up community & materials — 10 mentions **(1.4%)**

# Three- Month Evaluation



Leaders and Managers are asked to complete a follow up evaluation form three months after attending the 2-day Our Leaders event, to measure impact and progress against actions

**435** 435 participants were sent the survey

**22** 22 participants have completed the survey



OD and Our Leader co-facilitators, completed 15 semi-structured interviews to shape leader and team impact stories

# Impact Stories

**Leader:** Deputy Lead Cancer Nurse

**Their Teams:** The Oncology Breast, Lung, Urology, Acute Upper GI and Gynae Teams

**Actions undertaken since Our Leaders:**

- Successfully facilitated the Our Way Team tool with four teams, empowering teams to drive their own improvement actions and contributing to increased engagement and positive cultural outcomes.
- Introducing protected time in CNS meeting - a “safe space” to raise issues with facilitated peer to peer support
- Flattening the hierarchy - becoming approachable and vulnerable
- An increase in confidence in thoughts / reflections and actions
- Reaffirmed work underway aligned to Trust values and priorities
- As a result of all leadership development undertaken staff have noted the working environment feeling “a nicer place to work”



**Leader:** Dietitian Manager

**Their Teams:** Adult Dietetics and Adult Speech and Language Therapy Teams

As an experienced and capable leader, many of these behaviours were already evident within their leadership approach. However, participation in the Our Leaders programme provided an opportunity to reflect, refine and strengthen their practice, resulting in a renewed focus on leadership development, team culture and continuous improvement within the wider team.

**Actions undertaken since Our Leaders:**

- Ensuring all band 7 leaders in team attended the course, with follow up conversations in relation to the Our Leaders framework and further learning
- On-going use of the EDI calendar
- A commitment to focus on building psychological safety in each team
- Successfully facilitated the Our Way Team tool with Adult Dietetics
- Personally undertaken the Our Leaders 360 feedback tool – consequently identifying stop/start/ continue actions and sharing these with the team
- Team Development Sessions focused on Organisation Strategy and Trust Sustainability Plan
- Ongoing timeline in place for annual use of Our Way Team Tool to use alongside service objective and priority setting
- Timeline in place for use of the Our Way team tool with Adult Speech and Language Therapy



**Leader:** Senior Occupational Therapist

**Their Teams:** Falls West, South, North Teams

**Actions undertaken since Our Leaders:**

- Reflecting on team culture and behaviours as a result of changes within the team, resulting in use of the Our Way Team Tool (the first team to use the tool)
- Using the tool facilitated the team to hear one another and formulate a plan to move forward
- The use of the tool was a turning point in team culture and behaviours
- An agreement within the team forward to share any frustrations as early as possible to ensure no consequent negative impacts
- Team cohesion and acceptance have improved along with team leader confidence
- A follow up Our Way Team Tool survey to be completed to compare results



**Job Role:** Deputy Chief Pharmacist

**Responsible for:** Pharmacy Senior Leadership Team

**Actions undertaken since Our Leaders:**

- Mentoring and coaching –started this through making connections via the NW Deputy Chief Pharmacist network
- Also completed a 9-month inclusive leadership programme and taken learning form this – completed learning via CPP
- Using the national Inclusive pharmacy practice Toolkit, completed benchmarking against this. Has identified a number of workstreams for improvement, especially regarding inclusive recruitment i.e. improving Job Descriptions, person specs to be more inclusive
- More reflective in advance of decisions – how they might be taken, pre-empting challenge might get in response, thinking about view-points / response
- Moving away from “this is what we’re doing” to thinking about different people and their views and how to share messages accordingly. Trying to engage with staff informally to help shape decisions made.



**Leader:** Deputy Operational Business Manager

**Their Teams:** Outpatients

**Actions undertaken since Our Leaders:**

- Our Leaders and University learning helped adapt leadership and management style – hugely impactful over the last 12 months
- Recognition that all staff are different – probably wouldn't have acknowledged this without Our Leaders
- Our Leaders inspired attending a Coaching Conversations session – very impactful, team responds well to coaching, brings out the best in them
- Uses the EDI Calendar monthly:
  - Shares screenshots and celebrates events like Eid, Diwali, and Christian holidays.
  - Celebrated Diwali with games, activities, knowledge sharing, and homemade sweets; Eid with a Jacobs join.
  - Team feedback: these events are meaningful for everyone, regardless of religion.
  - Next year: choose something new each month to learn about as a team-building activity



| | | | | |
|---|---|---|---|---|
| **Report Title:** | Finance & Investment Committee AAA Chairs' Reports | | | |
| **Meeting:** | Board of Directors | **Action Required** | Assurance | ✓ |
| **Date:** | 30 July 2026 | | Discussion | |
| **Executive Sponsor** | Chief Finance Officer | | Decision | |

| | |
|---|---|
| **Purpose of the report** | The purpose of these reports is to provide an update and assurance to the Board of Directors on the work delegated to the Finance & Investment Committee. |
| **Previously considered by:** | The matters included in the Chairs' reports were discussed and agreed at the Finance & Investment Committee. |
| **Executive Summary** | The attached reports from the Chair of the Finance and Investment Committee provide an overview of matters discussed at the meetings held on 24 June and 22 July.<br>The reports also set out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors. |
| **Proposed Resolution** | The Board of Directors are asked to ***receive*** the Finance & Investment Committee Chair's Report from the meetings held on the 24 June and 22 July 2026. |

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

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Sean Harriss<br>Chair of the Finance & Investment Committee | **Presented by:** | Sean Harriss<br>Chair of the Finance & Investment Committee |

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

| | | | |
|---|---|---|---|
| **Name of Committee:** | Finance and Investment Committee | **Reports to:** | Board of Directors |
| **Date of Meeting:** | 24 June 2026 | **Date of next meeting:** | 22 July 2026 |
| **Chair** | Sean Harriss | **Meeting Quoracy** | Yes |

**AGENDA ITEMS DISCUSSED AT THE MEETING**

- Cost Improvement Programme Update
- Month 2 Finance Report
- Procurement Update
- Digital Programme Update
- Electrical Substation Business Case
- Green Plan Annual Report
- 2025/26 National Cost Collection Pre Submission Report

**ALERT**

| **Agenda items** | Action Required |
|---|---|
| **Cost Improvement Programme Update**<br>• The Trust reported a planned PYE of £29.25m against a total target of £38m.<br>• The risk adjusted savings, considering the governance rating of each individual scheme was £20.83m.<br>• Combined reported savings for M1 and M2 are currently at £1.27m. This is above plan.<br>• The full target has not yet been identified and work continues across several themes to address this.<br><br>**Month 2 Finance Report**<br>• The Trust had a cumulative accounts deficit at Month 2 of £6.0m. This was £22k favourable to plan.<br>• The in-month deficit was £2.9m, £5k favourable to plan.<br>• The planned deficit for the year was £7m.<br>• The underlying deficit at the end of 2025/26 was judged to be £25.4m.<br>• Income was £0.4m adverse to plan year-to-date, driven by under-performance on CDC and lower volumes of pass-through drugs costs, the latter with an expenditure offset.<br>• The cash balance of £12.5m was above plan by £9.8m, the underlying cash position was £8.4m. It was expected that Cash support will be required by September.<br>• CIP at £1.3m YTD was £0.3m favourable to plan, although the plan was significantly 'hockey sticked' and heavily focused on CIP delivery in Q3 and 4.<br>• Capital spend to date was £1.8m, which is £0.7m below plan. The capital plan for the year was £37m, including £17.8m of RAAC.<br>• WWTE was 122 below plan.<br><br>**Digital Programme Update**<br>The Committee were advised of the Trust's ddigital review being well underway with many of the scheduled meetings completed. Once finalised a report will be presented | |

| | |
|---|---|
| to the Executive Directors and subsequently the Board of Directors.<br><br>Though there was still no definitive 'go live' date for Maternity EPR the committee were advised that all major concerns which had previously paused the Maternity EPR go live date had been resolved with mitigations agreed for elements that were holding up the project and specifically the link between mother and baby has now been resolved following escalation to the highest level at Altera.<br><br>Once completed a report on digital project prioritisation and resource allocation will be presented to the Executive Directors with focus on EPR optimisation and clinical correspondence. | |

**ADVISE**

**Procurement Update**

- As of June 2026, ratified procurement savings of £1.57m had been achieved against a £7m forecast, comprising £0.79m cost avoidance, £0.73m cash-releasing savings and £43k inflation avoidance.
- The rollout of the Inventory Management System, Genesis, continues, with completion across all areas expected by September 2026. The system was supporting savings through VAT recovery and reduced stock obsolescence, while also improving the Trust's cash position.
- Several significant contract renewals are being monitored through the Procurement Steering Group and will be managed in accordance with the Trust's Standing Financial Instructions. Further papers will be presented to the Finance and Investment Committee and Trust Board where required.
- The Procurement Steering Group meets monthly with the focus on cost avoidance.

**Electrical Substation Business Case**

The committee approved this business case for a £1.2 million upgrade to substation 2, which supplies the maternity unit. The upgrade was necessary to meet increased electrical demand and ensure compliance with safety standards. The project was part of a larger £2.93 million estate safety allocation.

**ASSURE**

**Green Plan Annual Report**

The first Green Plan Annual Report was presented to the Committee. The report covered actions taken, carbon emission data, and future priorities. Notable achievements include improvements to the steam network, installation of solar panels and EV chargers, and acquisition of electric vehicles. The report has been submitted to the ICB and will be published internally and externally. The Committee approved the Green Plan Annual Report.

**2025/26 National Cost Collection Pre Submission Report**

The Finance & Investment Committee approved the National Cost Collection 2025/26 Pre Submission Report.

