

BOARD OF DIRECTORS' AGENDA

MEETING HELD IN PUBLIC

To be held at 1.00 pm on Thursday 24 September 2026
 in the Boardroom, Royal Bolton Hospital, Minerva Road

Ref N ^o .	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB090/26	Chair's welcome and note of apologies <i>Purpose: To record apologies for absence and confirm the meeting is quorate.</i>	Verbal	Chair	
TB091/26	Patient and Staff Story <i>Purpose: To receive the patient and staff story.</i>	Presentation	Chair	
TB092/26	Declarations of Interest relating to agenda items <i>Purpose: To record any interests relating to agenda items.</i>	Verbal	Chair	13:00 (20 mins)
TB093/26	Minutes of the previous meeting held on 30 July 2026 <i>Purpose: To approve the minutes of the previous meeting.</i>	Report	Chair	
TB094/26	Matters Arising and Action Log <i>Purpose: To consider matters arising not included on the agenda, review outstanding actions and approve completed actions.</i>	Report	Chair	
WELL LED FRAMEWORK				
TB095/26	Chair's Update <i>Purpose: To receive the Chair's Update.</i>	Verbal	Chair	13:20 (10 mins)
TB096/26	Consent Agenda • Senior Information Risk Owner (SIRO) Report • Compliments, Complaints and Concerns Annual Report • Health and Safety Annual Report • Safeguarding Annual Report <i>Purpose: To approve the reports</i>	Report		13:30
TB097/26	Chief Executive's Report <i>Purpose: To receive the Chief Executive's Report.</i>	Report	CEO	13:30 (10 mins)

AN ORGANISATION THAT'S FIT FOR THE FUTURE

TB098/26	Sustainability Plan	Report	CNO	13:40 (30 mins)
	<i>Purpose: To approve the Sustainability Plan.</i>			
TB099/26	Sustainability Board AAA Report	Report	CEO +	14:10 (30 mins)
	a) Integrated Performance Report		Exec Directors	
	<i>Purpose: To receive the Sustainability Board AAA Report and Integrated Performance Report.</i>			

COMFORT BREAK (10 min)

14:40

IMPROVING CARE, TRANSFORMING LIVES

TB100/26	Quality Assurance Committee Chair's Report	Report	QAC Chair	14:50 (05 mins)
	<i>Purpose: To receive assurance on the work delegated to the Committee.</i>			
TB101/26	Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme/ Maternity and Neonatal 10 Point Plan Assurance Process Report	Report	CNO + Director of Midwifery	14:55 (10 mins)
	<i>Purpose: To receive the CNST Maternity Incentive Scheme and Maternity and Neonatal 10 Point Plan Assurance Process Report.</i>			
TB102/26	Clinical Correspondence Update	Report	MD	15:05 (10 mins)
	<i>Purpose: To receive the Clinical Correspondence Update.</i>			

A GREAT PLACE TO WORK

TB103/26	People Committee Chair's Report	Report	PC Chair	15:15 (05 mins)
	<i>Purpose: To receive assurance on the work delegated to the Committee.</i>			
TB104/26	Staff Health and Wellbeing Report	Report	CPO	15:20 (10 mins)
	<i>Purpose: To receive the Staff Health and Wellbeing Report.</i>			
TB105/26	Medical Appraisal and Revalidation Report - 2025-2026 Annual Submission to NHS England North West: Framework for Quality Assurance	Report	MD	15:30 (10 mins)
	<i>Purpose: To approve the Medical Appraisal and Revalidation Report - 2025-2026 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement</i>			

A HIGH PERFORMING PRODUCTIVE ORGANISATION

TB106/26	Finance and Investment Committee Chair's Report <i>Purpose: To receive assurance on the work delegated to the Committee.</i>	Report	F&I Chair	15:40 (05 mins)
TB107/26	Audit and Risk Committee Chair's Report <i>Purpose: To receive assurance on the work delegated to the Committee.</i>	Report	ARC Chair	15:45 (05 mins)
TB108/26	Winter Plan <i>Purpose: To approve the Winter Plan.</i>	Report	COO	15:50 (05 mins)

A POSITIVE PARTNER

TB109/26	Questions to the Board <i>Purpose: To discuss and respond to any questions received from members of the public.</i>	Verbal	Chair	15:55 (01 min)
TB110/26	Feedback from Board Walkabouts <i>Purpose: To receive feedback following walkabouts.</i>	Verbal	Members	15:56 (02 min)

CONCLUDING BUSINESS

TB111/26	Messages from the Board <i>Purpose: To agree messages to be shared with all staff.</i>	Verbal	Chair	15:58 (01 min)
TB112/26	Any Other Business <i>Purpose: To receive any urgent business not included on the agenda.</i>	Verbal	Chair	15:59 (01 min)
Date and time of next meeting: Thursday 26 November 2026				16:00 Close

Chair Dr Niruban Ratnarajah

Board of Directors Register of Interests – Updated September 2026

Name:	Position:	Interest Declared	Type of Interest
Tony Allen	Non-Executive Director	Locala Community Partnership	Financial Interest
		Inclusion Group	Financial Interest
		YMCA Together Liverpool	Non-Financial Professional Interest
		Kiklees ICB Finance Committee member	Financial Interest
Gita Bhutani	Associate Non-Executive Director	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

Board of Directors Register of Interests – Updated September 2026

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

Board of Directors Register of Interests – Updated September 2026

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 30 July 2026

Subject to the approval of the Board of Directors Meeting on Thursday 24 September 2026

Present

Name		Initials	Title
Ratnarajah	Niruban	NR	Chair
Allen	Tony	TA	Non-Executive Director
Bhutani	Gita	GB	Associate 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
Noden	Fiona	FN	Chief Executive
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

Carter	Rachel	RC	Associate Director of Communications and Engagement
Cotton	Janet	JC	Director of Midwifery (for item 078)
Crompton	Victoria	VC	Corporate Governance Manager
Garde	Tracey	TG	Freedom to Speak Up Guardian (for item 80)
Noble	Rachel	RN	Director of Strategy

Apologies

White	Sharon	SW	Chief of Strategy and Partnerships
There were two observers in attendance			

AGENDA ITEM	DESCRIPTION	Action Lead
TB067/26	Chair’s Welcome and Note of Apologies	
	The Chair welcomed everyone to the meeting and apologies for absence were as noted above.	

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

TB068/26 Patient and Staff Story

The Chief Nursing Officer introduced Mel Wildman, Assistant Divisional Director of Nursing, Families and Diagnostics, who presented the patient story of Ocean and the support provided by the Enhanced Midwifery Team throughout the antenatal, birth and postnatal periods.

Ocean booked with maternity services shortly before her 15th birthday and was referred to the Enhanced Midwifery Team. Ocean and her partner, Ashton, were supported by both families throughout the pregnancy. It was noted that Ocean had initially felt anxious and guarded following telephone conversations regarding potential referrals to safeguarding and Children's Social Care. The team acknowledged the learning that such sensitive information would have been better communicated face to face, with appropriate explanation, reassurance and support.

A trusting relationship was subsequently developed between Ocean and her allocated Enhanced Midwife through consistent, personalised and compassionate care. Clinical care and parent education were provided within Ocean's home, supported by one-to-one practical sessions covering areas including safe sleeping, feeding and caring for the baby. Information was provided in different formats to meet Ocean's individual learning needs and to support her to make informed choices about her birth and postnatal care.

The continuity of care provided throughout Ocean's journey enabled her to feel informed and empowered during labour, birth and her transition to motherhood. Ocean gave birth to her daughter, Pixie, in water, supported by Ashton and both mothers. Ocean, Ashton and Pixie were discharged as a family 17 days later. The family-first approach adopted by the Enhanced Midwifery Team ensured that support was embedded around Ocean, Ashton, Pixie and their wider family, and that no concerns requiring escalation to Children's Social Care were identified.

Staff Story

MW presented the staff story of Kayleigh Burke, Midwife, who was on maternity leave. The story focused on Kayleigh's role as Ocean's lead midwife and the continuity of care she provided from the initial booking appointment through the antenatal and postnatal periods. It reflected the personalised and compassionate approach taken to meeting Ocean's individual needs, as well as the close working relationship developed with Ocean, Ashton and their families. The story demonstrated the importance of

AGENDA ITEM	DESCRIPTION	Action Lead
	continuity in building trust and enabling the maternity team to support the family throughout their care journey. SH commented that the perception of care described within the story was positive and sought assurance on how expectations were managed for patients who may not have a reference point for maternity care. In response, MW advised that patients were provided with information on what to expect from staff and in relation to the delivery of care. TR added that maternity inpatient scores had been impacted by the limited choice available to women following the closure of Ingleside. NR further emphasised the importance of ensuring that patients were clearly informed in advance about what to expect from their care and that expectations were appropriately set. It was suggested that the video should be shared with all team members to demonstrate the level of care the service aspired to provide. RESOLVED: The Board of Directors received the Patient and Staff Story.	
TB069/26	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.	
TB070/26	Minutes of the previous meetings The Board of Directors received and approved the minutes of the meeting held on 28 May 2026, as a correct and accurate record of proceedings. RESOLVED: The Board of Directors approved the minutes from the meeting held on 28 May 2026.	
TB071/26	Matters Arising and Action Logs The Board considered updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. RESOLVED: The Board of Directors approved the action log.	

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

TB072/26 Chair’s Update

The Chair reported that Seth Crofts had stepped down as a Non-Executive Director in July 2026. The Board recorded its thanks for his significant contribution to the Trust, including his service as Senior Independent Director and Chair of the Charitable Funds Committee.

The Chair also noted that this was Annette Walker’s final Board meeting. Annette had served as Chief Finance Officer since June 2017 and had made a significant contribution to the Trust. The Board of Directors recorded its sincere thanks for her commitment, leadership and support as a valued member of the Executive Team and the Board and wished her every success for the future.

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

TB073/26 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 continued innovation in healthcare was highlighted, including the first anniversary of the Emergency Department (ED) opt-out blood-borne virus testing programme, which supported earlier diagnosis, treatment and improved outcomes.
- The NHS 78th anniversary was marked through the Trust’s Annual Long Service Awards, recognising more than 30 colleagues for 25 and 40 years’ service.
- Nominations for the FABB Awards 2026 had closed, with hundreds of entries received. The longlist would be announced at the end of July, with winners confirmed at the ceremony on 09 October 2026.
- A further planning application had been submitted to support development of a modern main entrance at the Royal Bolton Hospital site which would improve access, navigation and the overall arrival experience.

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

TB074/26 Board Assurance Framework (BAF)

The Director of Corporate Governance presented the Quarter 1 Board Assurance Framework (BAF), the Board’s principal mechanism for overseeing strategic risks to delivery of the Trust’s Ambitions. Strategic risks had been reviewed with Executive

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

Director leads and relevant committees, with risk descriptions, controls, assurances, gaps and actions updated accordingly.

The update strengthened alignment with the Trust Strategy, 2026/27 priorities and Sustainability Plan and reflected committee challenge regarding controls, assurances and actions to address remaining gaps. Key revisions related to productivity, workforce sustainability, digital and data maturity, transformation governance, benefits realisation, quality and patient safety, health inequalities and financial sustainability.

Strategic Risk 12 within Ambition 4 had been reprofiled to reflect delivery risks associated with the Sustainability Plan. The inherent risk was rebased to 25, with a residual score of 20 and target of 8, reflecting exposure across financial sustainability, recurrent Cost Improvement Programme (CIP) delivery, productivity, benefits realisation and transformation. SH advised that F&I Committee had reviewed and supported the increase to Strategic Risk 12, noting that it reflected the Trust’s most significant current risk.

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

TB075/26 Sustainability Board AAA Report

Fiona Noden, Chief Executive, presented her Chair’s Report from the Sustainability Board meeting held on 13 July 2026. The following key points were highlighted:

- There had been limited movement in the Cost Improvement Programme (CIP) position, with part-year effect savings of £29.58m and risk-adjusted savings of £23.07m against the revised £38m target, and the requirement for a significant increase in pace to identify further opportunities, progress existing schemes through governance and strengthen delivery assurance.
- The Sustainability Board Terms of Reference were approved subject to the development of an oversight mechanism to support quality management system assurance, stage-gate oversight and alignment of priorities and resources.
- Assurance was received from the updated Data and Intelligence Dashboard and the work underway to establish a single organisational improvement portfolio, prioritisation methodology, resource framework and refreshed benefits realisation approach.

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

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

A) Integrated Performance Report

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

- Elective performance: Referral to Treatment (RTT) performance was 61.3%, with 52-week waits and the overall patient tracking list above trajectory. Data quality and Electronic Patient Record (EPR) issues had contributed to the reported position, with additional validation and specialty recovery actions in place. DM01 performance also remained above plan, driven mainly by pressures in CT, Audiology and Cystoscopy.
- There was a continuing Business Continuity Incident, with four theatres unavailable due to estates and environmental infrastructure issues. Cancer and clinically urgent patients were being prioritised. The incident was expected to affect RTT and long-wait performance, with recovery plans in place. Safe recommencement remained subject to clinical and engineering assurance.
- ED four-hour and ambulance handover performance remained below plan, reflecting increased demand, sustained OPEL 4 escalation and workforce pressures. Improvement actions focused on patient flow, workforce capacity, alternative pathways, length of stay and discharge.
- Community 18-week performance remained ahead of plan, and 52-week waits had reduced from 454 in December 2025 to 177 in June 2026. Capacity pressures remained within Integrated Community Paediatric Services, Adult Audiology and Neurology, with improvement and validation plans in place.
- Linked elective, urgent care and community improvement programmes remained focused on productivity, diagnostics recovery, reducing long waits, improving flow and discharge, and increasing virtual ward utilisation.

Quality and Safety

The Chief Nursing Officer presented the Quality and Safety update, advising that hospital-acquired pressure ulcer performance had improved, with no Category 3 or 4 cases reported and sustained progress through the Pressure Ulcer Change Package. Community-acquired pressure ulcers remained within expected variation. Inpatient falls remained within common cause variation; two incidents resulted in moderate harm, although reviews confirmed care complied with Trust policy and identified no care delivery concerns.

Mixed-sex accommodation breaches had increased due to patient flow pressures; assurance was provided on mitigating actions, reporting and executive oversight.

AGENDA ITEM	DESCRIPTION	Action Lead
	Healthcare-associated Clostridioides difficile cases remained above trajectory, with actions underway to strengthen infection prevention and control. Bacteraemia performance improved, with no Methicillin-Resistant Staphylococcus aureus (MRSA), Klebsiella spp. or Pseudomonas aeruginosa cases reported. Antimicrobial stewardship also progressed, including achievement of the interim Access prescribing target and improved intravenous-to-oral switching. Actions to address ED patient experience feedback, particularly regarding waiting times, communication and patient flow, were outlined. No induction of labour delays exceeding six hours were reported in June 2026, and assurance was provided on monitoring against the new NHS England metric. The Medical Director reported that clinical correspondence issues continued within some departments. It was noted that these were longstanding challenges; however, there was now renewed focus on the issue, with priorities and targets to be agreed and reviewed at the next meeting. In relation to outpatient clinical correspondence, the Division was exploring options for a digital solution, although it was recognised that this would take time to implement. In the interim, additional administrative and clerical support may be required to support delivery and address the backlog. Finance The Chief Finance Officer presented the Month 3 financial performance update advising that the Trust had reported a year-to-date adjusted deficit of £8.9m, £30k favourable to plan, and a forecast year-end deficit in line with plan of £7.0m, including £2.0m of deficit support funding. The current mid-case forecast remained significantly adverse to plan, reflecting risks associated with cost improvement delivery and variable income performance. The CIP delivery was ahead of plan year to date, agency expenditure remained low and below NHS England spending thresholds, and workforce numbers were below the planned establishment. Capital expenditure was behind plan but expected to accelerate during the year, whilst cash balances remained favourable due to timing benefits, although cash support from NHS England was anticipated later in the financial year.	

AGENDA ITEM	DESCRIPTION	Action Lead
	Workforce The Chief People Officer presented the workforce position advising that total workforce usage had reduced by 28 whole-time equivalents (WWTE) between May and June 2026, with the June position 138 WWTE below plan. Substantive staffing and agency usage had reduced, although bank usage remained slightly above plan. Agency usage continued to be low and had remained below the NHS England agency expenditure target since Month 8 of 2025/26. Sickness absence had increased from 5.22% in May 2026 to 5.54% in June 2026, following five consecutive months of reduction. Additional staff support continued to be available through the Employee Assistance Programme and early intervention services provided by Occupational Health. SH noted that the presentation referred to changes in some areas as percentages and in others as percentage points and asked that this be reviewed to ensure consistency. IW referred to the nine-box matrix and sought further assurance regarding the number of areas reflected within the matrix. TR advised that this was the first time the matrix had been included within the report and acknowledged that further quality assurance may be required. It was confirmed that, where issues were identified through the matrix, these would be reflected within the relevant presentation slides. NR commented on the EPR-related findings and queried how the Board could be assured that appropriate steps had been taken to avoid further issues. RW advised that, following the implementation of EPR, the size of the Patient Tracking List and the length of time patients had been waiting had identified the need for further work on outcomes and associated processes. It was noted that changes to the system had taken time to implement and that there remained a training requirement, particularly in relation to staff understanding and recording of outcomes. The Board noted that the waiting list continued to increase and that this remained an area of ongoing focus. In relation to community business cases, it was noted that the position was positive overall; however, the area remained underspent. The Board discussed the need to support divisions to increase the pace of expenditure where appropriate, with continued dialogue taking place with divisions and recognition that further work was required.	

AGENDA ITEM	DESCRIPTION	Action Lead
	In respect of clinical correspondence, members noted that digital technology was being used more widely across the NHS and expressed concern that a further nine-month delay would not be acceptable, given the length of time the issue had been ongoing. The Board requested a further update at the next meeting, setting out the actions being taken and the associated timeline. RM acknowledged the concern, advised that some changes had already been made and confirmed that a detailed report would be brought to the Board in September. ACTION: A Clinical Correspondence report, setting out the actions being taken and associated timescales, to be presented to the Board in September. RESOLVED: The Board of Directors received the Sustainability Board AAA and Integrated Performance Reports.	RM
TB076/26	Quality Assurance Committee Chair's Report Fiona Taylor, Non-Executive Director, presented the Chair's Report from the Quality Assurance Committee meeting held on 29 July 2026. The committee had received assurance regarding progress across a range of quality, patient safety, clinical effectiveness, performance and transformation priorities. The Committee reviewed the Quarter 1 BAF, which had been refreshed to align with the Trust's Sustainability Plan and 2026/27 priorities, and received assurance regarding the adequacy of associated controls, assurance mechanisms and mitigating actions. Assurance was also provided on progress in delivering the Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme, quality improvement priorities, health inequalities reduction initiatives and community services transformation. RESOLVED: The Board of Directors received the assurance on the work delegated to the Committee.	
TB077/26	Maternity Review: Post-Death Care and Fuller Inquiry Board Assurance Statement The Chief Nurse presented the Maternity Review: Post-Death Care and Fuller Inquiry Board Assurance Statement advising that there was a national emphasis, following the	

AGENDA ITEM	DESCRIPTION	Action Lead
	Nottingham maternity review and Fuller Phase 2 recommendations, on ensuring that all deceased people cared for in NHS settings are treated with respect, dignity, security and compassion. NHS England had requested Board assurance from all relevant providers by 31 July 2026. The Trust confirmed compliance with all statements and reported that its self-assessment had identified compliance with 15 of the 18 applicable recommendations, with an action plan in place to address the remaining areas in progress. RESOLVED: The Board of Directors approved the Maternity Review: Post-Death Care and Fuller Inquiry Board Assurance Statement.	
TB078/26	Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Report The Director of Midwifery presented the CNST Maternity Incentive Scheme Report advising that the Year 8 maternity scheme had launched in a revised format, with six safety actions and 27 sub-actions. All sub-actions had been allocated, with two not yet commenced within expected timescales and three identified as compliance risks, primarily linked to training requirements. Weekly oversight of training compliance was in place to mitigate the risk. The Board further noted progress in relation to workforce and capacity, learning from reviews, service user engagement, care bundle compliance, neonatal pulse oximetry and culture. Business cases to address neonatal nursing, neonatal medical and midwifery staffing gaps, with a combined value of circa £1.3m, were due to be presented to Capital Revenue and Investment Group (CRIG) in August 2026. Work also remained ongoing to benchmark compliance against national maternity care bundle requirements. FLT expressed concern on the length of time taken to implement the Maternity Electronic Patient Record (EPR). JM advised that the business case had been approved by the Board of Directors in 2023 and acknowledged the continued impact of the delay on colleagues and patients. He noted that further check and challenge was required, particularly in relation to the timescale, and emphasised the importance of establishing a clear delivery rhythm moving forward. In response to NR’s query regarding timescales, JM advised that he was not in a position to provide a timescale as to when the Board could receive the update but	

AGENDA ITEM	DESCRIPTION	Action Lead
	anticipated this would be available by the next Finance and Investment Committee, although there remained a number of dynamic factors to work through. TR added that the Trust remained committed to progressing implementation as early as possible, while ensuring that the approach was appropriate and effective. It was noted that maternity EPR remained a challenging area nationally. NR asked whether there was an opportunity to pool resources with other trusts; however, TR advised that the Trust was significantly further ahead than many other organisations. RESOLVED: The Board of Directors received the CNST Maternity Incentive Scheme Report.	
TB079/26	People Committee Chair's Report Ian Williamson presented his Chair's Report from the People Committee meeting held on 21 July 2026. The Committee had received assurance that overall workforce performance remained strong and ahead of the Medium-Term Plan, although further work was required to deliver planned workforce reductions. Sickness absence remained above expectations, and an update on the actions being taken to reduce absence would be presented at the next meeting. The Committee had also considered progress relating to organisational development, culture and leadership. The development of a Trust-wide People and Culture Plan and continued delivery of the Our Leaders programme were noted. RESOLVED: The Board of Directors received assurance on work delegated to the Committee.	
TB080/26	Freedom to Speak Up (FTSU) Annual Report Tracey Garde, Freedom to Speak Up Guardian, presented the FTSU Annual Report, which provided assurance on speaking up activity, themes, learning and improvement actions during 2025/26. The Board noted that 198 cases had been raised across the Trust, reflecting continued engagement with speaking up routes. A Quarter 2 increase was linked to targeted listening events, with activity subsequently returning to baseline. The key themes included inappropriate attitudes and behaviours, with worker safety and wellbeing becoming more prominent in the latter half of the year. Responsiveness remained strong, with almost all staff acknowledged within 48 hours. Key issues included the impact of financial and organisational pressures on workforce morale,	

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

increasing complexity of culture-related cases and national uncertainty following the closure of the National Guardian’s Office.

RESOLVED:
The Board of Directors **received** the Freedom to Speak Up Annual Report.

TB081/26 Leadership Development Programme

The Chief People Officer presented the Leadership Development Programme report advising that *Our Leaders* had launched in January 2025 in response to staff feedback and people and culture intelligence, with the aim of strengthening leadership and management capability and supporting the Trust’s culture ambitions. By June 2026, 967 colleagues had attended the programme, with the 1,000th attendee expected in August 2026. Attendance from the target group of Band 7+ leaders and managers was 36%, and increasing participation remained a priority.

The Board noted positive engagement across leadership groups, achievement of EDI participation targets and alignment with the NHS Leadership and Management Framework. Ongoing focus would be required on programme impact, attendance and future accredited development routes.

RESOLVED:
The Board of Directors **received** the Leadership Development Programme Update.

TB082/26 Finance and Investment Committee Chair’s Report

Sean Harriss, Non-Executive Director presented his reports from the Finance and Investment Committee meetings held on 24 June and 22 July 2026 highlighting the ongoing financial pressures, including the gap between the CIP target and identified schemes, with a Month 3 cumulative deficit of £8.9m and a forecast year-end deficit of £24m. A comprehensive mitigation and recovery plan would be required, and revenue cash support was expected to be considered in September 2026.

The Board received assurance on progress with the digital transformation programme, including the phased implementation of the Maternity Electronic Patient Record, and noted progress with the Neighbourhood Health Programme. The Committee had reviewed its 2025/26 effectiveness and approved its 2026/27 work plan, with further focus required on benchmarking, longer-term financial strategy and digital governance.

AGENDA ITEM	DESCRIPTION	Action Lead
	The Board noted the revised Maternity RAAC programme position, including an updated completion date of April 2028 and an additional funding requirement of £8.9m. The Committee recommended approval of the updated business case submission and a number of business cases and contracts, including Microsoft 365 licensing, Managed Equipment Service extension, phase one of the Main Entrance Business Case and the N Block first-floor redesign. RESOLVED: The Board of Directors <i>received</i> assurance on work delegated to the Committee.	
TB083/26	Audit and Risk Committee Chair’s Report Fiona Taylor presented the Chair’s report from the Audit and Risk Committee meeting held on 25 June 2026 advising that the Committee had approved the Audited Annual Accounts, Annual Report and Annual Governance Statement for 2025/26 and recommended these to the Board for approval. The external auditor was expected to issue an unqualified audit opinion, with a continuing value-for-money weakness reported in relation to financial sustainability. The Committee had received Moderate assurance through the Final Head of Internal Audit Opinion, which confirmed that an adequate system of internal control was in place whilst recognising some weaknesses in control design and application. Progress in implementing outstanding internal audit recommendations remained an area of focus. The Board noted the control weakness associated with retrospective purchase orders and the further measures being introduced to strengthen compliance. Assurance had been received regarding compliance with the Foundation Trust Code of Governance, banking arrangements, salary overpayment recovery arrangements and the Trust’s risk profile, which remained stable with no new risks or escalations reported. The Committee’s Annual Report confirmed that it had taken appropriate steps to discharge the responsibilities delegated to it by the Board and had no matters of significant concern to raise in respect of its work during 2025/26. RESOLVED: The Board of Directors <i>received</i> assurance on work delegated to the Committee.	

AGENDA ITEM	DESCRIPTION	Action Lead
TB084/26	Audit and Risk Committee Annual Report Tony Allen presented the Committee's Annual Report. The Board noted the report's overview of the Committee's membership, meetings, governance arrangements, effectiveness and work during 2025/26, including oversight of internal audit, external audit and counter fraud. The Board further noted the Committee's role in seeking assurance on internal control, information governance, risk management, financial management and corporate governance, and in reviewing and approving the Trust's Annual Report and Accounts. The Chair confirmed that the Committee had discharged its duties as delegated by the Board and had no matters of significant concern to escalate arising from its work during 2025/26. RESOLVED: The Board of Directors received the Audit and Risk Committee Annual Report.	
TB085/26	Green Plan Annual Report The Chief Finance Officer presented the Green Plan Annual Report, the first annual report for iFM Bolton and Bolton NHS Foundation Trust's Green Plan 2025–2030. The Board noted progress against carbon emissions, key achievements during the financial year and delivery against the Green Plan priority actions. RESOLVED: The Board of Directors approved the Green Plan Annual Report.	
TB086/26	Questions to the Board A question had been received seeking assurance that the Trust's 2026/27 financial recovery plan and savings programme would be delivered in a way that protected patient care and services, supported staff, and included appropriate consultation, equality assessment and contingency planning. The Chair advised that the Trust had a clear financial recovery plan for 2026/27, underpinned by an efficiency and cost improvement programme designed to support financial sustainability while maintaining safe, high-quality care. The savings programme had been developed through detailed planning with clinical and operational leaders and was focused on improving productivity, reducing duplication, streamlining processes and making best use of resources.	

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

Workforce reductions would, where possible, be achieved through natural turnover, vacancy management, retirement and voluntary approaches, with continued engagement with staff and trade union representatives. It was confirmed that there were no plans to compromise patient safety or quality of care, and that any proposed service changes would be subject to appropriate clinical review, impact assessment, engagement and governance processes. Equality impacts would be considered through the Trust's decision-making arrangements, with assessments undertaken where required.

The Trust would continue to monitor the impact of the programme on patient care, waiting times, staff wellbeing and service performance. Progress would be regularly reviewed by the Board and regulators, with contingency arrangements in place and further action taken where necessary to support delivery of the Trust's financial and operational objectives. The Board remained committed to balancing financial sustainability with its overriding responsibility to provide safe, effective and compassionate care for the population served.

TB087/26 Feedback from Walkabouts

FLT reported that she had visited Ophthalmology and noted that the booking-in process could be difficult for patients, particularly those who may be visually impaired. It was also noted that the J Block reception area was a shared space; however, the reception desk related to Radiology, which meant that staff were frequently interrupted by queries from patients and visitors attending other areas.

IW reported that he had visited Winifred Kettle, where he had observed good teamwork and positive discussion in relation to community services.

SH reported that he had visited Coronary Care and noted that staff had been willing to engage and discuss their experiences.

NR reported that he had visited Ingleside. Although there were no births taking place at that time, the unit remained full each day. He noted the excellent work being undertaken by midwives and highlighted the positive work taking place with communities.

NR also reported that he had held a staff drop-in session, which had been attended predominantly by colleagues from global majority backgrounds. During the session, members heard from a staff member who had been attacked, which prompted further discussion from colleagues sharing their own experiences. It was noted that

AGENDA ITEM	DESCRIPTION	Action Lead
	colleagues wanted an avenue through which to speak up, although usual mechanisms did not always work effectively for all staff groups. The Freedom to Speak Up Guardian advised that alternative approaches to supporting colleagues to speak up were being explored.	
	RESOLVED: The Board of Directors received the Feedback from Walkabouts.	
TB088/26	Messages from the Board The key messages from the meeting were noted for communication through appropriate Trust channels.	
TB089/26	Any Other Business There being no further business, the Chair thanked everyone for attending and brought the meeting to a close. The next Board of Directors meeting would be held on Thursday 24 September 2026 at 1pm in the Boardroom.	

Meeting Attendance 2026							
Members	Title	Jan	Mar	May	July	Sept	Nov
Niruban Ratnarajah	Chair	✓	✓	✓	✓		
Annette Walker	Chief Finance Officer	✓	✓	✓	✓		
Fiona Noden	Chief Executive	✓	✓	✓	✓		
Fiona Taylor	Non-Executive Director (NED)	✓	✓	A	✓		
Gita Bhutani	Associate NED	✓	✓	✓	✓		
Ian Williamson	Non-Executive Director	✓	✓	✓	✓		
James Mawrey	Chief People Officer / Deputy Chief Executive	✓	✓	✓	✓		
Janat Hulston	Non-Executive Director	✓	✓	✓	✓		
Martin North	Non-Executive Director	✓	✓	✓	✓		
Rae Wheatcroft	Chief Operating Officer	✓	✓	✓	✓		
Rauf Munshi	Medical Director	✓	✓	✓	✓		
Sean Harriss	Chief Finance Officer	✓	✓	✓	✓		
Seth Crofts	Non-Executive Director	✓	✓	✓	✓		
Sharon Katema	Director of Corporate Governance	✓	✓	✓	✓		
Sharon White	Chief of Strategy and Partnerships	✓	✓	A	A		
Tiri Mutambasere	Associate NED	✓	✓	✓	✓		
Tony Allen	Non-Executive Director	✓	✓	✓	✓		
Tyrone Roberts	Chief Nursing & Quality Officer	✓	✓	✓	✓		
✓ = 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 July 2026



ONGOING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
TB088/25	31/07/2025	Our Leaders Programme and Culture Update	HS and RK to return to a Board of Directors meeting in 12 months' time to provide a progress update.	LR	Jul-26	Jul-26	A progress update will be presented at the November 2026 Board of Directors meeting.	
TB075/26	30/07/2026	Integrated Performance Report	A Clinical Correspondence Report, setting out the actions being taken and associated timescales, to be presented to	RM	Sep-26	Sep-26		On agenda

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:	SIRO Annual Report for 2025-26.			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 2026		Discussion	✓
Executive Sponsor	Senior Information Risk Owner (SIRO)		Decision	✓

Purpose of the report	The purpose of the report is to outline the key activities, achievements, and issues related to Information Governance (IG) within the Trust for the period from 01 July 2025 to 30 June 2026.
-----------------------	--

Previously considered by:	The report was previously considered at the Audit and Risk Committee meeting held on 09 September 2026
---------------------------	--

Executive Summary	The SIRO Annual Report provides assurance on Information Governance and cyber security activity for 1 July 2025 to 30 June 2026 and confirms progress against the Data Security and Protection Toolkit, now aligned to the Cyber Assessment Framework. It summarises Board cyber assurance, cyber risk management, policy compliance, FOI and Subject Access Request performance, IG training, data protection incidents, internal audit findings and current accreditations. Key points include achievement of the 95% IG training target, 915 FOI requests with 79% compliance, no ICO complaints, 3,920 SARs across reporting departments, 167 IG incidents with two reported to the ICO, and continued ISO 27001, ISO 9001 and Secure Email Standards certification. Internal audit identified Moderate Risk overall assurance and High Confidence in the veracity of the Trust’s self-assessment. Priorities for 2026-27 include strengthening cyber resilience, backup and restoration capability, MFA enforcement, business continuity testing for essential functions, improved FOI compliance, standardised SAR arrangements, updated information asset and data flow registers, and stronger contract and supply chain assurance.
-------------------	--

Proposed Resolution	The Board of Directors are asked to receive and note the SIRO 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 Implications	No	No direct financial implications identified. Any future investment requirements will be managed through existing governance routes.
Legal/ Regulatory	Yes	Yes. The report supports assurance on compliance with UK GDPR, DPA 2018, NIS requirements, FOI and DSPT/CAF standards. Mitigations include continued SIRO oversight, audit, training, incident management and delivery of the improvement plan.
Impact on Health Inequalities	No	No direct health inequalities implications identified.
Impact on Equality, Diversity and Inclusion	No	No direct equality, diversity or inclusion implications identified.
Is a Quality Impact Assessment required	No	No Quality Impact Assessment is required as the report is for assurance and does not propose service change.

Prepared by:	Deiler Carrillo, Head of Information Governance and DPO	Presented by:	James Mawrey, Chief People Officer/Deputy Chief Executive
---------------------	---	----------------------	---

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

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

Bolton NHS Foundation Trust

Senior Information Risk Owner (SIRO) Annual Report 2025-26



Contents

Executive Summary 4

Recommendation to the Committee 4

1. Introduction 4

2. Key Trust Roles & Reporting Structure over the Period 5

 2.1 Senior Information Risk Officer (SIRO), Deputy CEO & Chief People Officer 5

 2.2 Caldicott Guardian 5

 2.3 Data Protection Officer/Head of Information Governance..... 5

 2.4 Reporting Structure for Information Governance 5

3. Data Security and Protection Toolkit: 01st July 2025 – 30th June 2026 6

 3.1 Changes for 2025-26 6

 3.1.1 NHS England Board and Executive Assurance Framework 9

 3.2 Essential Functions 9

 3.3 Data Security and Protection Toolkit submission..... 12

4. Information Governance training 15

5. Information Governance/ Cyber Security Related Policies – Keeping Up to Date 15

6. Freedom of Information (FOI) Request..... 16

 6.1 Complaints raised to the ICO 17

 6.2 Section 50 Decision Notices 17

7. Subject Access Requests 17

 7.1 Subject Access Requests from patients – Medical Legal Department..... 18

 7.2 Subject Access Requests from patients – Litigation Department 18

 7.3 Subject Access Requests from patients/staff – Information Governance Department..... 19

 7.4 Subject Access Requests from staff – Workforce..... 19

8. Data Protection Incidents..... 20

 8.1 Incidents reported externally..... 21

9. Internal Audit Findings..... 21

 9.1 Auditor key findings and conclusions..... 23

 9.1.1 Overall Assurance Rating (NHSE profile for the in-scope outcomes)..... 23

 9.1.2 - Veracity of the organisation’s self-assessment..... 24

 9.2 Areas of good practice 24

 9.3 MIAA findings and recommendations 25

10. Data Privacy Impact Assessments..... 26

11. Accreditations & Certifications 27

 11.1 Ensuring Data Security: Our ISO 27001 accreditation 27

 Why ISO 27001 Matters in Healthcare: 27

11.2 Ensuring Data Security: Our ISO 9001 accreditation..... 28

Why ISO 9001 Matters in Healthcare:..... 28

11.3 Ensuring Data Security: Secure Email Standards (DCB1596)..... 28

Why DCB1596 Matters in Healthcare: 28

12. Recommendation and priorities for 2025-26 period 29

Appendix A – Trust Governance Structure..... 31

Appendix B – DSPT Improvement Plan..... 33

Executive Summary

This report provides assurance to the Audit and Risk Committee and the Board on Information Governance activity for 1 July 2025 to 30 June 2026 and sets out priorities for the year ahead. It summarises progress against the Data Security and Protection Toolkit, now aligned to the Cyber Assessment Framework, and confirms the Trust’s continued focus on meeting legal and regulatory duties, including UK GDPR, the Data Protection Act 2018, NIS Directive and Caldicott Principles. The report highlights strengthened SIRO oversight, cyber assurance arrangements, essential functions scoping, IG training compliance, policy maintenance, incident reporting, FOI and subject access performance, internal audit findings, and continued ISO and secure email certifications. Key areas for improvement include strengthening backup and restoration capability, improving FOI compliance, standardising SAR processes, maintaining accurate information asset and data flow registers, and embedding cyber resilience, business continuity and supply chain assurance across essential functions.

Recommendation to the Committee

The Audit & Risk Committee is requested to:

- **RECEIVE** and **ACCEPT** this annual report which provides assurance on the Information Governance and Security activity for the period 1st July 2025 to 30th June 2026.

Senior Information Risk Owner (SIRO)
Annual Report
1st July 2025 to 30th June 2026 (2025-26)

1. Introduction

The purpose of this report is to outline key activity, achievements and issues relating to Information Governance (IG) within the Trust for the period 2025-26 and state objectives for the forthcoming year.

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

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

- | | |
|--|--|
| <ul style="list-style-type: none">• UK General Data Protection Regulation (UK GDPR) and Data Protection Act 2018 (DPA 2018).• Network and Information Systems Regulation (NIS Directive), as an Operator of Essential Services.• Compliance with the expected data security standards for health and social care for holding, processing or sharing personal data.• Readiness to access secure health and care digital methods of information sharing, such | <ul style="list-style-type: none">as NHS mail and Summary Care Records, Greater Manchester Care Record (GMCR).• Good data security to the CQC as part of the Key lines of Enquiry (KLOEs).• Freedom of Information Act 2000.• Access to Health Records Act 1990.• Computer Misuse Act 1990.• Common Law Duty of Confidentiality.• Privacy and Electronic Communications• Freedom of Information Act 2000. |
|--|--|

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

2. Key Trust Roles & Reporting Structure over the Period

2.1 Senior Information Risk Officer (SIRO), Deputy CEO & Chief People Officer

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

In line with NHS England Board and Executive Assurance guidance, the SIRO provides strategic leadership for information risk, cyber security assurance and organisational resilience. The role ensures cyber risks are understood at Board level, appropriately reflected within the Board Assurance Framework, and supported by effective management controls, assurance mechanisms and improvement plans.

2.2 Caldicott Guardian

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

2.3 Data Protection Officer/Head of Information Governance

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

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

2.4 Reporting Structure for Information Governance

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

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

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

Please see [appendix A](#) the Governance Structure in terms of the reporting structure.

3. Data Security and Protection Toolkit: 01st July 2025 – 30th June 2026

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

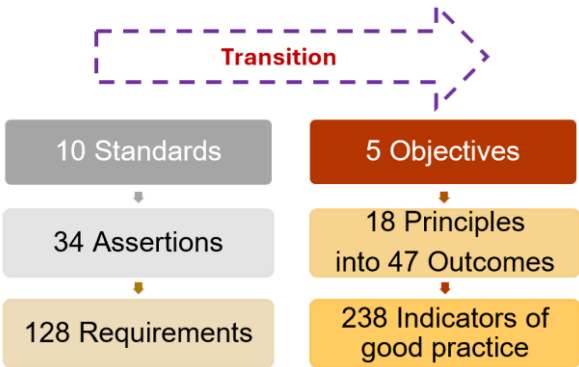
This information standard is published under section 250 of the Health and Social Care Act 2012. Completion of the DSPT is therefore a contractual requirement specified in the NHS England Standard Conditions contract and it remains Department of Health and Social Care policy that all bodies that process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

3.1 Changes for 2025-26

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

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

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



Objective A – Managing risk.

Establish strong risk management frameworks, with key roles and accountability.

Objective B – Protecting against cyber-attack and data breaches.

Implement and maintain robust security controls that safeguard critical systems and sensitive data.

Objective C – Detecting cyber security events.

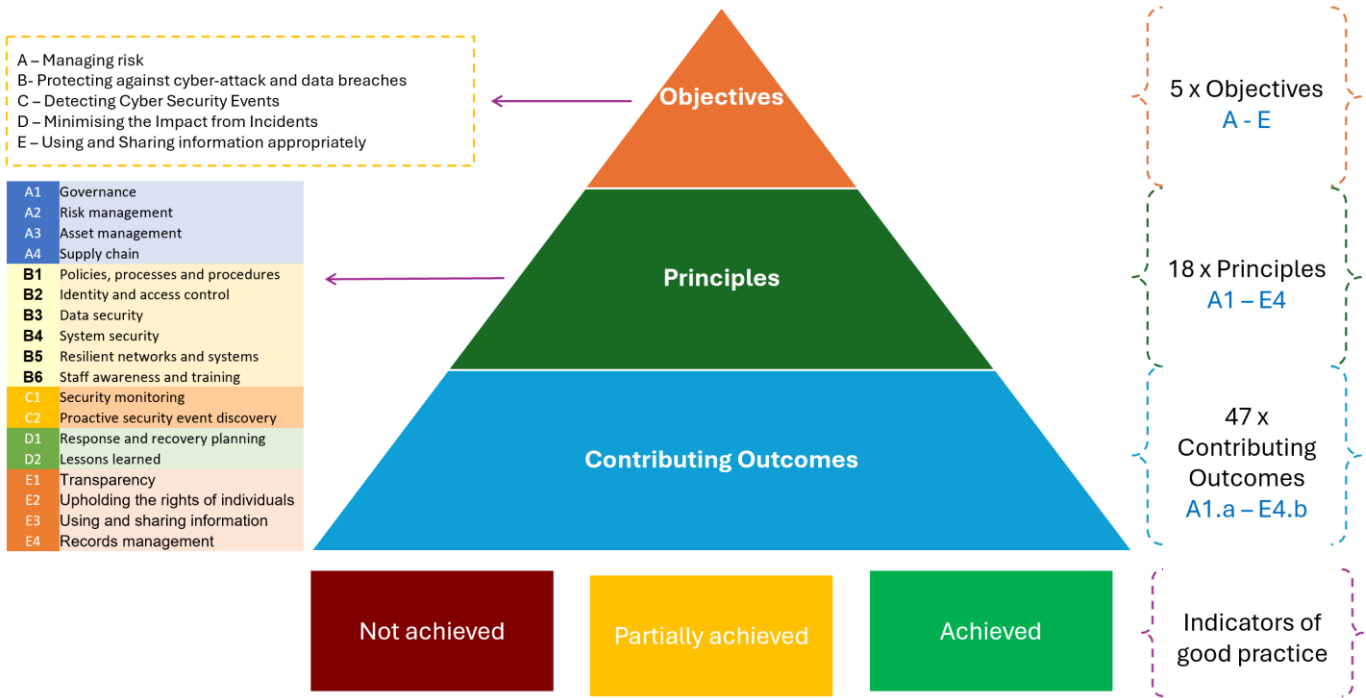
Enhance detection capabilities to rapidly identify and respond to potential incidents.

Objective D – Minimising the impact of incidents.

Develop effective response, recovery and business continuity plans to limit the consequences of any security breach.

Objective E – Using and sharing information appropriately.

Ensure that data handling practices meet legal and ethical standards and that information sharing supports security without compromising privacy.



For the 2025–26 period, the Data Security and Protection Toolkit (DSPT) comprises 240 indicators of good practice, distributed across 47 outcomes aligned to five overarching objectives.

Data Security & Protection Toolkit 2024-25

Objective A – Managing risk	Objective B- Protecting against cyber-attack and data breaches	Objective C – Detecting Cyber Security Events	Objective D – Minimising the Impact from Incidents	Objective E – Using and Sharing information appropriately
•A1 - Governance •A1.a - Board Direction •A1.b - Decision-making & approval •A1.c - Roles & responsibilities •A2-Risk Management •A2.a - Assurance •A2.b - Risk Management Process •A3-Asset Management •A3.a - Asset management •A4-Supply chain •A4.a - Supply chain	•B1-Policies, processes and procedures •B1.a - Policy, process and procedure development •B1.b - Policy, process and procedure implementation •B2-Identity and access control •B2.a - Device management •B2.b - Identity and access management (IdAM) •B2.c - Identity verification, authentication and authorisation •B2.d - Privileged user management •B3-Data security •B3.a - Data in transit •B3.b - Media/equipment sanitisation •B3.c - Mobile data •B3.d - Stored data •B3.e - Understanding data •B4-System security •B4.a - Secure by design •B4.b - Secure configuration •B4.c - Secure management •B4.d - Vulnerability management •B5-Resilient networks and systems •B5.a - Backups •B5.b - Design for resilience •B5.c - Resilience preparation •B6-Staff awareness and training •B6.a - Culture •B6.b - Training	•C1-Security monitoring •C1.a - Generating alerts •C1.b - Identifying security incidents •C1.c - Monitoring coverage •C1.d - Monitoring tools and skills •C1.e - Securing logs •C2-Proactive security event discovery •C2.a - Proactive attack discovery •C2.b - System abnormalities for attack detection	•D1-Response and recovery planning •D1.a - Response and recovery capability •D1.b - Response plan •D1.c - Testing and exercising •D2-Lessons learned •D2.a - Incident root cause analysis •D2.b - Using incidents and near misses to drive improvements	•E1-Transparency •E1.a - Privacy and transparency information •E2-Upholding the rights of individuals •E2.a - Consent •E2.b - Managing data subject rights under UK GDPR •E2.c - National data opt-out policy •E3-Using and sharing information •E3.a - Using and sharing information for direct care •E3.b - Using and sharing Information for other purposes •E4-Records management •E4.a - Clinical Coding •E4.b - Managing records

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



3.1.1 NHS England Board and Executive Assurance Framework

NHS England has published Board and Executive Assurance guidance to support Boards, Senior Information Risk Owners (SIROs) and executive teams in understanding, governing and overseeing cyber security risk. The guidance emphasises that cyber security should be managed as an organisational risk rather than solely an IT issue and should be integrated into corporate governance, risk management, operational resilience and business continuity arrangements.

The Trust's approach to Information Governance, Cyber Security, Emergency Preparedness, Resilience and Response (EPRR), Digital Services and Essential Functions aligns with these principles through:

- Board oversight through the Audit and Risk Committee.
- Executive accountability through the SIRO.
- Annual DSPT and Cyber Assessment Framework (CAF) assessments.
- Cyber risk reporting through corporate governance structures.
- Integration of cyber resilience, business continuity and disaster recovery arrangements.
- Independent assurance through internal and external audit reviews.

During 2026-27 the Trust will continue to strengthen alignment with NHS England expectations relating to cyber governance, operational resilience, supply chain assurance and assurance reporting.

3.2 Essential Functions

In addition to the key updates around cyber security, one of the most significant changes the Trust must address for 2025–26 is the requirement to identify and manage Essential Services.

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

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

Defining Essential Functions

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

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

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

Scoping example

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

Essential services (example for NHS trust and foundation trust:

- Healthcare services

Essential functions:

- Booking appointments
- Nursing
- Catering

Systems that support the operation of essential functions:

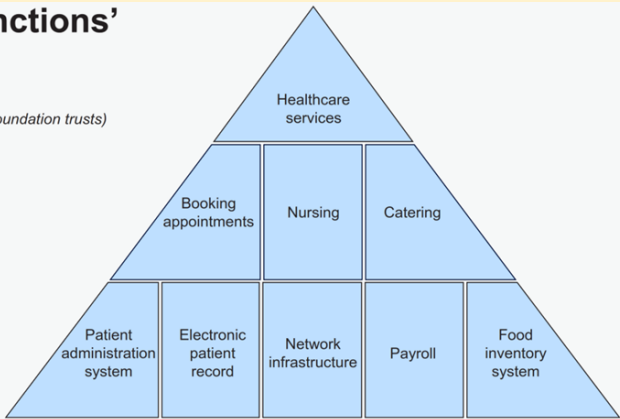
- Patient administration system
- Electronic patient record
- Network infrastructure
- Payroll
- Food inventory system

‘Essential functions’

Essential service
(example for NHS trusts and foundation trusts)

Essential functions

Systems that support the operation of essential functions



Trust Essential Services

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

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

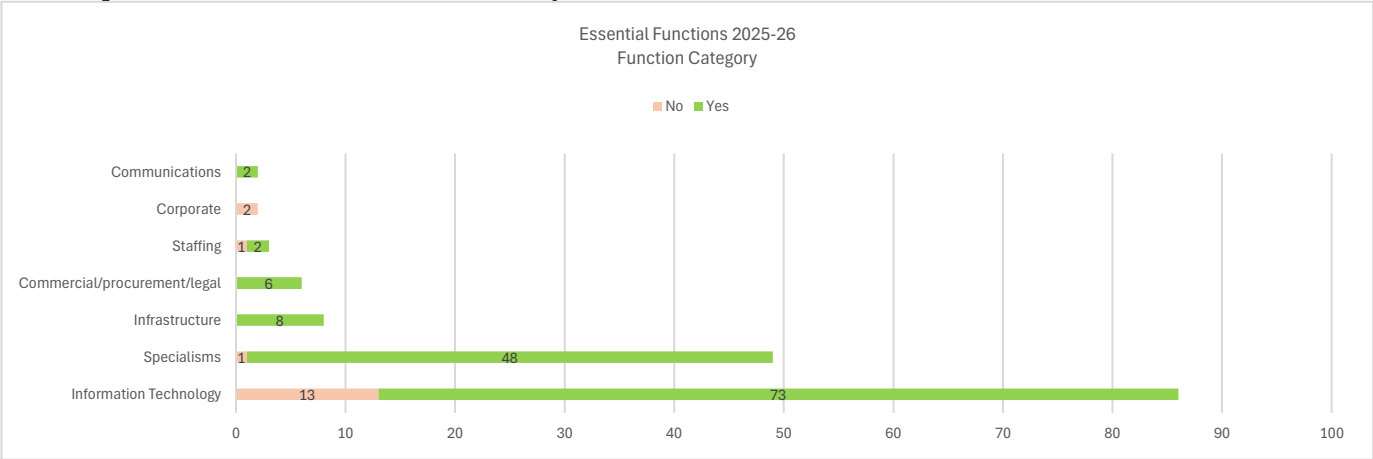
3. Identification of Products and Services upon Which The Organisation Depends.

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

3.1 What Are Critical Services? (List not exhaustive)

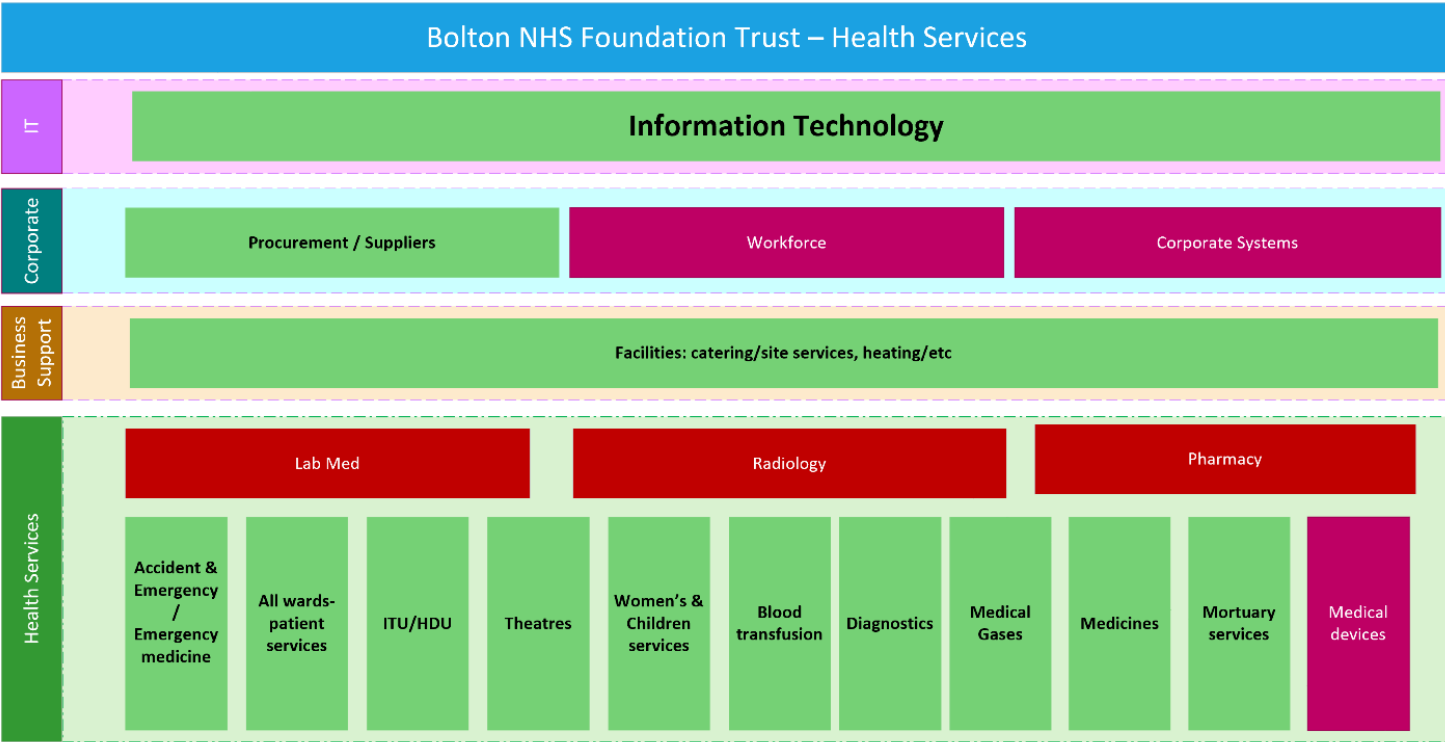
- ITU/HDU
- All Wards / patient services
- Accident and Emergency / Emergency Medicine
- Theatres
- Information Technology
- Women’s and Children’s services
- Blood Transfusion
- Communications
- Diagnostics
- Facilities / catering / Site Services / Heating etc
- Medical Gases
- Medicines
- Mortuary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

For the 2025-26 period, we assessed a total of 169 systems that support our essential functions. **From these we needed to remove 13. Of these, 156 have been considered eligible to be covered under the Data Security and Protection Toolkit for this period.**



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

Specialisms (Clinical specialties, Pharmacy, Radiology, Pathology, Adult Social Care)		Information Technology
Care delivery • Critical care/HDU • All Wards/patient services • Outpatients • Emergency Department/Emergency Medicine • Theatres/Surgery • Women's and Children's services • Community Teams • Access, Booking and Choice • Health Records Pharmacy • Medicines • Med gasses Pathology • Blood transfusion • Biochemistry • Haematology • Histopathology • Microbiology • Mortuary Services Radiology • Imaging HSDU		Information Technology • Network • Identity & Access Management • Storage Area Network • Virtual Environment • AppSense Windows SQL Servers for Desktop and profiles • Unified Comms (Telephony) • Remote Access • Critical Systems • Assets • M365 • Medical devices 3rd party services – service delivery • Bolton Locality – ICB • Bolton General Practices
Staffing		Commercial/procurement/legal
Human Resources / Payroll Staff • Nursing • Medical • Support / admin		• Finance • Procurement / Supplies • Legal
Infrastructure		Communications
Estates • Utilities • Buildings •	Facilities • Portering • Linen • Domestic • Security • Catering • EBME • Waste management • Switchboard • Reception services	• Communications
Corporate		Other
Other		Site management / flow

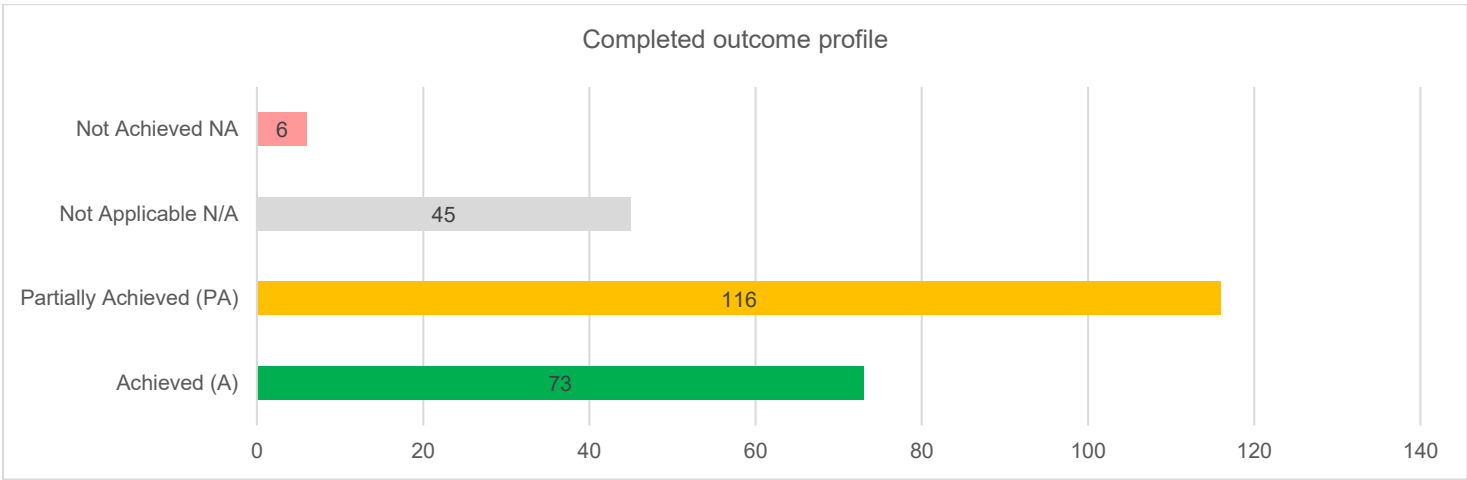


3.3 Data Security and Protection Toolkit submission

Bolton NHS Foundation Trust has made considerable progress across the 5 objectives in scope to meet the toolkit requirements for the 2025-26 period.

For this period the Trust completed 47 outcomes as follows:

Not Achieved NA	Not Applicable N/A	Partially Achieved (PA)	Achieved (A)
6	45	116	73



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

Summary

Organisation	BOLTON NHS FOUNDATION TRUST
Version	2025-26 (version 8)
Status	Approaching standards
Published	25 June 2026
Published by	

Status changed

The status of this publication has been changed

Status when published	Standards not met
Changed status	Approaching standards
Status changed by	08 July 2026 at 8:46am

Reason for change
Improvement plan accepted SCTASK0351599

NHS

Data Security and Protection Toolkit

Assessment

Audits

Manage organisation

Report an incident

News and support

[Back to assessment](#)

View previous publications

Select a publication to view further details.

Publication	Date	
CAF 2025-26 (version 8) - Approaching standards	25 June 2026	View Manage
CAF 2025-26 (version 8) - Interim	29 December 2025	View
CAF 2024-25 (version 7) - Standards met	27 June 2025	View
CAF 2024-25 (version 7) - Interim	19 December 2024	View
CAF 2024-25 (version 7) - Interim	16 December 2024	View
NDG 2023-24 (version 6) - Standards met	25 June 2024	View

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

Status	Date Published
CAF 2025-26 (version 8) Approaching standards	25/06/2026
CAF 2025-26 (version 8) Baseline	29/12/2025
CAF 2024-25 (version 7) Approaching standards	27/06/2025
CAF 2024-25 (version 7) Baseline	19/12/2024
2023-24 (version 6) Standards Met	25/06/2024
2023-24 (version 6) Baseline	27/02/2024
2022-23 (version 5) Standards Met	23/06/2023
2022-23 (version 5) Baseline	24/02/2023

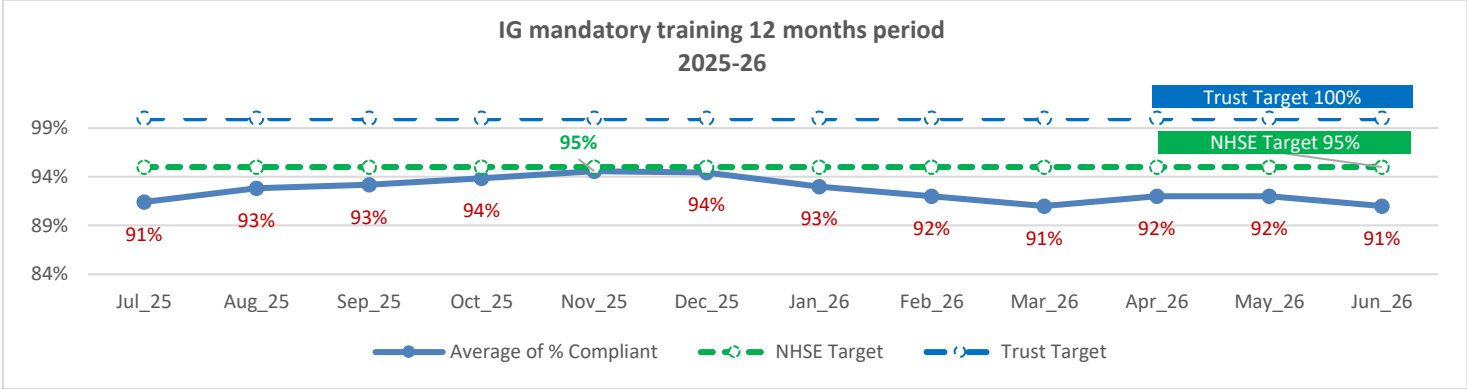
A comprehensive and risk-based action plan has been established within Informatics to address all identified gaps in backup coverage, immutability and restoration capability. This plan includes the development and progression of a funded business case for a new backup solution, alignment of backup arrangements to all essential functions (including non-IT systems), and the formalisation of restore processes and disaster recovery documentation. Measures are also in place to ensure improved resilience, including enhanced testing capability and the introduction of defined backup profiles that balance immutability with capacity.

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

	Principle	Outcome	Expected level of achievement	Trust Assessment Results		Principle	Outcome	Expected level of achievement	Trust Assessment Results
Objective A - Managing risk	A1 – Governance	A1.a - Board direction	A	A	Objective C - Detecting cyber security events	C1 - Security monitoring	C1.a - Monitoring coverage	PA	PA
		A1.b - Roles and responsibilities	A	A			C1.b - Securing logs	PA	PA
		A1.c - Decision-making and approval	A	A			C1.c - Generating alerts	PA	PA
	A2 - Risk management	A2.a - Risk management process	PA	PA			C1.d - Identifying security incidents	PA	PA
		A2.b – Assurance	A	A			C1.e - Monitoring tools and skills	NA	PA
	A3 - Asset management	A3.a - Asset management	A	A		C2 - Proactive security event discovery	C2.a - System abnormalities for attack detection	NA	NA
	A4 - Supply chain	A4.a - Supply chain	PA	PA			C2.b - Proactive attack discovery	NA	PA
Objective B - Protecting against cyber attack and data breaches	B1 - Policies, processes and procedures	B1.a - Policy, process and procedure development	PA	PA	Objective D - Minimising the impact of incidents	D1 - Response and recovery planning	D1.a - Response plan	PA	PA
		B1.b - Policy, process and procedure implementation	PA	PA			D1.b - Response and recovery capability	A	A
	B2 - Identity and access control	B2.a - Identity verification, authentication and authorisation	PA	PA			D1.c - Testing and exercising	A	A
		B2.b - Device management	NA	PA		D2 - Lessons learned	D2.a - Incident root cause analysis	A	A
		B2.c - Privileged user management	NA	PA			D2.b - Using incidents and near misses to drive improvements	A	A
		B2.d - Identity and access management (IdAM)	PA	PA	Objective E - Using and sharing information appropriately	E1 – Transparency	E1.a - Privacy and transparency information	PA	PA
	B3 - Data security	B3.a - Understanding data	PA	PA			E2.a - Managing data subject rights under UK GDPR	A	A
		B3.b - Data in transit	PA	PA		E2 - Upholding the rights of individuals	E2.b – Consent	A	A
		B3.c - Stored data	PA	PA			E2.c - National data opt-out policy	A	A
		B3.d - Mobile data	PA	PA		E3 - Using and sharing information	E3.a - Using and sharing information sharing for direct care	A	A
		B3.e - Media/equipment sanitisation	PA	PA			E3.b - Using and sharing information for other purposes	A	A
	B4 - System security	B4.a - Secure by design	PA	PA		E4 - Records management	E4.a - Managing records	A	A
		B4.b - Secure configuration	PA	PA			E4.b - Clinical coding	A	A
		B4.c - Secure management	PA	PA					
		B4.d - Vulnerability management	PA	PA					
	B5 - Resilient networks and systems	B5.a - Resilience preparation	PA	PA					
		B5.b - Design for resilience	NA	PA					
		B5.c – Backups	A	NA					
	B6 - Staff awareness and training	B6.a – Culture	PA	PA					
		B6.b - Training	A	A					

4. Information Governance training

The Trust has successfully met the 95% target set by NHS England over the last year, the target was achieved in November 2025. As a Trust, we are dedicated to consistently reaching our monthly targets, reflecting our commitment to excellence and patient care.



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

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

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

Information Governance Policies

No	Dept.	Information Governance	Type	Version	Expire date
1	IG	Records Management Policy	Policy	7	03/07/2028
2	IG	CCTV Policy	Policy	1.1	03/07/2028
3	IG	Freedom of Information Policy	Policy	6.3	03/07/2028
4	IG	Information Risk Management Policy	Policy	4.2	21/05/2029
5	IG	Health Record Keeping Policy	Policy	5.4	21/05/2029
6	IG	National Data Opt-Out Policy	Policy	1.0	18/01/2027
7	IG	Data Protection Policy	Policy	8.4	20/02/2028
8	IG	Information Governance Framework	Policy	1.2	21/05/2029
9	IG	Information Sharing Policy	Policy	1.3	20/02/2028
10	IG	Data Protection by Design and Default Policy	Policy	1.0	17/04/2028
11	IG	Personal Data Breach Procedure	SOP	8.4	20/02/2028
12	IG	Registration Authority Procedure	SOP	3.4	15/01/2027
13	Communications	Social Media Policy	Policy	5	24/05/2027
14	Business Intelligence	Data Quality Policy	Policy	2	30/08/2027
15	Business Intelligence	Responsible use of Artificial Intelligence Policy	Policy	1.34	15/05/2028

Cyber Security Policies

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

No	Dept.	Cyber Security Policies	Type	Version	Expire date
1	IT	Email and Internet Usage Policy	Policy	4.5	10/02/2029
2	IT	Information Security Policy	Policy	6.0	16/03/2026
3	IT	Mobile Device Management	Policy	1.0	15/02/2027
4	IT	Network Security Policy	Policy	1.0	15/02/2027
5	IT	Patching and CareCert Policy	Policy	1.0	24/05/2027
6	IT	Password, Single Sign On and Multi Factor Authentication Policy	Policy	1.2	08/01/2029
7	IT	Clear Desk and Screen Policy	Policy	1.0	21/11/2027
8	IT	Encryption Policy	Policy	1.0	21/11/2027
9	IT	Access Control Policy	Policy	1.0	17/04/2028
10	IT	Vulnerability Management Policy	Policy	1.0	01/03/2028
11	IT	Cyber Incident Response Plan	Policy	1.0	01/03/2028
12	IT	IT Business Continuity Plan	Policy	1.0	PDOG
13	IT	Information Classification Policy	Policy	1.0	01/10/2028
14	IT	M365 Overall Policy	Policy	1.0	Draft
15	IT	Ms Teams Policy	Policy	1.0	Draft
16	IT	Secure Transfer of Data Policy	Policy	1.0	Draft
17	IT	Backups Policy	Policy	1.0	Draft

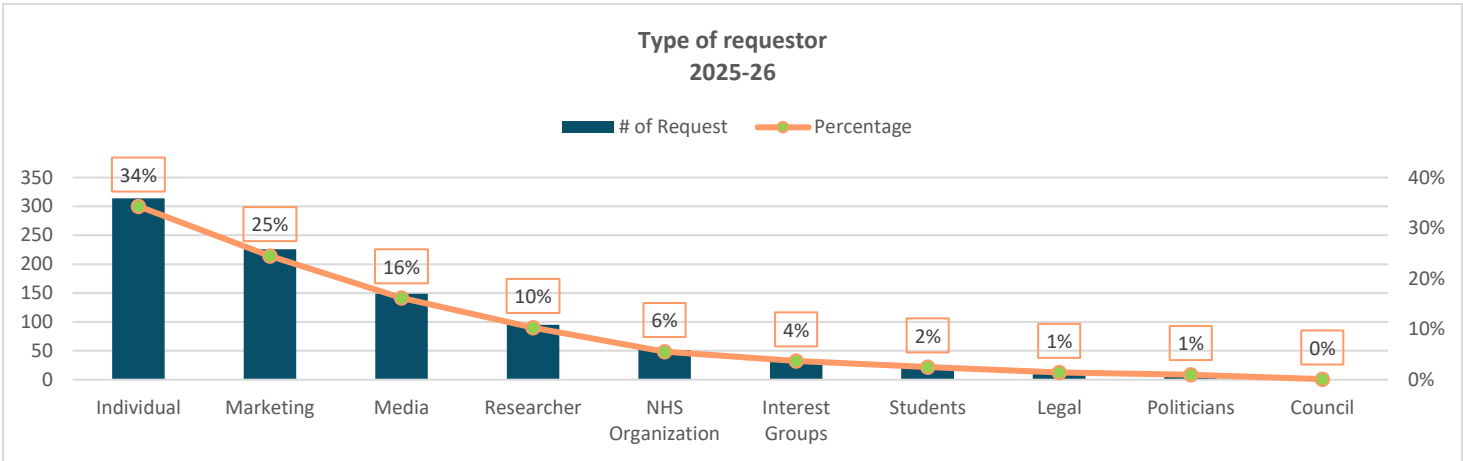
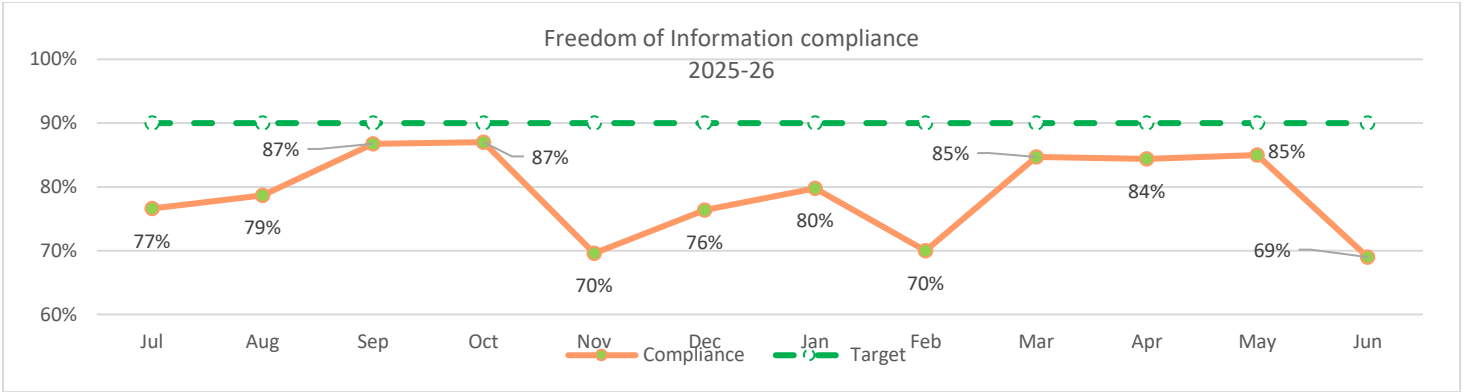
6. Freedom of Information (FOI) Request

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

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

	2023/24	2024/25	2025/26
Total number of requests	937	923	915
# of request completed within 20 days	536	780	721
Compliance	57%	85%	79%

During 2025/26, the Trust received **915 Freedom of Information (FOI) requests**, a slight decrease of 8 requests (0.9%) compared with 923 requests in 2024/25. However, the number of requests completed within the statutory 20-working-day deadline reduced from 780 in 2024/25 to 721 in 2025/26, **resulting in a decline in overall compliance from 85% to 79%**. Despite managing a similar volume of requests, the reduction in compliance indicates ongoing challenges in obtaining timely information from services and highlights the need for continued focus on divisional ownership and response performance to improve compliance with the requirements of the Act. **Note: the month of June is not complete yet, end 20/07/26.**



6.1 Complaints raised to the ICO

No complaints to the ICO during this period.

6.2 Section 50 Decision Notices

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

No decision notices served to the Trust for this period.

7. Subject Access Requests

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

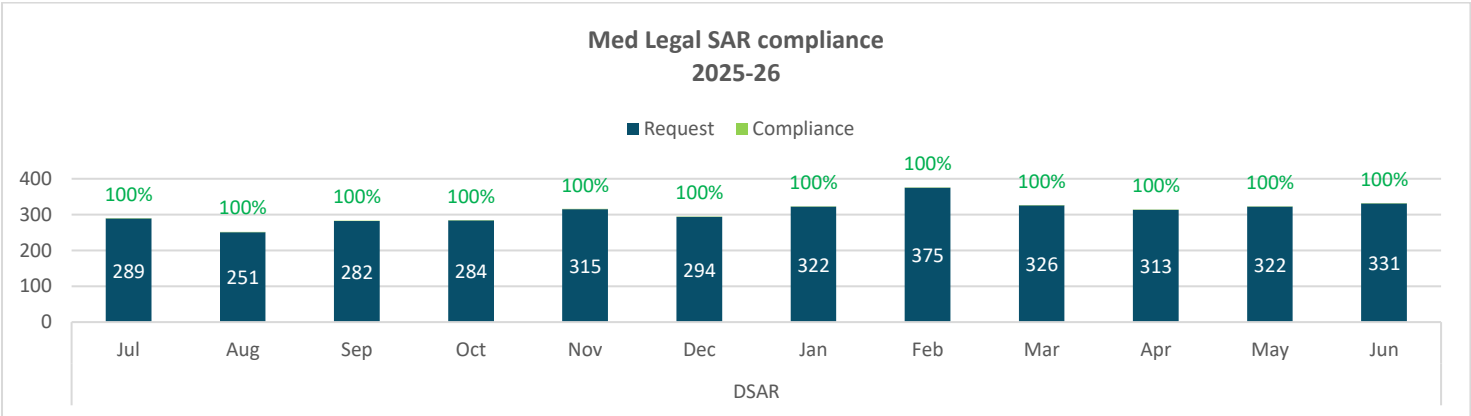
- The UK GDPR and Data Protection Act 2018 - rights for living individuals to access their own records. The right can also be exercised by an authorised representative on the individual's behalf (for example, a solicitor).
- The Access to Health Records Act 1990 - rights of access to deceased patient health records by specified persons.
- The Medical Reports Act 1988 - right for individuals to have access to reports, relating to themselves, provided by medical practitioners for employment or insurance purposes.

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

SAR is currently handled by four departments, which increases compliance and accuracy risks. The Trust should establish a standardised, centralized SAR team to ensure consistent and legal service.

7.1 Subject Access Requests from patients – Medical Legal Department

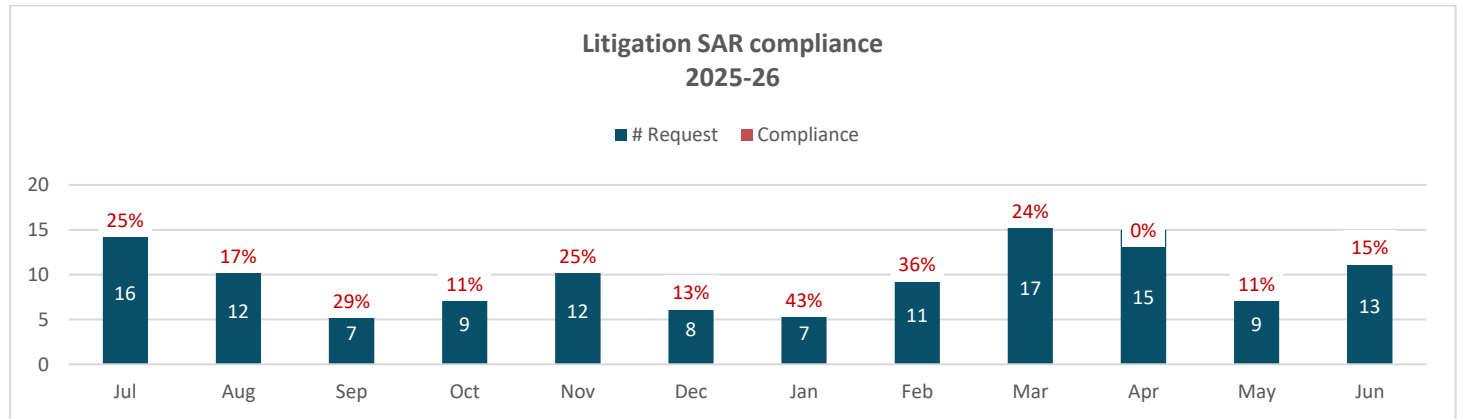
The table below shows subject access request compliance rate within 2025/26:



There were 3704 subject access requests in total during this period made to the Medical Legal Department, with an average compliance of 100%. This is an increase of 273 new request.

7.2 Subject Access Requests from patients – Litigation Department

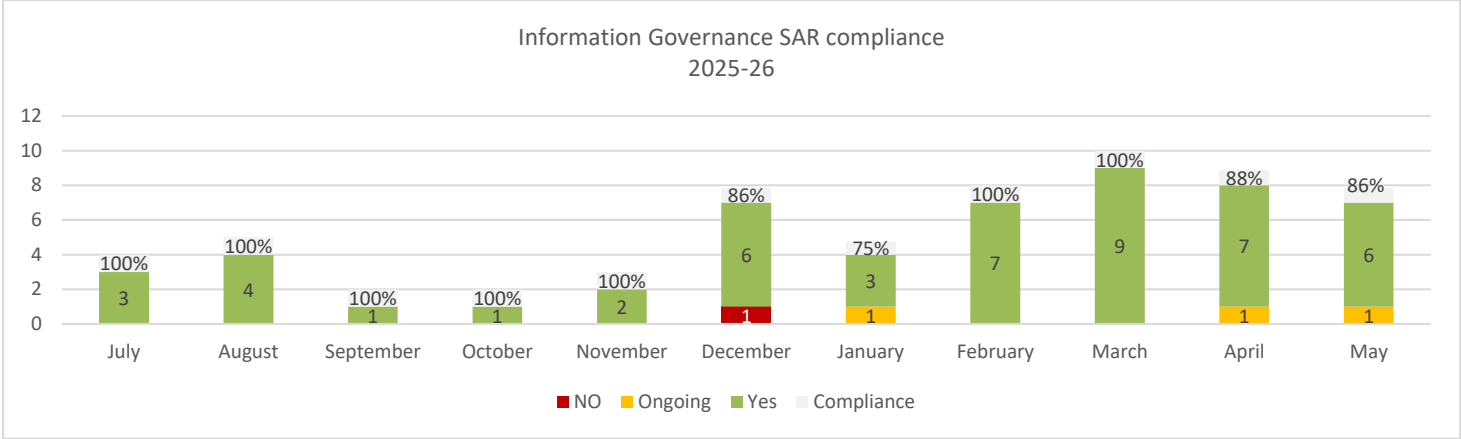
The table below shows subject access request compliance rate within 2025/26:



There were 136 requests in total during this period made to the Litigation Department, with an average compliance rate of 20%. Compliance within the Litigation Department has been impacted due to the loss of staff.

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

The table below shows subject access request compliance rate within 2025/26:

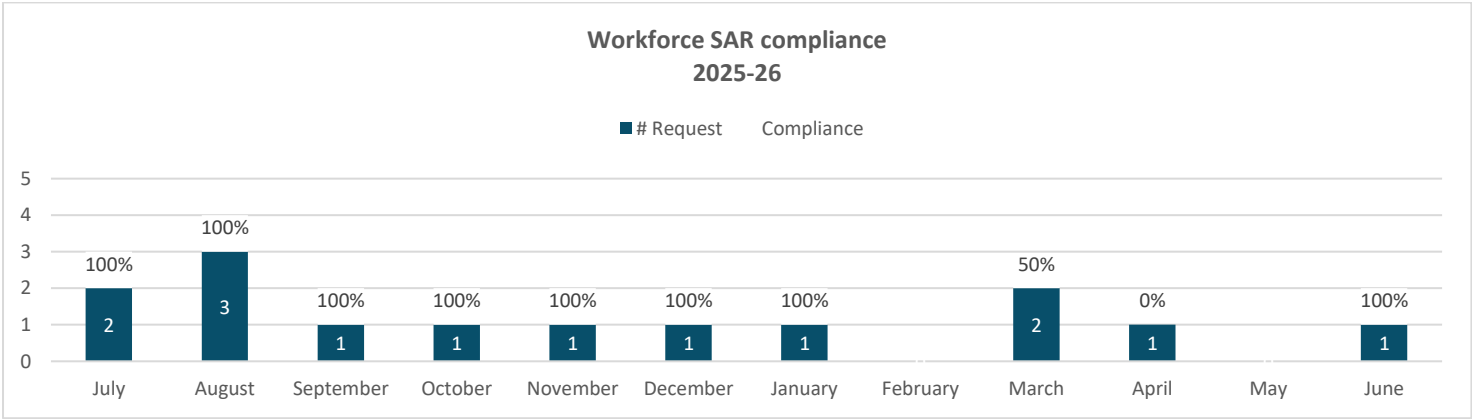


During this reporting period, a total of 66 subject access requests were received by the Information Governance team, there is an increase of 39 request. The department maintained an average compliance rate of 100%.

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

7.4 Subject Access Requests from staff – Workforce

The table below shows subject access request compliance rate within 2025/26:



There were 14 subject access requests in total during this period made to Workforce, with an average compliance rate of 85%.

8. Data Protection Incidents

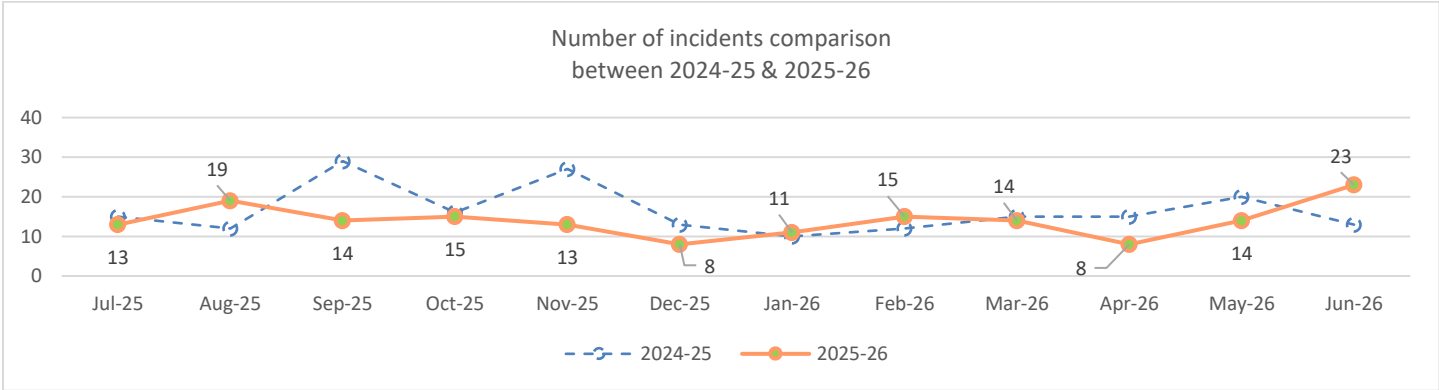
Patient confidentiality and security of information about service users is very important to the Trust. Confidential information is held largely in electronic and paper form, when is electronic information this is within different systems, for example EPR, PAS, ESR, E-rostering.

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

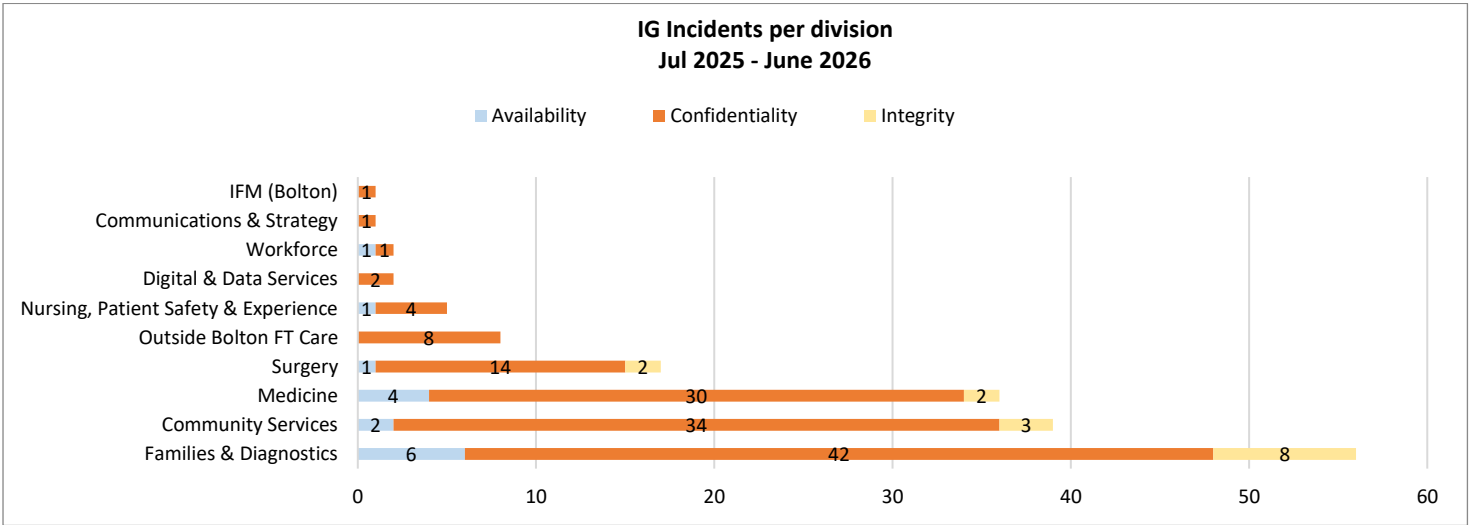
The Trust has a duty to report a notifiable breach to the Information Commissioner’s Office without undue delay, and within 72 hours after we became aware of the incident. Once submitted, the notification will be sent to NHS Digital, the Information Commissioners Office (ICO) and other regulators and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

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

During 2025/26 there were **167** Information Governance incidents reported via Safeguard.



- From the 167 incidents there were two incidents reported externally (Information Commissioners Office (ICO) via the Data Security and Protection Toolkit.
- No claims were made under UK GDPR during the period. Three prior cases were closed, costing the Trust £14k.



8.1 Incidents reported externally.

No.	Reference	Reported	What happened	Reported to
1	45194	17/11/2025 14:30	A parent raised concerns after receiving a report from a third-party agency that contained sensitive personal information related to their child. The parent queried how the information has been disclosed and expressed concern that they had not previously been aware of the matters referenced in their report.	ICO
2	44949	31/10/2025@ 12:54	The Patient Experience Team identified that 2 SD cards used to record complaint meetings were missing. These SD cards are used within a Trust-owned recording device to document conversations as part of the complaints process.	ICO

Cause	2025						2026						Grand Total
	Qtr3			Qtr4			Qtr1			Qtr2			
	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	
Breach Of Patient Confidentiality	13	19	14	15	13	8	7	15	14	8	13	20	159
Breach Of Staff Confidentiality							4				1	3	8
Grand Total	13	19	14	15	13	8	11	15	14	8	14	23	167

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

Whilst overall Information Governance incidents decreased from 197 in 2024/25 to 167 in 2025/26, the Families and Diagnostics Division remains the highest reporting division within the Trust. The division continues to account for the largest proportion of confidentiality-related incidents and remains a key area of focus for targeted improvement, awareness activities, and assurance monitoring.

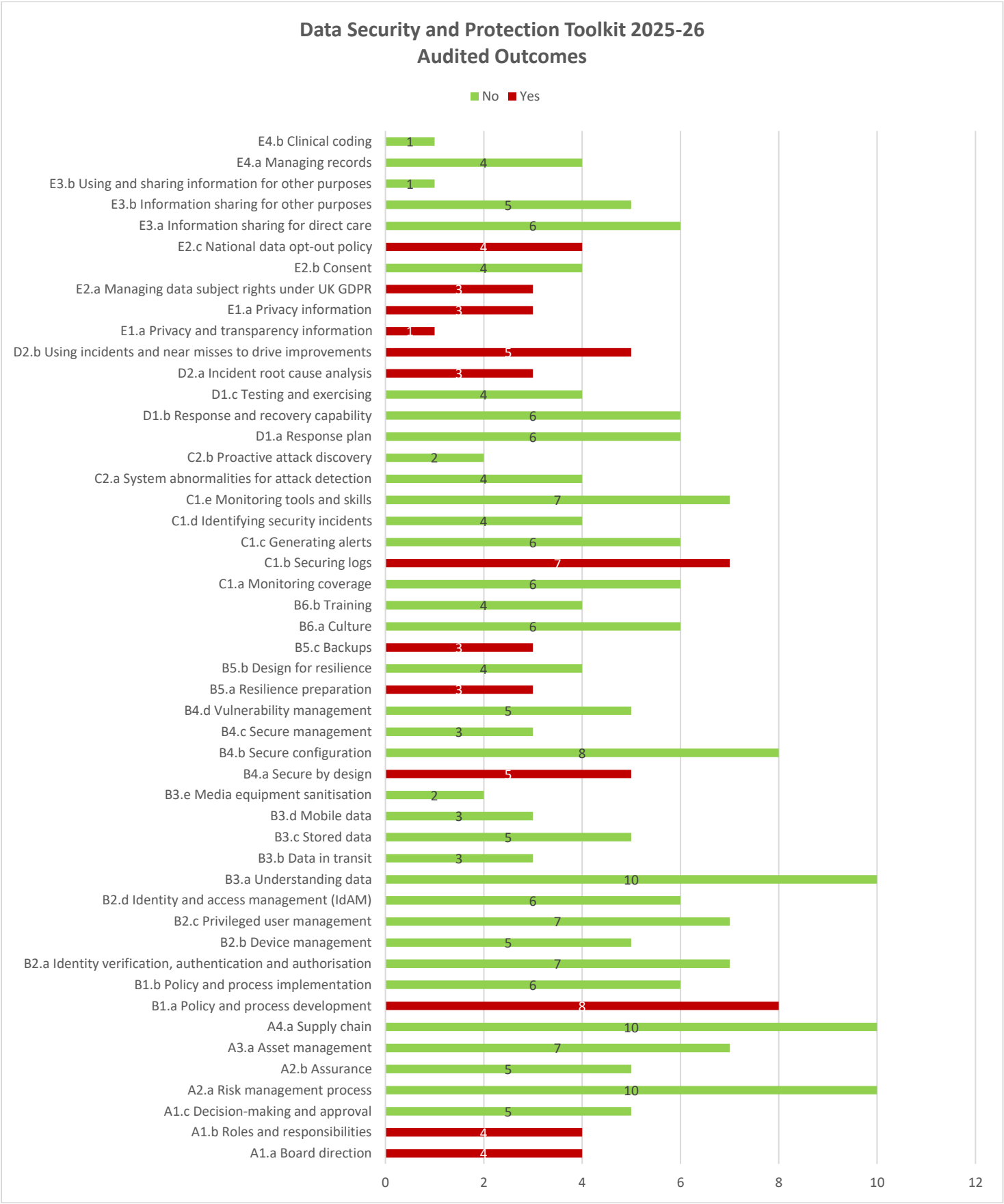
Every incident is individually assessed by the Head of IG/ IG Department and advice given to prevent the reoccurrence of this happening for example further training, raising team awareness, poster/checklist/ advice and developing letter templates for patients affected. The Information Governance team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

9. Internal Audit Findings

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

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

For 2025-26 there are a total of 53/240 indicators of good practice requirements to be audited under the framework, from the not achieve, partially achieve and achieve, across 12 outcomes.



9.1 Auditor key findings and conclusions

MIAA review followed the CAF-aligned DSPT Independent Assessment Framework and Guidance published by NHSE. We have reviewed 12 outcomes across the 5 objectives in the Cyber Assessment Framework. NHSE mandated 8 outcomes to be audited for 2025/26, the organisation was required to select and formally approve a further 4 outcomes to be audited. The scope of the audit has been approved by BHFT and the independent assessor.

As a result of our evidence assessment and interviews with key stakeholders, we have delivered 1 outcome with findings and recommendations for management response and follow up, in total; 1 High Risk. We have also delivered 11 outcomes, assessed as meeting the NHS England minimum profile, that do not require management responses but may have recommendations to strengthen evidence or processes further.

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

Overall Assurance Rating (NHSE profile for the in-scope outcomes)	Veracity of the organisation’s self-assessment
We have assessed 12 outcomes, and found that, for 11 outcomes, the organisation has met the minimum achievement level. However, we also found that for 1 outcome were rated as not meeting minimum achievement levels. We assessed the risk in these areas and outcomes reviewed as: Moderate risk	We have assessed 12 outcomes and found that for 1 of 12 outcomes, our rating aligned with the organisation’s self-assessment resulting in a low level of deviation between the independent and self-assessment. We therefore assessed the confidence level of the Independent Assessor in the veracity of the self-assessment as: High Confidence

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

Objective	Outcome	Minimum Achievement Level (as per the NHSE profile set for 25/26)	Assessment Result	Overall Assurance Assessment
A	A1.a	Achieved	Agreed	Moderate
B	B1.a	Partially Achieved	Agreed	
	B4.a	Partially Achieved	Agreed	
	B5.a	Partially Achieved	Agreed	
	B5.c	Achieved	Not met	
C	C1.b	Partially Achieved	Agreed	
D	D2.a	Achieved	Agreed	
E	E2.a	Achieved	Agreed	
	E2.c	Achieved	Agreed	
A	A1.b_DIS	Achieved	Agreed	
D	D2.b_DIS	Achieved	Agreed	
E	E1.a_DIS	Partially Achieved	Agreed	

9.1.2 - Veracity of the organisation’s self-assessment

Objective	Outcome	Minimum Achievement Level (as per the NHSE profile set for 25/26)	Organisation’s Self-assessment (Met / Not Met)	Auditor Assessment (Met / Not Met)	Deviation (No of IGP#s that differ)			Overall Confidence Level
					NA	PA	A	
A	A1.a	Achieved	Met	Met	0 of 4		0 of 4	High
B	B1.a	Partially Achieved	Met	Met	0 of 8	0 of 3		
	B4.a	Partially Achieved	Met	Met	0 of 4	0 of 5		
	B5.a	Partially Achieved	Met	Met	0 of 3	0 of 2		
	B5.c	Achieved	Met	Not Met	3 of 3	2 of 2	2 of 2	
C	C1.b	Partially Achieved	Met	Met	0 of 5	0 of 3		
D	D2.a	Achieved	Met	Met	0 of 2		0 of 3	
E	E2.a	Achieved	Met	Met	0 of 2		0 of 3	
	E2.c	Achieved	Met	Met	0 of 4		0 of 3	
A	A1.b_DIS	Achieved	Met	Met	0 of 4		0 of 4	
D	D2.b_DIS	Achieved	Met	Met	0 of 2		0 of 5	
E	E1.a_DIS	Partially Achieved	Met	Met	0 of 3	0 of 3		

9.2 Areas of good practice

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

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

- The Trust had zero Network and Information Systems (NIS) / cyber related incidents reportable to the Information Commissioner’s Office (ICO) in 2025/26.
- The Information Asset Register (IAR) had been extended to include essential functions. The Data Protection Officer (DPO) had led the collation of essential functions list and arranged meetings with a wide range of stakeholders to review and confirm controls and risks.
- A wide range of stakeholders had engaged in in the audit of this Trust-wide DSP toolkit.
- Information Asset Owners (IAOs) were being matured and embedded and the role and responsibilities for IAOs / procurement, especially for cloud-based systems clarified.
- The Trust had formally appointed an Emergency Preparedness Readiness and Response (EPRR) lead in December 2024.
- A new vulnerability management policy and cyber incident response plan were evidenced.
- A separate network for medical devices – Virtual Local Area Network (VLAN) had been implemented in 2024/25.

- IT had onboarded the Trust to a range of NHS England solutions / employed a range of threat intelligence sources and technology solutions to strengthen threat monitoring.
- **The Trust continues to enhance executive cyber assurance arrangements by aligning Information Governance, Cyber Security, EPRR and operational resilience activities with NHS England Board and Executive Assurance guidance. This supports improved oversight of Essential Functions, cyber resilience and organisational risk.**

9.3 MIAA findings and recommendations

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

Finding name	Finding description
Backups	Backups (B5.C) 1. A#1 - Formalise and agree an upgrade strategy / business case for a new backup solution. 2. NA#1 / PA#1 / A#1 - Ensure all essential functions are covered by immutable backups. 3. A#1 - Continuing to enhance the IT DR document library so it covers all essential function third parties and by ensuring that the essential functions list remains aligned to the IT DR documentation. 4. NA#2 / NA#3 / PA#2 / A#2 - Review and confirm that backup schedules and restore processes are appropriate for all essential functions (IT and Non-IT systems). 5. A#2 - Develop profiles for essential functions for the new backup solution to balance immutability and backup capacity. Management Response 1. Apply for funding from NHS England (complete) 2. Update the capital plan and present to the Trust 3. For the business case: a. review / update the business case for a new backup solution b. document an upgrade strategy c. agree initial profiles for essential functions balancing immutability and backup capacity 4. Baseline and present to IG and cyber groups : a. IT DR document library b. backup schedules and restore processes Responsible Officer/s: Farouk Patel / Deiler Carrillo / Brett Walmsley Implementation Dates: End of Sept. 2026
Wider risk	The following areas of wider risk were identified during our review and while they are outside of this year’s scope and have no impact on the assurance rating, could impact the organisation’s overall control environment / performance. These are for consideration as part of wider risk management processes and not subject to the DSPT formal follow up.

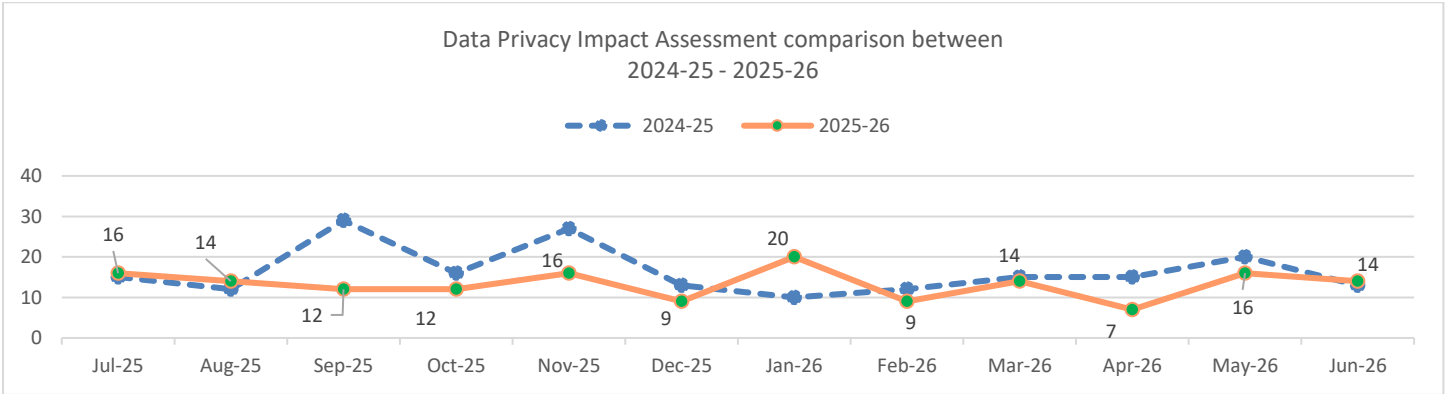
	Outcome	Comment
	A1.A - Board direction	✓ A#4- There was a dependency on the ICB strategy / SLA re ICB / GP services to be confirmed. The outcome will have implications for the Trust resourcing profile.
	A1.B – Roles and Responsibilities	✓ A#2 - Resourcing gaps were raised with regards Subject Access Requests (SARs), EPRR and cyber / infrastructure and succession planning was to be formalised and agreed.
	B1.A – Policy and process development	✓ The Trust were keeping a watching brief on the Cyber Resiliency Bill, were developing documentation around coding development and will review the Data Use and Access Act (DUAA) guidance once the Information Commissioner’s Office (ICO) guidance is refreshed.
	B4.A – Secure by design	✓ PA#2 - Formalise plans for the CAT 5 Data cabling replacement programme / the network fibre refresh business case to enhance resiliency. ✓ PA#5 - Confirm the email strategy for the Trust before submission in June 2026.
	B5.A – Resilience preparation	✓ The Synnovis incident has illustrated that an organisation may have to run business continuity measures in parallel to disaster recovery measures for an extended period of time. Also, that extreme scenarios are important to consider / test.
	E2.A – Managing data subject rights under UK GDPR	✓ A#1 - We were advised of an increase in SARs being received however there was limited resourcing to deliver the increased demand. ✓ The Trust should confirm plans for consolidating the teams / for seeking support for delivery of the process from partners.
DSPT	The Trust should complete and agree an overarching improvement plan with NHS England, as applicable.	

An improvement plan was submitted to NHS England and was accepted on 08th July 2026, this can be found in [Appendix B](#).

10. Data Privacy Impact Assessments

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

In 2025-26 we finished 159 DPIAs, but some of the DPIAs are not approved yet because they need more information or they are complicated projects that require a staged approach to assess the risks.



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

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

11. Accreditations & Certifications

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

11.1 Ensuring Data Security: Our ISO 27001 accreditation

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

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

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

Why ISO 27001 Matters in Healthcare:

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

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

11.2 Ensuring Data Security: Our ISO 9001 accreditation

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

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

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

Why ISO 9001 Matters in Healthcare:

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

11.3 Ensuring Data Security: Secure Email Standards (DCB1596)

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

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

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

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

Why DCB1596 Matters in Healthcare:

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

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

12. Recommendation and priorities for 2025-26 period

❖ Information Governance Group/SIRO

- **Board Cyber Assurance Framework** – Develop a formal Board cyber assurance framework aligned to NHS England Board and Executive Assurance guidance, ensuring cyber security risks, resilience measures, audit findings, Essential Functions, supplier risks and recovery capabilities are routinely reported through the Board Assurance Framework and Risk & Audit Committee.
- Continue to enhance risk management maturity – implementation of a threat informed risk modelling, aligning IG, cyber and clinical safety, supplier dependency and operational resilience to the delivery of Essential Functions.
- **Transparency & Legal Compliance** – develop a robust Publication Scheme within the new website and implement a series of dataset for the division that get the majority of request.
- **Culture & Behaviour Change** – update Training Need Analysis to reflect high risk roles with cyber training, to include directors, procurement, IT administrators
- To support the delivery of the Data Security and Protection Toolkit (DSPT) the Essential Functions sub-group will be strengthened and enhanced to improve oversight of system, suppliers and processes that support the Trust Essential Functions. There have been challenges from divisional system owners in terms of engagement and the overall assessment completion. **Risk identified as part of the assessments should be tracked per the stakeholder responsible, for example business continuity plan should be done by the EPRR Team with the support from the division and reported back to the Essential Functions sub-group.**
- Mature and embed the roles of the Information Asset Owners and Information Asset Administrators roles within the Trust and as part of the governance framework for essential functions.

❖ IG/Divisions:

- The Information Governance Department and divisions to continue to mature and prioritise the Information Assets and Data Flow

Mapping Registers. Maintaining information assets and data flow should become a standard procedure within each division, eliminating the need for IG to prompt updates to the register.

- Support from the divisions is essential for this work, as they are the only ones who can identify the type of asset they hold and how information is shared within their departments.

❖ Procurement:

- **Supply chain risk management** – introduce a formal supplier assurance framework.
 - Essential Function Y/N
 - Tier category: Critical, High, Medium, Low
- **Contractual controls** – standardise UK GDPR Article 28 with all security clauses across all contracts, such as:
 - Embed the right of audit and incident notification for all contracts
 - Defined minimum cyber security requirements (e.g. DSPT, ISO 27001 or equivalent).
 - Business continuity and incident reporting
- **Ongoing monitoring** - Implement annual supplier security reassessments (no just onboarding checks) for all Essential Functions. Such as:
 - DSPT submissions or certifications
 - Penetration testing summaries
 - Security incidents summary
- To trigger reassessment on change events, for example:
 - Contractual renewal
 - Security incident or breach
 - Significant system or data scope changes
- The development of a Procurement Framework Policy is needed to clearly define expectations for procurement activity across the Trust. The policy will need to outline the Trust's requirements for goods and services, ensure alignment with regulatory and legislative standards, and embed robust due diligence processes for assessing providers. Due diligence checks will include financial stability, legal compliance, data protection standards, and operational capability, ensuring that all suppliers meet the Trust's requirements before engagement.

- The Trust should maintain an up-to-date and comprehensive contracts register.
- Contracts processing personal data should be tracked, accredited, and regularly reviewed.
- An assurance strategy for the contract's lifetime should be formalised, specifying roles and responsibilities for both parties (Trust and supplier).
- All Essential Functions with a contractual risk should be prioritised within the Procurement programme. Progress made with these contracts should be reported via the Procurement/division governance mechanisms.

❖ Informatics:

Backup solution/resilience – main priorities

- Formalise and agree an updated strategy and business case for a new backup solution, ensuring that all Essential Functions are covered by immutable backups.
- Continue enhancing the IT Disaster Recovery documentation library so it covers all essential function third parties. Ensuring that Essential Functions list remains aligned to IT Disaster Recovery documentation.
- Review and confirm backup schedules and restore processes for all essential functions, including IT and non-IT systems.

Refresh digital and cyber strategy

- Refresh the Digital Strategy that expired in 2025
- Formalise and approve the Trust cyber strategy, this should be aligned with the ICB strategy.

Strengthen IT disaster recovery and business continuity

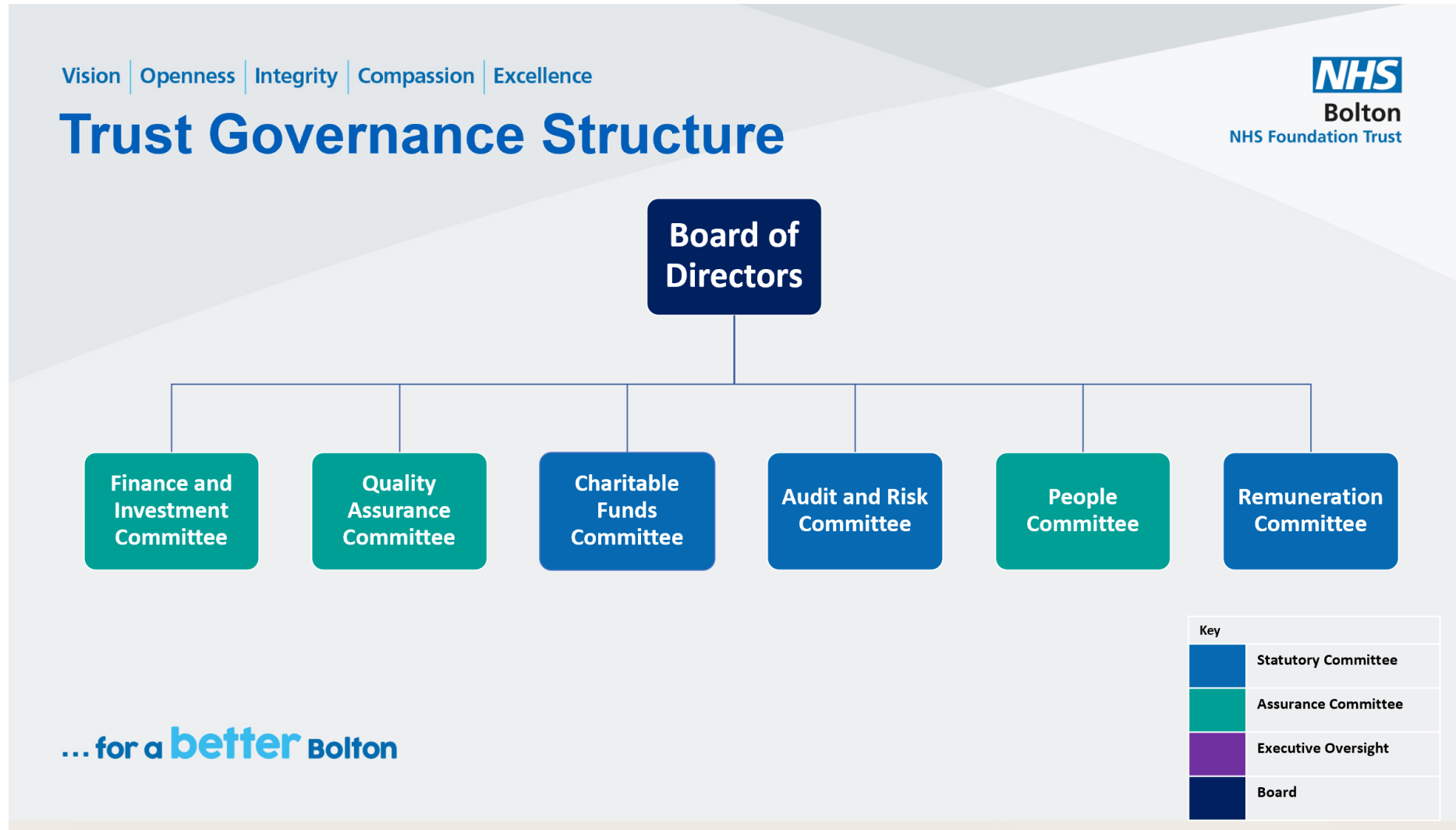
- Continue enhancing the IT DR document library, including third-party dependencies.
- Keep the essential functions list aligned with IT DR documentation.

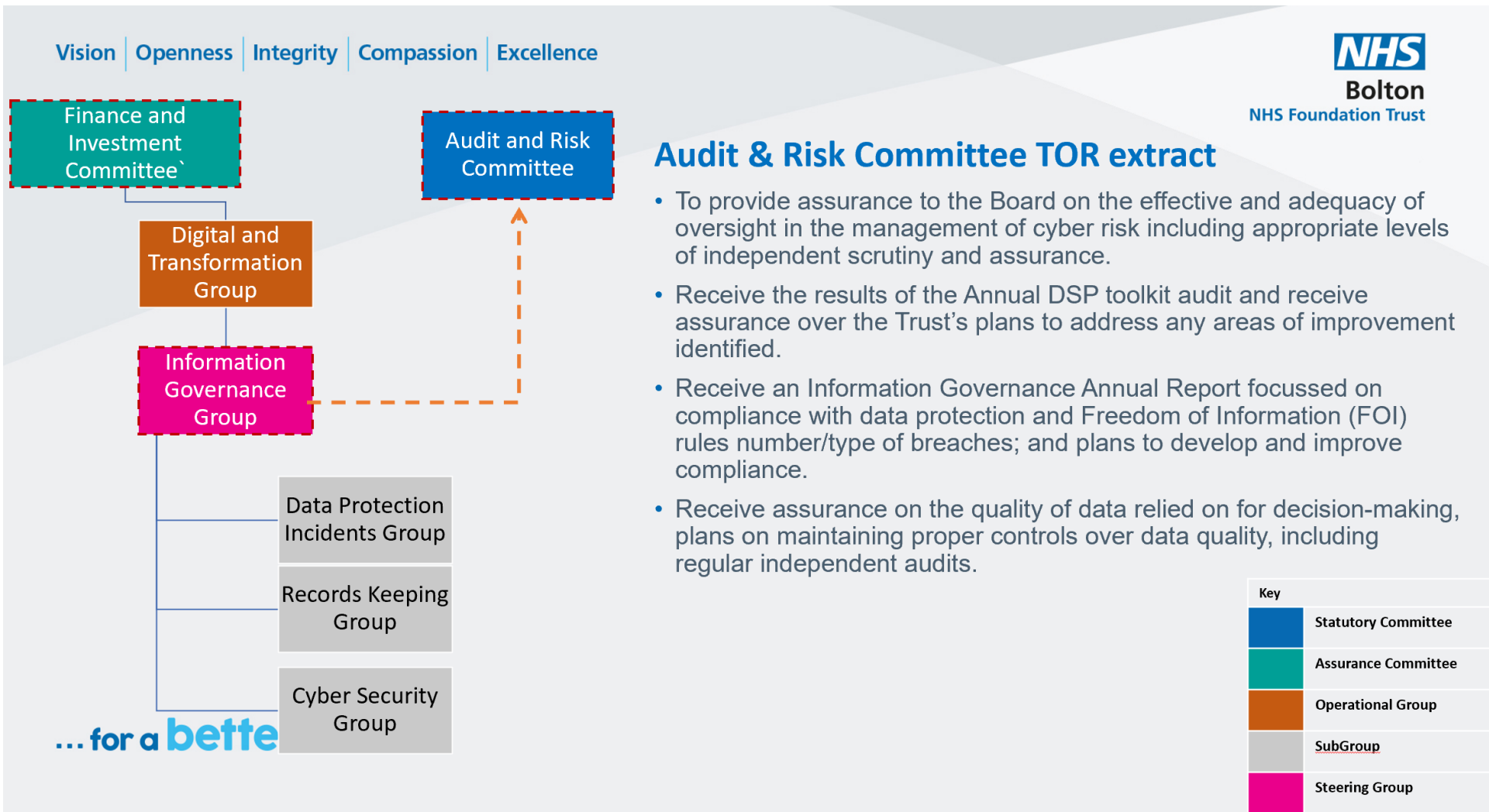
- Prioritise penetration test recommendations to mitigate cybersecurity risks.
- Report any recommendations that cannot be fixed promptly or will take longer than expected via the Risk Register.

❖ Emergency Planning:

- Confirm EPRR risk & Trust resilience risks registers are appropriately reflected and monitored through the Board Assurance Framework.
- Establish a 2026-27 programme to test the Trust business continuity plans and cyber incident response plan for all Essential Systems.
- Exercises for IFM must be carried for everything that cover the Essential Functions.
- There has been identified a gap in terms of resources within the EPRR Team due to capacity and succession plans.
- All the Essential Functions that has been identified without BCP, represent a significant resilience risk and should be prioritised within the EPRR work programme. Progress in implementing and testing continuity plans should be monitored and reported through EPRR governance mechanisms until adequate assurance is achieved.
- Understand essential functions and dependencies of services (internal or external) and this should form part of the BCP.
- Completion of business impact analysis will produce a functional BCP, while for others, it may highlight necessary improvements.
- **End to end integration** – fully integrate the Cyber Incident Response Plan, IT BCP and IT Disaster Recovery into all the business continuity plan within the divisions, so is one operational framework.

Appendix A – Trust Governance Structure





Appendix B – DSPT Improvement Plan

DSPT Outcome	Indicator of good practice (IGP) reference if relevant	What actions do you plan to take to meet the requirement? Please provide details of any milestones. This should include any action required to ensure the activity is funded and resourced to achieve the planned completion date. Please use an individual row for each action.	Action Owner	Priority (High, Medium, Low)	Initial Planned Completion date <i>A date is required for improvement plan to be completed</i>	Status <i>(Not Started, Complete, Work on-going, No further work planned)</i>
B5.C	A#1	Update the capital plan and present to the Trust	Brett Walmsley - Director of Digital	Medium	30/09/2026	Started
B5.C	A#1	3. For the business case:- a. review / update the business case for a new backup solution b. document an upgrade strategy c. agree initial profiles for essential functions balancing immutability and backup capacity	Farouk Patel - CTO	High	30/09/2026	Started
B5.C	A#2	4. Baseline and present to IG and cyber groups :- a. IT DR document library b. backup schedules and restore processes	Farouk Patel - CTO	Medium	30/09/2026	Started

Report Title:	Annual Complaints, Concerns and Compliments Report 2025-2026			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 2026		Discussion	✓
Executive Sponsor	Chief Nursing and Quality Officer		Decision	✓

Purpose of the report	In accordance with The Local Authority Social Services and NHS Complaints (England) Regulations 2009, the Trust must publish an Annual Complaints Report. This report provides an analysis of the complaints, concerns and compliments received by Bolton NHS Foundation Trust between 1 April 2025 and 31 March 2026.
-----------------------	--

Previously considered by:	02 September 2026: Report received by Clinical Effectiveness Group (CEG). CEG noted specifically complaint performance has remained stable despite increase in activity. Quality metrics positive indicating effective resolution of concerns raised. Noted significant increase in the number of compliments overall and significantly in Community Services Division. 23 September 2026: Due to the timing of the Quality Assurance Committee meeting, the report has been shared concurrently.
---------------------------	---

Executive Summary	In 2025/26, the Patient Experience Team managed 2,088 cases: 267 formal complaints, a 34.8% increase from 2024/25, and 1,821 PALS contacts, a 2% reduction. Performance remained stable, with 99% of complaints acknowledged within three working days and 71% responded to within the required timeframe. The main themes were clinical decision-making, treatment delays and communication, reflecting continued operational pressures across acute, elective and community services. Re-opened complaints reduced to 4%, while the Medicine Division saw the largest increase in complaints, from 83 to 126. The Trust received 969 compliments, up by 640 from 2024/25, with the highest number in Community Services. Equality monitoring broadly reflected the Trust's population, with improved ethnicity data capture. Most contacts were from females, and most complaints related to patients aged 71–80. Complaint activity by neighbourhood was broadly consistent with population size and service use, with no significant geographical disparities identified.
-------------------	---

	The 2026/27 focus will be complainant feedback, improvement plans, action recording, compliments, handler training and PALS response times.
--	---

Proposed Resolution	The Board of Directors is asked to receive and approve the Annual Complaints, Concerns and Compliments Report 2025-2026 for submission to Board.
----------------------------	---

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

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

Prepared by:	Ryan Wetherall, Patient Experience Team Lead	Presented by:	Tyrone Roberts, Chief Nursing and Quality Officer
---------------------	--	----------------------	---

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

NHS	National Health Service
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
EDI	Equality, Diversity and Inclusion
AI	Artificial Intelligence
EPR	Electronic Patient Record
EOL	End of Life
TVN	Tissue Viability Nurse
ADND	Assistant Divisional Nurse Director
SOP	Standard Operating Procedure
GP	General Practitioner
IV	Intravenous
IG	Information Governance
QR	Quick Response (QR Code)

Vision | Openness | Integrity | Compassion | Excellence



Bolton
NHS Foundation Trust

Annual Complaints, Concerns and Compliments Report 2025-2026

...for a **better** Bolton



	Contents	Page
1	Executive Summary and Key Highlights	3
2	Progress In 2025-2026	4
3	Trust Wide Activity – Complaints	5
4	Trust Wide Activity – PALS	7
5	Medicine Division Activity	8
6	Surgical Division Activity	11
7	Families and Diagnostic Division Activity	14
8	Community Services Division Activity	17
9	Our Performance	21
10	Quality Monitoring	22
11	Reopened Complaints	22
12	Parliamentary and Health Service Ombudsman (PHSO)	23
13	Compliments	23
14	Equality Monitoring 2025-2026: Ethnicity	24
15	Equality Monitoring 2025-2026: Gender and Age by Patient	26
16	Our Neighbourhoods	27
17	Our Focus for 2026-2027	30

1. Executive Summary

This report provides a comprehensive overview of complaints, concerns, and compliments received by Bolton NHS Foundation Trust between 1st April 2025 and 31st March 2026. It outlines key performance metrics, emerging themes, divisional activity, and the Trust's continued commitment to learning and improving patient experience.

1.1 Key Highlights

- **Overall Activity:** The Patient Experience Team managed in 2,088 cases during 2025–2026. Formal complaints increased by 34.8% compared with 2024/25 (267 compared to 198 in 2024–2025). PALS activity showed a slight reduction at 2% to 1,821 cases, continuing a gradual downward trend.
- **Performance:** The Trust continues to demonstrate strong performance in acknowledging complaints, maintaining approximately 99% compliance within 3 working days. However, timeliness of response remains an area for improvement, with performance below the 95% target. Work has continued to strengthen escalation and tracking processes to improve response times while ensuring complainants are kept informed.
- **Themes and Trends:** The most prominent theme across both complaints and PALS remains decisions relating to clinical treatment, followed by delays in treatment and communication issues. While communication continues to feature, its prominence varies across divisions and complaint types.
- **Divisional Insights:**
 - Medicine Division: Significant increase in complaints to from 83 to 126, with PALS activity increasing slightly from 553 to 569 reflecting pressures across urgent and acute services. Key issues relate to clinical decision-making and delays in treatment.
 - Surgery Division: Slight increase in complaints from 52 to 59, with PALS activity also rising from 672 to 747. Concerns primarily relate to appointment delays, cancellations, and clinical decisions.
 - Families and Diagnostics Division: Marked increase in from 16 complaints to 59, requiring further review to understand drivers. PALS activity has increased from 198 to 318.
 - Integrated Community Services: Complaints have increased slightly to from 8 to 21, reversing the previous downward trend. Themes include clinical decisions, access to services, and delays. PALS activity is stable at 111 in 2024/2025 and 121 in the current year.
- **Equality Monitoring:** Data collection continues to show a high proportion of ethnicity fields recorded as unknown or not captured, indicating gaps in data completeness rather than active non-disclosure. Work with EDI teams remains a priority to improve data capture, inclusivity, and access.

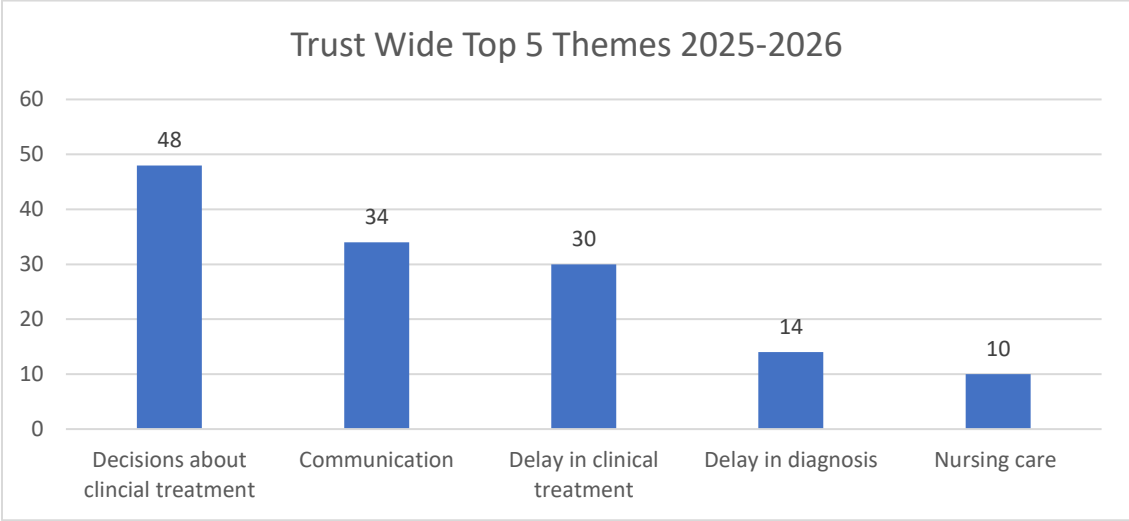
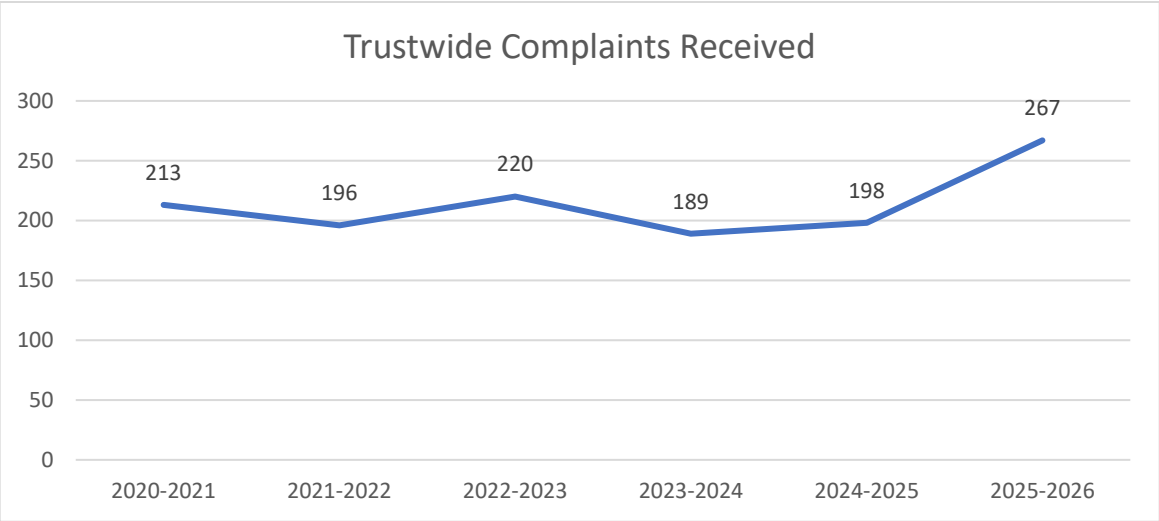
2. Progress in 2025/2026

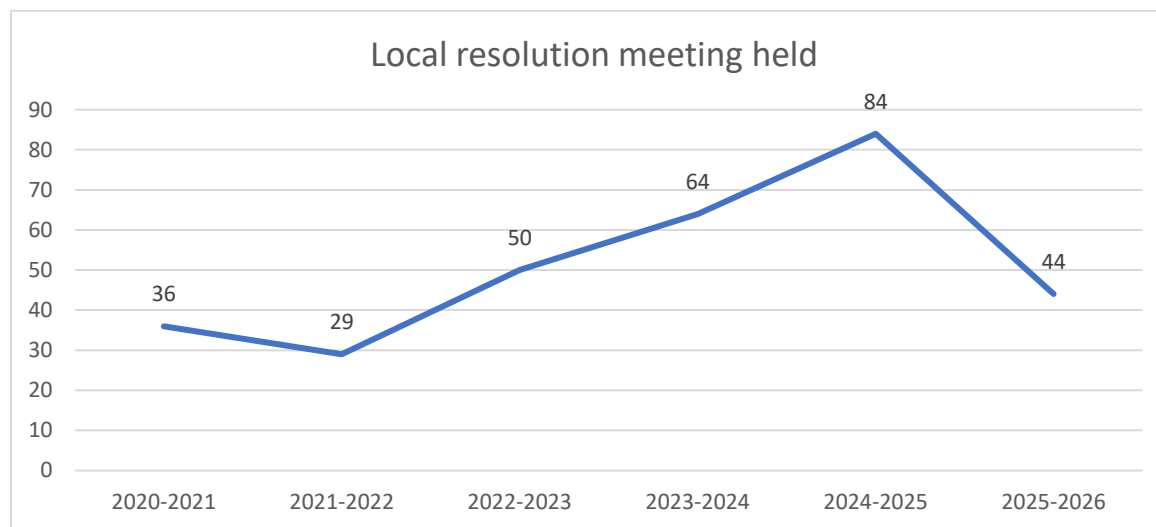
During the reporting period, the Patient Experience Team aimed to deliver a range of service improvements, including a full review of the service against local and national standards, enhancement of the Trust's external website, and increased engagement activity. However, delivery of these objectives was significantly impacted by sustained staffing challenges and reduced workforce capacity across the service over a prolonged period. This increased operational pressures and required prioritisation of core statutory and operational functions, which affected the team's ability to fully progress all planned improvement work within the intended timescales.

Despite these challenges, key statutory requirements continued to be met, and targeted assurance activity was undertaken to maintain compliance. Priority was given to maintaining core services, including complaints management, patient support through PALS, and ensuring patients and families continued to have access to online feedback routes.

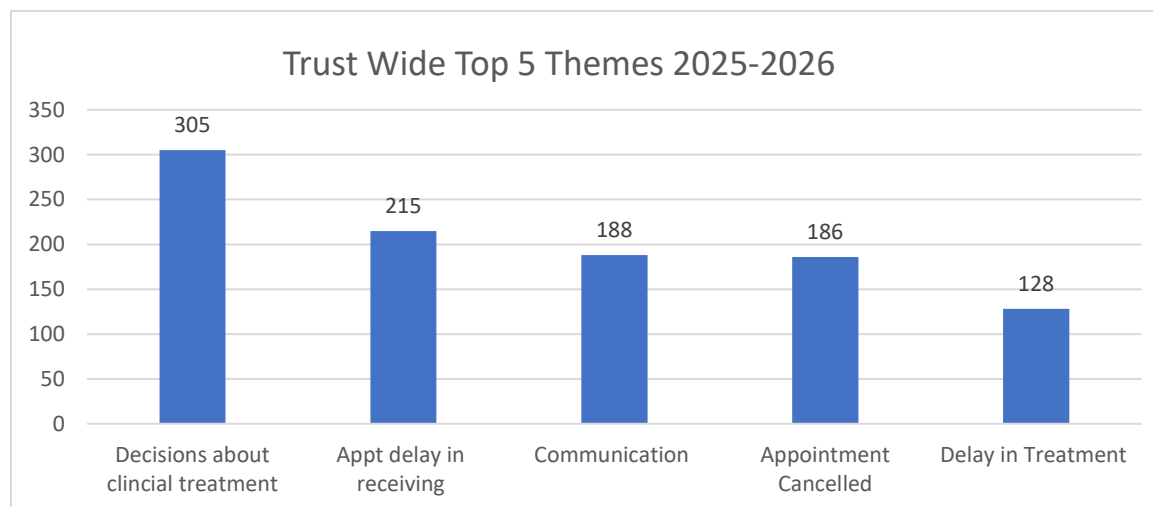
Actions are now in place for 2026/27 to strengthen service resilience, support workforce stability, progress outstanding objectives, and further enhance patient engagement, organisational learning, and maintain compliance with national standards.

3. Trust Wide Activity: Complaints

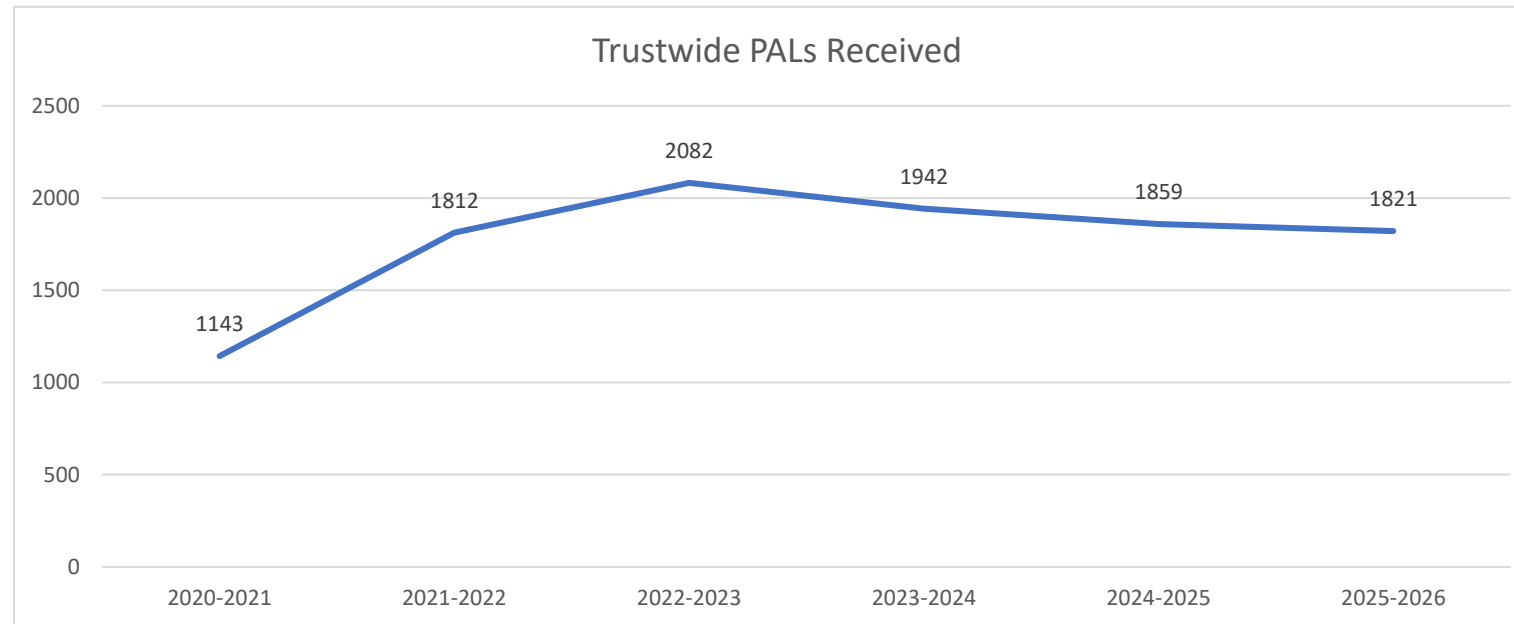




- Complaints have increased significantly to 267 in 2025–2026, rising from 198 in 2024–2025 and representing the highest level recorded in the last five years.
- This increase may reflect growing demand and service pressures, alongside improved awareness of complaints processes and accessibility to raise concerns.
- The most common theme remains decisions about clinical treatment (48 cases), followed by communication-related concerns (34) and delays in clinical treatment (30).
- Local resolution activity has declined, with meetings reducing from 84 in 2024–2025 to 44 in 2025–2026. While there is a trend towards written responses, further work is required to understand complainant perceptions of resolution meetings and to actively promote and support their use, in line with best practice.



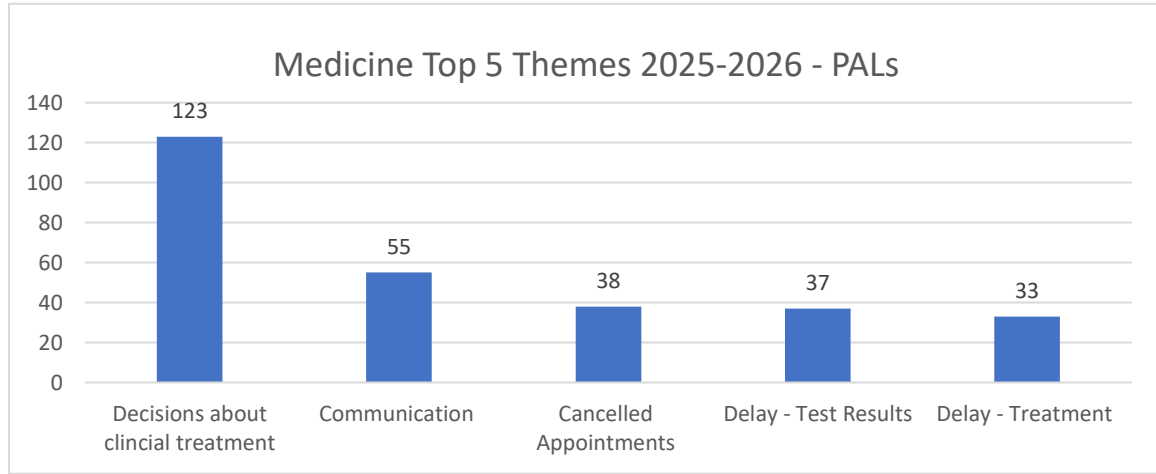
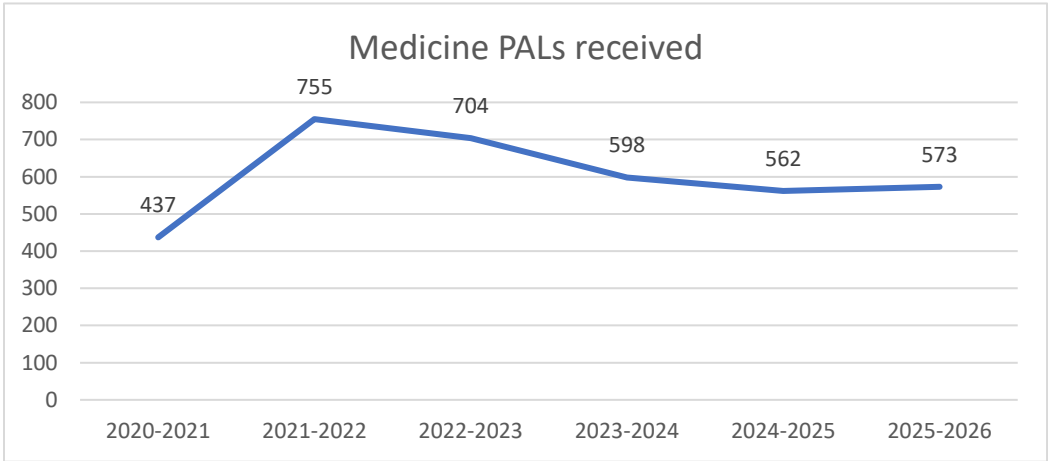
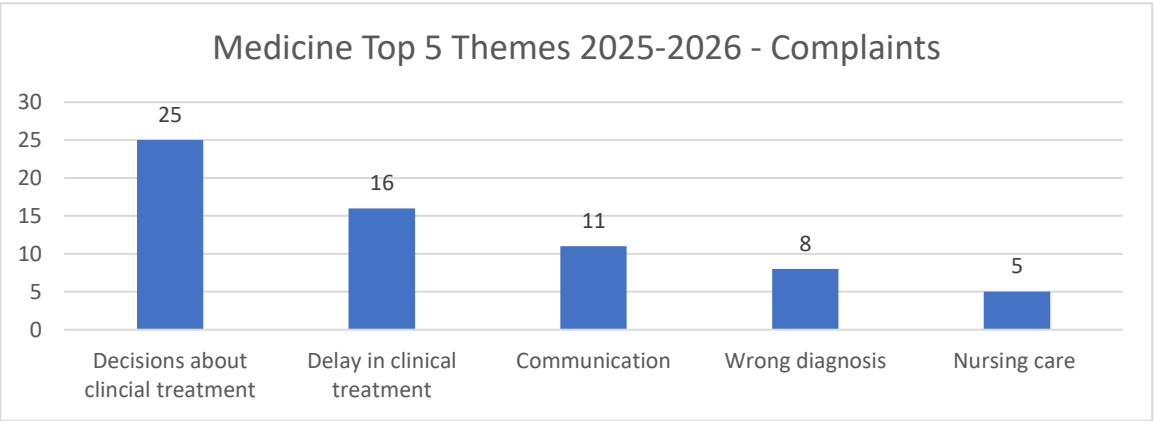
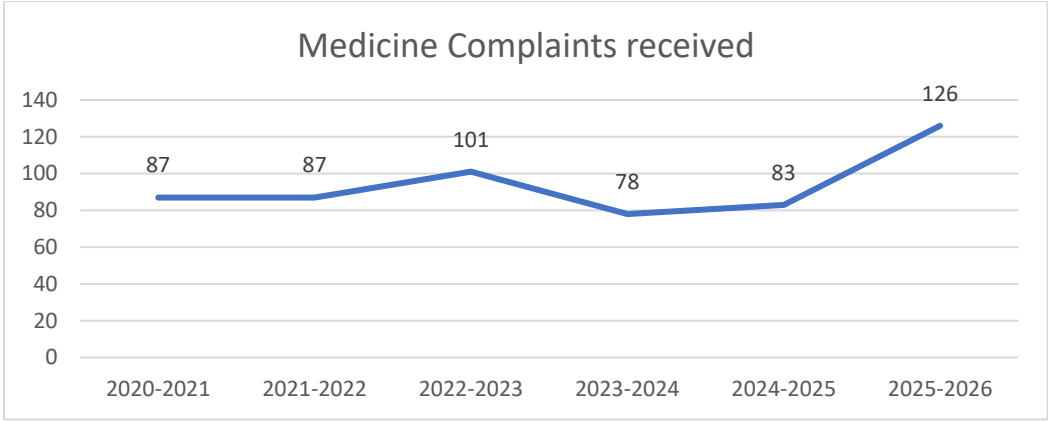
4. Trust Wide Activity: Patient Advice and Liaison Service (PALS)



- PALS activity decreased slightly to 1,821 cases, continuing a gradual stabilisation.
- Despite this slight reduction, demand remains consistent with previous years, indicating continued reliance on early resolution pathways.
- The main themes remain consistent:
 - Clinical decision-making (305)
 - Appointment delays and cancellations (401)
 - Communication issues (188)

5. Medicine Division Activity

The Medicine Division contains the busiest single-site Emergency Department in Greater Manchester and has 17 adult inpatient wards, providing acute medicine and specialist medical services.



- Complaints increased significantly to 126 in 2025–2026, compared to 83 in the previous year. There is no clear single driver for this increase, with complaint themes and departmental spread remaining consistent with previous years. The increase is likely due to a combination of factors, including service pressures, increased activity, and improved accessibility to raise concerns, supported by the use of AI and multiple submission routes such as Trust inboxes and the website.
- PALS activity has slightly increased to 573, indicating sustained demand.
- Key complaint themes:
 - Clinical decision-making (25)
 - Delays in treatment (16)
 - Communication issues (11)
- Although the most frequently reported complaint themes were decisions about clinical treatment and delays in clinical treatment, learning identified by Medicine services predominantly related to communication. Investigation of complaints found that communication issues were often an underlying factor within higher-volume complaint categories, particularly where patients felt treatment decisions had not been adequately explained or where updates regarding delays were insufficient. Consequently, services have focused improvement activity on communication practices to address a common root cause across several complaint themes.

5.1. Medicine Learning from Complaints

Concern Raised	Learning Identified	Improvement and Impact
A complaint was received regarding the lack of information within a patient's discharge paperwork. Important details around the patient's post discharge medication was not clearly explained which caused confusion and a short delay in the required change being	An investigation was undertaken by the Ward manager during which she reviewed the patients EPR. On review it was identified that the medication information had not being updated prior to the paperwork being printed. Whilst no harm had occurred, it was noted that discharge documents are often produced throughout the patient journey and that the final document should only be printed	The ward manager was tasked with undertaking an audit of discharge documents from the previous month. Staff were reminded of the importance of accurate discharge summaries during the safety huddles for a period of two weeks to ensure all staff received the message. The audit was to be repeated after 3 months to confirm compliance and improvement

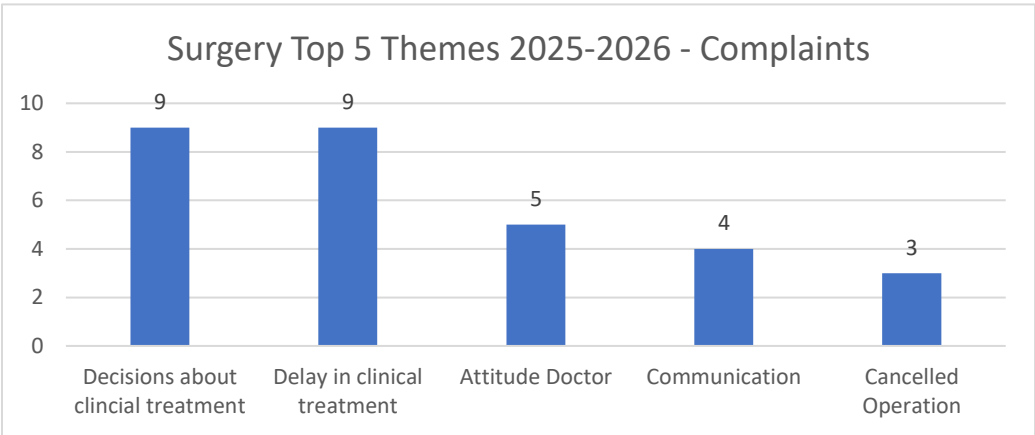
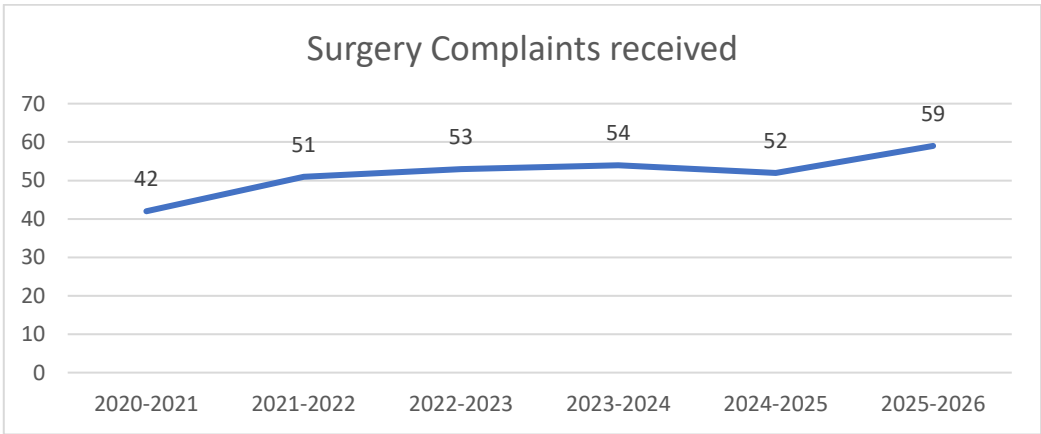
9

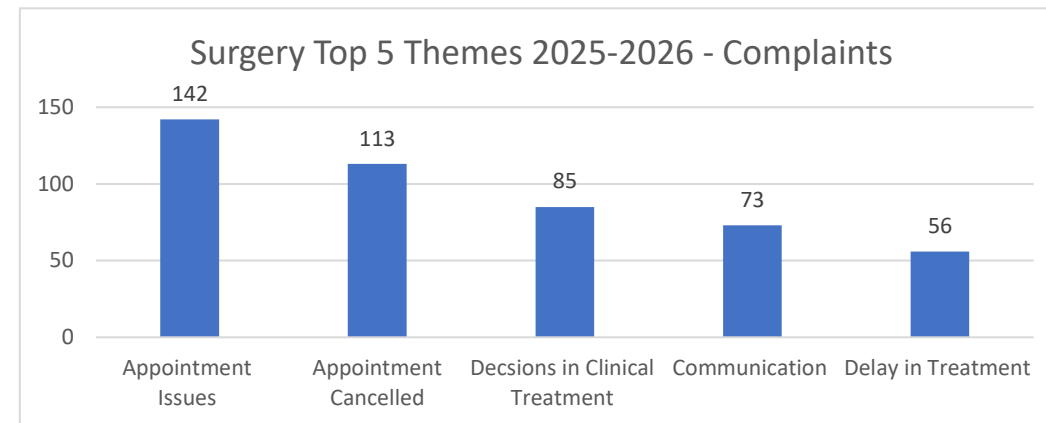
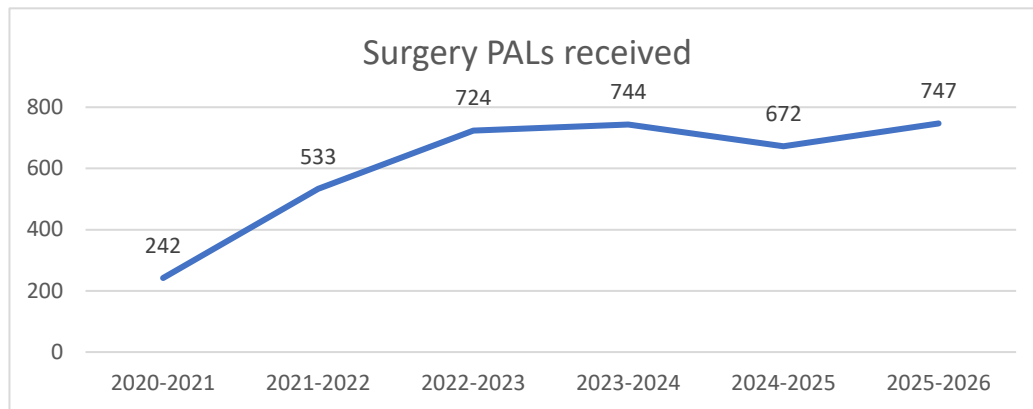
implemented when the patient arrived home	after all reviews and updates have been completed	
A complex complaint was received where one of the major concerns was around appropriate nutrition being provided for their family member. The patient had specific dietary requirements which were not being adequately met and the family were having to provide food from home	An investigation into the concerns was undertaken by the Ward Manager. It was found when speaking to the nursing team that the patient had not been supported with feeding at some meal times and had therefore not eaten the food provided. This gentleman required some assistance on occasions (but not all mealtimes) and could also refuse food when offered. However, this was not always documented in the electronic patient records.	This patient story was fed back to the Nutritional Steerage group. Fundamentals of care training was made mandatory for the team on the ward to complete, with the ward manager responsible for ensuring this was done. This patient experience was shared at the Divisional Patient Experience forum by the Governance Complaints Representative as shared learning across the division
A number of concerns were raised around miscommunication during the end of life (EOL) period for patients. A common theme was family members asking if their loved one was EOL and being told that they were not, and then experiencing sudden deterioration and the patient's passing	It was identified that the term End of Life means significantly different things to the layperson and medics. To the layperson, they understand it to mean their loved one is not going to recover and they should prepare for this, whereas to a medic, EOL is only when all active treatment is withdrawn. This leads to avoidable confusion and distress for families	These findings were shared at divisional patient experience forum and at Divisional Governance to highlight the issue to both nursing teams and the Governance leads within division. Med Div Governance are working with the ADNDs and the bereavement team to design a leaflet/patient information document to bridge this gap
A complaint was received from a patient with very complex, multiple health conditions for which she receives care across primary, community based and secondary care providers. There is often	A meeting was held with the complainant and her mother. The patient had been let down by a number of agencies and they were struggling to get any joined up care. The trust had failed the patient by not	TVN and Dermatology are now working closely together to ensure future patients with complex needs are identified early and their care plans / appointments managed by the service lead nurses. Div Gov have engaged with the patient to explore further her experiences of multi-service care and are putting together a patient story which will be

a lack of communication between these agencies and in the complaint it was evident that this is also true even within the Trust departments. Lack of interdepartmental communication has led to wasted hospital appointments and delays to receiving care	organising for the Tissue Viability Team to be in attendance for a dermatology appointment, which had a knock-on effect for the patient with her district nursing care. Representatives from both services were present during this meeting and a plan for the patient's ongoing care was put in place.	presented by the ADNDs later this year and available for Trust Wide learning.
---	---	---

6. Surgery Division Activity

Surgery Division delivers elective and non-elective specialist care across a wide range of clinical specialties.





- Complaints have increased slightly from 52 to 59, continuing a gradual upward trend.
- PALS activity has risen to 747 from 672 in 2025/2026.
- Complaint key issues:
- Clinical decision-making (85)
- Appointment Issues and cancellations (255)

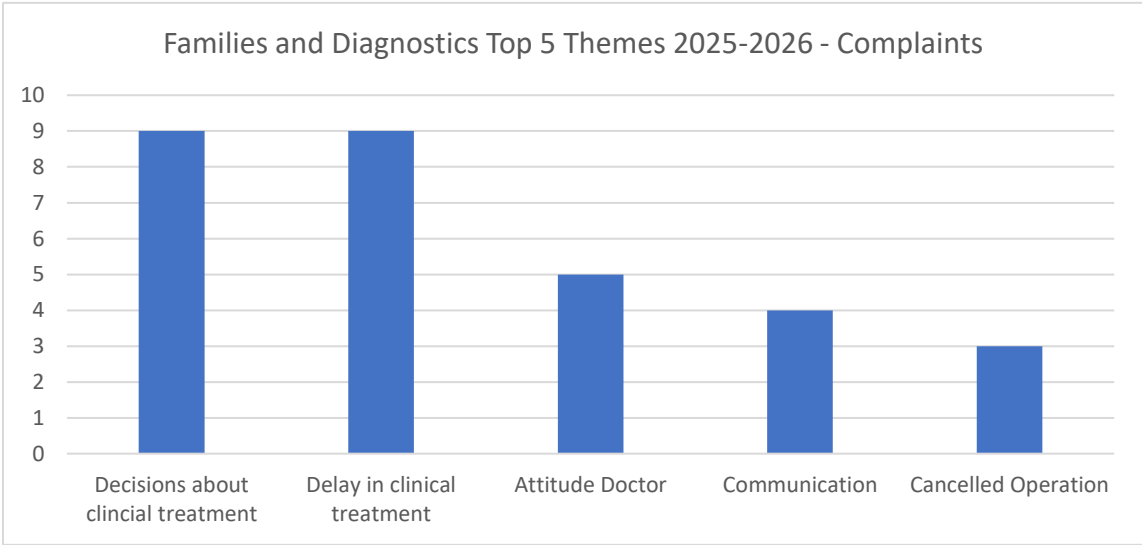
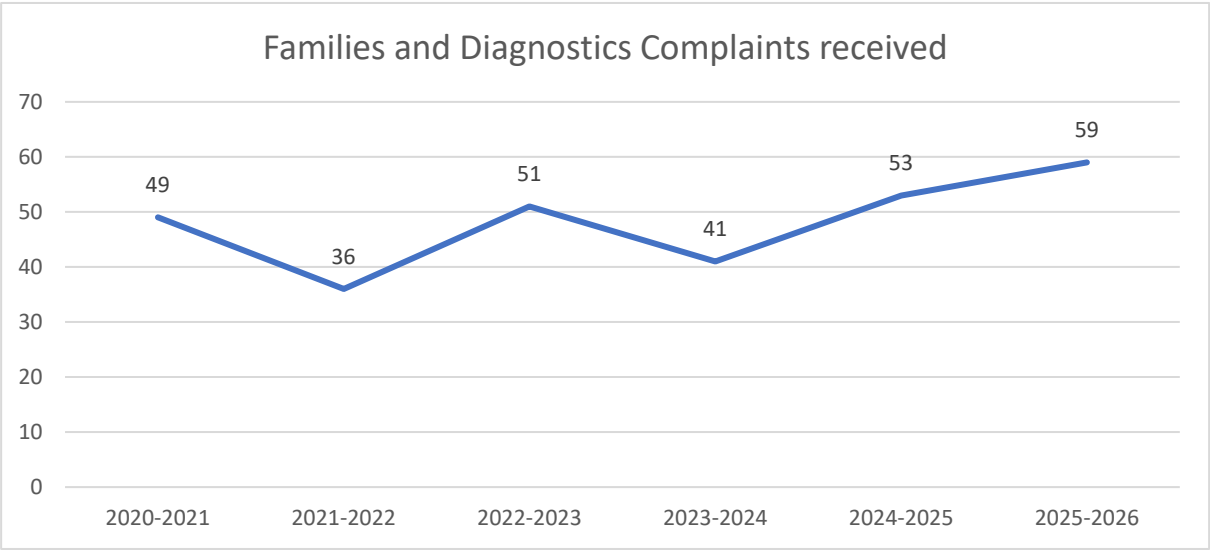
6.1. Surgery Learning from Complaints

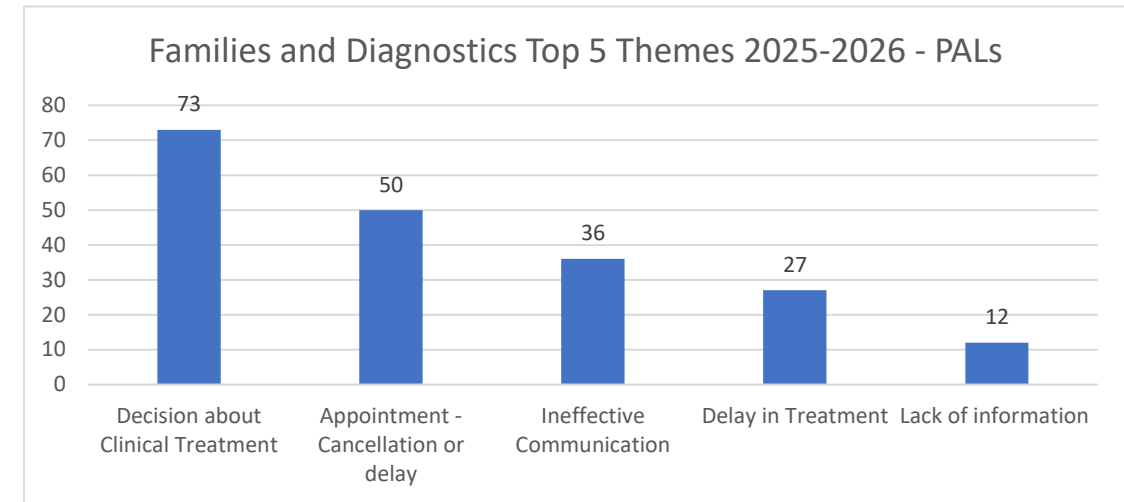
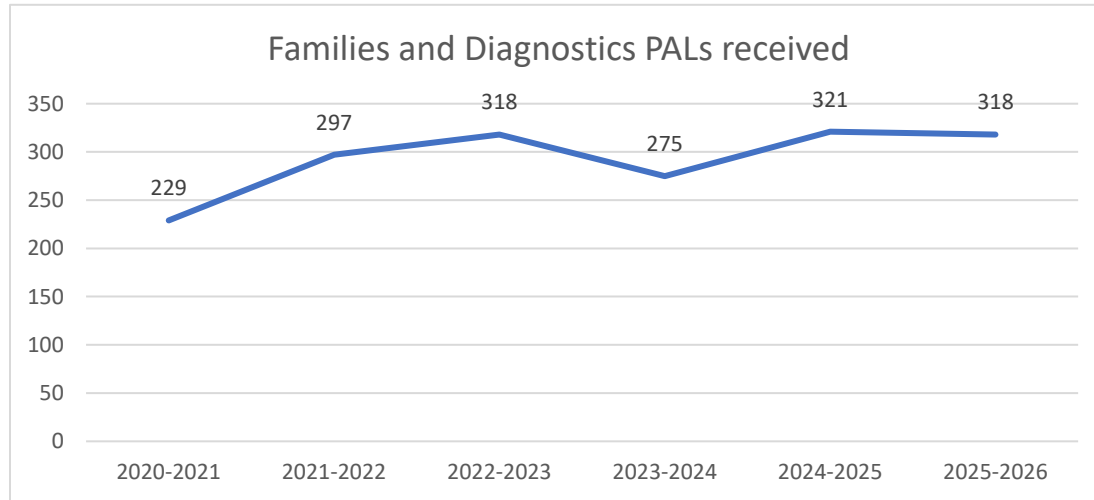
Concern Raised	Learning Identified	Improvement and Impact
A patient with ADHD who struggles to process verbal information quickly attended an outpatient appointment & felt he was unsupported when he tried to ask questions about his care/treatment. The patient's anxiety & need to ask many questions to understand, led to him coming across as aggressive to staff and he left the appointment feeling he'd been 'told off'.	The complaint highlighted the need for staff to be aware of the difficulties some patients may have with processing information they are being provided with verbally at appointments.	It was arranged for the staff to have neurodiversity training & the complaint was shared anonymously with the whole team. Arrangements were also made for the patient to have extended time in future appointments so that he could process the information & ask questions.
Patient expected his surgery would be carried out by the consultant he saw in clinic who listed him. When he was admitted for the surgery it was a different surgeon, this added to his anxiety about the procedure	The complaint highlighted the anxiety that can be caused for patients if there are changes from what they have been initially told about their procedure & therefore the importance of making them aware that changes may be made & communicating such changes with them prior to the admission where possible.	Patients are told that there may be a change in operating doctor & it has been arranged with the bookings team that the letters sent regarding surgery indicate any changes that may have been made.
Complaint regarding a patient seen in Ophthalmology with 2 different eye complaints: blurred vision & droopy left eye lid. A diagnosis made for blurred vision & patient referred appropriately to Manchester for surgery. The patient was also referred to Oculoplastic service at Bolton for the droopy eyelid. When he was seen in clinic at Bolton regarding the droopy eyelid he was advised he may need for surgery for this but needed to wait until after surgery at Manchester. The patient was subsequently discharged from the service to be referred back once surgery completed at Manchester.	There was poor communication with this patient regarding the waiting time & options to be treated. It should have been made clear to him that he would need to be re-referred to Bolton by Manchester once this surgery was completed & then he would be seen for further review regarding the droopy eyelid.	The complaint was shared via Ophthalmology Governance to ensure staff are aware of the importance of ensuring that patients understand about wait times/re-referrals & also that any correspondence with the GP make the plan very clear.

Patient felt they should not have had to be re-referred & then put on the wait list for the surgery for droopy eyelid.

7. Families and Diagnostics Activity

The Families and Diagnostics Division delivers maternity, neonatal, sexual health, gynaecology and a range of acute and community children’s services including hospital and community-based children’s clinical services, 0-19 Public Health Nursing, Paediatric Allied Health Professionals and Paediatric Learning Disability.





- Complaints increased slightly from 53 in the previous reporting period to 59 in 2025/26. This increase should be viewed in the context of the amalgamation of two divisions during the reporting period, which resulted in a larger service area and increased activity across the combined division.
 - 2024/2025 Complaints received: Diagnostics & Supports Services Division (11) Family Care Division (48)
- PALS activity remains high but stable (318).
- Key themes:
 - Clinical decision-making (73)
 - Appointment delays (50)
 - Communication and treatment delays (75)

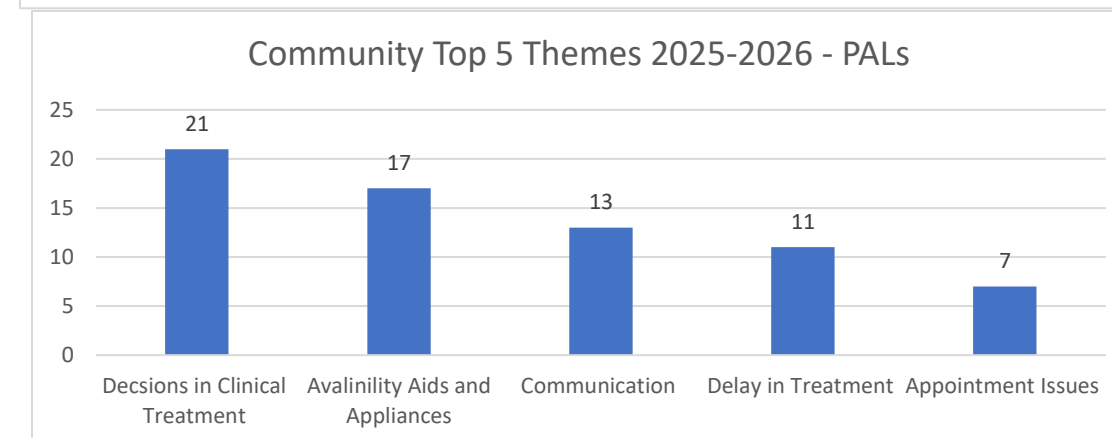
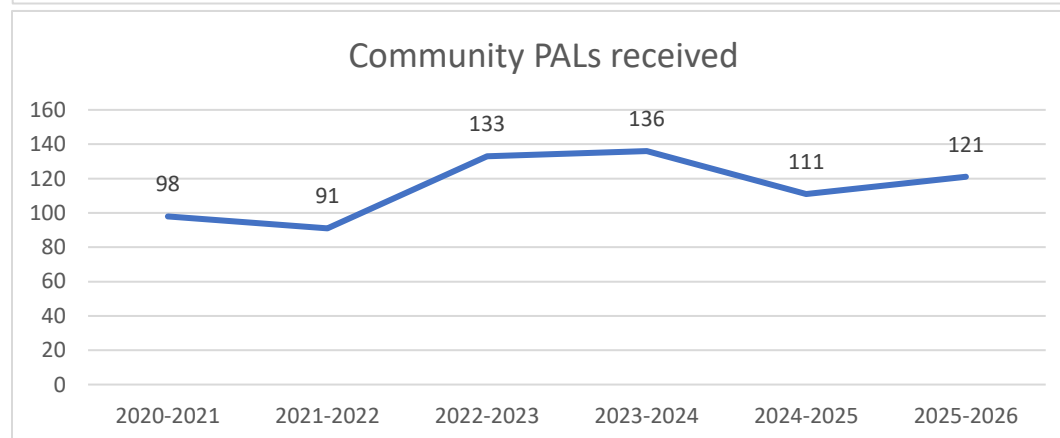
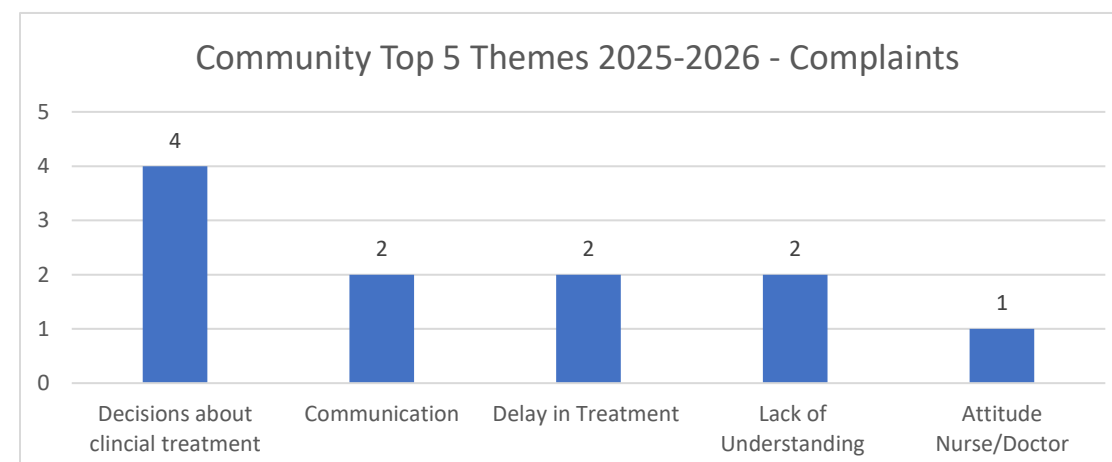
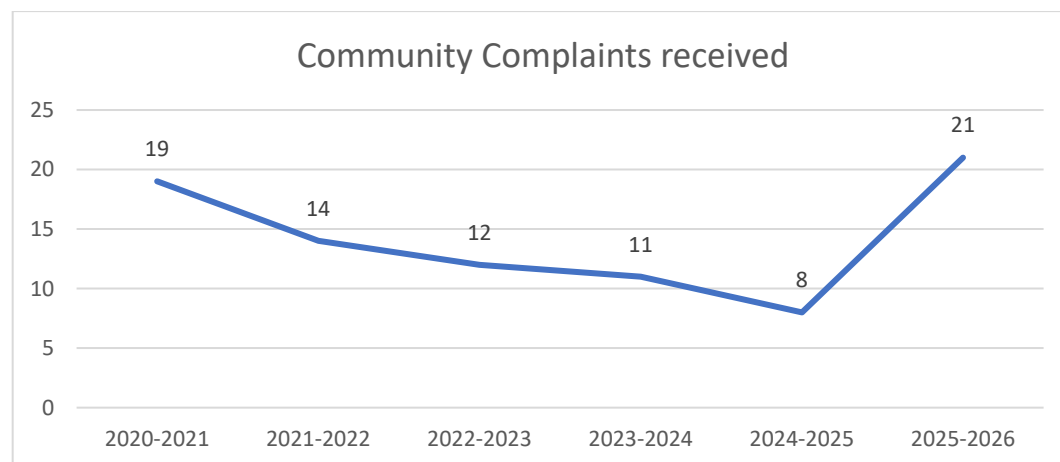
7.1. F&D Learning from Complaints

15

Concern Raised	Learning Identified	Improvement and Impact
Actions pointed to gaps in documentation, consent discussions, confidentiality, discharge information, patient information leaflets and recorded follow-up, leaving patients without clear written evidence or enough information to understand decisions.	Documentation must be contemporaneous and accurate, consent must include clear explanation of options and terminology, confidential conversations must be protected, and patients need accessible written information as well as verbal advice.	Updated checklists, forms and SOPs; procedure terminology updates; leaflet distribution; discharge-summary checks; confidentiality reminders; documentation standards reinforcement; and teaching on written/verbal information.
Several actions used the complaint itself as a learning event, indicating that lessons needed to be consistently shared beyond the individuals directly involved.	Complaint insight should be converted into team learning quickly, with reflective practice for staff involved and wider dissemination so repeated issues are prevented.	Ward and maternity safety huddles, staff meetings, governance discussions, reflective conversations, teaching sessions and shared patient stories across relevant wards and teams.
Patients and families described communication that felt insensitive, unclear, dismissive or insufficiently compassionate, including missed opportunities to listen, explain care decisions, communicate birth findings, introduce staff, or ensure people knew how to seek help.	Every interaction needs clear, compassionate and non-judgmental communication, active listening, and explicit checking of understanding, and timely escalation when women or families raise concerns.	Direct staff feedback, 1:1 reflective discussions, huddle and meeting reminders, patient stories, and reinforcement of compassionate listening, introductions, call-bell awareness and sensitive holistic reviews.
Actions pointed to gaps in documentation, consent discussions, confidentiality, discharge information, patient information leaflets and recorded follow-up, leaving patients without clear written evidence or enough information to understand decisions.	Documentation must be contemporaneous and accurate, consent must include clear explanation of options and terminology, confidential conversations must be protected, and patients need accessible written information as well as verbal advice.	Updated checklists, forms and SOPs; procedure terminology updates; leaflet distribution; discharge-summary checks; confidentiality reminders; documentation standards reinforcement; and teaching on written/verbal information.

8. Community Services Division Activity

Community Division places an emphasis on avoiding hospital attendances and admissions by responding to health and social care issues in our community, which includes providing intensive therapy and re-ablement packages to support our patients' independence.



- Complaints have increased from 8 to 21, reversing the previous downward trend.
- PALS activity has risen to 121 from 111 of the previous year
- Key themes remain:
 - Decisions in clinical treatment (21)
 - Availability of aids and appliances (18)

8.1. Community Learning from Complaints

Concern Raised	Learning Identified	Improvement and Impact
Complainant raised a complaint about the care and treatment provided to her father, by Bolton NHS Foundation Trust prior to his death. The concerns included aspects of care delivery, communication with the family, and issues relating to the use of a syringe driver. The Trust investigated the concerns and discussed the findings with the family at a meeting on 23 January 2026	The Trust acknowledged that aspects of the care and communication provided to the family fell below the expected standard and apologised for this. A formal investigation was undertaken and the findings were shared directly with the complainant to provide clarification and reassurance. Learning was taken from the experience to improve future patient and family care and communication The Trust also agreed to provide information about its Syringe Driver Policy, indicating a focus on improving understanding and transparency around end-of-life care processes.	A process change was introduced for District Nursing Teams, replacing standard white IV line bungs with blue two-way needle-free bungs. This improvement enhances patient safety and reduces risk by aligning practice with that of other NHS trusts. Unlike the white bungs, which must be removed and replaced each time the cannula is accessed, the blue two-way bungs contain an internal valve that allows flushing, medication administration, and aspiration without removing the connector. This reduces handling of the cannula hub, helping to minimise contamination risks and support safer intravenous access management.
Complainant raised concerns about the care her husband received following toenail surgery, including a lack of information about the use of phenol, the occurrence of a phenol burn to surrounding skin,	The complaint highlighted the need for strengthened patient communication, clearer post-operative advice, improved management and documentation of procedural complications, safer administration of	The team implemented the use of Safe-T Pens for Phenol application to improve safety and patient experience.

significant post-operative bleeding shortly after discharge, and whether adequate consideration had been given to his anticoagulant medication. She also reported difficulty accessing advice when bleeding occurred outside normal clinic hours and highlighted that an outdated patient information leaflet had been provided. The investigation found that the procedure was carried out in line with standard practice and that a phenol burn is a recognised complication of nail surgery. However, communication and patient understanding of risks could have been improved, the SOP did not specify a discharge observation period, patient information lacked clear guidance on persistent bleeding, escalation routes and out-of-hours support, and an outdated leaflet had been issued, highlighting the need for stronger information governance processes.	phenol, and more robust governance arrangements for patient information materials. Particular attention is required for patients receiving anticoagulant therapy to ensure bleeding risks and escalation pathways are clearly communicated.	Safe-T Pens are safer because they: - Keep phenol sealed in a protected glass ampoule, reducing spills, leaks, and evaporation. - Use a non-splash activation system, reducing accidental exposure to staff and patients. - Provide precise application through a fine tip, limiting damage to surrounding tissue. - Contain a fixed dose of phenol, helping prevent overuse. - Include a blue dye so clinicians can clearly see where phenol has been applied.
The complaint concerned a breach of confidentiality after a letter from Bolton NHS Foundation Trust displayed the wording "Consultant in Sexual Health and HIV" through a window envelope, potentially allowing others to infer the nature of the patient's care. The Trust's investigation found that the letter template had been designed in a way that allowed sensitive service information to be visible, and that a missing postcode may have increased handling of the correspondence. Although the incident was initially recorded as a patient safety issue and addressed locally through staff training and template amendments, the Trust later accepted that it should	The key learning was the need to strengthen confidentiality safeguards in all patient correspondence and ensure staff can correctly identify and escalate potential Information Governance breaches. Actions taken included redesigning the letter template to prevent service information being visible through envelope windows, reinforcing checks on outgoing mail and address accuracy, providing staff education on incident classification and Information Governance requirements, and sharing the learning across the Trust. Additional learning related to complaint handling and communication, with the Trust recognising the need to clearly explain processes to patients, improve	A learning slide was developed and shared across the team and wider division following a complaint involving an Information Governance (IG) breach. The slide highlighted how sensitive patient information became visible through an envelope window, emphasising that even small administrative errors can compromise confidentiality. Key learning was included in the slide including the importance of recognising and reporting all potential IG breaches promptly, checking

have been recognised and managed as an Information Governance breach. The complainant also raised concerns about delays, poor communication, difficulties contacting staff, and the lack of a formal PALS or complaints response.	escalation routes, ensure timely responses, and strengthen arrangements for managing concerns and complaints consistently.	correspondence before sending, ensuring complete patient details are used, escalating concerns to the Information Governance team, and recording incidents on Safeguard.
---	--	--

9. Our Performance

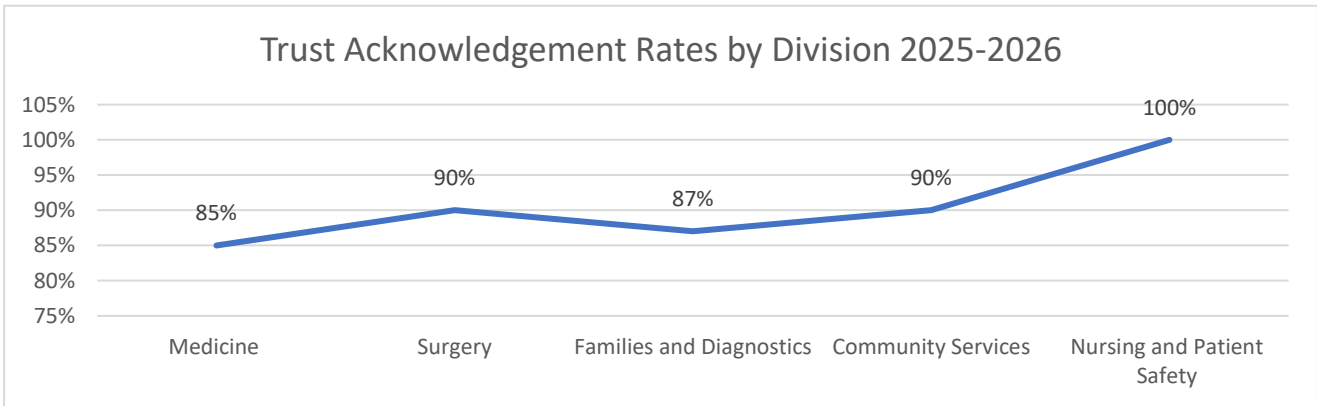
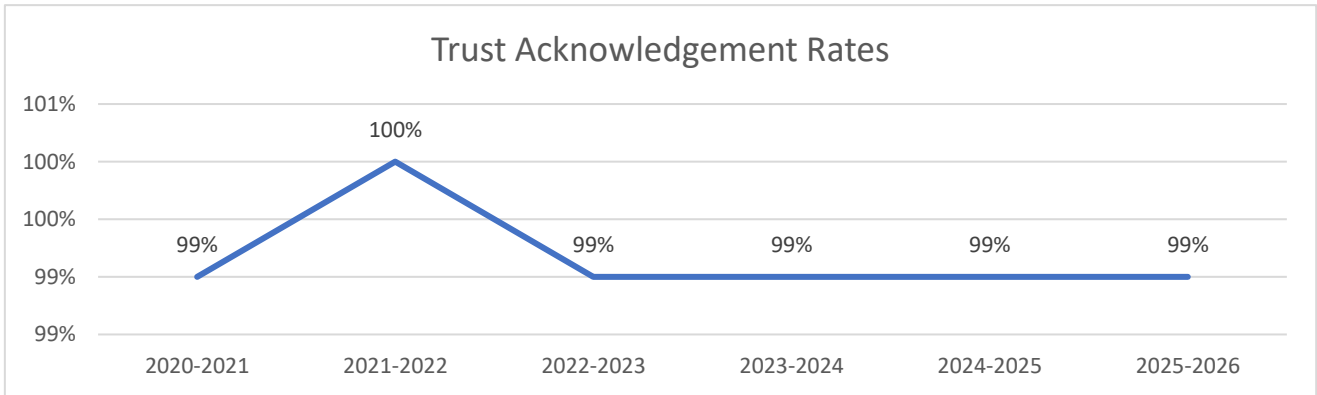
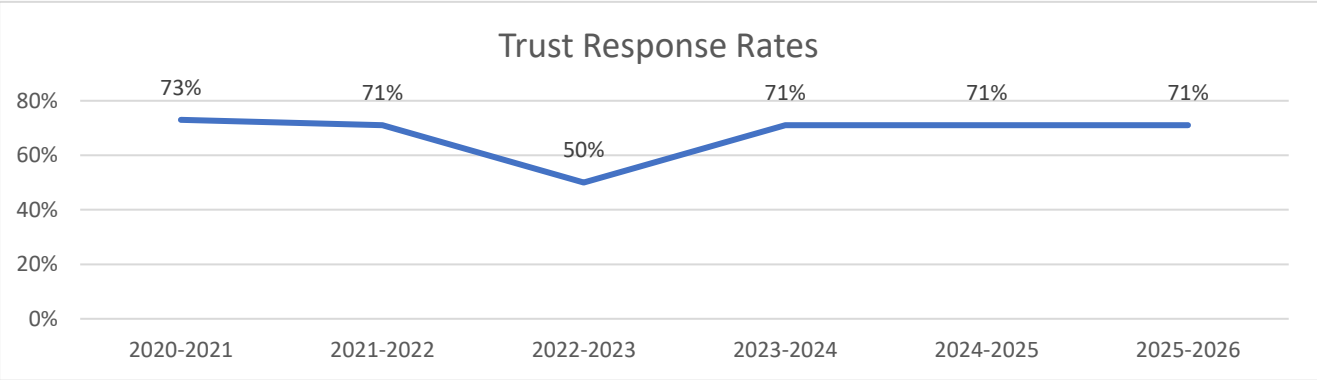
Performance is measured by monitoring our complaint acknowledgement rates within three working days from the date a complaint is received.

During 2025–26, 99% of complainants received an acknowledgement within the three working days’ target, which remains unchanged from 99% in 2024–25.

The response target rate is for 95% of complainants to receive a response within 35 working days, or 60 working days where the complaint is complex and/or involves multiple providers. During 2025–26, 71% of complainants received a response within this timeframe, consistent with 71% in 2024–25. This indicates that performance has been maintained despite the increase in complaint volumes and ongoing operational pressures.

In all cases where compliance with timescales was not achieved, complainants were kept informed of progress and the reasons for any delays throughout the complaints process. All complaints remained within the six-month timescale set out in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

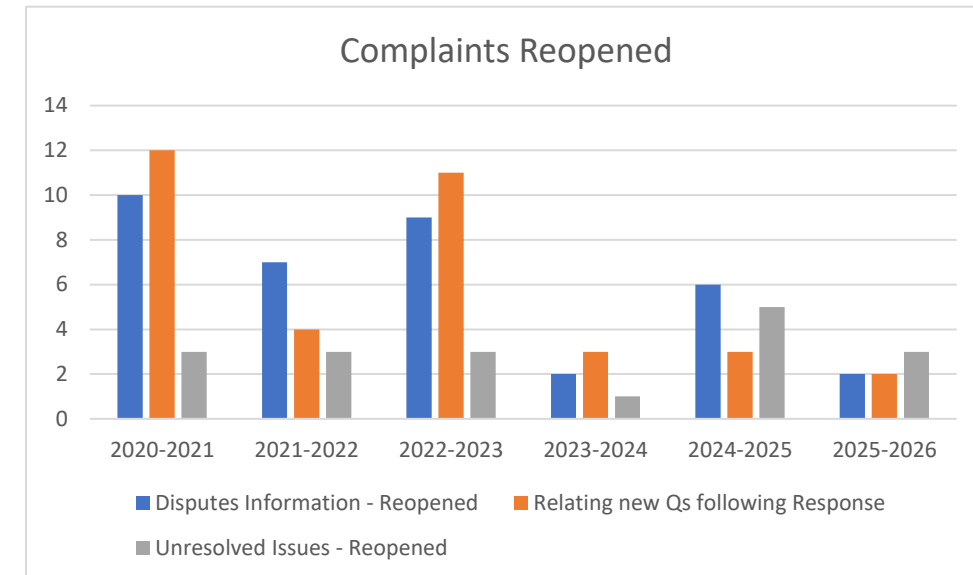
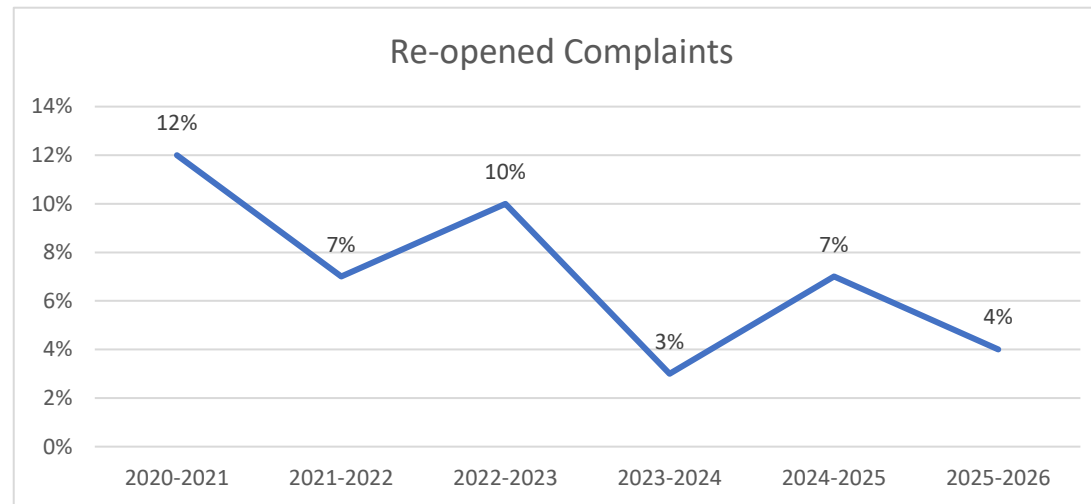
The proportion of reopened complaints has decreased from 7% in 2024–2025 to 4% in 2025–2026. This reduction suggests an improvement in the quality and effectiveness of initial complaint handling and responses, with fewer complainants requiring further review or escalation.



10. Quality Monitoring

We measure the quality of the responses provided to our complainants by monitoring re-opened cases, referrals to the Parliamentary and Health Services Ombudsman (PHSO) and offering local resolution meetings.

11. Re opened Complaints



The above data demonstrates that there has been a decrease in the number of reopened complaints in 2025-2026 indicating complaint responses are resolving the concerns raised by complainants at providing reassurance in relation to actions taken.

The criteria below is the reason why a case might be re-opened:

- Where the complainant disputes the information provided
- The complainant has unresolved issues from their complaint
- The complainant has new questions following receiving their response

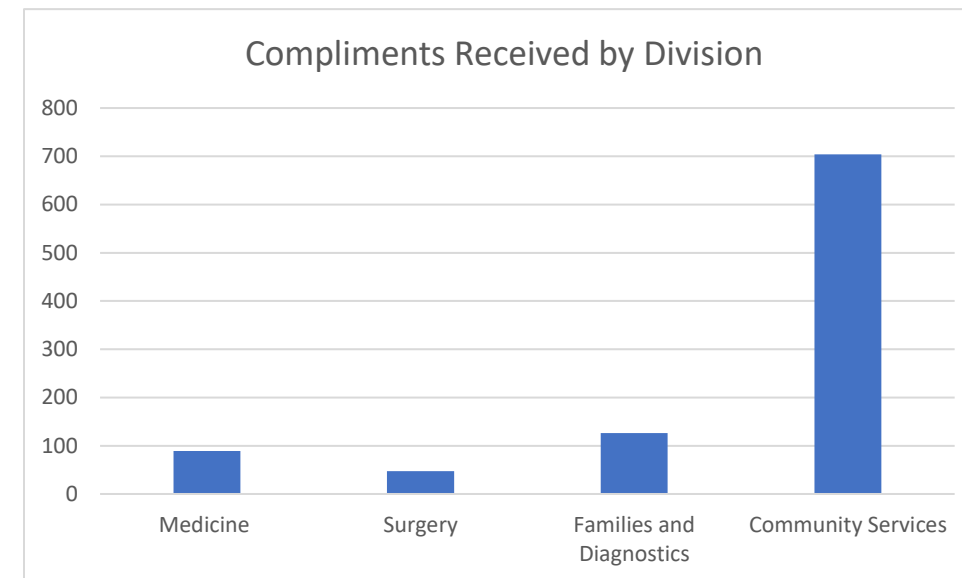
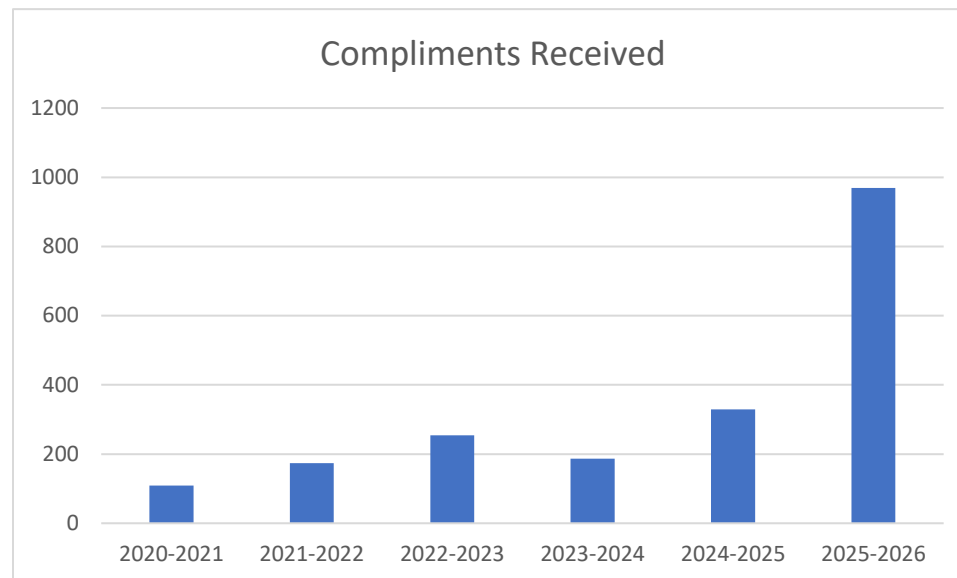
12. Parliamentary and Health Service Ombudsman (PHSO)

A PHSO enquiry is the receipt of a complaint made to the PHSO regarding an outcome provided by an NHS Trust. At this point a request might be made to request a copy of the complaint file for overview and to inform whether a PHSO investigation is indicated. An investigation is decided if the PHSO concludes that the NHS Trust have not provided a satisfactory outcome or is in wider public interest.

There were 4 new PHSO enquiries in 2025/26, however none of the enquiries resulted in further investigations by the PHSO. This therefore indicates that the PHSO is satisfied the Trust has made appropriate efforts to resolve concerns and has followed the correct procedures in doing so.

13. Compliments

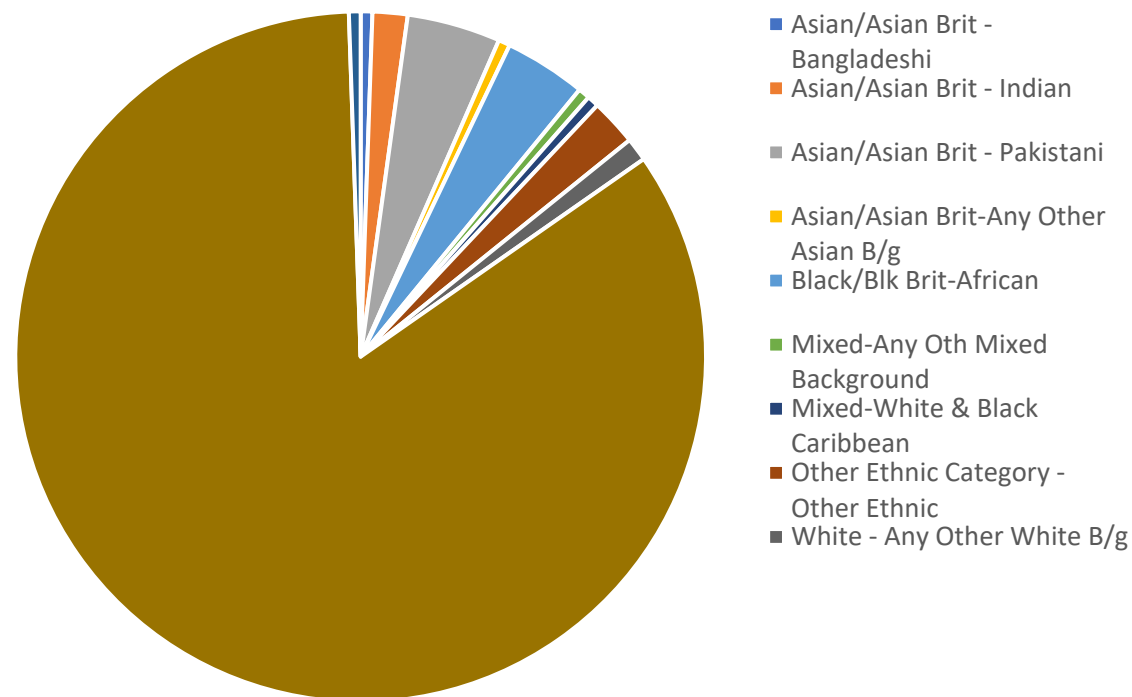
In 2025/2026, a central repository was introduced to strengthen the recording of compliments and positive feedback across the Trust. To improve accessibility and encourage feedback, a QR code was also developed which links directly to Thanks@boltonft.nhs.uk, enabling patients, carers and visitors to share their experiences quickly and easily. This has contributed to the significant increase in the number of compliments recorded during the year. Compliments are shared with the relevant divisions and teams to support awareness, recognition, and celebration of good practice.



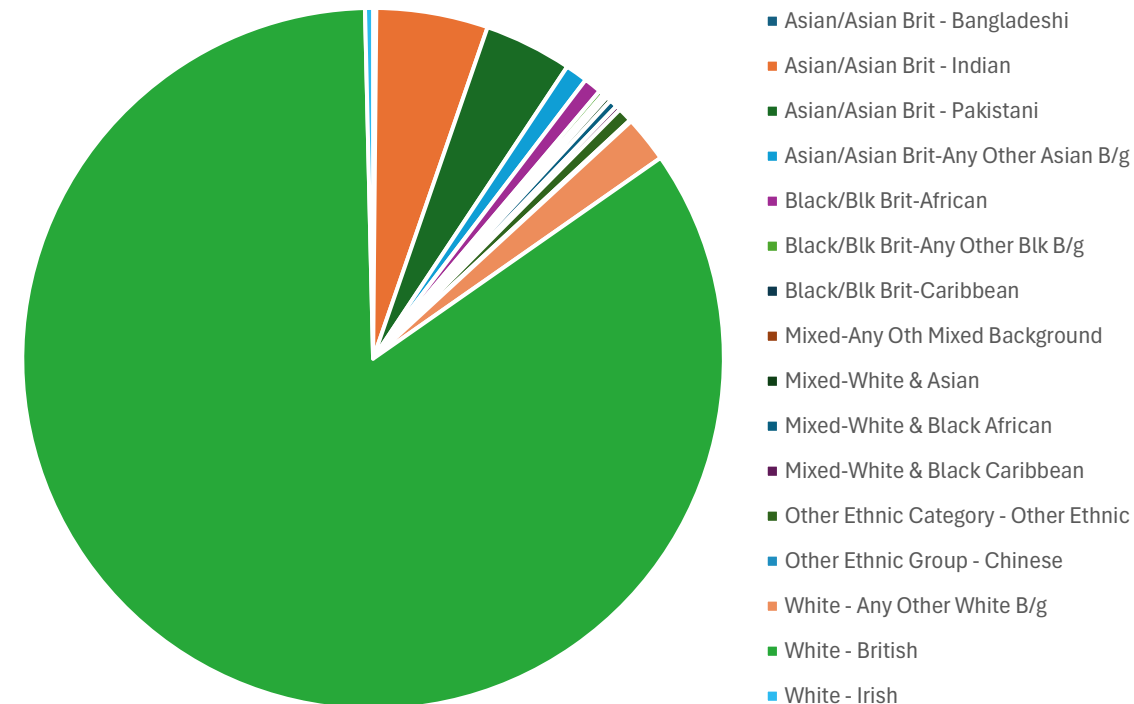
14. Equality Monitoring 2025-2026 Ethnicity

The Trust takes seriously that all members of the public should feel comfortable in accessing the PALS and complaints service and as such captures information on the patient's age, gender and ethnicity to support this. A summary of this data is provided which has been measured against patient profile activity.

Ethnicity of Complainants 2025 to 2026



Ethnicity of PALS Concerns Raised 2025 to 2026

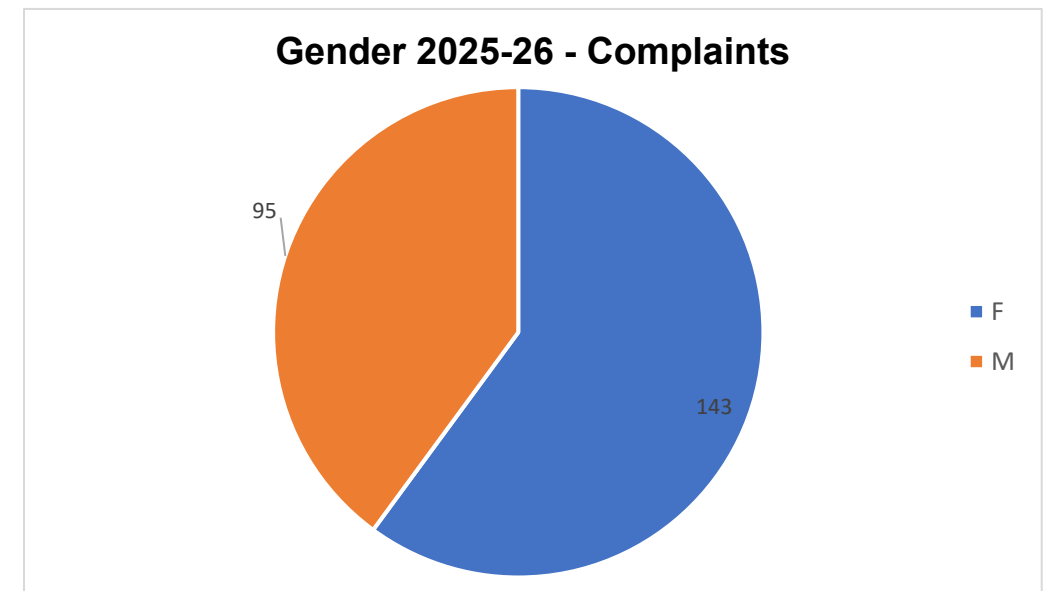
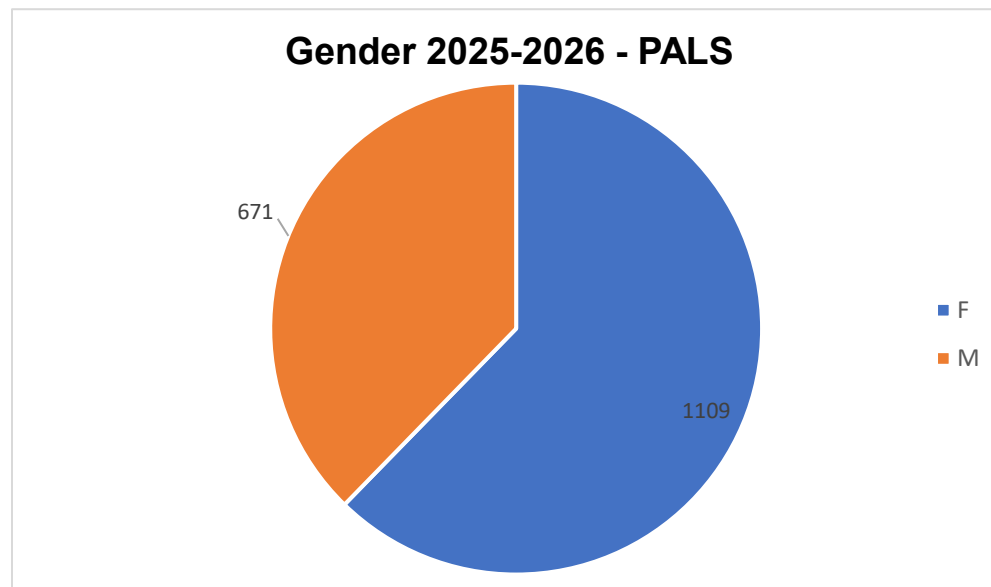


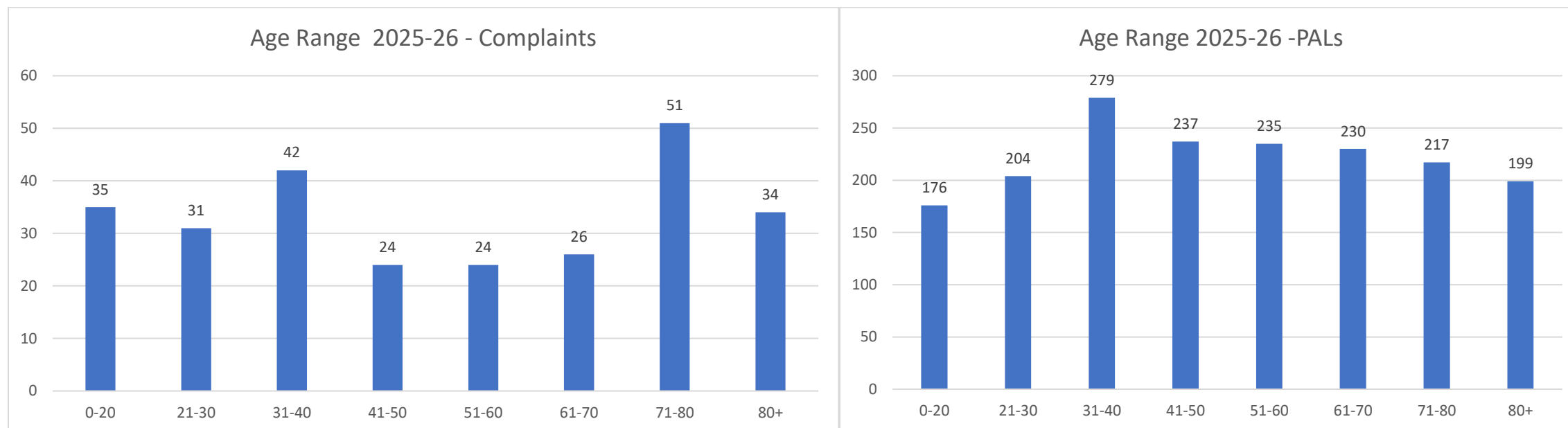
There is a notable increase in the number of service users sharing or specifying ethnicity when being supported by the Patient Experience Team to resolve their complaint/concern. This is attributable to the introduction of a new complaints form, which now captures this information more consistently.

During 2025/26, the majority of PALS concerns were raised by patients recorded as White British (84.3%; 1,147 of 1,360 contacts). Patients from Asian ethnic groups accounted for 10.4% of contacts (141), with all other ethnicities collectively accounting for 5.3% of contacts. The ethnicity profile of individuals accessing the PALS service is broadly reflective of the population served by Bolton NHS Foundation Trust and is therefore not unexpected. Variations in the use of feedback and advocacy services may also be influenced by factors such as awareness of PALS, cultural preferences for raising concerns, language requirements and differing levels of confidence in formal feedback processes.

Whilst no ethnicity group appears disproportionately represented within PALS activity, the Trust remains committed to ensuring equitable access to PALS support for all patients, families and carers. Equality monitoring continues to be reviewed to identify any emerging disparities and to support targeted engagement where required, ensuring all communities are aware of and able to access the service.

15. Equality Monitoring 2025-2026 Gender and Age by Patient





16. Our Neighborhoods

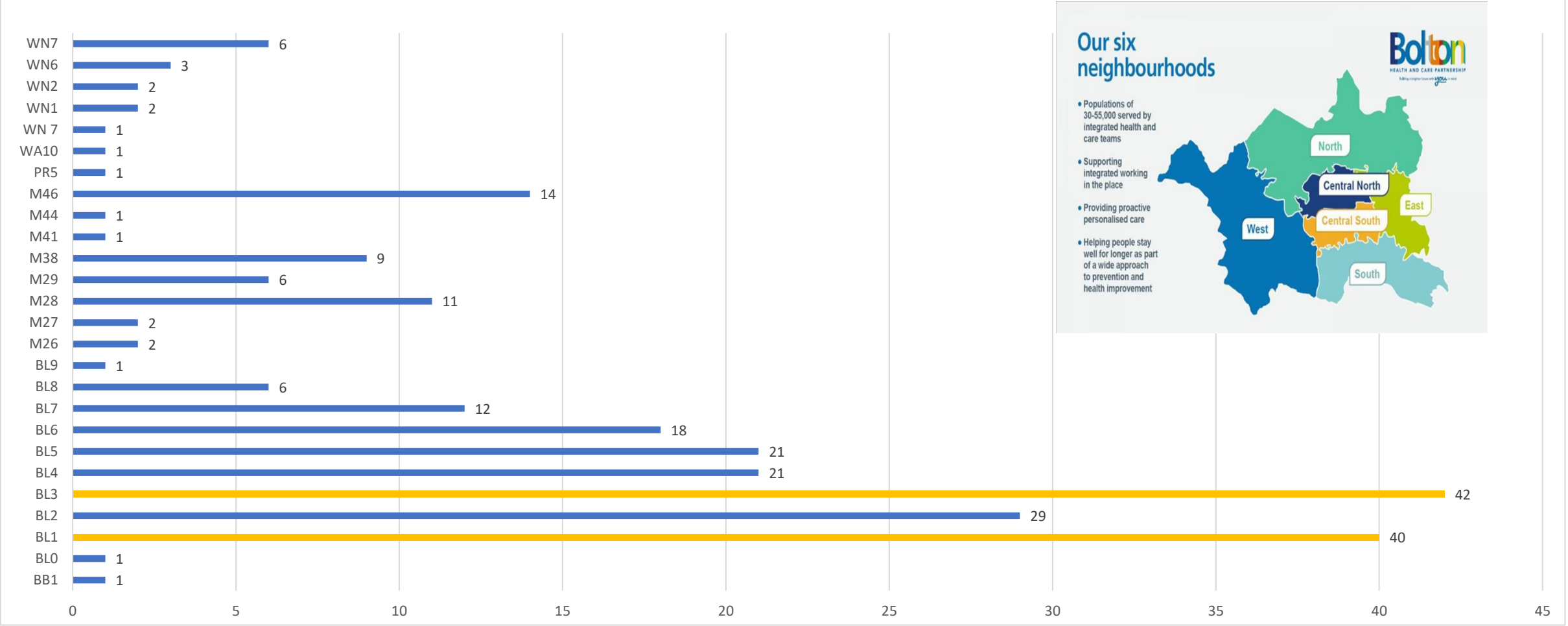
Bolton NHS Foundation Trust serves a population of approximately 310,000 residents. Analysis of complainants' postcodes demonstrates that the highest numbers of complaints were received from patients residing within the BL1 and BL3 postcode areas. This is not unexpected, as these postcodes represent some of the most densely populated areas within Bolton and are located closest to the Trust's acute hospital site, resulting in higher levels of service utilisation.

Conversely, the lowest numbers of complaints were received from residents within the WN7, WA10, PR5, M44, M41, BL9, BL0 and BB1 postcode areas. These locations are situated outside, or on the periphery of, the Trust's primary catchment area and therefore account for a smaller proportion of patients accessing services provided by the Trust.

It is important to note that complaint volumes should be considered alongside population size and service activity levels. Higher complaint numbers do not necessarily indicate poorer patient experience; rather, they may reflect the fact that a greater number of patients from these areas access Trust services. Similarly, lower complaint volumes may be attributable to lower patient activity rather than a reduced likelihood of raising concerns.

Overall, the geographical distribution of complaints broadly reflects the Trust's catchment population and patterns of service utilisation, with no significant anomalies identified through postcode analysis.

Complaints by Postcode 2025-26



17. Our Focus for 2026-2027

Focus	Objective	Target Date
Reinstate Feedback from Complainants	The organisation will reinstate complainant feedback following closure of complaints to better understand patient experience of the complaints process. Feedback received will be monitored regularly and used to support service improvement, staff learning, and improvements in communication and complaint handling practices	Quarter 2
Review Improvement Plans, Processes, and Recording of Actions	A review of complaint improvement plans and associated processes for recording and monitoring actions will be undertaken to strengthen organisational learning and governance oversight. Standardised action tracking and clearer accountability arrangements will support timely implementation and evidence of service improvements arising from complaints.	Quarter 2
Capture and Recognise Compliments	The organisation will strengthen processes for capturing and recording compliments and positive patient feedback to ensure good practice is recognised and shared across services. Enhanced reporting of compliments will support staff recognition, organisational learning, and improvements in patient experience	Quarter 3
Complaints Handler Training	A programme of complaints handling training will be implemented for managers and staff involved in complaint investigations. The training will focus on improving investigation quality, communication, response writing, and learning from complaints to ensure concerns are managed consistently and compassionately	Quarter 3
Improve PALS Response Times	A review of PALS processes will be undertaken to improve responsiveness. The service aims to reduce response times from the current 6–10 working days to within 5 working days through improved tracking, monitoring, and engagement with operational teams	Quarter 3

Report Title:	Health and Safety Report 2025 - 2026			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 2026		Discussion	✓
Executive Sponsor	Chief Nursing and Quality Officer		Decision	

Purpose of the report	To provide a clear overview of the Trust’s health and safety performance for the period 1 April 2025 to 31 March 2026.
-----------------------	--

Previously considered by:	Group Health and Safety Committee: Report received 27 August 2026. Clinical Effectiveness Group: Reported discussed on 2 September 2026 noting compliance with Health and Safety legislation. Due to the timing of the QAC, the report has been circulated simultaneously and discussed at the meeting held on 23 September 2026
---------------------------	---

Executive Summary	Although there is no legal requirement to produce an annual Health and Safety Report, doing so reflects best practice and supports assurance on regulatory compliance and the promotion of a safe working environment. During the reporting period, the Trust remained compliant with all relevant health and safety legislation and delivered a positive overall performance. • A total of 553 incidents were reported, the lowest number across the previous six reporting periods and a reduction from 597 in 2024/25. • The Trust and iFM reported five RIDDOR incidents, one of which was subsequently cancelled following investigation, representing a reduction from 16 in the previous year. Most incidents, 98.01%, resulted in no or low harm, although this was a slight reduction of 0.79% compared with 2024/25. Two real fire-related incidents were reported, consistent with the previous year. • The Trust received 19 LTPS claims, one more than in 2024/25. The LTPS contribution reduced from £260,610 in 2025/26 to £253,625 for 2026/27. • Manual Handling Level 1 training achieved the 95% compliance target in quarters 1, 2 and 3; However, in Q. 4 only Community and Surgery maintained compliance. • Health, Safety and Welfare training remained above the Trust target of 85% throughout the year, with overall Health and Safety mandatory
-------------------	--

	training achieved in all four quarters and the lowest recorded compliance at 93.38%. • Fire Safety online training averaged 95.29%, exceeding the 95% target and improving on the 2024/25 average of 92.8%. • Conflict Resolution online training did not meet the 95% compliance standard during the reporting period.
--	---

Proposed Resolution	The Board of Directors is asked to receive the Health and Safety Annual Report 2025/26.
----------------------------	--

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

Summary of key elements / Implications		
Implications	Yes/ No	If Yes, State Impact/Implications and Mitigation
Finance	Yes	The report notes a reduction in the Trust's LTPS contribution for 2026/27.
Legal/ Regulatory	Yes	The Trust must comply with legal and regulatory requirements which is supported through established governance, incident reporting, investigation, training monitoring.
Health Inequalities	No	No direct health inequalities implications have been identified.
Equality, Diversity and Inclusion	Yes	Health and safety arrangements apply to all staff, patients, visitors and contractors, supported by accessible training, risk assessment, incident reporting and reasonable adjustments where required.
Is a Quality Impact Assesment Required	No	A Quality Impact Assessment is not required as the report is for assurance.