**New Risks identified at the meeting: None**

**Review of the Risk Register: N/A**

| Meeting Attendance 2026 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Members** | **Role** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Sep** | **Oct** | **Nov** |
| Sean **Harriss** (Chair) | NED | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | |
| Seth **Crofts** | NED | ✓ | ✓ | ✓ | ✓ | **A** | ✓ | | | | |
| Janat **Hulston** | NED | ✓ | ✓ | ✓ | ✓ | **A** | **A** | | | | |
| Sharon **Katema** | Director of Corporate Governance | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | |
| James **Mawrey** | Chief People Officer / Deputy CEO | ✓ | ✓ | ✓ | **A** | ✓ | ✓ | | | | |
| Tiri **Mutambasere** | Associate NED | | ✓ | ✓ | ✓ | **A** | ✓ | | | | |
| Martin **North** | NED | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | |
| Annette **Walker** | Chief Finance Officer | ✓ | A | ✓ | ✓ | ✓ | ✓ | | | | |
| Rae **Wheatcroft** | Chief Operating Officer | ✓ | ✓ | ✓ | ✓ | **A** | ✓ | | | | |
| Sharon **White** | Chief of Strategy and Partnerships | ✓ | ✓ | ✓ | ✓ | **A** | **A** | | | | |
| Ian **Williamson** | NED | ✓ | **A** | ✓ | **A** | ✓ | **A** | | | | |
| ✓ = In attendance A = Apologies | | | | | | | | | | | |

| ALERT \| ADVISE \| ASSURE (AAA)<br>Key Issues Highlight Report | | | |
|---|---|---|---|
| **Name of Committee:** | Finance and Investment Committee | **Reports to:** | Board of Directors |
| **Date of Meeting:** | 22 July 2026 | **Date of next meeting:** | 17 September 2026 |
| **Chair** | Sean Harriss | **Meeting Quoracy** | Yes |

**AGENDA ITEMS DISCUSSED AT THE MEETING**

- Board Assurance Framework
- Corporate Risk Register
- Finance & Investment Committee Annual Report
- Sustainability & Cost Improvement Programme Update
- Month 3 Finance Report
- Cash Forecast and Revenue Support
- Neighbourhood Health Progress Update
- Maternity RAAC update
- Digital Programme Update
- Microsoft Licence Approval
- MES Contract Retender
- Main Entrance Business Case
- N Block 1st Floor Redesign

**ALERT**

| **Agenda items** | Action Required |
|---|---|
| **Sustainability & Cost Improvement Programme Update**<br>The Committee received an update on the Trust's Cost Improvement Programme (CIP) and noted a forecast year-end position of £29.58m against a target of £38m. Members were advised that the risk-adjusted value of identified schemes was £23.07m, with 16% of schemes rated as Plans in Progress, *45% as* Fully Developed *and 36% as* Delivered.<br><br>The Committee noted that reported savings of £2.35m had been achieved during the first three months of the financial year which exceeded the planned trajectory. Members were informed that several schemes remained subject to confirmation pending the availability of supporting data to evidence recurrent savings, and that the position would be further validated following confirmation of budgets. The Committee were presented with a comprehensive sustainability plan detailing the major change programme.<br><br>**Month 3 Finance Report**<br>The Committee noted that the Trust reported a cumulative deficit of £8.9m at Month 3, which was marginally favourable to plan, with an in-month deficit of £2.9m. Delivery of the annual planned deficit of £7m remained dependent on achieving a combined surplus of £2.9m over the remaining nine months of the year.<br><br>Income was adverse to plan, due to contract underperformance and lower pass-through drugs income, although this was partially offset by reduced expenditure. CIP delivery was ahead of plan at £2.4m year-to-date, while the Trust's cash position remained above plan; however, cash support was expected to be required by November.<br><br>Capital expenditure was also below plan at £1.9m, £3.7m behind the planned trajectory. | |

| | |
|---|---|
| The current mid case forecast outturn is a deficit of £24m and the Committee recognised that this would require a full mitigation and recovery plan.<br><br>**Digital Programme Update**<br>The Committee received an update on the digital transformation programme and noted that the Digital function continued to operate within a complex and evolving environment, with significant activity underway across core programmes, clinical systems and transformation initiatives.<br><br>Members were advised that the independent review had concluded and that the finding would be received by the Executive Team.<br><br>Maternity EPR was being rolled out in three phases, with the first phase due to commence during the current quarter with completion expected in January 2027. Further updates on phases 2 and 3 would be provided to the Committee at a later date. | |

**ADVISE**

**Cash Forecast and Revenue Support**
The Committee was updated on the Trust's current cash position, cash forecast and the anticipated requirement for Revenue Support. The Trust was currently £9.1m ahead of plan at Month 3 and considering the revised forecast the Trust was advised that a full Revenue Support application paper was scheduled to be presented to the Committee in September 2026.

**Finance & Investment Committee Annual Report**
The Committee reviewed its activity during 2025/26 against its Terms of Reference and annual work plan. Members noted that the Committee had discharged most of its core responsibilities, providing regular oversight of finance, capital, cash, cost improvement programmes, productivity, business cases, procurement and risk. The review identified areas for further focus during 2026/27, including benchmarking, longer-term financial strategy and digital governance. Members noted that the Digital Plan remained in development and that further work was required to strengthen digital budget tracking arrangements. The Committee noted the outcome of the review and approved the 2026/27 annual work plan.

**ASSURE**

**Board Assurance Framework (BAF)**
The Committee received the updated BAF noting that it had been revised to reflect the Trust's Sustainability Plan 2026/27 and Level 1 Trust Priorities, strengthening the alignment between strategic risks, organisational priorities and improvement actions.

**Neighbourhood Health Progress Update**
The Committee was advised that the Neighbourhood Health Programme had continued to provide a strong foundation for the strategic shift towards community-based care. Early benefits had been realised across several workstreams, supported by strong partner engagement and the development of a growing pipeline of schemes. The Committee noted that continued focus would be required to accelerate implementation and ensure the consistent delivery and realisation of benefits across all programme areas.

**Maternity RAAC update**

The Committee received an update on the RAAC removal and maternity refurbishment programme and noted that delivery timescales and costs had increased due to additional building condition issues and technical complexities identified during construction. Members were advised that the projected completion date had moved to April 2028 and that an additional funding requirement of £8.9m had been identified. The Committee recommended for approval to the Board of Directors the submission of an updated business case to secure additional funding to complete the programme, with further assessment ongoing in relation to ventilation cleaning works and the potential programme and financial impact.

**Microsoft Licence Approval**

A recommendation for approval to Board of Directors was sought for the award of a three-year contract for the provision of Microsoft 365 Licenses. The proposed contract moves from broad E5 allocation to a role-based Microsoft 365 licence model. Annual licence costs would reduce which would result in a recurrent saving with most staff retaining core Microsoft 365 services. Additional functionality will be approved only where there is a clear role-based requirement and recharged to the relevant division or corporate service. The Committee recommended the contract for approval at Board of Directors.

**MES Contract Retender**

In January 2025, the Finance and Investment Committee approved a two-year extension to support retendering of the service. Approval is now sought for a further 12-month extension to June 2028. This will provide sufficient time to finalise the tender specification, complete market engagement and mobilise the new contract with the successful provider. The Siemens Teamplay app will be installed to provide activity data across the equipment base and inform the specification. A Data Protection Impact Assessment (DPIA) and network review have been completed to confirm appropriate data security controls.

The Committee recommended the extension for approval at Board of Directors.

**Main Entrance Business Case**

The Committee was updated that significant progress had been made since Trust approval of this business case in January, including completion of the permitted development planning application, advancement of designs to RIBA Stage 3, completion of key legal documentation and confirmation of the procurement approach. Members noted that planning approval for external groundwork remained a key dependency.

Assurance was provided that the commercial model was supported by agreed Heads of Terms for five retail units, generating guaranteed rental income sufficient to meet the projected funding costs of the scheme. The Committee recommended the execution of documents for phase 1 for approval at Board of Directors.

**N Block 1st Floor Redesign**

The Committee was asked for approval of identified derogations from Health Building Note (HBN) guidance associated with the redevelopment of the first floor of N Block at Royal Bolton Hospital. The scheme would provide a 24-bedded Intermediate Care Unit and accommodation for the Integrated Transfer of Care Hub.

| |
|---|
| Subject to approval, the Committee was advised that the new facilities were expected to become operational in September 2026. The Committee recommended the business case for approval at Board of Directors. |
| **New Risks identified at the meeting: None** |
| **Review of the Risk Register:** The Committee received the Corporate Risk Register report and reviewed all risks which scored 15 or above. Members noted that the identified risks had been allocated to the Finance & Investment Committee as the most appropriate committee to provide oversight. Members were invited to provide feedback on the content, format and any additional information required to strengthen future reporting. |

**Meeting Attendance 2026**

| Members | Role | Jan | Feb | Mar | Apr | May | Jun | Jul | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Sean **Harriss** | Committee Chair | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | |
| Seth **Crofts** | NED | ✓ | ✓ | ✓ | ✓ | **A** | ✓ | | | | |
| Janat **Hulston** | NED | ✓ | ✓ | ✓ | ✓ | **A** | **A** | ✓ | | | |
| Sharon **Katema** | Director of Corporate Governance | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | |
| James **Mawrey** | Chief People Officer / Deputy CEO | ✓ | ✓ | ✓ | **A** | ✓ | ✓ | ✓ | | | |
| Tiri **Mutambasere** | Associate NED | | ✓ | ✓ | ✓ | **A** | ✓ | ✓ | | | |
| Martin **North** | NED | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | |
| Annette **Walker** | Chief Finance Officer | ✓ | A | ✓ | ✓ | ✓ | ✓ | ✓ | | | |
| Rae **Wheatcroft** | Chief Operating Officer | ✓ | ✓ | ✓ | ✓ | **A** | ✓ | ✓ | | | |
| Sharon **White** | Chief of Strategy and Partnerships | ✓ | ✓ | ✓ | ✓ | **A** | **A** | ✓ | | | |
| Ian **Williamson** | NED | ✓ | **A** | ✓ | **A** | ✓ | **A** | ✓ | | | |

✓ = In attendance A = Apologies

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Audit and Risk Committee Chair's Report | | | |
| **Meeting:** | Board of Directors | **Action Required** | Assurance | ✓ |
| **Date:** | 30 July 2026 | | Discussion | |
| **Executive Sponsor** | Audit and Risk Committee Chair | | Decision | |

| | |
|---|---|
| **Purpose of the report** | To provide an update from the Audit and Risk Committee meetings held since the last Board of Directors meeting. |

| | |
|---|---|
| **Previously considered by:** | The matters included in the Chair's reports were discussed and agreed at the Audit and Risk Committee held in June. |

| | |
|---|---|
| **Executive Summary** | The attached Chair's Report from the Audit and Risk Committee provides a detailed summary of the key matters discussed at the Committee meeting held on 25 June 2026. It outlines the Committee's oversight activities and deliberations across a range of financial, governance, assurance, and risk-related areas.<br><br>This report forms part of the committee's formal assurance framework and supports the Board in discharging its responsibilities for effective governance and oversight. |

| | |
|---|---|
| **Proposed Resolution** | The Board of Directors is asked to ***receive*** the Audit and Risk Committee Chair's Report. |