Prepared by:	Michael Hodds, Health and Safety Manager	Presented by:	Tyrone Roberts, Chief Nursing and Quality Officer
---------------------	---	----------------------	--

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

RA	Risk Assessment
COSHH	Control of Substances Hazardous to Health
GHSC	Group Health and Safety Committee
LTPS	Liabilities to Third Parties Scheme
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

Health and Safety Annual Report

01 April 2025 – 31 March 2026

Contents	Page
Executive Summary	4
Overview	6
Overview of Legal Compliance	8
Safety – Summary of Accident data, RIDDOR and Performance • Incidents reported by Financial Year • Incidents recorded by Divisions • Incident by Primary Cause Group • Top Ten Cause groups • Incidents by Actual Impact • Moderate Harm Incidents • Incidents by Month • Incidents by day and time • Days taken to report an Incident Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) • Types of reportable incidents • Trust & iFM Bolton Incidents that were reported to HSE under RIDDOR for the period 2025/26 • Theme, trends & learning • Timeframes of reporting to HSE RIDDOR reportable incidents • Next steps	9
Training Compliance Including: Background Conflict Resolution & Prevention and Management of Violence and Aggression (PMVA) Training Fire Safety Training Manual Handling Training Health and Safety Training	21
Manual Handling	31
Claims	31
Audits	34
Health and Safety Executive Inspections	34
Alerts	35

Policies	35
Fire Safety	36
Security	40
Asbestos	41
Ventilation Heating & Temperature Control	42
Water Safety	44
Occupational Health	44
Actions from 2025/26 Report	45
Actions for 2026/27 Report	48

Note: This report was reviewed with the assistance of AI tools to improve grammar, readability, and structure. No AI was used to generate technical content or conclusions.

Executive Summary:

During the period 01 April 25 to 31 March 2026 the Trust was compliant with all the relevant Health and Safety Legislation.

553 reported incidents is the lowest total for a reporting period against the previous 6 periods starting in 2019.

The total number of incidents reported between April 2025, and March 2026 has decreased against the previous year from 597 to 553.

The Trust had a decrease of incidents reported during 2025/26 compared to 2024/25 period of 60 incidents.

For the period FY2025/26 the Trust and iFM reported 5 RIDDOR incidents, 1 of which was subsequently cancelled after further investigation. This is a decrease of ↓12 against the previous 16 reported during the previous 2024/25 annual report period

98.01% of all reported incidents in 25/26 resulted in 'No or Low Harm'. This represents a slight reduction of 0.79% compared with the 2024/25 reporting period.

The Trust experienced 2 real fire related incidents in 2025/2026, which is the same number of reported Fire incident made during 2024/25 period.

In the period 1 April 2025 to 31 March 2026 the Trust received nineteen (19) LTPS claims, which is a slight increase of one from the previous reporting period (24/25) which was 18 received claims.

The Trust's LTPS contribution in 2025/26 was £260,610 and this has reduced to £253,625 for 2026/27.

Manual Handling Level 1 training, across all Divisions its mandatory requirement target of 95% compliance was achieved in Q1, Q2 & Q3, and in Q4 only Community and Surgery were compliant.

The Trust, Health Safety and Welfare training compliance remained consistently above the Trust target of 85% throughout 2025/26, in line with 2024/25 figures.

The Trust did not achieve its training compliance standard of 95% for Conflict Resolution undertaken on-line throughout the reporting period of this report.

The overall Trust compliance target for Health and Safety mandatory training is 85% which the Trust achieved in all four quarters of this reporting annual period, with the lowest training compliance percentage being 93.38%.

The Fire Safety on-line training figures provides data that during the period April 2025 – March 2026 the Trust achieved an average compliance figure of 95.29% against the required 95% target, which is an improvement against 2024/25 figure of 92.8% compliance average.

General Executive Summary Observation

The Trust has maintained full legislative compliance and delivered a positive overall health and safety performance in 2025/26, evidenced by a continued reduction in incidents to a six-year low and strong training compliance above corporate targets.

:

Overview:

Monitoring and reviewing health and safety performance is a statutory requirement; however, there is no legal obligation to publish this information within annual reports. Publishing such information is nevertheless recognised as best practice. In the interests of openness and transparency, the Health and Safety Team has produced this annual report to highlight the work undertaken across Bolton NHS Foundation Trust to maintain and continually improve standards of health and safety.

The Health and Safety at Work etc. Act 1974 establishes the legislative framework for promoting and sustaining high standards of workplace health and safety. Within the Trust, responsibility is delegated from the Chief Executive to nominated Directors, who are accountable for ensuring that effective systems are in place so that staff work safely, comply with statutory requirements, and protect themselves, patients and visitors from significant or avoidable harm.

This report provides the Trust Board with assurance that appropriate policies, procedures and governance systems were in place to manage health and safety across the Trust during the period 1 April 2025 to 31 March 2026.

It summarises the key legislative requirements underpinning health and safety management and outlines the local governance arrangements that support compliance and continuous improvement. The report also presents statistical analysis and key information relating to health and safety activity, including audit outcomes, training compliance, incident reporting and RIDDOR data.

In addition, the report provides an overview of performance and developments across the following areas:

- Alerts
- Asbestos
- Audits
- Claims
- Fire Safety
- Inspections
- Manual Handling Training
- Occupational Health
- Legal Compliance
- Policies
- Safety Performance
- Security
- Training Compliance

- Ventilation, Heating and Temperature Control
- Water Safety

This is the seventh Health and Safety Annual Report produced by the Trust. Its structure and purpose align with the Trust's Health and Safety Policy, the Safety Representatives and Safety Committees Regulations 1977, **and the** Health and Safety (Consultation with Employees) Regulations 1996.

***Note:** *Data provided in this report ended 31 March 2026*

Overview of Legal Compliance:

At the conclusion of this reporting period the Trust was compliant with all its Health and Safety legal requirements.

The table below outlines the main health and safety legislation and identifies the reactive and proactive work that the Trust has carried out to ensure compliance.

Legislation	Description of Actions/Compliance	Status
Health and Safety at Work Act 1974	Trust Health and Safety Management Policy published Competent persons in place to provide compliance advice. GH&SC held monthly	
Management of Health & Safety at Work Regulations 1999	Annual Health and Safety Audit programme Annual Health and Safety Work plan	
Display Screen Equipment Regulations 1992	DSE self-assessment tool has been updated and includes an action plan for users. Competent staff to provide additional support including Health and Safety and OH Department	
Reporting of Injuries, Disease and Dangerous Occurrences Regulations 1995 (RIDDOR)	Investigations have been implemented for all RIDDOR incidents, and the findings are shared with the GH&SC and divisions / iFM Bolton Management Teams	
Health & Safety Information for Employees Regulations (Amendment) 2009 Health & Safety Consultation with Employees Regulations 19996 Health & Safety Consultation with Employees Regulations 19996	Terms of reference are reviewed as part of GH&SC agenda cycle Trust Health and Safety Policy in place Health and Safety Trade Union Reps in place GH&SC is well attended by Managers, Trust Competent Persons and TU Safety Reps. GH&SC reports on audits, action plan progress, KPIs and risk register. GH&SC also acts as consultative committee for Health and Safety policies GH&SC reports to the Clinical Governance & Quality Committee and Quality Assurance Committee	

Legend:	
Compliant	
Non-compliant	

Safety – Summary of Accident data, RIDDOR and performance:

Health & Safety Incidents are reported through the Trust on-line Ulysses Safeguard (Safeguard) system. From 01 April 2025 to 31 March 2026 a total 553 incidents were reported in relation to health and safety.

Divisions that have contributed with data within this report include:

1. Community Services
2. Families & Diagnostics
3. Medicine
4. Surgery
5. iFM Bolton
6. Nursing, Patient Safety & Experience
7. Digital & Data Services
8. Work Force

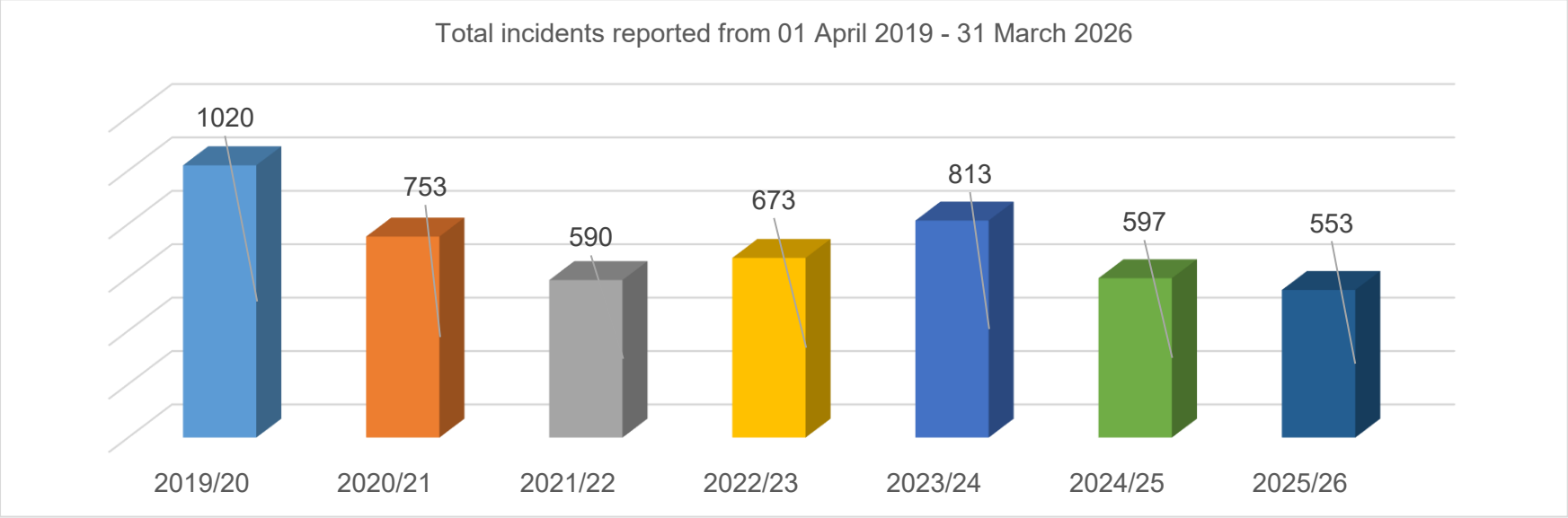
Data in this report relates to incidents reported on Safeguard covering a staff, visitor, or contractor accident/incident under the following cause groups:

- Accident/Incident
- Aggressive, Disruptive Behaviors
- Blood Exposure/Needle stick Injury
- Falls
- Moving & Handling
- Workplace Environment and Welfare

Incidents Reported by Financial Year:

Between 1 April 2025 and 31 March 2026, a total of 553 incidents were reported, compared with 597 in 2024/25, representing a 7% reduction. This is the lowest annual total recorded since 2019 and marks the second consecutive year of declining H&S incident reports.

Fig 1. Trust annual incidents 2019 - 2026



The reduction is likely attributable to:

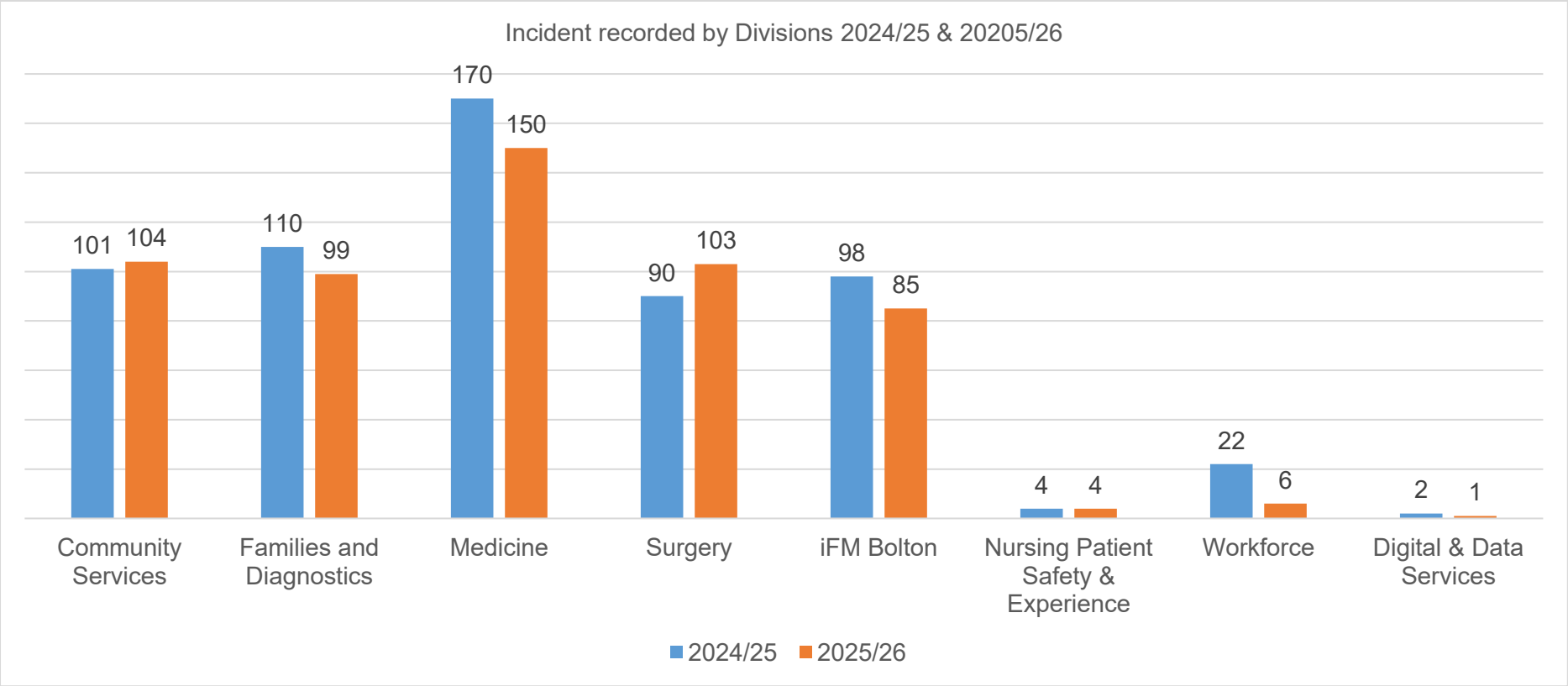
- A decrease in violent and aggressive incidents (**53 fewer reports**).
- Improved staff understanding of reportable health and safety incidents.
- Enhanced incident reporting and analysis through divisional data reports.
- Increased sharing of incident trends, lessons learned, and feedback across the Trust.
- Earlier identification and de-escalation of situations before they become reportable incidents.

Incidents Recorded by Divisions

Medicine Division remained the highest reporting division, with **150 incidents**, accounting for **27%** of all reported incidents. This represents a reduction of **20 incidents** compared to 2024/25.

The decrease may reflect the positive impact of improved access to incident data, sharing of lessons learned, and increased health and safety awareness initiatives, including the use of Health and Safety Workplace Folders across the division.

Fig 2. Reported incidents across the Trust covering the last 24 months



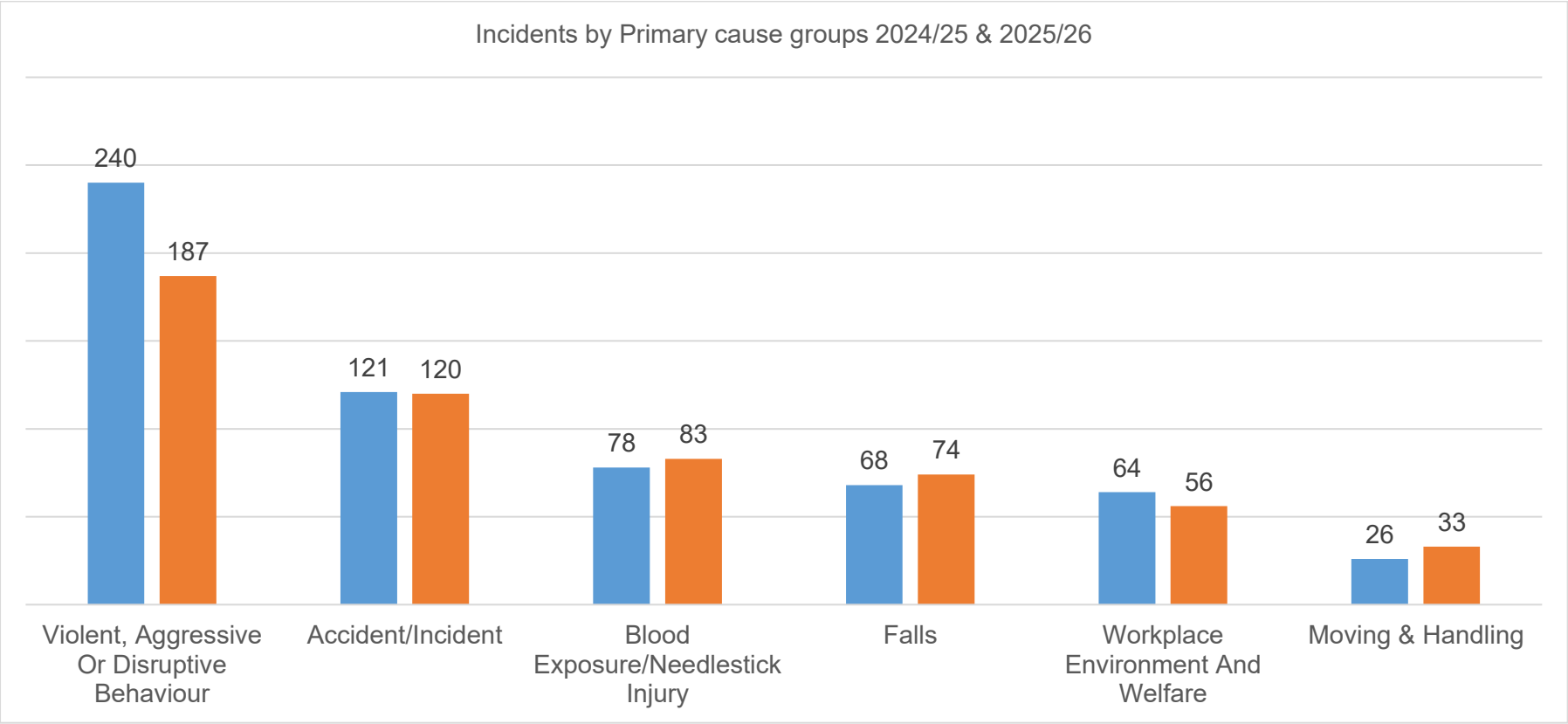
Note: During the reporting period the Trust restructured, and divisions were retitled and/or amalgamated.

Incident by Primary Cause Group:

The cause group themes are consistent with the previous year with the highest cause group reported remaining Violence, Aggressive or Disruptive behaviour.

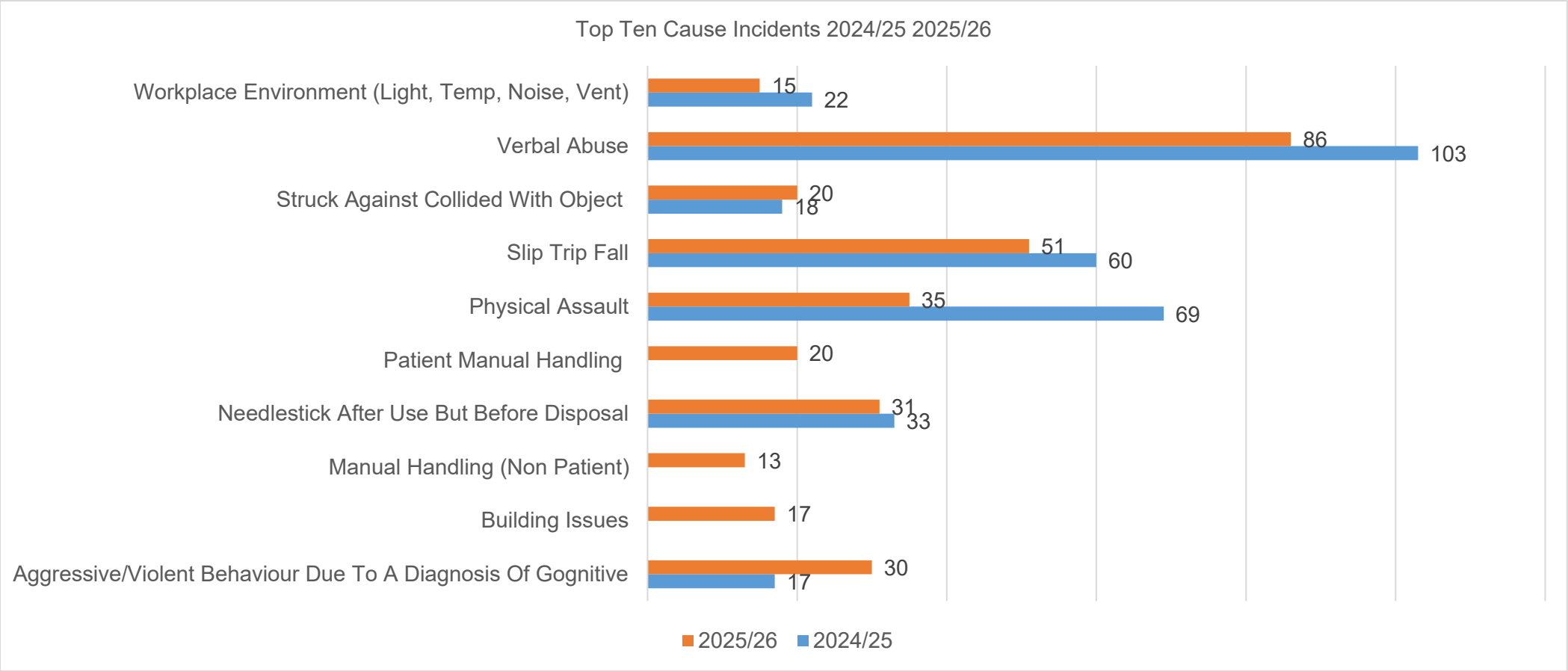
In this reporting period the Trust saw a reduction against reported incidents under the cause group Violent, Aggressive or Disruptive Behaviour from 240 (24/25) to 187 (2025/26) incidents. This reduction may be a result on the increase of staff numbers undertaking PMVA training recorded since March 2024 on top of a continued progressive increase reported during 2025/26 period.

Fig 3. Primary Cause Groups 2024/25 - 2025/26



Violent, Aggressive or Disruptive Behaviour incidents account for 34% of all Health & Safety incidents reported between April 2025 - March 2026 which is an 6% decrease on the number reported in 2024/25.

Fig 4. Top Ten Cause Groups:

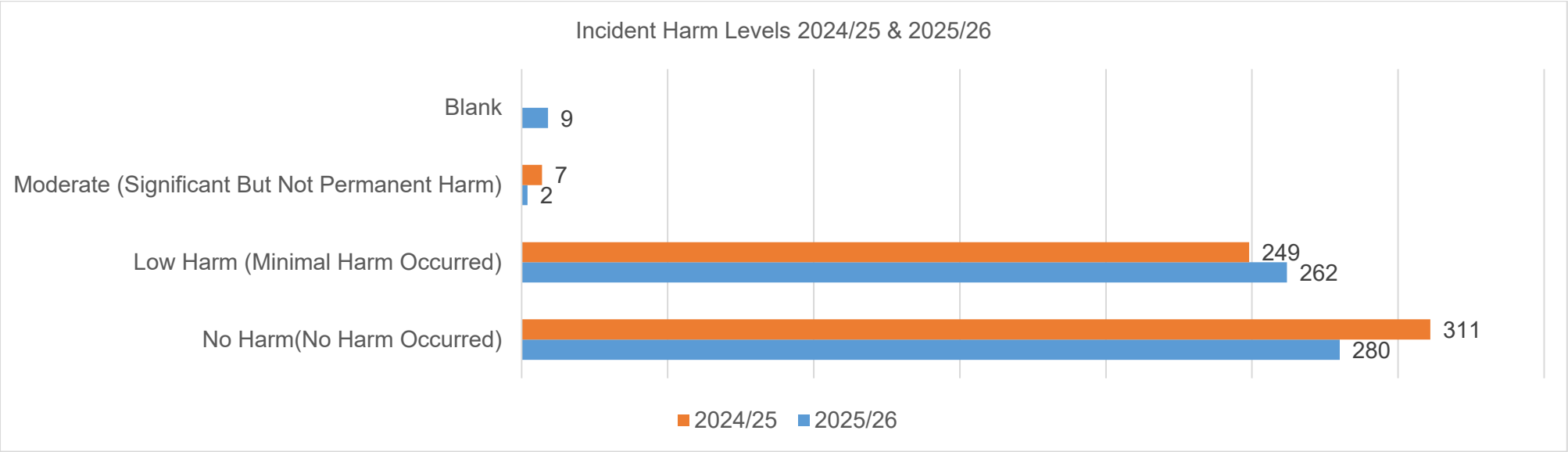


Note: Some causes have changed or been made inactive during this reporting period

Incidents by Actual Impact:

98.01% of all reported incidents in 25/26 resulted in ‘No or Low Harm’. This represents a slight reduction of 0.79% compared with the 2024/25 reporting period.

Fig 5. Incident Harm Levels 2024/25 – 2025/26



Note: Blank indicates an incident that had no category of harm entered

Moderate Harm Incidents:

In 2025/26, 2 incidents were reported as Moderate Harm, the two incidents have no joint themes.

- **Incident 285263** – Accident/Incident – Emergency Department

Staff were assessing patients in ambulances outside of the Emergency Department all day. Whilst a staff member was walking towards an ambulance to carry out an assessment on a patient, they tripped over the ambulance ramp and fell. They sustained injury to their right hand & wrist.

- **Incident 282027** – Falls Incident – Ward E5 (Children’s Ward)

Staff member was reacting to an emergency patient buzzer and whilst travelling fast (running) along the ward corridor they fell sustaining a torn Achilles tendon.

Incidents by Month:

On viewing the number of health and safety incidents reported per month occurring both during in 2024/25 and in 2025/26 there are correlation during against the 2 periods. The data shows seasonal patterns, which are consistent across both years. The strongest correlations relate to summer dips, winter spikes, **and** end-of-year declines.

Continue

iFM Bolton Estates continues to enhance the safety of the Trust's environment through a range of reactive and preventative measures, including timely repairs of environmental defects such as potholes, improved lighting, and targeted infrastructure upgrades in identified high-risk areas. These actions are informed by staff reporting via the Helpdesk, Safeguard incident responses, and regular estates walkabouts

iFM Bolton Estates continues to enhance the safety of the Trust's environment through a range of reactive and preventative measures, including timely repair of environmental defects such as potholes, improved lighting, and targeted infrastructure upgrades in identified high-risk areas. These actions are informed by staff reporting via the Helpdesk, Safeguard incident responses, and regular estates walkabouts

The Trust Group Health and Safety Committee continues to review incident themes and shared learning, while communication platforms such as the Trust intranet (BoB) are utilised to maximise awareness and reporting. These combined approaches contribute to a responsive and continuously improving safety management system.

Fig 6. Incidents during previous 24 months overlapped

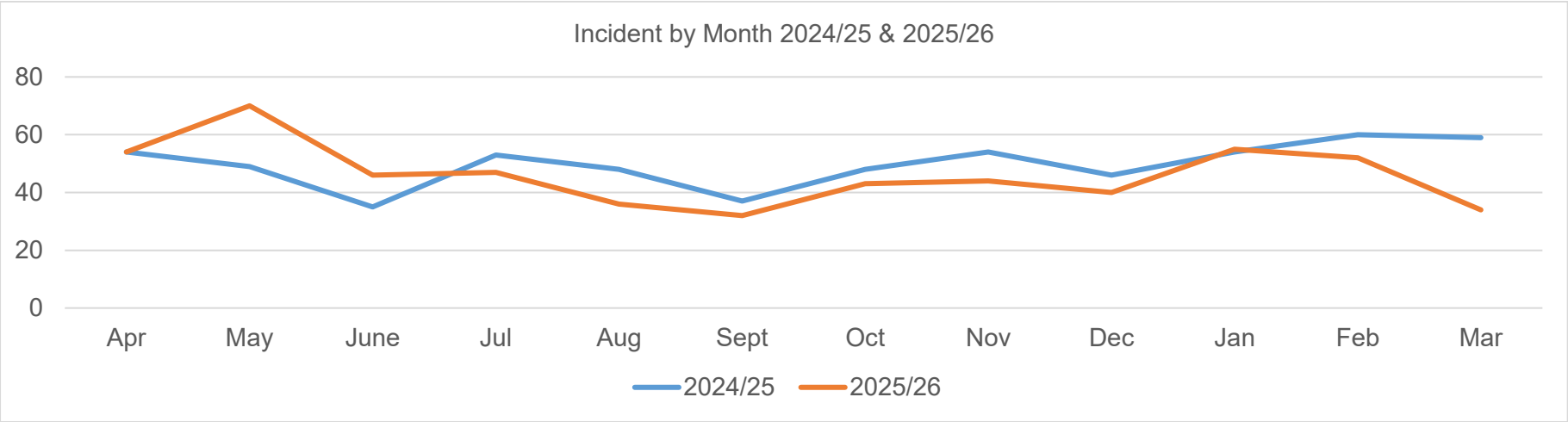
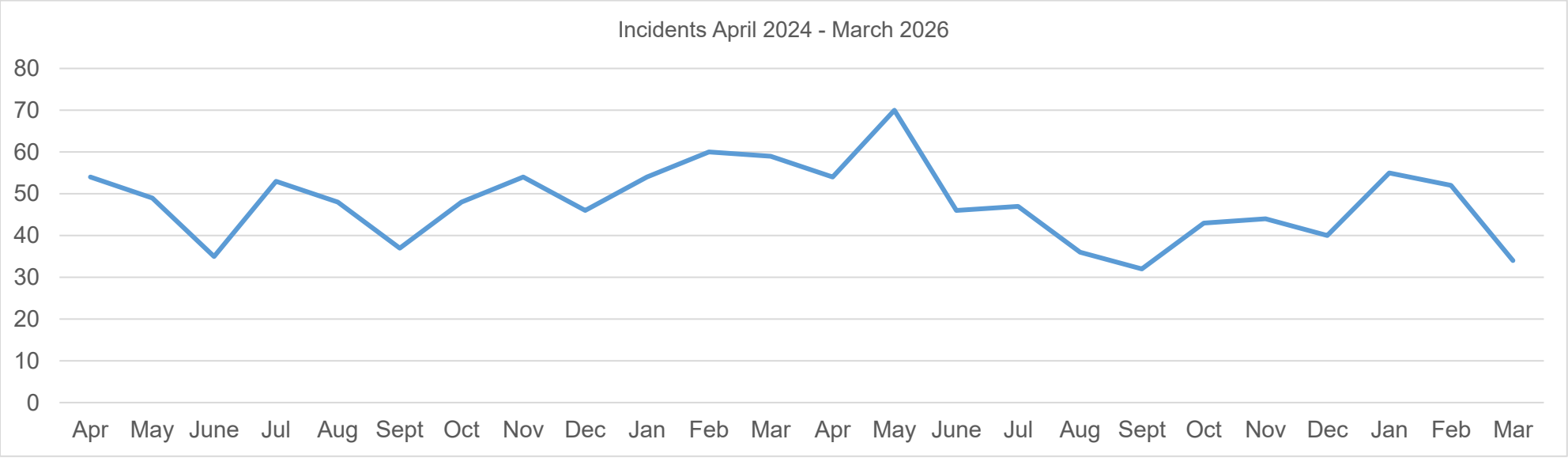


Fig 7. Continuous timeline from April 2024 to March 2026



Incidents by day and time:

Analysis of incident dates and times helps identify trends and supports targeted prevention measures.

The data shows no consistent link to a particular day of the week, with incident levels remaining relatively evenly distributed. While Thursday was the highest reporting day in 2024/25, Wednesday recorded the highest number of incidents in 2025/26.

The pattern of incidents by time of day remained unchanged, with the majority occurring during:

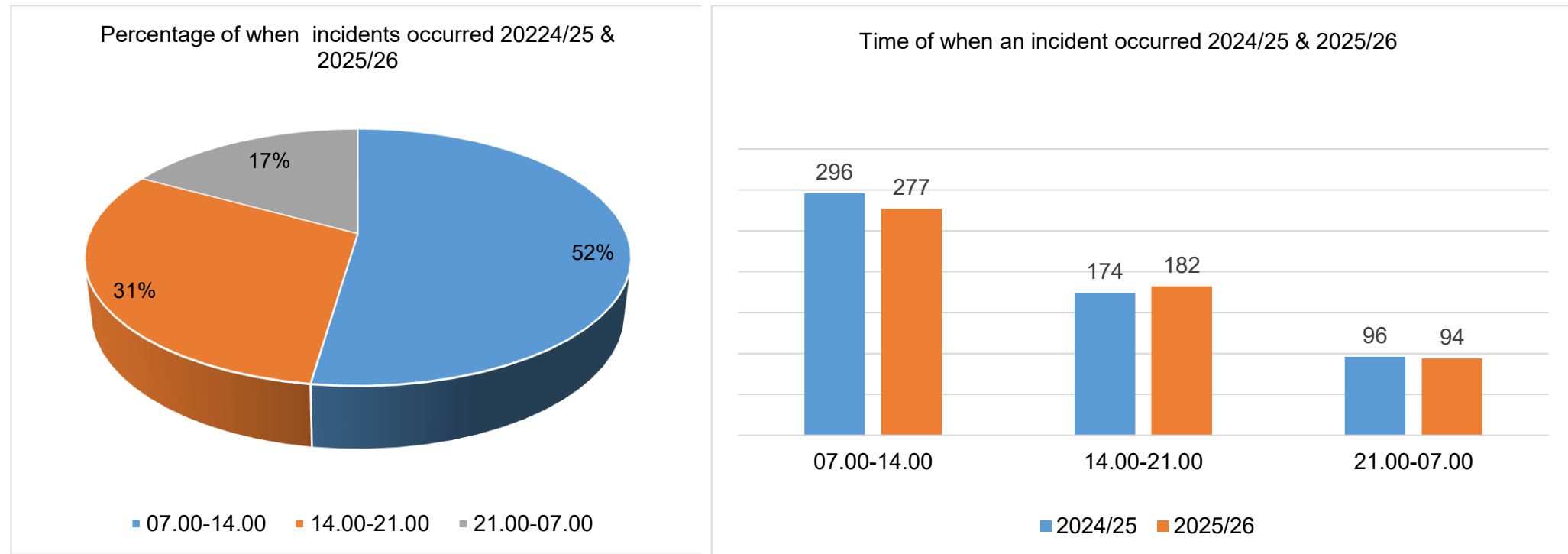
07:00–14:00

14:00–21:00

21:00–07:00

This suggests that incident occurrence continues to broadly reflect operational activity levels across the day.

Fig 8. Percentage and time breakdown of when incidents occurred 2025/26



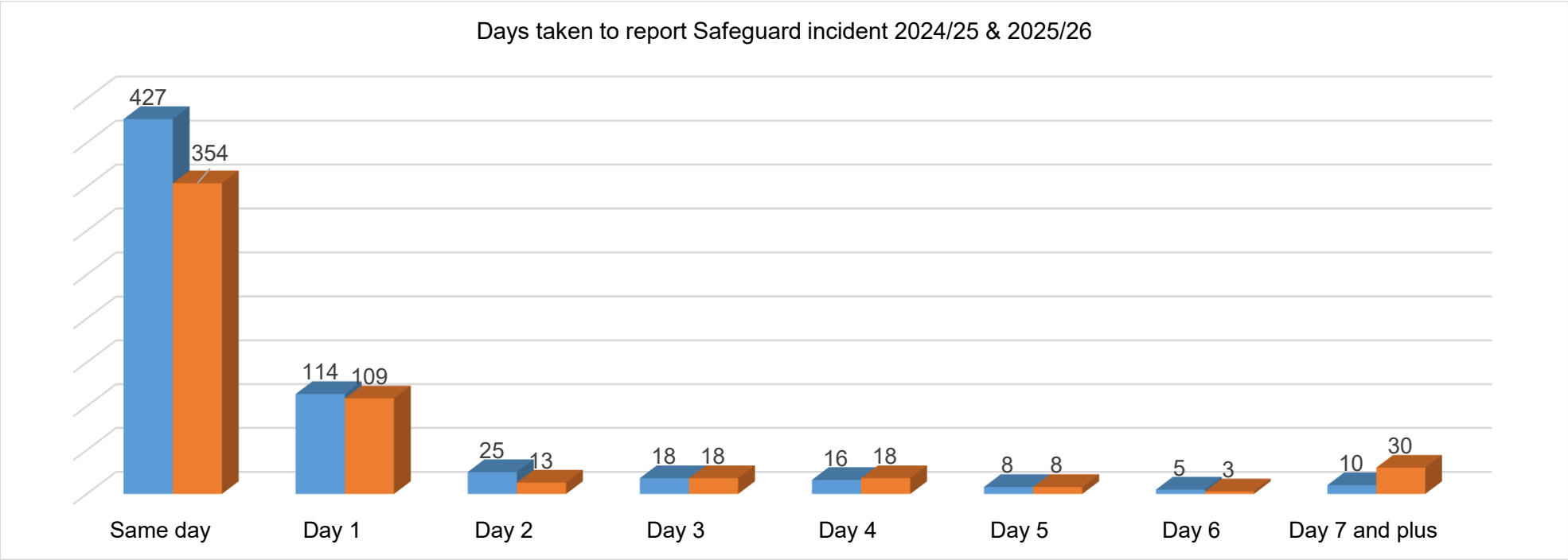
Days taken to report an incident:

Timely incident reporting supports effective risk management and helps prevent recurrence.

During 2025/26, 81.4% of incidents (450 of 553) were reported within one day of occurring, indicating a generally positive reporting culture. However, this is a decrease from 87% in 2024/25.

Delays in reporting may be influenced by factors such as workload pressures, limited access to reporting systems, and uncertainty over reporting requirements, or concerns about reporting incidents. Despite the reduction, the majority of incidents continue to be reported promptly.

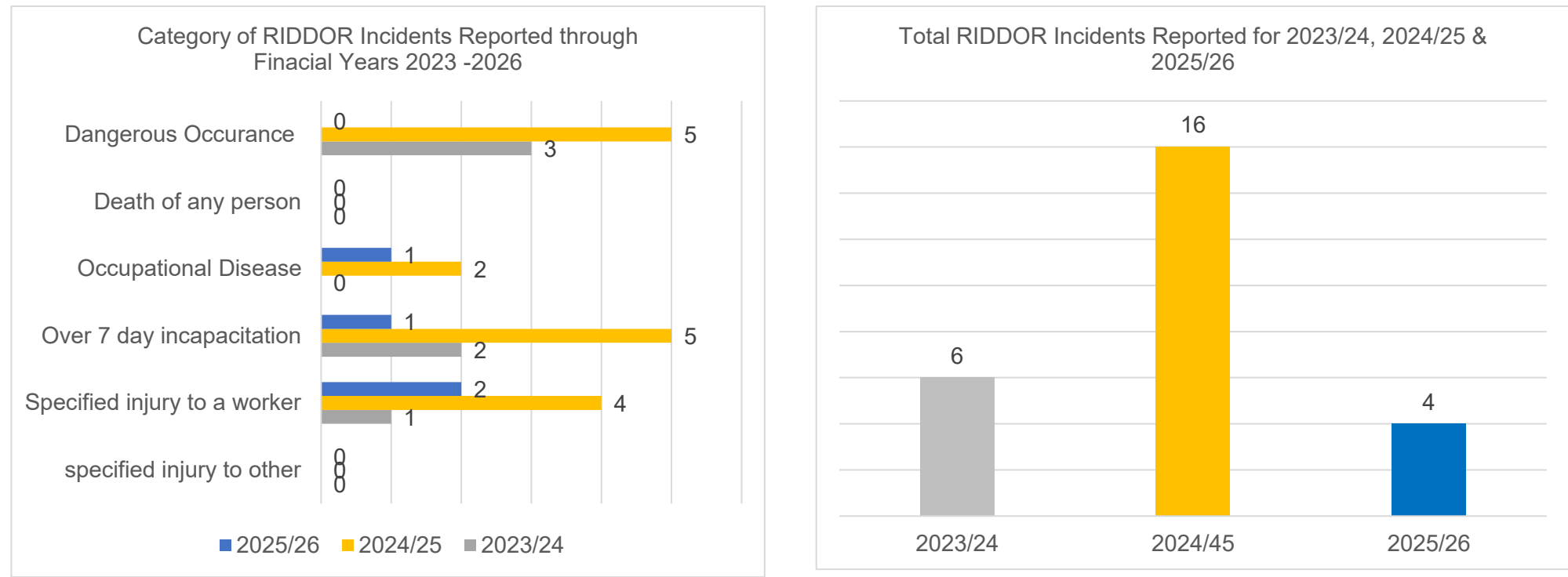
Fig 9. When incidents were reported during 2024/25 & 2025/26



Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR):

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), employers must report certain work-related injuries, illnesses and dangerous occurrences to the HSE.

Fig 10. Category of RIDDORS and total reported during the previous 36 months



RIDDOR Summary 2025/26

During 2025/26, the Trust and iFM Bolton reported 5 RIDDOR incidents, with 1 subsequently cancelled following investigation, resulting in 4 confirmed RIDDOR reports. This represents a significant reduction compared to 16 reports in 2024/25.

Key changes included:

- No Dangerous Occurrence reports relating to needle stick injuries.
- Over 7-Day Incapacitation reports reduced from 5 to 1.

- Occupational Disease reports reduced from 2 to 1.
- Specified Injury to a Worker reports reduced from 4 to 2.

Themes and Learning

The small number of RIDDORs limits meaningful trend analysis; however, three key themes emerged:

- Occupational Dermatitis remained a recognised healthcare risk, with one occupational disease report identified through ongoing health surveillance and awareness programmes.
- Violence and aggression accounted for two RIDDORs involving injuries caused by patients, highlighting the importance of staff training, appropriate deployment and effective communication between teams.
- Equipment maintenance was identified as a contributory factor in one specified injury, reinforcing the need for robust planned preventative maintenance (PPM) arrangements.

Reporting Performance

Of the RIDDOR incidents reported during 2025/26, one was submitted outside the HSE reporting timeframe due to delayed notification of the employee's absence. Once notified, the Health and Safety Team completed the report within the required timescale.

Conclusion

RIDDOR reports decreased significantly during 2025/26 and no clear trends by location or category were identified. The reported incidents highlight three key areas for continued focus:

- Management of occupational dermatitis risks.
- Prevention of violence-related injuries through training and communication.
- Assurance of equipment maintenance and PPM compliance.

Next Steps led by the Trust Health and Safety Team

Strengthen early identification and escalation of potential RIDDOR incidents.

- Increase manager awareness of RIDDOR criteria through targeted training and guidance.
- Continue joint reviews between Health & Safety, Litigation and iFM teams.
- Share lessons learned and promote a proactive reporting culture across the Trust.

Training compliance:

Background:

The Core Skills Training Framework (CSTF) provides a national standard for statutory and mandatory training across NHS organisations, setting minimum learning requirements, refresher frequencies, and alignment with relevant legislation and best practice guidance.

Key health and safety-related modules include:

- Conflict Resolution.
- Fire Safety.
- Moving and Handling.
- Health, Safety and Welfare.

Compliance Reporting Parameters

The following staff groups are excluded from compliance reporting:

- Staff absent through sickness for 21 days or more.
- New starters within their first 28 days of employment.
- Staff on maternity/adoption leave, parental leave, career breaks, or external secondments.

The following staff groups are included:

- Active employees.
- Staff undertaking acting-up roles.
- Staff on internal secondments.

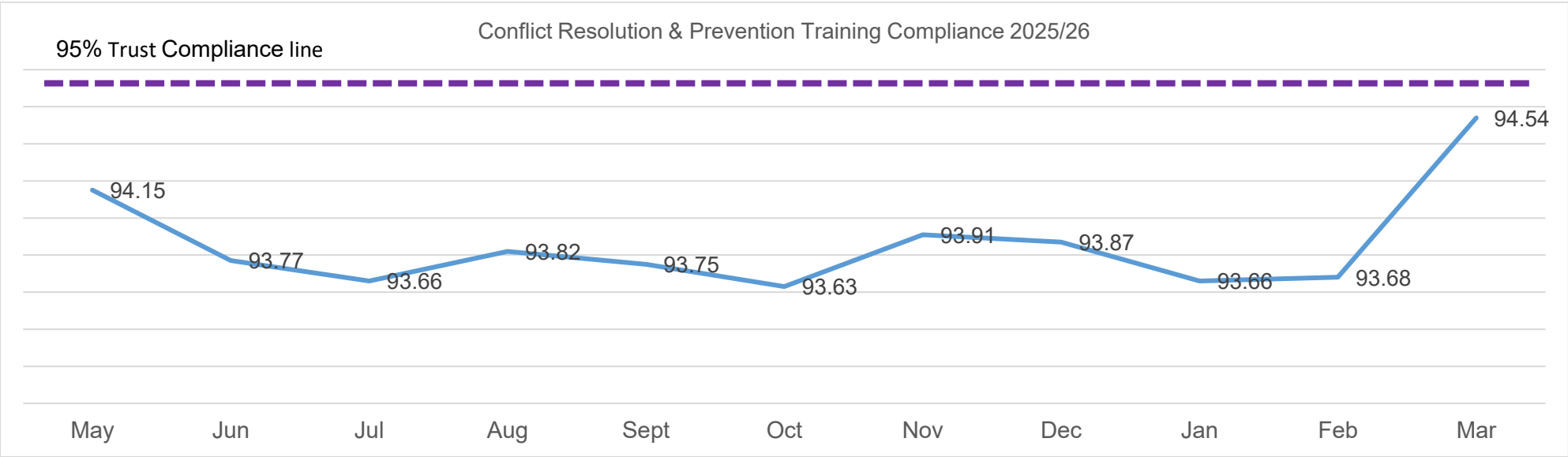
Conflict Resolution & Prevention and Management of Violence and Aggression (PMVA) Training:

The Trust did not achieve the 95% compliance target for Conflict Resolution and PMVA training during 2025/26. However, compliance remained consistently high throughout the year, ranging between 93% and 95%, with performance improving to 94.5% in March 2026, the highest level recorded during the reporting period.

Although PMVA training is not mandatory for all staff, uptake across PMVA Levels 2–4 remained strong following the Group Security Committee's decision to assign the appropriate level of training to relevant staff through ESR.

Key Observation: Compliance remained stable throughout the year, demonstrating continued engagement with Conflict Resolution and PMVA training despite the Trust narrowly missing the 95% target.

Figure 11. Conflict Resolution & Prevention Training Compliance figures between 01 April 2025 & 31 March 2026



Note: This data includes all completed Prevention and Management of Violence and Aggression (PMVA) training delivered through both eLearning and face-to-face sessions. Compliance figures incorporate PMVA Levels 1–4, with staff completing PMVA Levels 2, 3 or 4 automatically achieving the PMVA Level 1 (Conflict Resolution & Prevention) competency requirement.

Observation:

Compliance remained consistently high throughout 2025/26, fluctuating within a narrow range of approximately 93%–95%. Performance remained close to the Trust target of 95% across the year, with a gradual improvement during the final quarter and a peak of 94.54% in March 2026. The limited month-on-month variation indicates a stable level of staff engagement and sustained compliance with Conflict Resolution and PMVA training requirements.

Figures 12a, b, c, & d. Prevention and Management of Voilence and Agression (PMVA) trained staff training figures between 01 April & 31 March 25

Prevention and Management of Violence and Aggression (PMVA) training equips staff with the skills to recognise, prevent and safely manage challenging behaviour. The level of training required (Levels 1–4) is determined through the Trust's Training Needs Analysis (TNA), based on staff role and workplace risk profile.

PMVA Training Validity Periods

Level 2: 3 years

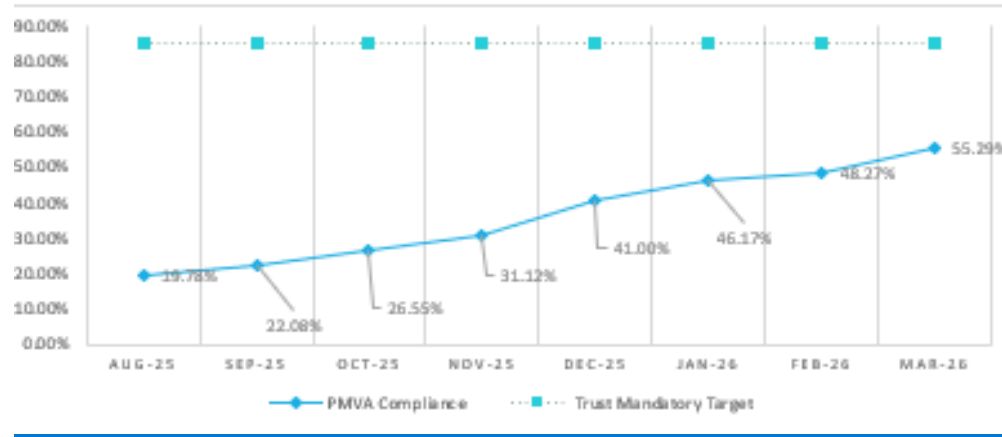
Level 3: 2 years

Level 4: Annual refresher

The programme helps ensure staff maintain the competence and confidence to manage violence and aggression safely and effectively.

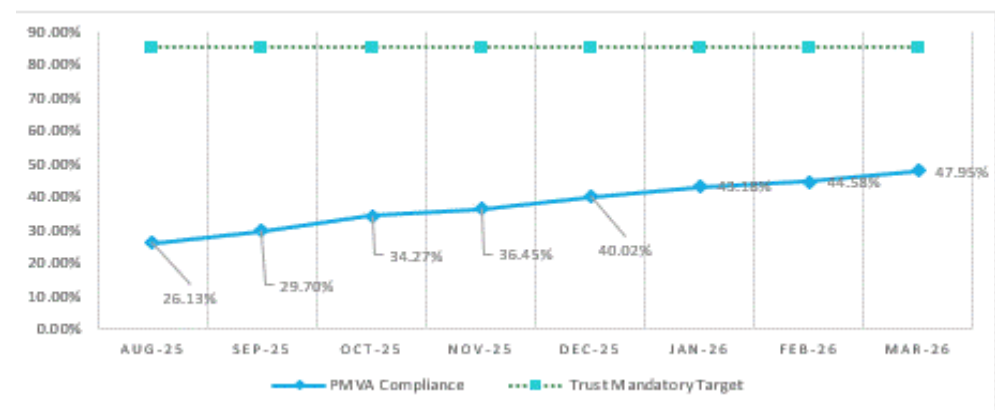
Divisional breakdown on the number of trained staff trained either in PMVA Level 2, 3 or 4

Fig 12a. Surgery – Total = 55.29%



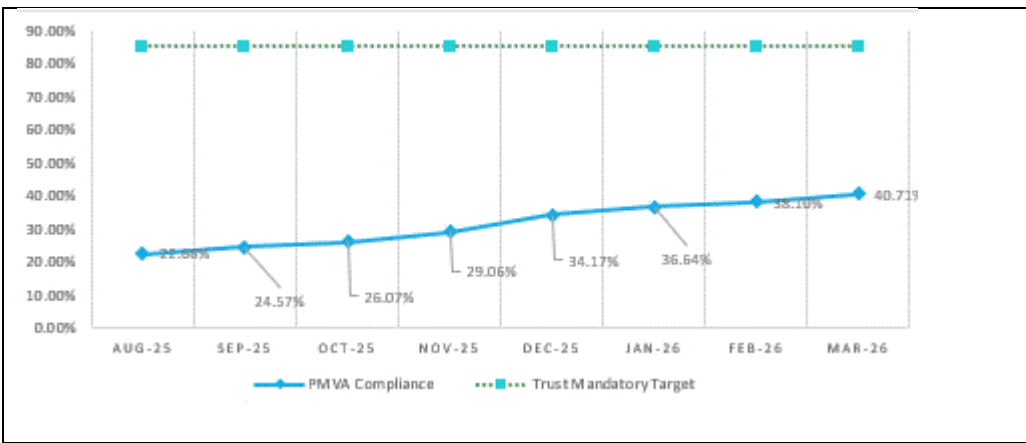
PMVA	% Compliance
Prevention Management of Violence and Aggression Level 2	61.44%
Prevention Management of Violence and Aggression Level 3	47.52%
Prevention Management of Violence and Aggression Level 4	60.44%

Fig 12b. Diagnostics – Total 47.95%



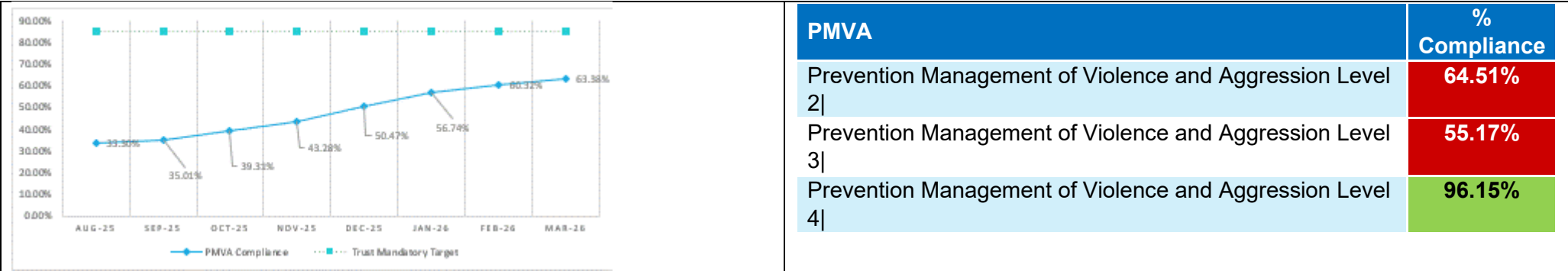
PMVA	% Compliance
Prevention Management of Violence and Aggression Level 2	51.52%
Prevention Management of Violence and Aggression Level 3	20.18%
Prevention Management of Violence and Aggression Level 4	N/A

Fig 12c. Medicine – Total 40.71%



PMVA	% Compliance
Prevention Management of Violence and Aggression Level 2	47.86%
Prevention Management of Violence and Aggression Level 3	47.42%
Prevention Management of Violence and Aggression Level 4	27.09%

Fig 12d. Community - Total 63.38%

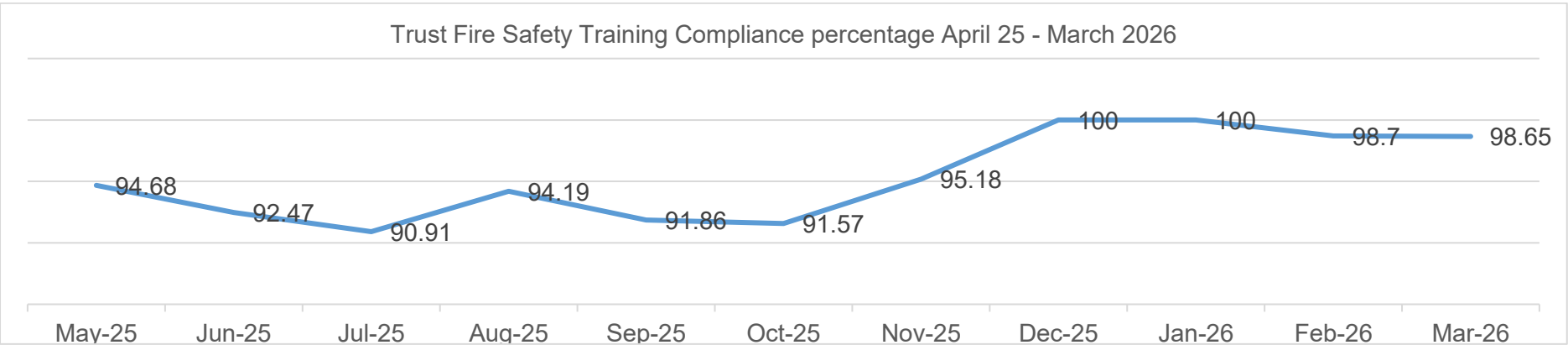


Note* The data presented within the graphs above run only from Aug 2025 to Mar 2026. This is due to an improvement change to record keeping on staff training which is now being accounted on an individuals' ESR profile. Previously this was collated by People and Development Trainers.

Fire Safety Training:

Fire Safety training compliance remained below the Trust target of 95% throughout 2025/26. Compliance peaked at 94.68% in May 2025 before declining to 90.91% in July 2025. Performance then remained relatively stable, indicating a sustained gap between actual compliance levels and the Trust target.

Fig 13. Fire Training Compliance 2025/26



Overall Interpretation:

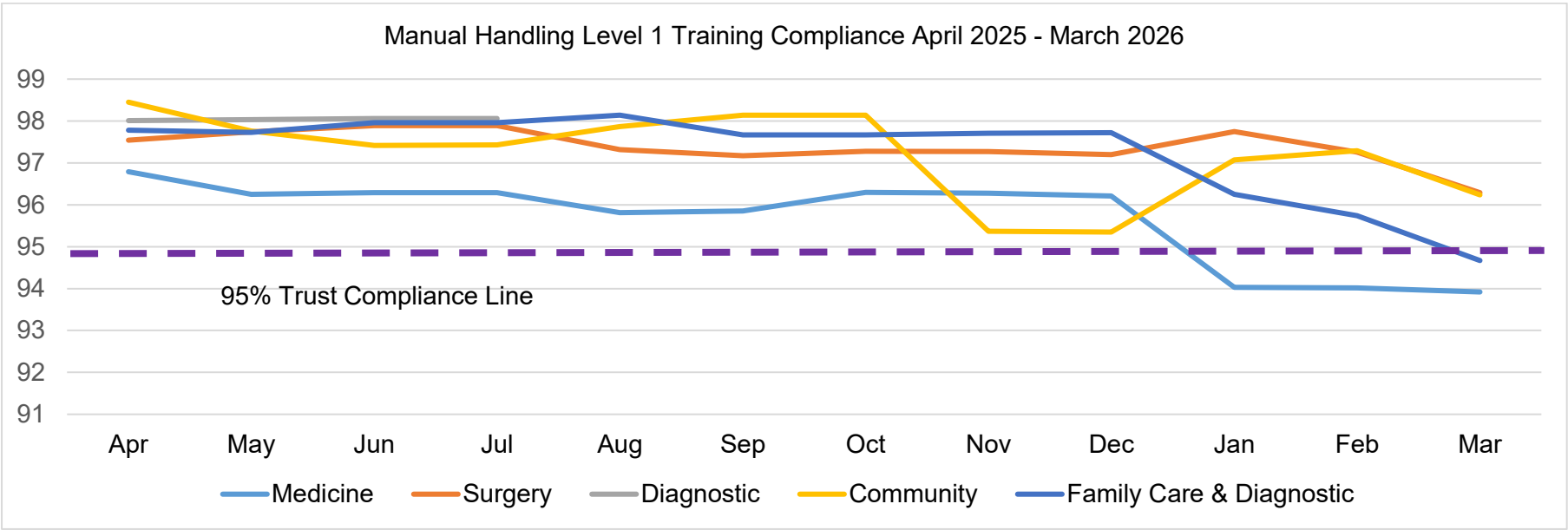
Fire Safety training compliance remained high throughout the year, despite a mid-year reduction in performance. Compliance improved significantly during the second half of the reporting period and finished the year at near-full compliance, reflecting effective recovery actions and strong commitment to mandatory training requirements.

Manual Handling Training:

The Trust achieved the 95% compliance target for Manual Handling Level 1 during Q1–Q3, but compliance fell below target in Q4. For Manual Handling Level 2, the Trust did not achieve the 95% compliance target during 2025/26.

Maintaining high levels of Manual Handling training compliance is essential to reduce the risk of workplace injuries, promote safe working practices, and ensure regulatory requirements are met. Divisions should continue to prioritise training attendance and timely refresher completion to sustain compliance levels.

Fig 14. Manual Handling Level 1 Training Compliance 01 April 2025 – 31 March 2026



Note: A Trust-wide divisional restructure took place during the reporting period which may have influenced compliance trends.

Key Findings:

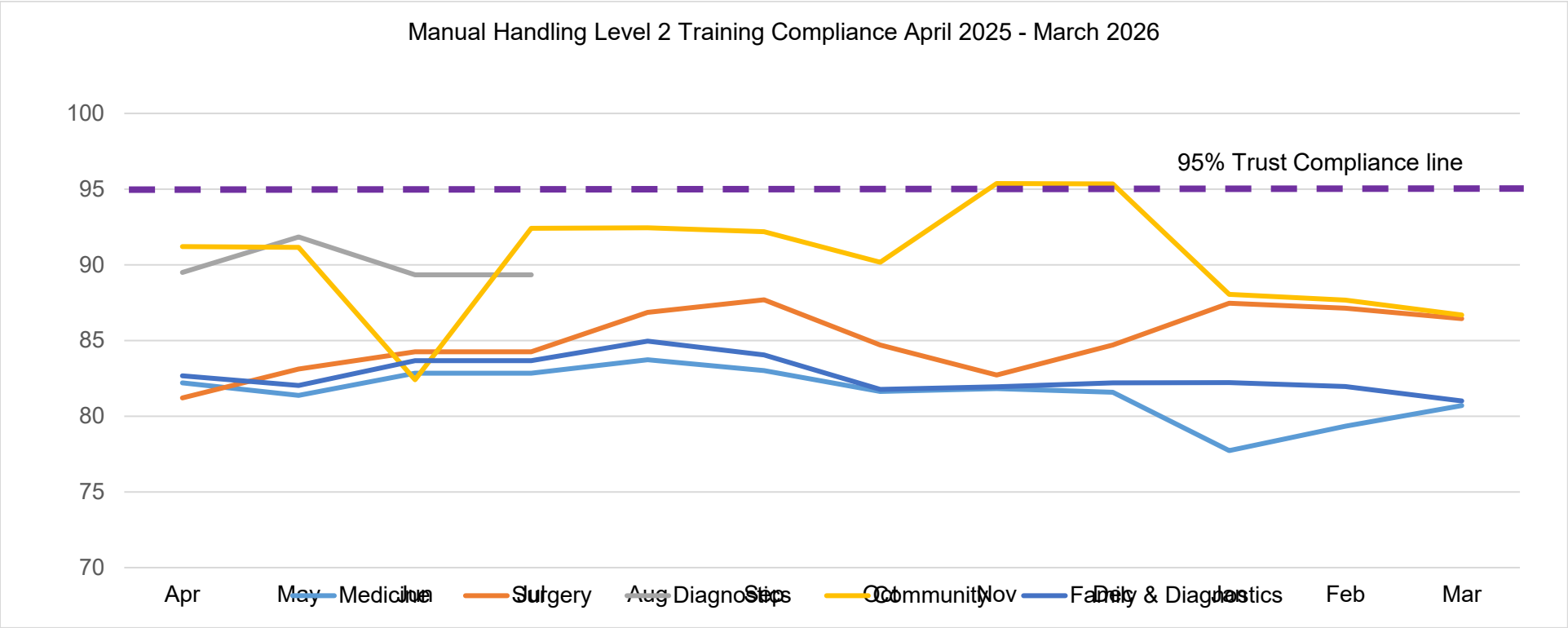
Trust-wide compliance met or exceeded the 95% target throughout Q1–Q3, before falling below target in Q4.

Surgery and Community Divisions maintained compliance above the 95% target throughout the year.

Medicine and Family Care & Diagnostics achieved compliance for most of the year but fell below target during Q4.

Observation Overall compliance remained strong across the Trust, with most divisions meeting or remaining close to the 95% target for the majority of the reporting period. A decline was observed during the final quarter, indicating a build-up of refresher training requirements and reduced compliance levels in some areas. Despite this, Surgery and Community Divisions demonstrated sustained compliance throughout the year, reflecting effective management of mandatory training requirements.

Figure 15. Manual Handling Level 2 training compliance percentages between 01 April 2025 & 31 March 2026



Note:
A Trust-wide divisional restructure took place during the reporting period and may have influenced compliance performance across some services. Figure 15 shows Manual Handling Level 2 compliance across the Trust's four Divisions against the 95% Trust compliance target.

Key Findings:
The Trust did not achieve the 95% compliance target for Manual Handling Level 2 at any point during 2025/26. Compliance across all Divisions remained below target throughout the reporting period, ranging from approximately 78% to 95%.

Community Services recorded the highest compliance level (95.37% in August 2025) and came closest to consistently achieving the Trust target.

Medicine Division recorded the lowest compliance level (77.73% in January 2026) and remained the lowest-performing Division overall.

Surgery and Family Care & Diagnostics demonstrated relatively stable compliance, although both remained below the Trust target throughout the year.

Observation:

Manual Handling Level 2 compliance remained a challenge across all Divisions during 2025/26, with no Division consistently achieving the Trust's 95% target. While performance was generally stable, a gradual decline was observed in several Divisions towards the end of the reporting period, particularly within Medicine and Family Care & Diagnostics. Community Services demonstrated the strongest overall performance and was the only Division to exceed the target during the year. The data indicates a continued need to prioritise refresher training, improve attendance at training sessions, and strengthen local oversight of compliance to reduce the gap between current performance and the Trust standard.

Health, Safety & Welfare Training:

Figure 16a. Health, Safety & Welfare training compliance percentages between 01 April 2025 & 31 March 2026

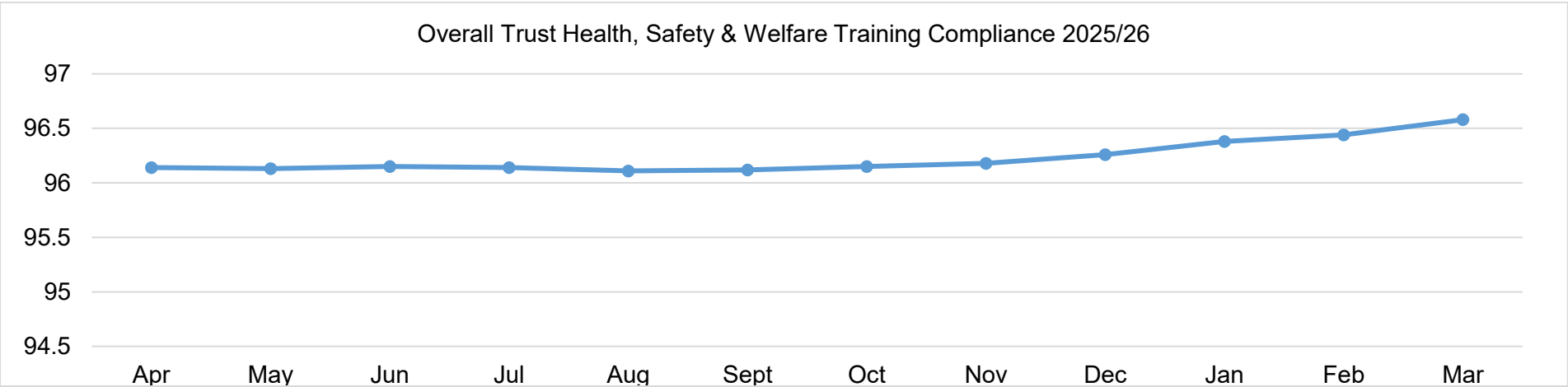


Figure 16b. Divisional Breakdown on Health, Safety & Welfare training compliance percentages between 01 April 2025 & 31 March 2026

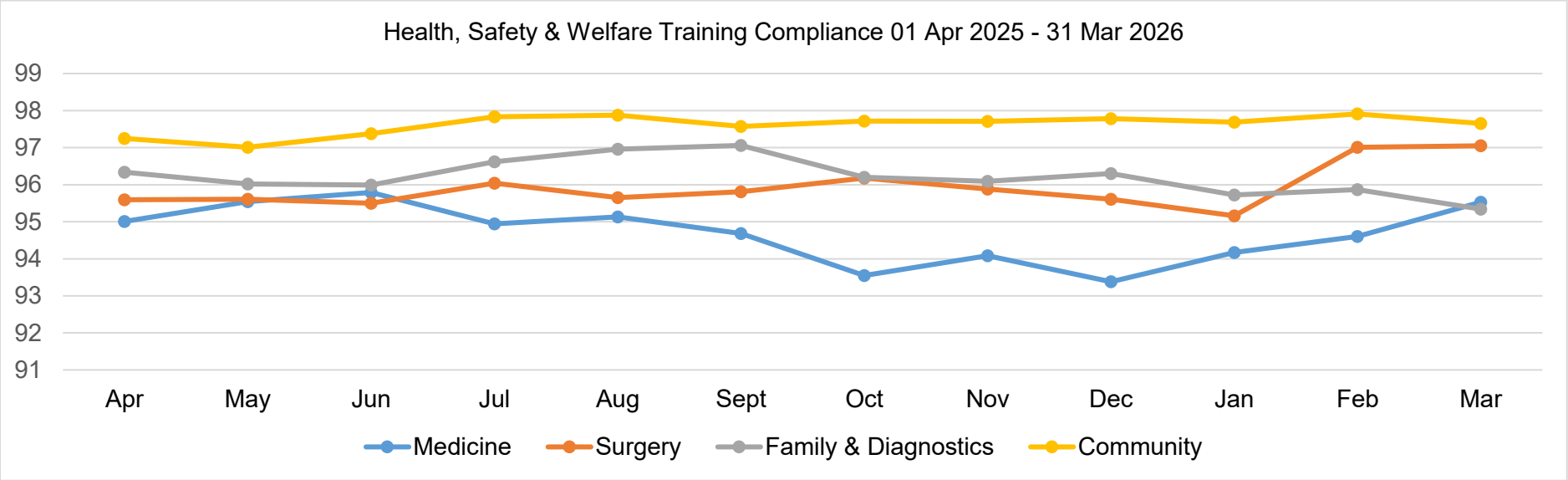


Figure 16a & b above, Shows Health, Safety & Welfare training compliance percentages between April 2025 & March 2026 as per Trust overall compliance percentage (Figure 16a) and per Division compliance percentage (Figure 16b).

Main Themes:

- The Trust exceeded its 85% compliance target throughout all four quarters of 2025/26.
- Compliance remained consistently high, with the lowest recorded figure being 93.38%.

Observation:

- The Trust maintained compliance above target throughout the reporting period.
- Community Division achieved the highest and most consistent compliance levels (97–98%).
- Medicine Division recorded the lowest compliance levels but remained above target and showed improvement towards year-end.

- Surgery Division maintained stable performance and improved to 97% in the final months.
- Family Care & Diagnostics remained consistently compliant, with only minor fluctuations during the year.

Manual Handling:

Manual Handling

During 2025/26, the Trust recorded 33 Manual Handling incidents, a 45% reduction from 60 incidents in 2024/25. Quarterly totals remained relatively consistent, with 10 incidents in Q1, 7 in Q2, 8 in Q3, and 8 in Q4.

Incident numbers were generally low throughout the year, with the fewest reports recorded in April, August and December 2025 (1 incident each) and the highest in November 2025 (5 incidents).

Observation

The reduction in incidents suggests improvements in manual handling practices, training, and risk controls across the Trust. All reported incidents resulted in either No Harm or Low Harm, with 22 incidents classified as Low Harm and no incidents resulting in actual moderate harm or above.

Incident investigations continue to support organisational learning and the implementation of preventative measures.

Next Steps for 2026/27

Key priorities include:

- Increasing access to Manual Handling Level 2 practical training for community staff.
- Reviewing and aligning moving and handling training and competency assessment processes.
- Strengthening post-falls procedures and staff training.
- Enhancing assurance of staff competence for patient handling equipment.
- Reviewing bespoke training for specialist services such as Theatres, Maternity and Paediatrics.
- Improving training facilities and resources.
- Embedding training and implementation of new patient handling equipment (PATPAQs slide sheets) and techniques.

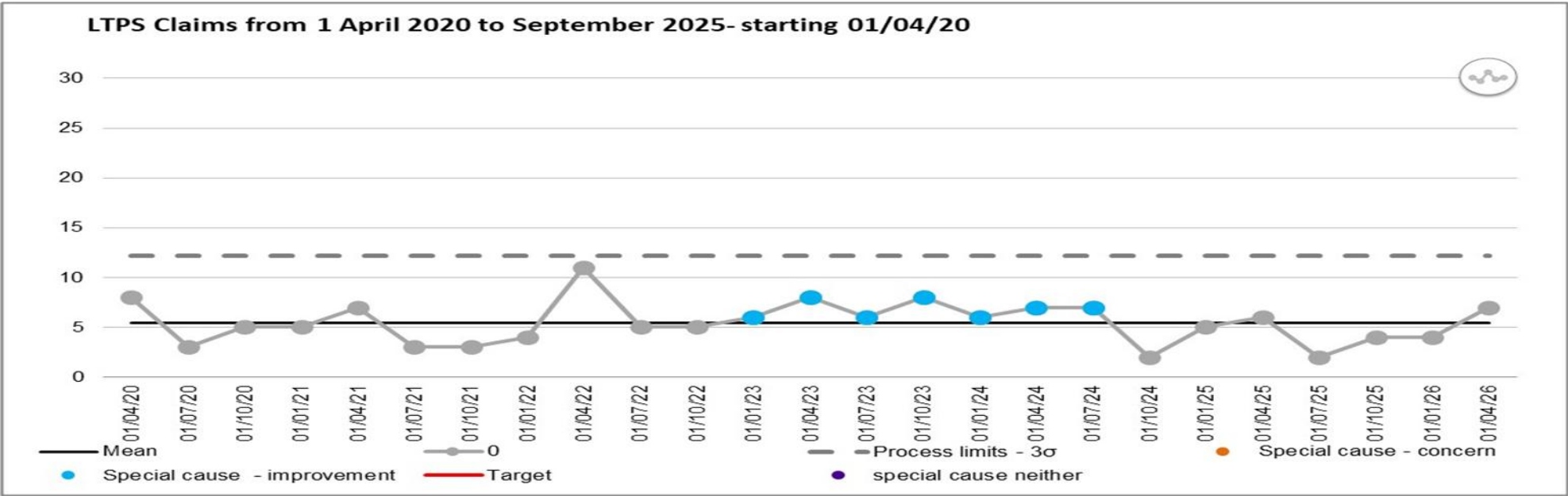
Claims:

The NHS Liabilities to Third Parties Scheme (LTPS), administered by NHS Resolution, provides cover for non-clinical negligence claims, including Employer’s Liability (EL) and Public Liability (PL) claims. Learning from claims helps reduce future incidents, associated costs and the Trust's overall contribution to the scheme.

LTPS claims are reported to NHSR through the Ministry of Justice Personal Injury Portal. There are some types of claims that are not reported via the Portal, and these are Data Protection claims and claims which involved assault on a member of staff by a patient. Claims that fall into this category are reported in accordance with the LTPS reporting guidelines.

Learning from claims and applying the learning plays an essential role in reducing the costs to the Trust associated with EL and PL claims. The excess payable by the Trust under the LTPS cover to the Trust’s insurer is £10,000 (EL) and £3000 (PL) for each claim.

Figure 17. LTPS Claims 01 April 2025 – 31 March 2026



The Trust’s contribution to the Risk Pooling Schemes for Trusts remained within the expected annual planning assumptions, with a reduction noted for 2026/27.

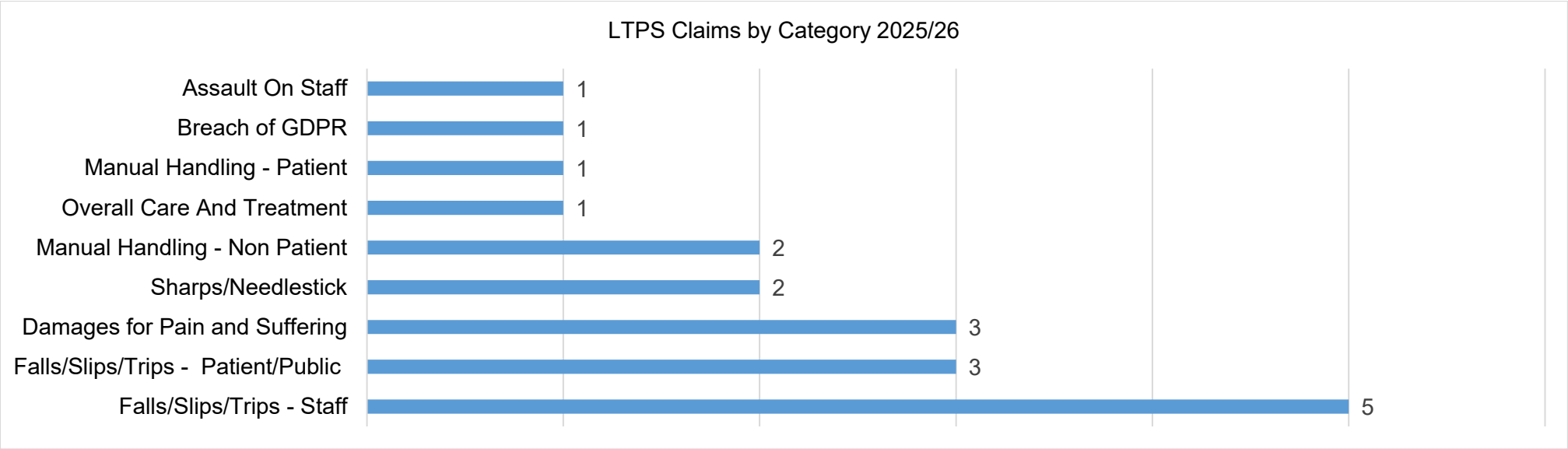
During 2025/26, the Trust received 19 LTPS claims, broadly consistent with the previous reporting period.

- Claims related to staff and third-party liability matters.
- Claims activity and associated learning continued to be reviewed through established governance routes.

Observation:

Claim numbers remained broadly stable compared to the previous year, with only a marginal increase in claims received. Continued learning from incidents and claims remains important in reducing the financial, operational and wellbeing impacts associated with workplace injuries and liability claims.

Figure 18. Category type and number of claims during the period 01 April 25 & 31 March 2026



During the reporting period, closed claims were reviewed to identify learning and support improvements in safety, risk management and claims prevention.

- 22 claims were closed. It should be noted that the closed claims will relate to claims received in other financial years.
- Employer liability claims were reviewed, with learning identified and shared to support safer working practices and reduce recurrence.
- Public and occupiers' liability claims were also reviewed, with outcomes monitored through the Trust's claims management processes.
- Detailed financial information is monitored internally and reported through the appropriate governance and assurance routes.
- The maximum cost payable by the Trust for public liability and occupiers' liability claims from either visitors or iFM Bolton employees, the excess for these claims is £3000, therefore in total the Trust paid £21,000 out to cover the excess for these claims.

Learning from closed claims:

- Collaborative working across the Trust to successfully defend claims.
- Radiology hub decluttered to ensure safe passage for staff.
- Recommend unit manager of Radiology Hub to review staff slips/trips/falls risk assessment with support from Health & Safety team.
- Learning from claims has supported improvements in local record management processes and reduced reliance on paper-based arrangements.
- Processes involving sensitive information have been reviewed and strengthened to support confidentiality and reduce the risk of recurrence.

Audits:

While health and safety audits are not a legal requirement, they are recognised as good practice. However, where a Trust has mature governance arrangements, effective risk management processes, and a positive safety culture, a formal audit may not be an immediate priority.

The Health and Safety Team has identified that a formal audit is not currently required due to the following assurances:

- The Trust has robust governance arrangements, with assurance committees holding divisions accountable for health and safety compliance, including risk assessments.
- The Group Health & Safety Committee (GH&SC) reports to the Quality Assurance Committee and escalates risks through established assurance processes.
- Health and safety training compliance exceeds required standards.
- Divisions provide regular assurance that Workplace Health and Safety Folders are reviewed, maintained and supported by action plans where necessary.
- Workplace assurance is also provided through Bolton System Care Accreditation (BoSCA) and previous Health and Safety Team inspections.
- Manual handling equipment is subject to planned preventative maintenance, inspection and calibration programmes.
- Medical device management is overseen by the Medical Devices Committee, with formal reporting through the Trust's governance structure.
- A programme of ward visits linked to the Workplace Health and Safety Folder process is planned for 2026/27, with findings reported to wards, Governance Managers and the Group Health & Safety Committee.

These arrangements provide ongoing assurance that health and safety risks are being effectively identified, monitored and managed across the Trust.

Health and Safety Executive (HSE) inspections:

During 2025/26 the Health and Safety Executive (HSE) undertook no inspections to the Trust, as was the previous reporting period 92024/25).

Alerts:

During 2025/26 there was Nil (0) National Patient safety Alerts relating to Health and Safety, issued by CAS 9Central Alerting System between 01 April & 31 March 2026.

Policies: Status of health and safety policies

Name	Doc Type	Review Date	Status
Control of Contractors Policy.pdf	Policy	31/03/2028	
Management of Violence and Aggression Policy.pdf	Policy	21/11/2027	
Personal Protective Equipment Policy (PPE).pdf	Policy	17/04/2028	
Medical Devices Training Policy.pdf	Policy	01/05/2028	
Control Of Substances Hazardous to Health (COSHH) Policy.pdf	Policy	01/12/2026	
Medical Devices Operational Policy v10.pdf	Policy	01/12/2026	
Electrical Safety Policy.pdf	Policy	01/04/2027	
Health and Safety Policy.pdf	Policy	01/04/2027	
Workplace Ergonomics and Display Screen Equipment	Policy	01/08/2028	
First Aid at Work Policy	Policy	01/05/2027	
Control of vibration at work policy.pdf	Policy	01/06/2027	
Safe Management of Sharps Policy	Policy	01/06/2027	
Latex Policy	Policy	01/06/2027	

Using Bedrails Safely Policy	Policy	01/06/2027	
Log Roll Technique and Training Policy .pdf	Policy	01/08/2027	
Manual Handling Policy .pdf	Policy	01/08/2027	
Prevention of Slips, Trips and Falls	Policy	17/04/2028	

Legend:	
In date	
Out of date	

Fire Safety:

Fire Risk Assessments for all Royal Bolton Hospital buildings including Community buildings

Reporting period 2025/26

FM Bolton has a KPI target of 95% compliance for completing Fire Risk Assessments (FRAs) across all Royal Bolton Hospital and Community buildings.

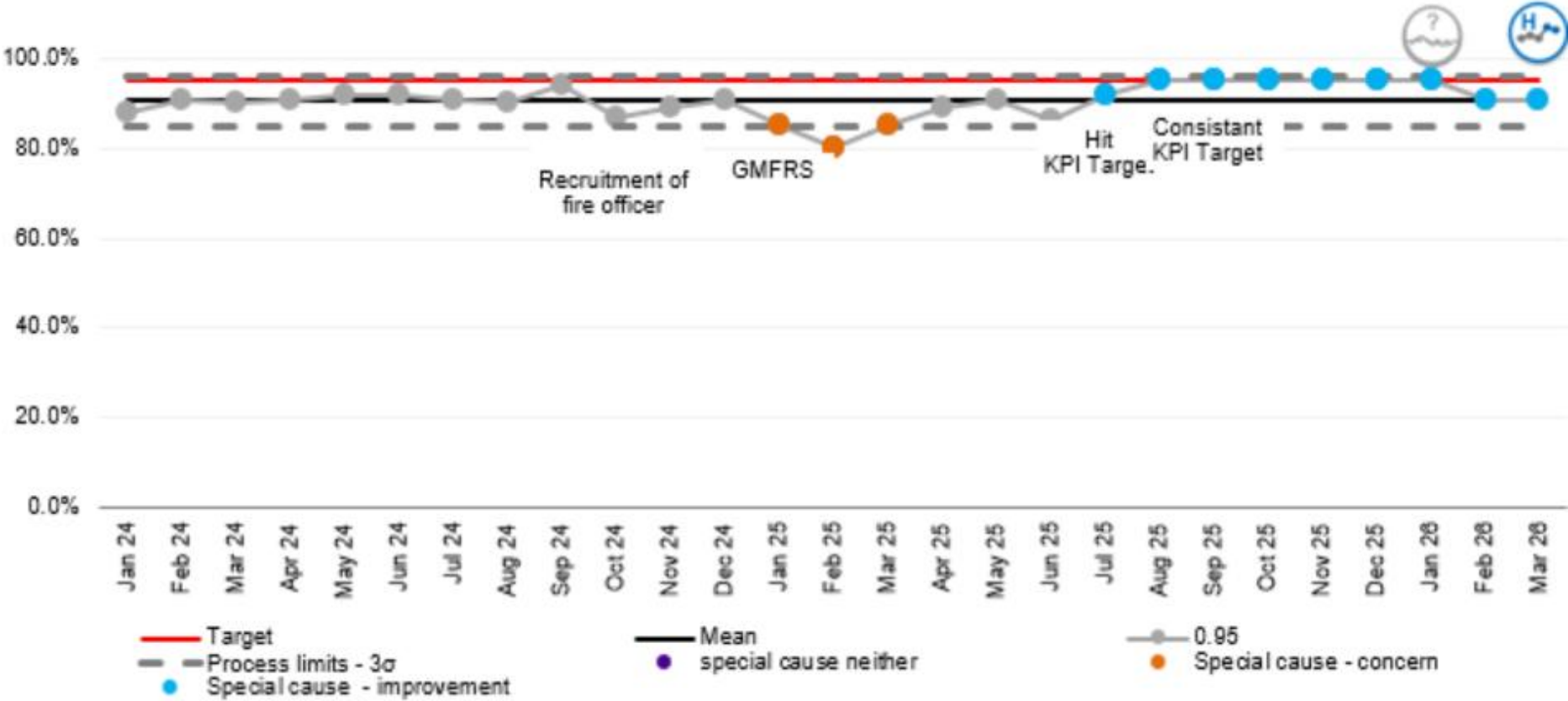
During 2025/26, FRA compliance achieved 90%, representing a 5% reduction from 2024/25. Despite this decrease, compliance continues to be monitored now via the Group Health & Safety Committee (GHSC), previously this was the Joint Fire Safety Committee, with iFM Bolton continuing to provide competent fire safety support across the Trust estate.

The reduction in compliance is primarily due to the introduction of Primary Fire Risk Assessments (Primary FRAs) in 2025. These more detailed assessments were implemented following national learning from the Grenfell Tower disaster and focus on building-wide fire safety risks, including compartmentation, structural fire protection, escape routes, external wall systems and fire safety management arrangements.

The requirement to complete both Primary and Secondary FRAs concurrently has increased the workload for Fire Safety Officers and temporarily impacted completion rates. This was reported through the GHSC and will continue to be monitored through established governance arrangements.

Figure 19 shows monthly performance during the reporting period. Overall, iFM Bolton completed 90% of 191 scheduled FRAs, with progress reviewed monthly through the Fire Safety Committee and GHSC assurance processes.

Figure 19. Compliance figures covering the period 01 April- 31 Mar 26



Fire Safety Governance

Fire safety performance was overseen by the Joint Fire Safety Committee for most of 2025/26, with governance transferring to the Group Health & Safety Committee (GHSC) during the year. The Fire Safety Dashboard continued to provide assurance and support escalation of any identified concerns through the appropriate governance routes.

The dashboard monitors key performance indicators including:

- Unwanted Fire Signals (false alarms)
- Fire Risk Assessment (FRA) compliance

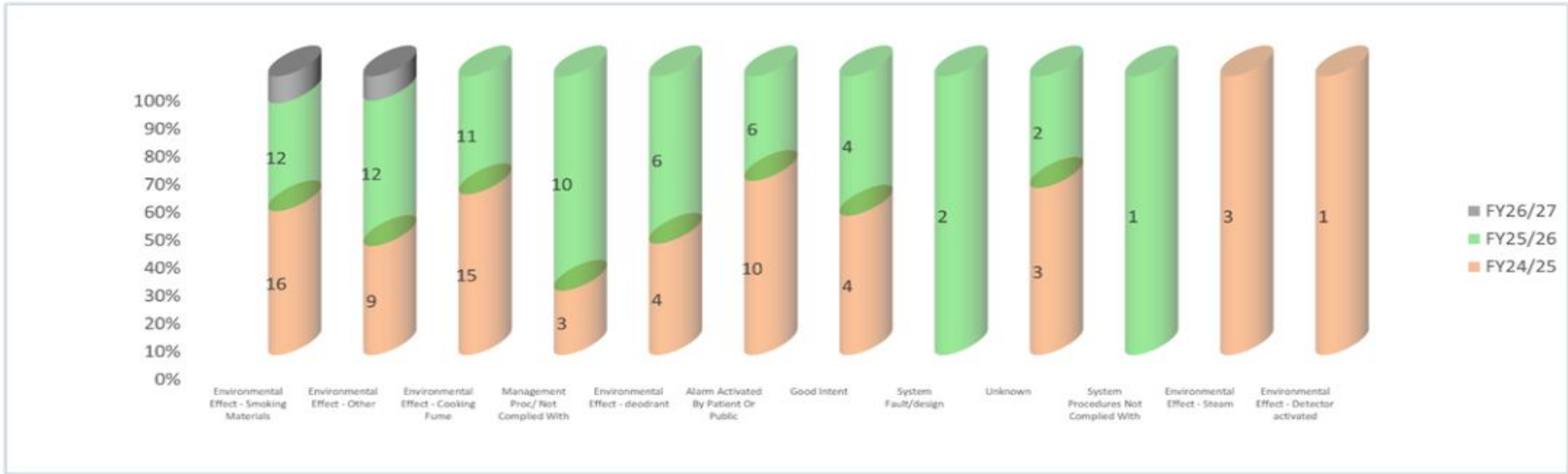
- Monthly FRA completion rates
- Outstanding fire safety actions and due dates
- Unwanted Fire Signals (UwFS) - (False Alarms)

An unwanted fire signal (false alarm) occurs when a fire alarm activates for reasons other than a genuine fire, such as cooking fumes, steam, dust, equipment faults, accidental activations, or work activities.

During 2025/26, a total of 66 false alarms were recorded, representing a small improvement on the previous year, with 2 fewer incidents. As shown in Figure X, environmental factors, particularly cooking and smoking fumes, remained the most common causes of false alarms, although incidents from these sources reduced compared with 2024/25.

Performance continues to be monitored through the Fire Safety Dashboard, providing assurance that trends are identified and addressed through established governance arrangements.

Fig 20. Environmental factors



As shown above, environmental factors—particularly cooking and smoking fumes—remained the leading cause of false alarms in FY25/26. Encouragingly, incidents attributed to these sources have decreased when compared with the previous year’s figures.

Present Risks

Compartmentation

Background

Compartmentation is a key fire safety measure that limits the spread of fire, smoke and heat, protecting patients, staff and visitors while supporting safe evacuation and firefighting activities.

Current Position

Work to address compartmentation deficiencies across both clinical and non-clinical areas remains ongoing. Funding for non-clinical works is progressing through the capital programme, while clinical works are being delivered through the ward decant programme.

Several areas have already been completed through the deep clean programme, including C3, B1, B3, C2 and A4. Phase 2 has commenced following approval of the business case, with works planned across C3, D3, F3 and D1. Completion of all identified works is expected within the next two financial years.

In the interim, risks are managed through:

- Trust-wide evacuation procedures.
- Mandatory fire safety training.
- Fire detection and alarm systems.
- Support from specialist response personnel, including Fire Safety Officers and EPRR staff.

These controls continue to provide assurance and support compliance with NHS EPRR standards.

Fire Incidents 2025/26

The Trust recorded two fire-related incidents during 2025/26.

Incident 1 – Fly-Tipped Waste Fire (30 April 2025)

A small fire involving fly-tipped waste outside the Diabetes Centre was identified and extinguished by a staff member before it could spread. No injuries or property damage occurred.

Key Learning

- Fly tipping presents a potential fire and security risk.
- Prompt staff action prevented escalation.
- Actions have been completed with local authority, community safety and policing partners to reduce future risk and improve reporting arrangements.

Incident 2 – Computer on Wheels (COW) Fire (3 June 2025)

A small equipment-related fire safety incident occurred during the reporting period. Staff responded promptly in line with emergency procedures, the equipment was isolated, and no injuries were reported.

Key Learning

- The device had been connected using an incorrect power cable after the original cable was lost.
- The unit may have been moved whilst connected to the mains supply, causing damage to the connector.

Actions:

- Only approved charging cables are to be used.
- Equipment must be disconnected before movement.
- Planned preventative maintenance (PPM) inspections will continue to ensure equipment remains safe and serviceable.

iFM Bolton continues to support the Trust in managing fire safety risks and maintaining compliance across the estate.

Security:

Security Team – Staffing and Assurance

The iFM Bolton Security Team continued to provide security support across the Royal Bolton Hospital site, with appropriately licensed and trained officers in place to support staff, patient and visitor safety.

The Group Security Committee, a subcommittee of the Group Health & Safety Committee, did oversee for the first part of this reporting period security standards and arrangements to manage risk to staff, patients and visitors. Security now reports directly into the Group Health and Safety Committee:

- Security and lone worker risk assessment compliance.
- Emerging security risks and controls.
- PMVA and Conflict Resolution training compliance.
- Learning from security-related incidents.
- Security Risk Assessments

The Security Team supports departments in completing annual security risk assessments, with actions recorded and managed through the Trust Risk Register.

Compliance (2025/26):

- Royal Bolton Hospital: 98% (May 2026)
- Community Sites: 100% (May 2026)
- External buildings (e.g. J & K Blocks): 95%
- Royal Bolton Hospital was 99% compliant in April 2026.

Additional Assurance

A member of the Security Team qualified as a PMVA Trainer in November 2024, providing additional support for Trust and iFM training requirements.

Future Plans

- Planned improvements to access control arrangements will continue to be progressed through the relevant governance and capital planning processes.
- All iFM Bolton security policies have been reviewed and updated.

Asbestos:

Asbestos Management

Arrangements

iFM Bolton maintains arrangements to comply with asbestos legislation through the identification, assessment and ongoing management of asbestos-containing materials (ACMs). This includes maintaining an Asbestos Management Plan, ensuring staff and contractors receive appropriate information and training, and regularly monitoring the condition of known ACMs.

For leased premises, iFM Bolton seeks assurance from landlords through the provision of current asbestos surveys and management documentation. Anyone undertaking work on Trust premises must be made aware of any known ACMs within the work area, and any suspected asbestos incidents must be reported immediately.

Inspections and Monitoring

A new specialist asbestos contractor was appointed during 2025/26 to undertake inspections and provide expert advice. There are currently 49 locations on the asbestos register requiring annual inspection, all of which were completed during the reporting period. The number of locations is expected to reduce following the demolition of Davenport House.

Refurbishment and Demolition (R&D) surveys have increased due to ongoing estate improvement projects, supporting the safe removal or management of asbestos where required. ACMs that remain in good condition are managed in situ and monitored in line with HSE guidance.

Incidents and Training

No asbestos-related incidents were reported during 2025/26.

The specialist contractor delivered annual refresher training to Estates and Health & Safety staff, ensuring continued competence in asbestos awareness and management.

Summary

Compliance is maintained through regular inspections, up-to-date risk assessments, staff training, contractor controls and effective management of the asbestos register. All asbestos-related activities have been undertaken in accordance with relevant legislation and HSE Approved Codes of Practice, ensuring asbestos risks remain effectively controlled across the Trust estate.

Ventilation/heating and Temperature Control:

Ventilation Safety

The Ventilation Safety Group (VSG) operates in line with the NHS England Premises Assurance Model (PAM) and provides joint governance between the Trust and iFM Bolton. The group oversees ventilation safety, compliance and risk management, ensuring systems meet relevant legislation and NHS guidance, including HTM 03-01.

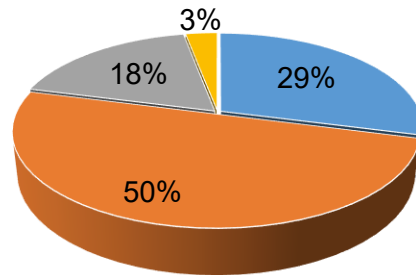
Chaired by the Deputy Director of Infection Prevention and Control, the VSG meets bi-monthly and reports to both the Group Health and Safety Committee and Infection Prevention and Control Committee.

Key Findings

The VSG continues to monitor the condition and performance of critical ventilation systems across the estate. A programme of maintenance, investment planning and replacement is in place to support ongoing compliance and safe clinical environments.

Fig 21. Breakdown on condition on current Critical Air Handling Units

Percentage Condition of The Trust Critical Ventilation Systems
2025/26



■ Good ■ Average ■ Poor ■ End of life

Risk Management

The risks associated with these systems are recorded on the Trust Risk Register and monitored through the Risk Management Committee.

Ventilation-related risks are recorded and monitored through the Trust's risk management framework, with controls and improvement actions overseen through the relevant governance committees.

Current Controls

- Building Management Systems monitor temperatures and system performance.
- Annual ventilation condition audits inform maintenance planning.
- Backup fan motors are available for critical systems.
- Additional measures are implemented during periods of extreme temperatures.

Actions and Assurance

A business case is being developed to secure funding for the replacement and upgrade of ageing ventilation systems.

During 2025/26, ventilation issues identified within the Elective Care Centre (ECC) theatres were reviewed and rectified following assessment by the Authorised Engineer (Ventilation). Lessons learned from the commissioning process have been identified and will be incorporated into future ventilation projects.

Water Safety:

Water Safety Group

The Trust's Water Safety Group (WSG) operates in line with NHS and legislative requirements, providing oversight of water safety risks across the estate. Chaired by the Deputy Director of Infection Prevention and Control, the group meets bi-monthly and reports to the Group Health and Safety Committee and Infection Prevention and Control Committee. No issues requiring escalation were identified during 2025/26.

Key Achievements 2025/26

- Developed new water safety training resources to support implementation of the updated Water Safety Policy.

Strengthened assurance processes for low-use outlet flushing regimes to reduce the risk of stagnation and microbial growth.

- Updated and approved the Water Safety Plan, including confirmation of Responsible, Authorised and Competent Persons.
- Enhanced the site's Water Business Continuity Plan to improve resilience during service disruptions.
- Introduced a new contractor to deliver an enhanced water quality monitoring programme, including:
 - Legionella temperature and sampling checks.
 - Pseudomonas sampling in augmented care areas.
 - Improved digital reporting, audit trails and automated alerts.

These arrangements provide continued assurance that water systems are managed safely and remain compliant with relevant legislation and NHS guidance.

Occupational Health:

Occupational Health and Wellbeing

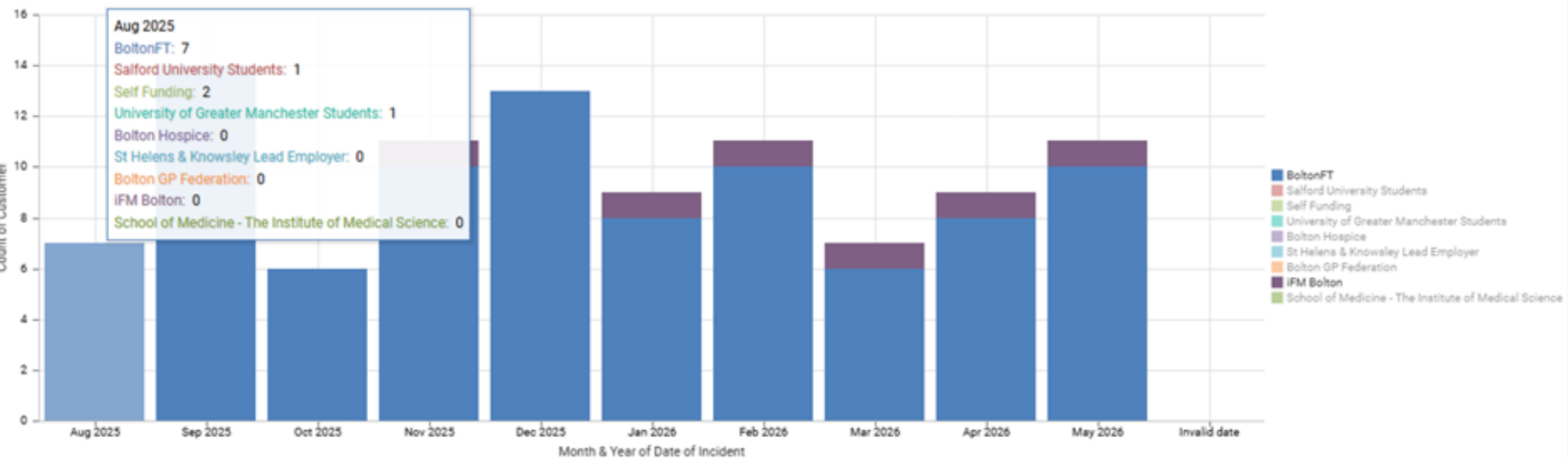
Occupational Health and Wellbeing continues to support staff health through occupational health services, vaccination programmes, health surveillance, infectious disease management, and a range of wellbeing initiatives.

The introduction of the OPAS-G2 system and a new departmental management structure in August 2025 has improved data quality, reporting, and service oversight. In March 2026, the department successfully renewed its SEQOHS accreditation, demonstrating continued compliance with recognised occupational health quality standards.

Key Updates

- Since August 2025, there have been no RIDDOR-reportable sharps or splash incidents, despite an average of approximately eight reports per month. Future reports will include divisional breakdowns to support targeted improvement actions.
- 16 health surveillance appointments were scheduled in June for Plaster Room staff, with the programme now being extended to iFM staff.
- Since August 2025, 8 staff members have undergone skin surveillance assessments, with no RIDDOR-reportable cases identified.
- A same-day drop-in service remains in place to support early identification and prevention of work-related dermatitis.
- These arrangements continue to provide assurance that staff health risks are effectively monitored and managed, supporting workforce wellbeing and safety.

Fig 21. Staff Needle Stick reported incidents since August 2025



- None were RIDDOR reportable where previously on average approximately 8 were report per month. This report moving forward will identify Divisional breakdown

Action Annual Report 24/25 Actions:

Action	By Whom	By when	Update
Ventilation: Produce and submit a Business Case to secure funding to upgrade/replace ventilation system	iFM Bolton supported by Trust Water Safety Group	Sept 25	Not Completed: The AHU in 'end of life' condition and four of the AHUs in 'poor' condition are in the process of being replaced. Three AHUs in average condition will be replaced with new AHUs. This action is moved to Action 2026/27
Manual Handling Training: To produce and introduce a revised iFM Manual Handling course for its staff, aligned to the Trust Manual Handling training standards/expectation	Manual Handling Advisor	Aug 25	Not Completed. Discussion had started with representatives from iFM Bolton but Trust MH Advisor took Maternity Leave June 25-June 26. This action is to be pick up for inclusion in 26/27.
Manual Handling: Post Falls Process and Equipment Flowchart Update jointly with Enhanced Care Lead to ensure effective post falls process is in place including staff training to enable them to utilise all equipment available in the event of a fall.	Manual Handling Advisor	Aug 25	Completed. This was completed May 25, information available on Trust Intranet. For review May 2027.

Fire Safety: Building Fire Risk Assurances (FRA), now with the iFM Fire Safety Team fully staff their aim is for iFM Bolton to achieve at least the compliance figure of 95% by June 2025	iFM Fire Safety Team	Jun 25	Completed. iFM Fire Safety Team achieved this 95% figure by June 2025.
Security: iFM Bolton to have installed by the end of 2025 new CCTV system for the hospital, which will provide a better visual deterrent across the building assisting with any issues that arise helping both GMP and the Trust.	IFM Security	Dec 25	Not completed. Due to a financial review this project is currently on hold UFN. (until further notice)
Health and Safety: To ensure that compliance reporting covering the requirement for staff to access to workplace risk assessments, becomes a mandatory Agenda item within the Group Health and Safety Committee meetings along with Divisions submitting a status of in date workplace risk assessments presented in sequence with the Annual H&S Compliance Calendar	Health and Safety Team	Sept 25	Completed. Divisional Assurance reporting is embedded within the Group Health and Safety Committee meetings

Action Annual Report 26/27 Actions:

Action	By Whom	By when	Update
Ventilation: Produce and submit a Business Case to secure funding to upgrade/replace ventilation system	iFM Bolton supported by Trust Water Safety Group	Apr 27	
Manual Handling Training: To produce and introduce a revised iFM Manual Handling course for its Porter staff, aligned to the Trust Manual Handling training standards/expectation	Manual Handling Advisor	Apr 27	
Security: iFM Bolton to installed by the end of the reporting period a new CCTV system for the hospital, which will provide a better visual deterrent across the building assisting with any issues that arise helping both GMP and the Trust. (If financially viable)	IFM Security	Apr 27	
Litigation: Improve Cost Control and Claims Monitoring Action: Introduce quarterly claims performance reporting: • Number of claims • Costs vs excess thresholds • Trends by department/location Rationale: Better visibility will support earlier intervention.	Litigation Team	Apr 27	
Fire Safety:	Fire Safety Team	Apr 27	

Align Fire Risk Assessments with Ongoing Refurbishment Works. Ensure Fire Risk Assessments (FRAs) are reviewed and updated following all major refurbishment and demolition (R&D) works. Rationale: Increased R&D activity introduces changes in layout, compartmentation, and fire risks that must be reflected in FRAs. Outcome: Maintains compliance with the Regulatory Reform (Fire Safety) Order.			
Divisional Actions: Family Care & Diagnostics Implement urgent recovery plan for Level 3 training Target lowest compliance areas first (currently 47.95% overall, L3 at 20.18%) Medicine Prioritise Level 4 training completion (high-risk area) Focus resources on staff needing L4 (current overall 40.71%, L4 27.09%) Surgery Improve access to Level 3 training Address backlog in L3 completion (currently 47.51%) Community Maintain and sustain current performance (63.38%) Share best practice as a benchmark model across divisions People & Development Actions (PMVA Training Delivery) Increase availability of PMVA training sessions: Add evening and weekend sessions Deliver training closer to staff: Expand local/divisional-based sessions. Improve accessibility: Introduce ward-based / “pop-up” sessions for hard-to-release staff. Divisional Governance Teams & Risk Actions Include PMVA compliance in: Divisional risk registers (especially low-performing areas). Violence & aggression incident reviews. Monitor compliance regularly. Escalate where required:	Divisions supported by People & Development	Apr 27	

Ongoing low compliance will be monitored through divisional governance arrangements and escalated through Trust committees where required.			
--	--	--	--

Report Title:	Safeguarding Annual Report 2025 - 2026			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 2026		Discussion	
Executive Sponsor	Chief Nursing and Quality Officer		Decision	

Purpose of the report	To provide assurance on the effectiveness of the Trust's safeguarding arrangements, statutory compliance, learning, and improvement activities during 2025/26
-----------------------	---

Previously considered by:	Clinical Effectiveness Group
---------------------------	------------------------------

Executive Summary	This report provides substantial assurance that effective safeguarding arrangements are in place across Bolton NHS Foundation Trust and demonstrates compliance with the NHS Safeguarding Accountability and Assurance Framework. Strong assurance is provided through robust governance and executive oversight, comprehensive audit and quality assurance arrangements, sustained compliance across the majority of safeguarding training requirements, successful implementation of CP-IS Phase 2, strong multi-agency partnership working, and significant progress in safeguarding compliance and assurance activities during 2025/26.
	The report demonstrates effective leadership, statutory compliance and a strong culture of learning and continuous improvement. The principal area requiring continued focus during 2026/27 is Adult Safeguarding Level 3 training compliance, which remains below the Trust target and will be subject to enhanced divisional oversight and monthly review. Additional priorities include strengthening outcome-focused reporting, improving evidence of the voice of the adult, demonstrating the impact of safeguarding interventions and learning, and maintaining oversight of workforce pressures within Looked After Children's Services. These areas are recognised within existing governance arrangements and are supported by improvement plans.
	This report provides assurance that the Trust's safeguarding arrangements remain effective and continue to mature, with clear priorities identified to further

	strengthen safeguarding quality, assurance and outcomes during 2026/27.
--	---

Proposed Resolution	The Board of Directors is asked to receive the Safeguarding Annual Report 2025/26, take assurance that effective safeguarding arrangements are in place across the Trust, and note the key risks, challenges and improvement priorities identified for 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 financial implications for ongoing training and system improvements. Utilising eLearning to provide alternative resources and updating intranet pages
Legal/ Regulatory	Yes	Statutory safeguarding obligations upheld for 2025-2026 . Alignment with key legislation and guidelines
Impact on Health Inequalities	Yes	High volume of safeguarding referrals indicates potential health inequalities. Responsive to the needs of our population
Impact on Equality, Diversity and Inclusion	Yes	Implementation of 'Making Safeguarding Personal' approach promotes person-centred care. Review of referrals and DoLS applications alongside audit to check the impact
Is a Quality Impact Assessment required	No	This is an overall report on all the work completed during 2025/26, showing how the team have been responsive to our population needs.

Prepared by:	Corporate Safeguarding Team	Presented by:	Tyrone Roberts, Chief Nursing and Quality Officer
---------------------	-----------------------------	----------------------	---

Glossary	
ADASS	Association of Directors of Adult Social Services
ALTE	Apparent Life-Threatening Event
BoSCA	Bolton System of Care Accreditation
BSAB	Bolton Safeguarding Adults Board
BSCP	Bolton Safeguarding Children's Partnership
CEDAM	Child Exploitation Disruption and Missing Meeting
CoramBAAF	Legally compliant health and social work report forms used across the UK to assess and track children in care.
CP-IS	Child Protection Information Sharing
CTLP	Counter -Terrorism Local Profile
DARA	Domestic Abuse Risk Assessment
DASH	Domestic Abuse, Stalking and 'Honour'- based abuse. The DASH risk checklist helps practitioners identify and understand the risk that victims of domestic abuse are facing.
DoLS	Deprivation of Liberty Safeguards
DSP	Designated Safeguarding Person (Children's Partnership)
FGM	Female Genital Mutilation
ICB	Integrated Care Board
IFD	Integrated Front Door
IHA	Initial Health Assessment
LAC	Looked after Child (Child in Care)
LADO	Local Authority Designated Officer
LMNS	Local Maternity and Neonatal System
LSCPR	Local Safeguarding Child Practice Review
MALM	Multi-Agency Liaison Meeting
MARAC	Multi-Agency Risk Assessment Conference
MATAC	Multi-Agency Tasking and Co-ordination
MBRRACE	Mother and Babies: Reducing Risk through audits and Confidential Enquiries
PIPoT	Person in a Position of Trust
PSCAT	Provider Safeguarding Assurance Toolkit
RHA	Review Health Assessment
SAAF	Safeguarding Accountability & Assurance Framework
SARC	Sexual Assault Referral Centre
SEG	Safeguarding Effectiveness Group (Underpins BSAB and BSCP)

Safeguarding Annual Report 2025 – 2026

Safeguarding Adults, Children, Looked After Children and Maternity

Authors

Fiona Farnworth, Named Nurse Children's Safeguarding

Sheila Mooney, Named Nurse Adults Safeguarding

Nicola Plimley, Named Nurse Looked After Children

Jayne Maguire, Named Midwife Safeguarding

Angela Clough, Associate Director of Patient Safety and Quality

Contents

	Page No
Foreword	3
Reflecting Back	3
Introduction	5
Ambition 1: Improving Care, Transforming Lives • Safeguarding Activity • Adults Safeguarding • Mental Capacity Act and Deprivation of Liberty Safeguards • Children's Safeguarding • Looked After Children • Complex Safeguarding and Exploitation • Maternity Safeguarding • Female Genital Mutilation • Domestic Abuse • Prevent and Radicalisation • Making Safeguarding Personal	6 - 14
Ambition 2: A Great Place To Work • Safeguarding Training • Safeguarding Supervision • Workforce Development and Professional Support	15 - 16
Ambition 3: A High Performing Productive Organisation • Safeguarding Governance • Safeguarding Assurance • Audit and Quality Improvement • Risk	17 - 20
Ambition 4: An Organisation Fit For The Future • Digital Safeguarding • Data, Intelligence and Reporting • Innovation and Improvement • Future Workforce Sustainability	21 - 23
Ambition 5: A Strong System Partner • Bolton Safeguarding Childrens Partnership • Bolton Safeguarding Adult Board • Multi Agency Reviews and Learning • Prevent Partnerships • Corporate Parenting	23 - 27
Looking Forward: Next Steps	27
Conclusion	28
Glossary	29
Appendices	31 - 33

Foreword

Safeguarding remains a fundamental responsibility of Bolton NHS Foundation Trust and is integral to our commitment to delivering safe, person-centred care. Throughout 2025/26, the Trust continued to strengthen its safeguarding arrangements through improved training compliance, robust governance, active participation in multi-agency partnerships, and a strong focus on assurance and quality improvement.

During the year, the Trust demonstrated significant progress against the Greater Manchester Safeguarding Standards, increasing compliance from 46 fully compliant standards out of 86 at the start of the year to 81 fully compliant standards out of 86 by year end, with the remaining 5 standards being partially compliant. There were no remaining non-compliant standards. The safeguarding team across adults, children, looked after children (LAC) and maternity continued to respond effectively to increasing demand and complexity.

While notable achievements have been made, challenges remain, particularly around Safeguarding Adults Level 3 compliance, workforce capacity within LAC services, and system-wide delays in Deprivation of Liberty Safeguards (DoLS) authorisations.

Reflecting Back / Year in Review

The Trust has maintained effective safeguarding arrangements throughout 2025/26 and continues to meet its statutory responsibilities within the NHS Safeguarding Accountability and Assurance Framework.

The Trusts Priorities for 2025/26, recorded in the previous annual report, are evidenced below (table 1) with an update on the progress

2024/25 Priority	2025/26 Position	Assessment
Update internal and external website	The internal and external websites have been updated throughout the year, with clearer detail and supporting documents evidenced internally, and a clear statement on the role of Safeguarding on the external website. The oversight of the websites will be an ongoing piece of work to ensure all appropriate and relevant information is available to our staff and the people we serve.	Achieved

Further focus on capturing the voice of vulnerable adults, children and young people	Voice of the Child activity continued, partnership engagement strengthened and safeguarding practice increasingly references lived experience. The voice of the adult remains a challenge, and work is being undertaken across Bolton Safeguarding Adults Board to support this across the locality.	Partially achieved
Move to automated statutory returns for Looked After Children and develop EPR/BI reporting	External data reporting has remained compliant through the year however this remains a manual data collection at present. A DQUIP has been completed and progress is in place along with BI to determine how to support ongoing automation of the data. Health assessments have been added to the EPR system and are currently in the test phase to determine if these support better information recording and to determine if the use of these documents may support ongoing BI work for data collection.	Well progressed Partially achieved
Annual audit outcomes report to support learning	Extensive safeguarding audit programme delivered across adults, children, LAC and maternity services with findings informing improvement work now referenced in Annual Audit report	Achieved
Quality assure Section 42 process	Section 42 processes have been reviewed through a task and finish group and a table top exercise. Regular meetings with LA to ensure collaborative working to inform progress. Trust SOP developed.	Achieved

Table 1

Alongside the priority work detailed above, further notable achievements have been realised throughout the year. Where challenges have been identified, these have been actively monitored and managed through the Trust Safeguarding Committee to support ongoing improvement and assurance.

Key Achievements

- Significant improvement in Greater Manchester provider safeguarding standards compliance which demonstrates robust alignment with the ICB and National statutory frameworks therefore providing assurance to the Trust that we can demonstrate how we maintain relevant patient safety standards, legal compliance and regulatory requirements.
- Sustained compliance above 95% across the majority of Level 1 and Level 2 safeguarding training requirements.
- Successful implementation of CP-IS Phase 2.
- 100% safeguarding supervision compliance achieved within maternity services.

- Strong engagement with Bolton Safeguarding Children Partnership and Bolton Safeguarding Adults Board.

Key Challenges

- Safeguarding Adults Level 3 compliance remains below Trust target of 95%
- Ongoing delays in DoLS authorisations across all Local Authority partners.
- Medical workforce pressures affecting LAC statutory health assessments.
- Increasing complexity of child exploitation, domestic abuse and Prevent-related activity.

Introduction

This annual report provides assurance regarding the Trust's safeguarding arrangements for children, young people and adults at risk.

The report reflects compliance with:

- Children Act 1989 and 2004
- Care Act 2014
- Mental Capacity Act 2005
- Domestic Abuse Act 2021
- Working Together to Safeguard Children
- NHS Safeguarding Accountability and Assurance Framework

The report summarises activity, achievements, risks, audits, learning and priorities during 2025/26.

This report provides an overview of safeguarding practice across the Trust, highlighting key developments, achievements and areas of progress during the reporting period. It offers assurance that the Trust is meeting its statutory safeguarding obligations and sets out the priorities for 2026/27, reflecting the continued commitment of the Organisation and the Safeguarding Service to delivering safe, effective and responsive safeguarding arrangements.

Safeguarding includes the early identification and/or prevention of harm, all forms of exploitation, and abuse by adherence to national guidelines and legislative frameworks. The promotion of independence and wellbeing whilst maintaining dignity and advocating choice is paramount therefore the communication of a clear safeguarding vision and mission is necessary to promote the importance of safeguarding to all.

This Safeguarding Annual Report reflects our safeguarding journey over the past year, highlighting the progress made both within the Trust and in partnership with key agencies across the wider safeguarding system. Safeguarding remains at the heart of everything we do. It is the golden thread that runs through every contact, intervention and interaction, helping to create a network of support that protects, empowers and promotes the wellbeing of those who may be at risk of harm.

Ambition 1:

Improving Care Transforming Lives

Delivering Safe, Effective and Compassionate Care

Safeguarding in Action

The following feedback demonstrates the impact safeguarding professionals have on patients, families and clinical teams across Bolton NHS Foundation Trust.

“xx went above and beyond to support a family following the sudden death of a child ... This included liaising with other professionals; collecting prescriptions from pharmacy and delivering directly to the family home to avoid further distress at having to return to the hospital and also ensure the antibiotics were taken in a timely manner as required. She took time while she was there to offer bereavement support and listen to their concerns. These are all not direct roles in her safeguarding job but she did this in the best interests of the child and family and this should be acknowledged and commended”

“Support in managing children in ED who presented in crisis (3 children over 2 weeks) ... no medical needs and did not require an admission. xx provided advice and support to ED staff, escalated appropriately to Trust managers and Children's Social Care. The needs and voice of the child were a priority in difficult and challenging circumstances”

“I just wanted to let you know how impressed I have been in the team working with the young person I support. She had been expecting her second baby who was born yesterday. She had had a hugely traumatized childhood which led to a very difficult birth experience with her first child. The team have put so much work, empathy and compassion into supporting, that she had an experience which was much more in line with her safety, as well as her wishes and feelings”

The safeguarding team are available to provide advice and support to our teams. The number of referrals received per quarter (table 2) can be identified below.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total 2025/26
Adult referrals	716	746	643	796	2901
Children's referrals	1494	1444	1233	1232	5403

Table 2

Adult safeguarding referral activity remained consistently high throughout 2025/26, with a small increase (less than 1%) compared to the previous year. The Safeguarding Team has maintained effective oversight of referrals, with the majority managed through internal safeguarding processes where Section 42 criteria were not met but safeguarding advice, support and coordination remained necessary.

Analysis of referral themes has continued to inform service development, training priorities and safeguarding assurance activity. The most common themes included domestic abuse, self-neglect, neglect and acts of omission, concerns relating to care provision, financial abuse and exploitation. Individuals with dementia, cognitive impairment and mental health needs featured prominently within safeguarding activity, reflecting the increased vulnerability of these groups.

The complexity of safeguarding concerns has continued to increase, with cases frequently requiring multi-agency involvement and consideration of factors such as social isolation, frailty, carer stress and family breakdown. The Trust has responded through ongoing workforce development, strengthened safeguarding support and oversight arrangements, and continued partnership working to ensure risks are identified, managed and escalated appropriately. This provides assurance that safeguarding concerns are recognised, responded to and monitored in line with statutory and organisational requirements.

The Children's Safeguarding Team saw a small increase in referral activity during 2025/26 (less than 2% compared to the previous year), with referral numbers remaining consistently high throughout the reporting period. Ongoing analysis of safeguarding activity has enabled the Trust to identify and respond to emerging trends in a timely manner.

Mental health concerns continued to be a significant feature of safeguarding referrals, including self-harm, suicidal ideation, suicide attempts, overdose presentations and parental mental health concerns impacting on parenting capacity. Quarterly reporting identified.

1.2 Adult Safeguarding

A formal adult safeguarding enquiry under Section 42 of the Care Act 2014 is undertaken or commissioned by the Local Authority where concerns are raised about an adult with care and support needs who may be experiencing, or at risk of, abuse or neglect and is unable to protect themselves. The Adult Safeguarding Team supported this process and participated in approximately 37 safeguarding enquiries during 2025/26, a similar number to the previous year.

Through oversight of Section 42 enquiries, Bolton NHS Foundation Trust's Adult Safeguarding Team has provided advice, support, professional challenge and assurance to ensure safeguarding risks were appropriately identified and managed. Learning from enquiries has informed local practice improvements, including the introduction of pre-meetings with clinical teams to clarify concerns, identify required actions and support timely responses to Local Authority enquiries. Meeting minutes are shared to improve accountability and oversight of actions. The team has also promoted the Section 42 Standard Operating Procedure and developed a safeguarding concerns template in partnership with Bolton Council, improving the clarity and consistency of information shared and reducing the need for further clarification. Learning relating to documentation, mental capacity assessments and multi-agency communication has been disseminated through safeguarding forums, supervision and team discussions, supporting continuous improvement in safeguarding practice and outcomes for Bolton residents at risk of abuse or neglect.

1.3 Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

Mental Capacity Act and Deprivation of Liberty Safeguards training is not mandatory, however it is included within the L3 adult training, the Trust also delivers standalone training which is facilitated by the MCA/DoLS Lead Practitioner.

In certain cases, the restrictions placed upon a person who lacks capacity may amount to "deprivation of liberty". This must be judged on a case-by-case basis. Where a deprivation of liberty might happen, the Trust must apply to the local authority where the patient normally resides.

During 2025/26, the Trust submitted 634 Deprivation of Liberty Safeguards (DoLS) applications, of which 12 were authorised by the relevant local authority. The low number of authorisations reflects delays within the local authority process rather than any failure by the Trust to meet its statutory responsibilities. The Trust continued to submit all appropriate applications and follow required safeguarding processes to protect patients' rights and wellbeing. This issue remained under regular review through the Trust Risk Register, providing assurance that appropriate oversight and controls were in place and that the Trust was not at organisational risk. The matter was escalated throughout the year to the Safeguarding Effectiveness Group and Bolton Safeguarding Adults Board to ensure system-wide awareness and oversight. New legislation affecting the DoLS process was introduced prior to publication of this report and will continue to be implemented during 2026/27.

1.4 Children's Safeguarding

The number of children subject to a Child Protection Plan in Bolton continued to rise throughout 2025/26, increasing from 318 in March 2025 to 428 in March 2026, representing a 35% increase. Neglect remained the predominant category of concern, followed by emotional abuse, reflecting the continued impact of domestic abuse on children and families.

The Trust maintains oversight of children subject to Child Protection Plans through active participation in multi-agency safeguarding processes. The Specialist Nurse for Safeguarding Children attends the monthly Child Protection Plan review panel for children who have been subject to a plan for 12 months or more. This provides an additional level of scrutiny of the health contribution to Child Protection Plans and enables appropriate challenge, professional support and escalation where required.

No new Bolton-based Child Safeguarding Practice Reviews were initiated during Quarters 1 to 3; however, the Trust continued to contribute to peer reviews, rapid reviews and learning reviews, ensuring organisational learning and shared safeguarding intelligence are embedded into practice. Increased review activity during Quarter 4 highlighted recurring themes relating to neglect, child sexual abuse, trauma-informed practice, professional curiosity and the voice of the child. These themes have informed ongoing safeguarding training, audit activity and service development.

The Trust continues to strengthen child-centred safeguarding practice. Evidence of this includes the involvement of care-experienced young people in service development, trauma-informed approaches to exploitation and child-focused discharge planning. Assurance activity has demonstrated increasing recognition of the child's voice within safeguarding practice; however, audits have identified opportunities to improve the consistency of recording and evidencing children's views within clinical documentation. This remains a focus for ongoing quality improvement and safeguarding assurance activity during 2026/27

1.5 Looked After Children

Looked after children remain one of the most vulnerable groups within our communities, often having experienced abuse, neglect, family breakdown, parental illness or bereavement. Increasing numbers of unaccompanied asylum-seeking children have also experienced trauma, exploitation or trafficking, contributing to additional health and wellbeing needs.

Bolton NHS Foundation Trust continues to provide statutory health assessments and wider health support for looked after children, ensuring their health needs are identified, reviewed and addressed through multi-agency care planning. At the end of 2025/26, there were 653 children in the care of Bolton Local Authority and 717 looked after children accessing Trust services, a position comparable to the previous year.

Performance against statutory assessment requirements is monitored monthly through established governance arrangements and reported to the Integrated Care Board. Between April 2025 and March 2026, the Trust completed 214 Initial Health Assessments, with 89% completed within statutory

timescales, and 682 Review Health Assessments, with 95% completed within timescales. Whilst activity levels increased significantly compared to the previous year, with a 19% increase in Initial Health Assessments and a 36% increase in Review Health Assessments, performance remained stable, providing assurance regarding the resilience and responsiveness of the service.

The service continues to monitor and address factors affecting timeliness, including workforce pressures, out-of-area placements, placement instability, engagement challenges and delays in receiving information from partner agencies. Targeted actions, including enhanced performance monitoring, workforce planning specifically relating to the medical role which is being managed within the Community Services Division, escalation processes and collaborative work across Greater Manchester, have been implemented to mitigate these risks and support continued improvement. Performance for children residing within Bolton remains strong, with the greatest challenges continuing to relate to children placed outside the borough.

In addition to statutory assessment activity, the Looked After Children's Nursing Team provides ongoing health advocacy, care coordination and safeguarding support throughout the year. This includes contributing to multi-agency meetings, supporting transitions, escalating unmet health needs and working closely with partner agencies to improve health outcomes for looked after children and care leavers.

Feedback from children, young people and carers has been consistently positive, highlighting the value of relationship-based practice, effective communication and the support provided by the service. This feedback is routinely reviewed and used to inform service development, workforce training and continuous quality improvement, providing further assurance that the voices of children and young people remain central to service delivery.

This version moves beyond describing activity and provides assurance around performance, governance, risk management, quality improvement and service responsiveness.

1.6 Complex Safeguarding and Exploitation

Complex safeguarding remained a significant area of focus throughout 2025/26. The Trust maintained active involvement in the identification, assessment and management of children and young people affected by exploitation, serious youth violence and other contextual safeguarding risks. Quarterly data submissions were provided to the Greater Manchester Complex Safeguarding Hub, supporting oversight of activity and emerging risk patterns. Throughout the year, the number of children and young people open to exploitation pathways ranged between 22 and 32, with safeguarding teams working closely with multi-agency partners to support those at risk of child criminal exploitation, child sexual exploitation, county lines involvement, missing episodes and serious youth violence.

The Trust continued to demonstrate effective multi-agency engagement through participation in local and Greater Manchester forums relating to child exploitation, transitional safeguarding, serious youth violence and missing children. This provided assurance that safeguarding risks were being identified,

escalated and managed through established partnership arrangements, with appropriate health representation contributing to planning and decision making.

Health assessments consistently identified a range of unmet needs amongst vulnerable children and young people, including emotional and mental health difficulties, physical health needs, substance misuse, sexual health concerns, trauma, bereavement and neurodiversity. The Trust has continued to promote trauma-informed and child-centred approaches to safeguarding, ensuring that assessment, intervention and support arrangements reflect the complexity of children's lived experiences and vulnerabilities.

Multi-agency audit and peer review activity provided assurance regarding the quality of safeguarding practice, identifying strengths in relationship-based working, health engagement and trauma-informed interventions. Where opportunities for improvement were identified, including transitional safeguarding arrangements, information sharing, supervision and the consistent recording of the child's voice, these have informed service improvement plans and ongoing safeguarding priorities for 2026/27.

The Trust also continued to work proactively with Greater Manchester Police, Public Health and partner agencies in response to concerns relating to nitrous oxide misuse. Safeguarding intelligence and health data were used to support disruption activity, preventative interventions and harm reduction approaches. Subsequent monitoring demonstrated the value of early identification and multi-agency collaboration in responding to emerging safeguarding risks affecting children and young people.

Overall, the Trust has maintained effective oversight of complex safeguarding activity throughout the year, demonstrating strong partnership working, robust health involvement in multi-agency processes and a continued commitment to improving outcomes for children and young people at risk of exploitation, violence and other contextual harms.

1.7 Maternity Safeguarding

Throughout 2025/26, maternity safeguarding activity remained robust, with the Named Midwife for Safeguarding and the Enhanced Midwifery Team (EMT) providing leadership, oversight and support for women, unborn babies and families with complex safeguarding needs. Key areas of focus included early risk identification, multi-agency working, safeguarding supervision, statutory reporting and continuous quality improvement.

The EMT managed a high volume of complex cases, receiving 454 referrals, of which 207 were referred to the Local Authority and 74 resulted in interim care orders. Referral themes were consistently linked to domestic abuse, current children's social care involvement and women who had previously had children removed from their care.

Multi-agency working remained a key strength, with close collaboration across children's social care, safeguarding teams, commissioners and partner agencies to support pre-birth planning, child protection processes, safe discharge arrangements and information sharing. The Named Midwife also contributed to safeguarding reviews, audits and learning activity. Learning from case reviews

reinforced the importance of timely escalation, professional curiosity and robust multi-agency planning for families experiencing significant adversity.

Emerging themes included domestic abuse, maternal mental health concerns, social care involvement, previous child removals, delays in pre-birth assessments, the absence of allocated social workers in some cases, and the need for early intervention and coordinated planning. The service continued to support families through complex safeguarding pathways where there were concerns regarding parenting capacity and risks to unborn babies and children.

Overall, maternity safeguarding services demonstrated strong leadership, effective governance and sustained partnership working. High levels of safeguarding supervision, compliance with statutory reporting requirements, proactive audit activity and the management of complex cases provided assurance that vulnerable women, babies and families received timely support, assessment and intervention.

1.8 Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) remains a key safeguarding priority, and the Trust continues to maintain robust arrangements to ensure compliance with statutory responsibilities, mandatory reporting requirements and safeguarding guidance. Healthcare professionals are supported to identify, assess and respond appropriately to FGM through training, policy guidance and specialist safeguarding advice.

During 2025/26, 209 women with a history of FGM were identified within Trust services, all within Maternity Services. Assurance was gained through audit and case review processes, which demonstrated that FGM risk assessments were completed in all identified cases to assess potential risks to female children within the family, including newborn infants. No cases met the threshold for mandatory reporting under the FGM reporting duty.

The Trust remained fully compliant with mandatory FGM reporting requirements throughout the year, with no identified breaches or concerns relating to statutory reporting arrangements. Ongoing oversight is provided through safeguarding governance processes, supported by regular audit, quality assurance activity and review of safeguarding practice.

Audit findings demonstrated continued improvement in the identification, assessment and documentation of FGM, reflecting the impact of targeted staff training, policy development and enhancements to electronic recording systems. Where opportunities for improvement were identified, these related primarily to the consistency of demographic data collection and documentation standards, and actions have been implemented to address these areas.

Analysis of FGM activity continues to inform workforce development, awareness raising and quality improvement initiatives. Learning identified through audit and assurance processes has been

incorporated into service development plans, strengthening the Trust's ability to identify risk, safeguard children and young people, and meet its statutory safeguarding obligations. Overall, the Trust can provide assurance that effective systems and controls are in place to support the identification, management and reporting of FGM.

1.9 Domestic Abuse

We define domestic abuse as an incident, or pattern of incidents, of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in most cases by a partner or ex-partner, but also by a family member or carer, this is quite common.

Domestic abuse is a complex issue that is known to impact on the health and wellbeing of the victim and wider family and individuals. Domestic abuse takes place across all socioeconomic, cultural and gender groups. Irrespective of age, ethnicity, marital status, disability, sexuality, or lifestyle. Both men and women may perpetrate or experience domestic abuse.

The negative impact of domestic abuse can be huge for health and wellbeing; therefore, it is important to have the right guidance in place for staff to feel safe and supported at work to identify domestic abuse and escalate as appropriate.

Victims of domestic abuse were supported through safeguarding referrals, MARAC processes, IDVA engagement and multi-agency working.

The Trust continues to research both adults and children's cases that are being discussed at the weekly MARAC meetings, data across the year included 1366 cases discussed, 852 of these with child involvement, impacting on 1793 children. Also discussed were cases where the victim was aged 16/17 (36) and where the perpetrator was aged 16/17 (21).

1.10 Prevent and Radicalisation

Throughout the reporting period, Prevent remained a key safeguarding priority for Bolton NHS Foundation Trust, supported by strong governance arrangements, active multi-agency engagement and high levels of workforce compliance, with Prevent training consistently maintained above 95%. During the year 3 Prevent referrals were made demonstrating staff awareness and engagement with their safeguarding responsibilities in relation to Prevent.

The Trust also maintained ongoing involvement in Channel processes, with safeguarding staff providing specialist health advice, contributing information to screening and assessment processes, attending Channel Panels and supporting intervention planning where required. Emerging themes during the year included an increase in requests for health information relating to children and young people, particularly around concerns involving fascination with mass violence, school shootings, misogynistic ideologies and online influences. Referrals increasingly involved young people with diagnosed or emerging neurodevelopmental needs, including autism spectrum conditions, alongside wider vulnerabilities associated with complex safeguarding concerns and serious youth violence.

These trends further highlight the close relationship between Prevent, exploitation, serious youth violence and other complex safeguarding issues, reinforcing the importance of coordinated multi-agency responses and early intervention to reduce risk and support vulnerable individuals.

Learning from national incidents, including those involving online radicalisation, mass violence and youth vulnerability, has reinforced the importance of early identification, professional curiosity and effective multi-agency information sharing.

1.11 Making Safeguarding Personal

Capturing and responding to the voice of the child, adult and family is a key component of effective safeguarding practice. The examples below illustrate how listening to lived experience has informed decision-making, improved care and strengthened safeguarding outcomes across the Trust.

A care experienced young person shared her experiences by inviting staff to “walk in her shoes” during a Patient Experience Reporting Group meeting, describing how during a difficult period she had been labelled as a “bad child.” She spoke openly about experiencing a placement breakdown and the significant impact this had on her emotional wellbeing, including feelings of being overwhelmed, anxious, and labelled. The young person then reflected on the support she received during this difficult period and explained how this helped bring about positive changes in particular the support she receives from her care placement. She also shared her hopes and aspirations for the future, demonstrating her resilience and progress. This powerful narrative promotes the voice of the child and enhances staff understanding of the impact of trauma, encouraging a more compassionate, trauma-informed approach to practice.

“I cannot believe how amazing the specialist nurse has been we couldn’t have asked for more – thank you”

The Safeguarding Team provided strong leadership, coordination and advocacy throughout the patient’s journey. By identifying risks of self-neglect and exploitation, preventing discharge to an unsafe environment, coordinating multi-agency support, challenging decisions where necessary and ensuring the patient’s views remained central to planning, they helped create the conditions for improved health, recovery, independence and hope for the future

"When I was admitted to hospital, I didn't realise how bad things had become. Having people stick with me and not give up helped me start thinking differently about my future. For the first time in a long time, I felt listened to. I wanted to get away from drugs, improve my health and have somewhere safe to live. The support I received gave me hope that things could change."

Ambition 2:

A Great Place to Work

Supporting and Developing our People

2.1 Safeguarding Training

Training remains a key safeguarding priority, ensuring staff have the knowledge and skills required to recognise and respond to safeguarding concerns. Table 3 demonstrates Trust compliance against mandatory safeguarding and Prevent training requirements.

Compliance with Safeguarding Adults and Children Level 1 and 2 training, together with Prevent training, remained consistently above required standards throughout 2025/26. Whilst Safeguarding Level 3 compliance continued to improve, sustaining compliance within some staff groups remains a challenge and will continue to be a focus for 2026/27, with the requirement for divisional leads (nursing and medical) to provide a monthly update to Deputy Chief Nurse and Deputy Medical Director.

Key

	Meets Trust compliance target of 95%			
	Does not meet Trust compliance target but meets GM ICB compliance target of 90%			
	Below compliance target			
Training Level	%Trust Compliance Q1 25/26	%Trust Compliance Q2 25/26	%Trust Compliance Q3 25/26	%Trust Compliance Q4 25/26
Safeguarding Adults Level 1	96.61%	97.28%	96.97%	94.19%
Safeguarding Adults Level 2	97.27%	97.02%	97.62%	95.70%
Safeguarding Adults Level 3	81.26%	84.75%	79.55%	85.43%

Safeguarding Children Level 1	96.39%	96.57%	96.56%	93.23%
Safeguarding Children Level 2	96.69%	96.10%	96.06%	95.11%
Safeguarding Children Level 3	91.97%	92.52%	92.63 %	91.78%
Basic Prevent Awareness	96.20%	96.92%	96.50%	95.64%
Prevent	95.14%	95.87%	96.07 %	95.63%

Table 3

Specialist training was delivered in areas including Mental Capacity Act and Deprivation of Liberty Safeguards (MCA/DoLS), Child Protection Information Sharing (CP-IS), Looked After Children, Domestic Abuse and Maternity Safeguarding. Learning from audits, safeguarding reviews and emerging themes, including exploitation, serious youth violence, trauma-informed practice and professional curiosity, was incorporated into training programmes throughout the year.

In line with the Intercollegiate Documents, Named Professionals maintained Level 4 competencies through continuing professional development, safeguarding supervision, peer review, audit activity, safeguarding reviews and participation in local and regional safeguarding partnerships. This ensured ongoing compliance with national competency requirements and supported expert safeguarding leadership across the Trust.

2.2 Safeguarding Supervision

Safeguarding supervision is a key element of the Trust's assurance framework, supporting reflective practice, complex decision-making and staff wellbeing. Children's safeguarding practitioners continued to provide supervision, advice and case consultation across the organisation, alongside support for staff managing vulnerable children, young people and families.

Within maternity services, safeguarding supervision arrangements remained well established, with 100% supervision compliance achieved throughout the year, providing assurance that staff managing complex maternity safeguarding cases received regular professional support and reflective supervision.

Professional oversight of Looked After Children services continued through Named Nurse leadership, audit activity, peer review and specialist practitioner support. During 2025/26, the Trust also progressed the development of a formal Adult Safeguarding Supervision Framework and supporting policy in line with Greater Manchester safeguarding standards, strengthening future supervision arrangements across adult services.

2.3 Workforce Development and Professional Support

Throughout 2025/26, the safeguarding team provided specialist advice, education and professional support across all Trust divisions. This included support for staff managing complex safeguarding concerns relating to children and adults, domestic abuse, exploitation, MCA/DoLS, serious youth violence and multi-agency safeguarding processes.

Safeguarding professionals contributed to divisional governance, policy development, audits, case reviews and safeguarding reviews, providing expert advice, challenge and support. Staff feedback continues to demonstrate the positive impact of the safeguarding team in strengthening knowledge, supporting decision-making and improving safeguarding practice across the organisation.

Examples of staff feedback are included below.

“xx was superbly helpful, professional, supportive and excellent in managing a case which I was involved in. Going the extra mile to provide me with help, advice ... and as always so helpful ... was additionally emotionally supportive to myself. I am very grateful for all her hard work and outstanding effort”

“xx gave brilliant advice as usual ... listens to what your concerns are and looks at the problem from many angles. She is incredibly knowledgeable and really understands the priorities when keeping someone safe and communicates this very well. I was feeling like I was not able to help a patient and was struggling with my job, xx was able to help me see that the actions I took were ultimately required and necessary to help this patient find safety”

‘Since you have come into this role I have noticed a lot more consistency for our over 16's in regards to their health needs being highlighted and addressed. It is really beneficial having you at reviews as teenagers often don't share all their health needs in the meeting. It is great that you do your best to attend as many reviews as possible as this allows you to gather information and highlight any health needs for our YP that other professionals may miss

Ambition 3:**A High Performing, Productive Organisation****Governance, Assurance and Performance****3.1 Safeguarding Governance Framework**

The Trust has established robust safeguarding governance arrangements to provide assurance that statutory safeguarding responsibilities are being discharged effectively. Board-level oversight is provided by the Chief Nursing Officer, with responsibility delegated to the Deputy Chief Nurse, who maintains oversight of safeguarding performance, compliance, risks and improvement activity through the Trust Safeguarding Committee.

The Trust Safeguarding Committee meets quarterly and provides formal oversight of safeguarding arrangements across adults, children, young people, Mental Capacity Act and Deprivation of Liberty Safeguards. The Committee receives regular assurance regarding compliance with safeguarding legislation, national guidance, regulatory requirements and contractual standards, whilst monitoring safeguarding performance, risks, incidents, audits, reviews and action plans.

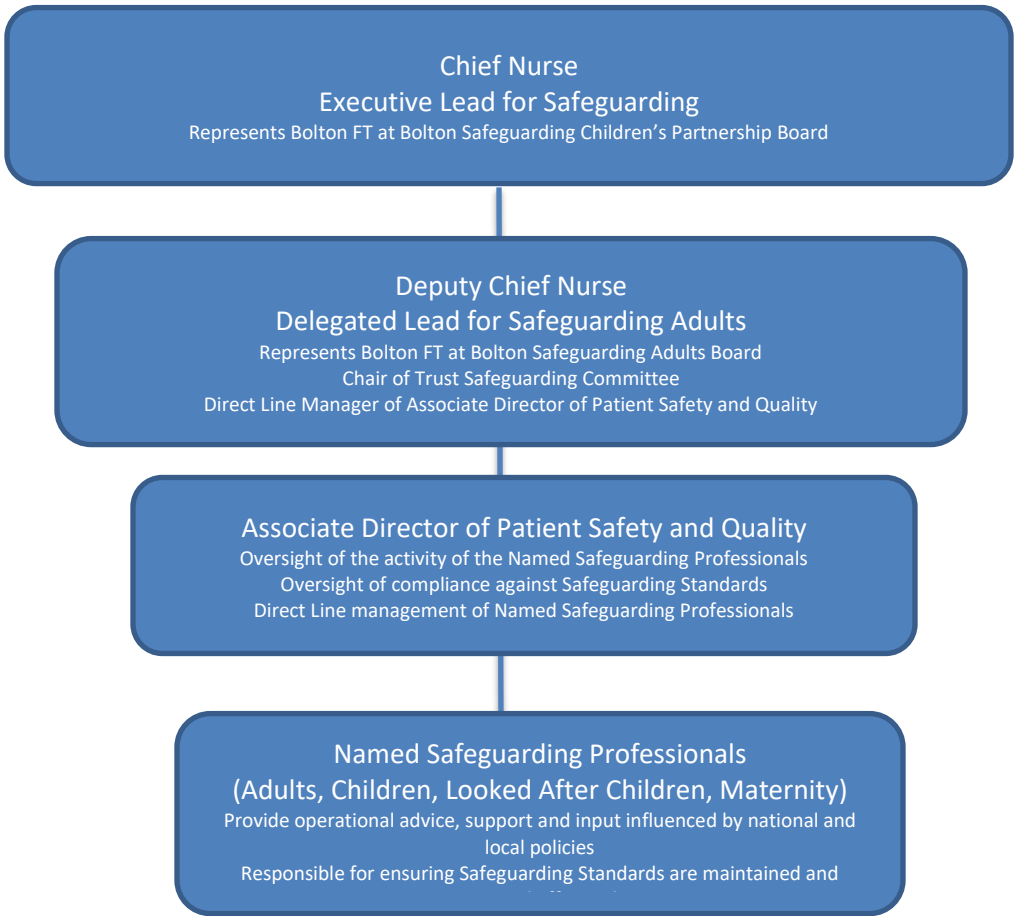
Throughout 2025/26, the Committee has maintained oversight of safeguarding priorities, reviewed areas of risk and challenge, monitored progress against improvement plans and supported the escalation of issues requiring further organisational or system-wide action. This has ensured that safeguarding remains a key organisational priority and that emerging risks are identified, managed and escalated appropriately.

Membership includes all Trust Named and Specialist Safeguarding Professionals together with divisional representatives, providing a multidisciplinary approach to assurance and governance. Divisions provide regular reports to the Committee, outlining safeguarding activity, performance, risks, learning and areas requiring support. This enables both divisional and corporate oversight of safeguarding practice and supports organisational learning and continuous improvement.

The Committee also benefits from engagement with partner agencies, including Designated Professionals from the Integrated Care Board and representation from local safeguarding partnerships. This supports effective partnership working, shared learning and system-wide safeguarding assurance.

The Trust Safeguarding Committee reports through the Trust governance structure to the Patient Safety and Experience Group, providing regular assurance regarding safeguarding performance, statutory compliance, emerging risks and improvement activity. Quarterly Chair's Reports utilise an alert, advisory and assurance framework to ensure that significant issues, achievements and areas of concern are clearly communicated and appropriately escalated.

These governance arrangements provide assurance that safeguarding systems and processes are subject to regular scrutiny, that safeguarding risks are identified and managed appropriately, and that the Trust maintains effective oversight of its safeguarding responsibilities across all services.



3.2 Safeguarding Assurance

During 2025/26, Bolton NHS Foundation Trust made significant progress in meeting and evidencing compliance against the Greater Manchester Safeguarding Contractual Standards. Key achievements included sustained improvements in safeguarding training compliance, successful implementation of Child Protection Information Sharing (CP-IS) Phase 2, strengthening of safeguarding supervision arrangements, enhanced governance and audit processes, development of adult safeguarding supervision and Section 42 frameworks, and the review and implementation of a range of safeguarding policies and procedures. The Trust further strengthened its safeguarding assurance

through robust multi-agency engagement, improved information sharing arrangements, enhanced Mental Capacity Act and Deprivation of Liberty Safeguards oversight, and the establishment of a comprehensive audit programme. These developments have provided greater assurance that safeguarding responsibilities are embedded throughout the organisation and that staff are supported to deliver safe and effective care to children, young people and adults at risk.

3.3 Audit and Quality Improvement

During 2025/26, the Trust delivered a comprehensive safeguarding audit programme across adult, children's, looked after children and maternity services, providing assurance regarding compliance with statutory requirements, safeguarding legislation, national guidance and Trust policies.

Key findings and actions included:

- **Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS):** Audits identified areas for improvement in documentation, recording of capacity assessments and best interest decision-making. In response, the Trust introduced targeted training, revised documentation, enhanced electronic recording systems and strengthened governance oversight.
- **Domestic Abuse:** Audit activity identified variation in the completion of routine enquiry and risk assessments. Actions implemented included additional staff training, strengthened monitoring arrangements and the development of dashboard reporting to improve oversight and compliance.
- **Children's Safeguarding:** Audits provided assurance regarding the quality of safeguarding referrals, health assessments, child protection processes and court reports. Multi-agency audit feedback identified health contributions as satisfactory or good, with positive feedback received regarding the quality of court report submissions.
- **Maternity Safeguarding:** Audit findings demonstrated improvements in domestic abuse enquiry processes and Female Genital Mutilation (FGM) assessment, documentation and reporting. Learning has informed policy updates, specialist training and improvements to electronic systems.
- **Compliance Monitoring:** Reviews against relevant NICE guidance, safeguarding standards and statutory requirements demonstrated overall compliance, with identified improvement actions monitored through governance processes and re-audit programmes.

During 2025/26, Structured Judgement Reviews, have been reviewed to identify safeguarding themes and opportunities for learning. The findings provided assurance that safeguarding processes were generally effective, with evidence of strong multidisciplinary working, family engagement and

appropriate use of legal safeguards for vulnerable patients. Areas for improvement relating to capacity assessments, DoLS processes, documentation and communication were identified. Learning from all reviews is shared through governance processes and incorporated into workforce development, audit and quality improvement programmes to strengthen safeguarding practice across the Trust.

Audit findings have directly informed policy development, workforce training, digital improvements and service change throughout the year. Action plans are monitored through established governance arrangements, providing assurance that learning is embedded, improvements are tracked and safeguarding practice continues to strengthen across the organisation.

3.4 Risk

Safeguarding risks are monitored corporately through the Trust's governance framework. The Safeguarding Team maintains a risk register, which is reviewed quarterly by the Safeguarding Committee, with oversight provided by the Trust Risk Management Committee.

At the start of 2025/26, two safeguarding risks were recorded on the Patient Safety and Experience Risk Register, one relating to the contractual requirement to implement a Trust-wide Reducing Restrictive Practice Policy, and one relating to delays in Deprivation of Liberty Safeguards (DoLS) authorisations. The original DoLS risk (Appendix 2) was closed in April 2025 to ensure the risk description accurately reflected the current position and mitigation activities following the appointment of a Mental Capacity Act (MCA)/DoLS Lead. A revised DoLS risk was subsequently added to the register to reflect the ongoing challenges associated with authorisation delays.

At year-end, two safeguarding risks remained on the register, relating to the implementation of reducing restrictive practice arrangements and the continued delays in DoLS authorisations (Appendix 3). All risks are supported by action plans that are regularly reviewed and monitored to ensure effective mitigation, ongoing oversight, and continuous improvement in safeguarding practice.

Ambition 4:

An Organisation That's Fit for the Future

Developing Future Safeguarding Services

4.1 Digital Safeguarding

During 2025/26, the Trust continued to strengthen its digital safeguarding infrastructure, improving information sharing, statutory compliance, oversight and organisational assurance.

Key developments included:

Successful implementation of Child Protection Information Sharing (CP-IS) Phase 2, with access extended to additional services, including the 0-19 Service and Sexual Health Services, improving the identification of children who are Looked After or subject to a Child Protection Plan.

Enhancements to electronic patient record systems to improve the recording, visibility and monitoring of:

- Domestic abuse concerns
- Safeguarding referrals
- Mental Capacity Act assessments
- Deprivation of Liberty Safeguards (DoLS)
- Female Genital Mutilation (FGM)

Development and successful testing of dedicated FGM functionality within the maternity electronic patient record, strengthening compliance with statutory recording and reporting requirements.

Continued collaboration with Business Intelligence teams and partner organisations to improve safeguarding dashboards, data quality and contractual reporting arrangements.

Improved access to safeguarding data and intelligence, supporting the identification of trends, monitoring of safeguarding activity and escalation of emerging risks through established governance processes.

These developments have strengthened the Trust's ability to record, monitor and report safeguarding activity, providing enhanced oversight and supporting timely safeguarding interventions, statutory compliance and informed decision-making across services.

4.2 Data, Intelligence and Reporting

During 2025/26, the Trust continued to develop safeguarding data collection and reporting processes to improve oversight, assurance and compliance. The Trust has achieved full compliance with NHS and ICB statutory data submission requirements, providing assurance regarding data quality, reporting accuracy and contractual performance.

Work has included the development of safeguarding dashboards and monitoring tools to support the identification of trends in referrals, domestic abuse activity, Mental Capacity Act and Deprivation of Liberty Safeguards processes, safeguarding training compliance and statutory safeguarding performance. New EPR developments and reporting functionality have strengthened organisational ability to monitor activity and respond to emerging risks

Trend analysis undertaken throughout the year identified several emerging safeguarding themes, including increasing presentations related to mental health crises in children and young people, child exploitation, serious youth violence, domestic abuse, unsafe sleep incidents, substance misuse and vaping, road traffic accident concerns, and neurodiversity within complex safeguarding cohorts. In adults, an increase in homelessness and self neglect was noted alongside providing intelligence to partner agencies in cases of “cuckooing” (home invasion), leading to a wider piece of work led by the BSAB relating to cuckooing.

Safeguarding intelligence was shared locally and across Greater Manchester, supporting preventative action and multi-agency responses

4.3 Innovation and Improvement

Throughout 2025/26, the Trust continued to strengthen and embed trauma-informed approaches across safeguarding services. Learning arising from care-experienced young people, safeguarding reviews, child exploitation activity and Family First developments has informed a more relationship-based approach to care and support. This learning has been incorporated into safeguarding practice, workforce development and service improvement activity, providing assurance that the impact of trauma, adversity and lived experience is increasingly recognised and considered within safeguarding interventions.

The Trust further strengthened its safeguarding assurance arrangements through the expansion of its audit programme, incorporating multi-agency audits, peer reviews and thematic reviews. A structured three-year safeguarding audit programme has been established, providing a systematic approach to monitoring compliance, identifying areas for improvement and evaluating the impact of safeguarding practice across services.

Learning identified through audits, rapid reviews, safeguarding reviews, peer reviews and partnership activity is reviewed through established governance processes and translated into action plans, policy updates, workforce training and service developments. Progress against improvement actions is monitored through safeguarding governance structures, providing assurance that learning is embedded, improvements are sustained and safeguarding practice continues to develop in response to identified risks, emerging themes and best practice.

4.4 Future Workforce Sustainability

Increasing safeguarding complexity, expanding contractual requirements, safeguarding reforms, audit expectations and workforce development responsibilities continue to place additional demands on specialist safeguarding services. Maintaining capacity to deliver assurance, training, supervision, quality improvement and partnership responsibilities will remain an important consideration in ensuring sustainable service delivery during 2026/27.

Ambition 5:

A Strong System Partner

Working Together to Safeguard Bolton

During 2025/26, Bolton NHS Foundation Trust continued to play an active role within both the Bolton Safeguarding Adults Board (BSAB) and Bolton Children's Safeguarding Partnership (BCSP), contributing to strategic safeguarding priorities, multi-agency learning, quality assurance and service improvement activity. The Trust maintained representation across a range of partnership boards, operational groups and multi-agency forums, ensuring that health perspectives informed local safeguarding arrangements and that learning from partnership activity was embedded within Trust practice

5.1 Bolton Safeguarding Children Partnership

Throughout the year, significant partnership focus was placed on the implementation of Working Together to Safeguard Children 2023, Children's Social Care Reform and the emerging Family First agenda. The Trust actively engaged in locality discussions and workstreams to support these developments and ensure alignment with evolving safeguarding expectations.

The BCSP also continued to prioritise:

- Child exploitation and contextual safeguarding.
- Serious youth violence.
- Child sexual abuse.
- Multi-agency information sharing.
- Trauma-informed practice.
- Corporate Parenting and outcomes for looked after children.
- Children presenting in crisis and mental health vulnerabilities.

The Trust contributed to multi-agency audits relating to child sexual abuse, Integrated Front Door referrals and child exploitation. Learning from these reviews highlighted the importance of professional curiosity, effective information sharing, health participation in strategy meetings and strengthening transitional safeguarding arrangements for vulnerable adolescents.

During 2025/26, the Trust continued to support implementation of the national Children's Social Care Reform programme, including the Family First Partnership model. The reforms aim to strengthen family help services, improve multi-agency working, reduce the number of children entering care where safe to do so, and ensure children and families receive the right support at the right time. Bolton FT has contributed to local planning and implementation arrangements, ensuring that health perspectives inform service development and that safeguarding practice remains aligned with

emerging national expectations. This work continues into 2026/27 and is led by the Local Authority transformation team, with Trust attendance as part of the steering groups and transformation board.

Emerging safeguarding reforms continue to place greater emphasis on transitional safeguarding, recognising the needs of young people moving between children's and adult services. The Trust will continue working with partners to strengthen pathways and support arrangements for vulnerable adolescents and care experienced young people.

5.2 Bolton Safeguarding Adults Board

The BSAB focused on a number of significant safeguarding priorities throughout the year, including:

- Access to mental health pathways and services.
- Deprivation of Liberty Safeguards (DoLS) delays and authorisation processes.
- Domestic abuse.
- Section 42 safeguarding enquiries.
- Self-neglect.
- Safeguarding Adults Reviews (SARs).
- Improving multi-agency safeguarding responses for adults with complex needs.

The Trust contributed to safeguarding effectiveness discussions and escalated concerns regarding the significant delays in DoLS authorisations, helping to ensure this issue remained a priority risk across the locality. Trust safeguarding staff also contributed to Safeguarding Adults Review activity and supported the dissemination of learning into operational practice.

5.3 Multi-Agency Reviews and Learning

A Safeguarding Adult review (SAR) is a multi-agency review process, triggered when an adult with care and support needs dies or suffers serious harm from known or suspected abuse or neglect and there is a concern about how local agencies worked together. The primary goal of a SAR is not to apportion blame but to identify lessons learned and to improve future multi agency safeguarding practices. Seven SARs/SAR-related reviews were identified in 2025/26. The predominant themes were mental health, multiple disadvantage, neglect/self-neglect, domestic abuse, exploitation/cuckooing, financial abuse, and challenges in multi-agency communication, care coordination, and service provision for adults with complex needs. Actions associated with these have predominantly included sharing the learning, with 7 minute briefings being presented at divisional safeguarding meetings and disseminated across the Trust, as well as Trust involvement in partnership working such as a cuckooing task and finish group to develop a campaign to increase awareness, and an increased focus on self neglect.

A children's safeguarding rapid review is a mandatory, multi-agency assessment triggered whenever a child dies or is seriously harmed and abuse or neglect is known or suspected. The Children's safeguarding team have been involved in 2 rapid reviews in 2025/26, providing reports as requested,

attending panel meetings and, along with staff from a range of services attending follow up practitioner events, one in Bolton that has concluded and one out of area that has not yet concluded.

The Safeguarding Children Team also made a referral to the Safeguarding Children Partnership following the sudden death of a care leaver however this was judged not to meet the criteria for a Rapid Review

Recommendations and actions from rapid reviews shared through the Trust Safeguarding Committee and to individuals involved, Team Leaders and Service Managers in 2025/26 include:

- Support for families where there are escalating challenging behaviours
- Children identified to be young carers
- Impact of parental substance use
- Importance of gathering details of the child's lived experience
- Aces and trauma – specifically the impact of bereavement and loss on families where children experience the death of their main carer
- Adultification – where children are falsely seen to be able to influence and control their environment and outcomes

The Trust has continued to actively contribute to Rapid Reviews, Child Safeguarding Practice Reviews and Domestic Abuse Related Death Reviews, ensuring that learning is identified, disseminated and embedded into practice through established safeguarding governance arrangements. Learning arising from a Rapid Review following a serious assault involving an adolescent identified opportunities to strengthen internal processes within 0-19 services and improve communication between health providers. In response, an audit of duty arrangements has been commissioned to provide assurance that safeguarding information is reviewed, acted upon and appropriately escalated. The review also reinforced the importance of professional curiosity, effective information sharing, recognition of significant adults within family networks and the application of transitional safeguarding principles. These themes have informed ongoing service development, practice discussions and workforce learning.

The Trust also contributed to two Child Safeguarding Practice Review processes during the reporting period. Whilst final reports are awaited, emerging learning has enabled early reflection and review of practice. Particular themes identified include the recognition and assessment of domestic abuse regardless of gender, consideration of the impact of domestic abuse on children within the household, and the need for equitable assessment of parenting capacity and risk. Learning from a Rapid Review involving an infant who sustained non-accidental injuries further reinforced the importance of professional curiosity, robust safeguarding assessment, consideration of the needs of fathers and male carers, and the identification of risk factors that may affect parenting capacity. The review highlighted the need to avoid optimism bias and ensure that information provided by families is considered alongside broader multi-agency intelligence and assessment. Assurance is provided through established governance arrangements that monitor safeguarding review findings, oversee

action plans and ensure learning is embedded through policy development, workforce education, audit activity and service improvement initiatives. Progress against identified actions is routinely reported through safeguarding governance structures, supporting continuous improvement and strengthening safeguarding practice across the Trust.

5.4 Prevent Partnerships

Trust safeguarding professionals continued to play an active role within local and Greater Manchester Prevent structures, including attendance at the Prevent Delivery Board, participation in multi-agency training, information sharing, and partnership work aligned to local safeguarding priorities. Learning from national incidents reinforced the importance of maintaining awareness of radicalisation risks across all services and ensuring Prevent remains embedded within safeguarding practice. Although the local Prevent Delivery Board was temporarily stood down during part of the year, collaborative work continued through established multi-agency networks, workforce development initiatives and early intervention activity.

5.5 Corporate Parenting

Bolton NHS Foundation Trust recognises its responsibilities as a Corporate Parenting Partner and is committed to improving the health, wellbeing and outcomes of looked after children and care leavers. The Trust works in partnership with local authorities, education providers and other agencies to address health inequalities and ensure children and young people receive timely access to healthcare and support.

During 2025/26, the redesign of the Corporate Parenting Board and development of the Looked After Children Strategic Plan strengthened local governance arrangements and the strategic framework for meeting statutory responsibilities. As a key partner, health services contributed intelligence relating to health needs, service access, placement stability and outcomes, helping to inform strategic decision-making and service planning.

Named and specialist safeguarding professionals continued to contribute to multi-agency forums, including the Corporate Parenting Board, Adoption and Fostering Panels and Permanency Panel. This ensured that the health needs of looked after children and care leavers remained central to care planning, permanence decisions and wider service development.

Priorities for 2026/27 include supporting delivery of the Looked After Children Strategic Plan, strengthening the voice of children and young people within service development, and continuing to improve health outcomes through partnership working and targeted support for vulnerable children and care leavers.

Looking Forward:

Priorities for 2026/27

Ambition	Next Steps
1 Improving Care, Transforming Lives	Strengthen Safeguarding outcomes reporting
	Enhance the voice of the adult and child
	Develop and implement a Domestic Abuse Action Plan
2 A Great Place to Work	Ensure training compliance continues to meet Trust standards, with a continued focus on Level 3 compliance
	Strengthen Safeguarding Supervision processes and reporting
3 A High Performing Organisation	Complete outstanding contractual standard actions and policy reviews
	Enhance Safeguarding quality assurance and outcome measurement
	Strengthen implementation and evaluation of learning from reviews and audits
4 Fit for the Future	Develop Safeguarding Dashboards to support oversight of themes, learning and information sharing
5 A Strong System Partner	Ensure National and Local Reviews recommendations are implemented and contribute to wider learning and improvements
	Continue to deliver partnership priorities and strategic plans

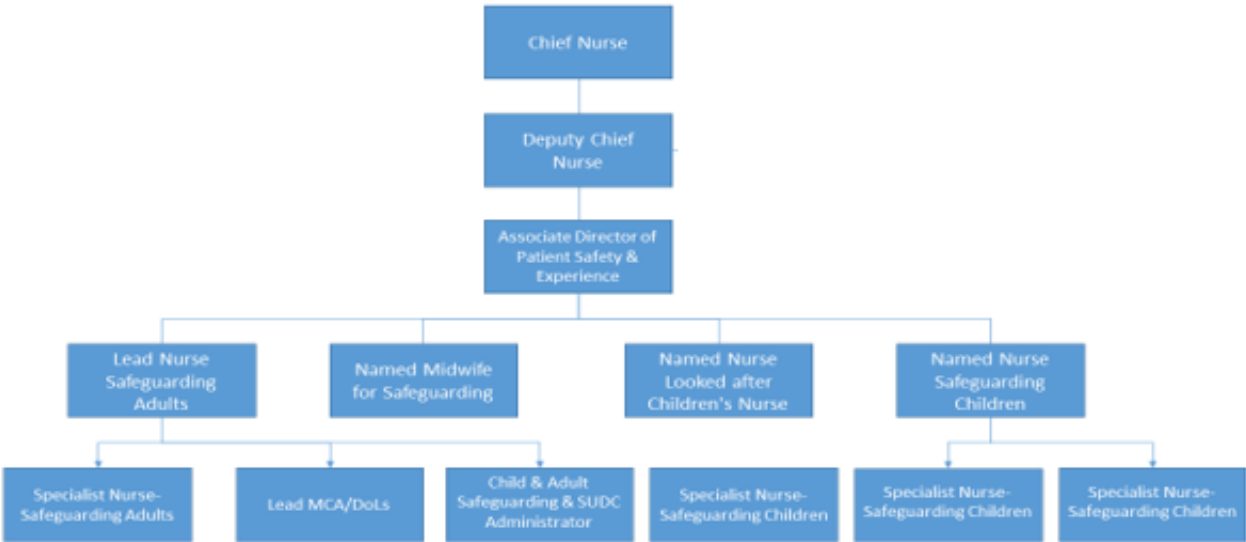
Conclusion

Throughout 2025/26, Bolton NHS Foundation Trust has continued to demonstrate a strong commitment to safeguarding, with robust governance arrangements, effective professional leadership and established systems in place to support the identification, management and escalation of safeguarding concerns. The Trust has maintained compliance with statutory safeguarding responsibilities and has continued to strengthen safeguarding practice through quality assurance activity, workforce development, audit, partnership working and service improvement initiatives.

Significant progress has been made during the year, including the further development of safeguarding governance, enhanced digital safeguarding systems, strengthened multi-agency working, implementation of safeguarding improvement programmes and continued compliance with Greater Manchester safeguarding standards and the Safeguarding Assurance and Accountability Framework (SAAF). Audit, review and assurance processes have provided evidence that safeguarding learning is identified, acted upon and embedded into practice across the organisation. Whilst a small number of challenges remain, including Adult Safeguarding Level 3 training compliance, workforce pressures within Looked After Children's Services and delays in external DoLS authorisation processes, these risks are understood, monitored through established governance arrangements and supported by clear improvement plans and executive oversight.

The Trust can therefore provide assurance that effective safeguarding arrangements are in place to protect children, young people and adults at risk, support staff in discharging their safeguarding responsibilities and ensure safeguarding remains a core organisational priority. The priorities identified for 2026/27 will build on the progress made to date, supporting continuous improvement and further strengthening safeguarding quality, assurance and outcomes for the populations we serve.

Appendix 1 – Corporate Safeguarding Team Structure



Appendix 2 Closed Risks (Closed 28/4/25)

Department Safeguarding Adult Team						
Number	Ver	Last Reviewed	Next Review	S x L = RR		
5535	14	28/04/2025	27/06/2025	3	2	6
No Actions in Place				If staff fail to complete a Mental Capacity Assessment and apply for a Deprivation of Liberty Safeguards based on the assessment for patients on enhanced care level 4 then there is a risk that these patients are being unlawfully deprived of their liberty to freely move around the ward and to leave the organisation		
Target Date				30/04/2025		
Control Type & Control Details				Gaps in Controls		
Policy/Guideline/Protocol Deprivation of Liberty Safeguards Policy.						
Working Practices All patients identified as level 3 or level 4 are reviewed by the enhanced care team. A conversation regarding DoLS is had at this review.						
Working Practices All patients enhanced care level 4 are reviewed by the MCA lead to ensure appropriate DoLS application completed						
Regular Committee Meeting / Group Numbers of DoLS referrals are reported via the safeguarding committee. Trends and numbers are reviewed.						
Policy/Guideline/Protocol All clinical areas are assessed via the BoSCA framework which details staff knowledge re DoLS and a review of safeguarding systems and processes.						
Performance Management Dashboard developed by BI to support monitoring of number of patients assessed as enhanced care level 4 with a DoLS in place						
Staff Training MCA training programme in place						
Policy/Guideline/Protocol Audit for policy now part of a wider audit process for safeguarding team, will support monitoring effectiveness of policy						

Appendix 3 Current Risks

Risk 6596 – DoLS Authorisation

Department Safeguarding Adult Team											
Number	Ver	Last Reviewed	Next Review	S x L = RR			Risk Description	Target Date			
6596	2	18/03/2026	17/05/2026	3	4	12	If the Supervisory Body (relevant Local Authority) is unable to fulfil its statutory duty to assess patients with a current Deprivation of Liberty Safeguards (DoLS) request within the Trust (legal requirement of Deprivation of Liberty Safeguards), then there is no assurance of scrutiny or oversight to ensure that the restrictions placed on these patients are lawful, leading to a potential unlawful deprivation of liberty for our inpatients. This will also impact on our regulatory responsibility to notify the CQC of these outcomes.	31/08/2026			
Control Type & Control Details							Gaps in Controls				
Policy/Guideline/Protocol The Trust has a policy in place with guidance on managing our DoLS applications to ensure that they are meeting the current legislation.											
Working Practices A review of all DoLS application form before being submitted to the Local Authority is undertaken by the MCA/DoLS Lead and with a backup by the safeguarding adults team.											
Regular Communications Weekly audit of current status is undertaken by the MCA/DoLS lead, with an update sent to Bolton Local Authority and fortnightly to other Local Authorities.											
Regular Communications Working closely with the Enhanced Care Team to ensure that legal framework is in place as required and any DoLS that may require escalation to the Local Authority.											
Staff Training Training is provided for all staff (although not mandated) on MCA and DoLS, which includes understanding of the legislation and how to put this into practice safely for our patients. The training is available on a monthly basis or bespoke where requested											
Partnership Working The MCA/DoLS lead maintains a database of all current urgent and standard DoLS application awaiting approval. This supports the monitoring of current patients being deprived of their liberty to allow regular communication with the relevant supervisory body to determine progress											
Partnership Working Quarterly updates to Bolton Safeguarding Adults Board (BSAB) Safeguarding Effectiveness Group to demonstrate position in relation to DoLS applications and approvals to ensure that this is noted as part of the BSAB risk register											
Completed Action											
Action 1	Owner	Angela Clough		Responsibility of		Helen Jones		Target Date	01/04/2026	Completed Date	25/03/2026
Details							Progress				
Close working with Bolton Local Authority DoLS team to develop a process to increase their compliance.							QI project has been completed. There continues to be developments to reduce this risk.				

Risk 6356 – Clinical Holding and Restraint

Department Safeguarding Adult Team									
Number	Ver	Last Reviewed	Next Review	S x L = RR			Risk Description	Target Date	
6356	5	23/02/2026	24/04/2026	3	3	9	If staff don't have the appropriate policy to follow in relation to safe least restrictive practice to support the current training offered by the Trust, then there is a risk that incorrect escalation and techniques could be used that may cause harm to our patients and/or staff members.	01/04/2026	
Control Type & Control Details						Gaps in Controls			
Policy/Guideline/Protocol A&E and Critical care have individualised processes that they follow: Management of Patients Presenting to Emergency Department with Mental Health Complaints Physical Restraints in Critical Care Guideline									
Working Practices All divisions have been asked to keep reporting and highlighting when any clinical holding or physical constraint has taken place to support data collection, deep dive to understand the current practices across the trust.									
Staff Training PMVA TNA in place with divisional and OD&L oversight and management									
Open Action									
Action 1	Owner	Angela Clough	Responsibility of	Rebecca Bradley		Target Date	01/05/2026	Completed Date	/ /
Details					Progress				
Task and Finish Group to complete current state policy. Expert advice to be sought from RRN Lead at GMMH					Policy sent to PDOG for final ratification - await final ratification and upload to trust documents page				
					Date Entered : 25/03/2026 12:19 Entered By : Angela Clough				

Report Title:	Chief Executive's Report			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 2026		Discussion	
Executive Sponsor	Deputy 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:	James Mawrey, Deputy Chief Executive	Presented by:	James Mawrey, Deputy Chief Executive
--------------	--------------------------------------	---------------	--------------------------------------

Ambition 1: Improving care, transforming lives

More [breast cancer survivors are now able to access specialist post-reconstruction care following the expansion of our Breast Unit's nipple tattoo service](#) at Royal Bolton Hospital. Nursing staff have undertaken specialist training to provide this treatment, which supports women who have undergone mastectomy and breast reconstruction as part of their cancer care. The service delivers more than 70 tattoos each year through dedicated clinics, helping patients achieve a more natural appearance and supporting confidence, wellbeing and recovery after breast cancer treatment.

Our [neonatal team has significantly improved outcomes for premature babies](#) through the introduction of a new delivery room respiratory care approach. Implemented as part of a quality improvement programme to reduce rates of bronchopulmonary dysplasia, the initiative has substantially reduced the need for invasive breathing support at birth. The proportion of babies born before 32 weeks requiring intubation in the delivery room fell from 68% to 35%, while rates for babies eligible for CPAP (Continuous Positive Airway Pressure) reduced from 70% to 12%. Increased use of less invasive treatments, including LISA (Less Invasive Surfactant Administration), has further enhanced care, with 85% of babies receiving the treatment avoiding the need for breathing tubes later, contributing to improved outcomes and a better experience for the most vulnerable newborn patients.

Two of our colleagues received [regional recognition at the North West Healthcare Science Awards for developing innovative solutions that improve patient care and experience](#). Clinical Scientist Jamie Osborne won the Research and Innovation Award for leading a project that enables people with prostate cancer to take blood samples at home, reducing the need for hospital visits and improving convenience for patients. Senior Clinical Scientist Lorenz Becker was also recognised as runner-up in the Data and Digital Transformation Award category. These achievements highlight the expertise of the Trust's healthcare scientists and their contribution to advancing patient care through research, innovation and digital transformation.

Our Discharge Facilitator Team continues to play a [vital role in supporting timely and safe discharges from Royal Bolton Hospital, helping more than 30 people return home each day following their treatment](#). Working closely with patients from the point of admission, the team coordinates with colleagues across health and social care to identify and address any barriers to discharge. Through daily collaboration with multidisciplinary teams, including nurses, doctors, pharmacists and therapists, Discharge Facilitators help ensure patients leave hospital as soon as they are medically ready, improving patient experience, supporting independence and helping to maintain hospital capacity.

Ambition 2: A great place to work

One of our community [nurses is celebrating after completing a prestigious leadership development programme](#), helping her build confidence, strengthen her leadership skills and connect with healthcare professionals across the country. After being nominated by her Matron, Claire Wright was selected by the Trust's Chief Nurse to be a part of the Florence Nightingale Foundation (FNF) programme. The

Florence Nightingale Foundation supports nurses and midwives to promote health, improve care and save lives by enabling access to leadership and development opportunities.

One of our healthcare assistants has opened up about finding a new family on a ward at Royal Bolton Hospital, more than 5,000 miles away from his birthplace in India. Joice Joy was born and raised in the state of Kerela in southwest India, where he spent time studying journalism, literature and communication and dreamed about where life might take him. Fast-forward a few years and Joice is now a much-loved and well-respected Healthcare Assistant, as he sets out on an ambitious career in the NHS. After experiencing the highs and lows of leaving behind his home in India, Joice has written a [heartfelt blog that captures the journey of finding a new home](#).

More than 600 [nominations were received for our annual For a Better Bolton \(FABB\) Awards 2026, highlighting the extraordinary contribution that our staff make to patients, families and communities across Bolton every day](#). The annual awards celebrate the dedication, compassion and commitment of colleagues working across local health and care organisations, recognising those who go above and beyond to improve experiences, outcomes and quality of care. The volume of nominations received across the 11 award categories demonstrates the significant impact staff continue to have on the lives of our local community. Winners will be revealed at a fully sponsored awards ceremony on Friday 9th October.

The Trust has appointed [Joanne Downs as its new Chief Finance Officer](#), succeeding Annette Walker, who leaves the organisation later this month after nine years of dedicated service and leadership. Joanne joins from Greater Manchester Mental Health NHS Foundation Trust, where she currently serves as Deputy Chief Finance Officer, bringing more than 28 years of strategic and leadership experience. With extensive knowledge of the Greater Manchester health and care system, gained through 18 years in senior commissioning and provider finance roles, Joanne will play a key role in supporting the Trust's financial sustainability and delivering its strategic ambitions for patients, staff and local communities.

The NHS Staff Survey remains a key opportunity to understand where we have made progress and where further improvement is needed. As we approach this year's survey opening on 1st October, we have reflected on the progress made in response to staff feedback of the last twelve months. Our People and Culture priorities continue to drive improvements across the Trust, helping to ensure Bolton remains a great place to work. Over the past year, we have invested in staff wellbeing and working environments, enhanced learning and leadership opportunities, embedded Our Way culture programme, and strengthened staff recognition through initiatives such as digital Thank You Cards, the Admin and Clerical Network, Thank You Thursday and Feedback Friday.

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

Our services have remained extremely busy, with high demand continuing across urgent and emergency care. This has affected performance in some areas, particularly Emergency Department waiting times and ambulance handovers. While some of our cancer services continue to perform well, reducing waiting times for planned care remains a key priority. Improvement programmes are in place across the Trust to enhance patient flow, reduce delays and make the best use of staff and resources, supporting sustained improvements for our patients and communities.

A major focus across the Trust is improving the quality of our operational data so that we have a complete and accurate understanding of the care we provide. Teams are reviewing activity recording, strengthening clinical coding and improving data quality processes to ensure the work undertaken by our staff is fully recognised and reflected in reporting, planning and funding arrangements. This work is particularly important as Greater Manchester Integrated Care Board begins the next medium-term planning cycle. Accurate activity data helps provide a clear picture of demand for services and population need, informing discussions about future service provision and investment. Ensuring that activity is recorded consistently and accurately supports effective decision-making, helps secure appropriate resources for the communities we serve, and strengthens our ability to deliver high-quality, sustainable services into the future.

Our hospital has begun rolling-out a [new artificial intelligence tool that could help diagnose prostate cancer faster](#) - helping doctors identify the men who need urgent treatment first. The technology is being introduced at hospitals in Bolton, Wigan, Stockport and Salford as part of a pilot led by Greater Manchester Cancer Alliance. The new AI tool will analyse prostate MRI scans using validated NHS data and flag scans that are most likely to show cancer, allowing radiologists to prioritise patients at highest risk.

We're continuing to invest in our people through opportunities that build leadership capability, strengthen networks and support personal development. Initiatives such as Proud2bOps@Bolton help colleagues share learning and strengthen relationships across teams. The recent Proud2bOps Conference focused on building personal resilience ahead of winter, celebrating operational excellence, exploring improvement opportunities and showcasing innovations, including Microsoft Copilot, that can support the future delivery of our services.

Bank holiday periods typically see increased demand for healthcare services. To help people access the right care as quickly as possible, [we continued to promote clear public messaging across our communities](#) throughout the Summer months, encouraging patients to choose the most appropriate NHS service for their needs. This helped raise awareness of the range of healthcare options available, reduce unnecessary delays, and support patients to access timely care in the most suitable setting.

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

The Trust is strengthening its financial position. However, achieving long-term financial sustainability by 2028/29 will require a broader focus on improving productivity, patient flow, reducing variation, maximising the use of available resources and ensuring the Trust is appropriately funded for the care it provides. The Sustainability Plan sets out a three-year programme of improvement, with a focus on embedding change and workforce initiatives in 2026/27, redesigning pathways and operational processes to deliver recurrent benefits in 2027/28, and establishing sustainable ways of working by 2028/29. Key priorities include improving patient flow and discharge processes, increasing elective and outpatient productivity, enhancing efficiency across community services, strengthening income recovery through accurate coding, and optimising workforce deployment. Together, these actions will support the continued delivery of high-quality patient care while securing the Trust's long-term financial sustainability.

Significant progress continues to be made across a number of [major capital developments at Royal Bolton Hospital](#), reflecting a substantial investment in the Trust's estate and infrastructure to enhance patient experience, improve clinical environments and support the delivery of high-quality services for the future.

Construction of the new main entrance is scheduled to begin this autumn. The development will create a more welcoming and accessible arrival point for patients and visitors, incorporating improved food and drink facilities, a dedicated patient drop-off area and wheelchair storage. Designed to enhance both accessibility and the overall hospital experience, the new entrance is expected to be completed by summer 2027.

Work is also progressing well on the £38 million Princess Anne Maternity and Women's Health Unit, which is due for completion in mid-2028. The development will provide modern, purpose-built facilities including birthing suites with pools, a seven-bed triage area, enhanced gynaecology and early pregnancy services, transitional neonatal care bays and refurbished maternity wards. The scheme will also deliver a new entrance and improved frontage, creating a more accessible and welcoming environment for women and families accessing services.

A new 24-bed Intermediate Care Unit, known as The Weaver Unit, is being established within N Block and is expected to open in October. The unit will support patients who require short-term rehabilitation and recovery following hospital treatment, helping them regain independence and return home as soon as appropriate. This additional capacity will further strengthen patient flow and support timely discharge from acute hospital services.

Preparatory work has also commenced on a new multi-million-pound laboratory facility adjacent to J Block. Once completed in spring 2027, the building will accommodate Microbiology and Antenatal Screening services, including a specialist laboratory dedicated to the diagnosis and management of serious infections. The development will enhance diagnostic capabilities and support the continued delivery of safe, effective and high-quality patient care.

Collectively, these developments represent a significant investment in the future of the Trust, improving accessibility, modernising facilities and strengthening the infrastructure required to support outstanding patient care and clinical outcomes across the organisation.

Ambition 5: A positive partner

As part of our commitment to working together as one Bolton Team, staff working in Bolton as part of the Greater Manchester Integrated Care Board (ICB) will now be hosted by the Trust, strengthening collaboration across organisations and supporting a more joined-up approach to meeting the needs of our communities. Bolton already has a strong history of partnership working across the NHS, the council, primary care, the voluntary, community and social enterprise sector, and the wider partnership. This hosting arrangement builds on the solid foundations that have been developed over many years and represents a natural next step in our integration journey.

Aligned with the ambitions set out in [Bolton's Locality Plan](#), it reinforces our shared commitment to being one team with a common purpose, vision and accountability, working together with our communities to improve health outcomes, reduce inequalities and help people live well for longer. Under the leadership of Fiona Noden, who serves as both Place-Based Lead for Bolton and Chief Executive of Bolton NHS Foundation Trust, we continue to strengthen how we work across organisational boundaries, making the best use of our collective resources and expertise to deliver seamless, person-centred care for the people of Bolton.

Bolton's Best Start [Family Hubs achieved Stage 1 accreditation under UNICEF UK's Baby Friendly Initiative](#), recognising the high-quality support provided to parents, babies and families across the borough. Delivered through a partnership between the Trust, Bolton Council, Bolton Together, Bolton CVS and Greater Manchester Mental Health NHS Foundation Trust, the accreditation reflects the strong culture, knowledge and skills of staff supporting infant feeding, parent-child relationships and early development. As the first step towards the prestigious Gold Award, this achievement demonstrates the partnership's commitment to delivering evidence-based support that gives children the best possible start in life and improves outcomes for families.

The Trust recently promoted opportunities for both Staff Governors and Public Governors, encouraging colleagues and local residents to become involved in shaping the future of the organisation. Vacancies were promoted for Staff Governors within the Nurses and Midwives, AHPs and Scientists, and Doctors and Dentists constituencies, alongside Public Governor vacancies across the Bolton North East, Bolton South East, Bolton West and Rest of England constituencies. Communications highlighted the important role governors play in representing staff, patients and communities, influencing decision-making and providing constructive challenge to help ensure the Trust continues to meet the needs of those it serves.

Report Title:	Sustainability Plan 2026-2029: Public Board Overview			
Meeting:	Board of Directors in Public	Action Required	Assurance	✓
Date:	24 September 2026		Discussion	✓
Executive Sponsor	Chief Nursing & Quality Officer		Decision	✓

Purpose of the report	To provide the Board and the public with an overview of the Trust’s Sustainability Plan for 2026-2029, including its background, revised strategic direction, scale of ambition, underpinning rationale and the focused actions to December 2026 supported by consultancy firm PSC.
-----------------------	---

Previously considered by:	Previous Board consideration of the Sustainability Plan and Medium-Term Plan; this paper presents the updated September 2026 public position.
---------------------------	---

Executive Summary	The Sustainability Plan responds to a continuing underlying financial gap and variable operational performance which adversely impacts both patients and staff. It builds on the 2025/26 grip and control approach and sets a new direction based on productivity, growth, pathway re-design and reliable improvement. The ambition is substantial. Existing commitments and median performance do not deliver balance, nor do they sufficiently ameliorate the variable reliability in patient experience. The highest-ambition scenario delivers a surplus of £3.8m. The rationale is that the gap reflects productivity, income, patient flow and cost pressures, requiring a whole-organisation and system response rather than cost reduction alone. This is in line with our direction of travel towards a Learning Organisation, underpinned by a Quality management system. Between now and 13 December 2026, focused action, supported by PSC, will address in-year financial gap mitigation, strengthened governance, integrated quality planning, and assessment of leadership capacity and capability.
-------------------	---

	Workstreams will be validated, sequenced, resourced and supported by clear measures, while protecting patient safety, quality of care and staff wellbeing.
--	--

Proposed Resolution	The Board is asked to note the updated strategic direction and scale of ambition; recognise that the modelling remains provisional; support the focused programme of work to 13 December 2026 with PSC; and seek assurance that delivery, quality safeguards, leadership capacity and accountability are being established.
----------------------------	---

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	The plan seeks a sustainable operating position.
Legal/ Regulatory	Yes	Delivery will remain subject to statutory, regulatory and financial governance requirements.
Impact on Health Inequalities	Yes	Community and pathway redesign may support prevention, access and care closer to home. Impacts will require explicit monitoring.
Impact on Equality, Diversity and Inclusion	Yes	Workforce and service redesign may have differential impacts. Equality considerations will be included in implementation and assurance.

Is a Quality Impact Assessment required	Yes	Quality impact assessment is required as workstreams are developed and validated. Patient safety, care quality and staff wellbeing are non-negotiable.
--	------------	--

Prepared by:	Tyrone Roberts, Chief Nursing & Quality Officer	Presented by:	Tyrone Roberts, Chief Nursing & Quality Officer
---------------------	---	----------------------	---

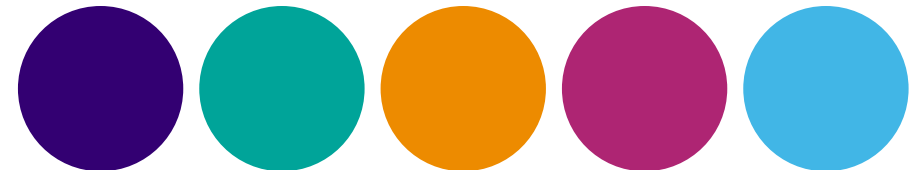
Glossary – definitions for technical terms and acronyms used within this document

PSC	The 'Public service consultants'
MTP	Medium-Term Plan
CIP	Cost Improvement Programme

Sustainability Plan 2026–2029

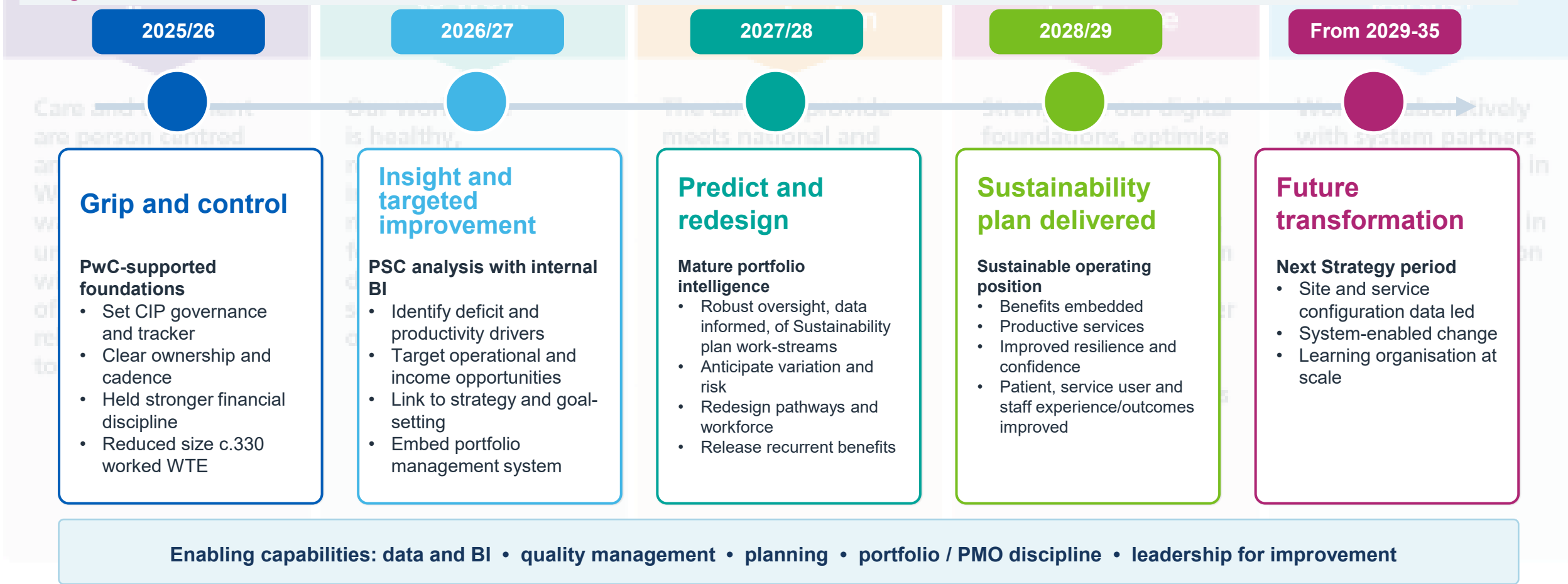
Public Board overview

Bolton NHS Foundation Trust · September 2026



The journey: from grip and control to sustainable delivery

Shift from retrospective control to predictive, learning-led delivery—improving the patient and staff experience through large scale change that delivers our ambition under a high performing, productive organisation, that the care we provide meets national and local quality standards and is delivered within budget



Where we are now: improvement is not yet reliable

- Core safety processes and the longest waits have improved, while persistent gaps in flow, access, workforce and outcomes continue to drive risk.

**SUSTAINED IMPROVEMENT**
Reliable delivery or clear positive trajectory



Safety processes and Outcomes

Safety Alerts and investigation turnaround 100%; nursing KPI audits 96.8%. Category 3-4 pressure ulcers, falls with harm and most IPC indicators improved; still births reduced.



Deterioration & Mortality

NEWS 100%; crude mortality within plan; HSMR improved to 105.6.



Elective & cancer

Zero 65, 78 and 104-week waits; 31-day cancer 99.2%; 28-day diagnosis 81.3%.



Maternity & community

1:1 care 99%; booking and breastfeeding above plan; ED deflections and community 18-week access strong.



Workforce controls

Vacancy below ceiling; nursing agency within plan; medical agency improved in June 2026.



REDUCED RELIABILITY
Deterioration, volatility or loss of compliance



Fundamental care

Inpatient category 2 pressure damage variability .



Flow & dignity

A&E 4-hour performance fell to 66.5%; non-elective LOS rose; same-sex breaches



Access pathways

Diagnostic waits above target worsened to 15.7%; 62-day cancer performance fell to 73.8%; community 52-week waits rose sharply.



Emerging outcomes

SHMI remains elevated; staff sickness rose to 5.54%.



IMPROVEMENT STILL NEEDED
Persistent gaps requiring focused recovery



Clinical correspondence

Inpatient 79.6% and outpatient 56.1% against 95% standards.



Urgent & elective care

1,005 twelve-hour waits; RTT and diagnostics off plan; only 36.2% of cancellations rebooked in 28 days.



Experience & maternity

A&E satisfaction and several FFT response rates below plan



Community & prevention

Health visitor contacts 85%; no-criteria-to-reside occupied days materially above plan.



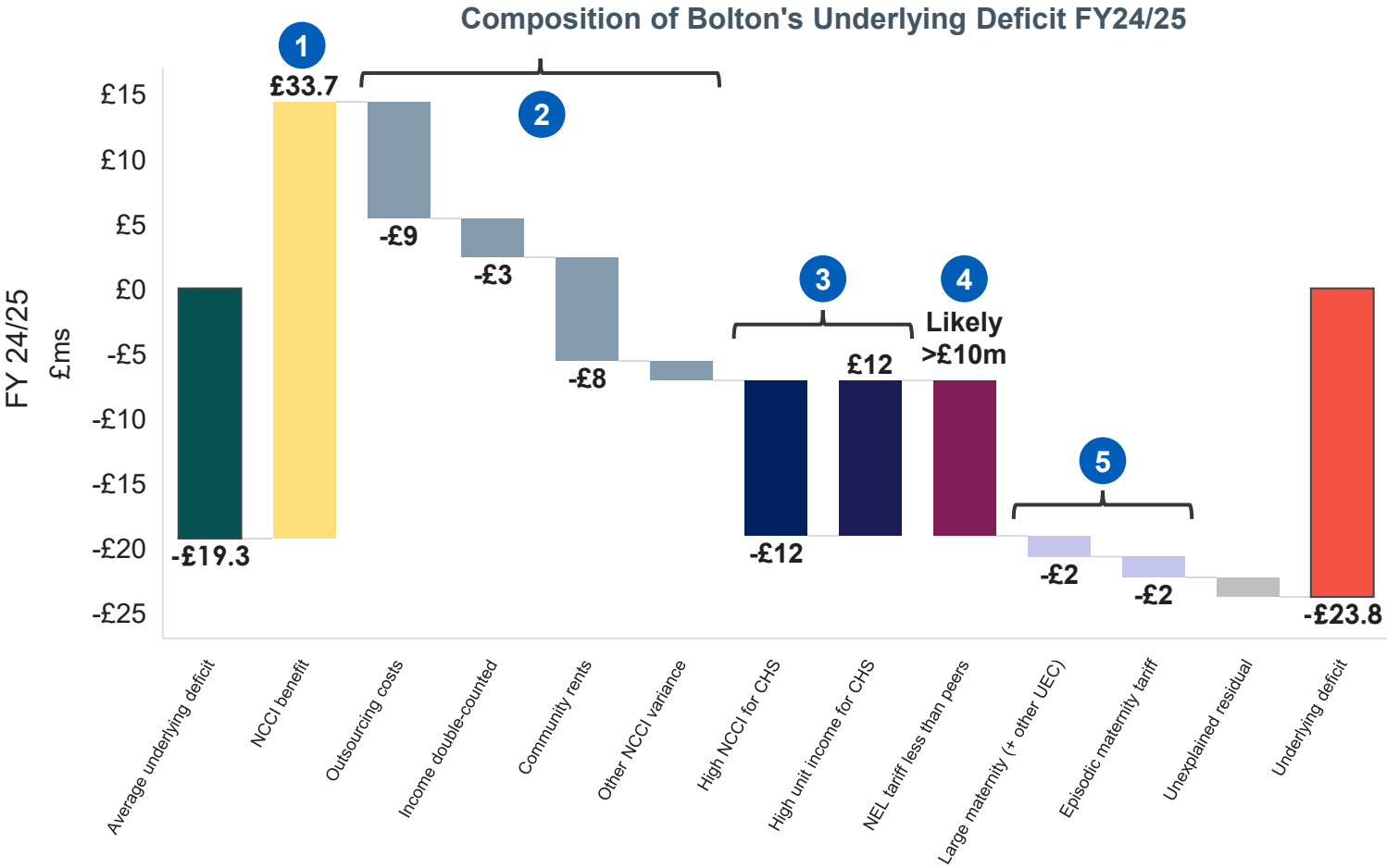
Workforce & culture

Sickness and turnover above plan; staff advocacy remains materially below target.

BOARD FOCUS	1 Test whether strong process compliance is translating into safer outcomes	2 Require time-bound recovery trajectories for flow, cancer and diagnostics	3 Maintain oversight of SHMI, workforce and capital delivery
--------------------	--	--	---

Why the gap persists: four operational drivers

The gap is operational—not simply overspend: productivity, lost income, patient flow and cost pressure all contribute.



- 1 The difference from national average surplus/deficit expected based on NCCI = 93
- 2 Value of overstated NCCI benefit resulting from inappropriately excluded NCCI costs. NCCI = 97
- 3 High community services unit costs relative to national average were offset by higher income, though there is a risk that the deconstructing the block exercise may remove the extra income
- 4 Multiple benchmarks point to Bolton FT receiving less income for similar casemix, particularly for non-elective activity
- 5 An outsized share of total costs made up of non-elective services (including maternity) that are historically less well reimbursed than other activity types

Operational levers span non-elective, elective, outpatients and community; income capture, workforce, corporate and estates complete the portfolio.

01 NON-ELECTIVE FLOW

- Reduce NCTR bed-days
- Expand SDEC / zero-day care
- Optimise front-door pathways

03 INCOME & WORKFORCE

- Deepen coding & close tariff gaps
- Capture community activity
- Improve WTE / activity & pay mix

02 ELECTIVE & COMMUNITY

- Lift theatre utilisation & day cases
- Reduce DNA / expand PIFU
- Improve community productivity

04 CORPORATE & ESTATES

- Reduce corporate service cost
- Improve estate utilisation



Operational productivity • Income growth • Cash-releasing efficiency

Scenario modelling approach and estimated impact

Five scenarios step from existing commitments through trust-led and system-led median performance, to upper-quartile over-performance. Scenarios start from the 2025/26 underlying exit run-rate of £31.6m, not the £32.9m underlying deficit reported earlier: the run-rate also adjusts for in-year timing, so it reflects the rate Bolton exits the year at.

Scenario	What it tests	Definition / assumptions	FY2028/29 underlying deficit (£m)
1. Do nothing new	Sizes the gap if nothing changes after 2025/26: exit run rate rolled forward with activity growth, inflation, drift and known pressures	Delivers from the baseline of 2025/26 performance, noting the substantial decisions made in that period.	(£74.8m)
2. Deliver existing commitments	Tests what the committed and risk-adjusted CIPs deliver, and what remains once non-recurrent benefit unwinds	Realises benefits from all planned CIPs for 2026/27, alongside the improvements set in 2025/26 and M1-4 of 2026/27.	(£49.4m)
3. Stretch to select median performance	Tests what Bolton can deliver in its own control, and how much converts to cash rather than released capacity	Reaches today's median performance threshold for trust-led metrics.	(£45.1m)
4. Stretch to persistent median performance	Tests the incremental effect of ICB, LA and community action beyond trust-led delivery, and the funding shift it needs	Reaches today's median performance for trust-led and system-led metrics.	(£33.5m)
5. Outperform across the board	Tests the most stretching evidenced position across every metric, and what balance by 2028/29 requires	Achieves either 2025/26 upper quartile or 90th percentile across selected metrics.	£3.8m surplus

Note: figures are estimates; a £5m range is recommended

Recovery portfolio I: operational improvement

- Operational opportunities span non-elective flow, elective theatres, outpatients and community services. The priority is to convert evidenced productivity gains into cash-releasing and income benefits.

Category	Indicator of opportunity	Sizing method	Potential CIP actions	Status	Benefit type
Non-elective	NCTR bed-days	Bed-days avoided → acute bed closures	Strengthen discharge pathways & step-down capacity	Evidenced	Cash-releasing
	Zero-day admissions (SDEC, AAU)	Admissions avoided → acute bed closures	Expand SDEC/AAU streaming and/or capacity	WIP	Cash-releasing
	ED attendances per weighted population	Attendances avoided → reduced costs	Expand UCR/High Intensity Use programmes	Evidenced	Cash-releasing
	Alternate front door use (UTC, GP OOO)	Attendances shifted → reduced costs	Strengthen clinical streaming and/or expand capacity	WIP	Cash-releasing
Elective	Theatre time utilised	Extra theatre capacity → increased activity	Optimise scheduling, reduce cancellations & turnaround	Evidenced	Income-increasing
	Day case / OPROC rate (esp. HVLC)	Cases shifted → reduced costs	Day case by default; optimise anaesthesia & list planning	Evidenced	Cash-releasing
Outpatients	DNA rates	Extra slots utilised → increased activity	SMS reminders / patient portals; reduce wait times	Evidenced	Income-increasing
	PIFU pathway rate	Follow-ups avoided → increased new episodes	Expand inclusion criteria & clinician adoption	Evidenced	Income-increasing
	Reliance on WLI / outsourcing	Increased capacity → reduced WLI/outsourcing spend	3-session days, ring-fenced cold capacity	Not yet started	Cash-releasing
Community	Contacts per WTE	Productivity increase → increased activity	Digital efficiency & scheduling optimisation	WIP	Income-increasing
	Intermediate care LOS	Bed-days avoided → increased activity	Strengthen therapy-led & home-first approaches	WIP	Income-increasing

Recovery portfolio II: income and enabling levers

- Income capture could contribute more than £10m by 2028/29. Workforce productivity, corporate efficiency and estate utilisation complete the eight-lever portfolio.

Category	Indicator of opportunity	Sizing method	Status	Benefit type
Income capture	Acute coding depth	Tariff impact of increase to national average depth of coding	WIP	Income-increasing
	Acute unit tariff value	Difference in unit tariff value from SUS data versus ICB peer median, accounting for difference in expected costs from NCCI	WIP	Income-increasing
	Community activity undercounted	Tariff impact of estimated invisible and undercoded activity	WIP	Income-increasing
Workforce	WTE per weighted activity	Reduction in substantive WTE	WIP	Cash-releasing
	Temporary staff	Cost of agency/bank hours, and cost per hour for medical locums, above benchmark	WIP	Cash-releasing
	Average pay per WTE	Cost of pay grade / seniority drift	WIP	Cash-releasing
Other	Corporate service cost	Corporate service efficiencies (TBC)	WIP	Cash-releasing
	Estates footprint utilisation	Estates footprint consolidation (TBC)	Not yet started	Cash-releasing

Four delivery tracks to 13 December 2026

Governance, focused support and named leadership run across recovery, quality planning and capability.

A IN-YEAR GAP MITIGATION Clinical Documentation Improvement under one accountable lead System NCTR sprint Phase 2 PSC analysis Two data-driven workstreams, each worth at least £5m	B GOOD GOVERNANCE Revised governance and escalation route c.25 PIDs with leading and lagging metrics Divisional challenge and validation Live Board performance and productivity view	C INTEGRATED QUALITY PLANNING Refresh Quality Management System priorities Integrate quality, Sustainability and Medium-Term plans Assure statutory and regulatory alignment	D LEADERSHIP CAPACITY & CAPABILITY Assess leadership capacity and capability Match resources to delivery needs Recommend structure and operating-model changes
---	---	---	---

OUTPUTS	In-year gap mitigation on track	Three-year workstreams sequenced; rollout resourced	Integrated quality-planning round completed	Governance implemented; push-and-pull data visibility live	Leadership assessment complete; recommendations shared
13 DEC 2026					

Board oversight: risks, controls and next steps

1

Delivery risks to manage

Provisional modelling (±£5m)
£66m–£80m benefit realisation
Leadership and delivery capacity
Productivity-to-cash conversion
System, data and infrastructure

2

Controls that build confidence

Revised governance and decision rights
Named Executive sponsor, SRO and Board oversight
Challenge-ready PIDs, metrics and quality safeguards

3

Next steps by 13 December

In-year mitigation on track
Workstreams sequenced and resourced
Data visibility live
Leadership assessment complete

NON-NEGOTIABLE Protect patient safety, quality of care and staff wellbeing while benefits are delivered.

Board oversight should test delivery evidence, risk reduction and accountability.

Report Title:	Sustainability Committee Chair Report - August			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 2026		Discussion	
Executive Sponsor	Tyrone Roberts		Decision	

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

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

Executive Summary	The attached report from the Chair of the Sustainability Committee provides an overview of matters discussed at the meeting held on 25 August 2026. The report also sets out the assurances received by the Sustainability Committee and identifies the specific concerns that require the attention of the Board of Directors.
-------------------	---

Proposed Resolution	The Board of Directors is asked to receive the Sustainability Committee 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:	Tyrone Roberts Chief Nursing and Quality Officer	Presented by:	Tyrone Roberts Chief Nursing and Quality Officer
--------------	---	---------------	---

ALERT ADVISE ASSURE (AAA) Key Issues Highlight Report			
Name of Committee:	Sustainability Committee	Reports to:	Board of Directors
Date of Meeting:	25 August 2026	Date of next meeting:	24 September 2026
Chair	Fiona Noden	Meeting Quoracy	Yes
AGENDA ITEMS DISCUSSED AT THE MEETING:			
- Drivers of Deficit and Sustainability Plan Update – The PSC - Sustainability Dashboard - Sustainability Programme Plan Update - Improvement and Transformation SMT AAA Report			
ALERT			
Drivers of Deficit and Sustainability Plan Update The Committee noted a material financial sustainability risk and delivery challenge following the Drivers of Deficit work undertaken by PSC. The work identified that historic National Cost Collection Index (NCCI) benchmarking and data quality, coding, costing and allocation issues may have masked productivity opportunities, particularly across community services, outpatients, elective and day case activity. The adjusted benchmarking position indicates a potential opportunity of at least £54m at upper quartile and around £70m at the 90th percentile over three years; however, the Committee recognised that these opportunities require further validation, operational testing, quantification and clear differentiation between productivity benefits, fully absorbed costs and cash-releasing savings. Urgent focus is also required on the non-elective tariff variance, currently marked as TBC but indicatively expected to be over £10m, and on validating the full and cash-releasable benefits of ward closures. The Committee further highlighted the need to ensure all work being undertaken by the Trust, PSC and PwC is aligned behind a single Sustainability Plan narrative to avoid duplication, conflicting messages or fragmented governance.			
Sustainability Dashboard - The Committee was alerted to a deteriorating operational and data quality position within the Sustainability Dashboard. A&E four-hour performance was significantly below plan and the 76% monthly ambition was no longer achievable for August, with a maximum position of approximately 73% considered possible only if breach tolerance materially reduced. - The Committee also noted outpatient slot utilisation, outpatient outcome recording and RTT PTL data quality issues as priority areas requiring urgent action due to their impact on activity reporting, income delivery and operational grip. Immediate follow-up was agreed, including review with operational, IT/BI and clinical leads, sharing of the outpatient slot utilisation deep dive, and an urgent meeting between the			

Medical Director, Chief Operating Officer and Director of Operations to agree a rapid process improvement approach with weekly executive tracking until resolved.

ADVISE

The Sustainability Plan

The Committee advises the Board that further development of the Sustainability Plan is required, particularly for Years 2 and 3, to incorporate the drivers of the deficit work being undertaken through the PSC and demonstrate a clear, evidence-based and credible route to financial balance by 2028/29.

The final plan will need to evidence the underlying deficit, reconcile the savings bridge, clarify delivery assumptions and set out the commitments required from system partners, including the ICB, local authorities, NHS England and the region. Scenario modelling will be developed across five positions: do nothing, do minimum, Trust-only delivery, system-enabled left shift and do maximum. The Committee supported maintaining an ambitious position whilst ensuring assumptions are evidence-based, operationally tested and translated into deliverable plans.

The timetable remains demanding, with key milestones including review through Executive Directors on 7 September, Finance and Investment Committee on 16 September, Board of Directors on 24 September and the NHS England Board-to-Board discussion on 1 October.

ASSURE

Improvement and Transformation SMT Chair Report

The Committee received assurance that programme governance and oversight arrangements had been established through the Improvement and Transformation SMT and the developing portfolio approach. The SMT had considered the Sustainability Plan update, Board preparation, sustainable services methodology, planning and improvement cycle integration, productivity opportunity gap analysis, income, counting and recording improvements, and forward planning arrangements.

The Committee was assured that cross-functional engagement across strategy, finance, workforce, performance, clinical and improvement teams is supporting a more consistent analytical approach and strengthening the evidence base. The Committee also supported simplification of governance arrangements to improve ownership, prioritisation, pace, accountability and escalation of barriers, with delivery to be tracked through existing executive governance routes.