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

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Fiona Taylor, Non-Executive Director | **Presented by:** | Fiona Taylor, Non-Executive Director |

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

| | | | |
|---|---|---|---|
| **Name of Committee /Group:** | Audit and Risk Committee | **Reports to:** | Board of Directors |
| **Date of Meeting:** | 25 June 2026 | **Date of next meeting:** | 09 September 2026 |
| **Chair** | Fiona Taylor, Non-Executive | **Meeting Quoracy** | Yes |

**AGENDA ITEMS DISCUSSED AT THE MEETING**

- Audit and Risk Committee Annual Report
- Audited Annual Accounts 2025/26
- Annual Governance Statement 2025/26
- Annual Report 2025/26
- 2025/26 Audit Completion Report
- Internal Audit Update
- Compliance with the FT Code of Governance
- Trust Banking Arrangements
- Salary Overpayments Report
- Retrospective Orders Report
- Risk Management Group Chair's Reports

## ALERT

| Agenda items | Action Required |
|---|---|
| • **Audited Annual Accounts 2025/26** – The Committee noted that final audit queries remained ongoing and that minor amendments to the accounts may be required prior to finalisation. Whilst a potential risk to the submission deadline was acknowledged, no delay was anticipated in meeting the statutory requirements for laying the accounts before Parliament. The Committee approved the Audited Annual Accounts 2025/26 and recommended approval by the Board of Directors, subject to minor amendments and delegated authority being granted to the Chief Finance Officer and Chief Executive to finalise any required changes. | The Committee requested that a lessons learned review of the year-end process be undertaken, with a reflective report to be presented at the next meeting. |
| • **Internal Audit Follow-Up Report** – The Committee noted that 58 recommendations had been reviewed since the previous meeting, of which 12 had been fully implemented. Remaining recommendations were either not yet due, not yet implemented, or awaiting further management responses and evidence. | Monthly reporting to Executive Directors to maintain focus on completion of outstanding recommendations. |

## ADVISE

- **2025/26 Annual Report** – the Committee approved the Annual Report 2025/26 and recommended approval by the Board of Directors, subject to minor amendments, including clarity in relation to climate-related disclosures.

- **2025/26 Audit Completion Report** – the external auditor indicated an expectation of an unqualified audit opinion, although some areas of audit work remained under review. A continued value-for-money

weakness relating to financial sustainability was reported, reflecting the Trust's underlying deficit position.

- **Final Head of Internal Audit Opinion 2025/26** – the committee noted the Final Head of Internal Audit Opinion 2025/26, which provided moderate assurance and confirmed that an adequate system of internal control was in place, while recognising that some weaknesses in control design and/or application placed the achievement of some organisational objectives at risk.

- **Retrospective Orders Report** – The Committee noted that 17% of approved discretionary spend requisitions had been raised retrospectively, with Corporate Services accounting for the highest proportion by volume at 35%. This was recognised as a control weakness despite the "No PO, No Pay" policy being in place. Continued strengthening of the process, including enhanced reporting, monthly compliance monitoring, targeted communications and requiring repeat offenders to attend the Audit and Risk Committee to provide an explanation.

**ASSURE**

- **Audit and Risk Committee Annual Report** – the Committee approved the Audit and Risk Committee Annual Report, which confirmed that the Committee had taken appropriate steps to perform its duties as delegated by the Board and had no issues of significant concern to raise with the Board arising from its work during 2025/26.

- **2025/26 Annual Governane Statement** - The Committee approved the Annual Governance Statement 2025/26 and recommended approval by the Board of Directors, noting that the Statement provided a balanced assessment of the effectiveness of governance, risk management and internal control arrangements.

- **Internal Audit Update** - There was progress in delivering the Internal Audit Plans, with two 2025/26 reviews finalised, one at draft report stage and two in fieldwork; and for 2026/27, three reviews in fieldwork and two at planning stage. The Staff Headcount Controls review provided moderate assurance and included one high-risk and one medium-risk recommendation. The Digital/Estates Remote Access Controls review provided moderate assurance and included one high-risk and three medium-risk recommendations.

- **Compliance with the FT Code of Governance** – the committee received assurance in relation to compliance with the FT Code of Governance, with the report and supporting appendices providing confirmation of the Trust's compliance position.

- **Trust Banking Arrangements** – the committee received the report noting the banking arrangements for the Trust, iFM Bolton and Our Bolton Charity.

- **Salary Overpayments Report** – the committee noted the arrangements in place to manage recovery of overpayments through discussion and agreed repayment plans with staff, with counter-fraud or debt recovery routes available where appropriate.

| |
|---|
| • **Risk Management Group Chair's Reports** - the Trust's risk profile remained stable, with no escalations and a reduction in both total risks and high-level risks. Key operational, financial and digital risks remained, including Emergency Department performance, infection control, financial deficit delivery, workforce capacity and system resilience. |
| **New Risks identified at the meeting: None** |
| **Review of the Risk Register: N/A** |

| Meeting Attendance | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Members** | | **Feb** | **May** | **June** | **Sept** | **Dec** | **Feb** | **May** | **June** | **Sept** | **Dec** |
| Tony Allen | **Committee Chair** | | | | | | ✓ | ✓ | A | | |
| Alan Stuttard | **NED** | **A** | ✓ | ✓ | ✓ | ✓ | | | | | |
| Sean Harris | NED | A | ✓ | ✓ | ✓ | ✓ | ✓ | **A** | ✓ | | |
| Fiona Taylor | NED | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| Tiri Mutambasere | Associate NED | | | | | | ✓ | ✓ | ✓ | | |
| **In Attendance** | | **Feb** | **May** | **June** | **Sept** | **Dec** | **Feb** | **May** | **June** | **Sept** | **Dec** |
| Annette Walker | Chief Finance Officer | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| Sharon Katema | Director of Corporate Governance | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| ✓ = In attendance A = Apologies NA = no longer a member | | | | | | | | | | | |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Audit and Risk Committee Annual Report 2025/26 | | | |
| **Meeting:** | Board of Directors | **Action Required** | Assurance | ✓ |
| **Date:** | 30 July 2026 | | Discussion | ✓ |
| **Executive Sponsor** | Director of Corporate Governance | | Decision | ✓ |

| | |
|---|---|
| **Purpose of the report** | This report provides a summary of the activities of the Audit Committee and sets out how the Committee met its terms of reference and key priorities in 2025/26. |

| | |
|---|---|
| **Previously considered by:** | Audit and Risk Committee |

| | |
|---|---|
| **Executive Summary** | This Audit and Risk Annual Report provides an overview and summary of the following key points:<br>• Membership, frequency and effectiveness of meetings<br>• Governance arrangements to support the committee<br>• The work and performance of the committee during the financial year including work supported by internal audit, external audit, and counter fraud.<br>• The Committee's role with regards to internal systems of control and receiving assurance on information governance, risk management, financial management and corporate governance.<br>• The role of the committee in reviewing and approving the Trust's Annual Report and Annual Accounts.<br><br>In preparing the report, the Chair of the Audit and Risk Committee is of the view the committee has taken appropriate steps to perform its duties as delegated by the Board of Directors and it has no cause to raise any issues of significant concern with the Board arising from its work during 2025/26. |

| | |
|---|---|
| **Proposed Resolution** | The Board of Directors is asked to ***receive*** and ***approve*** the Audit and Risk Committee Annual Report, noting the assurance it provides that the Committee has discharged its terms of reference. |

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

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Victoria Crompton, Corporate Governance Manager<br>Sharon Katema, Director of Corporate Governance | **Presented by:** | Tony Allen, Chair of Audit and Risk Committee |

# Audit and Risk Committee
# Annual Report
# 2025 - 26

# Contents

1. **Purpose** ..... 3
2. **Introduction** ..... 3
3. **Committee Membership and attendance at meetings** ..... 3
4. **Terms of Reference and Committee Workplan** ..... 4
5. **Reports to the Board of Directors** ..... 5
6. **Work of the Committee during 2025-26** ..... 5

a) Board Assurance Framework ..... 5
b) Risk Management ..... 6
c) Registers and Declarations of Interest process: ..... 6
d) Losses and Special Payments ..... 6
e) Tenders Waived ..... 6
f) Information Governance Annual Report ..... 6

7. **Counter Fraud** ..... 7
8. **External Audit** ..... 7
9. **Internal Audit** ..... 8
10. **Financial Reporting** ..... 10
11. **Effectiveness of the Audit and Risk Committee** ..... 10
12. **Conclusion** ..... 10
13. **Chair's Commendation** ..... 11

## 1. Purpose

The Audit and Risk Committee Annual Report supports good governance and demonstrates compliance with the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook. It covers the 2025/26 financial year.

Prepared for the Board of Directors, this report reviews the work and effectiveness of the Audit and Risk Committee in discharging its Terms of Reference. It will also be included in the Trust's Annual Report in line with best practice.

Following presentation to the Board, the report will be received and considered by the Council of Governors. It provides assurance on how the Non-Executive Directors, supported by internal and external auditors, have scrutinised systems of internal control and promoted good governance and accountability. It also outlines the work undertaken by Forvis Mazars, the external auditors appointed by the Council of Governors.

## 2. Introduction

The Audit and Risk Committee (Committee) is a formal Committee of the Board established under Board delegation with approved terms of reference aligned with the HFMA NHS Audit Committee Handbook.

The Committee provides an independent and objective review of the Trust's internal controls and seeks assurance on the effectiveness of the Trust's governance, risk management and systems of internal control. The Committee has responsibility for ensuring that independence is maintained for any non-audit work undertaken by the Trust's external auditors, Forvis Mazars.

There was no non-audit work carried out during the reporting period.

## 3. Committee Membership and attendance at meetings

The Chair and members are appointed by the Board of Directors from amongst the Non-Executive Directors of the Trust. The membership of the Committee is made up of three Non-Executive Directors. To ensure that Committee members have the skills required to carry out their role, all members have the opportunity to attend training courses including those provided by MIAA which cover topics that are relevant specifically to members of NHS Audit Committees.