New Risks identified at the meeting: N/A

Review of the Risk Register: N/A

Report Title:	Integrated Performance Report			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 2026		Discussion	✓
Executive Sponsor	Deputy Chief Executive/Chief People Officer		Decision	

Purpose of the report	To present the Month 05 Integrated Performance Report
-----------------------	---

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

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

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

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

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

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

Bolton NHS Foundation Trust

Integrated Performance Report

August 2026

Guide to Statistical Process Control

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 – September 2026 edition

No action: improving and consistently passing.   	Monitor: Improving but can be inconsistent    2 Hour Urgent Community Response %	Monitor: Improving but consistently not achieving target.    - Diagnostic Waits >6 weeks % - A&E 12 hour waits
No action: No change and consistently passing.   - Friends and Family Test (Inpatients) - Satisfaction % - Number of Acute Inpatient incidences - pressure damage (category 4) - Number of Acute Inpatient incidences - pressure damage (category 3 plus unstageables)	Consider action: No change and can be inconsistent with target.   - A&E 4-hour target 31 Day General Treatment Standard - Cancer: 28 day faster diagnosis - Summary Hospital-level Mortality Indicator (SHMI) - A&E Friends and Family Satisfaction Rates % - Total Healthcare Associated C. difficile Cases - Total Healthcare Associated MRSA Bacteraemia (days between cases) - Total Healthcare Associated E. coli Bacteraemia - RTT Incomplete pathways within 18 weeks % - Maternity Friends and Family Test - Satisfaction %	Take action: No change and consistently not achieving target.   - Sickness absence level – Trust - Same sex accommodation breaches
Caution: Declining but still consistently passing.   	Take action: Declining and inconsistent with target.    - Our staff tell us they would recommend the Trust as a place to work 62 Day General Standard	Take action: Declining and consistently not achieving target.    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.
	Indicates that special cause variation has occurred that is a cause for concern due to higher values in relation to the target.
	Indicates that special cause variation has occurred that is a cause for concern due to lower values in relation to the target.
	Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to higher values.
	Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to lower values.
Assurance	
	We can be confident in consistently meeting the required level of performance for this KPI.
	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

Trust Objective
Quality and Safety
Harm Free Care
Infection Prevention and Control
Mortality
Patient Experience
Maternity
Operational Performance
Urgent Care
Elective Care
Cancer
Community Care
Workforce
Sickness, Vacancy and Turnover
Organisational Development
Agency
Finance
Finance
Appendices
Heat Maps

Variation				
8	4	4	1	2
9	0	0	0	0
5	2	1	0	0
13	0	0	0	3
6	2	2	0	0
9	3	2	0	0
8	2	5	1	0
2	0	0	0	1
5	3	0	0	0
3	0	1	0	0
3	1	0	0	2
1	0	2	0	0
2	0	0	0	1

Assurance		
1	3	12
0	0	7
0	0	3
2	0	14
1	0	8
2	6	6
1	7	6
0	0	3
0	2	6
0	2	1
1	2	3
0	2	1
1	0	2

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

Assurance	
	We can be confident in consistently meeting the required level of performance for this KPI.
	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	
	Indicates how many times we have achieved the required level of performance across the last 6 data points.

Quality and Safety - Harm Free Care

Pressure Ulcers

Hospital-acquired pressure ulcer performance remains within common cause variation for Category 2 pressure ulcers and has moved into special cause improvement for Category 3 pressure ulcers (which include unstageable pressure ulcers), demonstrating sustained improvement.

Category 4 hospital-acquired pressure ulcers remain at zero.

Community-acquired pressure ulcers remain within common cause variation for Categories 2 and 3; however, Category 4 pressure ulcers continue to demonstrate special cause deterioration. Review of these cases indicates that the patients were receiving care in community settings, where individuals do not require or receive 24-hour nursing care. Whilst factors such as end-of-life care have been present in some cases, reviews undertaken to date have not identified any significant themes, concerns, or learning that can be directly attributed to the Category 4 pressure ulcers. Recognising the importance of fully understanding the drivers behind the observed deterioration and continuous learning, a corporate thematic review of all Category 4 pressure ulcers reported over the last seven months is underway. This review will provide additional oversight, enable triangulation of findings across cases, and ensure that any opportunities to strengthen prevention, early identification and management of pressure damage are identified and acted upon.

Falls

Inpatient falls per 1,000 bed days remain within common cause variation, although performance has marginally exceeded the Trust stretch threshold at 5.69. There were five falls resulting in moderate harm during the month, comprising three fractured neck of femur injuries and two head injuries. All patients had a falls risk assessment completed and falls management plans in place. Three of the falls were unwitnessed and two were witnessed. Review of the incidents identified that the POST enhanced care risk assessment had indicated the appropriate level of observation was in place in four cases. In the fifth case,, enhanced observation was in place and the patient was mobilising with a family member when the fall occurred. Review of these incidents has not identified any recurring themes or patterns that would indicate opportunities for immediate improvement in falls prevention processes. Falls performance remains within common cause variation. Learning from moderate harm falls continues to be reviewed through established governance processes, with divisions reviewing falls training compliance and local falls prevention arrangements to identify any opportunities to further reduce avoidable patient harm.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	93.0%	Aug-26		>= 95%	91.6%	Jul-26	>= 95%	94.3%	
9 - Never Events	= 0	0	Aug-26		= 0	0	Jul-26	= 0	0	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	5.69	Aug-26		<= 5.30	4.83	Jul-26	<= 5.30		
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	5	Aug-26		<= 1.6	6	Jul-26	<= 8.0	18	
15 - Number of Acute Inpatient incidences - pressure damage (category 2)	<= 6.0	3.0	Aug-26		<= 6.0	8.0	Jul-26	<= 30.0	36.0	

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
620 - Number of Acute Inpatient incidences - pressure damage (category 3 plus unstageables)	<= 1	2	Aug-26		<= 1	1	Jul-26	<= 3	6	
17 - Number of Acute Inpatient incidences - pressure damage (category 4)	= 0.0	0.0	Aug-26		= 0.0	0.0	Jul-26	= 0.0	0.0	
18 - Number of Community incidences - pressure damage (category 2)	<= 7.0	15.0	Aug-26		<= 7.0	15.0	Jul-26	<= 35.0	59.0	
621 - Number of Community incidences - pressure damage (category 3 plus unstageables)	<= 4	9	Aug-26		<= 4	5	Jul-26	<= 20	41	
20 - Number of Community incidences - pressure damage (category 4)	<= 1.0	1.0	Aug-26		<= 1.0	1.0	Jul-26	<= 5.0	9.0	
535 - Community patients acquiring pressure damage - significant learning category 2		0	Aug-26			0	Jul-26		0	
536 - Community patients acquiring pressure damage - significant learning category 3 plus unstageables		0	Aug-26			0	Jul-26		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Aug-26			0	Jul-26		0	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	78.7%	Aug-26		>= 95%	78.9%	Jul-26	>= 95%	78.5%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	60.0%	Aug-26		>= 95.0%	50.7%	Jul-26	>= 95.0%	56.1%	
86 - Patient Safety Alerts - Trust position	= 100%	100.0%	Aug-26		= 100%	100.0%	Jul-26	= 100%	100.0%	
88 - Nursing KPI Audits	>= 85%	96.2%	Aug-26		>= 85%	97.3%	Jul-26	>= 85%	96.4%	
91 - Patient Safety Incident Investigation turnaround performance by agreed deadline	= 100%	100.0%	Aug-26		= 100%	100.0%	Jul-26	= 100%		
8 - Same sex accommodation breaches	= 0	10	Aug-26		= 0	26	Jul-26	= 0	131	

6 - Compliance with preventative measure for VTE

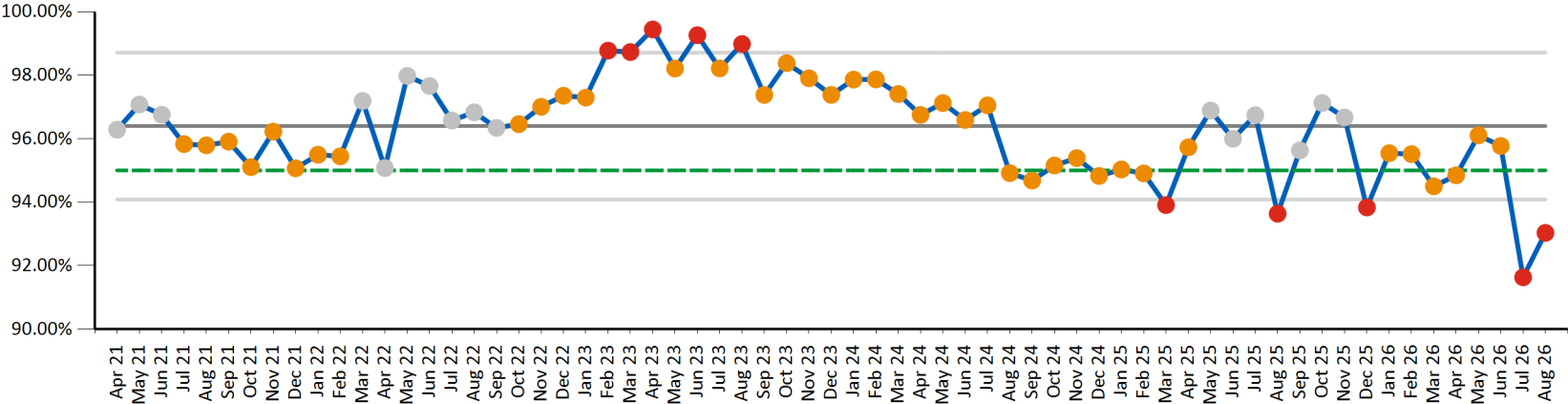


Special cause variation with deteriorating performance



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

2/6



Latest

Plan	Actual	Period
>= 95%	93.0%	Aug-26

Previous

Plan	Actual	Period
>= 95%	91.6%	Jul-26

Year to Date

Plan	Actual
>= 95%	94.3%

9 - Never Events

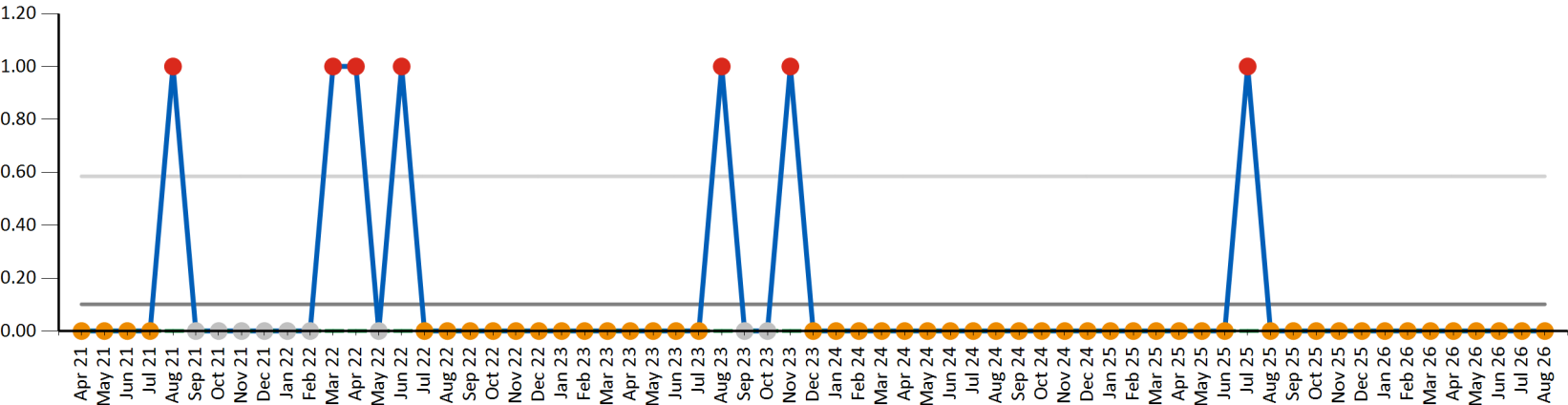


Special cause variation with improving performance



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

6/6



Latest

Plan	Actual	Period
= 0	0	Aug-26

Previous

Plan	Actual	Period
= 0	0	Jul-26

Year to Date

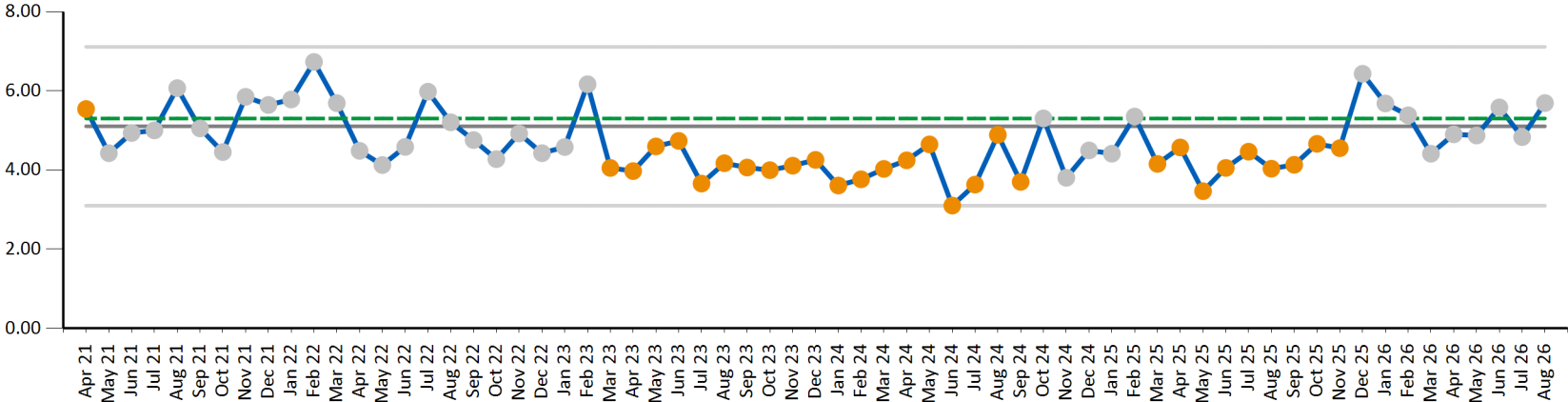
Plan	Actual
= 0	0

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

 Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 5.30	5.69	Aug-26

Previous

Plan	Actual	Period
<= 5.30	4.83	Jul-26

Year to Date

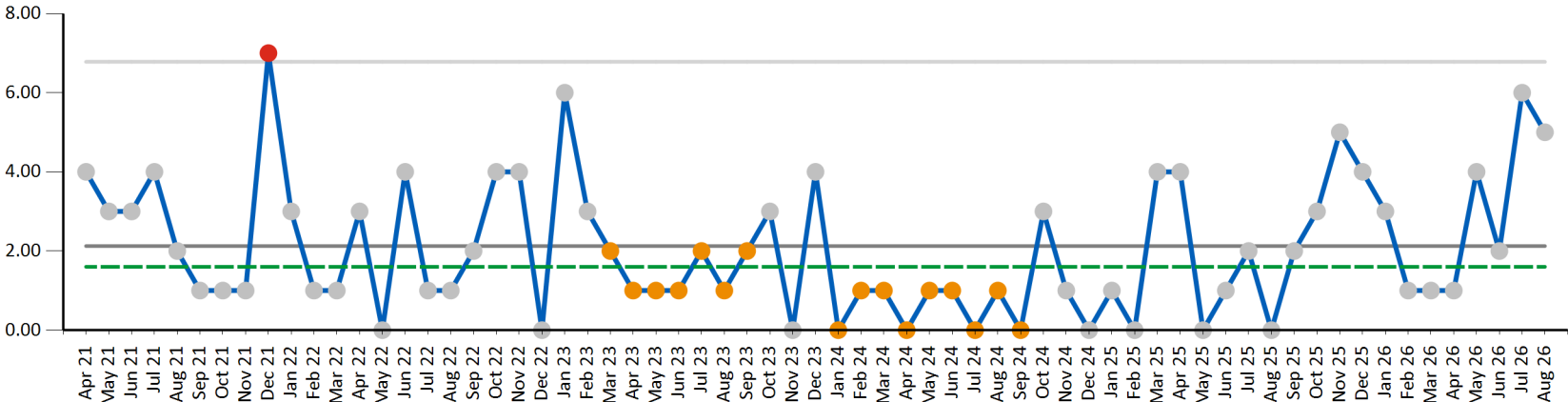
Plan	Actual
<= 5.30	

14 - Inpatient falls resulting in Harm (Moderate +)

 Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 1.6	5	Aug-26

Previous

Plan	Actual	Period
<= 1.6	6	Jul-26

Year to Date

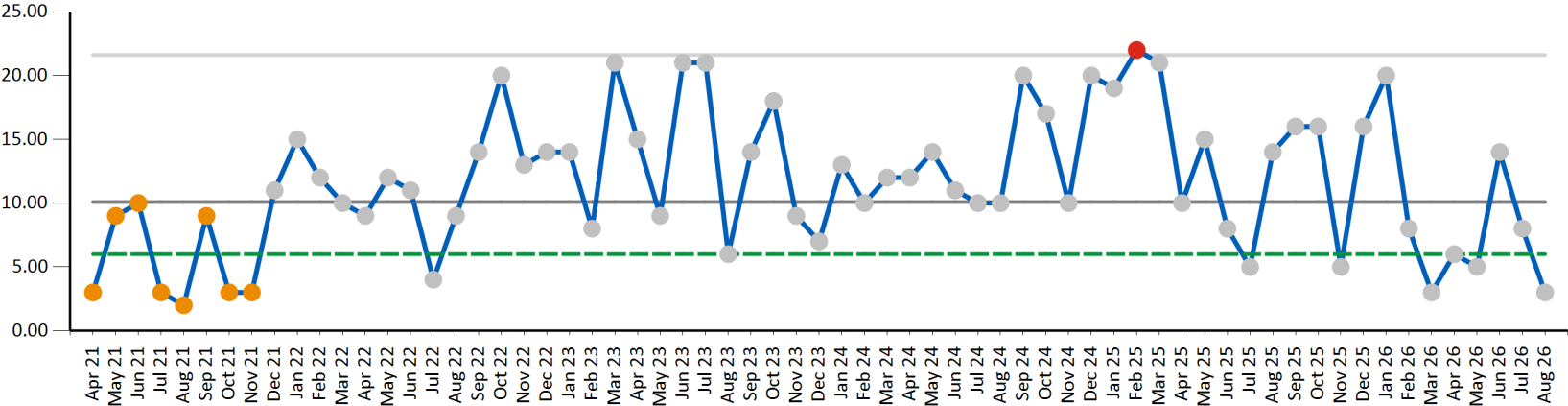
Plan	Actual
<= 8.0	18

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

 Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 6.0	3.0	Aug-26

Previous

Plan	Actual	Period
<= 6.0	8.0	Jul-26

Year to Date

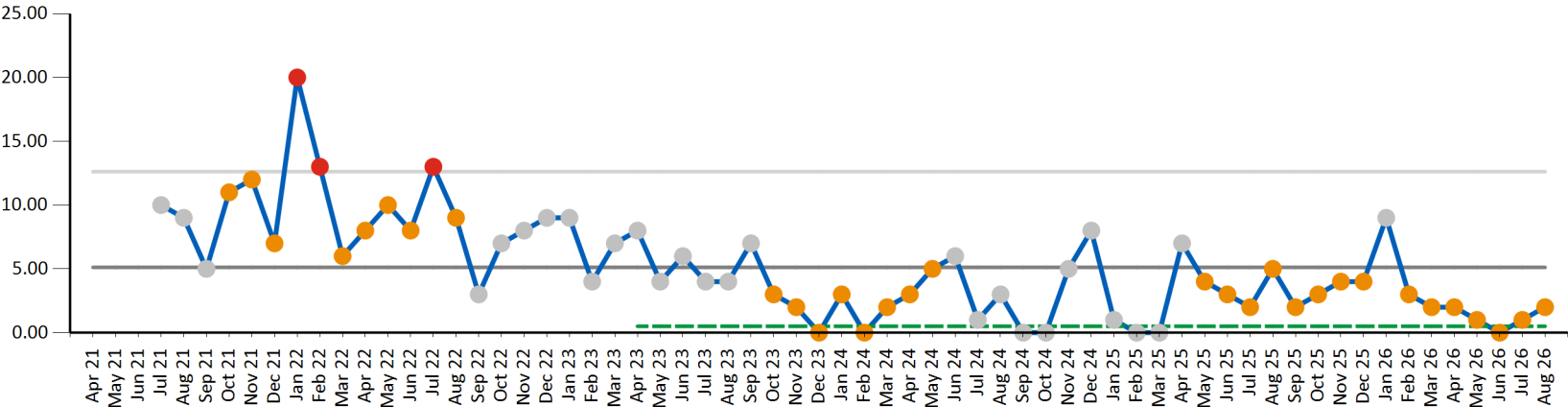
Plan	Actual
<= 30.0	36.0

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

 Special cause variation with improving performance

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

1/6



Latest

Plan	Actual	Period
<= 1	2	Aug-26

Previous

Plan	Actual	Period
<= 1	1	Jul-26

Year to Date

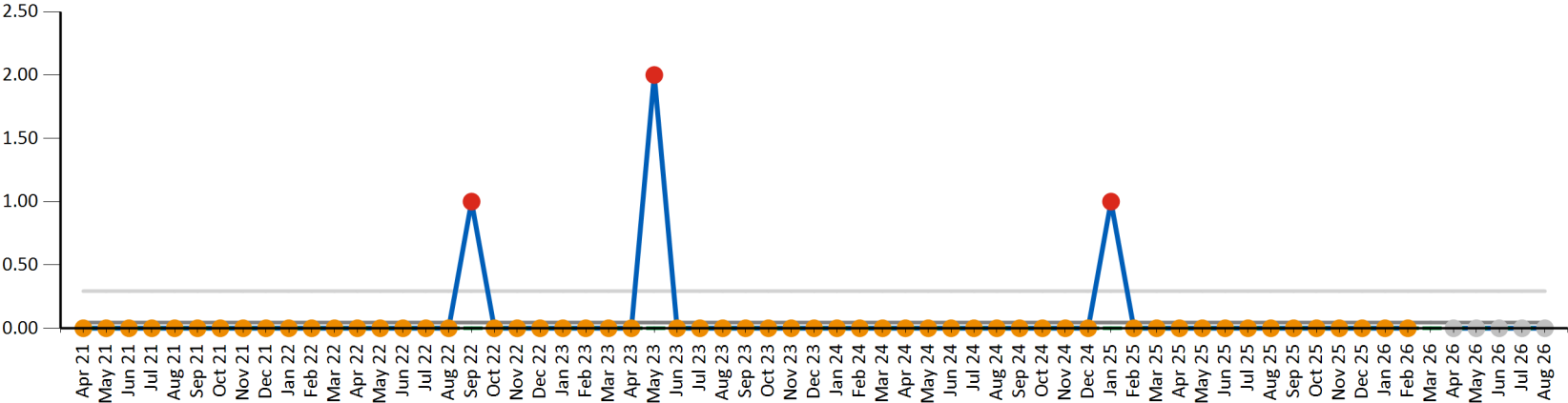
Plan	Actual
<= 3	6

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	Aug-26

Previous

Plan	Actual	Period
= 0.0	0.0	Jul-26

Year to Date

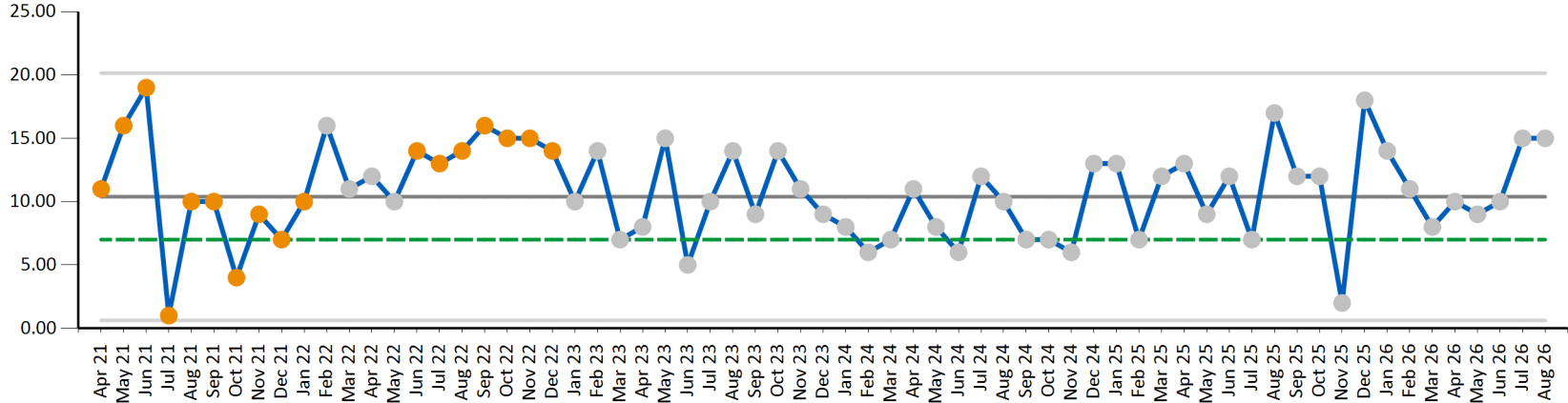
Plan	Actual
= 0.0	0.0

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	15.0	Aug-26

Previous

Plan	Actual	Period
<= 7.0	15.0	Jul-26

Year to Date

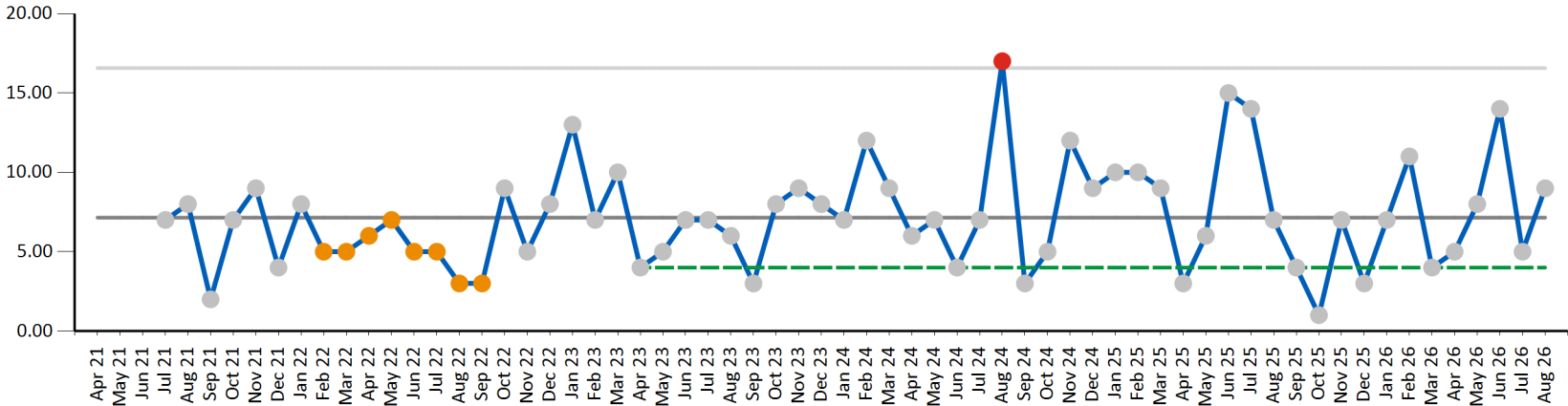
Plan	Actual
<= 35.0	59.0

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

 Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 4	9	Aug-26

Previous

Plan	Actual	Period
<= 4	5	Jul-26

Year to Date

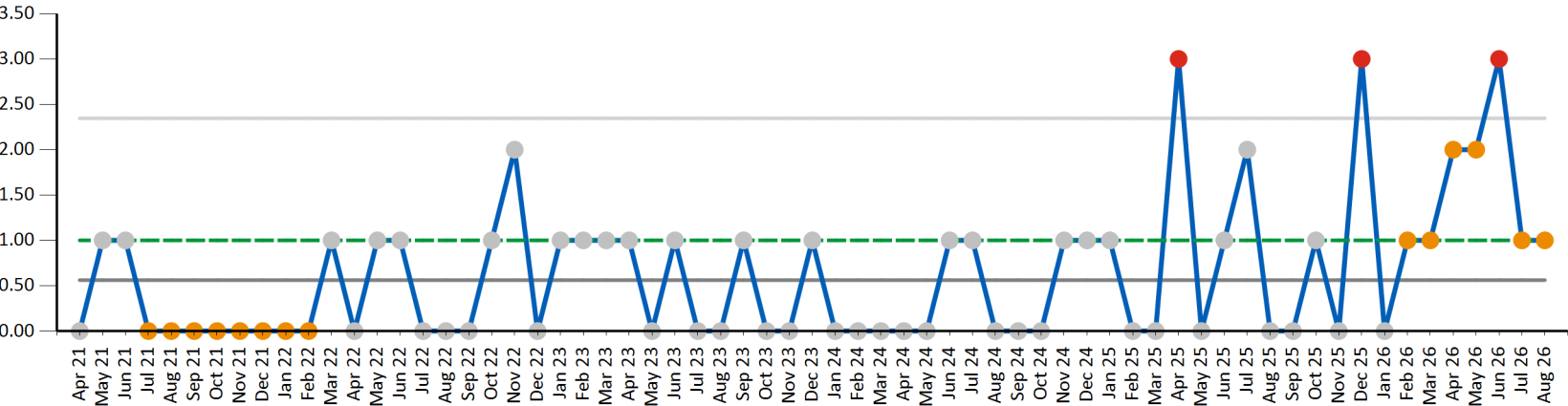
Plan	Actual
<= 20	41

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

 Special cause variation with deteriorating performance

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

3/6



Latest

Plan	Actual	Period
<= 1.0	1.0	Aug-26

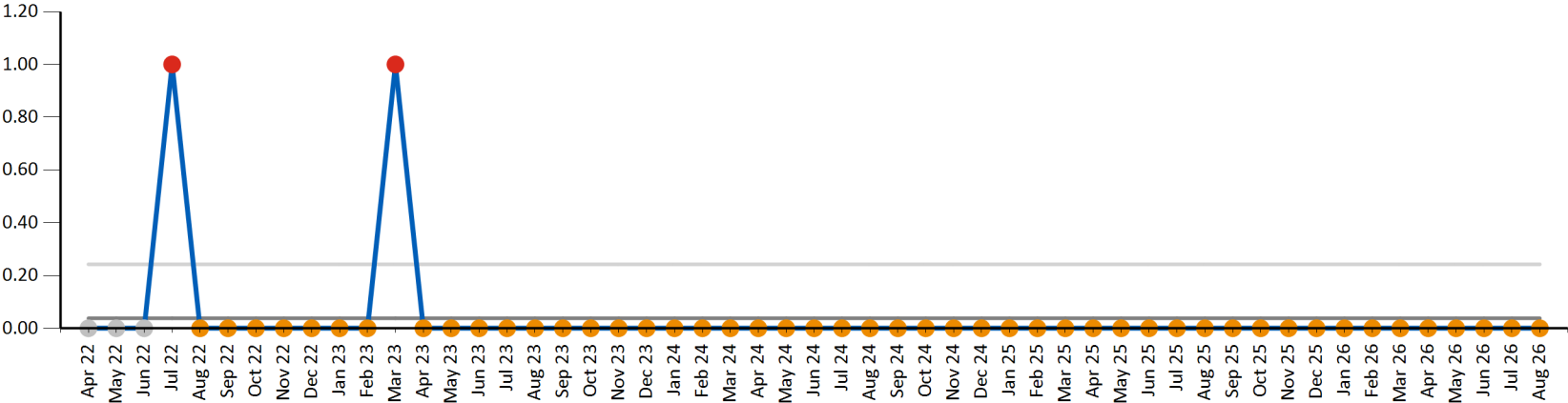
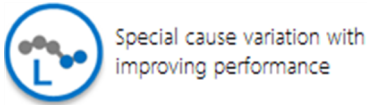
Previous

Plan	Actual	Period
<= 1.0	1.0	Jul-26

Year to Date

Plan	Actual
<= 5.0	9.0

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



Latest

Plan	Actual	Period
	0	Aug-26

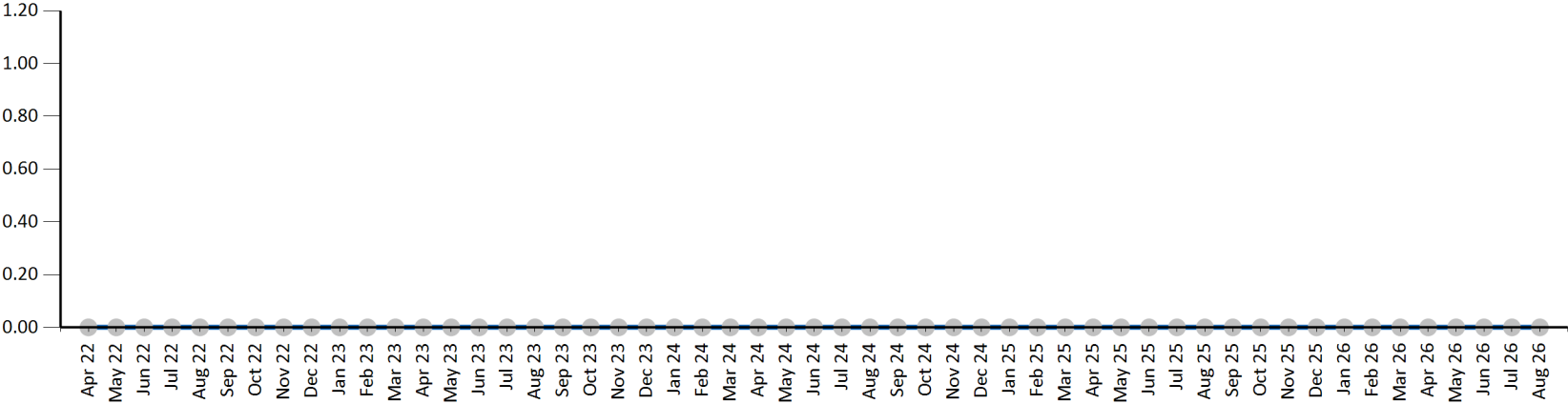
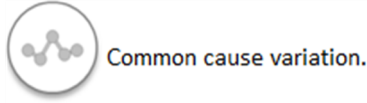
Previous

Plan	Actual	Period
	0	Jul-26

Year to Date

Plan	Actual
	0

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



Latest

Plan	Actual	Period
	0	Aug-26

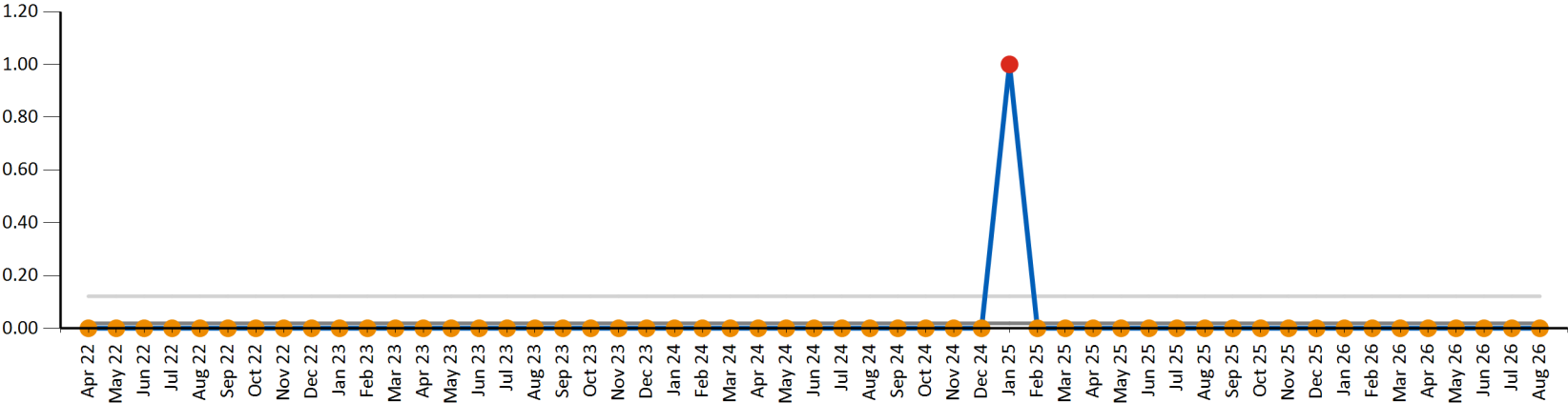
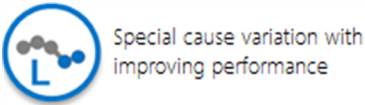
Previous

Plan	Actual	Period
	0	Jul-26

Year to Date

Plan	Actual
	0

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



Latest

Plan	Actual	Period
	0	Aug-26

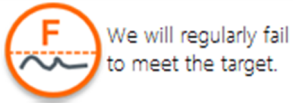
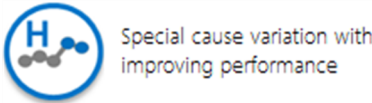
Previous

Plan	Actual	Period
	0	Jul-26

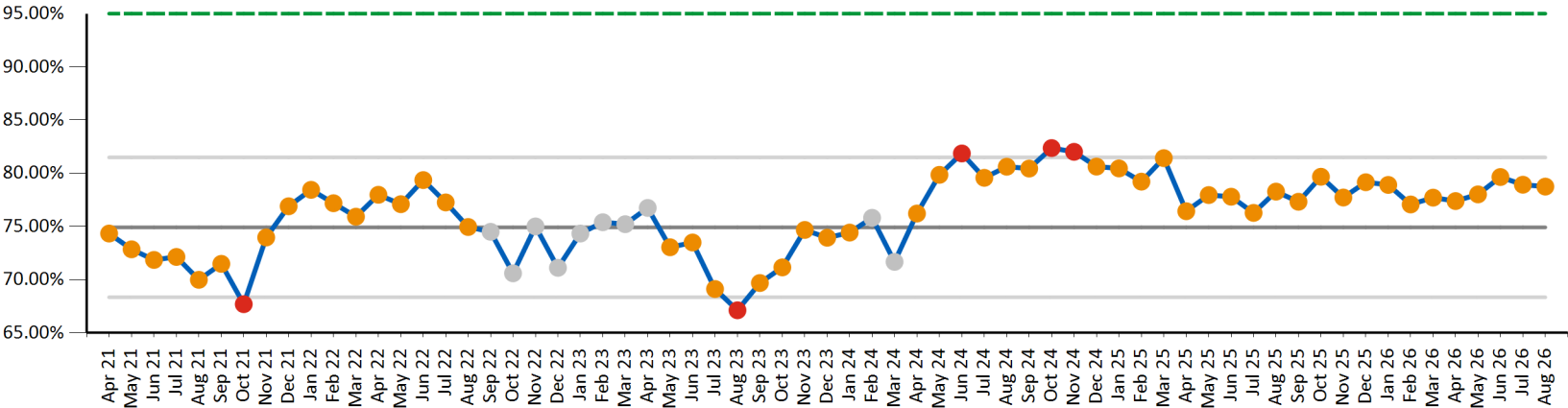
Year to Date

Plan	Actual
	0

30 - Clinical Correspondence - Inpatients %<1 working day



0/6



Latest

Plan	Actual	Period
>= 95%	78.7%	Aug-26

Previous

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

Year to Date

Plan	Actual
>= 95%	78.5%

31 - Clinical Correspondence - Outpatients %<5 working days

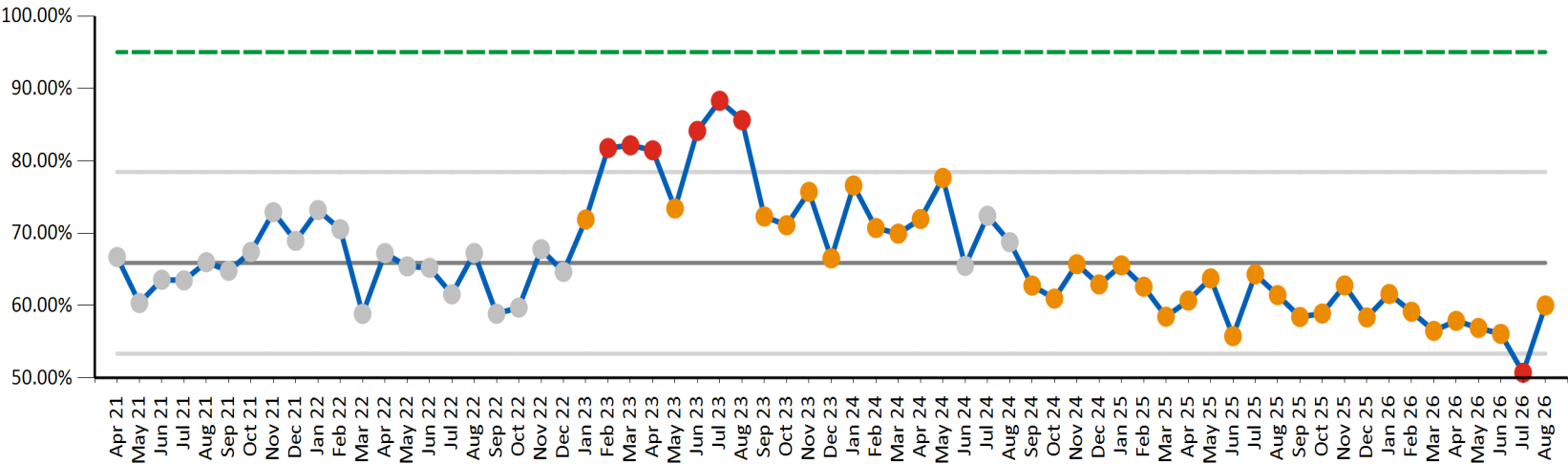


Special cause variation with deteriorating performance



We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95.0%	60.0%	Aug-26

Previous

Plan	Actual	Period
>= 95.0%	50.7%	Jul-26

Year to Date

Plan	Actual
>= 95.0%	56.1%

86 - Patient Safety Alerts - Trust position

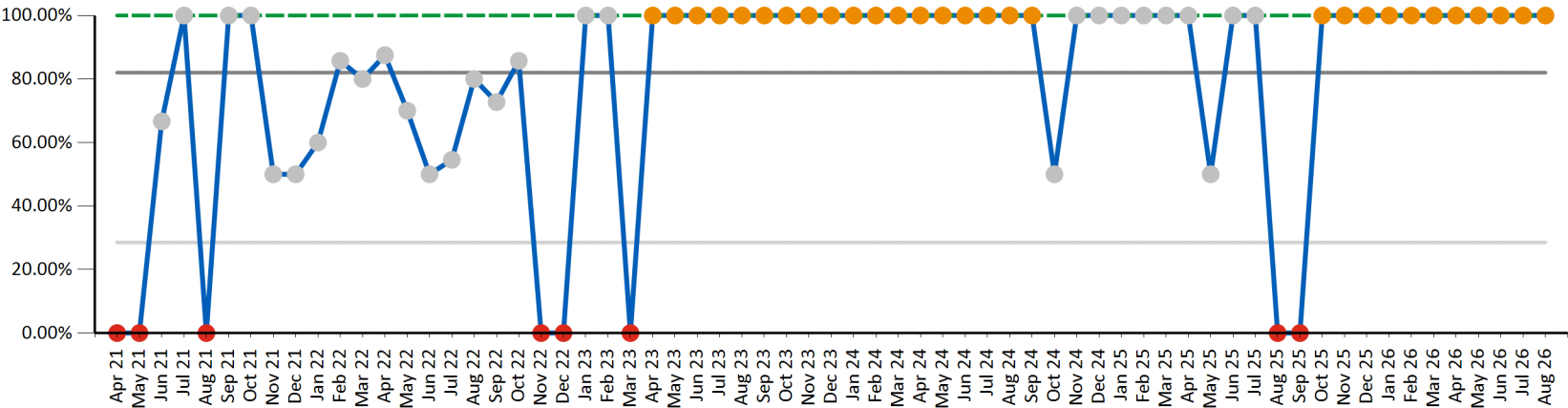


Special cause variation with improving performance



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

6/6



Latest

Plan	Actual	Period
= 100%	100.0%	Aug-26

Previous

Plan	Actual	Period
= 100%	100.0%	Jul-26

Year to Date

Plan	Actual
= 100%	100.0%

88 - Nursing KPI Audits

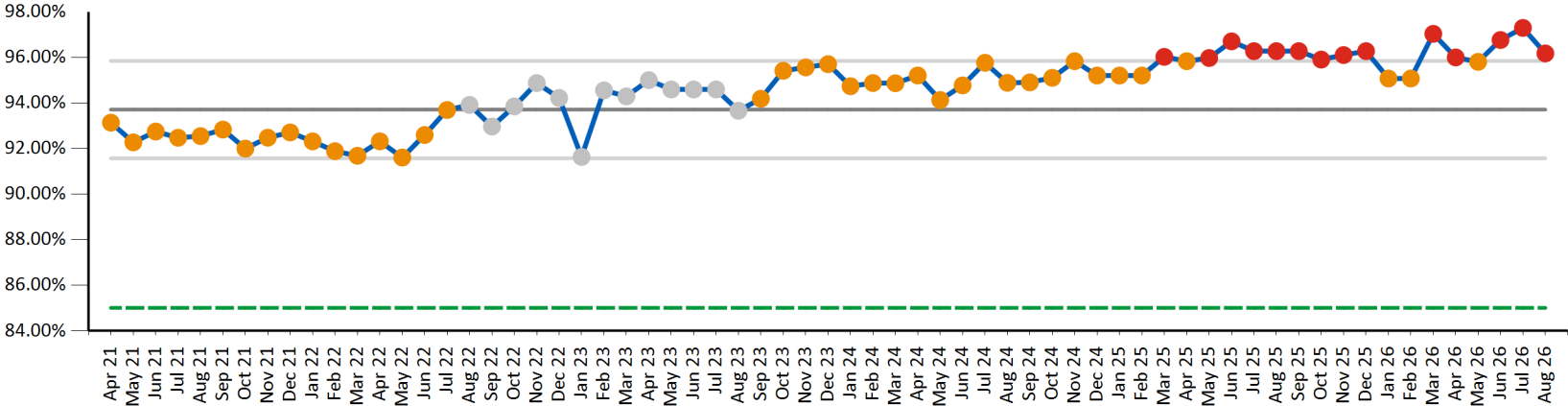


Special cause variation with improving performance



Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	96.2%	Aug-26

Previous

Plan	Actual	Period
>= 85%	97.3%	Jul-26

Year to Date

Plan	Actual
>= 85%	96.4%

91 - Patient Safety Incident Investigation turnaround performance by agreed deadline

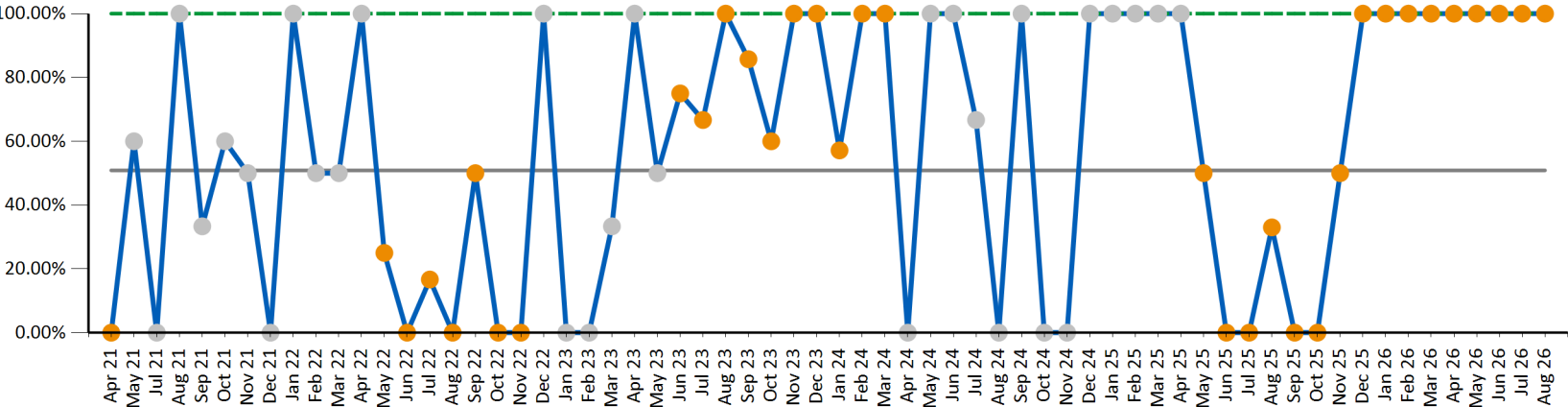


Special cause variation with improving performance



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

6/6



Latest

Plan	Actual	Period
= 100%	100.0%	Aug-26

Previous

Plan	Actual	Period
= 100%	100.0%	Jul-26

Year to Date

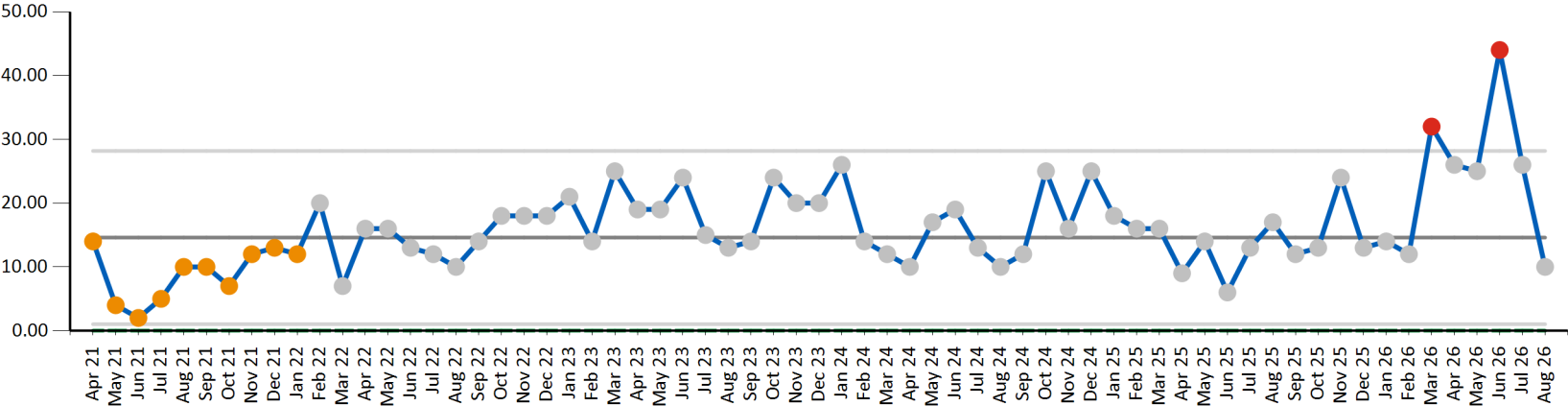
Plan	Actual
= 100%	

8 - Same sex accommodation breaches

 Common cause variation.

 We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	10	Aug-26

Previous

Plan	Actual	Period
= 0	26	Jul-26

Year to Date

Plan	Actual
= 0	131

Quality and Safety - Infection Prevention and Control

MRSA Bacteraemia: There have been 0 healthcare associated MRSA bacteraemia since 05/03/26 – more than 179 days since the last case to the end of August (one of three providers in GM not to have a case in 26/27).

MSSA Bacteraemia: There have been three healthcare associated MSSA bacteraemia in August; the Trust is nearly seven cases under the internal trajectory set to reduce cases by 10% year on year. Current performance is the best performance at the Trust since cases were recorded this way in 2021/22 and there have been five fewer cases than at the same point in 2025/26.

E. coli Bacteraemia: There have been three healthcare associated E. coli bacteraemia in August; the Trust is just under one case under the national trajectory set to reduce cases by 10% year on year. Current performance is the best performance at the Trust since cases were recorded this way in 2021/22 and there have been seven fewer cases than at the same point in 2025/26.

Klebsiella spp. Bacteraemia: There have been two healthcare associated Klebsiella spp. bacteraemia in August; the Trust is just under two cases under the national trajectory set to reduce cases by 10% year on year. Current performance is the second best performance at the Trust since cases were recorded this way in 2021/22 as and there have been four fewer cases than at the same point in 2025/26.

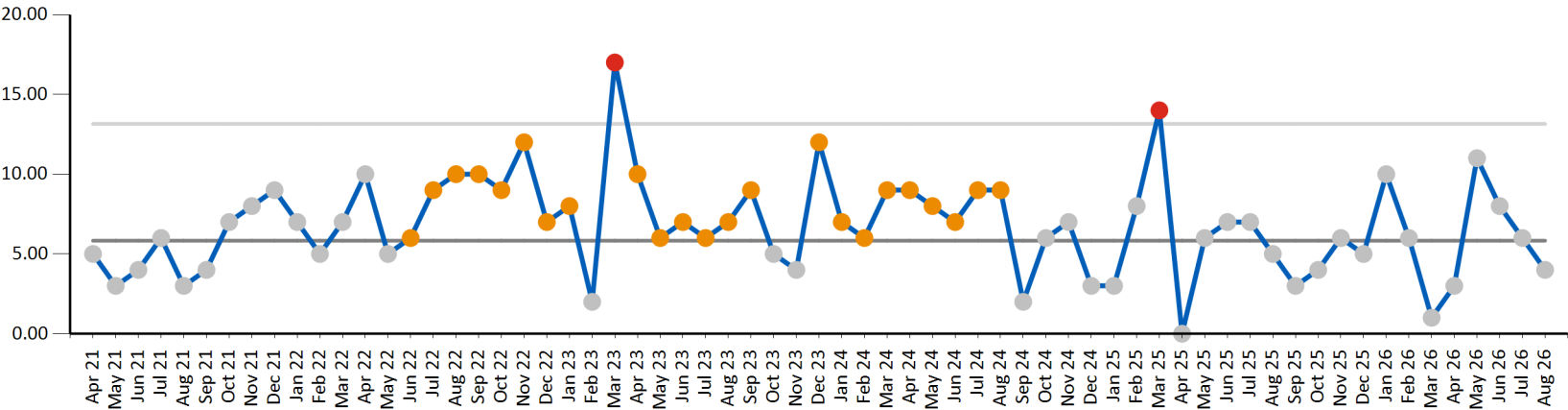
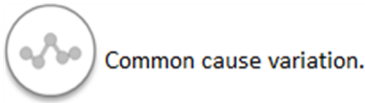
Pseudomonas aeruginosa Bacteraemia: There were 0 healthcare associated Pseudomonas aeruginosa bacteraemia in August; the Trust is just under two cases over the national trajectory set to reduce cases by 10% year on year. The Trust had the same number of cases at the same point in 2025/26.

C. difficile toxin cases: There were four healthcare associated C. difficile toxin cases in August – the lowest monthly number since March; the Trust is 8.5 cases over the national trajectory set to reduce cases by 10% year on year. The Trust had the same number of cases at the same point in 2025/26.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
215 - Total Hospital Onset, Healthcare-Associated C. difficile Cases		4	Aug-26			6	Jul-26		32	
346 - Total Community Onset, Healthcare-Associated C. difficile Cases		0	Aug-26			1	Jul-26		9	
347 - Total Healthcare Associated C. difficile Cases	<= 10	4	Aug-26		<= 10	7	Jul-26	<= 50	41	
217 - Total Healthcare Associated MRSA Bacteraemia (days between cases)	= 0	0	Aug-26		= 0	0	Jul-26	= 0		
218 - Total Healthcare Associated E. coli Bacteraemia	<= 5	3	Aug-26		<= 5	5	Jul-26	<= 26	18	

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
219 - Blood Culture Contaminants (rate)	<= 3%	2.9%	Aug-26		<= 3%	3.7%	Jul-26	<= 3%		
304 - Total Healthcare Associated MSSA Bacteraemia	<= 1.0	2.0	Aug-26		<= 1.0	0.0	Jul-26	<= 5.0	6.0	
305 - Total Healthcare Associated Klebsiella spp. Bacteraemia	<= 1	2	Aug-26		<= 1	1	Jul-26	<= 3	4	
306 - Total Healthcare Associated Pseudomonas aeruginosa Bacteraemia (days between cases)	= 0	0	Aug-26		= 0	1	Jul-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



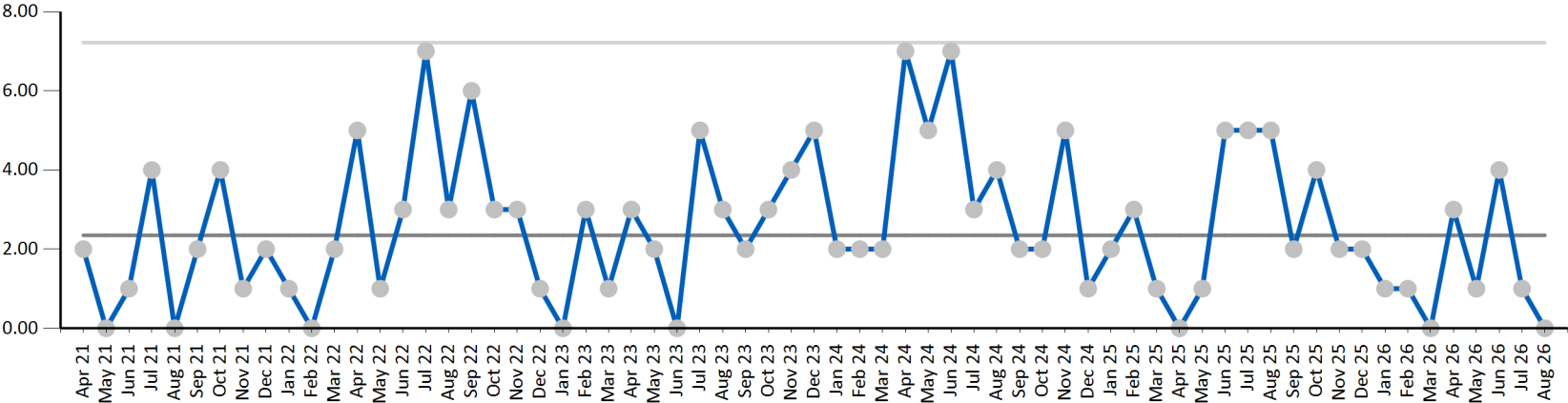
Latest		
Plan	Actual	Period
	4	Aug-26

Previous		
Plan	Actual	Period
	6	Jul-26

Year to Date	
Plan	Actual
	32

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

 Common cause variation.



Latest

Plan	Actual	Period
	0	Aug-26

Previous

Plan	Actual	Period
	1	Jul-26

Year to Date

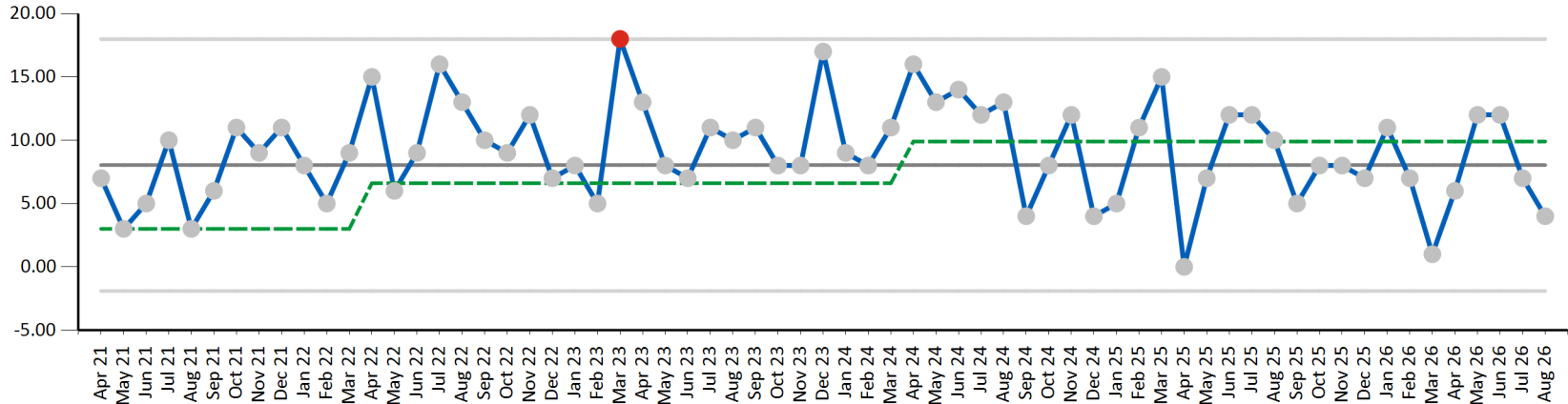
Plan	Actual
	9

347 - Total Healthcare Associated C. difficile Cases

 Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 10	4	Aug-26

Previous

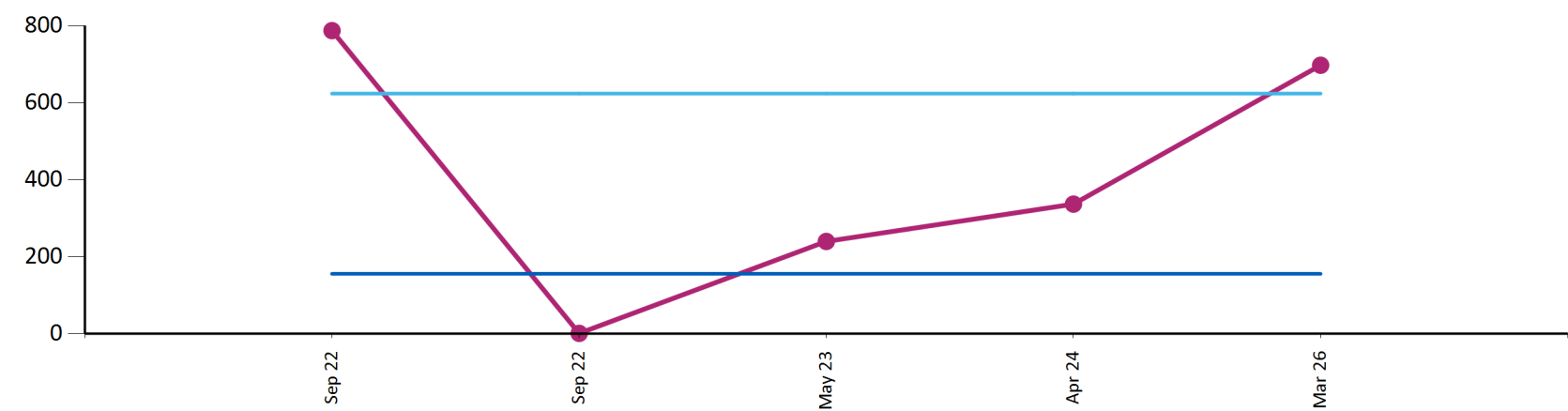
Plan	Actual	Period
<= 10	7	Jul-26

Year to Date

Plan	Actual
<= 50	41

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

0/6



Latest

Plan	Actual	Period
	0	Aug-26

Previous

Plan	Actual	Period
	0	Jul-26

Year to Date

Plan	Actual

218 - Total Healthcare Associated E. coli Bacteraemia

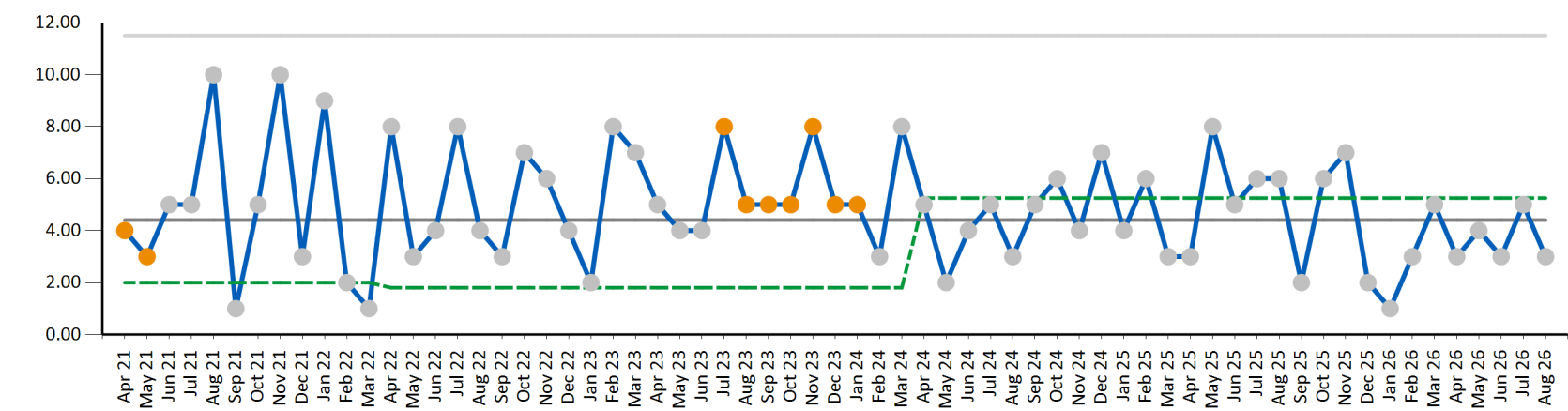


Common cause variation.



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

6/6



Latest

Plan	Actual	Period
<= 5	3	Aug-26

Previous

Plan	Actual	Period
<= 5	5	Jul-26

Year to Date

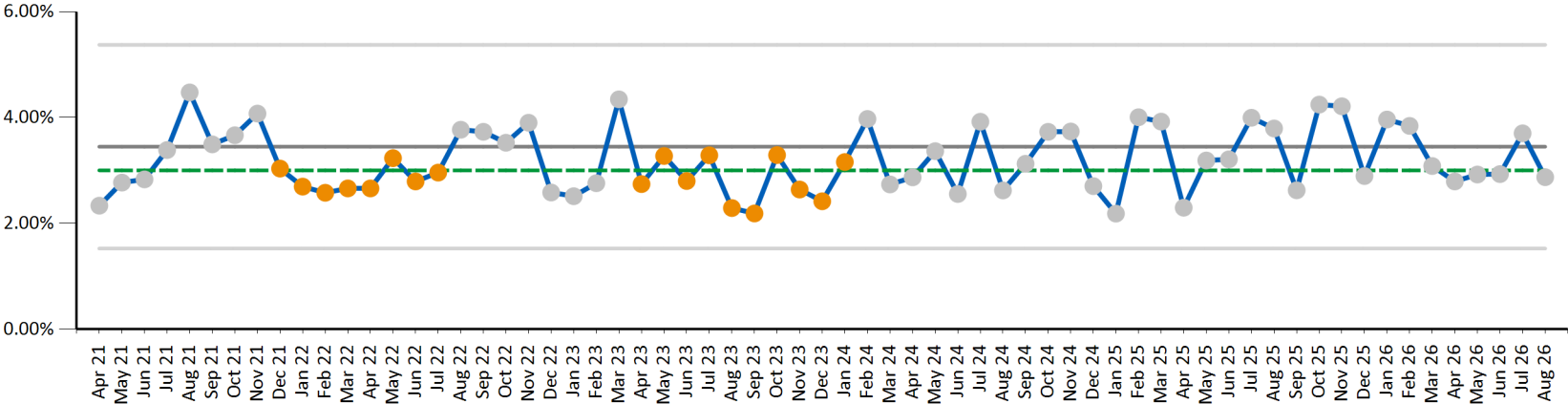
Plan	Actual
<= 26	18

219 - Blood Culture Contaminants (rate)

 Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 3%	2.9%	Aug-26

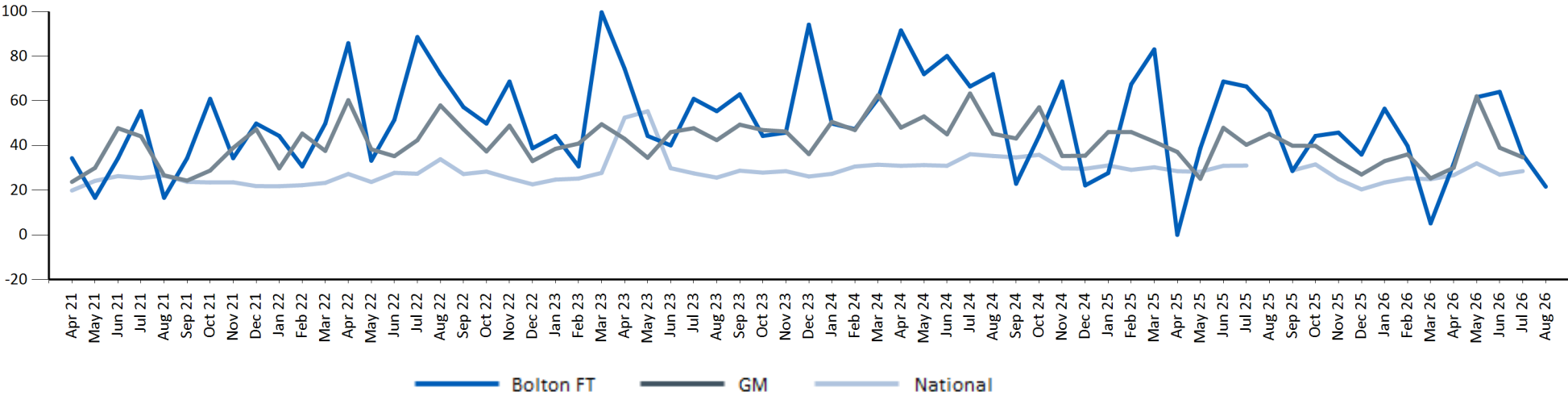
Previous

Plan	Actual	Period
<= 3%	3.7%	Jul-26

Year to Date

Plan	Actual
<= 3%	

549 - C Diff Rate Comparison

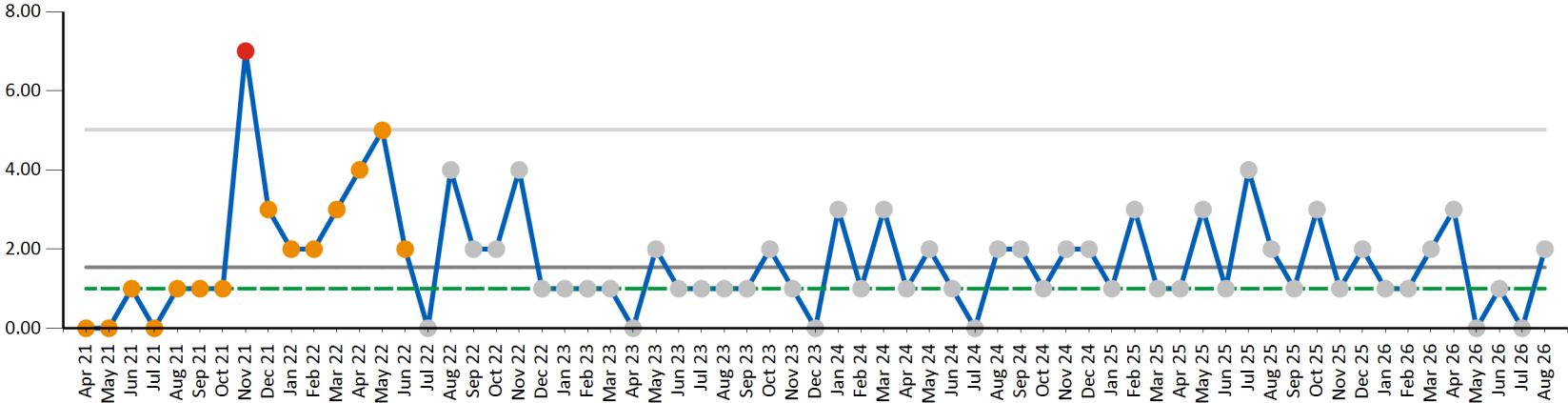


304 - Total Healthcare Associated MSSA Bacteraemia

 Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 1.0	2.0	Aug-26

Previous

Plan	Actual	Period
<= 1.0	0.0	Jul-26

Year to Date

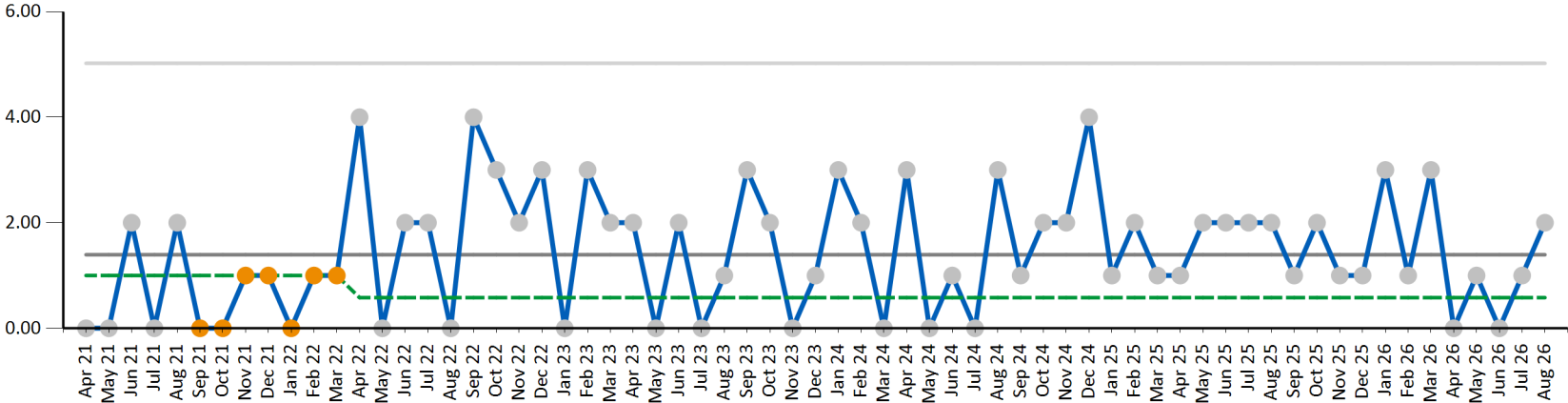
Plan	Actual
<= 5.0	6.0

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	2	Aug-26

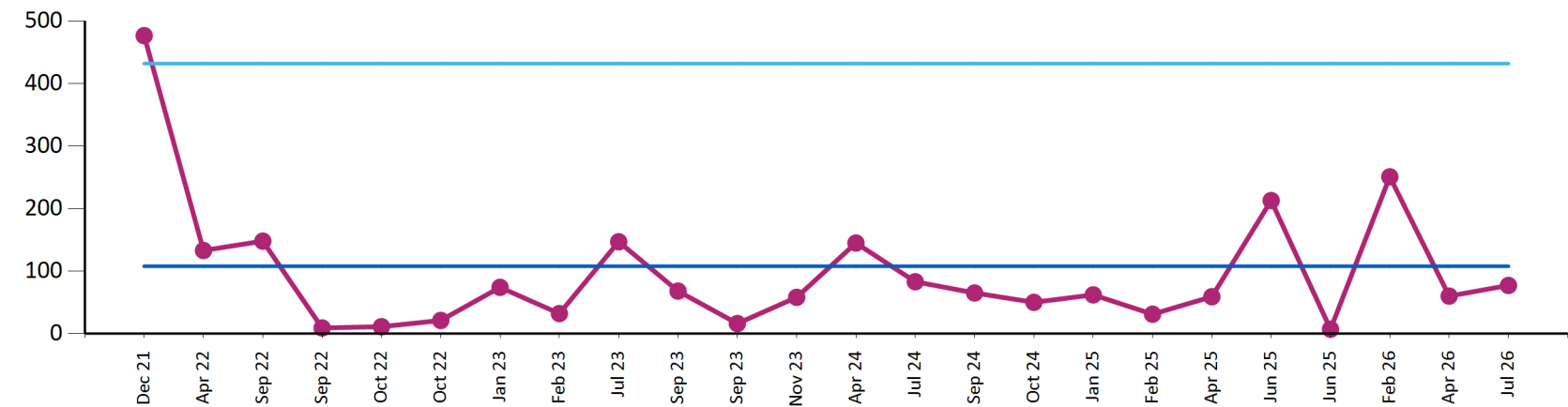
Previous

Plan	Actual	Period
<= 1	1	Jul-26

Year to Date

Plan	Actual
<= 3	4

306 - Total Healthcare Associated Pseudomonas aeruginosa Bacteraemia (days between cases)



0/6

Latest

Plan	Actual	Period
	0	Aug-26

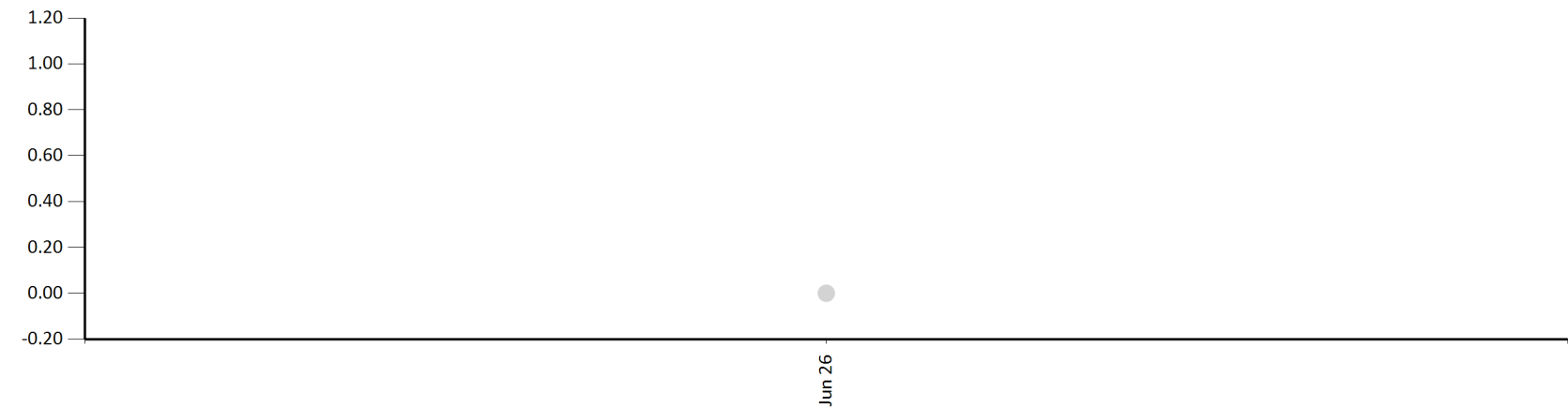
Previous

Plan	Actual	Period
	1	Jul-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

Crude – in month rate is below Trust target and average for the timeframe and is showing 27 points below the mean showing improved special cause. It has now remained in control for more than three years.

HSMR – in month figure is below average for the period and remains in control. The 12 month rolling average to May 2026 is 108.32, this is 'Amber' when compared to other Trusts.

SHMI – in month figure is below average for the time period and remains in control. The published rolling average for the period May 2025 to April 2026 is 112.27 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 indicators are still lower when benchmarked against the England average of all Acute Trusts but are showing a steady improving trajectory over time.

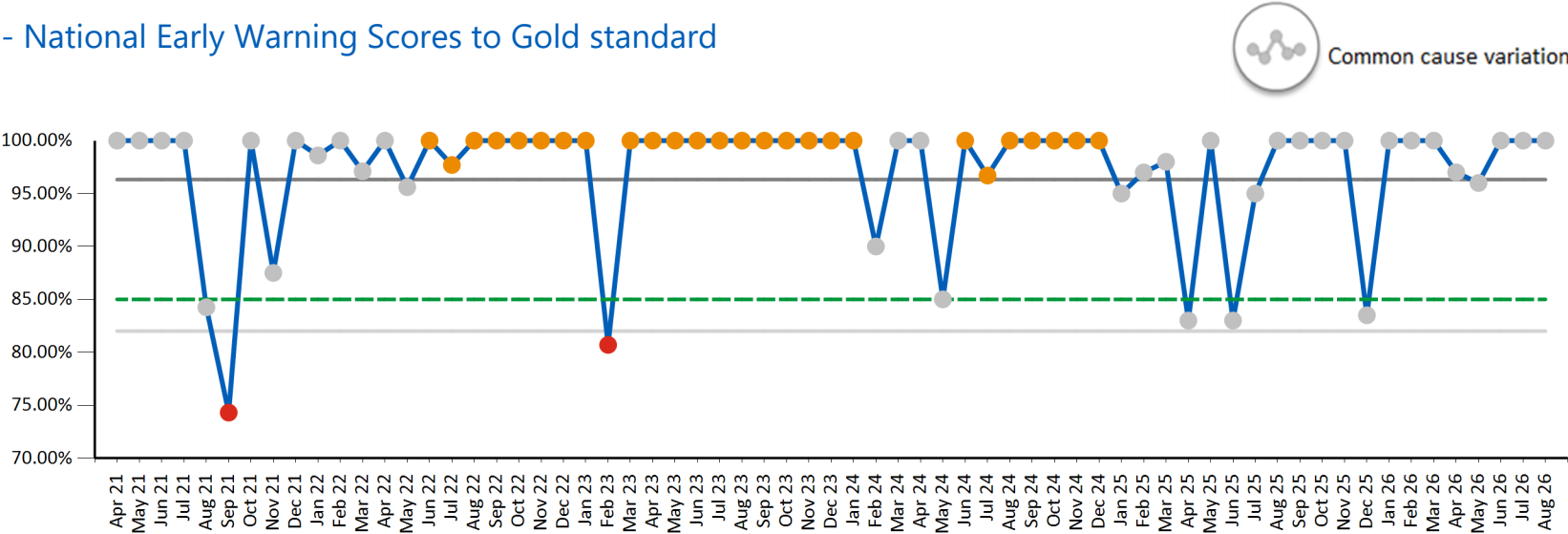
The proportion of coded records at the time of the snapshot remains above the average for the timeframe.

The early neonatal mortality rate is in control with the rate at zero for the reporting month.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Aug-26		>= 85%	100.0%	Jul-26	>= 85%	98.6%	
495 - HSMR		95.70	May-26			103.76	Apr-26		95.70	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	99.78	Mar-26		<= 100.00	111.22	Feb-26	<= 100.00		
12 - Crude Mortality %	<= 2.9%	1.5%	Aug-26		<= 2.9%	1.7%	Jul-26	<= 2.9%	1.8%	
519 - Average Charlson comorbidity Score (First episode of care)		5	May-26			4	Apr-26		9	
520 - Depth of recording (First episode of care)		6	May-26			6	Apr-26		13	
521 - Proportion of fully coded records (Inpatients)		100.0%	Apr-26			100.0%	Mar-26		100.0%	

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS)		0.00	Aug-26			2.40	Jul-26			

3 - National Early Warning Scores to Gold standard



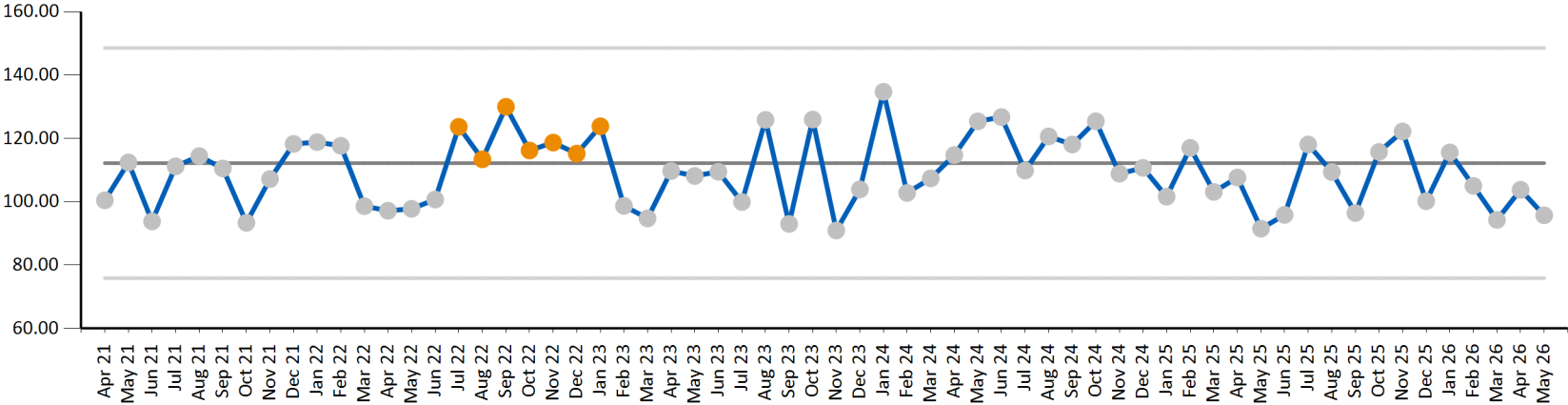
Latest		
Plan	Actual	Period
>= 85%	100.0%	Aug-26

Previous		
Plan	Actual	Period
>= 85%	100.0%	Jul-26

Year to Date	
Plan	Actual
>= 85%	98.6%

495 - HSMR

 Common cause variation.



Latest

Plan	Actual	Period
	95.70	May-26

Previous

Plan	Actual	Period
	103.76	Apr-26

Year to Date

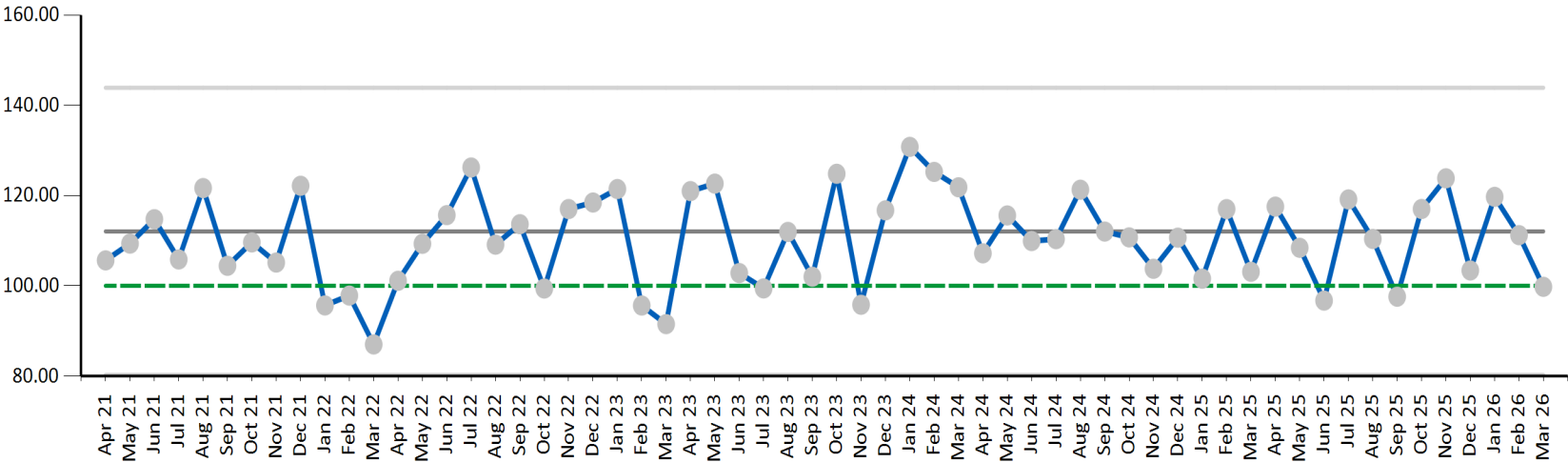
Plan	Actual
	95.70

11 - Summary Hospital-level Mortality Indicator (SHMI)

 Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 100.00	99.78	Mar-26

Previous

Plan	Actual	Period
<= 100.00	111.22	Feb-26

Year to Date

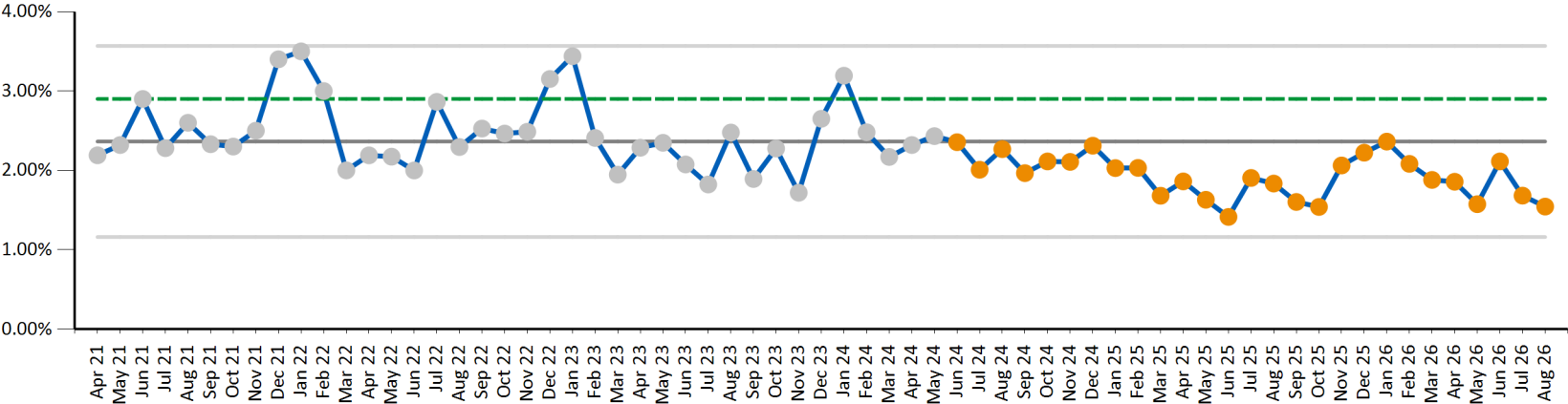
Plan	Actual
<= 100.00	99.78

12 - Crude Mortality %

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 2.9%	1.5%	Aug-26

Previous

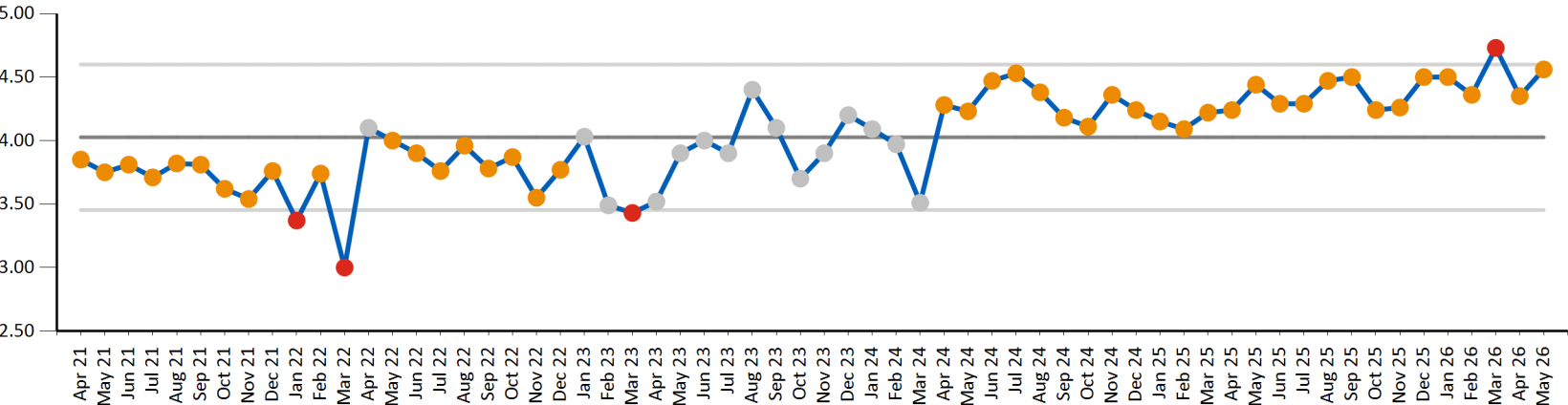
Plan	Actual	Period
<= 2.9%	1.7%	Jul-26

Year to Date

Plan	Actual
<= 2.9%	1.8%

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	5	May-26

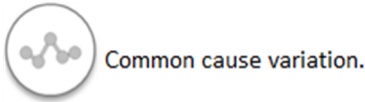
Previous

Plan	Actual	Period
	4	Apr-26

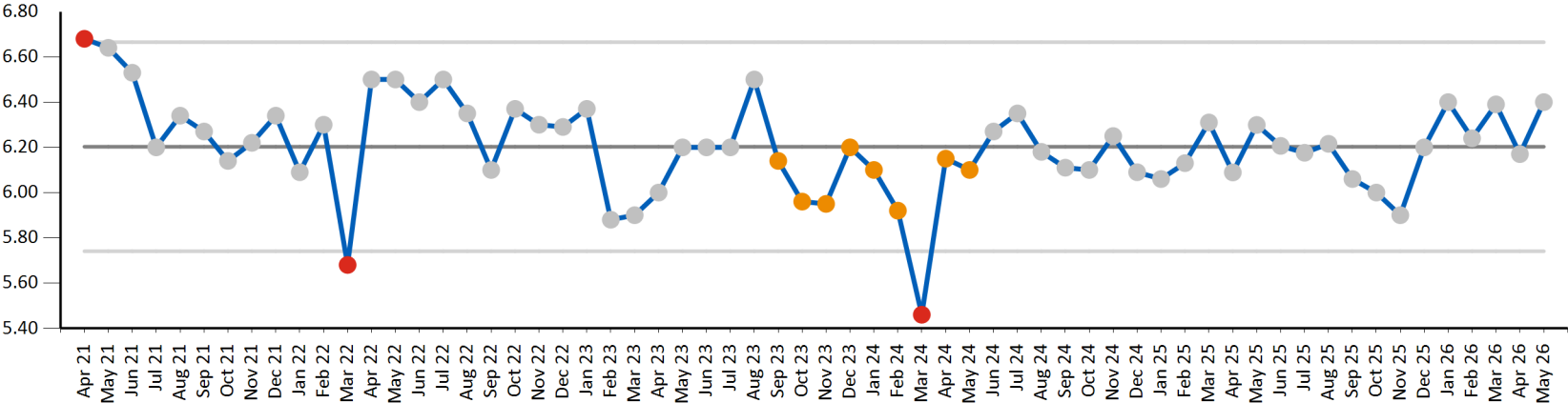
Year to Date

Plan	Actual
	9

520 - Depth of recording (First episode of care)



Common cause variation.



Latest

Plan	Actual	Period
	6	May-26

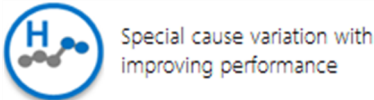
Previous

Plan	Actual	Period
	6	Apr-26

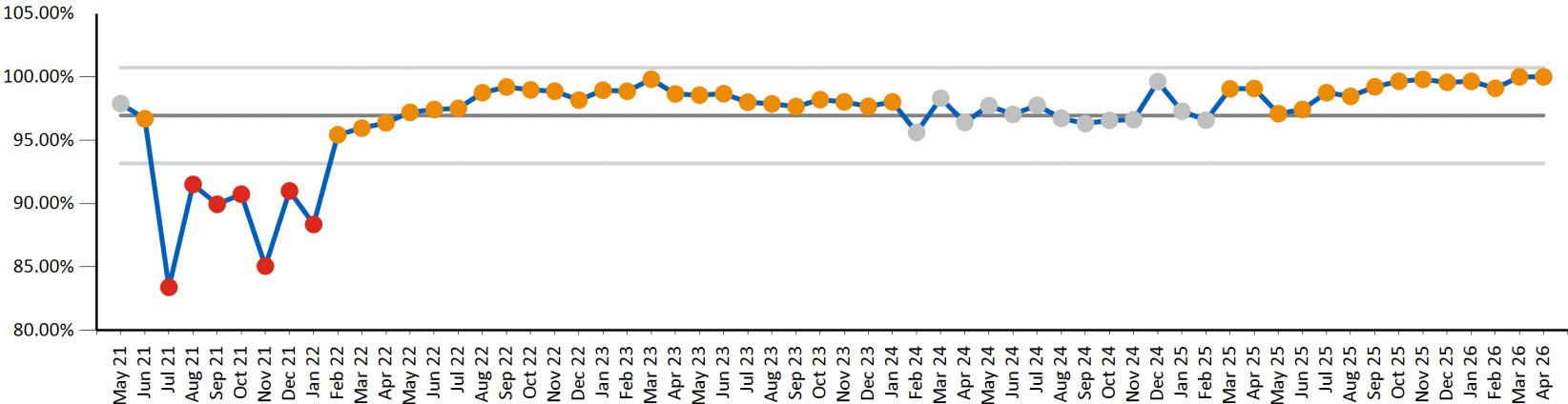
Year to Date

Plan	Actual
	13

521 - Proportion of fully coded records (Inpatients)



Special cause variation with improving performance



Latest

Plan	Actual	Period
	100.0%	Apr-26

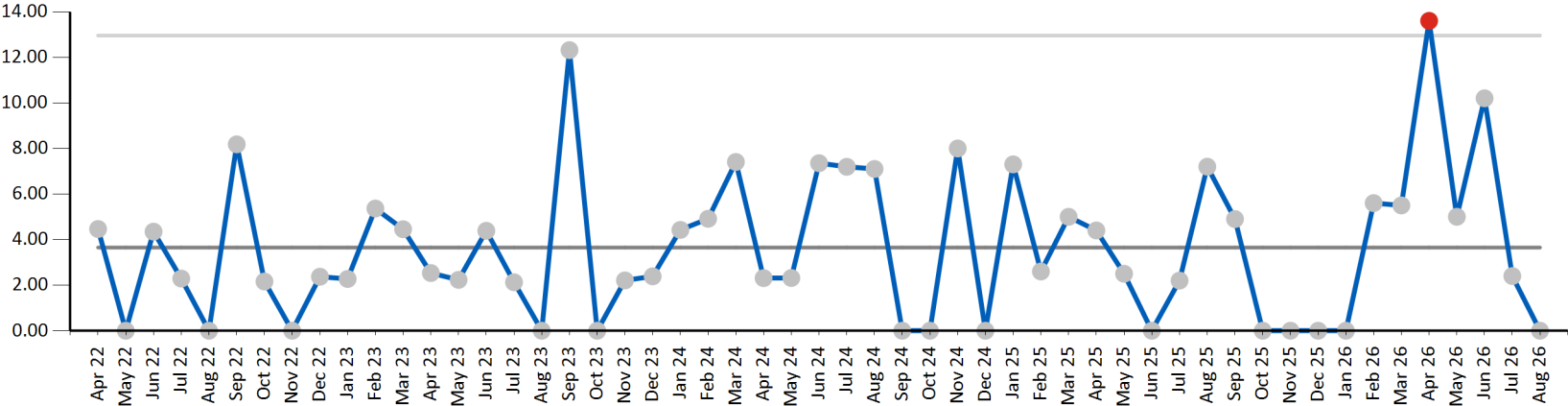
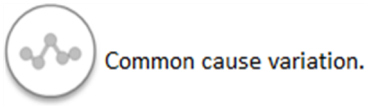
Previous

Plan	Actual	Period
	100.0%	Mar-26

Year to Date

Plan	Actual
	100.0%

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



Latest

Plan	Actual	Period
	0.00	Aug-26

Previous

Plan	Actual	Period
	2.40	Jul-26

Year to Date

Plan	Actual
------	--------

Quality and Safety - Patient Experience

Complaint Responses:

Complaint response rates remained below target during August. This is due to a combination of an increase in complaints received throughout July and August, placing significant pressures on divisions to respond to the complaints in time elaborated by sickness and annual leave during this period. The increasing use of AI tools to support the drafting of complaints has increased accessibility for complainants to raise both complaints and PALS, however in turn this is resulting in much more detailed and complex complaints and responses. This is a phenomena being experienced nationally.

Whilst some improvement was seen during the middle of the month, performance was not sustained across the reporting period due to ongoing capacity challenges.

FFT:

There has been a notable decrease in response rates across FFT for the NHSE mandatory reporting areas. The new FFT system launched on the 1st Aug 26, the transition to the new provider (IQVIA) the Trust with the opportunity to include more services to contribute to FFT questionnaires – subsequently the number of eligible patients invited to complete the questionnaire has increased, meaning that the greater denominator may then reflect as a lower response rate until the use of QR codes is embedded across the Trust. IQVIA also exclude patients receiving a duplicate if they have attended an additional service within 3 days of receiving their 1st questionnaire, as part of survey fatigue management. These patients do still have the option of using the QR code to complete a questionnaire but will not receive multiple text invites over several days. The uptake of FFT questionnaires will continue to be monitored at a Divisional and Trust level via Quality and Patient Experience Reporting Group.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	7.1%	Aug-26		>= 20%	13.6%	Jul-26	>= 20%	12.4%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	81.7%	Aug-26		>= 90%	86.1%	Jul-26	>= 90%	83.7%	
80 - Inpatient Friends and Family Response Rate	>= 30%	15.6%	Aug-26		>= 30%	20.8%	Jul-26	>= 30%	20.7%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	94.3%	Aug-26		>= 90%	95.7%	Jul-26	>= 90%	93.8%	
81 - Maternity Friends and Family Response Rate	>= 15%	11.9%	Aug-26		>= 15%	19.2%	Jul-26	>= 15%	19.0%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	95.5%	Aug-26		>= 90%	72.9%	Jul-26	>= 90%	89.3%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	9.9%	Aug-26		>= 15%	8.9%	Jul-26	>= 15%	12.0%	

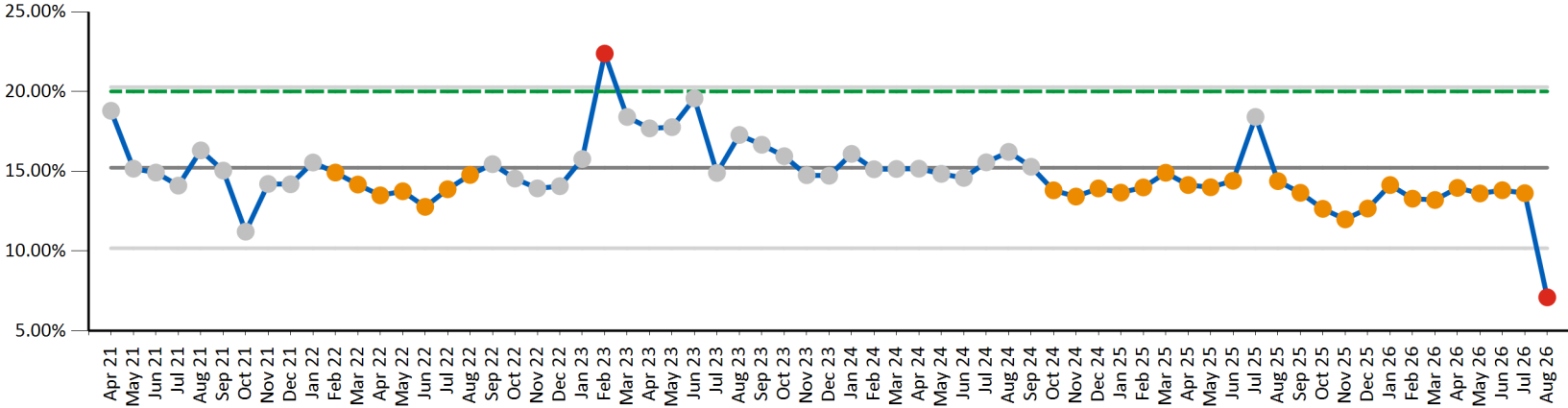
Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	90.0%	Aug-26		>= 90%	30.0%	Jul-26	>= 90%	86.2%	
83 - Birth - Friends and Family Response Rate	>= 15%	20.6%	Aug-26		>= 15%	29.9%	Jul-26	>= 15%	30.5%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	95.2%	Aug-26		>= 90%	88.9%	Jul-26	>= 90%	92.1%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	6.1%	Aug-26		>= 15%	22.7%	Jul-26	>= 15%	15.9%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	100.0%	Aug-26		>= 90%	85.5%	Jul-26	>= 90%	88.1%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	9.0%	Aug-26		>= 15%	17.3%	Jul-26	>= 15%	17.4%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	100.0%	Aug-26		>= 90%	59.0%	Jul-26	>= 90%	87.5%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Aug-26		= 100%	100.0%	Jul-26	= 100%	100.0%	
90 - Complaints responded to within the period	>= 95%	55.6%	Aug-26		>= 95%	54.2%	Jul-26	>= 95%	58.0%	

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%	7.1%	Aug-26

Previous

Plan	Actual	Period
>= 20%	13.6%	Jul-26

Year to Date

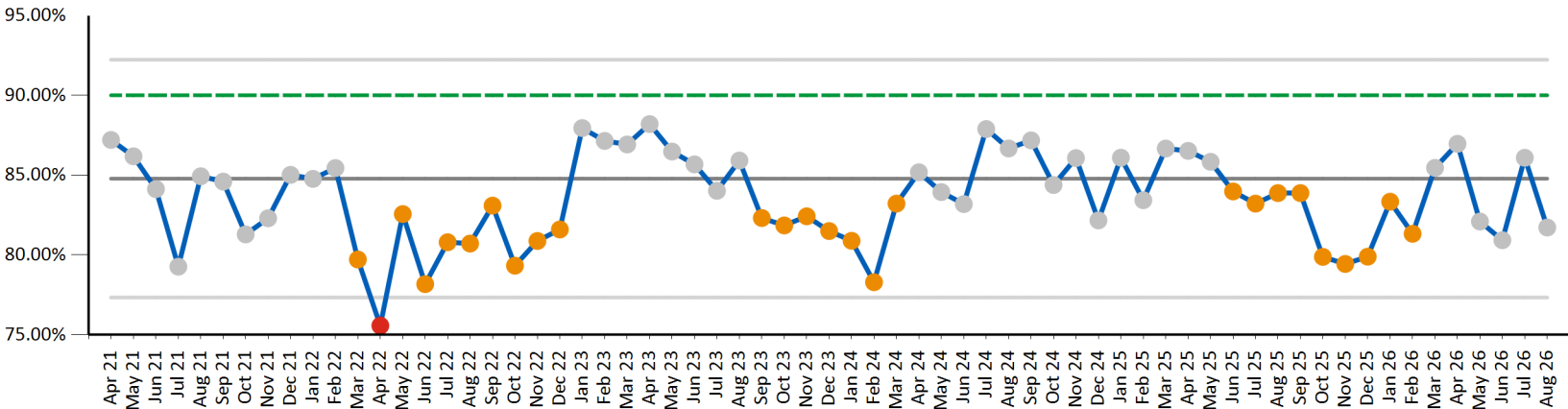
Plan	Actual
>= 20%	12.4%

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%	81.7%	Aug-26

Previous

Plan	Actual	Period
>= 90%	86.1%	Jul-26

Year to Date

Plan	Actual
>= 90%	83.7%

80 - Inpatient Friends and Family Response Rate

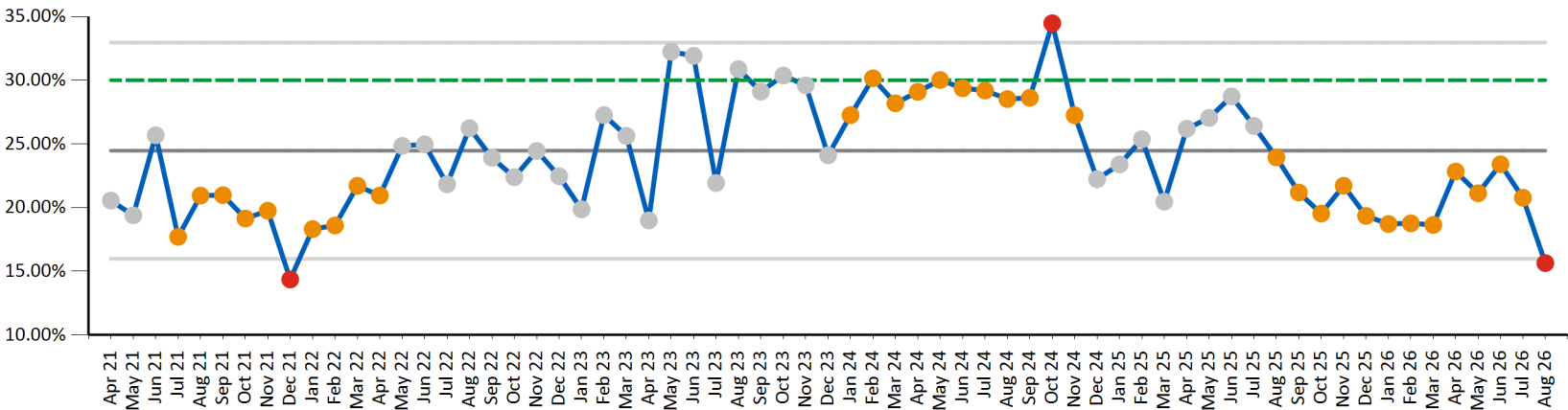


Special cause variation with deteriorating performance



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

0/6



Latest

Plan	Actual	Period
>= 30%	15.6%	Aug-26

Previous

Plan	Actual	Period
>= 30%	20.8%	Jul-26

Year to Date

Plan	Actual
>= 30%	20.7%

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

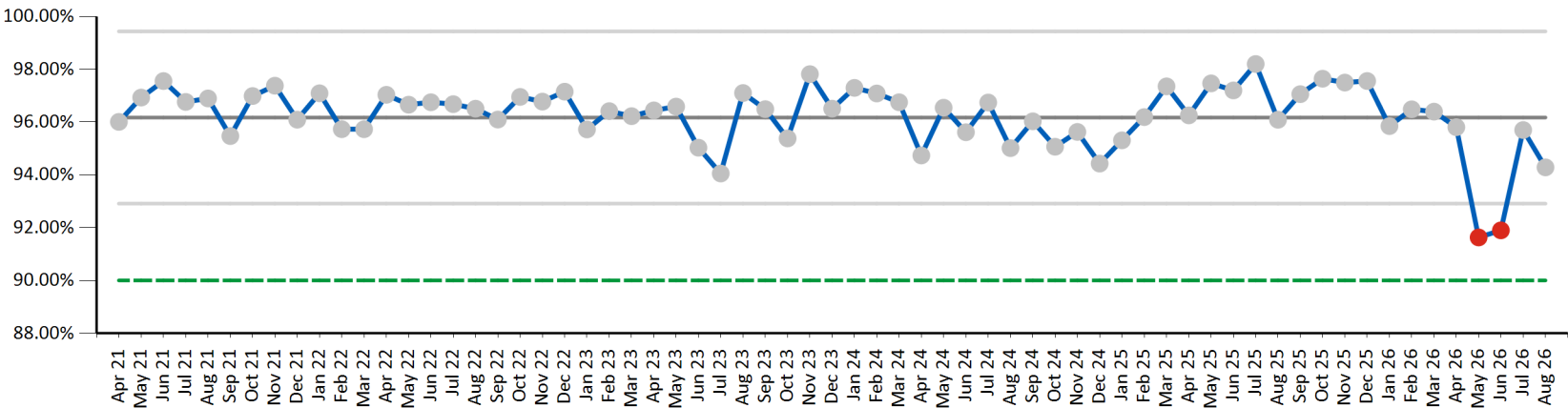


Common cause variation.



Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 90%	94.3%	Aug-26

Previous

Plan	Actual	Period
>= 90%	95.7%	Jul-26

Year to Date

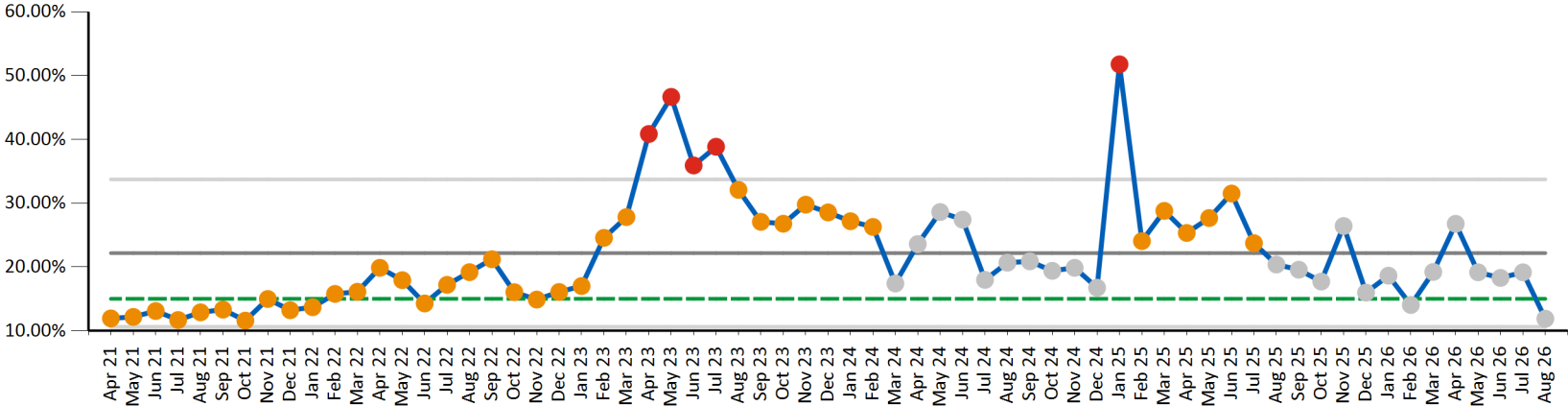
Plan	Actual
>= 90%	93.8%

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%	11.9%	Aug-26

Previous

Plan	Actual	Period
>= 15%	19.2%	Jul-26

Year to Date

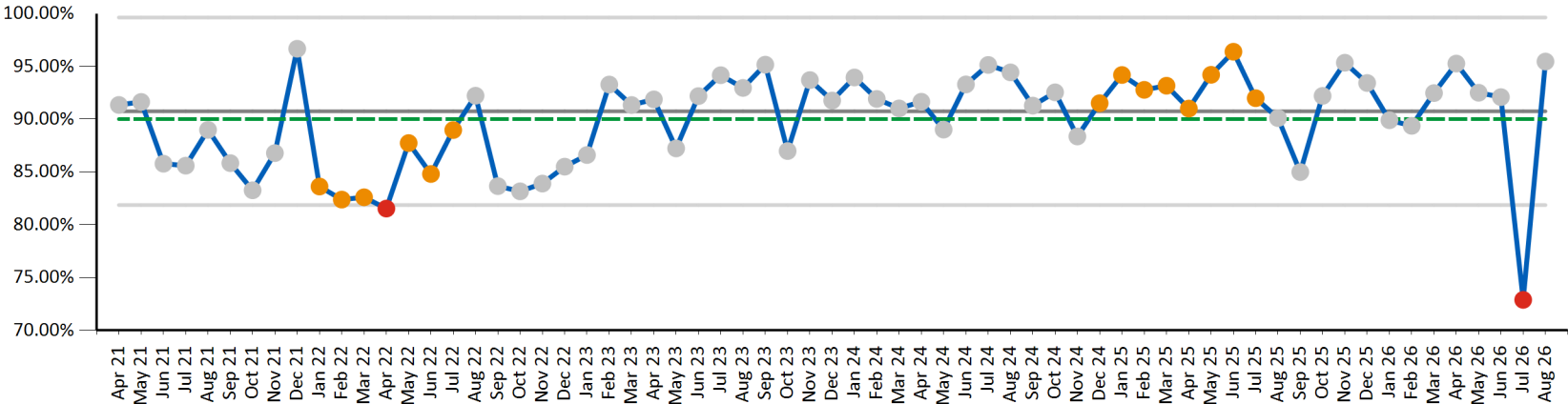
Plan	Actual
>= 15%	19.0%

241 - Maternity Friends and Family Test - Satisfaction %

 Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 90%	95.5%	Aug-26

Previous

Plan	Actual	Period
>= 90%	72.9%	Jul-26

Year to Date

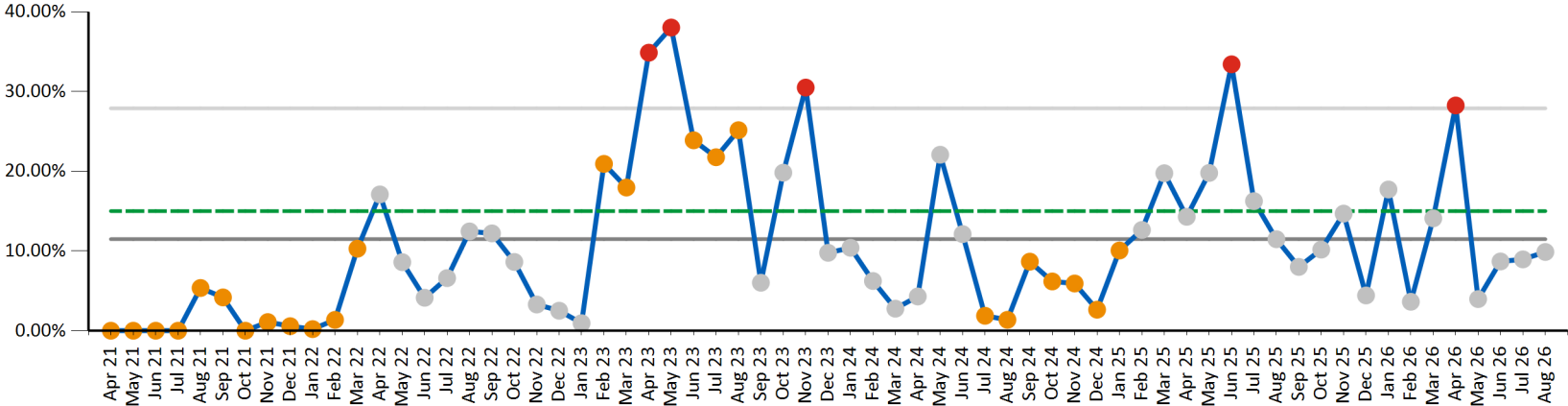
Plan	Actual
>= 90%	89.3%

82 - Antenatal - Friends and Family Response Rate

Common cause variation.

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

1/6



Latest		
Plan	Actual	Period
>= 15%	9.9%	Aug-26

Previous		
Plan	Actual	Period
>= 15%	8.9%	Jul-26

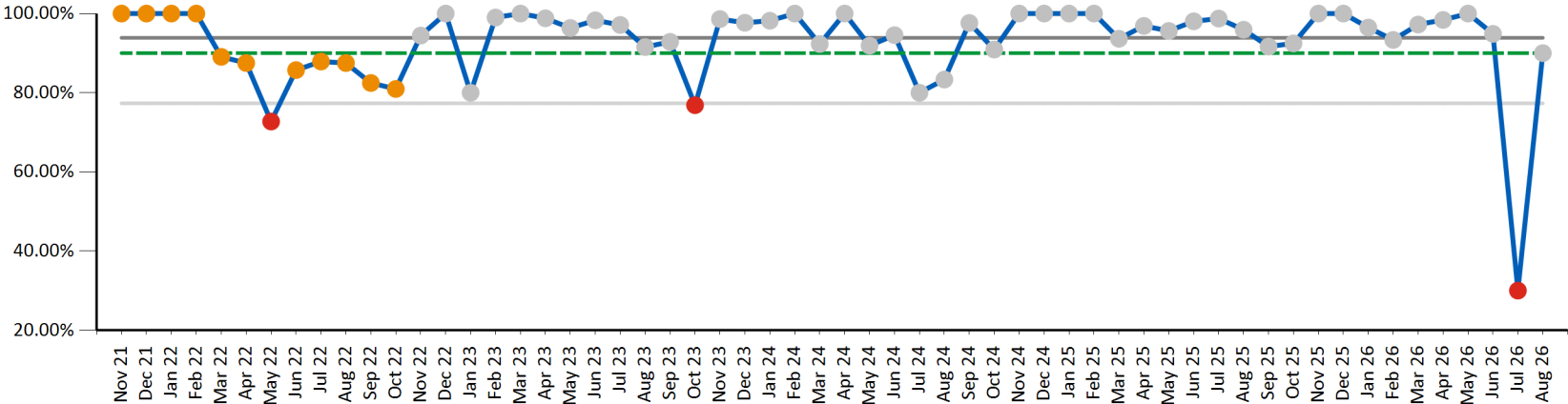
Year to Date	
Plan	Actual
>= 15%	12.0%

242 - Antenatal Friends and Family Test - Satisfaction %

Common cause variation.

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

5/6



Latest		
Plan	Actual	Period
>= 90%	90.0%	Aug-26

Previous		
Plan	Actual	Period
>= 90%	30.0%	Jul-26

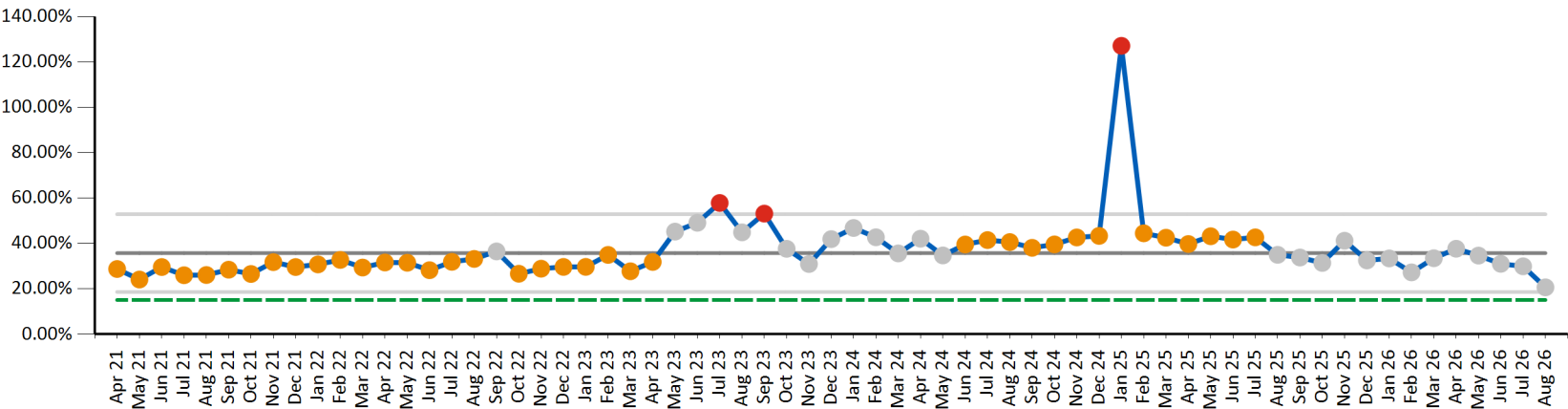
Year to Date	
Plan	Actual
>= 90%	86.2%

83 - Birth - Friends and Family Response Rate

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 15%	20.6%	Aug-26

Previous

Plan	Actual	Period
>= 15%	29.9%	Jul-26

Year to Date

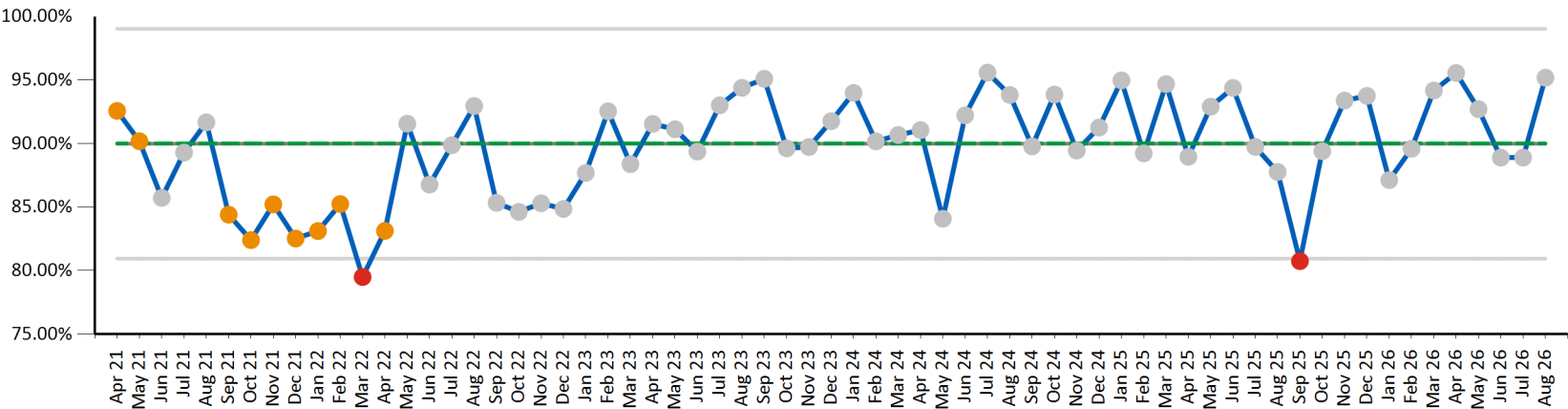
Plan	Actual
>= 15%	30.5%

243 - Birth 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%	95.2%	Aug-26

Previous

Plan	Actual	Period
>= 90%	88.9%	Jul-26

Year to Date

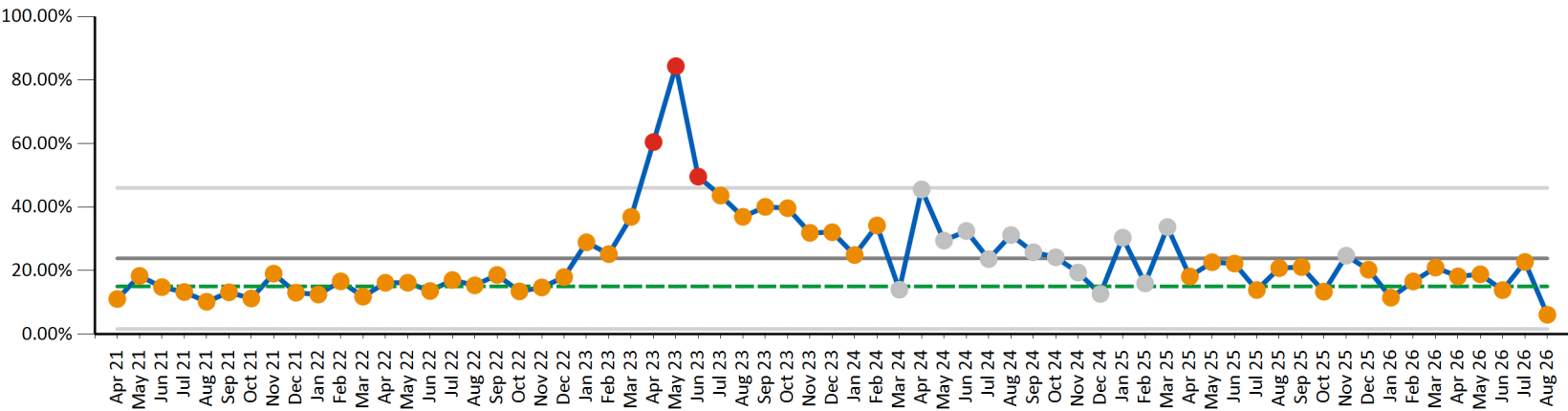
Plan	Actual
>= 90%	92.1%

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%	6.1%	Aug-26

Previous

Plan	Actual	Period
>= 15%	22.7%	Jul-26

Year to Date

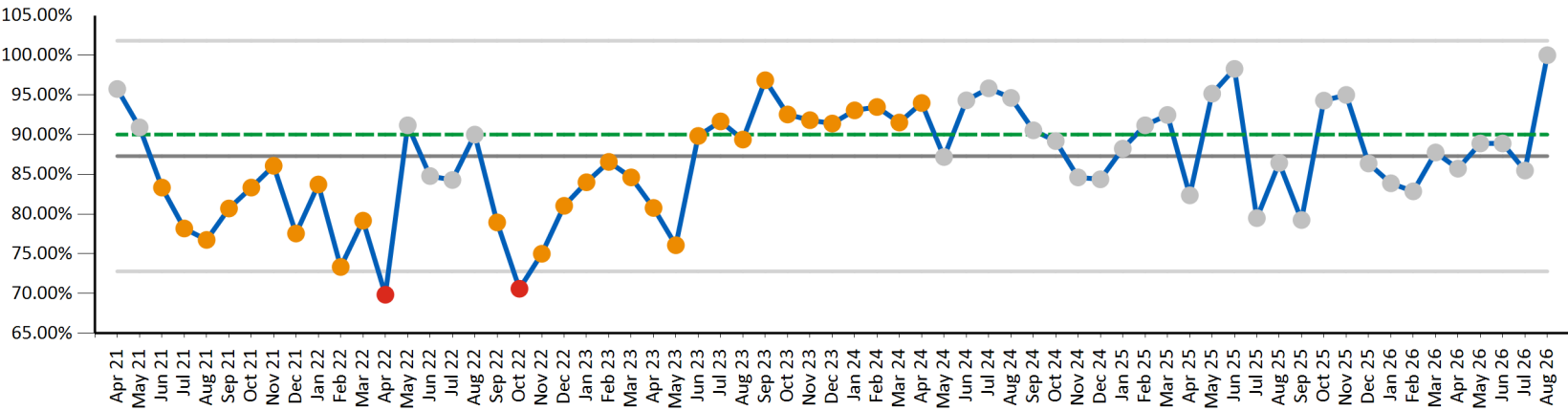
Plan	Actual
>= 15%	15.9%

244 - Hospital Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 90%	100.0%	Aug-26

Previous

Plan	Actual	Period
>= 90%	85.5%	Jul-26

Year to Date

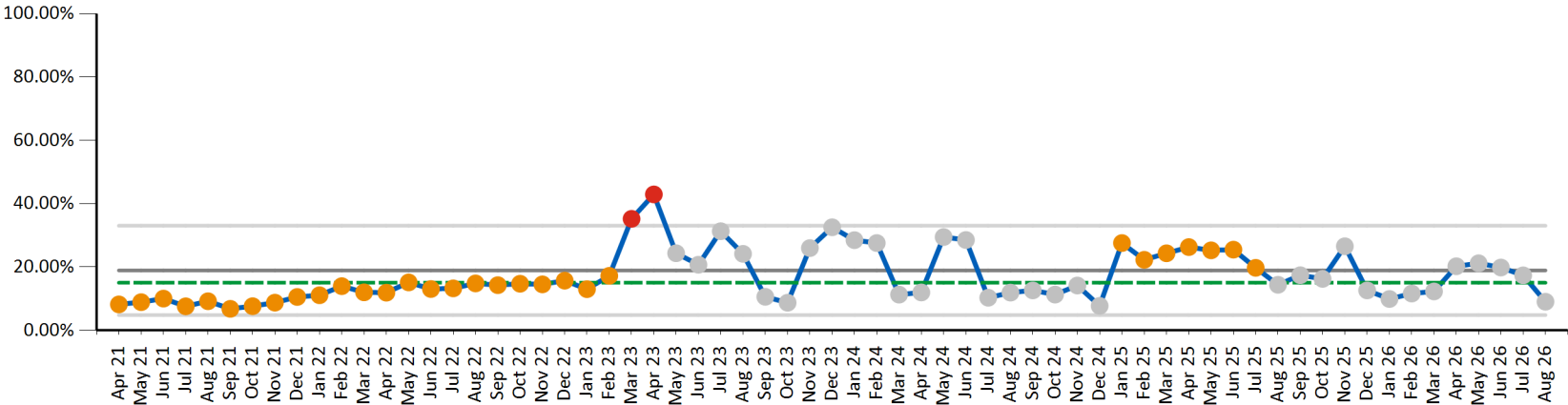
Plan	Actual
>= 90%	88.1%

85 - Community Postnatal - Friend and Family Response Rate

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
>= 15%	9.0%	Aug-26

Previous

Plan	Actual	Period
>= 15%	17.3%	Jul-26

Year to Date

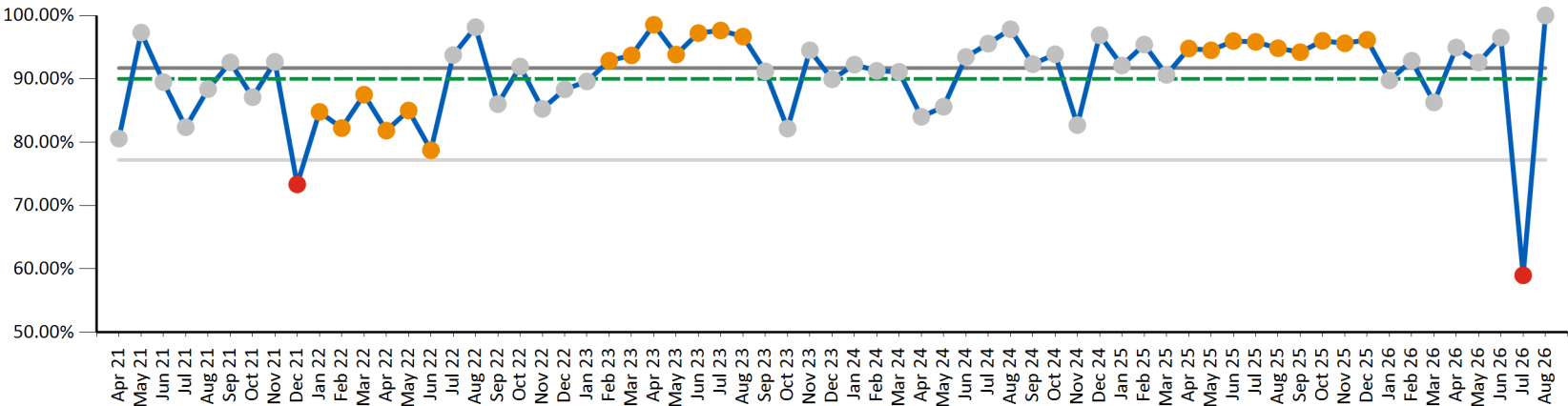
Plan	Actual
>= 15%	17.4%

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%	100.0%	Aug-26

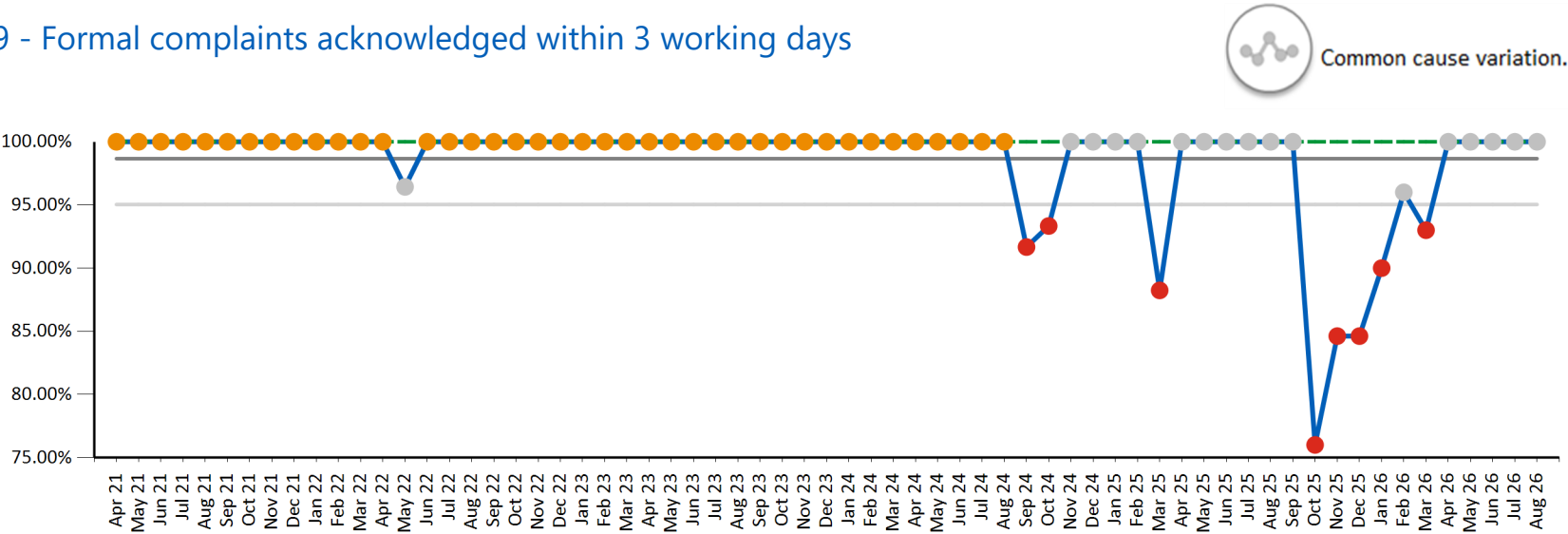
Previous

Plan	Actual	Period
>= 90%	59.0%	Jul-26

Year to Date

Plan	Actual
>= 90%	87.5%

89 - Formal complaints acknowledged within 3 working days



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

5/6

Latest

Plan	Actual	Period
= 100%	100.0%	Aug-26

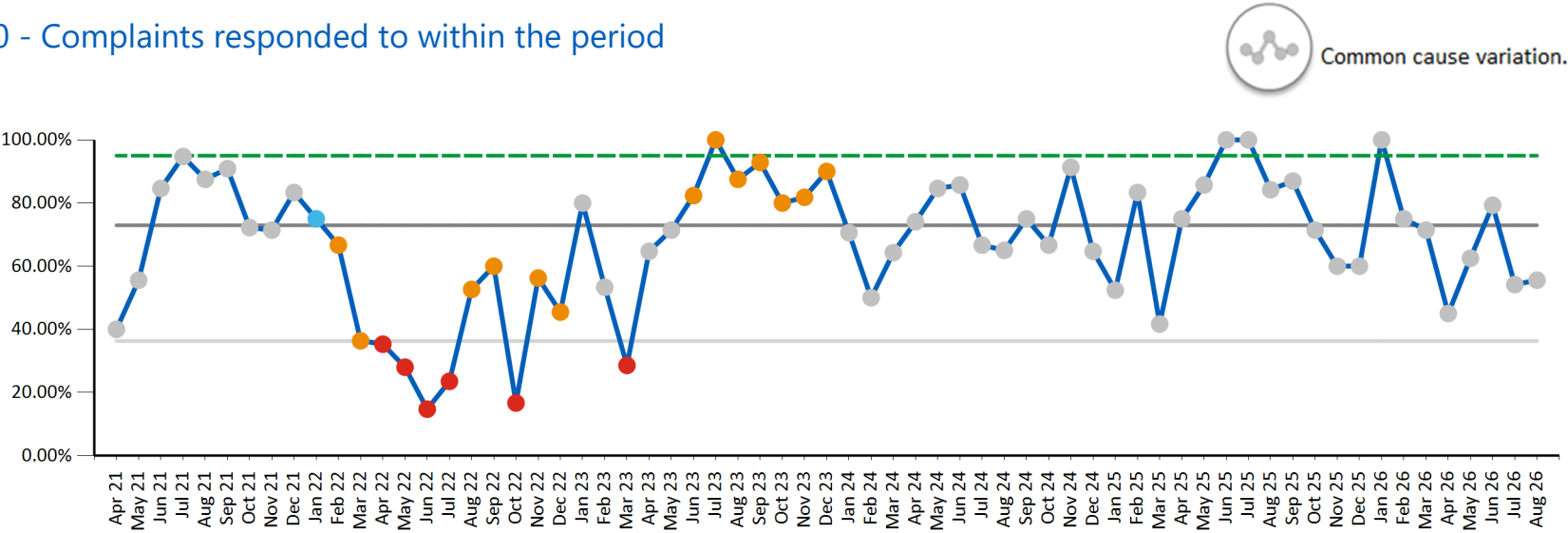
Previous

Plan	Actual	Period
= 100%	100.0%	Jul-26

Year to Date

Plan	Actual
= 100%	100.0%

90 - Complaints responded to within the period



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

0/6

Latest

Plan	Actual	Period
>= 95%	55.6%	Aug-26

Previous

Plan	Actual	Period
>= 95%	54.2%	Jul-26

Year to Date

Plan	Actual
>= 95%	58.0%

Quality and Safety - Maternity

Friends and Family response rate – low response rate noted in August following transition to new system – 11.9%. This is now collated using text and QR codes. New national maternity specific patient experience reported metric (PREM) still awaited.

Friends and Family satisfaction rate – Overall improved satisfaction rate despite low number of responses overall with 95.5% satisfaction noted in August 2026.

Maternity Stillbirth Rate (excluding termination of pregnancy (TOP) – sustained low rate overall over past three months – remains in common cause variation currently.

3rd & 4th Degree tears – Low incidence rate continued with 1% in August 2026 with target of $\leq 3.5\%$. Perinatal pelvic health service implementation ongoing.

1:1 care in labour - Current performance has shown a special cause sustained improvement at 98.9%. Improvement seen as a result of recruitment, retention, and strengthened roster management with enhanced oversight.

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 special cause sustained variation with 92.7% reported in August 2026 following the introduction of the. Early Pregnancy Information Clinics (EPIC).

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 sustained improvement this month with 68.2% 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. 2 cases of delay reported in August 2026. This metric tracks the number of women where induction of labour commencement is delayed more than 6hrs from their planned admission time.

Breastfeeding initiation – Slight deterioration noted in rates of initiation over past four months which is reported as common cause variation. The service has continued with service support and will continue to monitor compliance. The Trust has booked the external assessment for Stage 2 Baby Friendly Initiative accreditation to be undertaken on the 27 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 8.8% reported in August 2026. The PregnAncy Risk assessmenT aNd dEcision suppoRt tool (Partner trial - which is a risk assessment and clinical decision support tool) implementation has now been enacted to enhance screening to reduce placental disorders and preterm birth in pregnancy.

Early neonatal death – Rate in common cause variation and has reduced in August 2026. We had an elevated rate of early neonatal death in Q1 2026/2027 with 11 cases in total reported and the theme identified was extreme prematurity. No issues have been found in the cases reviewed to date.

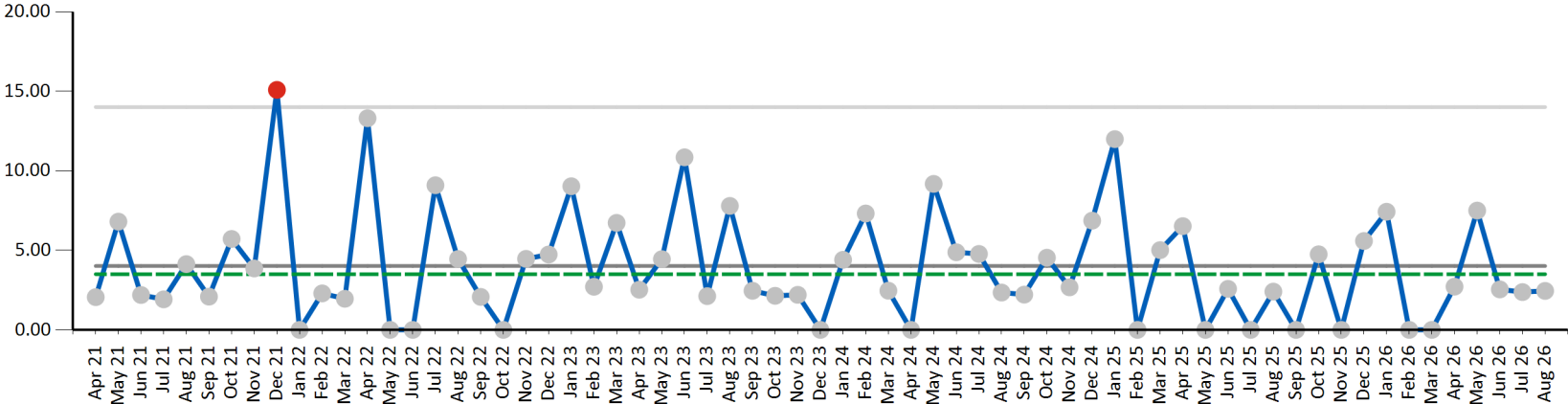
Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births (excludes termination of pregnancy)	<= 3.50	2.45	Aug-26		<= 3.50	2.38	Jul-26	<= 3.50	3.52	
23 - Maternity -3rd/4th degree tears	<= 3.5%	1.0%	Aug-26		<= 3.5%	2.5%	Jul-26	<= 3.5%	2.6%	
202 - 1:1 Midwifery care in labour	>= 95.0%	98.9%	Aug-26		>= 95.0%	98.5%	Jul-26	>= 95.0%	99.2%	
203 - Booked 12+6	>= 90.0%	92.7%	Aug-26		>= 90.0%	91.8%	Jul-26	>= 90.0%	91.8%	
586 - Booked 10+0		68.2%	Aug-26			68.4%	Jul-26		67.8%	
204 - Percentage of women induced	<= 40%	32.8%	Aug-26		<= 40%	29.9%	Jul-26	<= 40%	31.7%	
210 - Initiation breast feeding	>= 65%	68.32%	Aug-26		>= 65%	70.80%	Jul-26	>= 65%	71.56%	
213 - Maternity complaints	<= 5	5	Jul-26		<= 5	3	Jun-26	<= 20	11	
319 - Maternal deaths (direct)	= 0	0	Aug-26		= 0	0	Jul-26	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	8.8%	Aug-26		<= 6%	9.0%	Jul-26	<= 6%	9.1%	
631 - Number of Neonates with suspected HIE Grade 2 and 3, = 37 Weeks (Bolton Babies only)		0	Aug-26			1	Jul-26		2	
665 - Inductions of Labour >6 hours		2	Aug-26			9	Jul-26		24	

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

 Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 3.50	2.45	Aug-26

Previous

Plan	Actual	Period
<= 3.50	2.38	Jul-26

Year to Date

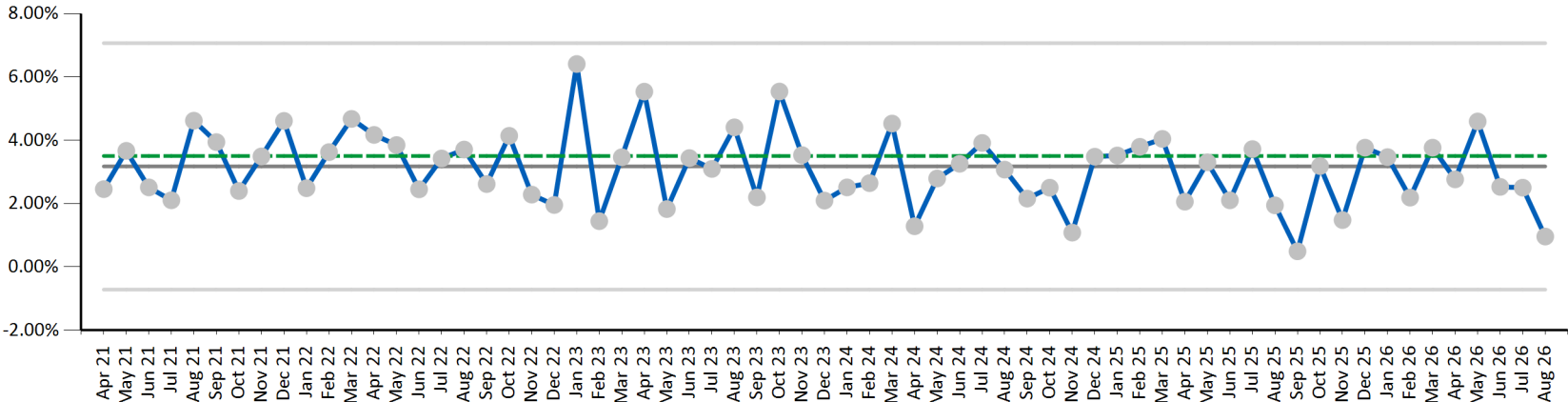
Plan	Actual
<= 3.50	3.52

23 - Maternity -3rd/4th degree tears

 Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 3.5%	1.0%	Aug-26

Previous

Plan	Actual	Period
<= 3.5%	2.5%	Jul-26

Year to Date

Plan	Actual
<= 3.5%	2.6%

202 - 1:1 Midwifery care in labour

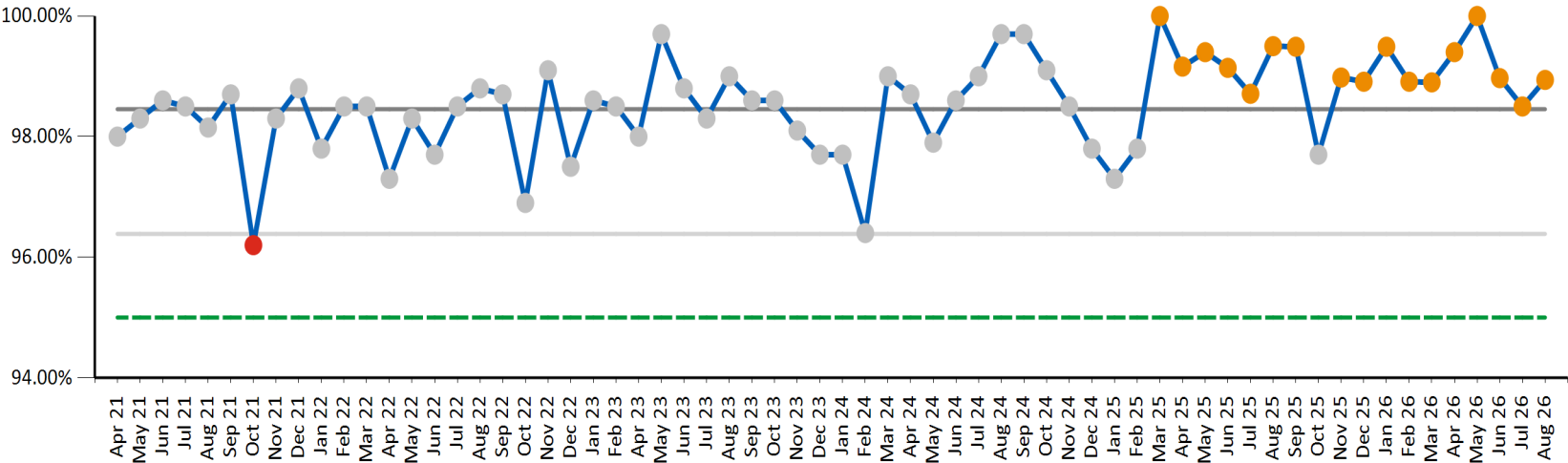


Special cause variation with improving performance



Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 95.0%	98.9%	Aug-26

Previous

Plan	Actual	Period
>= 95.0%	98.5%	Jul-26

Year to Date

Plan	Actual
>= 95.0%	99.2%

203 - Booked 12+6

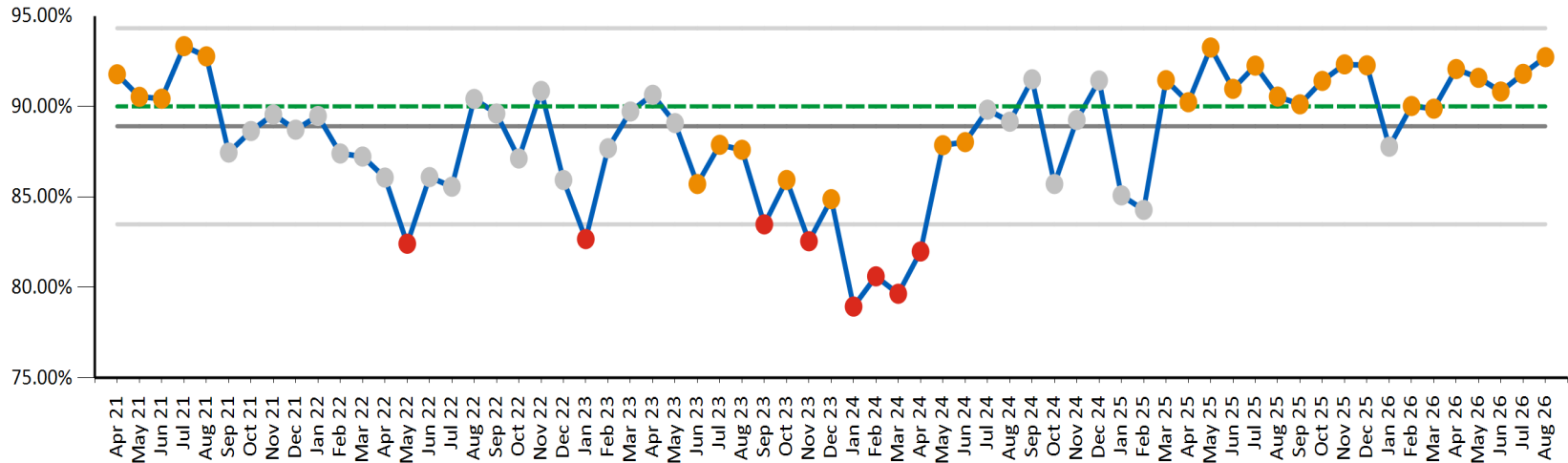


Special cause variation with improving performance



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

5/6



Latest

Plan	Actual	Period
>= 90.0%	92.7%	Aug-26

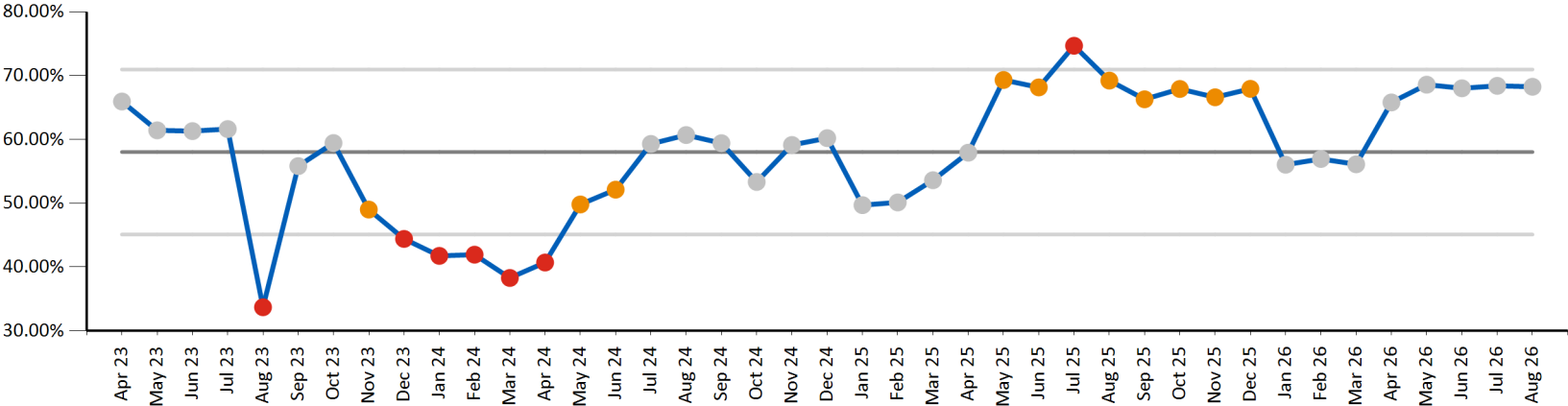
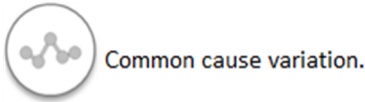
Previous

Plan	Actual	Period
>= 90.0%	91.8%	Jul-26

Year to Date

Plan	Actual
>= 90.0%	91.8%

586 - Booked 10+0



Latest

Plan	Actual	Period
	68.2%	Aug-26

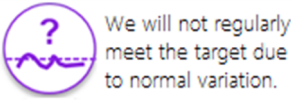
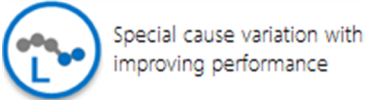
Previous

Plan	Actual	Period
	68.4%	Jul-26

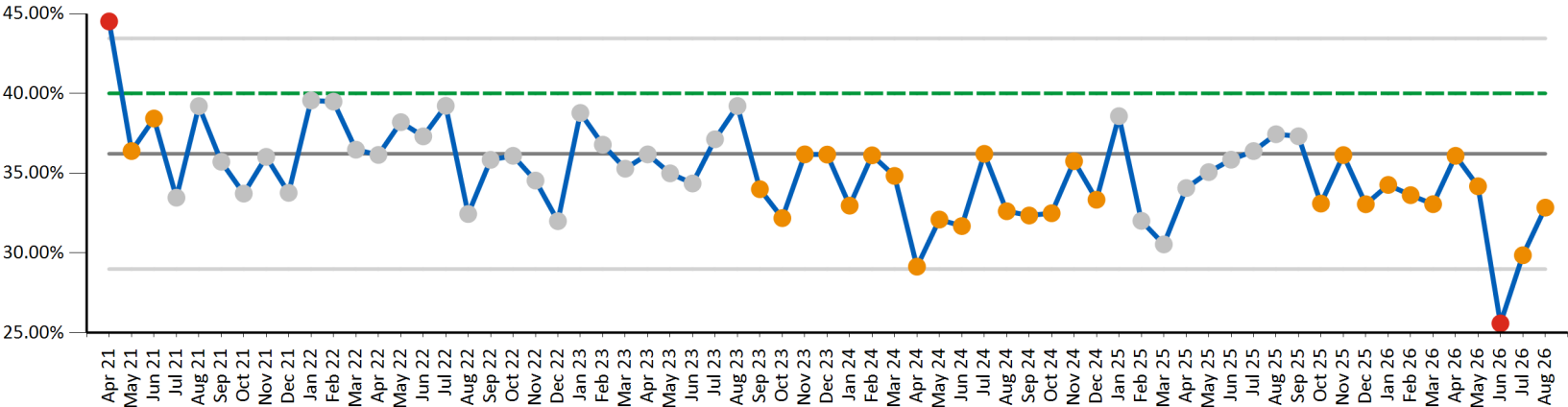
Year to Date

Plan	Actual
	67.8%

204 - Percentage of women induced



6/6



Latest

Plan	Actual	Period
<= 40%	32.8%	Aug-26

Previous

Plan	Actual	Period
<= 40%	29.9%	Jul-26

Year to Date

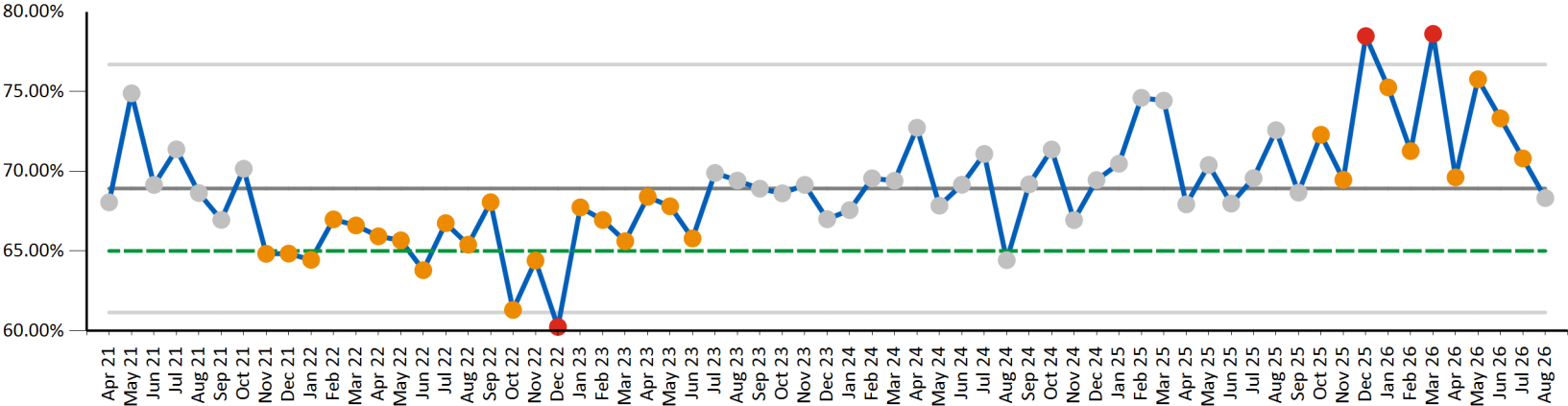
Plan	Actual
<= 40%	31.7%

210 - Initiation breast feeding

 Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 65%	68.32%	Aug-26

Previous

Plan	Actual	Period
>= 65%	70.80%	Jul-26

Year to Date

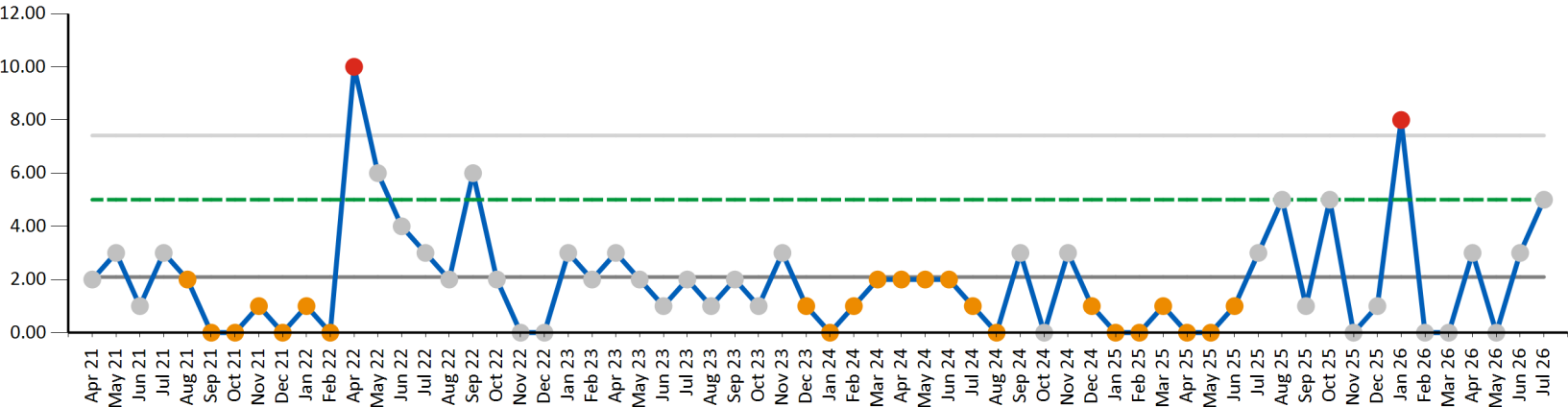
Plan	Actual
>= 65%	71.56%

213 - Maternity complaints

 Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 5	5	Jul-26

Previous

Plan	Actual	Period
<= 5	3	Jun-26

Year to Date

Plan	Actual
<= 20	11

319 - Maternal deaths (direct)

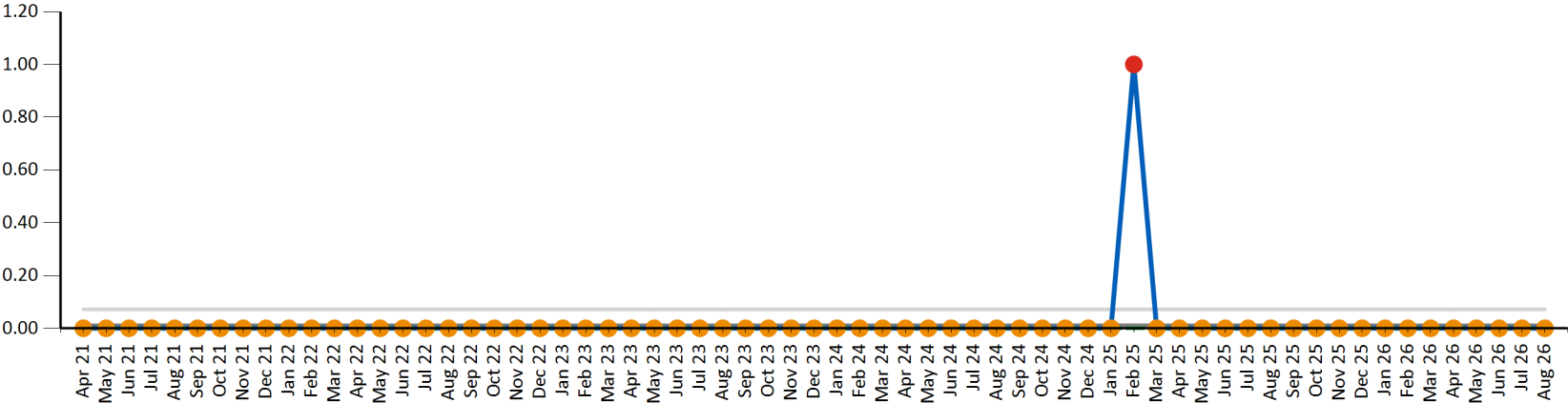


Special cause variation with improving performance



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

6/6



Latest

Plan	Actual	Period
= 0	0	Aug-26

Previous

Plan	Actual	Period
= 0	0	Jul-26

Year to Date

Plan	Actual
= 0	0

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

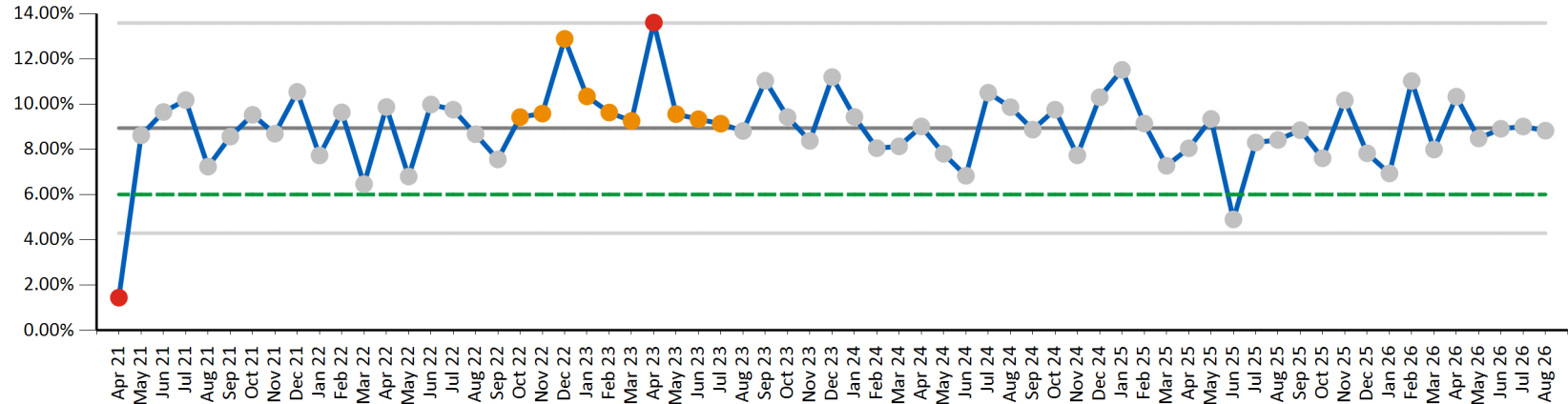


Common cause variation.



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

0/6



Latest

Plan	Actual	Period
<= 6%	8.8%	Aug-26

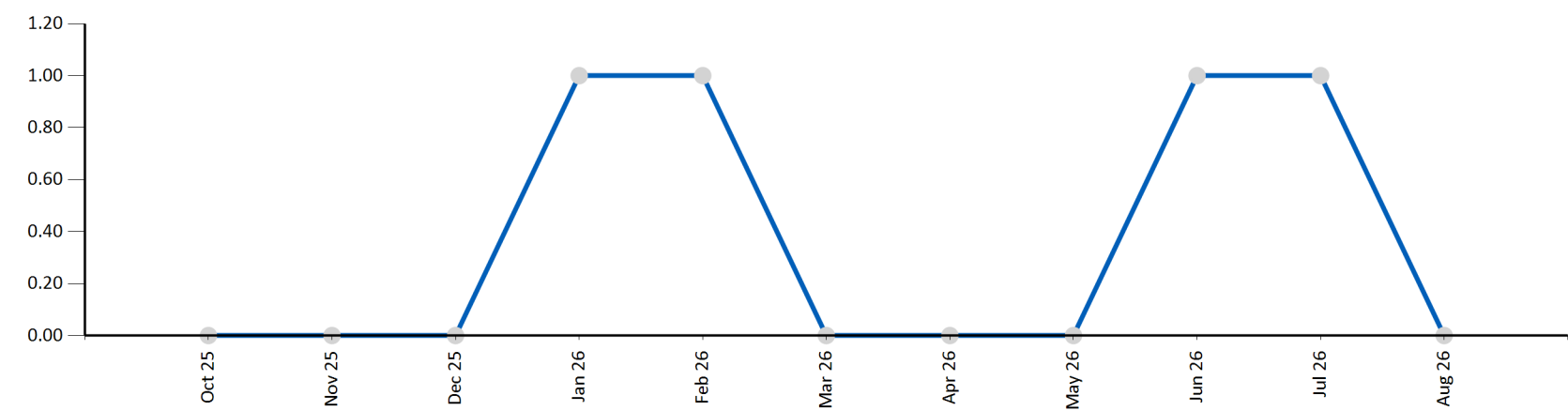
Previous

Plan	Actual	Period
<= 6%	9.0%	Jul-26

Year to Date

Plan	Actual
<= 6%	9.1%

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

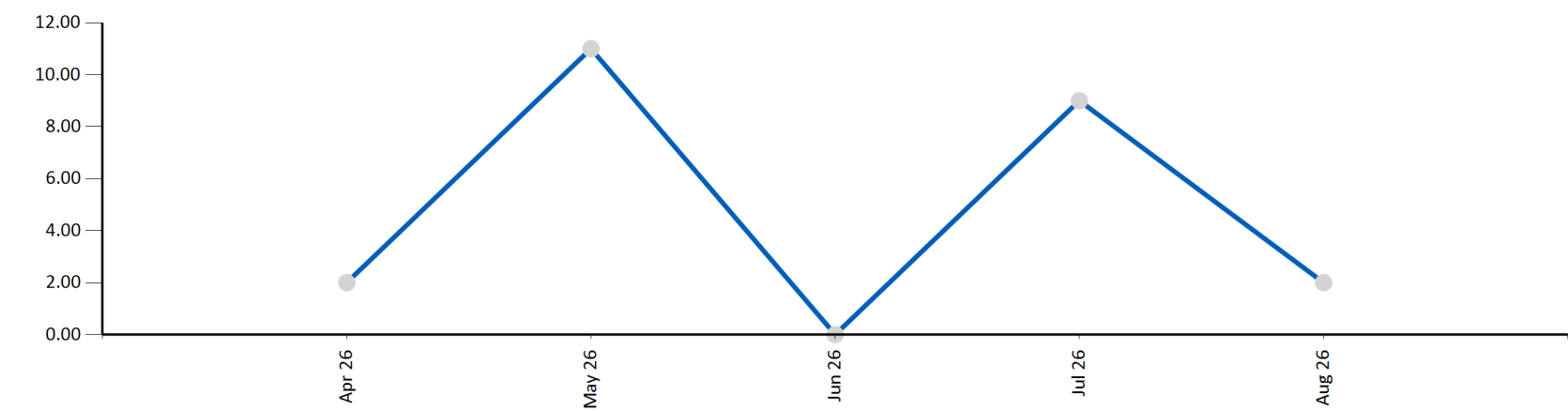


Latest		
Plan	Actual	Period
	0	Aug-26

Previous		
Plan	Actual	Period
	1	Jul-26

Year to Date	
Plan	Actual
	2

665 - Inductions of Labour >6 hours - SPC data available after 20 data points



Latest		
Plan	Actual	Period
	2	Aug-26

Previous		
Plan	Actual	Period
	9	Jul-26

Year to Date	
Plan	Actual
	24

Operational Performance - Urgent Care

Urgent Care

In August 2026, performance against the all types 4 hour standard was 66.8%, a deterioration compared to July 2026 (72.2%). Ambulance handovers within 15 minutes worsened to 47.2% (52.8 % in July), handovers within 30 minutes worsened to 90.1% (94.0% in July), while those completed within 60 minutes also worsened at 98.87% (99.86% in July). Whilst the metrics demonstrate challenges versus July performance, longer term improvement is evident, in particular 4-hour performance, which for context was 64.6% in August 2025.

The percentage number of over 12 hour waits worsened to 8.80% in August compared to 7.34% in July.

Trust non elective length of stay remained static, at 5.3 days in August versus July. In month length of stay which presents a more accurate representation of live performance indicates a deterioration to 4.8 days in August from 4.4 days in July, correlating with NCR challenges in month.

Adult G&A bed occupancy was 90.38% in August versus 88.90% in July.

NOF

For August, our fractured neck of femur performance increased to 56.1%. We experienced a significant increase in the number of patients requiring surgery within 36 hours, up 33% from the previous months. 23 of the 41 eligible patients got to theatre within the 36 hour window. Of the 18x patients who breached the target, 5x 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 1x patients were delayed in the Emergency Department. The remaining 12x patients were due to delays to theatre capacity, largely all impacted by receiving 10x NOF patients admitted over one weekend in early August; this then had a knock-on effect on the rest of the month.

Both average hours to theatre and mortality (when adjusted for casemix) remain under the national average.

Emergency Department Deflections & 2 Hour UCR

AAT/Home First ED deflections decreased to 556 from 624 and this remains above plan (400) but has decreased in month, this is related to an overall reduction in UCR referrals. This reduction is due to seasonal variation experienced over summer months and ongoing reduction in NWS referrals. NWS have now agreed to support an onsite paramedic model across Bolton and Wigan to support a 7-day CBYC model this is expected to support an increase in UCR referrals and ED deflections to March 26 activity levels.

2 hour UCR performance remained high at 87.5% (target 70% and stretch target 80%). Referral numbers increased to 405 from 409 and this is below the national target of 457. Expansion and promotion of clinical pathways is continuing including acute urinary retention pathway and IV antibiotic pathway. CSD directory of services (DOS) is expected to go live in September and will be accessible on the trust intranet and website to enable quick access to clinical pathway information to support deflection from ED and earlier discharge. Primary care and system partners will have access to the DOS to support access to service information and referral pathways.

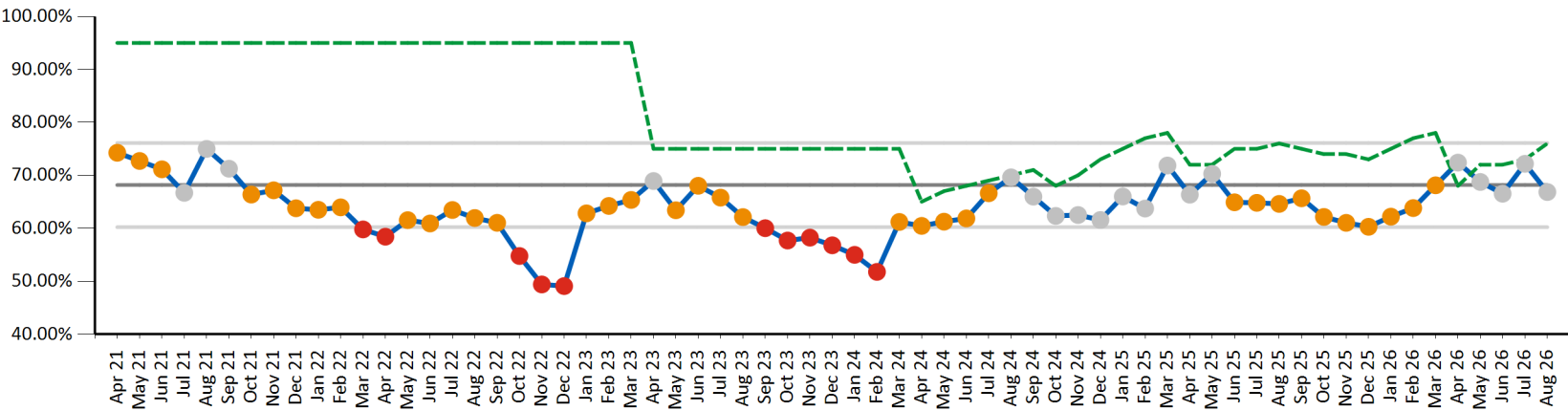
Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
53 - A&E 4 hour target	>= 76%	66.8%	Aug-26		>= 73%	72.2%	Jul-26	>= 76%	69.3%	
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	47.2%	Aug-26		>= 65.0%	52.8%	Jul-26	>= 65.0%	51.0%	
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	90.1%	Aug-26		>= 95.0%	94.0%	Jul-26	>= 95.0%	89.8%	
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100%	98.87%	Aug-26		= 100%	99.86%	Jul-26	= 100%	98.46%	
539 - A&E 12 hour waits	= 0	998	Aug-26		= 0	885	Jul-26	= 0	4,828	
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	56.1%	Aug-26		>= 75%	36.4%	Jul-26	>= 75%	48.5%	
56 - Stranded patients - over 7 days	<= 200	212	Aug-26		<= 200	227	Jul-26	<= 200	212	
307 - Stranded Patients - LOS 21 days and over	<= 69	84	Aug-26		<= 69	87	Jul-26	<= 69	84	
541 - Adult G&A bed occupancy	<= 92.0%	86.0%	Aug-26		<= 92.0%	84.7%	Jul-26	<= 92.0%	85.4%	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	5.35	Aug-26		<= 3.70	5.30	Jul-26	<= 3.70	5.17	
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	9.7%	Jul-26		<= 13.5%	10.8%	Jun-26	<= 13.5%	10.3%	
554 - 2 Hour Urgent Community Response %	>= 70.0%	87.5%	Aug-26		>= 70.0%	84.7%	Jul-26	>= 70.0%	87.1%	
555 - 2 Hour Urgent Community Response Referrals	>= 358	273	Aug-26		>= 358	261	Jul-26	>= 1,790	1,360	
664 - Urgent Community Response Referrals	>= 416	405	Aug-26		>= 488	409	Jul-26	>= 2,201	2,258	

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
>= 76%	66.8%	Aug-26

Previous

Plan	Actual	Period
>= 73%	72.2%	Jul-26

Year to Date

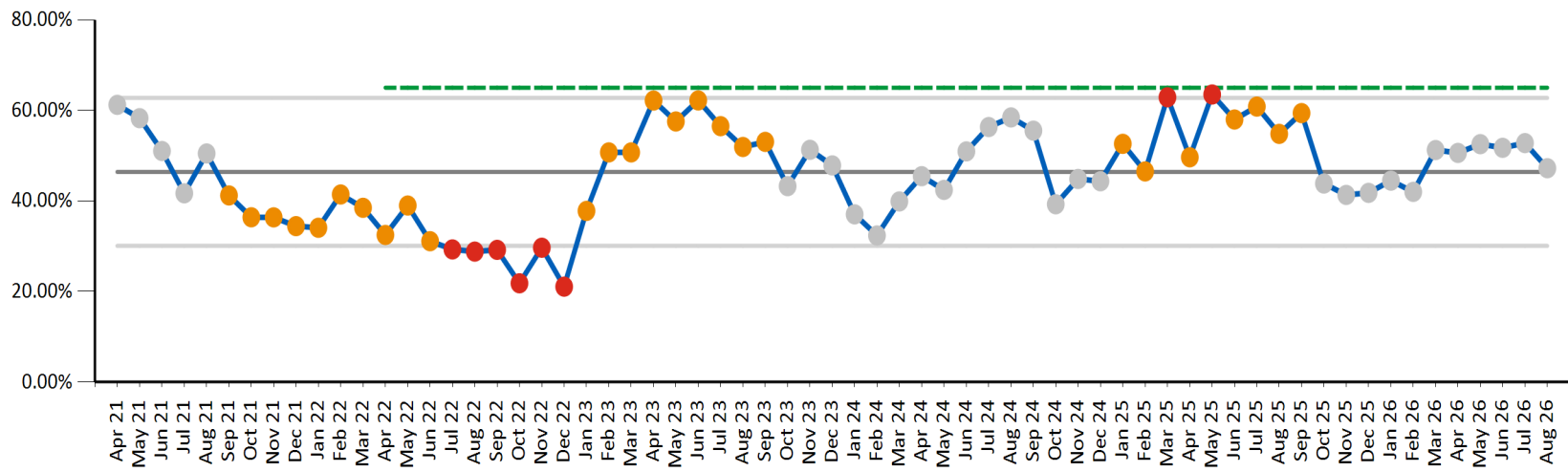
Plan	Actual
>= 76%	69.3%

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%	47.2%	Aug-26

Previous

Plan	Actual	Period
>= 65.0%	52.8%	Jul-26

Year to Date

Plan	Actual
>= 65.0%	51.0%

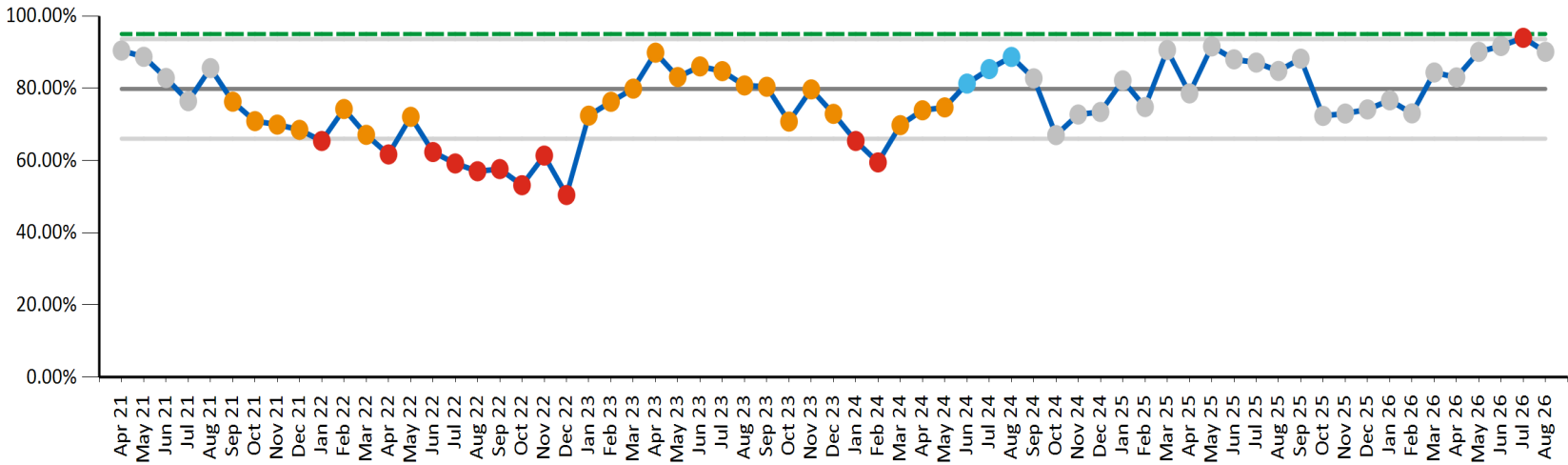
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins

Common cause variation.

F

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95.0%	90.1%	Aug-26

Previous

Plan	Actual	Period
>= 95.0%	94.0%	Jul-26

Year to Date

Plan	Actual
>= 95.0%	89.8%

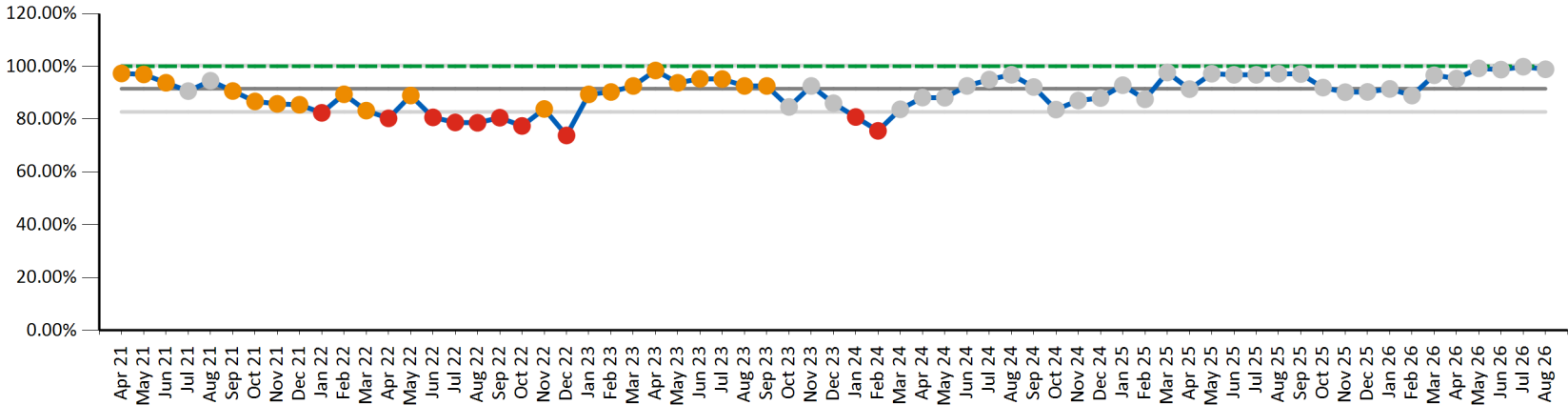
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes

Common cause variation.

?

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

0/6



Latest

Plan	Actual	Period
= 100%	98.87%	Aug-26

Previous

Plan	Actual	Period
= 100%	99.86%	Jul-26

Year to Date

Plan	Actual
= 100%	98.46%

539 - A&E 12 hour waits

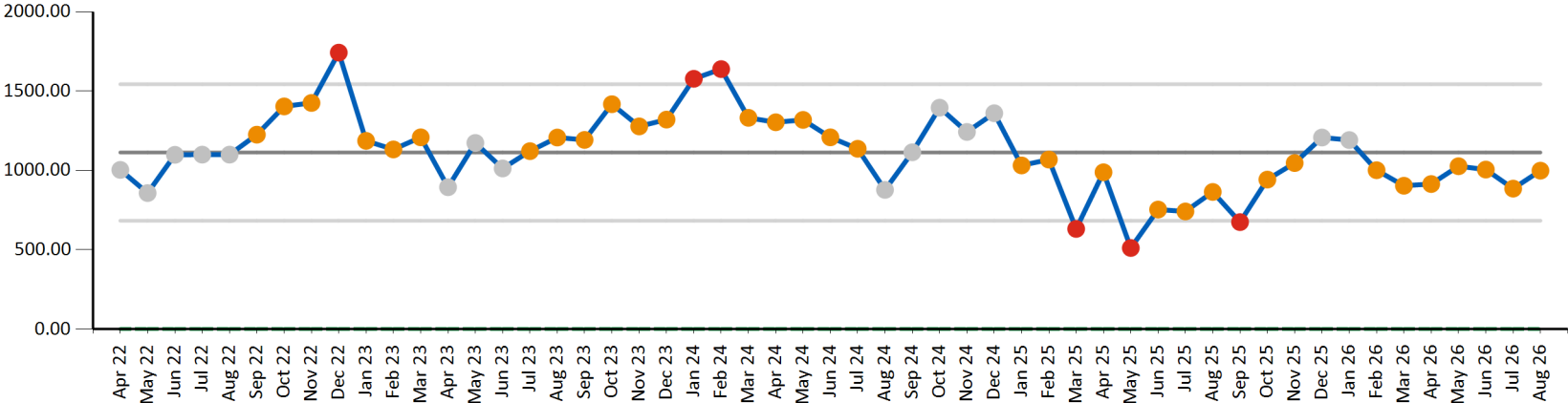


Special cause variation with improving performance



We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	998	Aug-26

Previous

Plan	Actual	Period
= 0	885	Jul-26

Year to Date

Plan	Actual
= 0	4,828

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

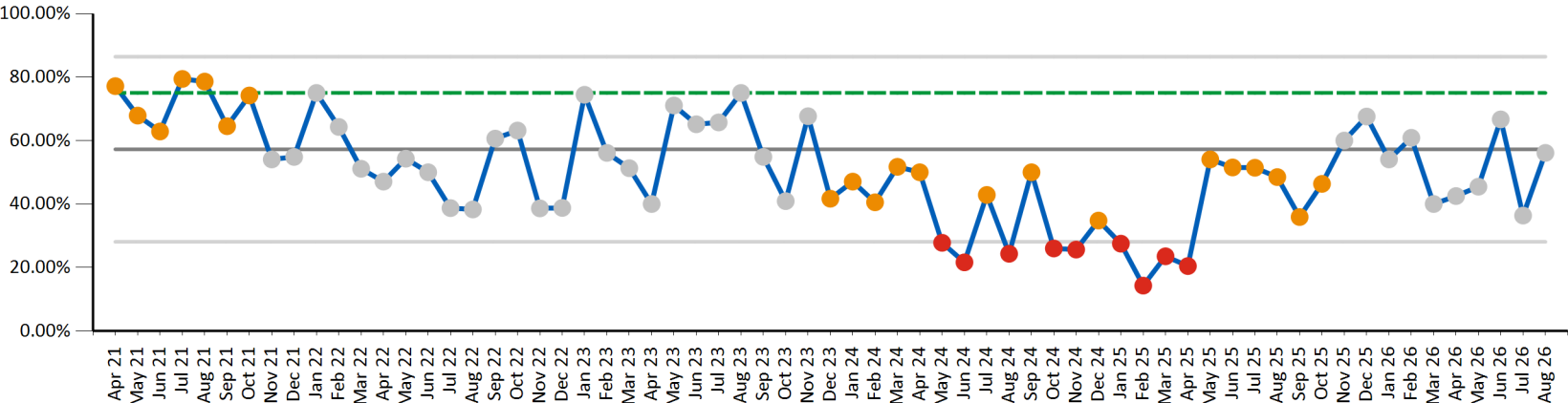


Common cause variation.



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

0/6



Latest

Plan	Actual	Period
>= 75%	56.1%	Aug-26

Previous

Plan	Actual	Period
>= 75%	36.4%	Jul-26

Year to Date

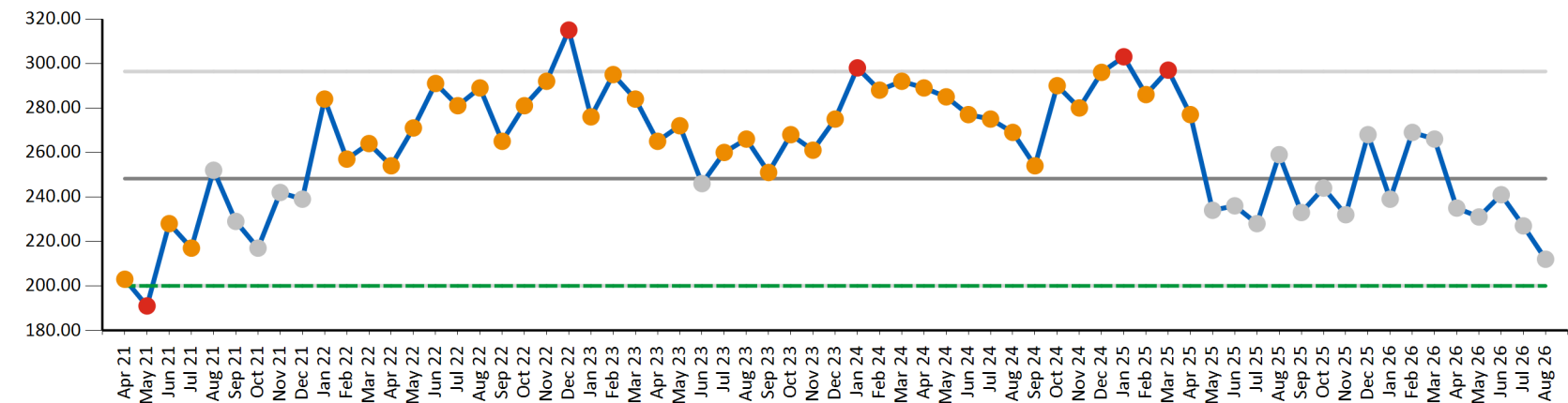
Plan	Actual
>= 75%	48.5%

56 - Stranded patients - over 7 days

 Common cause variation.

 We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 200	212	Aug-26

Previous

Plan	Actual	Period
<= 200	227	Jul-26

Year to Date

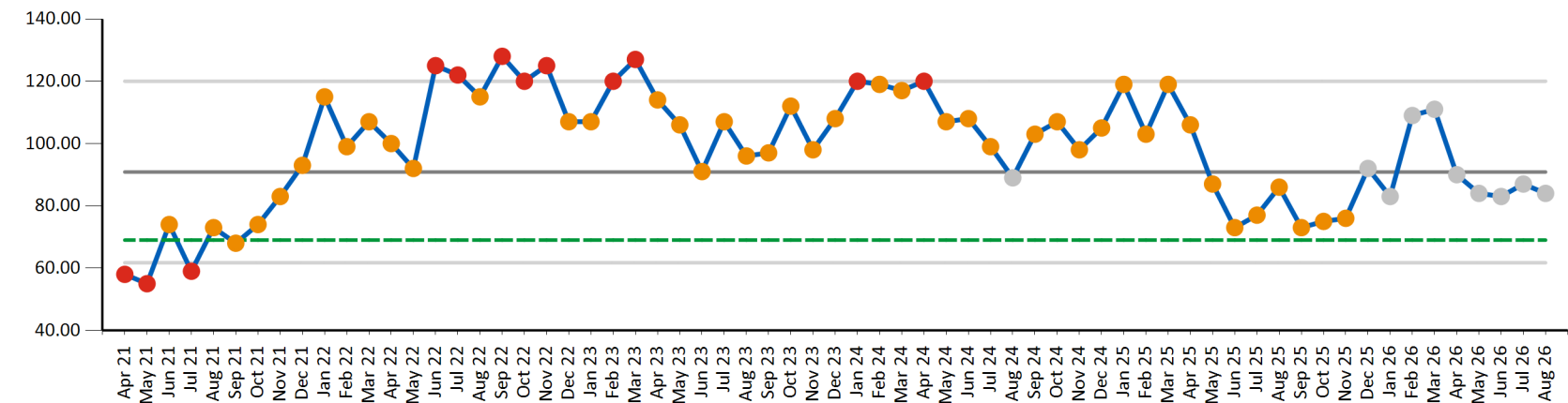
Plan	Actual
<= 200	212

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	84	Aug-26

Previous

Plan	Actual	Period
<= 69	87	Jul-26

Year to Date

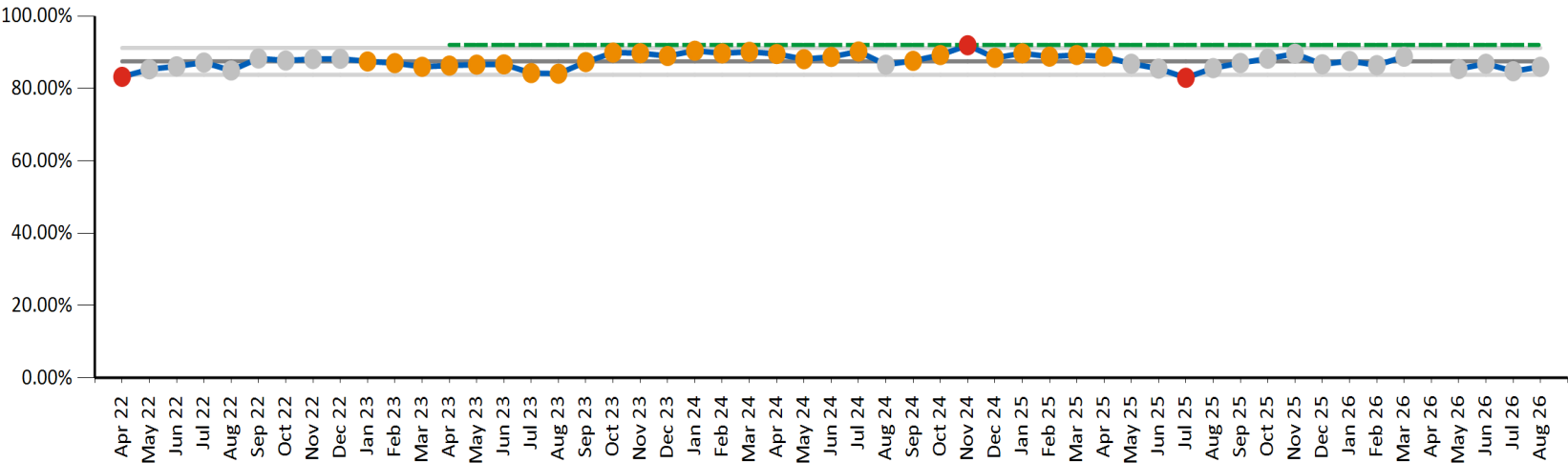
Plan	Actual
<= 69	84

541 - Adult G&A bed occupancy

Common cause variation.

Target will be regularly met.

5/6



Latest

Plan	Actual	Period
<= 92.0%	86.0%	Aug-26

Previous

Plan	Actual	Period
<= 92.0%	84.7%	Jul-26

Year to Date

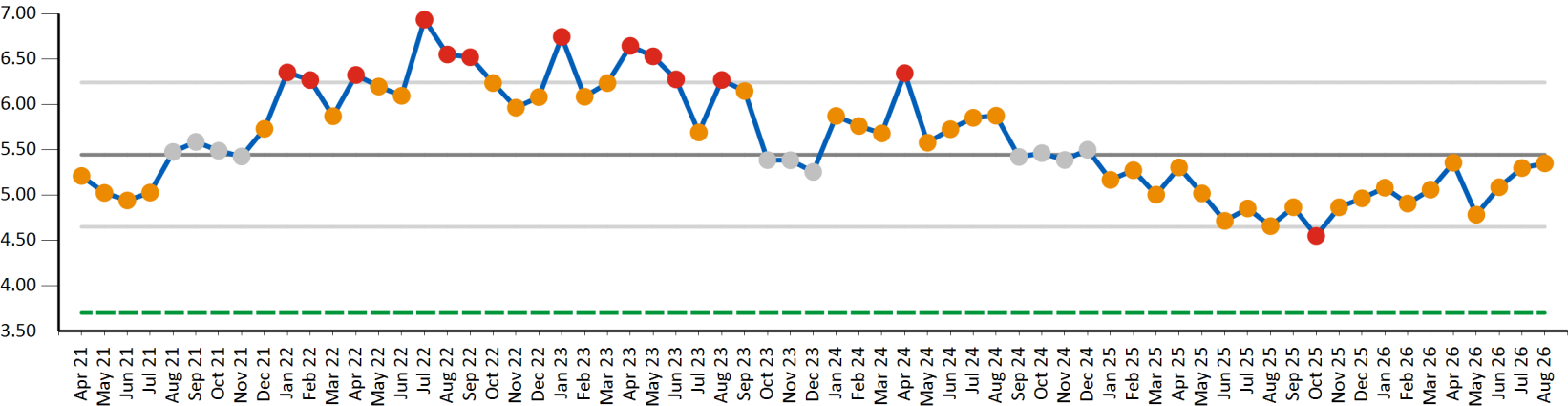
Plan	Actual
<= 92.0%	85.4%

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	5.35	Aug-26

Previous

Plan	Actual	Period
<= 3.70	5.30	Jul-26

Year to Date

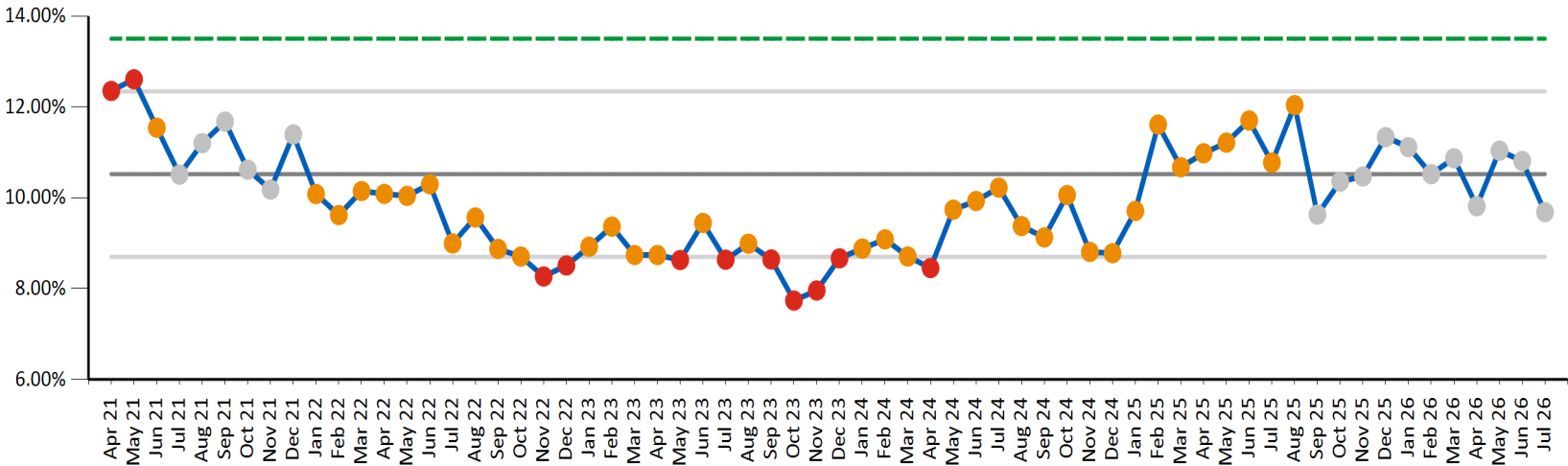
Plan	Actual
<= 3.70	5.17

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%	9.7%	Jul-26

Previous

Plan	Actual	Period
<= 13.5%	10.8%	Jun-26

Year to Date

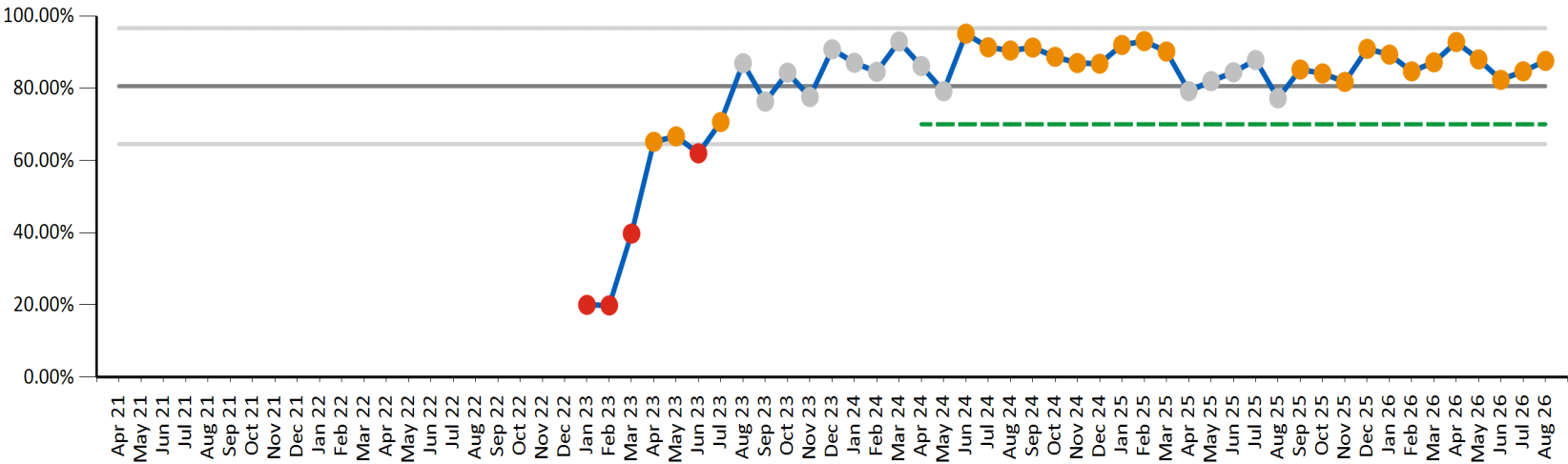
Plan	Actual
<= 13.5%	10.3%

554 - 2 Hour Urgent Community Response %

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
>= 70.0%	87.5%	Aug-26

Previous

Plan	Actual	Period
>= 70.0%	84.7%	Jul-26

Year to Date

Plan	Actual
>= 70.0%	87.1%

555 - 2 Hour Urgent Community Response Referrals

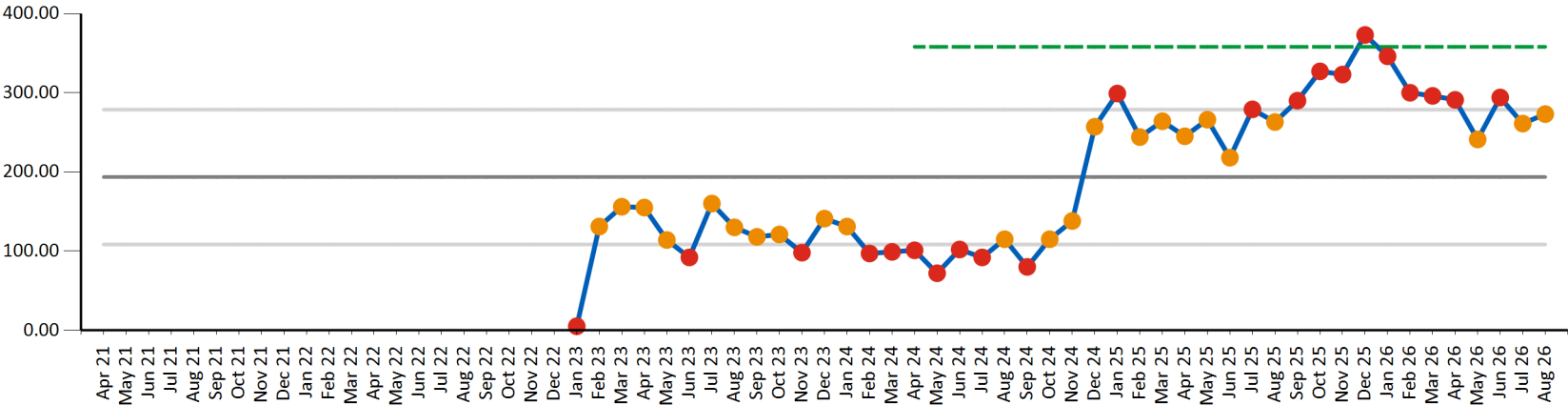


Special cause variation with improving performance



We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 358	273	Aug-26

Previous

Plan	Actual	Period
>= 358	261	Jul-26

Year to Date

Plan	Actual
>= 1,790	1,360

664 - Urgent Community Response Referrals

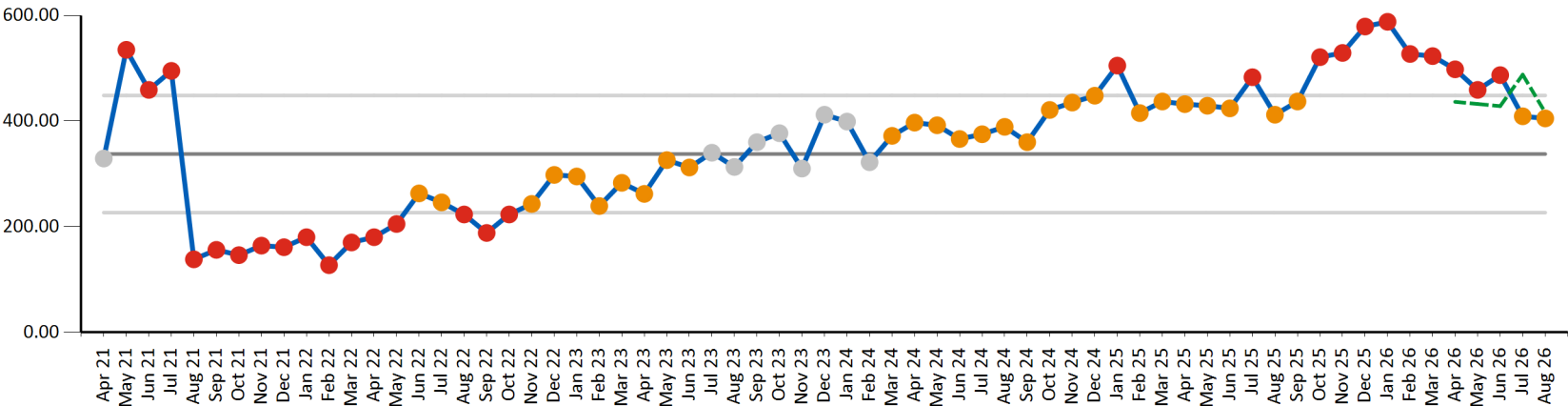


Special cause variation with improving performance



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

3/6



Latest

Plan	Actual	Period
>= 416	405	Aug-26

Previous

Plan	Actual	Period
>= 488	409	Jul-26

Year to Date

Plan	Actual
>= 2,201	2,258

Operational Performance - Elective Care

RTT

National submission for August's final position is not until 23rd September and so final position not confirmed for all metrics.

We finished August with 0x 78-week breaches.

We finished August with 19x 65-week breaches. All 19x were due to capacity issues, associated with the cancellation of procedures due to the closure of Elective Care Centre, and capacity relating to our Plastic Surgery service provided through an SLA with MFT.

We will finish August with circa 500x 52-week breaches. This is a reduction against July's position but continues to be above plan. This is due to the closure of the Elective Care Centre and the cancellation of 250x long-waiting routine procedures.

Our overall waiting list size remained significantly larger than plan; a recovery trajectory has been submitted to the regional and national teams with an expected recovery of October's month end position. This is heavily reliant on external additional validation support, however. For August's position it is expected that we will again improve against July's performance, which was an improvement against June.