The Chair of the Trust is not a substantive member of the Committee but may be invited to attend one meeting during the financial year.

The Chief Executive, in her role as Accounting Officer of the Trust, is invited to attend at least one meeting a year to present the Annual Governance Statement.

The Committee met on five occasions in the period covered by this report to discharge its responsibilities

for scrutinising the risks and controls which affect all aspects of the organisation's business.

Attendance at the Committee is shown in the table below.

| | Meeting Dates | | | | |
|---|---|---|---|---|---|
| | 07/05/25 | 25/06/25 | 17/09/25 | 03/12/25 | 11/02/26 |
| Alan Stuttard (Chair) | ✓ | ✓ | ✓ | ✓ | |
| Fiona Taylor | ✓ | ✓ | ✓ | ✓ | ✓ |
| Sean Harriss | ✓ | ✓ | ✓ | ✓ | ✓ |
| Tony Allen (Chair) | | | | | ✓ |
| Tiri Mutambasere | | | | | ✓ |

During the 2025-26 financial year, meetings of the Committee were attended on a regular basis by

- Chief Financial Officer
- Director for Corporate Governance
- Associate Director of Finance - Financial Services
- Mersey Internal Audit Agency (MIAA)
- External audit representation was provided by Forvis Mazars
- Local Counter Fraud Specialist

Invitations were extended to members of the executive team who attended meetings to present and make assurances on Limited Assurance Opinion internal audit reviews.

The Committee is assured that its members and regular attendees, have sufficient knowledge of the organisation's business to identify key risks.

## 4. Terms of Reference and Committee Workplan

The Terms of Reference of the Audit and Risk Committee are reviewed annually and were last reviewed in December 2025 and are attached at Appendix 1 for information.

The Chair and members of the Audit and Risk Committee confirm that the Committee has fulfilled its role as the primary governance and assurance committee in accordance with its Terms of Reference.

The Audit and Risk Committee members met in private with both the Internal and External Auditors during the reporting period.

The Audit and Risk Committee agenda is formulated from the Annual Workplan and is constructed in order to provide assurance to the Board of Directors across a range of activities including corporate governance, financial management, risk management and information governance.

## 5. Reports to the Board of Directors

The Chair of the Audit and Risk Committee provides a summary report of the Committee's activities to the next available Board of Directors' meeting. This report seeks to assure the Board on the main items discussed by the Committee, and, should it be necessary, to escalate to the Board any matters of concern or urgent business which the Committee is unable to conclude. The Board may then decide to give direction to the Committee as to how the matter should be taken forward or it may agree that the Board deals with the matter itself.

The Committee Chair has also made recommendations for items that needed to be considered the by the Quality Assurance Committee of the Board.

## 6. Work of the Committee during 2025-26

The Committee's work predominantly focusses on the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives. The Committee had a pivotal role to play in reviewing the disclosure statements from the organisation's assurance processes; in particular, the Annual Governance Statement, which includes the Head of Internal Audit Opinion. The Committee also has a key role in reviewing the reports of the External and Internal Auditors and their findings for the Trust.

The Annual Governance Statement describes the system of internal control that supports the achievement of the Trust's policies, aims and key priorities. The Audit and Risk Committee is scheduled to review the draft Annual Governance Statement for the period 01 April 2025 to 31 March 2026 at its meeting on 6 May 2026.

The Audit and Risk Committee will consider all audit reports and findings in respect of IFM Ltd, the wholly owned subsidiary of the Trust and the Trust Charity.

The Audit and Risk Committee agendas in the reporting period covered the following:

### a) Board Assurance Framework

The Audit and Risk Committee received the Board Assurance Framework at its December 2025 and May 2026 meetings. The Committee reviewed the framework as a key source of assurance on the principal risks to delivery of the Trust's strategic objectives, including the controls, assurances and gaps identified. The framework supports Board decision-making by providing a clear and structured view of

the most significant risks, enabling the Board to focus its attention on areas requiring oversight, challenge or further action. On both occasions, the Committee was assured by the content and supporting process and did not recommend any amendments.

### b) Risk Management

In line with its workplan, the Committee received AAA Key Issues Reports from the Risk Management Group, chaired by the Chief Nursing Officer, together with the Trust Corporate Risk Register. This enabled the Committee to maintain oversight of the key corporate risks, the controls in place to manage them, and any areas requiring further assurance or escalation. The Committee reviewed the register, considered the supporting information presented, and referred any queries to the Chief Nurse for further consideration at the next meeting. Following review, no amendments to the content of the register were recommended.

### c) Registers and Declarations of Interest process:

The Committee reviewed the Declarations of Interest Register, including the Gifts and Hospitality Register and Sponsorship Register, to seek assurance on the appropriateness and completeness of the information recorded.

As part of the annual internal audit plan, the Committee received the Conflicts of Interest review and considered the findings and associated follow-up actions.

The Committee also reviewed the Register of Interests for 2025/26, noting a 48% declaration completion rate for identified decision makers, which was lower than the previously reported rate of 86.7% in 2024.

### d) Losses and Special Payments

The Audit and Risk Committee was provided with regular information regarding the levels and values of losses and special payments within the Trust and IFM Ltd. There were no areas of concern noted with these payments.

### e) Tenders Waived

The Audit and Risk Committee received a summary of all tenders waived by both the Trust and IFM Ltd above a £50k value at each meeting. The Committee reviewed the explanations given for the waivers to ensure that there is effective control over the financial and procurement process with the overall aim of reducing the number of waivers.

### f) Information Governance Annual Report

In line with the change to the Terms of Reference, the Committee received the Information Governance Annual Report which provided assurance on the information governance and security activity for the period 01 July 2024 to 30 June 2025. The report sets out objectives for the forthcoming year and

highlighted areas including the Data Security and Protection Toolkit, Freedom of Information requests, Subject Access requests, data protection incidents and ensuring data security. The Audit and Risk Committee received the Information Governance Annual Report.

## 7. Counter Fraud

Counter Fraud services are provided through a Service Level Agreement with Wrightington, Wigan and Leigh NHS Foundation Trust. A nominated Local Counter Fraud Specialist (LCFS) works with the Trust and regularly attends Audit and Risk Committee meetings.

The Audit and Risk Committee received Local Counter-Fraud Progress Reports and details of investigations carried out at each of its regularly scheduled meetings throughout the year. These updated the Committee on the major findings and any lessons learnt from individual cases on counter-fraud. Assurances were received about the processes in place to tackle fraud and bribery.

The Committee approved the 2025/2026 Counter Fraud Work Plan which is designed to help manage fraud, bribery and corruption risks across the Trust ensuring compliance with the NHS Counter Fraud Authority (NHS CFA) requirements and the expectations detailed in the Government's Functional Standards (GovS 013), relating to Fraud, Bribery and Corruption.

The Chair and Chief Financial Officer signed off the annual return to the NHS Counter Fraud Authority during the financial year.

## 8. External Audit

The Audit and Risk Committee received and approved the External Audit Plan for 2025/26. The Plan identified significant inherent audit risks related to:

- Management override of controls
- Fraud in revenue recognition
- Fraud in expenditure recognition
- Valuation of land and buildings revalued in year

The Committee received the 2025/26 External Audit Report (including the ISA 260 Report) at its meeting held on 25 June 2026. The report confirmed that no significant audit issues had arisen in respect of the significant inherent audit risks and key audit judgements listed above. The report further confirmed that no audit adjustments or disclosure deficiencies had been identified. An Unqualified audit opinion was given on the Trust's accounts for 2025/26.

As part of their Audit work the External Auditors also undertook the Value for Money risk assessment for the year ended 31 March 2026 as required by the Code of Audit practice the auditors reported that "we have completed our work in respect of the Trust's arrangements for the year ended 31 March 2026 and have identified one significant weakness in arrangements and have made associated

recommendations".

Following the Committee meetings in June 2026, the Committee made recommendations to the Board of Directors to approve the Audited Accounts, Annual Report and Annual Governance Statement for 2025/26.

In addition to reviewing the Accounts for the Trust the External Auditors also undertake the External Audit for IFM Ltd and conduct the Independent Review of the Charitable Fund Accounts, Forvis Mazars provided regular progress reports and technical updates to the Audit and Risk Committee.

## 9. Internal Audit

The Internal Auditors, MIAA were in attendance at all Committee meetings and presented findings of internal audit reviews and the associated management responses and monitored the implementation of recommendations through regular progress reports. The conclusions, as well as the findings and recommendations, of all Internal Audit reports finalised during the year were shared with the Audit and Risk Committee.

The Committee challenged Internal Audit on assurances provided and, where appropriate, requested additional information, clarification and follow-up work if considered necessary. Progress towards the implementation of agreed recommendations was also reported (including full details of all outstanding recommendations) to the Executive Management Team. The Audit and Risk Committee reviewed and was satisfied by the progress reports.

The Committee also referred some reports to the other Board Committees for consideration where concerns had been raised or to support the work of the other Committees in the provision of assurance to the Board of Directors.

The Head of Internal Audit Opinion for 2025/26 presented to the Audit and Risk Committee stated that Moderate Assurance, can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk.

The following Internal Audit Reports were received by the Audit and Risk Committee during the reporting period:

| Audit Title (Final Reports) | Report classification | Critical | High | Medium | Low | Total |
|---|---|---|---|---|---|---|
| | | Number of findings | | | | |
| Assurance Framework | N/A | N/A | N/A | N/A | N/A | **N/A** |
| Risk Management Core Controls | Substantial | 0 | 0 | 1 | 0 | **1** |
| Conflicts of Interest | Moderate | 0 | 1 | 2 | 0 | **3** |
| Fit and Proper Person Test | Substantial | 0 | 0 | 1 | 3 | **4** |
| Key Financial Transactional Processing Controls | Substantial | 0 | 0 | 2 | 3 | **5** |
| Finance Systems Deep Dive – Agency Costs (Draft) | Moderate | 0 | 2 | 2 | 1 | **5** |
| Quality Spot Checks – Infection Prevention Control (Clostridium Difficile Toxin) | Limited | 0 | 1 | 5 | 0 | **6** |
| Did Not Attend Controls Review | Substantial | 0 | 0 | 1 | 1 | **2** |
| ESR Payroll | Substantial | 0 | 0 | 2 | 3 | **5** |
| Remote Access Controls (Draft) | Moderate | 0 | 1 | 3 | 0 | **4** |
| Staff Headcount Controls (Draft) | Moderate | 0 | 1 | 2 | 0 | **3** |
| CAF aligned DSPT | High Risk/High Confidence | 0 | 4 | 0 | 0 | **4** |
| Procurement | Substantial | 0 | 0 | 3 | 3 | **6** |
| **TOTAL** | | **0** | **10** | **25** | **13** | **48** |

**Action tracking:**

The Committee received regular reports in respect of progress with the implementation by managers of agreed audit recommendations and sought assurance on progress of outstanding actions.

## 10. Financial Reporting

During and in respect of the financial year, the Committee reviewed the Annual Accounts for IFM Ltd for the year ended 31 March 2025 and the Charitable Fund Accounts for the year ended December 2025.

The Committee received, gained assurance and actioned the following:

- Approved the Annual Report & Quality Account 2025/26 timetables for production.
- Confirmed that the Accounts for 2025/26 be prepared on a going concern basis
- Recommended approval of the 2025/26 Annual Report and Annual Accounts to the Board of Directors following completion of the External Audit in June 2026.
- Reviewed the Draft Annual Accounts for 2025/26 prior to submission to the External Auditors
- To review the Annual Accounts following completion of the audit by the External Auditors and recommended the Accounts for approval by the Board of Directors.
- Reviewed the Letter of Representation 2025/26 for approval by the Board of Directors and signing by the Accountable Officer.
- Reviewed the Annual Report and recommended the Report for approval by the Board of Directors.

## 11. Effectiveness of the Audit and Risk Committee

In November 2025, the Committee undertook a self-assessment of its effectiveness. This involved a range of questions covering different elements of the work of the Committee. This follows good governance practice in accordance with the NHS Audit Committee Handbook.

The results were generally positive and indicate that the Committee has demonstrated clear and sustained improvement in effectiveness over the three years. Leadership and committee environment are consistent strengths, while balancing quality and financial assurance and improving inter-committee information flow remain areas to address. The positive trajectory in scores and feedback reflects a strong commitment to governance and continuous improvement.

## 12. Conclusion

The Audit and Risk Committee plays a central role in supporting the Board's governance and assurance arrangements by providing independent oversight, constructive challenge and scrutiny of the Trust's systems of risk management, internal control and financial governance.

During the year, the Committee received assurance through its review of the Board Assurance Framework, Corporate Risk Register, internal and external audit reports, counter fraud activity, financial reporting, information governance, declarations of interest and the implementation of agreed audit recommendations. The Committee has used these sources of assurance to assess whether appropriate controls are in place, whether identified weaknesses are being addressed, and whether matters requiring further oversight are escalated appropriately to the Board or relevant Board Committees.

The Committee recognises the progress made during 2025/26, including the continued strengthening

of assurance reporting, action tracking and scrutiny of key areas of risk. It also acknowledges the importance of maintaining focus on areas where further improvement is required, particularly where audit findings, completion rates or assurance gaps indicate the need for sustained management action and follow-up.

Overall, the Committee is assured that there are established governance, risk management and internal control arrangements in place, supported by regular reporting, audit review and escalation processes. The Committee will continue to seek assurance that these arrangements remain effective, that agreed actions are implemented in a timely way, and that appropriate governance and control arrangements are maintained for iFM Ltd.

## 13. Chair's Commendation

As Chair of the Audit and Risk Committee, I would like to express my sincere thanks to Committee members for their continued support, commitment and constructive challenge throughout the year. Their contributions have strengthened the Committee's ability to discharge its responsibilities effectively and to provide robust assurance to the Board on key matters of governance, risk management, internal control and financial stewardship.

I would also like to record particular thanks to Annette Walker, the Chief Finance Officer, who will shortly be leaving the Trust after nine years of service and a longer period of contribution across the Bolton system. The Committee has valued Annette's leadership, professional advice and support to the Committee's work, particularly in relation to financial governance, annual reporting and the external audit process. The Committee extends its very best wishes for the future.

Finally, I would like to thank all regular attendees, internal and external audit representatives, the Local Counter Fraud Specialist and the Corporate Governance team for their continued support, advice and administrative assistance. Their collective input has enabled the Committee to maintain effective oversight, receive timely assurance and ensure that matters requiring further action or escalation have been appropriately followed up.

Chair Tony Allen
Date 25 June 2026

| | | | | |
|---|---|---|---|---|
| **Report Title** | Green Plan Annual Report | | | |
| **Meeting** | Board of Trust Board | **Action Required** | Assurance | |
| **Date** | July 2026 | | Discussion | |
| **Executive Sponsor** | Chief Finance Officer | | Decision | ✓ |

| | |
|---|---|
| **Purpose of the report** | The purpose of this report is for the Board of Directors to approve the 2025-26 Green Plan Annual Report for internal and external publication. |

| | |
|---|---|
| **Previously considered by** | Approved by Our Green Group, iFM Executives, Finance and Investment Committee, and Strategic Estates Group. |

| | |
|---|---|
| **Executive Summary** | The Energy and Sustainability Manager has prepared iFM Bolton's and Bolton NHS FT's first Green Plan Annual Report for the Green Plan 2025-30.<br><br>This report details progress on carbon emissions, key achievements in the financial year and details progress against all the priority actions from the 2025-30 Green Plan. |

| | |
|---|---|
| **Proposed Resolution** | The Board of Directors is asked to ***approve*** the Green Plan Annual Report. |

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

| Summary of key elements / Implications | | |
|---|---|---|
| **Implications** | **Yes /No** | **If Yes, State Impact/Implications and Mitigation** |
| **Finance** | Yes | To achieve our targets there are financial requirements for investment of our estate and service infrastructures to achieve our Net Zero Goals |
| **Legal/ Regulatory** | Yes | Non-compliance with sustainability regulations can lead to legal repercussions and fines, making it essential for businesses to stay informed about the latest regulations. |
| **Health Inequalities** | Yes | Have an opportunity to intentionally manage our land and buildings in a way that has a positive social, economic, and environmental impact. |
| **Equality, Diversity and Inclusion** | Yes | We will deliver high quality, patient centered accessible services and as an employer provide a positive, inclusive and fair workplace culture free from discrimination. |
| **Is a Quality Impact Assessment Required** | No | |

| | | | |
|---|---|---|---|
| **Prepared by:** | Charlotte Houghton, Energy and Sustainability Manager | **Presented by:** | Charlotte Houghton, Energy and Sustainability Manager |

## 1. Purpose of Report

As part of the NHS standard Contract 25/26 Service Condition clauses 18.2 & 18.3, and the Task Force for Climate-related Financial Disclosures (TCFD) requirements in the Trust Annual Reporting Manual 25/26, each Trust is required to provide evidence of compliance to the Greater Manchester Integrated Care Board as per the below each year.

| | **Format of Report** |
|---|---|
| Report on progress against Green Plan in accordance with SC18.2 and SC18.3 (NHS Trust/FT only) – aligned with NHS FT Annual Reporting Manual 2024/25.<br><br>NHS Standard Contract 25/26<br><br>NHS England » NHS foundation trust annual reporting manual 2025/26 | Provision of an annual summary of progress of delivery of the Green Plan including the following as a minimum:<br><br>• actions taken and planned<br><br>• quantitative progress data<br><br>• evidence that a summary has been published in the Trust's annual report<br><br>• Clear detailed plans in relation to; air pollution (fleet vehicles, promotion of and increased use of sustainable travel and phasing out of fossil fuel for primary heating), climate change (how organisation will take action to reduce greenhouse gas emissions, reduce carbon impacts of anaesthesia, nitrous oxide and inhalers and adapt premises and services to reduce risks from climate change)<br><br>• TCFD (Task Force on Climate-Related Financial Disclosures) |

Bolton NHS FT have previously only submitted a Task Force on Climate-Related Financial Disclosures for the Trust Annual Report (Appendix 1), and although there is no requirement to produce a separate Green Plan Annual Report. This gives a clear summary of progress against the Green Plan and shows areas that require focus over the next financial year.

**Appendix 1 – Taskforce for Climate-Related Disclosures 25/26**
**Appendix 2 – Green Plan Annual Report 25/26**

## 1.1. Taskforce On Climate-Related Financial Disclosures (TCFD)

NHS England's NHS foundation trust annual reporting manual adopted a phased approach to incorporate the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures are as interpreted and adapted for the public sector by HM Treasury. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications where appropriate.

### Board's oversight of climate-related issues

The Trust is committed to advancing the Green Plan's initiatives, ensuring responsibility, compliance, and effective communication, as well as cultivating a culture of sustainability within the organisation.

A priority action in the Green Plan 2025-30 is to document the Green Plan governance and embed into the Trust governance process, including an annual review to ensure updates are given regularly to all stakeholders. During 2025-26, this action has been progressed as a new group has been established for oversight of the Green Plan progress. The Joint Green Plan Delivery Group will be launched in Q1 2026-27 and will meet quarterly. Each meeting will produce a report that goes to Strategic Estates Group (chaired by the Net Zero Board Lead). These will then be combined into an annual report to the Finance and Investment committee and the Trust Board.

As well as this robust governance route detailing quarterly progress, there will be an annual sustainability report published that can be reviewed by the board with a narrative on carbon emissions, and progress against each priority action in the Green Plan 2025-30. The sustainability annual report 2025-26 is the first to be produced, giving the board better oversight on progress on climate-related issues.

### Management's role in assessing and managing climate-related issues

To implement the Green Plan 2025-30, management has a vital role in making sure that the organisation's values and behaviours reflect sustainability. This also involves setting up necessary groups to make changes, reducing the carbon footprint, developing an environmental policy, and measuring carbon emissions against the Green Plan's targets.

The Joint Green Plan Delivery Group has a broad membership that includes a lead for each area of focus within the Green Plan 2025-30. This quarterly meeting will bring forward any climate-related issues, and these can continue through the relevant governance route as necessary to address.

**Describe the climate-related risks and opportunities identified over the short, medium and long term**

The Green Plan 2025-30 has identified multiple climate-related opportunities that will support Bolton NHS FT to be more sustainable both environmentally and financially. A key action in 2025-26 has been to commission a heat decarbonisation plan for the Royal Bolton Hospital site. This will identify projects for future years that will mitigate climate-related risks and capitalise on the opportunities for environmental and financial sustainability due to the mitigation of these risks.