RTT overall performance is impacted by the above; a recovery trajectory to October has been submitted. For August's position it is expected that we will again improve against July's performance, which was an improvement against June.

DM01

July position is 16.8% against a plan of 9.85%, which is 6.95% points above plan.

DM01 performance has deteriorated in month by 1% due to worsening performance in CT, Urodynamics and Cystoscopy. Audiology remains challenged, however performance remained consistent.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
41 - RTT Incomplete pathways within 18 weeks %	>= 62%	61.0%	Jul-26		>= 62%	61.0%	Jun-26	>= 62%	60.9%	
314 - RTT 18 week waiting list	<= 33,311	37,306	Jul-26		<= 33,484	37,808	Jun-26	<= 33,311	37,306	

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
42 - RTT 52 week waits (incomplete pathways)	<= 283	580	Jul-26		<= 306	444	Jun-26	<= 1,258	1,859	
667 - Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	>= 0.80%		Jul-26		>= 0.90%		Jun-26	>= 0.80%	1.20%	
540 - RTT 65 week waits (incomplete pathways)	= 0	7	Jul-26		= 0	0	Jun-26	= 0	7	
526 - RTT 78 week waits (incomplete pathways)	= 0	0	Jul-26		= 0	0	Jun-26	= 0	0	
527 - RTT 104 week waits (incomplete pathways)	= 0	0	Jul-26		= 0	0	Jun-26	= 0	0	
72 - Diagnostic Waits >6 weeks %	<= 10%	16.8%	Aug-26		<= 11%	15.8%	Jul-26	<= 10%	14.1%	
489 - Daycase Rates	>= 85%	83.6%	Aug-26		>= 85%	84.4%	Jul-26	>= 85%	82.8%	
582 - Theatre Utilisation - Capped		78.3%	Aug-26			80.7%	Jul-26		79.2%	
583 - Theatre Utilisation - Uncapped		82.4%	Aug-26			86.7%	Jul-26		84.8%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.4%	Aug-26		<= 1%	1.9%	Jul-26	<= 1%	1.7%	
62 - Cancelled operations re-booked within 28 days	= 100%	46.8%	Jul-26		= 100%	57.4%	Jun-26	= 100%	44.3%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	3.91	Aug-26		<= 2.00	2.66	Jul-26	<= 2.00	3.39	
309 - DNA Rate - New	<= 6.3%	9.8%	Aug-26		<= 6.3%	9.3%	Jul-26	<= 6.3%	9.4%	
310 - DNA Rate - Follow up	<= 5.0%	9.6%	Aug-26		<= 5.0%	9.6%	Jul-26	<= 5.0%	9.2%	

41 - RTT Incomplete pathways within 18 weeks %

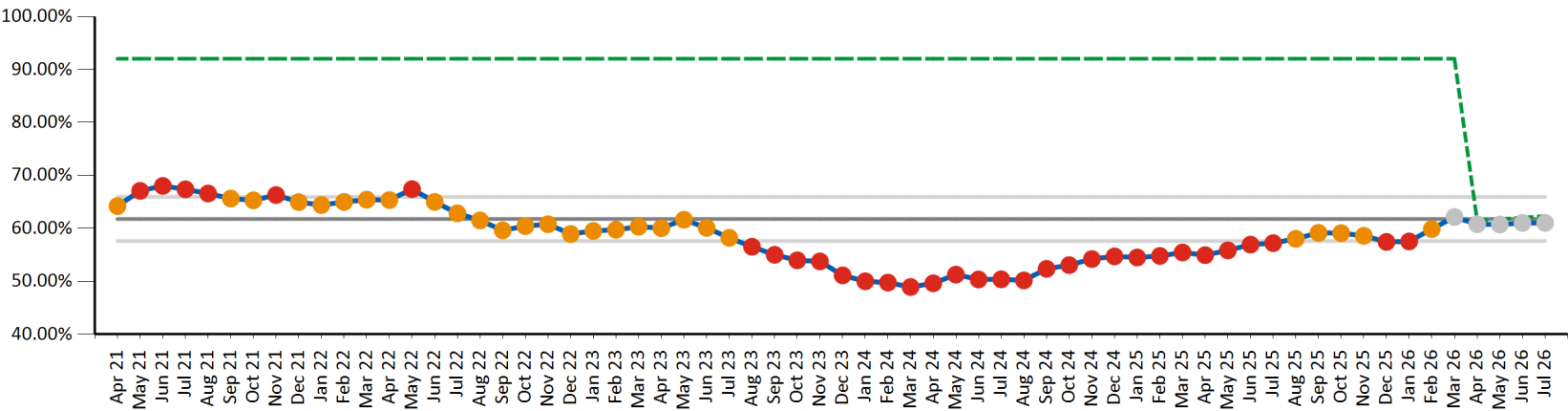


Common cause variation.



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

0/6



Latest

Plan	Actual	Period
>= 62%	61.0%	Jul-26

Previous

Plan	Actual	Period
>= 62%	61.0%	Jun-26

Year to Date

Plan	Actual
>= 62%	60.9%

314 - RTT 18 week waiting list

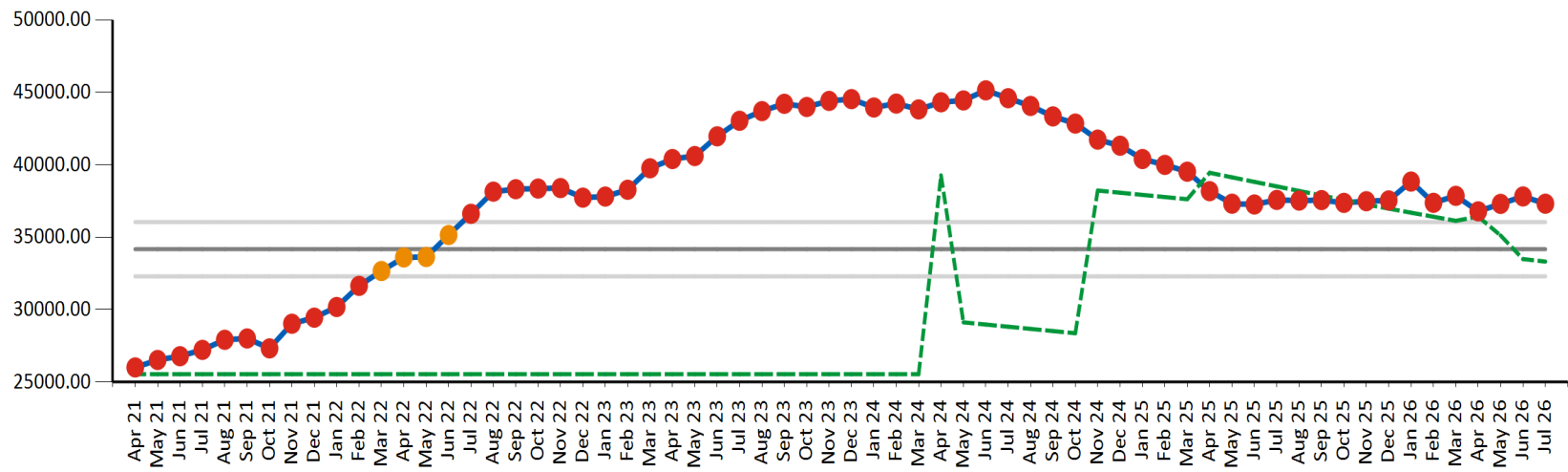


Special cause variation with deteriorating performance



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

0/6



Latest

Plan	Actual	Period
<= 33,311	37,306	Jul-26

Previous

Plan	Actual	Period
<= 33,484	37,808	Jun-26

Year to Date

Plan	Actual
<= 33,311	37,306

42 - RTT 52 week waits (incomplete pathways)

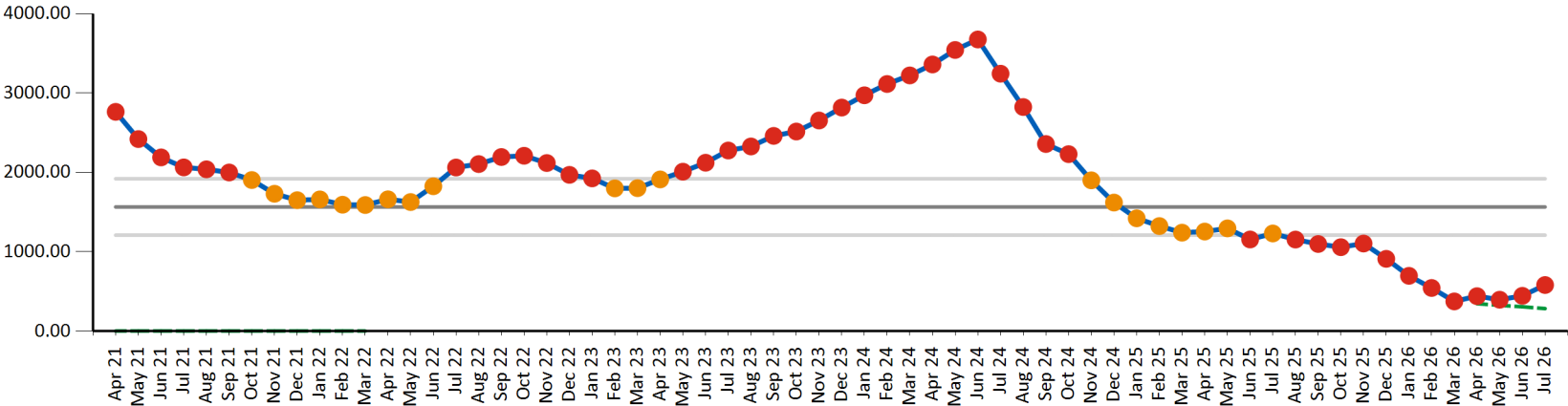


Special cause variation with improving performance



We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 283	580	Jul-26

Previous

Plan	Actual	Period
<= 306	444	Jun-26

Year to Date

Plan	Actual
<= 1,258	1,859

667 - Percentage of cases where a patient is waiting more than 52 weeks for elective treatment

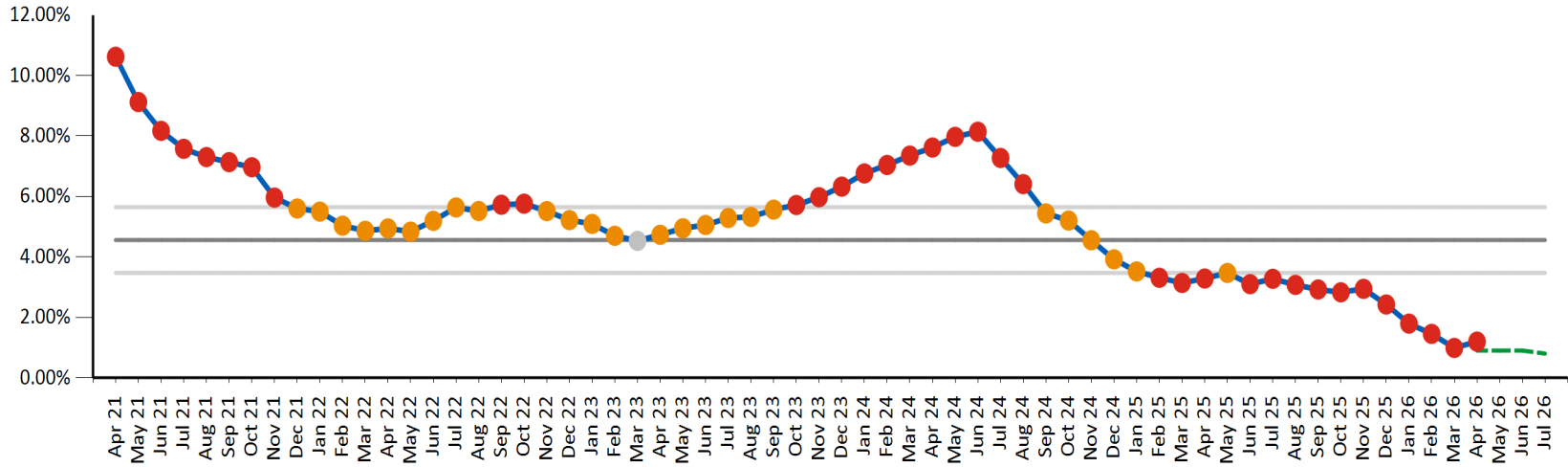


Common cause variation.



Target will be regularly met.

1/6



Latest

Plan	Actual	Period
>= 0.80%		Jul-26

Previous

Plan	Actual	Period
>= 0.90%		Jun-26

Year to Date

Plan	Actual
>= 0.80%	1.20%

540 - RTT 65 week waits (incomplete pathways)

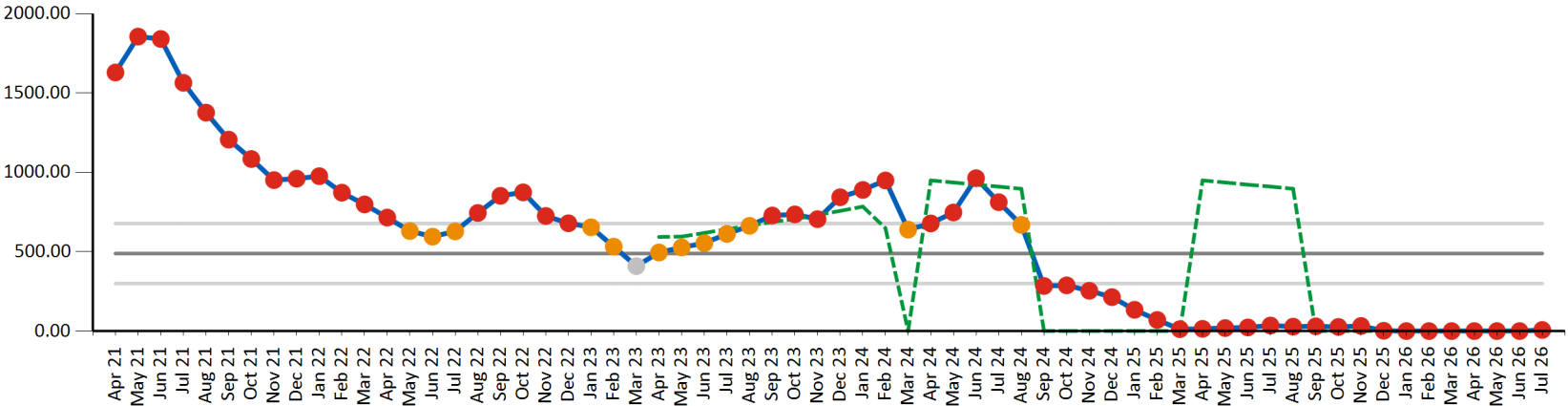


Special cause variation with improving performance



We will regularly fail to meet the target.

5/6



Latest

Plan	Actual	Period
= 0	7	Jul-26

Previous

Plan	Actual	Period
= 0	0	Jun-26

Year to Date

Plan	Actual
= 0	7

526 - RTT 78 week waits (incomplete pathways)

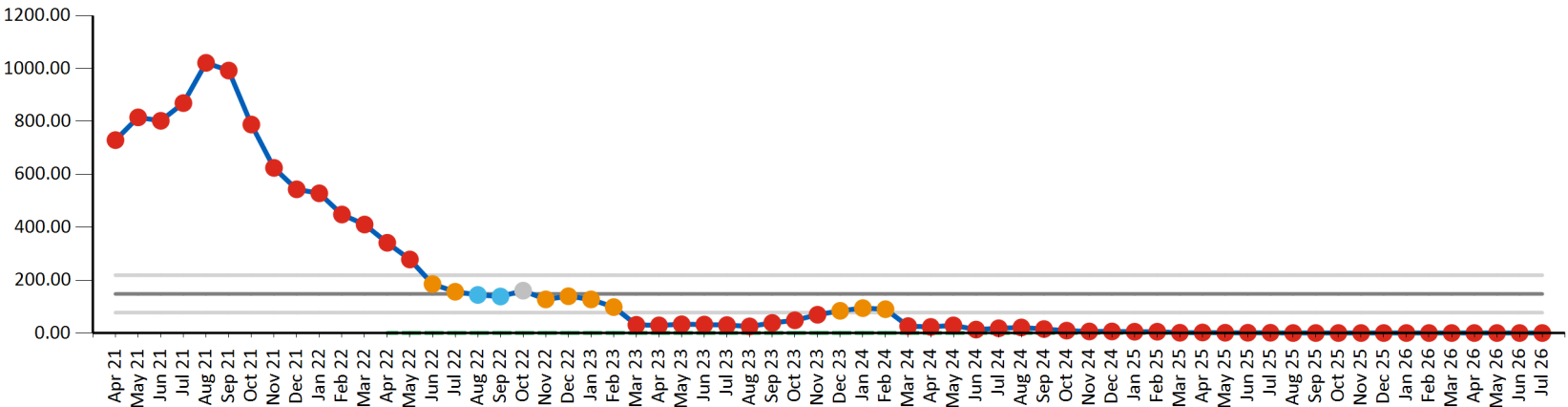


Special cause variation with improving performance



We will regularly fail to meet the target.

6/6



Latest

Plan	Actual	Period
= 0	0	Jul-26

Previous

Plan	Actual	Period
= 0	0	Jun-26

Year to Date

Plan	Actual
= 0	0

527 - RTT 104 week waits (incomplete pathways)

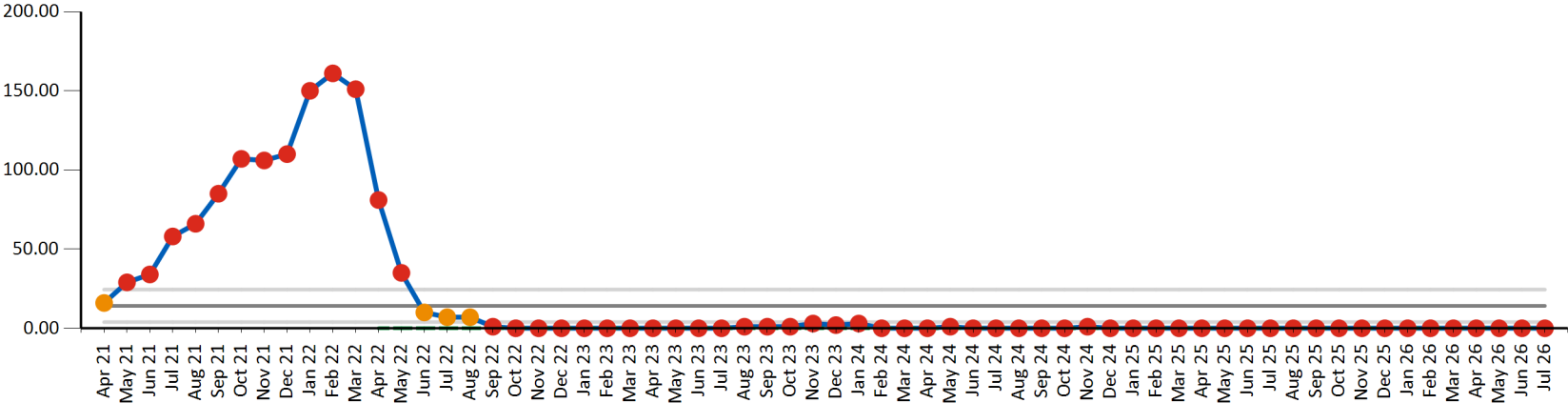


Special cause variation with improving performance



We will regularly fail to meet the target.

6/6



Latest

Plan	Actual	Period
= 0	0	Jul-26

Previous

Plan	Actual	Period
= 0	0	Jun-26

Year to Date

Plan	Actual
= 0	0

72 - Diagnostic Waits >6 weeks %

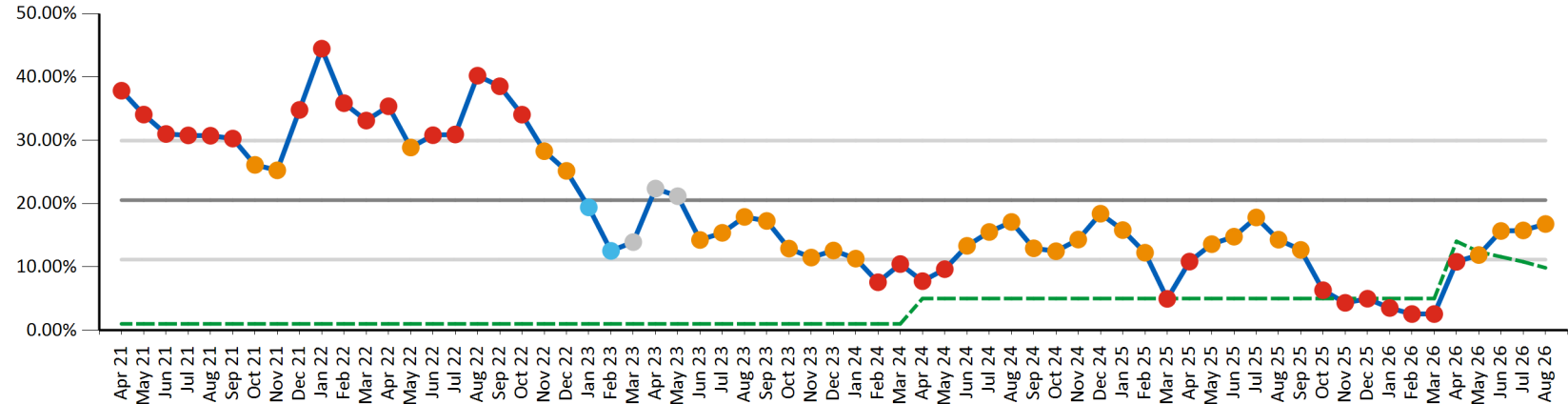


Special cause variation with improving performance



We will regularly fail to meet the target.

3/6



Latest

Plan	Actual	Period
<= 10%	16.8%	Aug-26

Previous

Plan	Actual	Period
<= 11%	15.8%	Jul-26

Year to Date

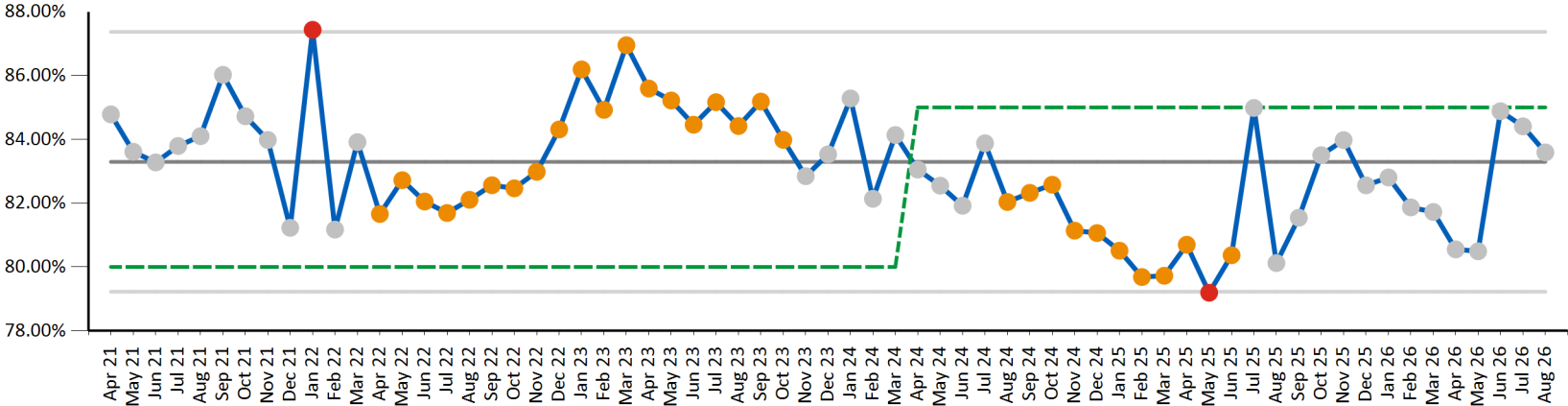
Plan	Actual
<= 10%	14.1%

489 - Daycase Rates

 Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 85%	83.6%	Aug-26

Previous

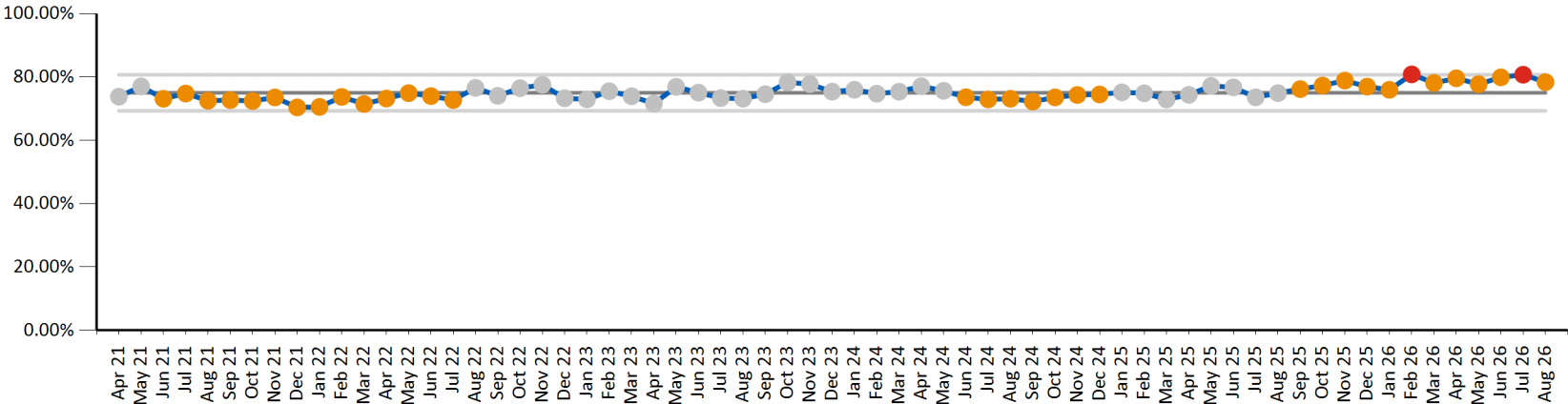
Plan	Actual	Period
>= 85%	84.4%	Jul-26

Year to Date

Plan	Actual
>= 85%	82.8%

582 - Theatre Utilisation - Capped

 Special cause variation with improving performance



Latest

Plan	Actual	Period
	78.3%	Aug-26

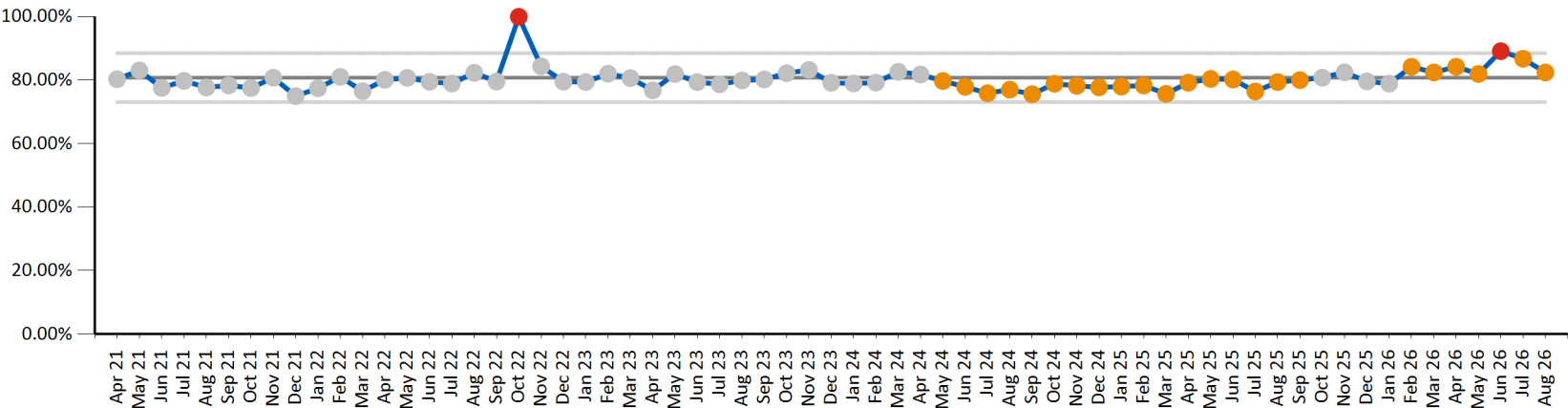
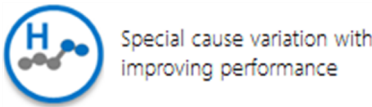
Previous

Plan	Actual	Period
	80.7%	Jul-26

Year to Date

Plan	Actual
	79.2%

583 - Theatre Utilisation - Uncapped



Latest

Plan	Actual	Period
	82.4%	Aug-26

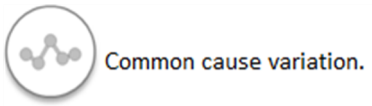
Previous

Plan	Actual	Period
	86.7%	Jul-26

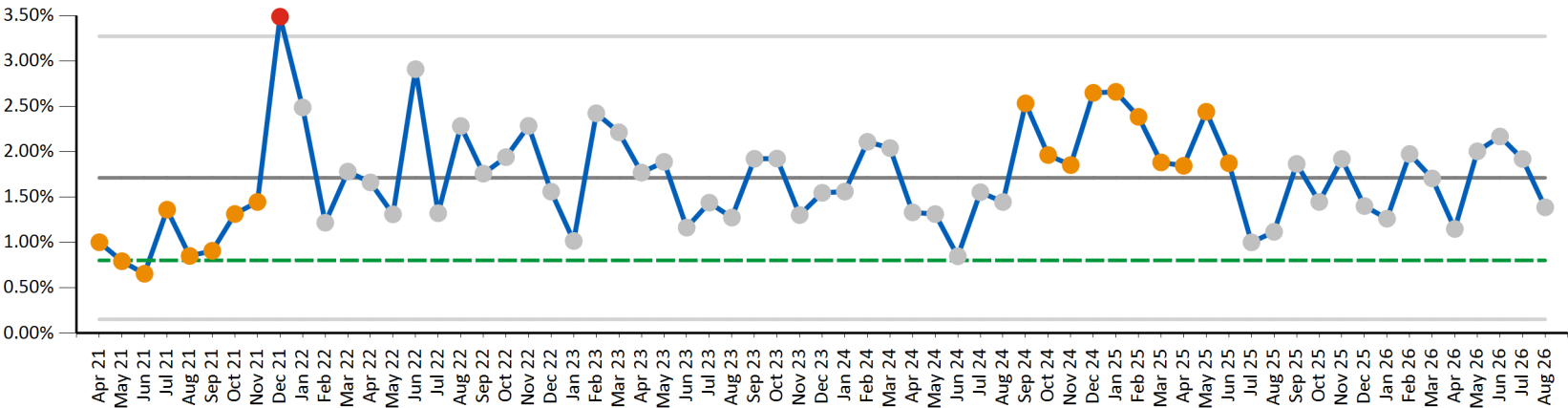
Year to Date

Plan	Actual
	84.8%

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



0/6



Latest

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

Previous

Plan	Actual	Period
<= 1%	1.9%	Jul-26

Year to Date

Plan	Actual
<= 1%	1.7%

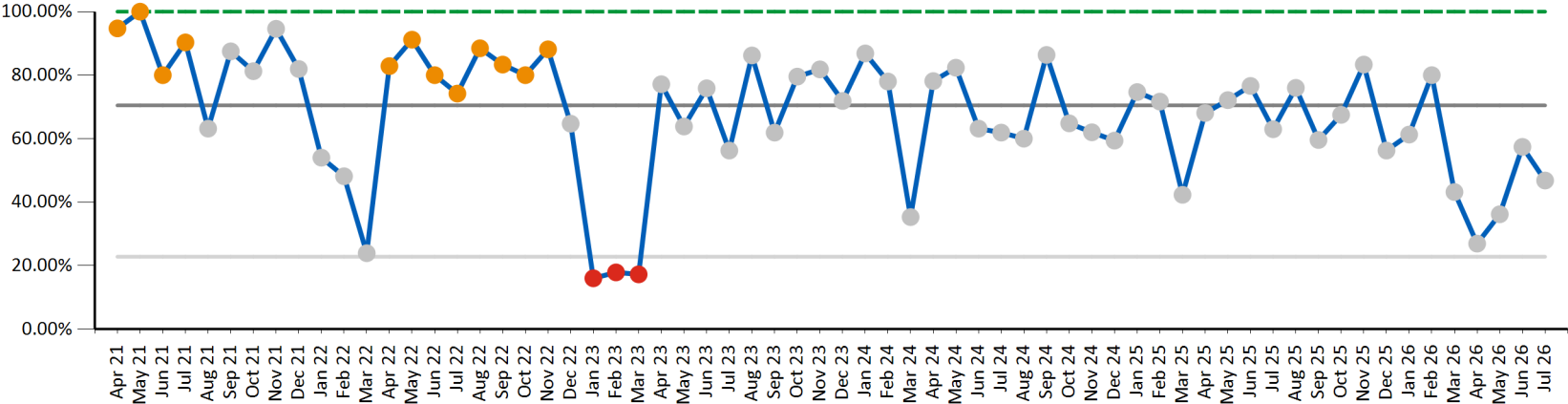
62 - Cancelled operations re-booked within 28 days

Common cause variation.

?

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

0/6



Latest

Plan	Actual	Period
= 100%	46.8%	Jul-26

Previous

Plan	Actual	Period
= 100%	57.4%	Jun-26

Year to Date

Plan	Actual
= 100%	44.3%

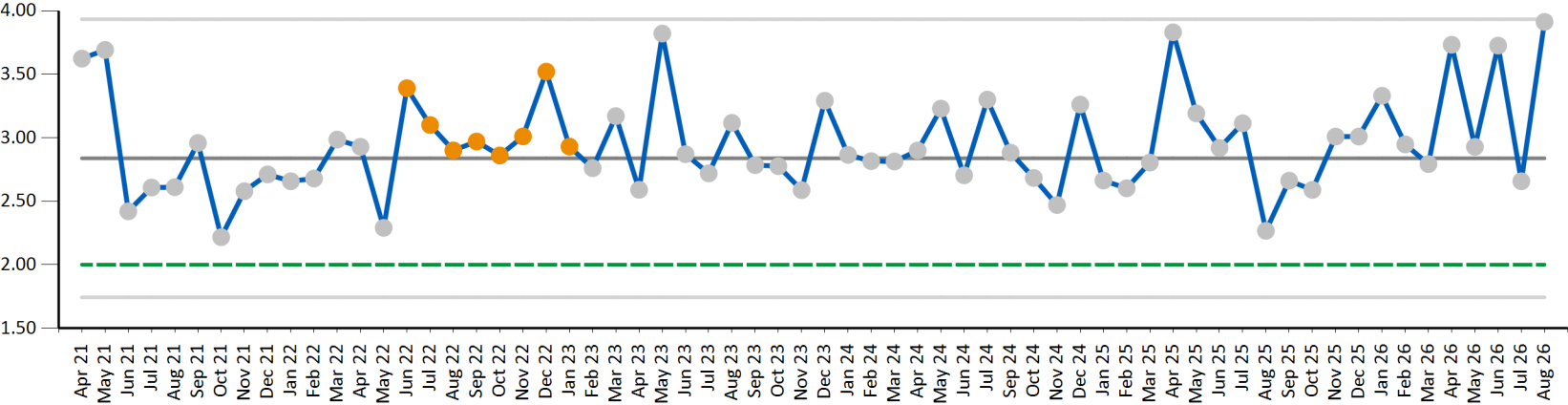
65 - Elective Length of Stay (Discharges in month)

Common cause variation.

?

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

0/6



Latest

Plan	Actual	Period
<= 2.00	3.91	Aug-26

Previous

Plan	Actual	Period
<= 2.00	2.66	Jul-26

Year to Date

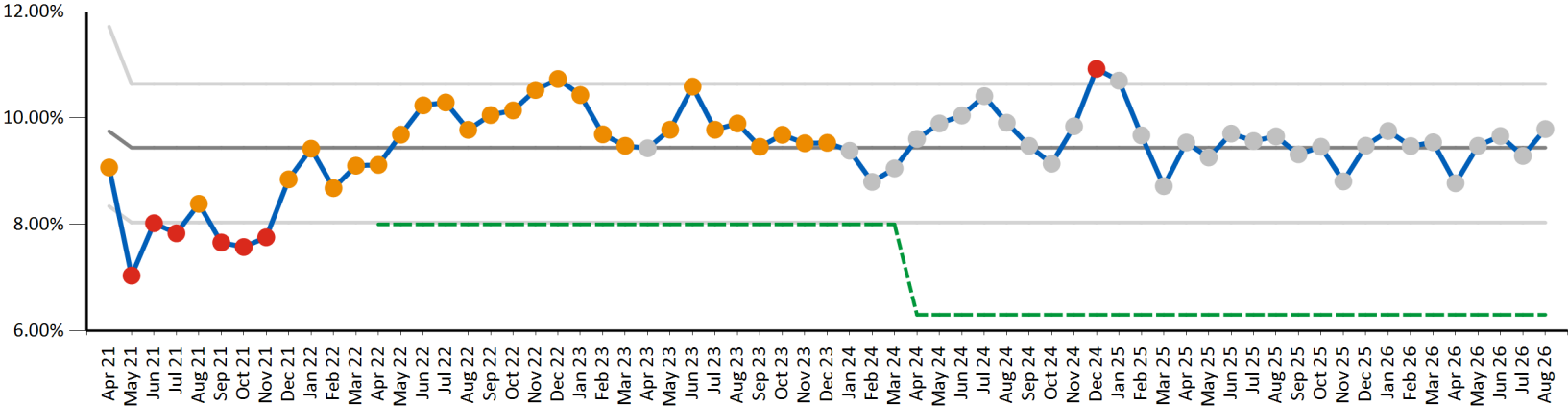
Plan	Actual
<= 2.00	3.39

309 - DNA Rate - New

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

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

Previous

Plan	Actual	Period
<= 6.3%	9.3%	Jul-26

Year to Date

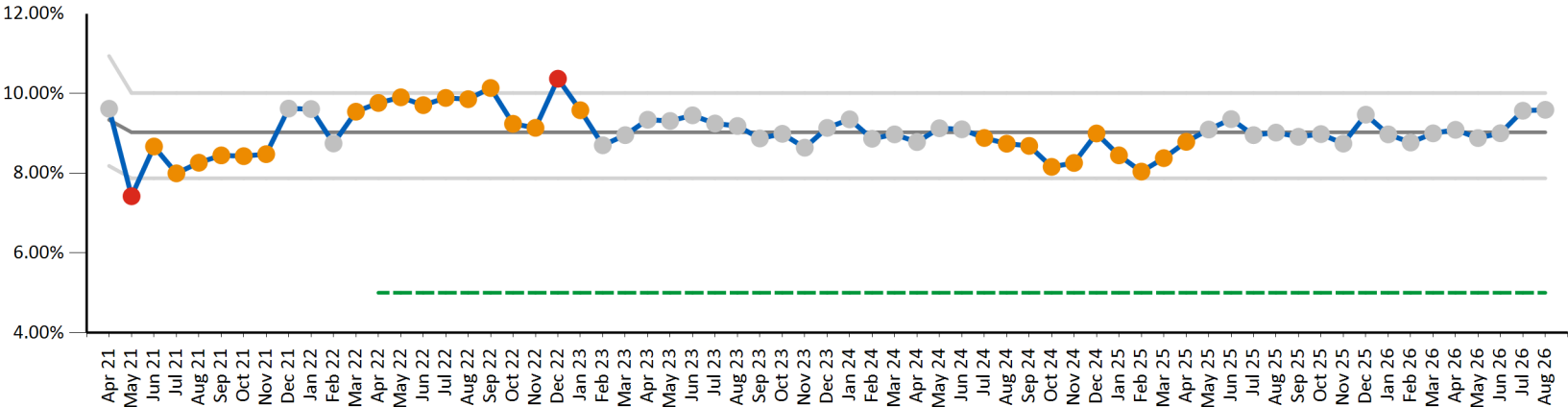
Plan	Actual
<= 6.3%	9.4%

310 - DNA Rate - Follow up

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5.0%	9.6%	Aug-26

Previous

Plan	Actual	Period
<= 5.0%	9.6%	Jul-26

Year to Date

Plan	Actual
<= 5.0%	9.2%

Operational Performance - Cancer

For July, we achieved the faster diagnosis standard, and the 31-day treatment standard.

We failed to achieve the 62-day standard for July, with performance of 69.88% 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, Breast, and Gynaecology. A cancer recovery plan is in place and will be monitored monthly through Trust governance routes. It is expected that performance for August will improve against the 62-day target. It is unfortunately, however, expected that September's performance will deteriorate due to the range of challenges facing almost all tumour groups.

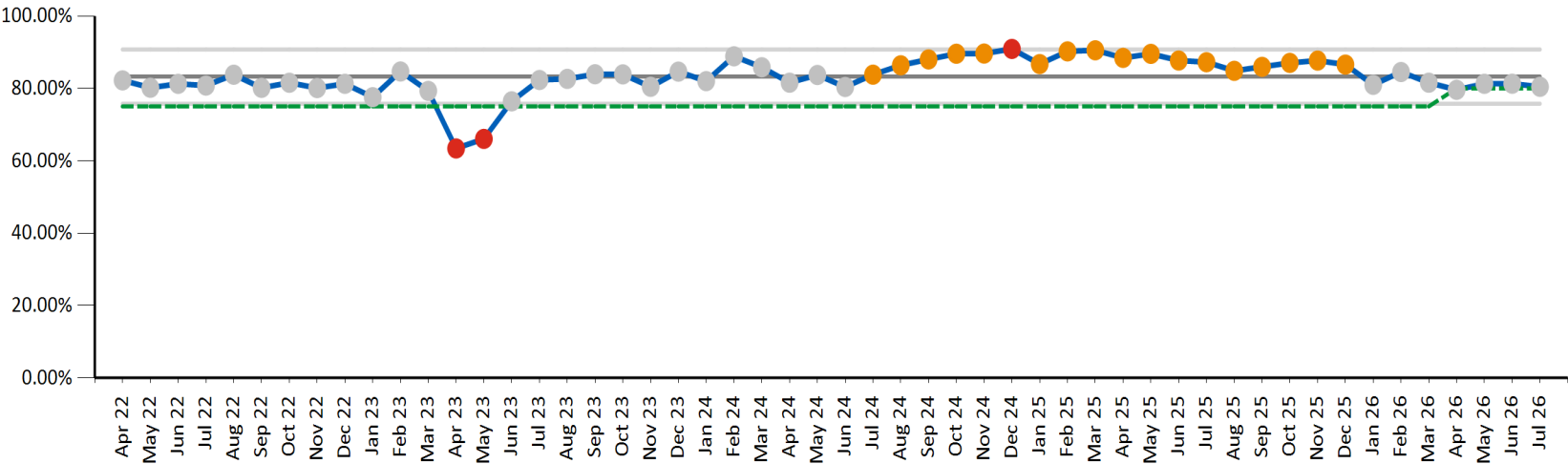
Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
542 - Cancer: 28 day faster diagnosis	>= 80.0%	80.4%	Jul-26		>= 80.0%	81.3%	Jun-26	>= 80.0%	80.6%	
584 - 31 Day General Treatment Standard	>= 96%	96.5%	Jul-26		>= 96%	99.3%	Jun-26	>= 96%	98.2%	
585 - 62 Day General Standard	>= 85%	69.9%	Jul-26		>= 85%	77.4%	Jun-26	>= 85%	76.0%	

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%	80.4%	Jul-26

Previous

Plan	Actual	Period
>= 80.0%	81.3%	Jun-26

Year to Date

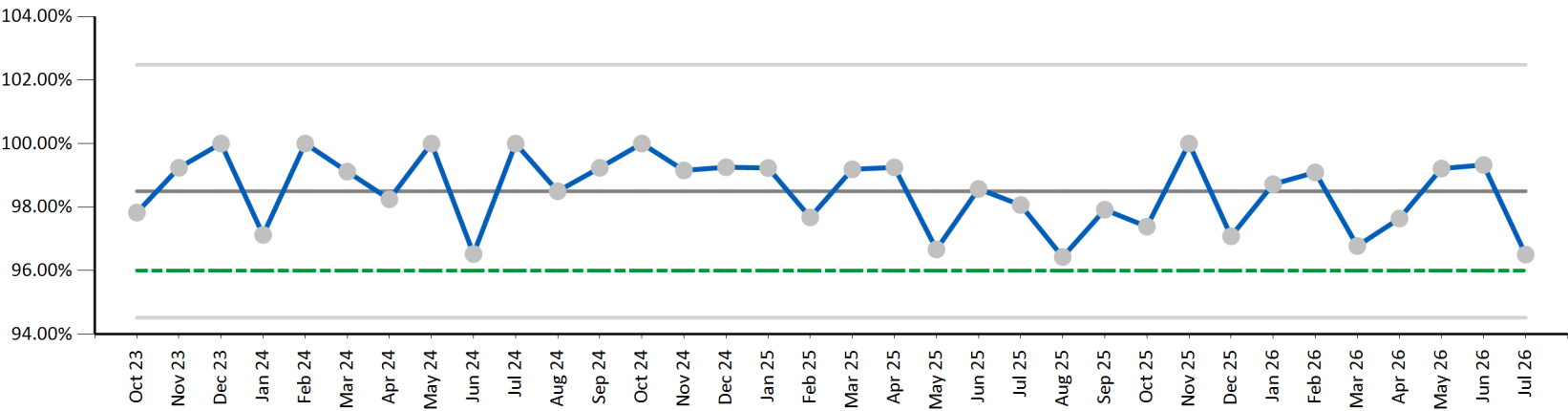
Plan	Actual
>= 80.0%	80.6%

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%	96.5%	Jul-26

Previous

Plan	Actual	Period
>= 96%	99.3%	Jun-26

Year to Date

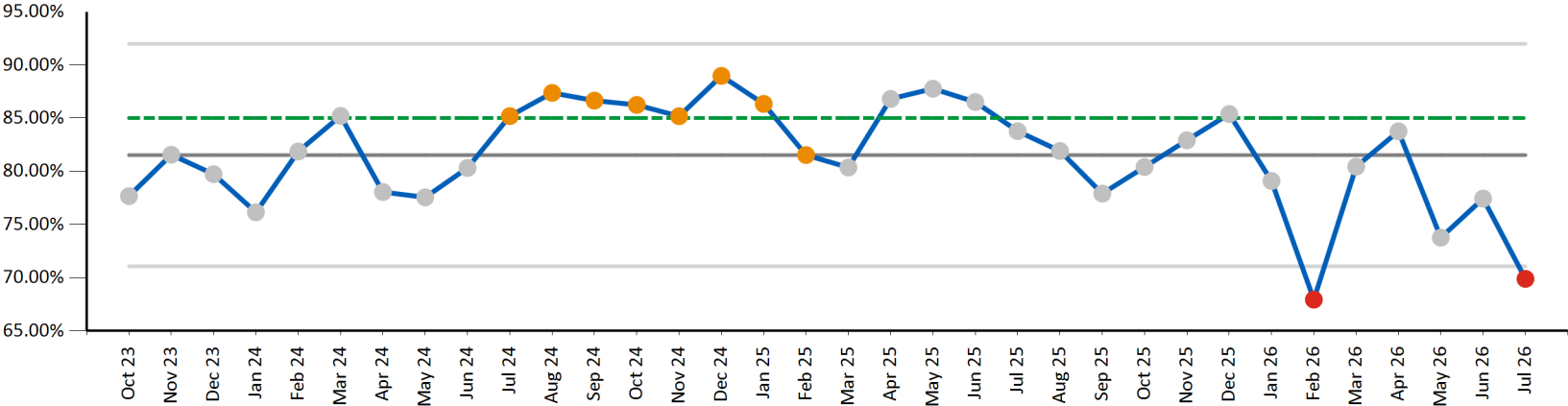
Plan	Actual
>= 96%	98.2%



Special cause variation with deteriorating performance



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



Latest

Plan	Actual	Period
>= 85%	69.9%	Jul-26

Previous

Plan	Actual	Period
>= 85%	77.4%	Jun-26

Year to Date

Plan	Actual
>= 85%	76.0%

Operational Performance - Community Care

NCTR

Month 5 NCTR numbers increased slightly to from 94 to 103, above the operational target of 90. NCTR lost bed days saw an increase from 530 to 806. Both were expected to increase in month owing to the changes in configuration of units as part of the IMC Transformation, however, have seen higher performance declines than original projected.

Works relating to the Weaver Unit and ITOCH are ongoing and close daily monitoring of NCTR continues.

This, however, is less linked to bed availability (units have remained open and with availability) but more linked to systemic pressures and complexity of patients. High volumes of system cell escalations and delays across M5 through staffing availability in various sectors has resulted in this performance decline. System escalation continues to unblock delays, and additional focus has been implemented for patients with a LOS over 30 days which has supported these escalations, however physical staffing capacity, availability of care home beds and extended stay/high volumes of out of area patients.

5 Years Mandated Contacts

Performance remains below target (83.7% vs 95%). Following a period of sustained improvement this has settled in the last few months in the Mid 80%s. albeit this being the lowest % for over 12 months. M5 has historically been a challenging month due to high levels of annual leave, however is further driven through levels of sickness and subsequent vacancy within the service with posts actively being recruited into. Following Neighbourhood model swich, new processes around internal mutual aid are being developed as it is felt some of these could have been avoided with more proactive internal escalation, particularly given higher numbers of cancel/rearrangement requests from families due to the school holidays.

EHCP compliance

Compliance was 97% in M5, achieving the 95% target. This 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, and evidence of these new ways of working are visible in the data

Looked after Children

Has achieved 95% against the of 90% for School Nursing and Health Visitor, however IHA within 4 weeks from the Consultant base has seen a sharp decline owing to annual leave and vacancy. This is being picked up locally in relation to the agreement of annual leave during these periods and ensuring suitable provision. Review Health Assessments in Special Schools remained 100%

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 200 by the end of M5, with the actuals resulting in 131 (69 ahead of plan).

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 been adjusted to 70.

Community Waits 18 week % Combined

Performance against the 18-week community wait standard is currently above plan at 85.91%. Seeing a continued trend of increased performance and sitting well above the National Target of 78%. Audiology, Podiatry 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. Podiatry has seen some improvements, however through the nature of their booking on ERS are subject to late patient choice changes for 1st Appointment. ICPS is limited based on commissioning arrangements. As a result, the 18-week position is expected to deteriorate for this service. However, the 52+ week position is expected to remain minimal, with ongoing discussions taking place with ICB colleagues.

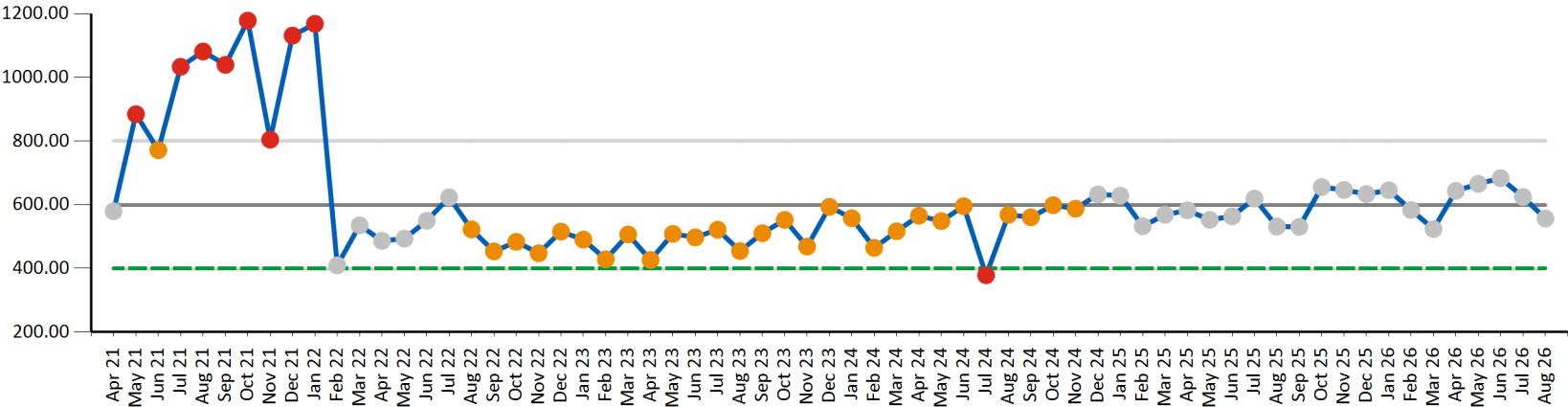
Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	556	Aug-26		>= 400	624	Jul-26	>= 2,000	3,171	
641 - Community Service Waits - 52 weeks +		145	Jul-26			156	Jun-26		596	
644 - Community Service Waits - 18 weeks % (Combined)	>= 78.0%	85.7%	Jul-26		>= 78.0%	84.8%	Jun-26	>= 78.0%	85.3%	
493 - Average Number of Patients: with no Criteria to Reside	<= 93	103	Aug-26		<= 92	94	Jul-26	<= 93	103	
494 - Average Occupied Days - for no Criteria to Reside	<= 360	806	Aug-26		<= 360	530	Jul-26	<= 1,800	3,211	
267 - 0-5 Health Visitor mandated contacts	>= 95%	84%	Aug-26		>= 95%	88%	Jul-26	>= 95%	85%	
269 - Education, health and care plan (EHC) compliance	>= 95%	97%	Aug-26		>= 95%	97%	Jul-26	>= 95%	96%	
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse	>= 90.0%	95.0%	Aug-26		>= 90.0%	97.0%	Jul-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	556	Aug-26

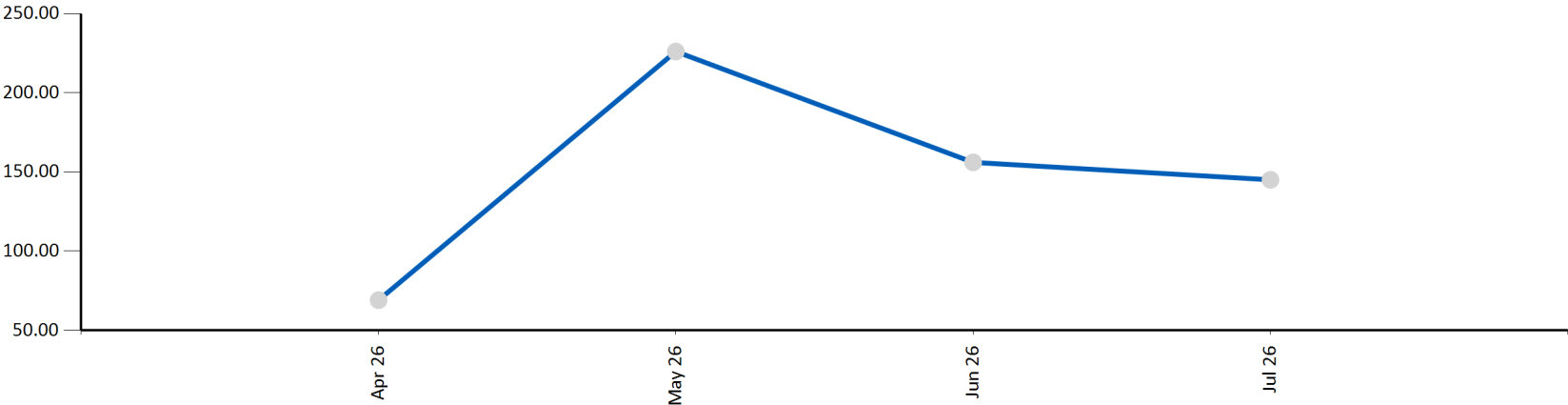
Previous

Plan	Actual	Period
>= 400	624	Jul-26

Year to Date

Plan	Actual
>= 2,000	3,171

641 - Community Service Waits - 52 weeks + - SPC data available after 20 data points



Latest

Plan	Actual	Period
	145	Jul-26

Previous

Plan	Actual	Period
	156	Jun-26

Year to Date

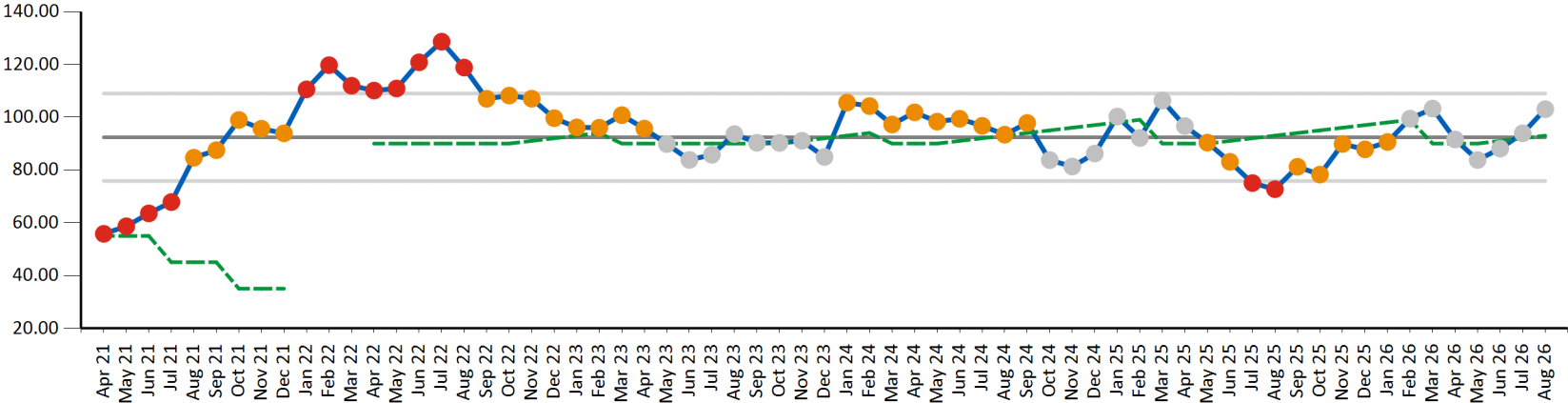
Plan	Actual
	596

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

 Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 93	103	Aug-26

Previous

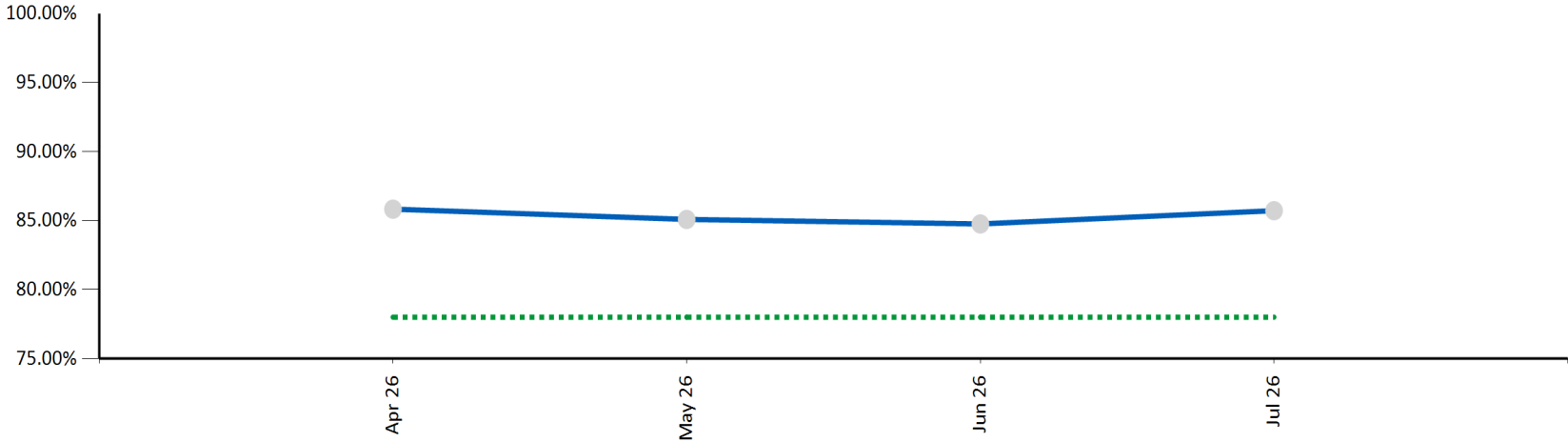
Plan	Actual	Period
<= 92	94	Jul-26

Year to Date

Plan	Actual
<= 93	103

644 - Community Service Waits - 18 weeks % (Combined) - SPC data available after 20 data points

4/6



Latest

Plan	Actual	Period
>= 78.0%	85.7%	Jul-26

Previous

Plan	Actual	Period
>= 78.0%	84.8%	Jun-26

Year to Date

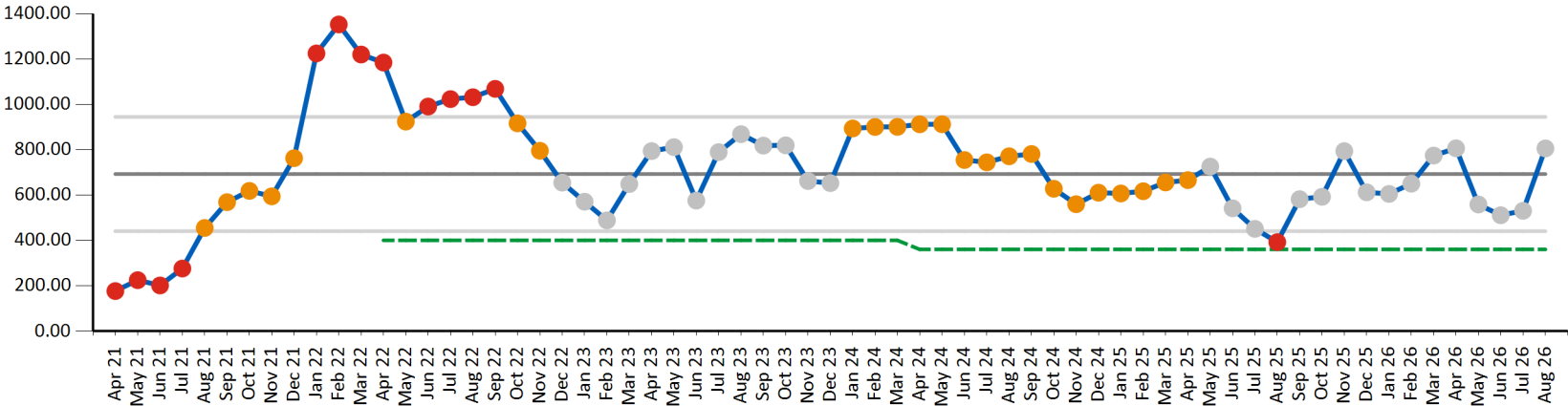
Plan	Actual
0.78	85.3%

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	806	Aug-26

Previous

Plan	Actual	Period
<= 360	530	Jul-26

Year to Date

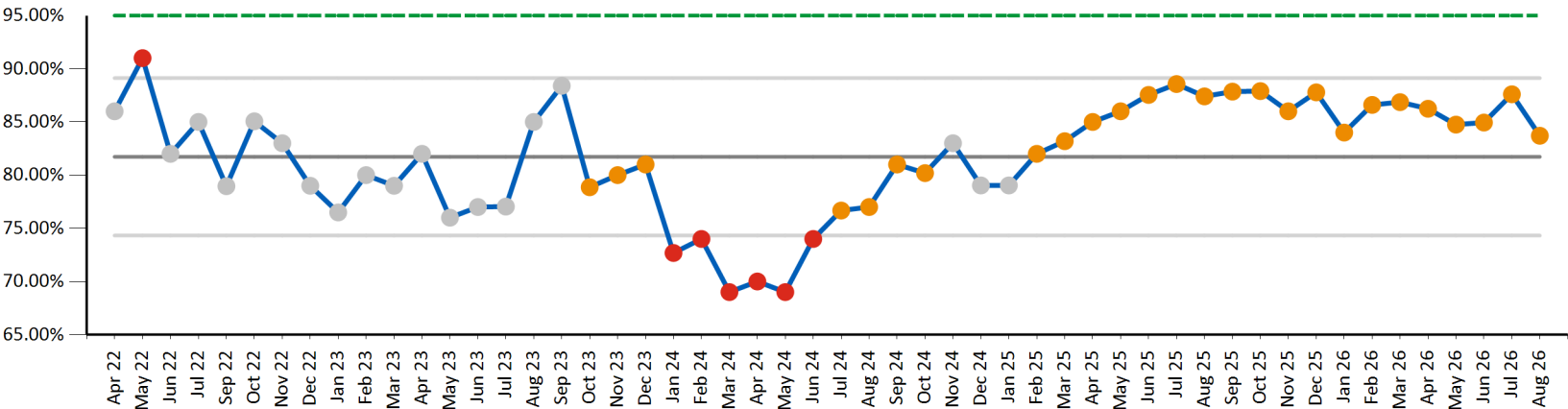
Plan	Actual
<= 1,800	3,211

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%	84%	Aug-26

Previous

Plan	Actual	Period
>= 95%	88%	Jul-26

Year to Date

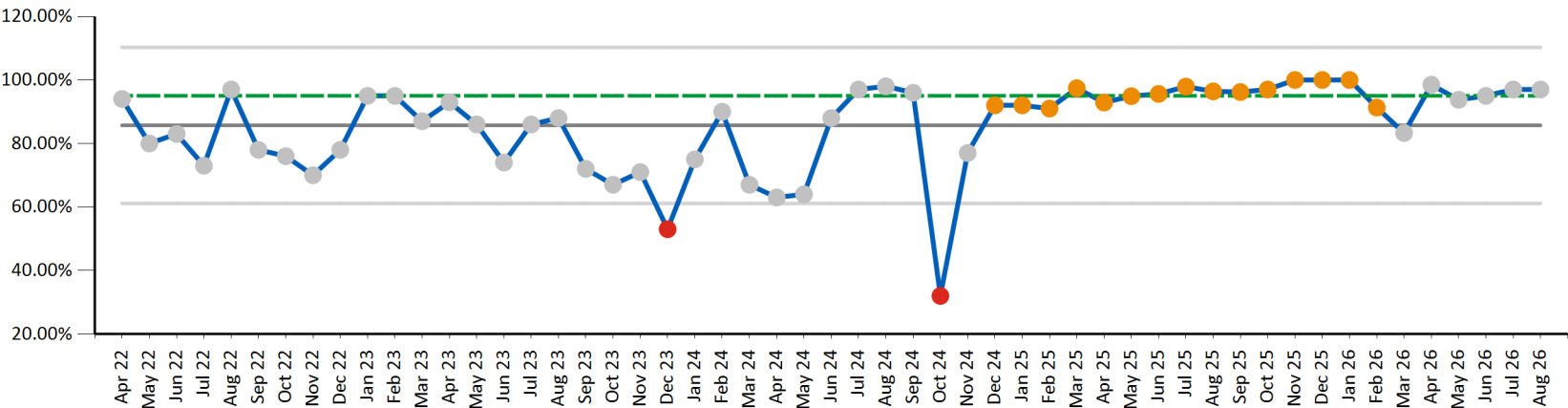
Plan	Actual
>= 95%	85%

269 - Education, health and care plan (EHC) compliance

 Common cause variation.

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

4/6



Latest

Plan	Actual	Period
>= 95%	97%	Aug-26

Previous

Plan	Actual	Period
>= 95%	97%	Jul-26

Year to Date

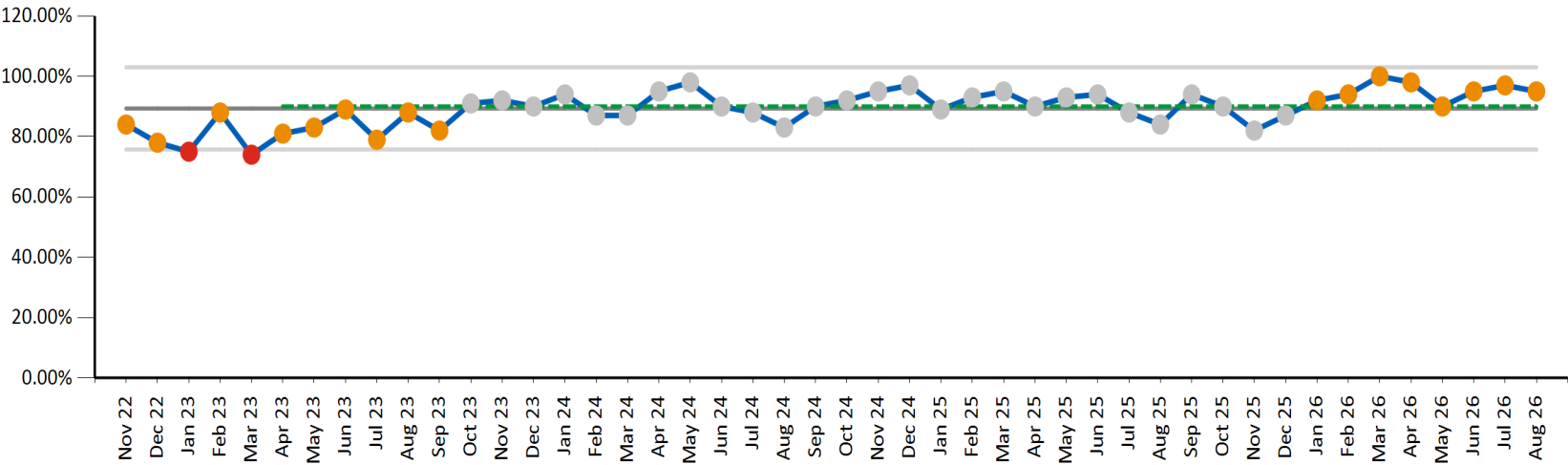
Plan	Actual
>= 95%	96%

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

 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%	95.0%	Aug-26

Previous

Plan	Actual	Period
>= 90.0%	97.0%	Jul-26

Year to Date

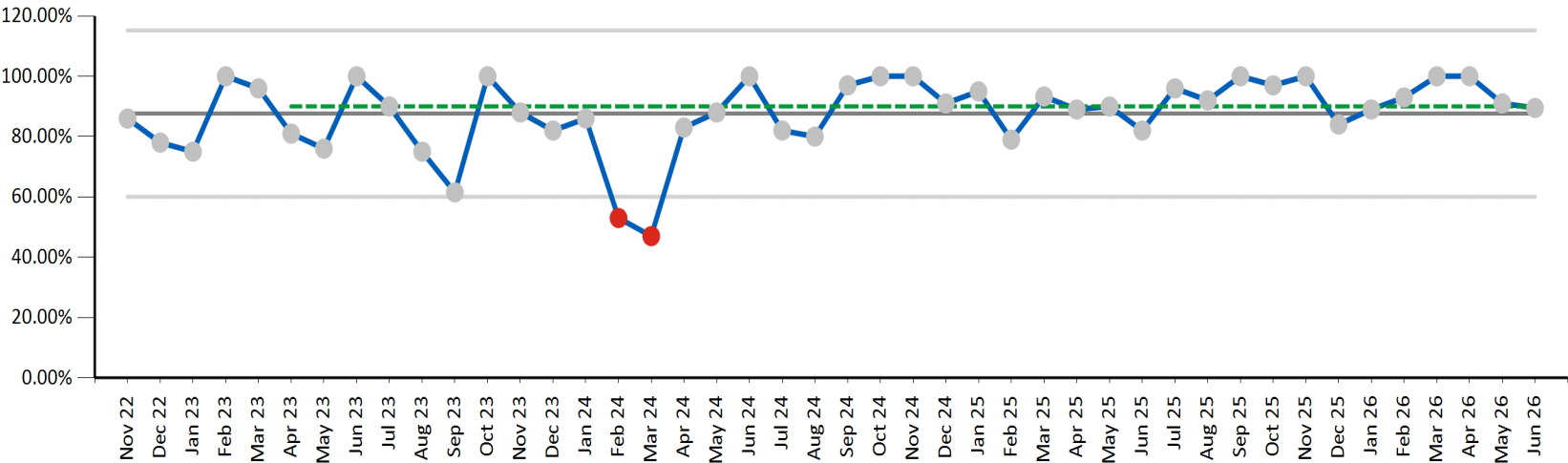
Plan	Actual
>= 90.0%	

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

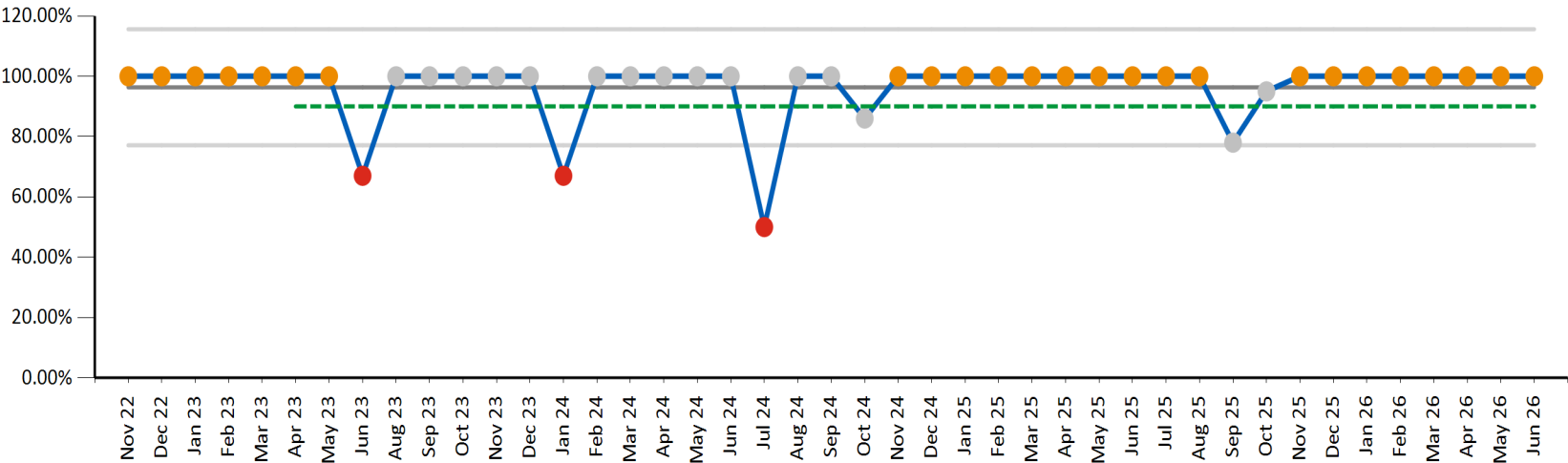
Plan	Actual
>= 90.0%	

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

Sickness:

Sickness has increased slightly in August 26 to 5.65%, compared to 5.60% in July 2026. The Trust continues to review its sickness action plan to reduce sickness absence and is continuing 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:

Turnover was static in-month and is performing in line with our expectations. Highest staffing groups for turnover are Admin and Clerical, and Additional Clinical Services (mostly Health Care Assistant roles). Low turnover rates noted in Nursing and Midwifery, and Medical, staffing groups.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	5.65%	Aug-26		<= 4.20%	5.60%	Jul-26	<= 4.20%	5.47%	
120 - Vacancy level - Trust	<= 6%	4.62%	Mar-25		<= 6%	5.08%	Feb-25	<= 6%		
121 - Turnover	<= 9.90%	11.40%	Aug-26		<= 9.90%	11.13%	Jul-26	<= 9.90%	11.81%	
366 - Ongoing formal investigation cases over 8 weeks		0	Aug-26			0	Jul-26		0	

117 - Sickness absence level - Trust

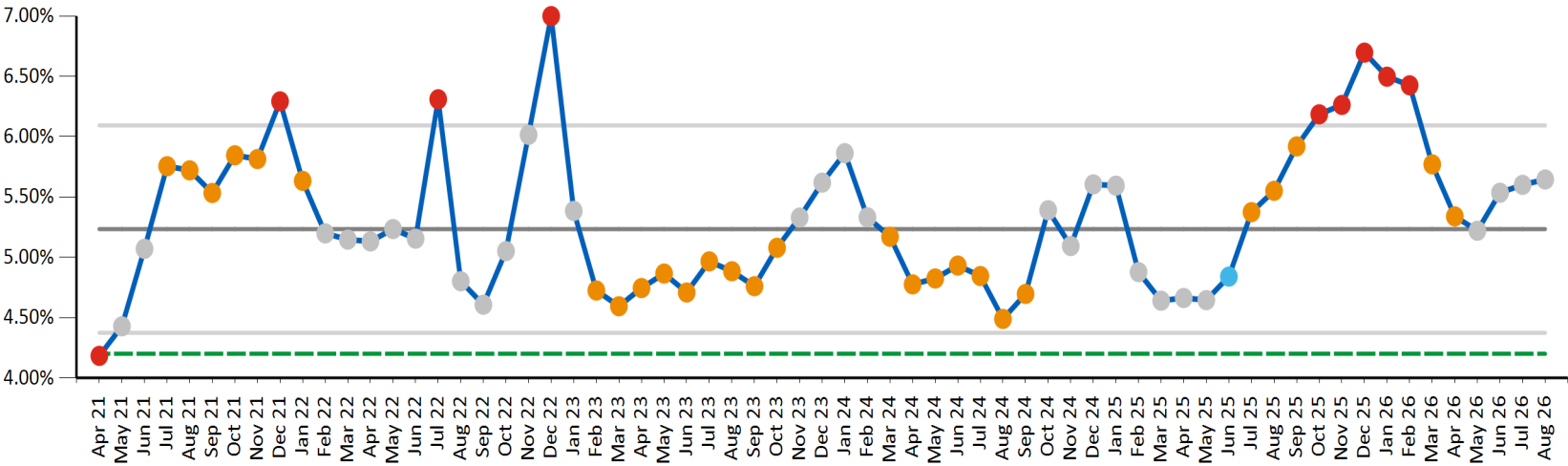


Common cause variation.



We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 4.20%	5.65%	Aug-26

Previous

Plan	Actual	Period
<= 4.20%	5.60%	Jul-26

Year to Date

Plan	Actual
<= 4.20%	5.47%

120 - Vacancy level - Trust

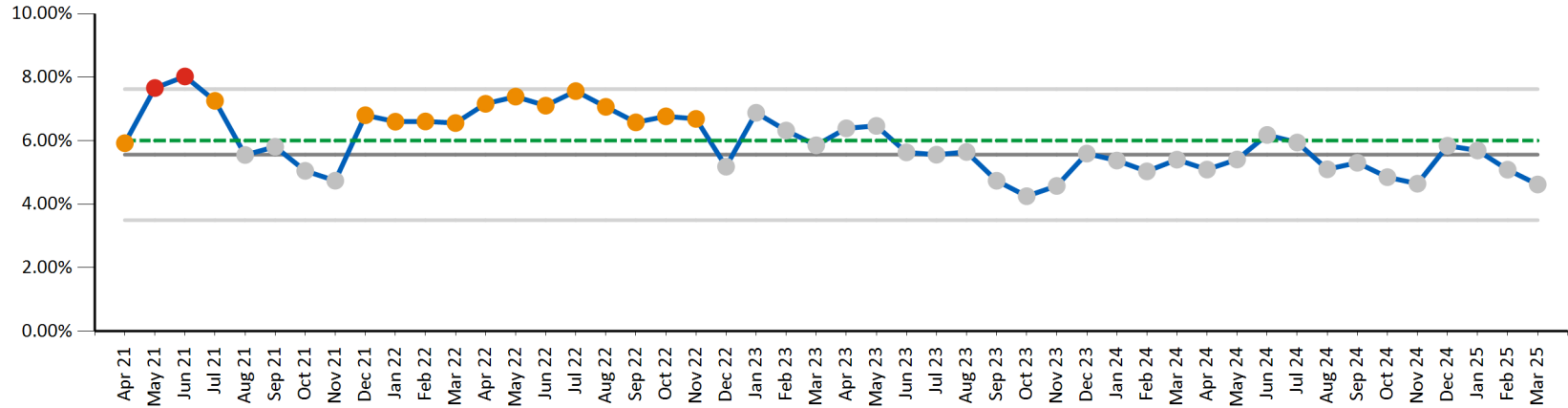


Common cause variation.



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

6/6



Latest

Plan	Actual	Period
<= 6%	4.62%	Mar-25

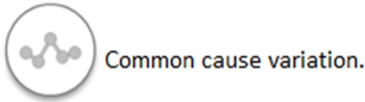
Previous

Plan	Actual	Period
<= 6%	5.08%	Feb-25

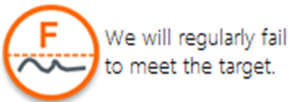
Year to Date

Plan	Actual
<= 6%	5.31%

121 - Turnover

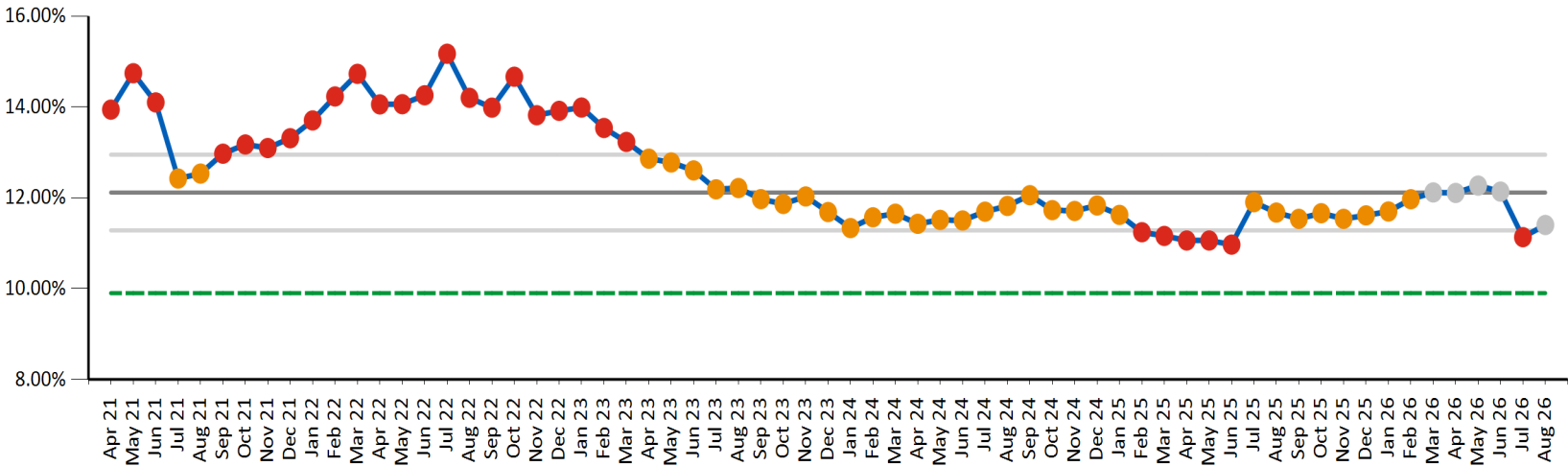


Common cause variation.



We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 9.90%	11.40%	Aug-26

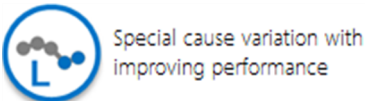
Previous

Plan	Actual	Period
<= 9.90%	11.13%	Jul-26

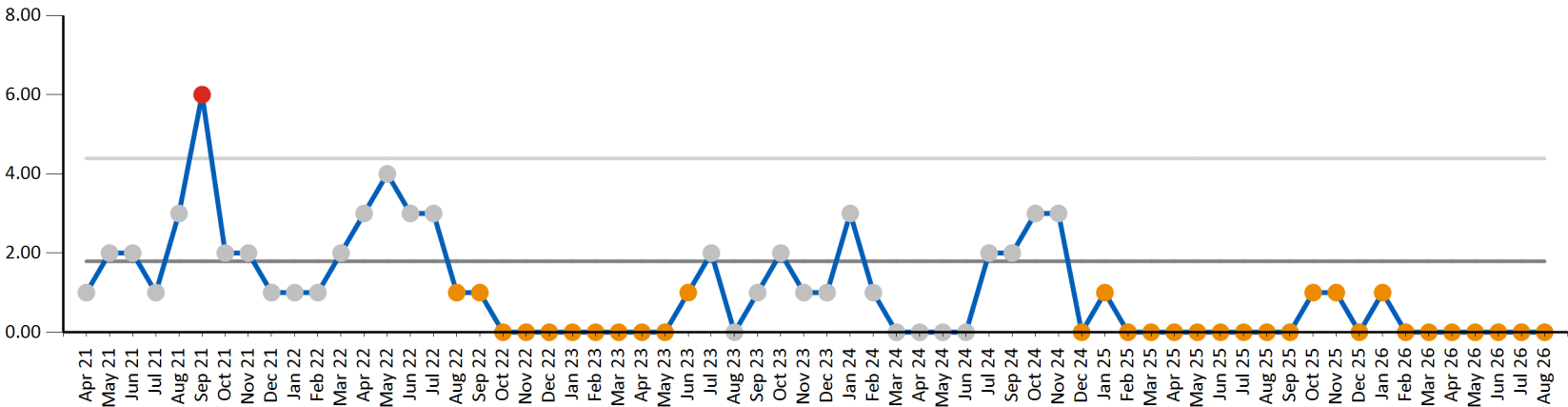
Year to Date

Plan	Actual
<= 9.90%	11.81%

366 - Ongoing formal investigation cases over 8 weeks



Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Aug-26

Previous

Plan	Actual	Period
	0	Jul-26

Year to Date

Plan	Actual
	0

Workforce - Organisational Development

Compulsory Training

A slight decrease in compulsory training compliance was recorded during August, reducing from 94.56% to 94.30%, leaving the Trust 0.7 percentage points below the 95% target. Improvement was seen in a number of areas, including Divisional Management Operations, Workforce & OD, Medical Education, Community Services, Patient Safety & Experience, and Families & Diagnostics. However, performance within the larger Surgery and Medicine divisions declined and continues to have the greatest impact on overall Trust compliance.

Basic Life Support compliance has improved to 89.9% following targeted activity with staff whose competency had expired. In addition, the Moving and Handling Level 2 training programme has been redesigned, combining theory and practical elements into a single face-to-face session from October 2026 to simplify the booking process and support improvements in compliance

Trust Mandated Training

Trust Mandated Training compliance reduced slightly during August from 90.90% to 90.02%; however, performance remains comfortably above the Trust target of 85%. Positive performance was maintained in a number of areas, including Community Services, Patient Safety & Experience, Workforce & OD and Medical Education. Whilst Divisional Management Operations showed significant improvement in compulsory training, mandated training reduced to 80.0%. The largest impact on overall performance continues to come from the Surgery and Medicine divisions, both of which recorded in-month reductions, although Medicine remains just above the compliance target at 85.64%. The Chief Executive & Board and Strategy Directorates continue to be priority areas for improvement, both remaining below target compliance levels

Appraisal

Appraisal rate has decreased very slightly from 82.9% to 82.6% but remains below the 85% target. Five of the areas below 85% are non-clinical directorates, one focus of the next two months is to support these areas by understanding the barriers to a quality appraisal being completed. Additional meetings have been set up to further review current rates of compliance and identify any further actions and support.

Staff Survey Data

Results from the July 2026 Pulse Survey (Q2 2026/27) demonstrate improvement in both key staff engagement metrics. The percentage of staff who would be happy with the standard of care provided by the Trust if a friend or relative required increased from 45.9% to 49.3%, whilst the percentage of staff who would recommend the Trust as a place to work improved from 36.5% to 42.1%. Whilst both measures show positive progress, performance remains below the Trust's aspirational targets of 80% and 66% respectively.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Compulsory Training	>= 95%	94.3%	Aug-26		>= 95%	94.6%	Jul-26	>= 95%	94.3%	
38 - Staff completing Trust Mandated Training	>= 85%	90.0%	Aug-26		>= 85%	90.9%	Jul-26	>= 85%	90.4%	
39 - Staff completing Safeguarding Training	>= 95%	94.68%	Aug-26		>= 95%	94.85%	Jul-26	>= 95%	94.35%	

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
101 - Increased numbers of staff undertaking an appraisal	>= 85%	82.6%	Aug-26		>= 85%	82.9%	Jul-26	>= 85%	82.6%	
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	42.1%	Q2 2026/27		>= 66%	36.5%	Q1 2026/27	>= 66%		
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	49.3%	Q2 2026/27		>= 80%	45.9%	Q1 2026/27	>= 80%		

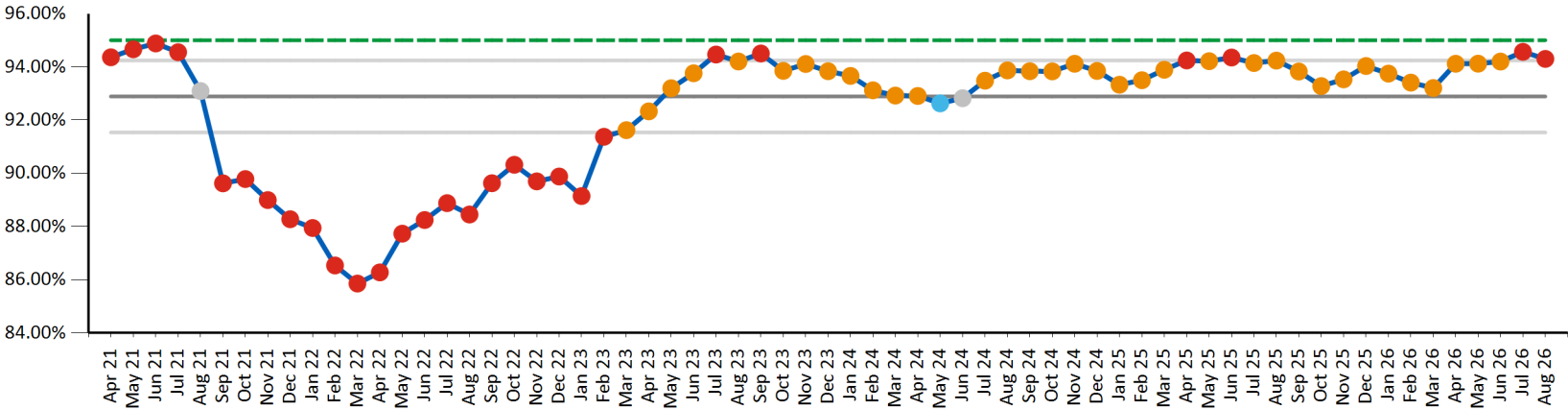
37 - Staff completing Compulsory Training



Special cause variation with improving performance



We will regularly fail to meet the target.



Latest

Plan	Actual	Period
>= 95%	94.3%	Aug-26

Previous

Plan	Actual	Period
>= 95%	94.6%	Jul-26

Year to Date

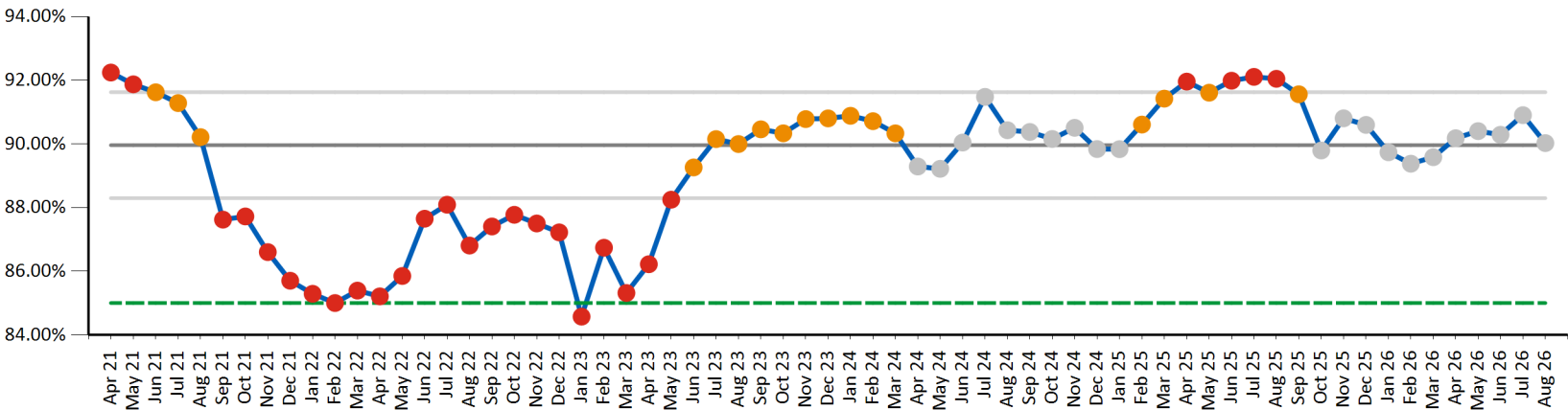
Plan	Actual
>= 95%	94.3%

38 - Staff completing Trust Mandated Training

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	90.0%	Aug-26

Previous

Plan	Actual	Period
>= 85%	90.9%	Jul-26

Year to Date

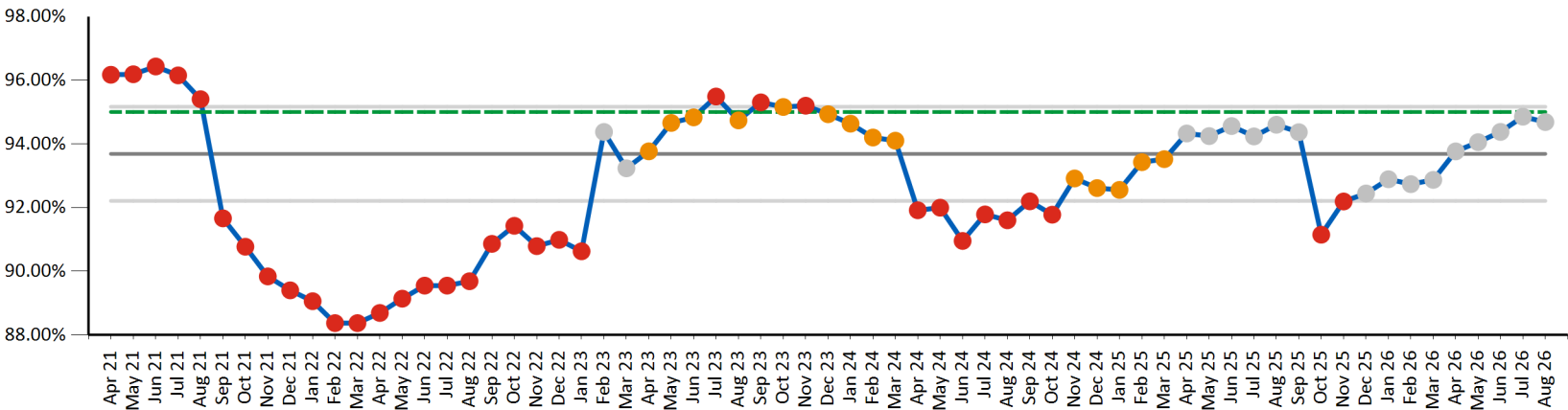
Plan	Actual
>= 85%	90.4%

39 - Staff completing Safeguarding Training

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 95%	94.68%	Aug-26

Previous

Plan	Actual	Period
>= 95%	94.85%	Jul-26

Year to Date

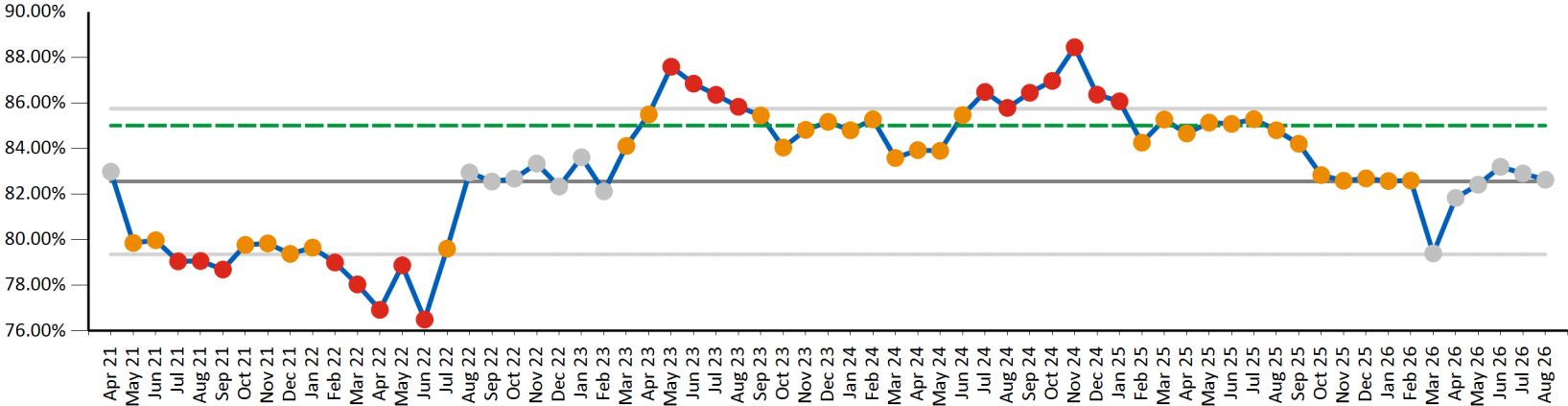
Plan	Actual
>= 95%	94.35%

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%	82.6%	Aug-26

Previous

Plan	Actual	Period
>= 85%	82.9%	Jul-26

Year to Date

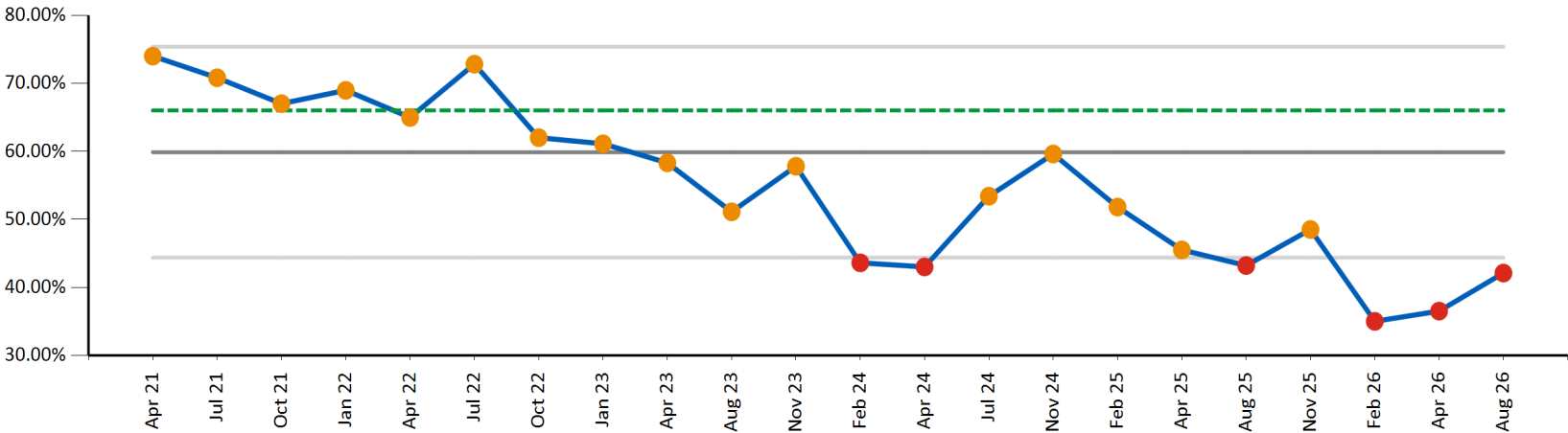
Plan	Actual
>= 85%	82.6%

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%	42.1%	Q2 2026/27

Previous

Plan	Actual	Period
>= 66%	36.5%	Q1 2026/27

Year to Date

Plan	Actual
>= 66%	

79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)

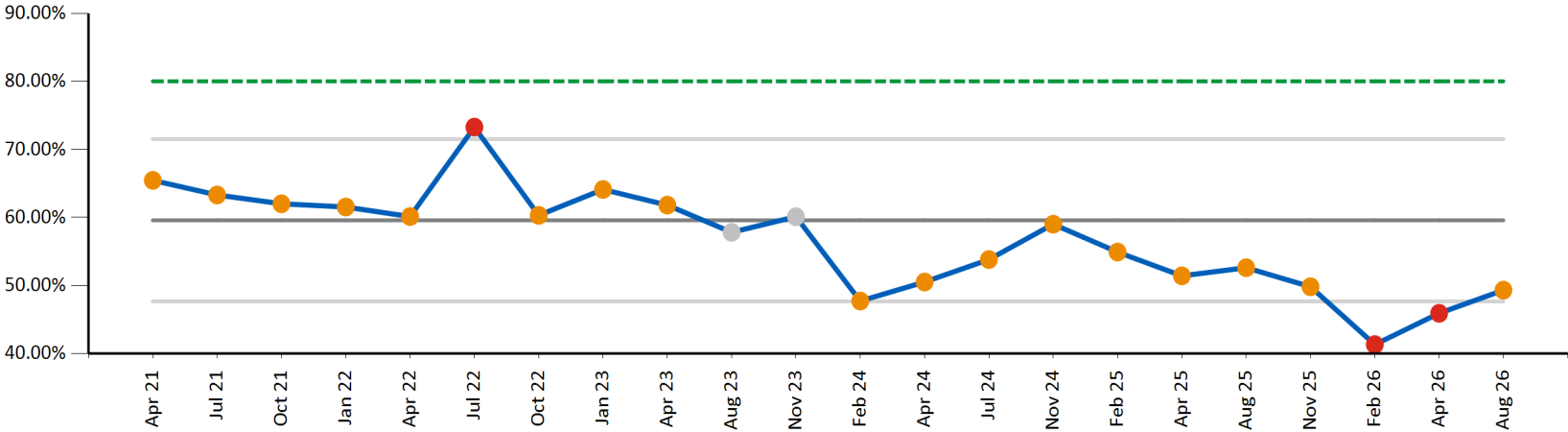


Special cause variation with deteriorating performance



We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 80%	49.3%	Q2 2026/27

Previous

Plan	Actual	Period
>= 80%	45.9%	Q1 2026/27

Year to Date

Plan	Actual
>= 80%	

Workforce - Agency

Agency usage remains low with the majority of all agency being used to cover hard-to-recruit vacancies in the medical staffing group. However, despite this low usage, the nature of the agency roles being filled (highly specialised with rates being driven by market demands) means that the Trust is currently over our ceiling for medical agency spend. We are actively looking to fill medical vacancies through rolling recruitment and targeted recruitment campaigns.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.40	0.40	Aug-26		<= 0.40	0.40	Jul-26	<= 2.09	2.07	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.01	0.01	Aug-26		<= 0.01	0.01	Jul-26	<= 0.05	0.04	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.38	0.37	Aug-26		<= 0.38	0.39	Jul-26	<= 1.90	1.95	

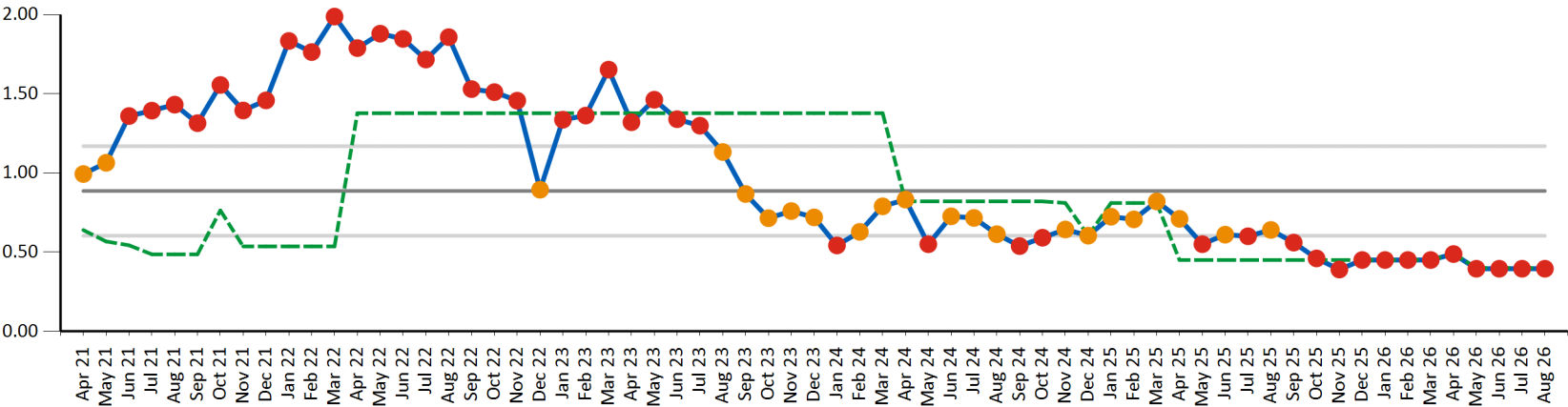
198 - Trust Annual ceiling for agency spend (£m)



Special cause variation with improving performance



We will regularly fail to meet the target.