**Describe the impact of climate-related risks and opportunities on operations, strategy and financial planning and how these may materialise over the short, medium and long term, when considered against a global warming pathway of 2°C or lower**

In the Green Plan 2025-30, one priority action is to undertake a risk assessment for the Green Plan which will include the risk of achieving the Green Plan as well as the more general climate related risks. This has not been started since the Green Plan 2025-30 was published on 31st July and needs to be considered a high priority action over the next 12 months to ensure that climate-related risks are incorporated into any operational, strategic or financial planning activities.

**The processes for identifying and assessing climate-related risks**

Alongside a robust risk management process, and governance structure arising risks are also identified from the yearly NHS Core standards for Emergency Preparedness, Resilience and Response with specific emphasis in 2019 deep dive. Arising risks are extrapolated from the national and divisional risk registers into the Trust corporate/divisional risk register regarding:

- **Extreme Heat & Overheating**: High temperatures threaten patient safety, particularly with estimates that 90% of hospital wards are vulnerable to overheating, causing heat-related illness and death.
- **Flooding & Severe Weathe**r: Increased flood risks and extreme weather jeopardize healthcare infrastructure, including power and water supply, and disrupt transport for staff and patients.
- **Health System Demand & Delivery**: Climate change creates service disruptions and increases demand on emergency services, challenging the ability of the NHS to deliver consistent care.
- **Infectious Diseases**: Changing conditions are expected to increase the risk of vector-borne diseases and water-borne pathogens.
- **Mental Health Impacts:** Climate anxiety, along with the psychological effects of extreme weather events, presents a growing threat to public mental health

As well as planning for the mitigation and response to risks, where practicable through established business continuity plans and specific incident response plans under the Trust's Emergency preparedness, resilience and response (EPRR) that support the management of climate-related risks.

**The processes for managing climate-related risks**

The Joint Green Plan Delivery Group will have oversight of any identified risks, and due to the broad membership will be able to suggest mitigations and actions. These will be monitored through this group or escalated to the overarching risk management process as necessary.

Alongside a robust risk management process, there are established business continuity plans under the Trust's Emergency preparedness, resilience and response (EPRR) that support the management of climate-related risks.

**The processes for identifying, assessing, and managing climate-related risks are integrated into the organisation's overall risk management**

As seen in the risk management section para 2.6 and the corresponding governance associated with it, Principal Risks 12 of Ambition 4 are climate-related risks associated with the Trust's ambitions. Climate-related risks being highlighted as risks to the high-level Trust ambitions show how these risks are integrated into the Trusts' risk management processes.

**The metrics used to assess climate-related risks and opportunities in line with its strategy and risk management process**

The metrics used for assessing climate-related risks and opportunities follow the standard risk management and governance process within the Trust. Trend analysis is undertaken on ERIC (Estates Return Information Collection) each year on events such as overheating.

**The targets used to manage climate-related risks and opportunities and performance against targets**

The Green Plan 2025-30 includes actions that support the achievement of the NHS ambitions to be net zero for the NHS Carbon Footprint by 2040 and net zero for the NHS Carbon Footprint Plus by 2045. These targets are monitored through yearly carbon emission reporting, as can be seen in the 2025-26 sustainability annual report.

All other priority actions are also monitored through monthly KPIs and the annual report, that is reported through the Joint Green Plan Delivery Group governance process. Any climate-related risks or opportunities that are not detailed in the Green Plan priority actions but require work, will also be documented in this process.

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

# Green Plan Annual Report

2025-26




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

# Contents


- Executive summary 3
- Trust carbon emissions 4
- UK-ETS fines 7
- Key achievements 2025-26 8
- Priority action progress 11
- Appendix 1: Other initiatives 19
- Appendix 2: Funding and savings summary 20

# Executive summary

**Bolton NHS Foundation Trust (FT) have made valuable progress towards the Green Plan 2025-30 priority actions in the first year of publication.**

Bolton's carbon emissions continue to increase due to a continued year on year increase in gas usage, but the 2024-25 steam network repairs will reduce this in the 2025-26 figures and the heat decarbonisation plan that is currently being drafted will help generate projects to reverse this in future years.

Of the priority actions set out in the 2025-30 Green Plan, 60% have had progress against them. 10% have been fully completed in 2025-26 with a further 50% in progress. The completed actions were to complete a digital maturity assessment, to fully roll out a digital meal ordering system, and complete monthly sustainability reports that include relevant key performance indicators.

Further key achievements for 2025-26 include publishing and launching the new Green Plan, which also saw the relaunch of the Green Champions network, and the installation of 6 charging points that will allow the fleet to be converted to electric once the lease runs out in May 2026.

Appendix 1 covers initiatives that do not fit neatly into the priority actions but are supporting the Green Plan, including actions that have been completed in 2025-26, and actions that are in progress and are expected to be complete in 2026-27, such as solar panel installation across the hospital. Appendix 2 gives a summary of all the external funding received to support projects (£810k), along with the one-off financial savings (£799k), recurrent financial savings (£685k) and carbon savings achieved (252T).

# Trust carbon emissions

The NHS aims to be net zero carbon for the NHS Carbon Footprint by 2040, and net zero for the NHS Carbon Footprint Plus by 2045 (figure 1).

2019-20 is the baseline year, and the NHS England estimated contribution of Bolton NHS FT towards the overall NHS Carbon Footprint for 2019-20 was 15,900 tCO2e, and for the Carbon Footprint Plus was 55,900 tCO2e.

Bolton NHS FT will be analysing the NHS England annual data to verify all carbon reduction projects to prove they achieved the expected outcome, and to highlight areas that should be a focus for the coming years.

This data is provided annually but due to data collection timings, are 1 year behind so the latest figures are for 2024-25. This means that projects need to be tracked in terms of carbon emissions saved but also year of expected reductions.

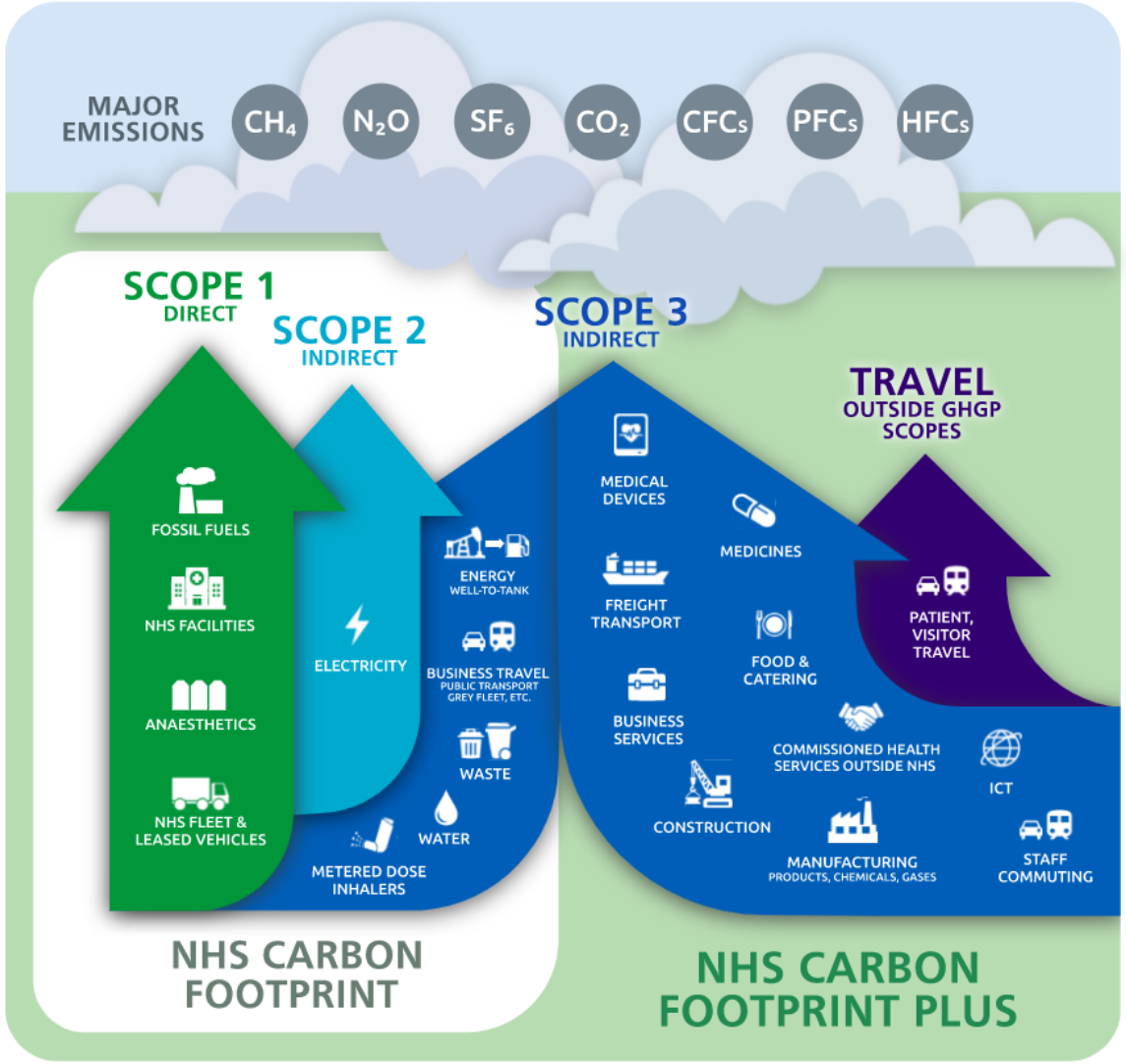
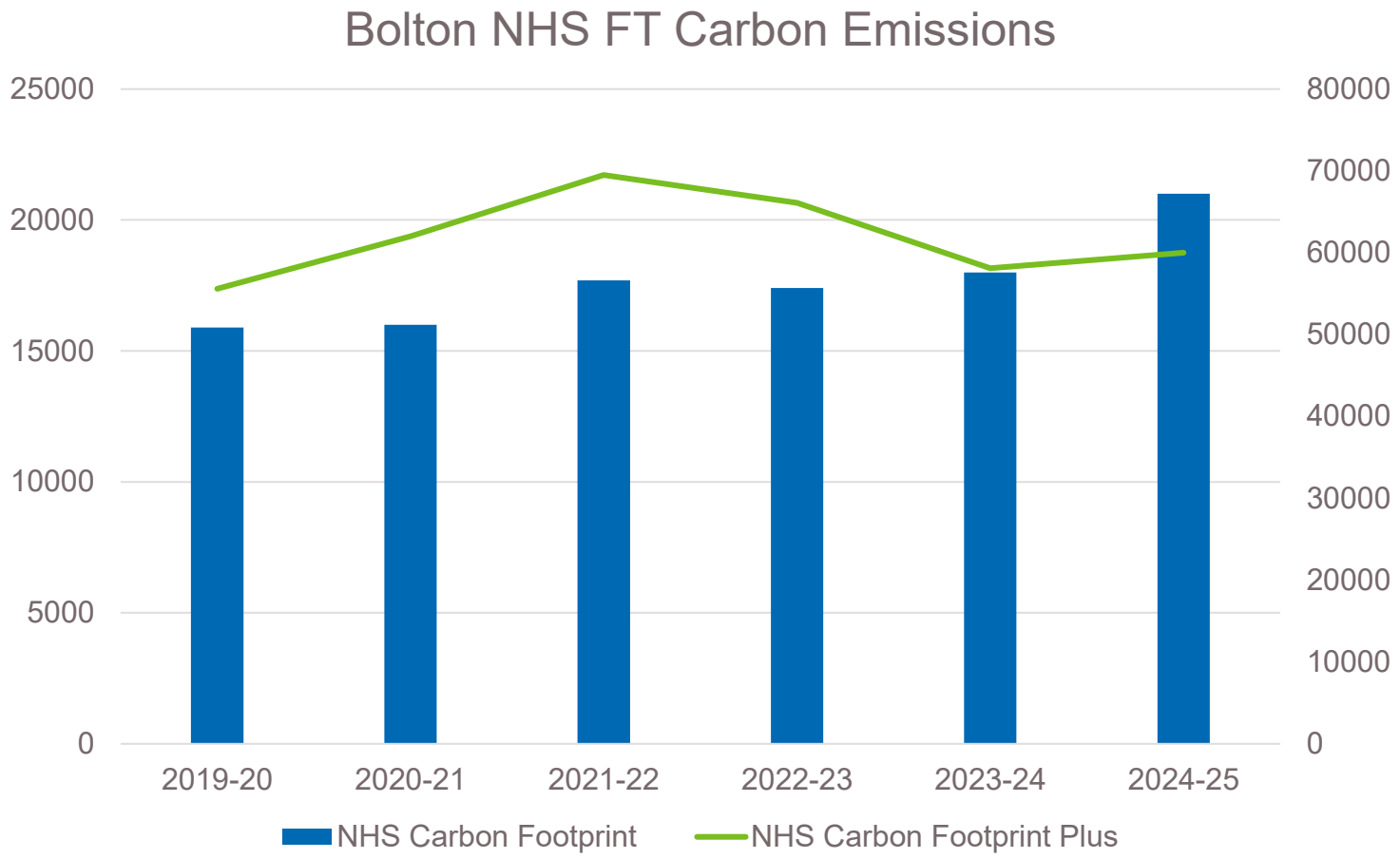



Figure 1 – NHS Carbon Footprint and NHS Carbon Footprint Plus

# Trust carbon emissions

| Reporting Year | NHS Carbon Footprint* | NHS Carbon Footprint Plus* |
|---|---|---|
| **2019-20** | **15,900** | **55,600** |
| 2020-21 | 16,000 | 62,000 |
| 2021-22 | 17,700 | 69,500 |
| 2022-23 | 17,400 | 66,100 |
| 2023-24 | 18,000 | 58,100 |
| **2024-25** | **21,000** | **60,000** |

*Figures rounded to the nearest ‘000



# Trust carbon emissions

## NHS Carbon Footprint

The Carbon Footprint figures for Bolton NHS FT continue to increase year on year, with 2024-25 being 21,000 tCO2e.There has been a decrease since the baseline year in emissions from the fleet, inhalers, volatile gases, waste and water. The year-on-year increase in gas usage outweighs the decreases resulting in a 32% increase since baseline, and 16% increase since 2023-24.

During 2024-25, significant repair works were made to the steam network which will be reflected in the 2025-26 emission figures.

During 2025-26, a heat decarbonisation plan was started which will give Bolton NHS FT a clear pathway to removing gas from site. The following years will see business cases developed directly from this plan which will reduce the NHS Carbon Footprint emissions from Bolton NHS FT.

## NHS Carbon Footprint Plus

The Carbon Footprint Plus figures for Bolton NHS FT were showing a decrease over the last few years, but 2024-25 has increased again to 60,000 tCO2e. This is an 8% increase since the baseline, and a 3% increase since 2023-24.

The significant areas of increase are construction and clinical supplies, which could be reduced by completing the following priority actions:

6.2 Create policies and procedures for all new builds and refurbishments to comply with the NHS zero carbon standards for buildings

7.1 Explore reliance on single-use products in clinical and non-clinical settings with a view to reduce the purchased volume

7.2 Align all relevant procurement activities to the NHS net zero supplier roadmap, Carbon Reduction Plan and Net Zero Commitment

7.3 Ensure suppliers go beyond minimum requirements by engaging with the Evergreen Supplier Assessment

# UK-ETS fines

## UK-ETS carbon emissions fines

UK-ETS is a cap-and-trade system designed to reduce greenhouse gas emissions from participating industries by putting a price on carbon emissions from the direct burning of fossil fuels (gas).

All boilers with a gas combustion capacity over 3MW need to be declared and if the total across the site is over 20MW, the site is required to join UK-ETS and declare gas consumption for those boilers each year.

UK-ETS auditors provide the participating sites with targets, and the fine is calculated for every tonne of CO2 over the target. This is done on per calendar year and the latest 2025 data is available.

Bolton have three larger boilers, a combined heat and power plant and associated waste heat boiler with a total of 24.24 MW. Below are the last 5-years targets, emissions and fines.

| Year | Target ($TCO_2$) | Emissions ($TCO_2$) | Carbon Penalty (£) |
|---|---|---|---|
| **2021** | 5201 | 8862 | 175,581 |
| **2022** | 5060 | 8056 | 157,469 |
| **2023** | 4918 | 9057 | 343,661 |
| **2024** | 4777 | 10852 | 394,277 |
| **2025** | 4636 | 9518 | 204,258 |

In May 2025, the steam traps project was completed resulting in a reduction in gas for the second half of the year. The heat decarbonisation plan which was started in last 2025, with a June 2026 completion will generate projects to continue this downward trend.

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

# Key achievements 2025-26

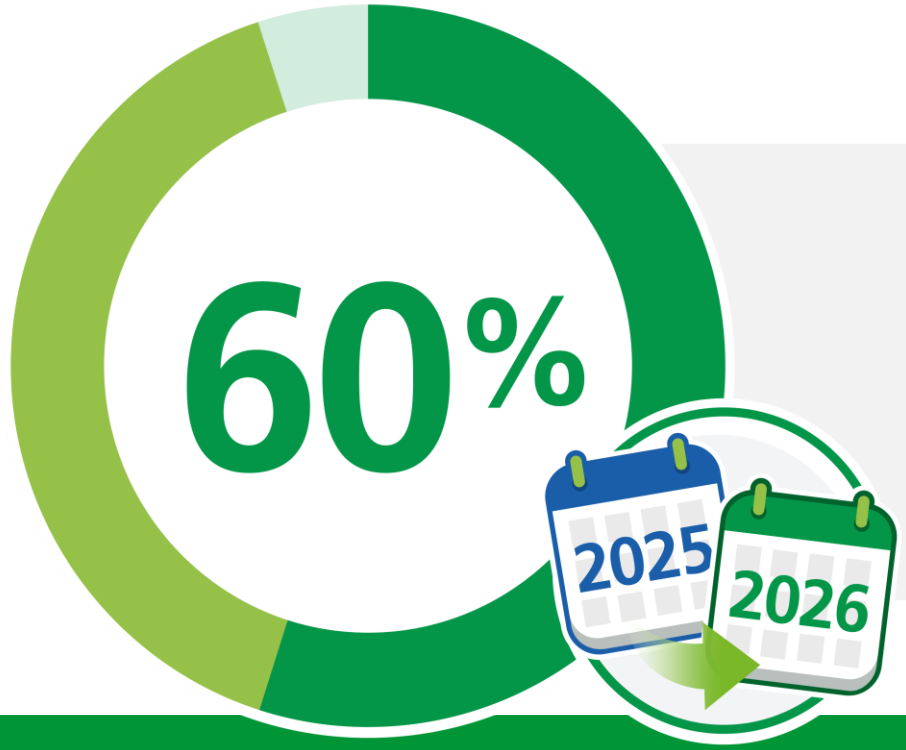


Improving care,
transforming lives...for a better Bolton

# Key achievements 2025-26

Bolton's Green Plan 2025-2030 includes 26 actions across 10 different areas of focus with an additional 4 actions relating to governance, tracking and reporting, and  risk. Out of those 30 actions, 60% (1 actions) had progress against them, with 10% (3 actions) being completed during 2025-26.

The focus for 2026-27 will be to progress actions that have not been started yet and continue to complete actions as projects and initiatives are completed.




**60%** (18 actions) had progress against them

**50%** (15 actions) are in progress

**10%** (3 actions) fully completed

# Green Plan relaunch

## Governance

- Green Plan 2025-30 written, approved, and published by the NHS England deadline of 31st July.
  - Internal stakeholder engagement meetings held to understand progress.
  - In progress actions combined into the new areas of focus and priority actions.
- Green Plan 2025-30 priority action tracker and dashboard created along with an ideas and opportunity log.
  - To include all initiatives related to sustainability.

- Green Plan 2025-30 relaunch week organised for w/c 15th September.
  - Staff update piece the week before and the week of the relaunch.
  - Daily BoB post and BoB turned green all week.
  - Two stands in the main entrance.
  - Slides included in the all-staff team briefing.
  - Fiona's Friday Green Plan takeover.
  - Meetings attended: Divisional People Committees, Divisional Directors of Operations.





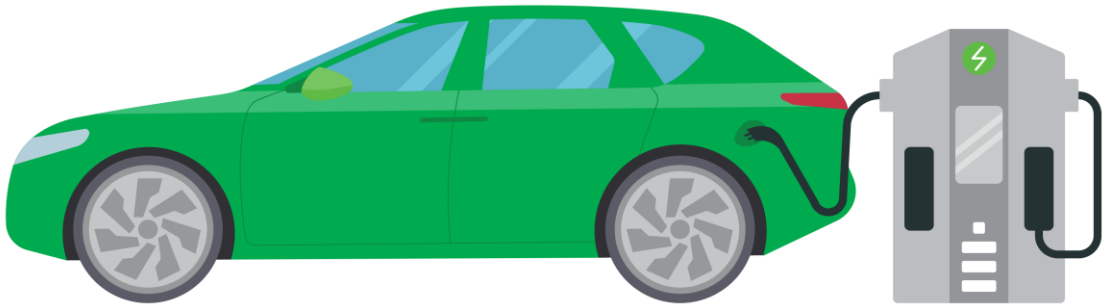

# EV charging point installation

## Travel and Transport




- NHS England target is for all new leased vehicles to be electric from 2027.
- Bolton NHS FT lease a fleet of 19 vehicles on an annual lease, due to expire in May 2026.
- Bolton NHS FT needed charging infrastructure to be installed prior to this conversion.
- NHS England provided £38k funding for 6 x 22 kw chargers to be installed outside the John Horlick Energy Centre in preparation for the fleet to be converted to electric.

- A business case is being prepared to convert either all or a part of the fleet to electric in the budget year 2026-27.
  - If the 10 highest mileage vehicles are converted to electric, £700/year will be saved in fuel costs.
  - If the whole fleet is converted to electric, £5,000 will be saved in fuel costs.
    - These savings were estimated using fuel prices in October 2025.



Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

# Priority Action Progress



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

# Green plan priority actions

| Area of focus | Reference | Action | Status | Comment |
|---|---|---|---|---|
| Workforce and leadership | 1.1 | Develop a Trust level communication and engagement scheme related to Sustainability | **In Progress** | Green Champions network relaunched |
| Workforce and leadership | 1.2 | Assess workforce capacity and skill requirements for delivering the green plan and investigate training possibilities for sustainability upskilling | **Not Started** | |
| Net Zero clinical transformation | 2.1 | Identify a clinical lead with formal links into board-level leadership and governance | **In Progress** | New Joint Green Plan Delivery Group will include clinical colleagues |
| Net Zero clinical transformation | 2.2 | Establish a multidisciplinary working group responsible for reducing emissions in clinical areas | **Not Started** | |
| Net Zero clinical transformation | 2.3 | Complete quality improvement project(s) in the clinical area(s) that focus on a measurable reduction in emissions, with co-benefits for outcomes and quality of care, efficiency and reducing healthcare inequalities | **Not Started** | |

# Green plan priority actions

| Area of focus | Reference | Action | Status | Comment |
|---|---|---|---|---|
| Digital transformation | 3.1 | Continue the move towards a paperless, technology focused hospital | In Progress | Work completed on moving appointment letters to electronic |
| Digital transformation | 3.2 | Complete the Digital Maturity Assessment to embed sustainability into all digital services | Complete | |
| Medicines | 4.1 | Reduce nitrous oxide waste from medical gas pipeline systems (MGPS) by progressing the actions outlined in the updated nitrous oxide waste mitigation toolkit | In Progress | Two manifolds decommissioned with £8k funding from NHS E |
| Medicines | 4.2 | Support patients to choose the most appropriate inhaler(s) in alignment with clinical guidelines, reducing the use of pressurised inhalers and moving towards powdered inhalers where clinically appropriate | In Progress | The % of pressurised inhalers used reduced from 95% in 2024-25 to 92% in 2025-26 |
| Medicines | 4.3 | Complete the Greener pharmacy toolkit | In Progress | Working towards the Bronze accreditation |

# Green plan priority actions

| Area of focus | Reference | Action | Status | Comment |
|---|---|---|---|---|
| Travel and transport | 5.1 | Prepare and publish a travel policy prepared in line with the other Greater Manchester Trust's by the end of 2026 | **In Progress** | Travel and Transport survey complete with 4.6% response rate to support travel policy development |
| Travel and transport | 5.2 | Investigate converting the NHS on site fleet to electric by end of 2027 | **In Progress** | 6 EV chargers installed for the fleet using £39k funding from NHS E |
| Estates and facilities | 6.1 | Develop a road map to net zero for the Royal Bolton Hospital site and Trust community centres | **In Progress** | Heat Decarbonisation Plan under development using £80k NHS E funding |
| Estates and facilities | 6.2 | Create policies and procedures for all new builds and refurbishments to comply with the NHS zero carbon standards for buildings | **Not Started** | |
| Estates and facilities | 6.3 | Implement and deliver the NHS waste strategy targets | **Not Started** | |

# Green plan priority actions

| Area of focus | Reference | Action | Status | Comment |
|---|---|---|---|---|
| Supply chain and procurement | 7.1 | Explore reliance of single-use products in clinical and non-clinical settings with a view to reduce the purchased volume | **Not Started** | |
| Supply chain and procurement | 7.2 | Align all relevant procurement activities to the NHS net zero supplier roadmap, Carbon Reduction Plan and Net Zero Commitment | **Not Started** | |
| Supply chain and procurement | 7.3 | Ensure suppliers go beyond minimum requirements by engaging with the Evergreen Supplier Assessment | **In Progress** | Evergreen status of suppliers is tracked and monitored |
| Supply chain and procurement | 7.4 | Improve the operation of walking aid recycling schemes across the community | **In Progress** | Improvement plans being prepared |
| Food and nutrition | 8.1 | Trial innovative ways to reduce food waste across the site in line with the KPI's already in place | **In Progress** | Blue plate trial carried out but results were unsuccessful, further trials being discussed |
| Food and nutrition | 8.2 | Ensure the digital meal ordering system for patients is available across all wards | **Complete** | Completed for all wards in October 2025 |

# Green plan priority actions

| Area of focus | Reference | Action | Status | Comment |
|---|---|---|---|---|
| Food and nutrition | 8.3 | Investigate increasing menu reviews from yearly to quarterly to add seasonal, lower carbon options | **Not Started** | |
| Biodiversity and greenspace | 9.1 | Prepare a biodiversity and greenspace strategy for the estate | **Not Started** | |
| Biodiversity and greenspace | 9.2 | Enhance the green space across the site to encourage employee wellbeing alongside increasing the environmental benefits. | **In Progress** | Walking routes work progressing along with funding applications for outdoor rest spaces |
| Climate adaptation | 10.1 | Develop and publish a long-term climate change adaptation plan, which has robust governance and reporting procedures. | **Not Started** | |
| Climate adaptation | 10.2 | Develop guidelines for Estates and Capital teams to factor in the effects of climate change when making infrastructure decisions and designing new facilities | **Not Started** | |

# Green plan priority actions

| Area of focus | Reference | Action | Status | Comment |
|---|---|---|---|---|
| Green Plan governance | 11.1 | Document the Green Plan governance and embed into the Trust governance process, including an annual review to ensure updates are given regularly to all stakeholders | **In Progress** | Joint Green Plan Delivery Group membership and Terms of Reference drafted for approval |
| Tracking and reporting progress | 12.1 | Adhere to the national reporting requirements, both quarterly and annually | **In Progress** | All reports sent on time |
| Tracking and reporting progress | 12.2 | Prepare monthly performance reports and AAA reports, alongside updating the relevant KPI's | **Complete** | Monthly performance reports now completed, which include AAA reports and KPI's |
| Finance, risks and challenges | 13.1 | Prepare a risk assessment for the Green Plan | **Not Started** | |

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

# Appendices



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

# Appendix 1 – Other initiatives

A lot of work has been carried out that does not fit neatly within the priority actions, and these are detailed below.

## Complete

- Community IV Therapy team won the GM health and care greener award, with savings of 3T/$CO_2$ per year.
- Tenant recharging process streamlined and discrepancies rectified. Additional income of £36k for 22/23 and 23/24 recovered.
- Meter maintenance contract changed with £1k/year savings.
- Forensic Energy Audit rebate of £763k received due to incorrect Climate Change Levy charges since April 2023.
  - Ongoing yearly savings of £307k.

## In Progress

- Installation of substation electrical metering and steam meters, all connected to the BMS (funded by NHSE). Expected completion May 2026.
- Installation of solar panels (funded by NHSE) started with £27k/year and 20 $TCO_2$ savings per year once complete in April 2026.
- Removal of a gas meter standing charges that was no longer on site, resulting in £300/year saving once verified in May 2026.
- Water Meters moved to automated meter readings for billing accuracy. Expected completion May 2026.
- Variable Speed Drives upgrade (funded by NHSE) started. £350k/year and 229 $TCO_2$ savings expected once complete in Sept 26.

# Appendix 2 - Funding and Savings Summary

| Project name | Description | External funding received (£'000) | One off saving (£'000) | Recurrent saving (£'000/year) | Carbon savings (T/year) |
|---|---|---|---|---|---|
| EV charging points | 6 x 22 kw chargers installed for the fleet | 39 | | | |
| Nitrous Oxide manifold decommission | Two manifolds decommissioned | 8 | | | 0.006 |
| Heat Decarbonisation Plan | Consultant commissioned to produce a heat decarbonisation plan for the site | 80 | | | |
| Community IV Therapy Team Award project | Greener way for administration of antibiotics in patients' homes | | | | 3 |
| Tenant recharging | Streamlined process and found discrepancies | | 36 | | |
| Meter maintenance | Contract changed to reduce expenditure | | | 1 | |
| Forensic energy audit | An audit of 6-year utility bills revealed a rebate was needed from Corona | | 763 | 307 | |
| Substation meter upgrades | Electrical metering infrastructure upgraded and connected to the BMS | 50 | | | |
| Steam meter upgrades | Old steam meters replaced and connected to the BMS | 100 | | | |
| Solar panel installation | Installation of 213 panels across four buildings on site | 343 | | 27 | 20 |
| Variable Speed Drive upgrade | Variable Speed Drive upgrade allowing for lower fan speeds | 190 | | 350 | 229 |
| **Totals** | | **£810** | **£799** | **£685** | **252T** |

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust




**Bolton NHS Foundation Trust**
Royal Bolton Hospital
Minerva Road, Farnworth
Bolton, BL4 0JR

**t|** 01204 390390 **w|** boltonft.nhs.uk

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