Latest

Plan	Actual	Period
<= 0.40	0.40	Aug-26

Previous

Plan	Actual	Period
<= 0.40	0.40	Jul-26

Year to Date

Plan	Actual
<= 2.09	2.07

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

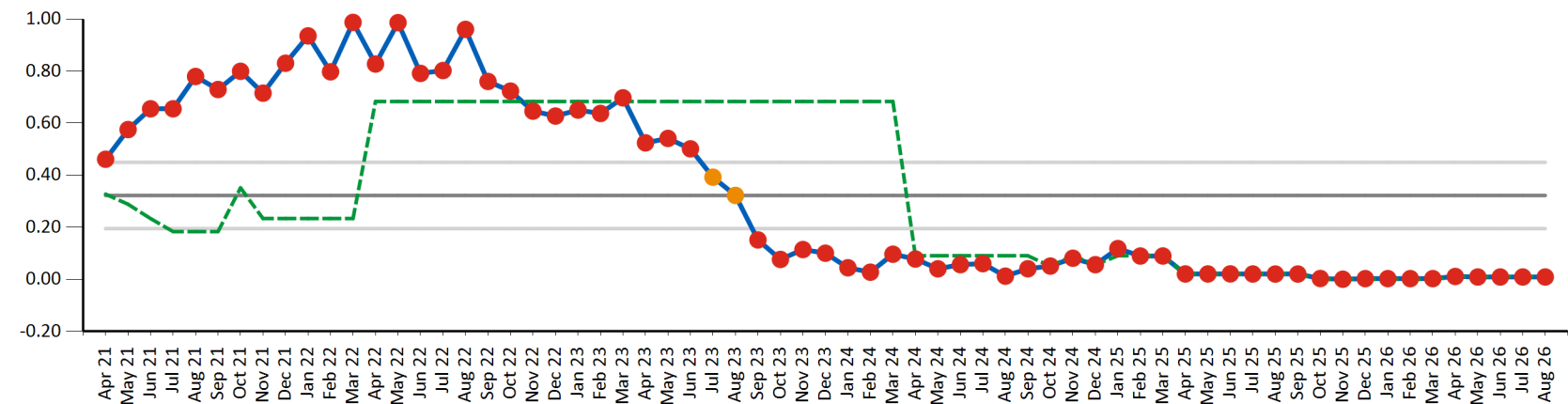


Special cause variation with improving performance



We will regularly fail to meet the target.

4/6



Latest

Plan	Actual	Period
<= 0.01	0.01	Aug-26

Previous

Plan	Actual	Period
<= 0.01	0.01	Jul-26

Year to Date

Plan	Actual
<= 0.05	0.04

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

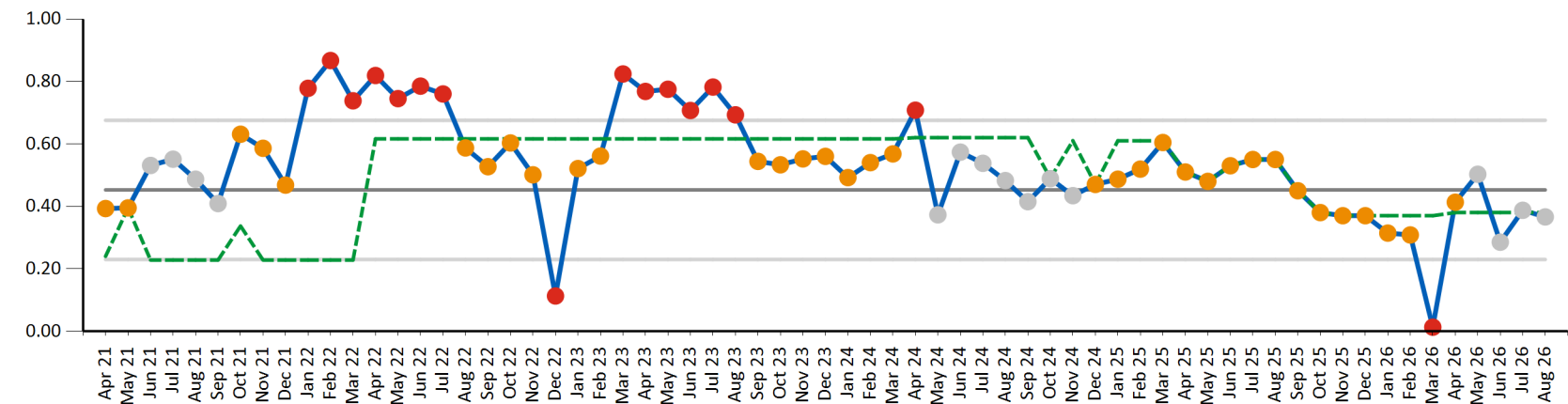


Common cause variation.



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

3/6



Latest

Plan	Actual	Period
<= 0.38	0.37	Aug-26

Previous

Plan	Actual	Period
<= 0.38	0.39	Jul-26

Year to Date

Plan	Actual
<= 1.90	1.95

Finance - Finance

Surplus / (Deficit)

The in-month position is a deficit of £2.4m, which is £5k favourable to plan. The cumulative deficit is £13.7m, which is £37k 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 6-12 need to average a surplus of £0.9m, which is a run-rate improvement of £3.3m vs the Month 5 position (7%), which needs to be delivered by CIP schemes and other cost control measures.

Forecast

The mid-case forecast is a deficit of £24.3m, which is £17.3m adverse to plan based on delivering £26.6m of CIP. The worst case forecast is a deficit of £31.7m, best case is £16.5m.

Income

Commissioner variable activity income is being reported £1.8m below plan, reflecting activity 'lost' due to industrial action, the June heatwave and July theatre downtime. Actual performance is calculated in arrears using coded activity information, initial estimates at Month 5 show that this is £5.1m lower than plan, with a potential clawback of £4.2m. At Month 5, it is assumed that £2.4m 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 5 position, which is a risk. Other adverse variances relate to CDC income and excluded Drugs/Devices, the latter is offset in Non Pay.

Deficit Support Funding (DSF)

Q1 Deficit Support funding has been paid at £0.5m per quarter, up to £2m for the full year. Month 5 DSF income is included within the position and it is anticipated that Q2 DSF will be paid. Q3-4 DSF will need to be achieved through delivery of financial and CIP targets.

Pay

Underlying pay costs have reduced significantly since March 2026, when allowing for the 2026/27 Pay Award, and are cumulatively favourable to the Trust Plan. Underlying pay costs have increased from M4 to M5 due to WTE increases. 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 6,093 at Month 3, but have since increased for 2 consecutive months and stand at 6,116 at Month 5

Non Pay

Non Pay costs have increased from M4, which included a cumulative adjustment to Rates/Utilities Costs.

Non Operating

Interest received has been slightly higher than planned due to the favourable cash balance

Cash

The Trust was above plan by £9.8m in Month 5, largely due to PDC capital monies and cash received in advance of being paid out, e.g. education income. The opening cash balance was also higher than planned. The underlying cash is an overdrawn balance of £0.2m, excluding values which are required to pay creditor invoices which are due or overdue. It is expected that cash support will be needed by November.

CIP Delivery

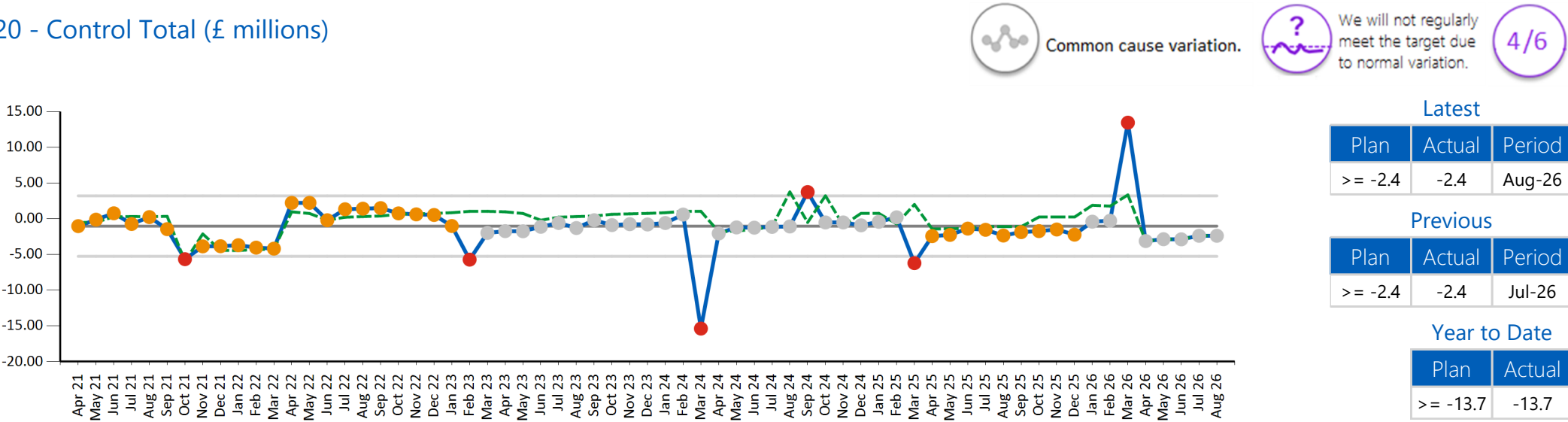
Year to date achievement is ahead of plan, although the plan is significantly end-loaded, with only 9.7% of the £39.3m target (£38.0m for 2026/27 plus £1.3m full-year effect of 2025/26 schemes) in the cumulative plan at Month 5. Over-achievement is therefore needed in earlier months to reduce risk in later months. There is currently a shortfall of £7.0m in identified schemes, or £13.0m based on the risk-rated value.

Capital

Capital plan of £37.0m including £17.8m of RAAC. Cumulative expenditure of £3.5m is £9.3m behind plan.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= -2.4	-2.4	Aug-26		>= -2.4	-2.4	Jul-26	>= -13.7	-13.7	
222 - Capital (£ millions)	>= 3.4	0.6	Aug-26		>= 3.8	1.0	Jul-26	>= 12.8	3.5	
223 - Cash (£ millions)	>= 2.7	12.5	Aug-26		>= 2.7	13.8	Jul-26	>= 2.7	12.5	

220 - Control Total (£ millions)

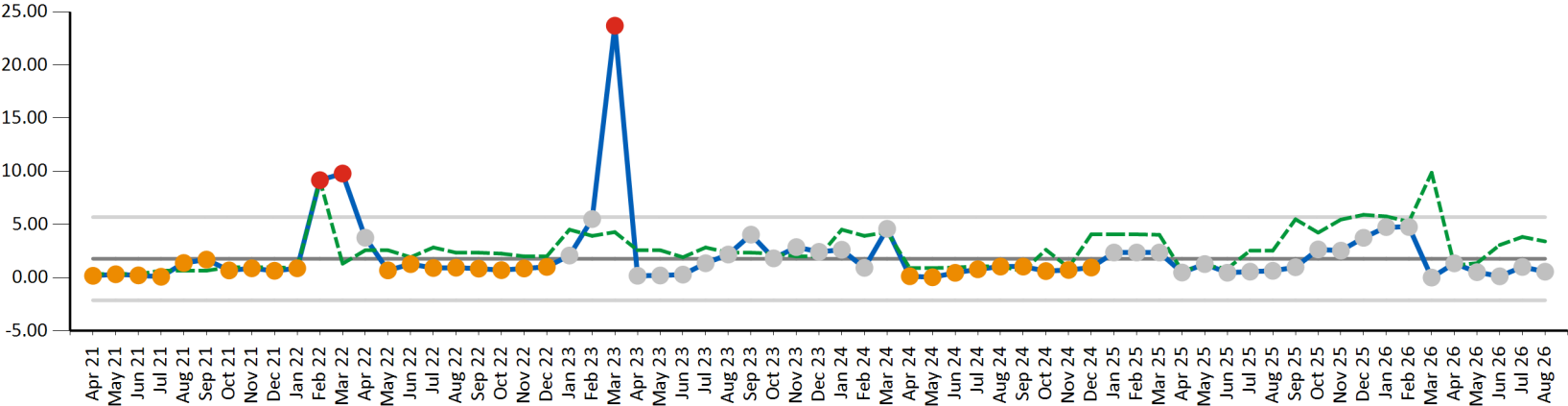


222 - Capital (£ millions)

 Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 3.4	0.6	Aug-26

Previous

Plan	Actual	Period
>= 3.8	1.0	Jul-26

Year to Date

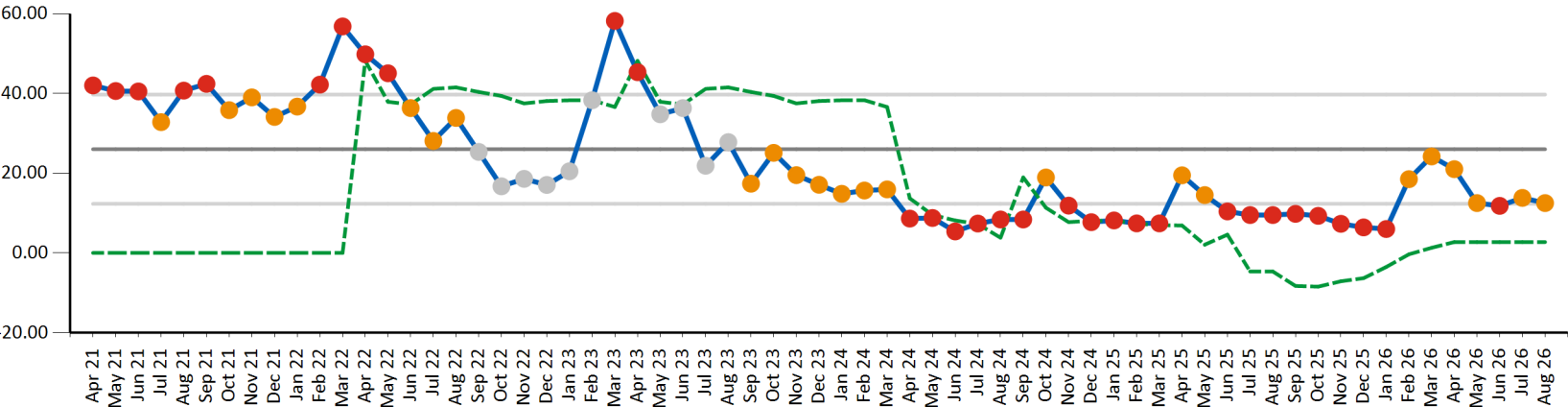
Plan	Actual
>= 12.8	3.5

223 - Cash (£ millions)

 Special cause variation with deteriorating performance

 Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 2.7	12.5	Aug-26

Previous

Plan	Actual	Period
>= 2.7	13.8	Jul-26

Year to Date

Plan	Actual
>= 2.7	12.5

Report Title:	Quality Assurance Committee Chair’s Report			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 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 23 September 2026. It highlights the areas where the Committee expects to receive assurance relating to the Trust’s operational performance, quality governance, patient safety, and clinical effectiveness. As the September Board meeting takes place before the QAC convenes, this Chair’s Report is submitted in advance and therefore summarises the main items planned for consideration, rather than presenting detailed outcomes. Any urgent or significant issues arising from the QAC meeting will be escalated verbally to the Board by the Committee Chair at the meeting. The report aims to ensure the Board remains sighted on forthcoming areas of focus within the QAC agenda and is aware of any potential matters that may require attention or future discussion.
-------------------	--

Proposed Resolution	The Board of Directors is asked to receive the Quality Assurance Committee Chair’s Report.
---------------------	---

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

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

Prepared by:	Sharon Katema, Director of Corporate Governance	Presented by:	Ian Williamson, Non-Executive Director
---------------------	---	----------------------	--

ALERT ADVISE ASSURE (AAA) Key Issues Highlight Report			
Name of Committee /Group:	Quality Assurance Committee	Reports to:	Board of Directors
Date of Meeting:	23 September 2026	Date of next meeting:	25 November 2026
Chair	Ian Williamson	Meeting Quoracy	Yes
AGENDA ITEMS DISCUSSED AT THE MEETING: (report written prior to the meeting)			
• Integrated Performance Report • Trust Heatmap • Maternity Incentive Scheme Year 7 Progress Update (CNST Update) • Health and Safety Annual Report • Compliments, Complaints and Concerns Annual Report • Safeguarding Annual Report • BoSCA Annual Report • MIAA Cancer Follow Up Quality Spot Check • Winter Plan		• Total Laparoscopic Hysterectomy (TLH) Update • Theatres Lessons Learnt Report • Maternity and Neonatal 10 Point Plan Assurance Process (NHS England) • Learning Organisation Update • Patient Safety Incident Investigation • Clinical Effectiveness Group Chair’s Report • Patient Safety and Experience Group • Performance & Transformation Group Chair’s Report • Health Inequities Reduction Group Chair’s Report	
ALERT			
Agenda items		Action Required	
Any alerts following from discussions held at the meeting will be provided verbally by the Committee Chair.			
ADVISE			
Clinical Correspondence – Digital Facilitation of Improvement Plans Clinical correspondence remains a Trust-wide risk, with delays in completion and transmission impacting communication with primary care and creating potential patient safety risks. A digitally led improvement programme is required to address workflow, system and template issues, with clear governance, timescales and prioritisation of digital resource needed to support sustainable improvement.			
MIAA Cancer Follow-Up Review: Progress Update, Assurance and Audit Concluding Report The Trust has made strong progress against the MIAA cancer follow-up recommendations, strengthening governance, accountability, monitoring and assurance. A small number of actions remain dependent on regional or system developments, with interim controls and Cancer Board oversight in place.			
ASSURE			
Trust Heatmap The heatmap illustrates Month 5 (August 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.			

Maternity Incentive Scheme Year 7 Progress Update (CNST Update)

The CNST Year 8 scheme has commenced across all 27 sub-actions, with three remaining compliance risks linked to training metrics and subject to weekly oversight. The Committee noted required improvements across maternity and neonatal assurance areas, while taking significant assurance on compliance with recent triage standards.

Annual Health and Safety Report 2025/26

The Trust maintained full health and safety legislative compliance in 2025/26, with incidents reducing to a six-year low and RIDDOR reports decreasing significantly. Overall harm levels remained low and training compliance was strong, although conflict resolution and some manual handling compliance require further improvement.

Annual Complaints, Concerns and Compliments Report 2025-2026

The Patient Experience Team managed 2,088 cases in 2025/26, with formal complaints increasing and themes focused on clinical decision-making, treatment delays and communication. Performance remained broadly consistent, compliments increased significantly, and 2026/27 priorities include improving feedback, action tracking, complaint handling and PALS response times.

Safeguarding Annual Report

The report provided substantial assurance that safeguarding arrangements remain effective, supported by strong governance, audit arrangements and training compliance. Priorities for 2026/27 include Adult Safeguarding Level 3 compliance, enhanced divisional oversight, outcome-focused reporting and continued oversight of Looked After Children's Services workforce pressures.

Bolton System of Care Accreditation (BoSCA) Annual Report April 2025 - March 2026

The BoSCA Programme provided effective assurance, with 32 assessments completed, 85% overall compliance and positive accreditation outcomes across most services. Improvement areas in Harm Free Care and ACE Audit Compliance have informed a revised framework, strengthened governance and implementation of the GENOME digital audit platform.

Trust Winter Plan 2026/27

The Winter Plan 2026/27 sets out the Trust's approach to maintaining safe, high-quality care and operational resilience through five priorities. It reflects learning from last winter, includes clear escalation and capacity arrangements, and will be monitored through established operational and executive governance routes.

Total Laparoscopic Hysterectomy Service: Review Findings, Progress and Readiness for Safe Reintroduction

The TLH service was paused following surgical complications and has since undergone internal and external review, with improvements made to governance, competency, pathways, consent, documentation and audit arrangements. The Division is assured that the required safeguards and monitoring arrangements are now in place to support safe reintroduction, strengthening local patient choice and access to minimally invasive gynaecological surgery.

Becoming a Learning Organisation: Committee Summary Paper The Trust has strong foundations as a learning organisation, with evidence of improvement in pressure ulcers, C. difficile, cardiac arrests and recurrent cost impact. Key priorities remain ensuring consistent deployment from Board to ward, strengthening the golden thread, embedding visible daily management, and further developing improvement capability and QMS assurance during 2026/27. Review of Homebirth Services The homebirth service review identified established operational arrangements, 24/7 escalation processes and multidisciplinary support, with no immediate safety concerns requiring suspension of the service. Assurance gaps have been captured within an action plan, with current arrangements maintained pending further review once national guidance is issued. Clinical Effectiveness Group Chair’s Report The Clinical Effectiveness Group received assurance across key annual reports, with ongoing oversight in place for identified improvement actions relating to Surgery, missed dose reporting, ionising radiation compliance and Homebirth Services. Patient Safety and Experience Group Chair’s Report The Patient Safety and Experience Group Chair’s Report provided assurance on the key matters discussed at its meeting held on 5 August 2026. The report summarised updates across patient safety and patient experience. Performance and Transformation Group Chair’s Report The Chair’s Report provided assurance on progress across key operational improvement programmes, while highlighting ongoing concerns in urgent care performance, income recovery, discharge, NCTR pressures and delivery risks within urgent care improvement plans. Health Inequities Chair’s Report The Chair’s Report from the Health Inequalities Reduction Group highlighted a key delivery risk in relation to the Reasonable Adjustment Digital Flag, noting the need for Trust-wide mobilisation to meet the national compliance deadline. The Group agreed to establish a multidisciplinary implementation group and received assurance on progress with interim digital arrangements, health inequalities evidence and research activity, EDS2022 work, and accessible medicines labelling.
New Risks identified at the meeting: None
Review of the Risk Register: N/A

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	A		

Report Title:	Clinical Negligence Scheme for Trusts (CNST) year 8 update/Maternity and Neonatal 10 Point Plan Assurance Process Report			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 2026		Discussion	✓
Executive Sponsor	Tyrone Roberts - Chief Nurse		Decision	✓

Purpose of the report	The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services and ongoing work regarding the NHS Resolution CNST Maternity Incentive Scheme (MIS).
------------------------------	---

Previously considered by:	Clinical Effectiveness Group – 02 September 2026 Quality Assurance Committee – 23 September 2026
----------------------------------	---

Executive Summary	Key highlights: • All 27 sub-actions within the CNST year 8 scheme have now commenced and 3 remain classified as a compliance risk 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. • This report outlines the findings of the baseline assessment tool issued relating to the 10 point plan for maternity and neonatal services and identifies areas of further improvement required relating to the implementation of Martha's Rule, the publication of the homebirth review, improving the use of inequalities data to drive improvement in patient outcomes and the presentation of the gap analysis and subsequent audit undertaken in response to the national triage specification published in July 2026. • Following recent benchmarking of the national maternity care bundle requirements limited assurance can be provided that the service is compliant with the defined standards and will be in a position to implement by March 2027. A detailed action plan for Board approval has been collated in response. • This report details the findings of the benchmarking assessment undertaken in response to the triage benchmarking tool and provides significant assurance of compliance with the recent triage specifications.
--------------------------	--

Proposed Resolution	The Board of Directors are asked to:
	1. Receive the contents of the report and note the findings of the reviews undertaken relating to the maternity care bundle, review of homebirth provision and triage service benchmarking in accordance with national standards.
	2. Approve the action plans detailed within this report.
	3. Approve the sharing of this report within the local maternity and neonatal system and the regional level quality surveillance meeting, with subsequent submissions to committees as required.

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

Summary of key elements / Implications		
Implications	Yes/No	If Yes, State Impact/Implications and Mitigation
Finance	Yes	Potential impact upon maternity incentive scheme fund reimbursement if all requirements of the scheme not fulfilled.
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	
Is a Quality Impact Assessment required	No	

Prepared by:	Janet Cotton, Director of Midwifery, Tyrone Roberts, Chief Nursing and Quality Officer	Presented by:	Janet Cotton, Director of Midwifery Tyrone Roberts, Chief Nursing and Quality Officer
---------------------	--	----------------------	--

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

ATAIN	Avoiding Term Admissions into Neonatal Units
BAPM	British Association of Perinatal Medicine
CNST	Clinical Negligence Scheme for Trusts
GMEC	Greater Manchester and East Cheshire
ICB	Integrated Care Board
MIS	Maternity Incentive Scheme
NIPE	Newborn and Infant Physical Examination
NWNODN	North West Neonatal Operational Delivery Network
NHSR	NHS Resolution
PMRT	Perinatal Mortality Review Tool
PQSM	Perinatal Quality Surveillance Model
PROMPT	Practical Obstetric Multi-Professional Training
LMNS	Local Maternity and Neonatal System
MBRRACE	Mothers and babies; reducing risk through audit and confidential enquiries
RCOG	Royal College of Obstetricians and Gynaecologists

1. Introduction

The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services and ongoing work regarding the NHS Resolution Clinical Negligence Scheme for Trusts year 8 (CNST) Maternity Incentive Scheme (MIS).

2. CNST year 8 scheme

The CNST year 8 maternity scheme launched on 23 April 2026.

The focus of the maternity incentive scheme this year is on strengthening the core elements of safe, effective care and making the scheme simpler through a model which is more principles based, outcomes focused and aligned with the needs of women, families and the workforce.

All 27 sub-actions within the CNST year 8 scheme have now commenced and 3 remain classified as a compliance risk relating to attainment of training metrics at the two defined checkpoints. Weekly oversight of training performance and compliance is in progress to mitigate this risk.

Table 1 – CNST year 8 progress to date as of 18 August 2026

Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully embedded	Total sub-actions
A	0	0	7	0	0	7
B	0	3	2	0	0	5
C	0	0	6	0	0	6
D	0	0	2	0	0	2
E	0	0	3	0	0	3
F	0	0	4	0	0	4
Local work	0	0	0	0	0	0
National	0	0	0	0	0	0
Total	0	3	24	0	0	

2.1 Safety Action A – Workforce and Capacity

The outcome of the safety action is to ensure Board oversight of effective multidisciplinary (MDT) workforce and capacity planning.

Neonatal workforce establishment (nursing & medical)

Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation (Neonatal Intensive Care Unit (NICU), Local Neonatal Unit (LNU), Special Care Unit (SCU) and the neonatal nursing workforce calculator output (2020).

Neonatal medical cover

The business case to recruit to the additional staffing resource required to meet the Tier 3 required British Association of Perinatal Medicine national standards of medical staffing was presented to CRIG in August 2026 and will now proceed to the next level.

Neonatal nursing cover

The business case to recruit to the additional staffing resource required to meet the required British Association of Perinatal Medicine national standards of neonatal staffing was presented to CRIG in August 2026 and will now proceed to the next level of approval.

Midwifery workforce establishment

The business case to seek the funding to uplift the establishment of 18.52WTE to align with the Birthrate plus recommendations detailed in the 2025 report was presented to CRIG in August 2026. Further detail has been requested, and this will need to be resubmitted to CRIG in October 2026 prior to progression of the business case for the next level of approval.

Planned caesarean birth capacity mapping

The CNST year 8 scheme requires Trusts to demonstrate that capacity is sufficient to deliver timely elective and emergency maternity and neonatal care.

In response the service has now commenced capacity mapping for planned caesarean section births covering the full pathway as per CNST requirements. The initial data has been obtained, and a report is being collated in response.

Integrated workforce report

The CNST year 8 scheme published on the 23 April 2026 stipulates a six-monthly integrated workforce report covering maternity and neonatal staffing levels and rota gaps is required for board and governance oversight.

The last Trust bi-annual maternity and nursing staffing papers were presented in May 2026 as per Board cycle that fulfilled the CNST year 7 specific requirements. NHSR have

confirmed that it is acceptable to introduce the combined integrated workforce report to meet CNST year 8 requirements in November 2026 when the next submission is due.

2.2 Safety Action B – Training

The outcome of this safety action is to ensure effective Board oversight of maternity and neonatal MDT training and competency.

Insitu MDT perinatal emergencies simulation

Trusts are required to deliver at least two insitu multiprofessional perinatal emergencies simulations during the MIS reporting period. Interdepartmental hospital scenarios continue to be delivered on a 6 weekly basis in the hospital setting and community-based sessions have been scheduled with NNAS colleagues for the 14 September 2026 and the 4 October 2026 to meet the required standard.

Training compliance

A CNST training board has been established to promote multi-disciplinary engagement with the oversight of training compliance during the CNST year 8 period.

In August 2026 the Quality Assurance Committee gave approval for the second checkpoint for training compliance to be assessed as 30 September 2026. This checkpoint is in addition to the 30 November 2026 checkpoint. Attainment of the three training elements at the two checkpoints has been classified as a compliance risk. In response a weekly review of training compliance is in progress with appropriate escalation where required to mitigate the risk of non-delivery.

Table 1 – CNST training compliance as of 24 August 2026

Course	Total	Advanced Neonatal Practitioners	Consultant Obstetricians	Obstetric Medical Doctors	MSW	HCA	Midwives	Neonatal Consultants	Neonatal Doctors	Neonatal Nurses	Obstetric Anaesthetic Consultant	Obstetric Anaesthetist
PROMPT	95.11%	NA	88.24%	85.19%	97.87%	84.00%	97.43%	NA	NA	NA	81.82%	92.00%
Fetal Monitoring Core Competency Stds.	97.07%	NA	88.24%	94.74%	NA	NA	97.79%	NA	NA	NA	NA	NA
Neonatal Life Support	96.35%	100.00%	NA	NA	95.74%	NA	97.10%	100.00%	100.00%	93.58%	NA	NA

2.3 Safety Action C - Learning from reviews and investigations

The outcome of the safety action is to ensure effective Board oversight of thematic learning and progress with actions arising from local and national reviews of adverse incidents.

Reporting and review

Appendix 1 provides assurance that the standards relating to reporting and review of eligible morbidity and mortality events continue to be fulfilled.

The action plan detailing ongoing work in response to the themes identified in the reviews is detailed in appendix 1a.

Learning and governance

Thematic reports of learning and actions

The Trust is required to produce thematic reports that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes.

A thematic review reflecting the Q1 period has been completed as per required standard and the themes identified from the thematic review relate to:

1. Delayed recognition of deterioration
2. Inconsistent adherence to clinical pathways
3. Delays in escalation and intervention

The report was presented at speciality level in July 2026 and is scheduled for presentation at the next Safety Champions meeting on 16 September 2026 prior to presentation at Quality Assurance Committee.

2.4 Safety Action D - Service user voice and equity

Communication, equity, language support and accessible information

The outcome of the safety action is to ensure the voices and experiences of all women accessing maternity and neonatal services are used to drive local improvements, using local population demographics to understand and target efforts to support a reduction in inequities in experience and outcomes.

Targeted engagement work took place between January - May 2026 by the Maternity and Neonatal Voice Partnership (MNVP) Engagement Officer and families using the service. The engagement was deliberately designed to reach women and families who may experience barriers to accessing services, poorer maternity outcomes or who are less likely to engage in traditional consultation exercises. Whilst the report can evidence positive feedback, it has highlighted a need to improve communication relating to postnatal visits

and clearer communication relating to plans of care, induction processes and discharge expectations. Findings of this engagement session were presented at the Board development session in August 2026.

Service-user voice driving safety and quality improvement

In April 2026 a session led by the MNVP lead was held with maternity support workers to share survey feedback from service users of their perception of care provided by maternity support workers in our service. The session that included feedback commentary from clients was evaluated positively by the team.

The Bereavement Team have also responded to family feedback received that highlighted parents were often unaware of the direction of Mecca when wishing to pray following the loss of their baby in the maternity service. To address this, discreet directional signage has now been installed in all bereavement rooms, ensuring families can meet their spiritual needs without additional distress. Early feedback has been positive, with families and staff reporting improved experience and reduced reliance on staff for guidance. This action strengthens culturally sensitive care and aligns with the Trust's commitment to equitable bereavement support.

2.5 Safety Action E - Care bundles

The outcome of the safety action is to ensure Board oversight of progress with implementation of Saving Babies' Lives Care Bundle (SBLCBv3.2), a plan to implement the Maternal Care Bundle by March 2027, and assurance that a guideline for neonatal pulse oximetry testing has been developed in line with national guidance.

Maternal Care Bundle

A new Maternal Care Bundle (MCB) has been launched that sets best practice standards across 5 areas of clinical care namely, venous thromboembolism, pre-hospital and acute care, epilepsy in pregnancy, maternal mental health and obstetric hemorrhage, for implementation by NHS providers and commissioners across England. The aim is to reduce maternal mortality and morbidity and reduce inequalities in these adverse outcomes.

A gap analysis has been undertaken using the national tool. In response the Trust has a limited assurance rating regarding the implementation of all five elements of the bundle as of 20 August 2026.

The limited assurance rating relates predominantly to the inability to currently evidence implementation of some of the elements outside of the maternity care setting and in secondary care settings, the lack of established service provisions such as relating to care of women with epilepsy and the inability to collate digital data in the absence of an end to end digital maternity electronic patient record (epr) system.

Table 2 Implementation compliance with the maternal care bundle requirements as of 24 August 2026

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (Trust Board Validated)	% of Interventions Fully Implemented (Trust Board Validated)	Escalation required for board review*
Element 1	Venous thromboembolism (VTE)	Not implemented	0%		0%	No
Element 2	Pre-hospital and acute care	Partially implemented	33%		0%	Yes
Element 3	Epilepsy in pregnancy	Not implemented	0%		0%	Yes
Element 4	Maternal mental health	Not implemented	0%		0%	No
Element 5	Obstetric haemorrhage	Partially implemented	33%		0%	No
All Elements	TOTAL	Partially implemented	14%		0%	*If yes, please refer to 'Board summary - action plans' worksheet for details.

The CNST year 8 guidance stipulates that the service is required to agree a plan with the Trust Board to implement the Maternal Care Bundle by March 2027 with implementation reviewed quarterly thereafter.

The actions to be taken in response to the bundle implementation are defined in Appendix 2. The Director of Clinical Governance has validated all evidence with the Assistant Divisional Midwifery and Nursing Director prior to submission of this paper to the Quality Assurance Committee. Approval of the validated position and action plans will be required from the Trust Board thereafter with subsequent oversight at quarterly intervals until fully implemented.

2.6 Safety Action F - Board oversight, governance, culture and leadership

The outcome of the safety action is to ensure The Trust Board has effective oversight of the quality and safety of their maternity and neonatal services.

Maternity Outcomes Signal System

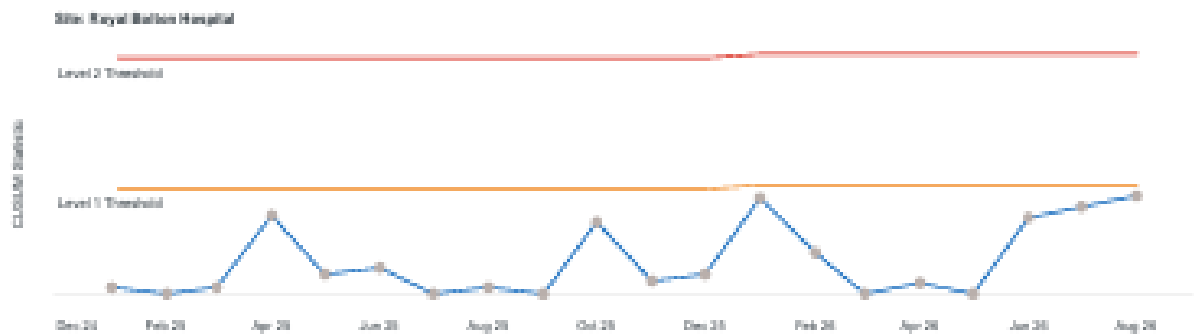
The Maternity Outcomes Signal System (MOSS) has been developed by NHS England and is intended to be used as part of routine safety monitoring within the Perinatal Quality Oversight Model (PQOM).

The chart currently produces 'signals' of potential safety issues in maternity care using term stillbirth and term neonatal death data up to 28 days.

The Trust has received no formal alert notifications to date following submission of data to the dashboard.

As per CNST requirements a formal simulation has been scheduled for 16 September 2026 to ensure the Trust is fully prepared for a future alert.

Table 3 MOSS dashboard reflecting Trust data for the period January 2025 – 3 August 2026



Maternity and Neonatal Board Safety Champions

The Maternity and Neonatal Safety Champions last met on the 2 July 2026. The focus of the meeting was on improving perinatal culture within the maternity and neonatal services.

Perinatal culture improvement plan

The perinatal quadrumvirate are due to commence Intake 4 of the Perinatal Equity and Anti-Discrimination Programme (PEADP) in September 2026. Any additional actions identified during the training will be added to the perinatal cultural action plan.

3. Ten point plan

On the 24 June 2026 the findings of the independent review of maternity services at Nottingham University Hospital NHS Trust were published followed on the 30 June 2026 by publication of the independent investigation undertaken by Baroness Amos into Maternity and Neonatal Services in England.

In response a ten point plan for maternity and neonatal services was published on 30 June 2026 by Sir James Mackey. The plan includes a set of urgent actions collated in response to the recommendations in both reports that Trusts and the wider system are being asked to prioritise. In due course the ten urgent actions will support, and report into, the National Maternity and Neonatal Taskforce as it develops the National Action Plan, which will be published in December 2026.

All Trusts have been asked to complete and submit a standardised national template to their NHS England region by 25 September 2026 with a further progress update provided by 31 December 2026.

A summary of the baseline compliance defined using the parameters within the national tool is detailed in Table 4. Areas of ongoing focus relate to the implementation of Martha's Rule, the publication of the homebirth review, improving the use of inequalities data to drive improvement in patient outcomes and the presentation of the gap analysis and subsequent audit undertaken in response to the national triage specification published in July 2026.

Table 4 – Baseline assessment completed in August 2026 using national benchmarking tool (starting position against the 10-point plan)

Summary by Action - Baseline		Compliance			
Action	Total	Not applicable	Non-compliant	Partially compliant	Compliant
1. Listening to women and families by rolling out Martha's Rule	1	0	1	0	0
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	3	0	0	3	0
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	2	0	0	2	0
5. Addressing inequalities in maternity and neonatal outcomes	3	0	0	3	0
6. Ensuring 24/7 safety and responsiveness of services	7	0	0	6	1
7. Trust review of homebirth services	2	0	1	1	0
8. Responding to incidents, complaints and concerns with humanity and candour	3	0	0	3	0
9. Deliver safe and effective triage in maternity services	3	0	1	2	0
10. Post death care	2	0	0	1	1

4. Homebirth Service

On the 26 November 2025 a formal letter was received from NHS England requesting an urgent review of the homebirth service within all Trusts was undertaken following the issue of a Prevention of Future Deaths report. In response all Trusts were advised to review the

operational function of the homebirth service provided, the care planning and risk assessment process and governance/oversight arrangements.

The review has demonstrated that the Trust has an established homebirth service with clear operational arrangements, defined escalation pathways, and a range of clinical guidelines and governance processes that support the safe delivery of homebirth care.

The review found evidence of robust multidisciplinary support, personalised care planning, and mechanisms for responding to women who choose birth options outside of standard guidance. These arrangements provide a level of assurance that significant safety controls are in place across the service.

The review has highlighted a number of areas, however, where assurance is limited and where further strengthening is required. Key gaps include the absence of a formal competency framework for homebirth practitioners, incomplete Neonatal Life Support compliance, limited audit and oversight of equipment checks, fatigue management arrangements, transfer planning documentation, risk assessment compliance, and homebirth-specific board assurance reporting. In addition, there is currently no annual homebirth audit programme, no routine oversight of transfer times and outcomes, and no agreed training standards for homebirth-specific practice.

NHS England and system partners are currently developing enhanced national guidance, standards, and supporting resources for homebirth services following the completion of urgent reviews across NHS trusts. When received a further review of the Trust homebirth service will be required in accordance with the national guidance released.

In the interim period an action plan has been collated, and the Trust will maintain current service arrangements while continuing to monitor risks and implement actions that will strengthen local assurance processes. Immediate priorities include achieving full training compliance, improving audit and monitoring arrangements, strengthening governance reporting, and preparing to align local policy, competency requirements, and service standards with forthcoming national guidance once published. This approach ensures continued safe service delivery whilst avoiding unnecessary local variation ahead of the expected national direction that is likely to necessitate further change to the homebirth provision at provider level.

5. National maternity triage specification

On the 7 July 2026 NHS England released a national maternity triage specification. There is an expectation that organisations will have fully implemented the specification within 12 months of publication.

Trust have been advised to audit within 3 months of publication their current maternity triage services, completed a gap analysis against this specification, and developed an

implementation plan, with progress reported through a public Trust Board meeting and shared with regional NHS England teams.

The initial gap analysis has been completed and provides significant assurance that the maternity triage service within the Trust fulfils the requirements of the national specification (See Table 5). In response to the gap analysis the service will collate an improvement plan and commence the audit of compliance as requested. Areas of main improvement relate to the need to support maternity triage with modern interoperable digital solutions; ensure the location of the service is separated from the day assessment activity and ensure the digital collation of data for ongoing reporting. The audit of compliance is due to be completed by October 2026.

Table 5 – Maternity Triage Specification benchmarking tool dashboard – August 2026

Maternity Triage Specification Benchmarking Audit Tool Dashboard						
Click below to link through to each principle		Fully in place	Partially in place	Not in place	Not relevant	Data not complete
Principle 1: Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	36%	55%	9%	0%	0%
Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	60%	40%	0%	0%	0%
Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	80%	0%	0%	20%	0%
Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	67%	33%	0%	0%	0%
Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	100%	0%	0%	0%	0%
Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	60%	0%	40%	0%	0%
Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	80%	0%	20%	0%	0%
Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	75%	17%	0%	8%	0%
Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	100%	0%	0%	0%	0%
Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	100%	0%	0%	0%	0%

6. Maternity and Neonatal Service Metrics

The maternity and neonatal safety champions dashboard was updated in April 2026 to reflect the standard required in the CNST year 8 maternity incentive scheme launched on the 23 April 2026 (Appendix 3) that requires Trusts to report compliance quarterly in a clear trend format ideally using statistical process charts.

The maternity IPM dashboard with SPC analysis is detailed in appendix 3. The dashboard highlights improving compliance in training metrics with particular regard to PROMPT emergency skills training over the past month.

The metrics also highlight a slight increase in the number of inductions of labour delayed by 6hrs during the month of July and further analysis has confirmed this was related to an increase in the number of maternity diverts due to reduced bed capacity.

Assurance can be provided in relation to the downward trend in newborn life support training compliance that training compliance is being tracked and all staff are booked to attend their sessions prior to the 30 September to ensure the service attains the required 90% CNST compliance standard.

The Committee are to note that currently most of the digital metrics required for the Board reporting relating to the maternal care bundle and measure within the national triage specification cannot currently be extracted digitally and thus full oversight of the metrics will not be presented in full on the dashboard until implementation of the maternity electronic patient record (epr) system in due course. A manual audit of the triage specification is in progress as per national reporting requirements and one maternal care bundle metric is currently included in the dashboard.

7. Summary

Maternity and neonatal services continue to demonstrate strong progress across the range of national safety, quality and assurance programmes, with substantial work underway to deliver the requirements of the CNST Year 8 Maternity Incentive Scheme and the wider national maternity improvement agenda. All 27 CNST sub-actions have commenced, and while a small number of areas remain at risk of non-compliance, these risks have been clearly identified, are subject to enhanced oversight, and have defined mitigation plans in place.

The implementation of the Maternal Care Bundle, Homebirth Service improvement programme, Maternity Triage Specification and Mackey 10 Point Plan will remain key priorities for the remainder of 2026 and into 2027. Whilst the current position provides assurance that many requirements are already in place, further work is required to address identified gaps, particularly in relation to digital infrastructure, digital data capture, workforce capacity, implementation of Martha's Rule, and strengthening evidence of compliance across organisational pathways that extend beyond maternity services alone.

The absence of a fully implemented maternity electronic patient record system continues to present a limitation in relation to automated data collection and reporting against several national standards. However, interim governance, audit and manual assurance processes remain in place to support oversight of compliance and performance.

Continued focus on delivery of the identified improvement programmes will support the Trust in further strengthening safety, quality, equity and experience for women, babies and families, whilst maintaining compliance with national standards and expectations.

8. Recommendations

It is recommended that the Board of Directors:

1. Receive the contents of the report and note the findings of the reviews undertaken relating to the maternity care bundle, implementation of the ten point plan, review of homebirth provision and triage service benchmarking.
2. Approve the action plans detailed within this report.
3. Approve the sharing of this report within the local maternity and neonatal system and the regional level quality surveillance meeting, with subsequent submissions to committees as required.

Appendix 1 – Perinatal mortality review tool cases as from 1 April 2026

KEY
Joint Trust Cases
Not for PMRT review
Targets Met

Care ID as SPEM number (CHST Y8)	SB/HND/ TOP/LAT FETAL LOSS	Gestatin n	DOB/ Death	Reported within 7 days	Date parent informed/c uncertain quarter (CHST Y8)	PMRT information a letter given (CHST Y8)	Report to draft Deadline Date - 4 months	Report published Deadline Date - 6 months	Additional informet ion provided (MNSI, MNSR EN scheme) (CHST Y8)	External Particip ants and Trusts that support 4 (CHST Y8)	SPN/HND appointment date (CHST Y8)	SPN/HND attendee	SPN/HND brief summary of discussion
QUARTER 1 2026 to 2027													
103151 MAT 002-633	HND	23+5	03.04.2026	0	10.04.2026	10.04.2026	03.05.2026	03.10.2026	N/A	Procton, Tomerido 09.07.2026	AWAITING WYTHENSHAW - JOINT		
103222 MAT-002-	HND	23+1	08.04.2026	0	10.04.2026	10.04.2026	05.05.2026	08.10.2026	N/A		21.10.2026 - JB		
103232 MAT-002-	SB	37+2	08.04.2026	0	09.04.2026	09.04.2026	08.05.2026	08.10.2026	N/A		02.11.2026 - KJ		
103288 MAT-002-	HND	20+4	10.04.2026	1	Notifiable case, not for PMRT support						28.09.2026 - JK		
103358 MAT-002- 830	HND	22+6	16.4.2026	1	17.04.2026	17.04.2026	16.05.2026 Draft meeting completed care assigned to MFT	16.10.2026	N/A		04.11.2026 - AA		
103496 MAT-002-	ENND	22+3	27.04.2026	0	27.04.2026	27.04.2026	27.05.2026	27.10.2026	N/A		02.12.2026 - AA		
103572 MAT-003-	SB	33+0	01.05.2026	1	02.05.2026	02.05.2026	01.09.2026	01.11.2026	N/A		30.11.2026 - KJ		
103576 MAT-003-	ENND	27+3	02.05.2026	0	03.05.2026	03.05.2026	02.09.2026	02.11.2026	N/A		30.11.2026 - KJ		
103630 MAT-003- 128	SB	24+5	05.05.2026	1	06.05.2026	06.05.2026	05.09.2026	05.11.2026	N/A		AWAITING WYTHENSHAW - JOINT		
103693 MAT-003-	ENND	23+1	11.05.2026	0	11.05.2026	13.05.2026	11.09.2026	11.11.2026	N/A		AWAITING BLACKPOOL - JOINT		
103754 MAT-003-	TOP/SE	30+3	14.05.2026	1	Notifiable case, not for PMRT support						15.09.2026 - AM		
103859 MAT-003-	SB	31+1	21.05.2026	1	22.05.2026	22.05.2026	21.09.2026	21.05.2026	N/A		02.12.2026 - AA		
104111 MAT-003-	SB	38+2	06.06.2026	0	09.06.2026	09.06.2026	06.10.2026	06.12.2026	N/A		30.12.2026 - AA		
104124 MAT-003-	SB	23+6	06.06.2026	0	12.06.2026	12.06.2026	06.10.2026	06.12.2026	N/A		13.01.2027 - JB		
104148 MAT-002-	HND	25+2	08.06.2026	1	10.06.2026	10.06.2026	08.10.2026	08.12.2026	N/A		12.01.2027 - BW		
104171 MAT 003-669	HND	? Term	10.06.2026	1	12.06.2026	12.06.2026	10.10.2026	10.12.2026	MNSI, ENS		25.01.2027 - KJ		
104173 MAT-003-	HND	39+3	10.06.2026	1	11.06.2026	11.06.2026	10.10.2026	10.12.2026	MNSI - rejected		30.12.2026 - AA		
MAT-003- 929	HND	28+2	27.06.2026	0	29.06.2026	29.06.2026	27.10.2026	27.12.2026	N/A		25.01.2027 - KJ		
QUARTER 2 2026 to 2027													
104601 MAT-004- 062	TOP/SE	25+3	03.07.2026	0	Notifiable case, not for PMRT support								
104827 MAT 004-318	SB	38+0	22.07.2026	0	22.07.2026	22.07.2026	22.11.2026	22.01.2027	MNSI - rejected				
104979 MAT-004- 472	SB	39+2	03.08.2026	0	03.08.2026	03.08.2026	03.12.2026	03.02.2027	N/A				

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

relevant to

		Key Actions		Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status
						1 2 3 4
1.		There was no documentation regarding the risks of declining speculum examination on triage. Share learning with midwifery and obstetric team.	Pre-Term birth obstetric and maternity lead	30.09.26		2
2.		Liaise with consultant obstetricians and review referral process to diabetic teams for cases of with accelerated growth.	Dr Singh, Obstetric Consultant	31.09.2026		2
3.		Use short iTime when giving IPPV during initial resus and stabilization. share case during neonatal training. To provide assurance through attendance and training data that this is being delivered through training.	Sundaram Shanmuga, Neonatal Consultant	31.08.2026		2
4.		Medical and nursing documentation should be thorough so that it reflects the accurate timeline of events. To provide evidence that it has been shared with the neonatal team	Cath Bainbridge, Neonatal Matron	31.08.2026		2

		Key Actions		Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status
						1 2 3 4
5.		Drop in temperature when central lines were inserted. Share case in teaching.	Sundaram Shanmuga, Neonatal Consultant	31.12.2026		2
6.		Patient complaining of shortness of breath when she phoned choose and book. Ask choose and book to direct women to triage if any clinical concerns are shared on the phone	Samantha Whelan, Governance Matron	31.07.2026	Staff contacting ANDU during normal working hours see email evidence attached to INC 288240. Action expanded as part of a stillbirth thematic review see action number 9.	Action completed 02.06.2026
7.		Patient wanted to move her c-section date and telephoned choose and book. Ask choose and book to direct women to the ANDU if any scheduling queries	31.07.26	Samantha Whelan, Governance Matron	See email evidence attached to INC 288240	Action completed 02.06.2026
8.		MDT review across teams to identify a failsafe pathway to ensure that women who present at EPU who are continuing with their pregnancy have made contact with the midwifery team for a booking appointment.	31.09.26	Tina Gundlach, EPAU matron, Elizabeth Dean, ANC Matron		

		Key Actions		Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status
						1 2 3 4
9.		A review to be conducted regarding the Caesarean section booking form and process, to ensure completion of the form is mandatory. To be included as part of the on-going task and finish group.	28.02.2027	Emma Jones CDS Matron & Samantha Martin		

Appendix 2 – Maternity Care Bundle Action plan – awaiting Board

validation

Element 1 – Venous Thromboembolism

Element 1: Venous thromboembolism (VTE)						
Intervention Ref	Self-Assessment Status	Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially	SMART actions to achieve full compliance	Progress	Escalations required (If required, specify who and what)
11	Not implemented	Not implemented	No evidence of implementation of national self assessment questionnaire on VTE risk at first care contact or evidence that LM/WH offered.	Ensure the early pregnancy risk assessment question is integrated into the current antenatal pregnancy referral form used by all Trust parties.	Meeting to be arranged to discuss revision of antenatal referral form.	
				Develop Trust communications that can be used by staff and clients to raise the awareness of the need for the early pregnancy risk assessment to be	Liaise with Trust communications team and MNVP to develop communication to relay message.	
				Liaise with key stakeholders and agree a plan to embed the VTE risk assessment at the first point of contact	Meeting to be arranged with key stakeholders across the wider hospital	Escalation to GMICB to seek support with implementation of first point of contact guidance
12	Not implemented	Not implemented	No evidence of implementation at ICB level in early pregnancy within 72 hours.	Seek clarification from ICB of arrangements in place for the prescription of LM/WH in early pregnancy within 72hrs.	Contact GM ICB for clarity regarding arrangements agreed and in place for prescribing of LM/WH within 72 hours.	As above
13	Not implemented	Not implemented	No evidence of implementation.	Ensure a process is detailed in policy for the prescribing of a standardised dose of LM/WH when a women is identified as high risk on completion of	Contacted the maternity guideline lead to identify policy owner	

Element 2 – Pre-hospital care and acute care

Element 2: Pre-hospital and acute care						
Intervention Ref	Self-Assessment Status	Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially	SMART actions to achieve full compliance	Progress	Escalations required (If required, specify who and what)
2.1	Partially implemented	Partially implemented	Further work required to embed MEWS in maternity information system and secondary care settings. No data available to evidence uptake of MEWS outside of the maternity care setting	Implement the national maternity early warning score (MEWS) tool on Patient Track across all Trust settings for women who are or have been pregnant in	Maternity Observation, Maternity Early Warning Score (MEWS) and Sepsis Screening Policy V6 available to all areas across the	
2.2	Partially implemented	Partially implemented	Further signage required.	Implement additional signage opposite the maternity car park to aid ambulances in view of recent building works	20.8.26 Signage reviewed. Additional signage required. Email escalation sent to IFM 5.8.26	
2.3	Fully implemented	Fully implemented	Evidence reviewed	Review the maternal medicine pathways annually with the Maternal Medicine Network	Awaiting confirmation of date of review from Maternal Medicine Lead	

Element 3 – Epilepsy in pregnancy

Element 3: Epilepsy in pregnancy						
Intervention Ref	Self-Assessment Status	Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially	SMART actions to achieve full compliance	Progress	Escalations required (If required, specify who and what)
3.1	Not implemented	Not implemented	Work still required to establish required team and defined clinic offer for epilepsy.	Scope the required multidisciplinary staffing requirements to enable a dedicated epilepsy team (including medical, midwifery and support staff)	Dr Emily Pegg available on Wed am to join a dedicated clinic at Bolton. Funding secured for 12 months via Maternal Medicine network	
				Revisit Maternal Medicine Obstetrician job plan to move from a Thursday clinic slot to a Wednesday slot	Meeting scheduled 5.9.26 to discuss options	
				Collate business case for funding to support long term enablement of epilepsy service	Awaiting completion of SLA prior to commencement of business case	Funding approval required to sustain service delivery offer of neurologist following compilation
				Complete SLA to access funding for 12 month funded neurologist to support service	Clinical Director for obstetrics to arrange meeting with Deputy Director of Operations	
3.2	Partially implemented	Partially implemented	Maternal medicine pathway for epilepsy being developed.	Ensure completion of referral by Maternal Medicine Midwife and Maternal Medicine Obstetrician to the Maternal Medicine Network for eligible cases	Clarification requested of failsafe process for ensuring all MMN referrals made when required	
				Ensure all relevant Trust Maternal Medicine colleagues attend the MMN MDT meeting	Maternal medicine midwife currently joins the MDT MMN meetings. To clarify obstetric attendance.	

Element 4 - Maternal Mental Health

Element 4: Maternal mental health						
Intervention Ref	Self-Assessment Status	Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially implemented, why?	SMART actions to achieve full compliance	Progress	Escalations required (If required, specify who and what)
4.1	Partially implemented	Partially implemented	Service unable to evidence digital pathways or collate required data currently using a manual or digital system. No patient self administration process or mode of data collection in place for the completion of defined assessments.	Update the Trust Antenatal and Postnatal Mental Health Guideline to include both the 'whooley' questions	GMCA regional guideline reflecting the MCB changes is currently out for comments	
				Update Maternity EPR to include both the whooley questions and the Edinburgh Postnatal Depression Scale (EPDS)	Arrange to meet with the maternity EPR team to update the system in accordance with the recommended care pathways	
				Ensure that the digital data points (booking, 28, 34 and PN) are added to the new maternity EPR system being developed.	Arrange to meet with both the maternity EPR and BI teams to understand how the data points can be added and data extracted.	
				Audit		
4.2	Not implemented	Not implemented	Process yet to be established fully into the care pathway.	Update Maternity EPR to include both the whooley questions and the Edinburgh Postnatal Depression Scale (EPDS)	Arrange to meet with the maternity EPR team to update the system in accordance with the recommended care pathways	
				Ensure equity across the service in ensuring the self assessment tool is available in other languages when English is not the service users first language.	Explore if access to the tool could be possible via the PKB App	
				Ensure a process in place to trigger the need for the EPDS in paper format or digital format	Support required from digital to ensure EPDS is added to the new maternity EPR	
4.3	Not implemented	Not implemented	Pathways yet to be fully established in the service.	Provide education and training to the Antenatal and Community midwifery teams to enable them to feel confident holding conversations and have the	Meet with the Maternity Education team to discuss adding to the agenda on Mat Day 4	

Element 5 – Obstetric haemorrhage

Element 5: Obstetric haemorrhage						
Intervention Ref	Self-Assessment Status	Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially implemented	SMART actions to achieve full compliance	Progress	Escalations required (If required, specify who and what)
5.1	Fully implemented	Fully implemented	Evidence reviewed and approved.	Ensure scales are available at all birth settings including a chart to record all weighed blood loss.	Order placed for specific weighing scales which measure to 0.1g for each birth room.	
5.2	Partially implemented	Partially implemented	Limited evidence of detailed case review within defined timeframe.	Ensure appropriate escalation process detailed in a standard operating procedure including attendance of relevant persons in place (including process for	Community Matron asked to review homebirth guideline	
5.3	Partially implemented	Partially implemented		Ensure all women who have had a significant blood loss of >2000ml or all cases that that have received Cryoprecipitate and fibrinogen must have a MDT	Meeting schedule arranged to commence in Sept 2026	
				Establish monthly MDT meeting to review all cases of PPH >2000mls	Meeting schedule arranged to commence in Sept 2026	

Appendix 3 – Maternity and Neonatal safety champions dashboard – July

2026

CQC rating	Overall	Safe	Effective	Caring	Well -Led	Responsive
Regional Support Programme	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good

		Latest				Previous			Year to Date		Target	
Outcome Measure	Data Type	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance	Performance
Births	Actual		421	Jul 26	👍		393	Jun 26		1582		
Caesarean Section rate at full dilation	Percentage		3%	Jul 26	👍		2%	Jun 26		3%		
Inductions of Labour >6hrs	Actual		9	Jul 26	👍		0	Jun 26		11		
Post partum haemorrhage rate >= 1000mls - < ..	Percentage		13%	Jul 26	👍		10%	Jun 26		14%		
Post partum haemorrhage rate >= 2000mls	Percentage		1%	Jul 26	👍		3%	Jun 26		2%		
% of Births with Cumulative Measured Blood L..	Percentage		100%	Jul 26	👍		100%	Jun 26		100%		
Rate of PPH >= 1,500 mL	Percentage		4%	Jul 26	👍		6%	Jun 26		6%		
Number of Bleeds > 2L	Actual		6	Jul 26	👍		10	Jun 26		32		
VTE (Venous Thromboembolism) assessment c..	Percentage	>=95.0%	99%	Jul 26	👍	>=95.0%	99%	Jun 26	>=95.0%	97%	👎	5/6
HIE (Hypoxic-ischemic encephalopathy) Grade..	Actual	0	1	Jul 26	👍	0	1	Jun 26	0	2	👎	5/6
Stillbirths excluding Terminations of Pregnancy	Actual		1	Jul 26	👍		1	Jun 26		6		
Stillbirths per 1000 births (per month) (Exclud..	Average	<= 3.5%	2.38	Jul 26	👍	<= 3.5%	2.54	Jun 26	<= 3.5%	3.79	👎	5/6
Early Neonatal Deaths (Bolton Births only)	Actual		1	Jul 26	👍		4	Jun 26		12		
Early Neonatal Death rate in month	Percentage		0%	Jul 26	👍		1%	Jun 26		1%		
Late Neonatal deaths	Actual		0	Jul 26	👍		0	Jun 26		0		
1:1 Midwifery Care in Labour	Percentage	>=95.0%	98%	Jul 26	👍	>=95.0%	99%	Jun 26	>=95.0%	99%	👎	5/6
Compliance with supernumerary Coordinator a..	Percentage		100%	Jul 26	👍		100%	Jun 26		100%		
BAPM (British Association of Perinatal Medici..	Percentage	>=95.0%	89%	Jul 26	👍	>=95.0%	87%	Jun 26	>=95.0%	93%	👎	5/6
Fetal monitoring training compliance (overall)	Percentage	>=90.0%	90%	Jul 26	👍	>=90.0%	95%	Jun 26	>=90.0%	93%	👎	5/6
Newborn Life Support training compliance (ov..	Percentage	>=90.0%	80%	Jul 26	👎	>=90.0%	91%	Jun 26	>=90.0%	88%	👎	5/6
PROMPT (PRactical obstetric Multi-Profession..	Percentage	>=90.0%	94%	Jul 26	👍	>=90.0%	93%	Jun 26	>=90.0%	94%	👎	5/6
Midwife:birth ratio (rolling) actual worked Inc...	Ratio		1.2	Jul 26	👍		1.2	Jun 26		4.7		
% Pregnant Women with Epilepsy	Percentage		0%	Jul 26	👍		1%	Jun 26		1%		
% Women Completing Whooley Questions at B..	Percentage		94%	Jul 26	👍		94%	Jun 26		94%		

To: NHS trust:

- chief executives
- chairs
- chief nursing officers
- medical directors
- chief operating officer
- communications directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

12 August 2026

cc. Integrated care board (ICB):

- chief executives
- chief nursing officers
- medical directors

NHS England:

- regional directors
- regional chairs
- regional chief nurses
- regional chief midwives
- regional medical directors
- regional obstetricians

Dear colleagues,

Maternity and Neonatal 10 Point Plan assurance process

Following the publication of Baroness Amos' independent investigation into maternity and neonatal services in England and Donna Ockenden's independent review of maternity services at the Nottingham University Hospitals NHS Trust, our chief executive, chief nursing officer, and medical director leadership community came together to discuss a 10 Point Plan of urgent actions for maternity and neonatal services.

We are now writing to outline the [assurance process](#) and the expectations for trusts.

While trusts will want to reflect on the findings of both reports, the immediate priority is delivery of the 10 Point Plan. This sets out the most urgent actions arising from the reports and should be the focus of local leadership, improvement activity and board oversight while the Maternity and Neonatal Taskforce develops a comprehensive national action plan by the end of the year.

The assurance process is intended to support and evidence progress, not create additional reporting burdens. Expectations for provider boards, chief executives and regional teams are set out and accountability for delivery is embedded within existing governance arrangements wherever possible.

For example, the template has been designed to align with [Maternity Incentive Scheme \(MIS\) Year 8](#) requirements, enabling trusts to draw on existing assurance activity for this, as well as evidence from board papers and minutes.

Trusts are asked to submit the [standardised national template](#) to their NHS England region at two points:

- **Baseline assessment:** 25 September 2026
- **Progress update:** 31 December 2026

Both submissions must be approved by the trust board. Boards should provide visible ownership and scrutiny of delivery, ensuring actions are progressing at pace, risks are managed appropriately and any significant concerns are escalated through ICB and regional routes.

Regional teams will review returns, provide constructive challenge where needed, identify where additional support is required, and escalate significant concerns nationally to enable timely action.

Alongside this, 'Amos into action' will launch an NHS-wide opportunity for an open conversation for all our maternity and neonatal staff to help shape real and sustainable change in services. Further details will follow shortly about how staff can get involved and how the outputs will help support culture change and improvement work in your trust. This builds on feedback from more than 9,000 staff members who contributed their views to the Amos investigation.

As Sir Jim set out [in his letter](#), this is a moment that requires collective leadership across the NHS. We must act with urgency to address the failings and harm experienced by women, babies and families.

We have listened carefully to what you told us you need to deliver the Maternity and Neonatal 10 Point Plan successfully. You asked for practical tools and best practice templates, opportunities to learn from peers and exemplar services, and clearer guidance. In response, we are providing practical support including webinars, standardised audit tools and templates, and opportunities for peer learning. We are also today sharing a [maternity](#)

[triage benchmarking tool](#) to support implementation of the [national maternity triage specification](#). You can find the full detail in the Appendix.

We remain committed to working alongside trusts and systems to improve outcomes for women, babies and families.

As part of our wider work, we are keen to highlight and share how and where progress and improvement is taking place – and the positive impact for women and families and our staff. We would welcome working with you and your communications teams to showcase this work.

Thank you for your continued leadership and commitment to improving maternity and neonatal care. As ever, if you need any further support, please do not hesitate to reach out to us or colleagues in the regional team.

Yours sincerely,



Duncan Burton

Chief Nursing Officer for England



Professor Frankie Swords

National Medical Director

Appendix: Maternity and Neonatal 10 Point Plan – support available

The assurance return is designed to help trusts articulate how they are providing the oversight and support NHS maternity and neonatal services need, rather than establishing a standalone process. Where evidence is already available, for example through board papers, committee reports, dashboards or evidence collected to inform Maternity Incentive Scheme returns, trusts should reference that evidence rather than producing new material. If not already doing so, trusts may wish to use the [Model Board Report](#) to support their reporting process.

Support will be available to help trusts and systems implement the 10 Point Plan and complete the assurance process consistently. An outline of the available and upcoming support is provided in the table below. For any queries relating to the reporting template, please contact england.maternitytransformation@nhs.net.

Action	National Support Available
Martha's Rule	Trusts should follow the implementation and reporting processes outlined by the Martha's Rule national team in NHS England. A webinar is scheduled for Wednesday 12 August, 15:00–16:30hrs to provide information on implementation support and reporting requirements. Trusts will be expected to work closely with national and regional colleagues triangulating data to minimise reporting burden and duplication. The session will provide key information to support local implementation, including: • an overview of the three components of Martha's Rule • the national implementation approach • learning and insights from sites already implementing Martha's Rule in maternity and neonatal settings • the implementation support, resources and tools available to local teams.

	The webinar is an opportunity for colleagues to understand what implementation involves, hear from early implementer sites, and begin their local Martha's Rule implementation journey with the support of the national programme team. The session will be recorded and uploaded to Futures for those who cannot join live. If you haven't already received an invite and would like to attend, please email england.psimprovement@nhs.net
Maternity and Neonatal 10 Point Plan supporting webinar series	The national team will host a series of webinars for clinical directors, chief nursing officers, directors/heads of midwifery, obstetric Leads, neonatal Leads, quality Leads and other senior maternity leaders in August. The webinars are designed to support trusts in delivering the actions in the plan, with a particular focus on: 1. Listen to women and their families using real-time and transparently reported outcomes and experience, Monday 17 August 2026, 11:30 – 12:00 2. Clinical audit, Wednesday 19 August 2026, 15:30 – 16:00 3. Ensuring 24/7 safety and responsiveness of services, Wednesday 19 August 2026, 11:30 – 12:00 4. Responding to patient safety incidents, complaints and concerns within maternity and neonatal services with openness, humanity and candour, Thursday 20 August 2026, 12:00 – 12:30 Further information will be shared soon.
Amos into Action staff listening exercise	This action is being nationally led and no return is required within the template. 'Amos into action' is an NHS-wide open conversation for all our staff to help shape real and sustainable change in services. Trusts are encouraged to engage in these NHS wide conversations and support staff to do the same. Trusts should consider how local learning will be governed and action any recommendations that

	follow. We will be in touch shortly with details on how staff can get involved and how the outputs will help support culture change and improvement work in your trust.
Safe and effective maternity triage	The triage benchmarking tool has been shared by NHS England to support implementation of the maternity triage specification. Trusts should use the triage benchmarking tool to assess their current position, identify gaps and develop an action plan to deliver against the national triage specification. The tool will be shared alongside the letter and reporting template and should be used to complete the board-level triage audit. The expectation is that the audit will be completed by the September submission, with board oversight of triage quality and performance and plans to implement improvements in line with national triage guidance within 12 months.
Post death care	Trusts should confirm completion of the board assurance statement by 31 July 2026. Evidence should demonstrate continued board assurance and oversight of matters relating to mortuaries, as outlined by existing actions and recommendations. Communications and templates shared for completion can be found here: NHS England » Nottingham maternity review findings on post-death care and key actions required following the Fuller Inquiry

10-Point Plan for Maternity & Neonatal Services

How to Use This Template



The adoption and implementation of the 10 point plan in response to Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England is the responsibility of each organisation and trusts must demonstrate compliance with the 10 Point Plan .

The reporting template is a tool designed to support a baseline assessment against the 10 point plan and support reporting to regional and national teams. It is ordered as per the 10 point plan and allows for evidence of compliance, gaps in compliance, mitigations and comments to be recorded in text format. This template is intended to be built around existing governance structures. The use of the reporting tool is compulsory and should be used by Trust Boards to assure against the actions.

Trust boards should complete tab 1. Submission A-Baseline once only and returned to regional teams by **Friday 25 September 2026**. Tab 2. Submission B-Progress Report, should be completed by **Thursday 31 December 2026**. Each return should be completed once and returned regionally for assurance. Regional teams will provide further detail on their submission process. Both submissions must be signed off by the trust board. Boards should provide visible ownership and scrutiny of the 10 Point Plan actions and should continue to use existing board or committee governance for detailed review of progress, evidence improvement and risk management, in line with the MIS. Regional teams will review returns and, where necessary, provide constructive challenge, identify where trusts might need additional support and escalate significant concerns for discussion at national level.

Action 4 of the 10 point plan 'Amos into action' an NHS-wide open conversation for all our staff to help shape real and sustainable change in services will be led by the NHS England national team. Although this is not featured within the reporting template, Trust Boards should ensure staff are supported and enabled to engage with this work.

The Evidence Log should be used to reference or embed the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates; and the evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may span more than one deliverable where appropriate.

The compliance rating column allows for the selection of a RAG rating for each criteria using a dropdown list. Specifically: not applicable, non-compliant, partially compliant and compliant.

Source: <https://www.england.nhs.uk/long-read/publication-of-baroness-amos-independent-investigation-into-maternity-and-neonatal-services-in-england/>

1. Summary tab: Provides instructions for completion and an overview of the key metrics for 1. Baseline assessment and 2. Progress Report. Please note all tables are automated and the information should pull directly from the relevant tabs.

2. Submission A Baseline Assessment tab: Record the trust's starting position against each of the 10 actions before improvement work begins. To be completed once and returned **Friday 25 Sept 2026**

3. Submission B Progress Report tab: One row per deliverable/scoping prompt (24 in total); Baseline Compliance tab updated automatically, all other columns to be manually updated. To be completed once and returned **Thursday 31 Dec 2026**

4. Evidence Log tab: Log supporting evidence against each action number; reference the Evidence ID in the Baseline Assessment and Progress Tracker tabs as required.

5. Evidence examples: Provides some example areas of evidence submission to be considered.

Rating definitions:
RAG guide: Red = no route to compliance or immediate safety risk. Amber = plan in place but gaps/risks remain. Green = evidence confirms requirement met or on track.

The **baseline compliance / compliance ratings** should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission therefore 'Not applicable' would be apply.*

Non-compliant: There is no, or very limited, evidence that the requirement has been met.

Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.

Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Name of trust or organisation:

Report prepared by:

Report date:

Reporting period covered:

Bolton NHS Foundation Trust

Director of Midwifery

30/06/2026 - 14/08/2026

Baseline Assessment		
Key Metrics		
Total deliverables		26
Compliance	0. Not applicable	0
	1. Non-compliant	0
	2. Partially compliant	0
	3. Compliant	0
Regional Match	Regional match - Yes	0
	Regional match - No	0

Summary by Action - Baseline		Compliance				
Action		Total	Not applicable	Non-compliant	Partially compliant	Compliant
1. Listening to women and families by rolling out Martha's Rule		1	0	1	0	0
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level		3	0	0	3	0
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care		2	0	0	2	0
5. Addressing inequalities in maternity and neonatal outcomes		3	0	0	3	0
6. Ensuring 24/7 safety and responsiveness of services		7	0	0	6	1
7. Trust review of homebirth services		2	0	1	1	0
8. Responding to incidents, complaints and concerns with humanity and candour		3	0	0	3	0
9. Deliver safe and effective triage in maternity services		3	0	1	2	0
10. Post death care		2	0	0	1	1

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)



This template should be completed once and submitted on the **Friday 25th September 2026**. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2. Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a greenrating if significant residual risk remains.

Baseline compliance definitions

The baseline compliance / compliance ratings should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore*

'Not applicable' would be apply.

Not applicable: There is no evidence that the requirement has been met

Report signed off by Trust Board (named Exec):



Trust Board sign off date:

Trust Board Assurance Template						
No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference <i>Please input reference number as listed in 3. Evidence Log tab</i>	Gaps in Assurance <i>Please provide detail of any gaps in assurance</i>	Improvement Actions (Including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Non-compliant	EV01	Launch of Marthas Rule awaited+B9:B9:H33	Trust representative attended launch event on 12 August 2026 and plan to attend community of practice event scheduled for 24 September 2026	Initial meeting held with Trust Lead for Marthas Rule implementation who will support service implementation. Trust lead attended launch event on 12 August 2026 and booking made to attend the community of practice event scheduled for 24 September 2026.
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.						
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Partially compliant	EV02, EV31	Board of Directors report bi-monthly MNVP detail captured bi-monthly in Trust reports	Continue review of shared learning and outcome data at speciality meetings held on a monthly basis to supplement bi-monthly Board oversight	
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant	EV03, EV04 EV05, EV06, EV07, EV08	CNST thematic quarterly learning report commenced in Q1 2026/2027	Ongoing presentation of quarterly thematic learning reports, stillbirth reviews and scorecard reports	
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant	EV06	Limited access to ethnic and deprivation data currently. Q1 2026/2027 collated and due to be presented to QAC in September 2026.	Include update from inequalities dashboard in all future Board level reports.	
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Partially compliant		Formalisation of revised agreement awaited	Board Terms of Reference and job description of the Trust Medical Director to be updated	Confirmation received via email of change to responsibilities and change to shared accountability.
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant	EV09, EV10	Clinical Director does not currently attend every Board of Directors meeting	Clinical Director to prioritise attendance at all Board meetings with Director of Midwifery	
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Partially compliant		Launch date - 4 November 2026 confirmed and all Trust participant notified - Trust launch event meeting date awaited.	Trust launch event meeting date awaited.	
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant	EV34	Data currently presented at Health Inequalities Group within Trust.	Include update from inequalities dashboard in Board level reports every six months.	
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Partially compliant	EV11	MCB benchmarking tool and action plan not yet presented to Board	Action plan for submission and approval by Trust at Board on 24 September 2026.	

6. Ensuring 24/7 safety and responsiveness of services						
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	EV12, EV13	No gaps in assurance.	Ongoing RCOG audit in place and continues to be reported in Board report quarterly	
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? <i>(In line with MIS Year 8)</i>	Partially compliant		No gaps in assurance.	Ongoing recording of cases of certificate of eligibility relating to Locum cover and inclusion of detail in quarterly Board of Directors report.	
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? <i>(In line with MIS Year 8)</i>	Partially compliant	EV14, EV15	Funding for required uplift not yet secured	Business case to be submitted to Trust Finance and Investment Group - September 2026 for next stage of financial approval.	
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? <i>(In line with MIS Year 8)</i>	Partially compliant	EV16	Funding for required uplift not yet secured	Business case to be submitted to Trust Finance and Investment Group - September 2026 for next stage of financial approval.	
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? <i>(In line with MIS Year 8)</i>	Partially compliant	EV17, EV18	No gaps in assurance.	Receive ongoing quarterly evidence of ACSA 1.7.2.1 standard compliance and report compliance in quarterly Board of Directors report	
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Partially compliant	EV19, EV20	Revised integrated workforce report scheduled for November 2026.	Present integrated workforce report to Board in November 2026	
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Partially compliant	EV21	Internal review of specific roles not yet undertaken	Internal review of specific roles to be included in November integrated workforce report	
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Partially compliant		Initial review undertaken to be collated in a formal report for presentation to Trust Committee	Review awaiting approval by Trust at Board on 24 September 2026.	
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Non-compliant		Review not yet shared with NHSE		
8. Responding to incidents, complaints and concerns with humanity and candour						
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Partially compliant	EV22, EV32, EV33	Evidence to be sought of sharing of learning with MNVP and families.	Ongoing presentation of MNSI and PSII cases to Board of Directors and Quality Assurance Committee	
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Partially compliant	EV23, EV24, EV25, EV26		Ongoing thematic learning as per PSIRF with presentation at Board of Directors and QAC	
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Partially compliant	EV26, EV27, EV35, EV36, EV37		Seek evidence as to how feedback has influenced practice	
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Non-compliant		Internal audit undertaken of Triage performance until national audit tool awaited.	Amend internal audit tool to reflect defined Triage measures until national tool shared.	
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Partially compliant	EV28	Metrics relating to Triage performance are not collated digitally or reported to Board of Directors in the IPM pack	Ensure inclusion of the Triage metrics in future Executive IPM reporting packs.	

9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant	EV29	Benchmarking triage specification using national tool ongoing and actions to be identified.	Triage compliance review due to be presented in September 2026 QAC report	
10. Post death care						
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	EV30	No gaps in assurance	Not applicable	
10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	Partially compliant	EV31	Swipe access to mortuary required Ongoing assurance report to be scheduled in Board of Directors cycle of business	Ensure assurance report relating to Fuller standards add onto Trust Board / Quality Assurance Committee cycle of business.	

Submission B: Progress against baseline (December 2026)



This template should be completed and submitted on **Thursday 31st December 2026**. This template reports on progress against the baseline assessment. Where a deliverable has already been reported as achieved in the baseline assessment, trusts should not complete this information again. The baseline status will automatically update and should indicate where any progress updates are required.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a green rating if significant residual risk remains.

Report signed off by Trust Board (named Exec):

Trust Board sign off date:



									To be completed by Regions	
No.	Deliverable	Baseline Compliance Rating	Current Status	RAG	Evidence ID <i>Please input reference number as listed in 3. Evidence Log tab</i>	Key Gaps / Risks	Improvement action required	Due Date(s)	Regional Compliance Rating	Comments
1. Listening to women and families by rolling out Martha's Rule										
1.1	Is the trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	Non-compliant							Non-compliant	
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level										
2.1	Has the trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Partially compliant								
2.2	Is the trust board continuing to receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant								
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant								
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care										
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Partially compliant								
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant								
5. Addressing inequalities in maternity and neonatal outcomes										
5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Partially compliant								
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant								
5.3	Is the trust board receiving reviewing and acting on (through the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	Partially compliant								
6. Ensuring 24/7 safety and responsiveness of services										
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum 280% consultant presence in defined acute care situations?	Compliant								
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (<2 weeks) working on tier 2/3 obstetric rotas? (In line with MIS Year 8)	Partially compliant								
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? (In line with MIS Year 8)	Partially compliant								
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? (In line with MIS Year 8)	Partially compliant								
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	Partially compliant								
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Partially compliant								
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.									
7. Trust review of homebirth services										
7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?									
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?									
8. Responding to incidents, complaints and concerns with humanity and candour										

8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?								
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?								
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?								
9. Deliver safe and effective triage in maternity services									
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?								
9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?								
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?								
10. Post death care									
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?								
10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?								



Evidence Log - Supporting Evidence Submission

The evidence log should be used to list and reference the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates. The evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may support more than one deliverable where appropriate. Trusts are encouraged to use existing evidence and established governance documentation wherever possible. Trusts should use the minimum evidence necessary to demonstrate assurance.

Log each piece of supporting evidence here. Reference the Evidence ID against the relevant row in the Baseline Assessment and Progress Report as needed. Please note the evidence submitted should be accessible externally (to the trust).

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Date	Owner	Location / Link Reference	Assurance Notes	Evidence Quality
EV-01	1.1	Booking confirmation	Community of Practice Ticket			J:\DOM\Governance\Mackay - 10 Point Plan	Event scheduled 240926	
EV-02	2.1	Trust Board Report	Integrated Performance Report - July 2026			J:\DOM\Governance\Mackay - 10 Point Plan	Includes maternity narrative and metrics	
EV-03	2.2	Maternity Board Report	CNST paper - Q4 data 2025/2026			J:\DOM\Governance\Mackay - 10 Point Plan	PQOM requirements	
EV-04	2.2	Maternity Board Report	Bi-annual maternity staffing report - May 2026			J:\DOM\Governance\Mackay - 10 Point Plan	CQC survey findings included	
EV-05	2.2	Maternity Board Minutes	Board of Director Minutes - May 2026			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-06	2.2	Maternity Board Report	Q1 Thematic MIS report - September 2026			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-07	2.2	Maternity Board Report	QAC Maternity Deep Dive - November 2025			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-08	2.2	Maternity Board Report	QAC minutes - November 2025			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-09	3.2	Maternity Board Report	CNST Board report - January 2026			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-10	3.2	Maternity Board Minutes	Board of Director Minutes - January 2026			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-11	5.3	Maternity Board Report	QAC Report - July 2026			J:\DOM\Governance\Mackay - 10 Point Plan	Reference made to MCB benchmarking in progress	
EV-12	6.1	Audit Report	RCOG Audit report Q1 2025/2026Compliance			J:\DOM\Governance\Mackay - 10 Point Plan	Quarterly audit to demonstrate compliance with standard	
EV-13	6.1	Policy	Consultant Attendance Policy			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-14	6.3	Business Case	Neonatal Nursing Business Case			J:\DOM\Governance\Mackay - 10 Point Plan	Case to seek uplift to funding presented August 2026	
EV-15	6.3	Business Case	Neonatal Medical Business Case			J:\DOM\Governance\Mackay - 10 Point Plan	Case to seek uplift to funding presented August 2026	
EV-16	6.4	Business Case	Birthrate Plus Business Case			J:\DOM\Governance\Mackay - 10 Point Plan	Case to seek uplift to funding presented August 2026	
EV-17	6.5	Maternity Board Report	QAC CNST Board report - July 2026			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-18	6.5	Allocation Rota	Anaes Rota - Q1 26/27			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-19	6.6	Board Report	Bi-annual nursing staffing report - May 2026			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-20	6.6	Maternity Board Report	Bi-annual maternity staffing report - May 2026			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-21	6.7	External Staffing Report	Birthrate Plus Staffing Report - April 2026			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-22	8.1	Trust Report	PSIRF Trust Plan 2025-2027			J:\DOM\Governance\Mackay - 10 Point Plan	Includes maternity and neonatal plan	
EV-23	8.2	Trust Report	QAC Maternity Thematic Review - November 2025			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-24	8.2	External Review	NHSR Review of Claims / Trends - October 2025			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-25	8.2	Trust Report	Thematic Review - Antenatal CTG			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-26	8.3	Trust Agenda	Maternity Safety Summit Agenda - October 2025			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-27	8.3	Trust Report	Incident Learning Slide example - Sepsis			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-28	9.2	Trust Internal Audit Report	Triage Outcome Audit - Internal Audit			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-29	9.3	LMNS Review	LMNS Assurance review of Triage 2025			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-30	10.1	Trust Report	Fuller Assurance Statement			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-31	2.1	MNVP Report	Engagement event with bereaved families - 2025			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-32	8.1	Trust Report	Trust Learning from Experience Report - May 2026			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-33	8.1	Trust Report	Trust Mortality and Learning from Deaths report - May 2026			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-34	5.2	Trust Report	Trust EV 34 - . Health Inequity for QAC May 2026			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-35	8.3	Policy	Postnatal Debrief and Special Postnatal Follow Up			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-36	8.3	Policy	Being open policy			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-37	8.3	Presentation	Personalised Care and Birth reflections-Themes, Trends and Actions			J:\DOM\Governance\Mackay - 10 Point Plan		
EV-38	10.1	Assurance Statement	Assurance Statement			J:\DOM\Governance\Mackay - 10 Point Plan		

Evidence: examples



This section is designed to support trust boards in identifying appropriate evidence to support their assurance assessments. We encourage trusts to make use of existing data sources and processes wherever appropriate to support their assurance. There may also be instances where an individual item e.g. board report may account for evidence against multiple deliverables. The model board report is available for use on the Futures platform. Trusts not already using the model board report may wish to adopt this template.

It should be noted that Trusts are not required to provide all suggested evidence to evidence compliance. **Trust should use the minimum amount of information to demonstrate compliance.**

Action		Deliverable	Suggested evidence
Action 1	1.1	The trust continuing to make progress with rollout of Marthas Rule across maternity and neonatal services?	Trusts are not asked to submit any evidence for this action as data will be collected via the national Marthas rule programme team. It is however expected that providers attend the launch webinar to understand process and next steps and continue work with the Marthas rule team to commence roll out.
	2.1	The trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Analytical reports
Action 2	2.2	The trust board continuing to receive and publish a regular report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Board report and minutes
	2.3	The insight and audit data presented by ethnicity and deprivation and does the board scrutinise variation?	- Board report and minutes - Quarterly MIS thematic report
Action 3	3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	- Board ToR - Job plans
	3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are discussed?	- Job plans - Minutes of Executive board meetings
Action 5	5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Board report and minutes
	5.2	The trust board regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	- Board report - Quarterly MIS thematic report - Equity dashboard reports - Core20PLUS5 reporting - Maternity equity action plans
	5.3	Is the trust board receiving reviewing and acting on (at the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	- Maternal Care Bundle implementation plans. - Board Report - MIS return
	6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8 is there a minimum 280% consultant presence in defined acute care situations?	- Workforce plan - Biannual workforce papers - Staff experience survey - Cappuccini-style assurance exercise
	6.2	The trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? (In line with MIS Year 8)	Database

Action 6	6.3	The trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? (In line with MIS Year 8)	• Workforce plan • Biannual workforce papers • BAPM workforce standards compliance • Staff experience survey
	6.4	The trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? (In line with MIS Year 8)	• BR+ review and workforce plan • Biannual workforce papers • Staff experience survey
	6.5	The trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	• Workforce plan • Biannual workforce papers • Cappuccini-style assurance exercise
	6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
	6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
Action 7	7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	• Board report and minutes
	7.2	Where significant risks have been identified, have they been communicated with the Regional NHSE team?	• Correspondence
Action 8	8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	• Board report and minutes • A Trust-wide SOP for PSIRF is implemented across Maternity and Neonatal Services • PSIRF implementation within Maternity and Neonatal Services, governance and review processes. • Process for sharing outcomes and learning from PSIRF reviews with women and families. • Mechanisms to identify, monitor and learn from positive practice and areas of improvement.
	8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	• Board report and minutes • Thematic reviews of complaints and concerns using a learning-focused and inquisitive approach. • Recommendations arising from thematic reviews are monitored, reviewed and acted upon.
	8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	• Board report and minutes • Debrief guidance • Education and Training for Staff involved in debriefing women and families
Action 9	9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	• Triage Benchmarking tool completed template
	9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes?	• Board paper

Report Title:	Clinical Correspondence – Digital Facilitation of Improvement Plans			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 2026		Discussion	✓
Executive Sponsor	Dr Rauf Munshi		Decision	

Purpose of the report:	The report outlines the current position on clinical correspondence across inpatient, outpatient and urgent care pathways, with a focus on digital improvement. It summarises Trust-wide workflow, system and capacity challenges, and seeks assurance on the proposed digitally led approach, including prioritisation, resource reprioritisation and/or outsourcing.
------------------------	--

Previously considered by:	Executive Directors
---------------------------	---------------------

Executive Summary	Clinical correspondence remains a longstanding Trust-wide challenge, with divisions unable to consistently achieve the national standard for timely communication to primary care. While most discharge summaries are completed, delays in completion and transmission continue to create avoidable clinical risk, including medication errors, missed follow-up actions, poor communication with GPs and increased risk of readmission. Following the appointment of the Chief Medical Information Officer, a digital review has been undertaken to understand current pathway issues, digital opportunities, interdependencies and risks across inpatient, outpatient and urgent care correspondence. The review identifies that the issue is not solely related to workforce performance, but to system design, workflow reliability, manual processes, digital capacity and template functionality. A digitally led improvement programme is required to deliver sustainable improvement. This includes automation of discharge summary sending, optimisation and rationalisation of documentation and templates, outpatient digital dictation and voice recognition solutions, and urgent care correspondence redesign. Delivery will require organisational prioritisation, clear governance, confirmed timescales and potential reprioritisation or outsourcing of digital resource.
-------------------	--

Proposed Resolution	The Board of Directors is asked to receive the Clinical Correspondence – Digital Facilitation of Improvement 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	Yes	National standards
Health Inequalities	Yes	Delays in discharge summaries disproportionately affect vulnerable groups, increasing risk of medication errors and missed follow up. Mitigation through standardised, timely processes improves continuity of care and reduces variation for patients at greatest risk.
Equality, Diversity and Inclusion	Yes	Inconsistent discharge processes can disadvantage patients with language barriers, disabilities, cognitive impairment, or complex social needs. Mitigation through standardised, accessible, and reliable discharge communication promotes equitable care and inclusive handover for all patients.
Is a Quality Impact Assessment Required	No	

Prepared by:	Dr Simon Irving, Chief Medical Information Officer Nicola Caffrey, Corporate Business Manager for the Medical Director	Presented by:	Dr Rauf Munshi, Medical Director
---------------------	---	----------------------	----------------------------------

1. Background

The Trust has faced significant issues and variances in the achievement of the clinical correspondence standards, and no division has consistently ever met the 95% standards since its implementation.

There have been several initiatives to try and address the issues meeting this standard, with varying success across divisions.

Following the appointment of the CMIO, this paper provides the digital review and focus and builds on the organisational history relating to the known issues with clinical correspondence providing oversight of the digital solutions identified across inpatient and outpatient programmes.

2. National Standards

Inpatient Correspondence

The NHS Standard Contract states 'when transferring or discharging a Service User from an inpatient or day case or accident and emergency Service, the Provider must within 24 hours following that transfer or discharge issue a Discharge Summary to the Service User's GP' (NHS England, 2023).

3. Current Performance Issues

Across the Trust, data suggests that most discharge summaries are eventually completed but that performance failure is driven by numerous factors including delays in completion and failure to send summaries once completed. However, there are instances where there are significantly long delays, (up to 80 days to send) which indicate system-wide issues.

Key insights from earlier work identified that the most common failure is discharge summaries are completed but not sent on time and this issue remains true. However, there are delays that occur across the whole pathway which include:

- Late initiation
- Workforce and workflow constraints
- Pharmacy dependencies
- Ward administrative processes
- System and IT limitations

Therefore, this indicates that this improvement work requires a full pathway approach, not a single or divisional level intervention, and this review from the CMIO provides the following digital view and recommendations.

4. Risk Position

There are well recognised issues relating to delays in sending discharge summaries which include Medication errors, delayed follow-up, poor communication with primary care and increased readmissions.

There is a requirement to understand where the clinical risk sits as there remains concerns from pharmacy relating to the point of automation to be balanced with the potential for the communication to not be sent at all, exacerbating the current known issue.

5. Digital Improvement Approach

To design the full pathway approach requires a transformational approach and the digital aspect to this work is critical to be able to scale the improvement required across the organisation.

The newly appointed CMIO (Chief Medical Information Officer) has been working across the teams to analyse current state, identify digital solutions, map interdependencies and understand risk position and has established the following:

Inpatient Digital Approach

To be able to really provide insight into the required digital solution relating to inpatient correspondence requires a full mapping of the process to compliment the ongoing work. To enable the achievement of the 95% standard, there are three main areas of focus, all of which will require organisational alignment and reprioritisation of other digital projects and workstreams, or agreement for outsourcing funding.

Theme	Details	Solution	Lead	Risks/Issues	Timescale for delivery
Automation of sending discharge summaries	Our EPR system allows for automation of sending discharge summaries at any point within the process, and there are several options available to us relating to at which point the letter is sent (under discussion with pharmacy)	Confirm and agree automation point and implement	SI/ZF/HB	Continued clinical risk conversations Minimal capacity in current digital team	Requires reprioritisation of other digital projects to deliver or outsourcing (Would require writing of full service spec to provide timescales as advised)
Optimisation of discharge summary documentation	Discharge summaries being built throughout the episode of care through auto population from fields within the EPR document, meaning that there is less clinical documentation required at point of discharge	Need MDT working group to review and optimise documentation	SI	Minimal capacity in digital team	Requires reprioritisation of other digital projects to deliver or outsourcing (Would require writing of full service spec to provide timescales as advised)
Rationalisation of templates	Multiple templates for discharge currently within EPR system	Full review and removal of unnecessary templates, and training of clinical teams	SI	Minimal capacity in digital team	Requires reprioritisation of other digital projects to deliver or outsourcing (Would require writing of full service spec to provide timescales as advised)

Theme	Details	Solution	Lead	Risks/Issues	Timescale for delivery
Rebuilding of discharge letter templates	Output from EPR to the physical discharge letter	Following from documentation optimisation, all templates require rebuild in EPR system – must also include Accessible Information Standard	SI	Currently no internal delivery capability	Outsourcing required (Would require writing of full service spec to provide timescales as advised)

Outpatient Digital Approach

heme	Details	Solution	Lead	Risks/Issues	Timescale for delivery
G2 Digital Dictation	Following the admin modernisation programme and the rationalisation of the administrative teams has left an admin burden without digital transformation.	Increase administrative capacity in the short term to provide required support	K Beh	Current financial organisation position	Requires organisation prioritisation
AVT (Ambient Voice Technology) Voice Recognition Software	Enabling instant dictation and reducing the administration burden on transcription.	Aid documentation including clinical documentation and clinical letters	SI/SMcK	Due process oversight including DPIA, Information Governance, alignment to organisational and NHSE AI standards all require oversight and consideration	End of September 2026 for procurement process – up to 3 years for implementation (some specialities live within 12 months)
Move templates and storage of letters from PAS to an Electronic	Currently all templates and letters are stored with the PAS (Patient Administration System) – there is a requirement for the optimisation of	As part of the current PAS procurement, there needs to be procurement of an EDMS system for	DD	Needs to be linked into the digitalisation of medical records, has to be	Currently under review and all feeds into the AVT and PAS projects

heme	Details	Solution	Lead	Risks/Issues	Timescale for delivery
Documents Management System (EDMS)	workflow and correct use of the systems and capabilities	correspondence templates and storage		searchable and procured with consideration of interoperability across all systems	

Urgent Care Discharge Correspondence Digital Approach

Theme	Details	Solution	Lead	Risks/Issues	Timescale for delivery
Optimisation of discharge summary documentation	Discharge summaries being built throughout the episode of care through auto population from fields within the EPR document, meaning that there is less clinical documentation required at point of discharge	Optimised documentation to allow for accurate and timely creation of discharge letter and reduction of duplication	SN	Work started but lead is currently off sick	Requires digital developers time which is currently not available within organisational team (Would require writing of full service spec to provide timescales as advised)
Rebuilding of discharge letter templates	Output from EPR to the physical discharge letter	Following from documentation optimisation, all templates require rebuild in EPR system	SI	Currently no internal delivery capability	Outsourcing required (Would require writing of full service spec to provide timescales as advised)

6. Reflection, conclusion and next steps

Since the appointment of the CMIO, there have been a number of priorities that have been reviewed, clinical correspondence being one of them. However, it needs to be understood that this work is a significant, time consuming and costly digital programme of work, requiring understanding of interdependencies, organisational priorities and internal and external commissioning of teams.

To be able to deliver the clinical correspondence standards requires organisational reprioritisation of existing digital projects to be able to redirect the internal digital team capacity, or an agreement to the costs associated with outsourcing across these projects.

Now the issues are defined, further work will be carried out to cost, prioritise, risk assess and confirm the timescales for delivery for the three known aspects to clinical correspondence for inpatient, outpatient and urgent care.

The next steps for the CMIO, is to work with teams to understand what these costs and timescales are as it is now fully understood that to achieve these standards requires an optimised and organised approach to digital oversight for delivery. This work will then require Executive decision making to support organisational priorities.

Whilst previous iterations of this workstream have included digital aspects, it is now fully recognised that a digitally led and optimised solution is the only way to achieve the required standards. This workstream oversight will be led by the CMIO and will be reported through the Medical Director, the Director of Digital and reported through the appropriate governance structures.

Report Title:	People Committee AAA Chair Report			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 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 15 September 2026. The report also sets out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors.
-------------------	---

Proposed Resolution	The Board of Directors are asked to receive the People Committee Chair’s Report.
---------------------	---

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

Summary of key elements / Implications		
Implications	Yes / No	If Yes, State Impact/Implications and Mitigation
Finance Implications	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:	Janat Hulston, Non-Executive Director	Presented by:	Janat Hulston, Non-Executive Director
--------------	---------------------------------------	---------------	---------------------------------------

ALERT | ADVISE | ASSURE (AAA)

Key Issues Highlight Report

Name of Committee /Group:	People Committee	Reports to:	Board of Directors
Date of Meeting:	15 September 2026	Date of next meeting:	17 November 2026
Chair	Janat Hulston	Meeting Quoracy	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- | | |
|--|--|
| <ul style="list-style-type: none"> • Workforce Delivery • Attendance Management Update • OD & Culture Update – People & Culture Plan • Workforce Digitalisation Update • Employee Relations Update • Freedom to Speak Up Q1 Report | <ul style="list-style-type: none"> • Lord Mann Report - recommendations • Medical Appraisal and Revalidation Report 25-2026 Annual Submission to NHS England NW • Steering Group Chair Reports • Divisional People Committee Chair Reports |
|--|--|

ALERT

Workforce Delivery

- Sickness absence increased in August 2026 and is above expectation.
- Turnover remained static and within expectation.
- Vacancy rates were low in most staffing groups.
- Substantive staffing WWTE has been on a reducing trend since Month 8 2025/26.
- For Temporary Staffing, Bank was showing an increasing trend and above plan. Agency continued to be low and under plan.
- Organisational Development metrics were in the main positive.
- The Trust used less WWTE staffing than expected in the Medium-Term Plan for both July 2026 and August 2026. This was predominantly delivered through substantive staffing, which was significantly below plan.
- The gap between where our plan expects us to be (WWTE) by the end of March 2027, and current performance is significant (circa 161 WWTE).

Action

More work required regarding WWTE reductions in the next iteration of the sustainability plan..

ADVISE

Attendance Management Update

- Sickness absence increased during winter 2025/26, peaking at 6.69% in December 2025, but has since improved to a 2026/27 year-to-date average of 5.14%, remaining above the Trust's 4.8% target.
- Long-term sickness was shown to be more concentrated among staff aged 31 to 45, which reflected a younger absence profile than in 2019.
- The main causes of sickness absence remain anxiety, stress and depression, cold, cough and flu and musculoskeletal conditions, with mental health continuing to be the leading cause of long-term absence.
- Action plans are in place, with further work progressing on the flu campaign, NHS Staff Standards for Health and Wellbeing, staff and manager engagement, and ongoing governance through monthly unavailability meetings.

ASSURE

Employee Relations Update

The Committee received an update on employee relations activity which took place between April and June 2026, including disciplinary, grievance and tribunal cases, and activity within the Job Evaluation Policy.

OD & Culture Update – People & Culture Plan

The Committee approved the People and Culture Plan 2026-29, which provided a single framework for the Trust's workforce, culture, leadership and staff experience priorities, informed by workforce data, staff survey findings and engagement across the Trust. The Committee put forward a number of suggestions and proposed changes which will be brought back to the November meeting prior to Board.

The Committee noted that the latest NHS People Pulse Quarterly Survey results showed continued improvement across all four staff experience measures since the last survey but remained below the previous year.

Freedom to Speak Up (FTSU) Q1 Report

The Committee received the numbers and themes relating to FTSU activity in Quarter 1 2026/27. There had been an increase in cases from 32 in Q4 to 42 in Q1. Of the 42 cases in Q1, 11 were closed by the end of the quarter. Three concerns were anonymous (two via QR code and one by letter), and five other staff asked FTSU to maintain their anonymity.

Lord Mann Report – recommendations

The Committee considered the Lord Mann review report and requested a further report be brought to the November meeting highlighting the risks and recommendation.

Medical Appraisal and Revalidation Report - 2025-2026 Annual Submission to NHS England NW

The Trust maintained robust appraisal and revalidation processes throughout the year. A key challenge remained the continued growth in the medical workforce, with a 57% increase in doctors connected to the Responsible Officer since 2013. Combined with financial constraints and limited administrative capacity, this had increased pressure on appraisal and revalidation services. To address this, appraisal and revalidation budgets had been centralised, a business case for additional appraiser capacity had been approved, and recruitment of new appraisers was underway.

Separate submissions were included for Bolton NHS Foundation Trust and Bolton Hospice, reflecting the Responsible Officer role held across both designated bodies. It was highlighted that there were two figures awaiting HR input, which would be completed prior to the Board meeting and NHSE submission. The Committee approved the submission.

Workforce Digitalisation Update

The Head of Workforce Systems gave a presentation on Workforce Digitalisation which covered the programme of work badged under 'Workforce Systems'. The programme includes a range of projects from rostering and temporary staffing through to artificial intelligence employee support and automation of manual tasks, with the presentation highlighting interdependencies between them. The Committee sought clarification on the governance aspects of the projects, for which a paper will be prepared and brought back to the Committee. It was agreed that the AAA report from the Workforce Systems Project Board will be reported to the People Committee for oversight.

The Committee received Chair reports from Steering Group meetings and Chair reports from Divisional People Committee meetings held since the last People Committee.

New Risks identified at the meeting: None
Review of the Risk Register: None
Meeting Attendance 2026/27

Members	Role	Jan	Mar	May	Jul	Sep	Nov
Ian Williamson	(NED) Committee Chair	✓	✓	✓	✓	A	
Tony Allen	Non-Executive Director					✓	
Gita Bhutani	Associate NED	-	✓	✓	A	A	
Janet Hulston	Non-Executive Director	✓	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	✓	A	
Fiona Taylor	Non-Executive Director	✓	A	A	✓	A	
Annette Walker	Chief Finance Officer	✓	✓	A	A		
Sharon White	Chief of Strategy and Partnerships	✓	-	A	A	A	
Martin North	NED	✓	✓	✓			

✓ = In attendance A = Apologies - = left the Trust

Report Title:	Staff Health and Wellbeing Report			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 2026		Discussion	✓
Executive Sponsor	Chief People Officer		Decision	

Purpose of the report	This report provides assurance on the Trust’s management of staff attendance, sickness absence and workforce wellbeing, including current arrangements, benchmarking and key workforce health factors.
-----------------------	--

Previously considered by:	The report was presented at Executive Directors and the People Committee prior to presentation at Board. They reviewed the report in full, including sickness absence performance, key causes, workforce trends and the action plan. The Committee noted that whilst absence remains above target, with mental health, minor illness and musculoskeletal conditions as the main causes, there was assurance provided through local audits, manager training, monthly unavailability meetings, divisional reporting and ongoing monitoring of policy compliance.
---------------------------	---

Executive Summary	Sickness absence remains a significant workforce challenge, peaking at 6.69% in December 2025 before improving to a 2026/27 year-to-date average of 5.14%, still above the 4.8% target. The main causes remain anxiety, stress and depression, cold, cough and flu, and musculoskeletal conditions, with variation by staff group, age and postcode. Attendance management, wellbeing and governance arrangements were in place, including divisional oversight, hotspot and return-to-work audits, case management and regular reporting. Further work is focused on consistent application of the Attendance Management Policy, internal audit actions, manager support and targeted wellbeing interventions, aligned to the People Plan ambition to make Bolton a great place to work.
-------------------	---

Proposed Resolution	The Board of Directors is asked to receive the Staff Health and Wellbeing 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	Yes	Impact of sick pay to staff and indirect cost of backfill
Legal/ Regulatory	No	
Impact on Health Inequalities	Yes	Indirectly as some staff are also part of the local population.
Impact on Equality, Diversity and Inclusion	No	
Is a Quality Impact Assessment required	No	

Prepared by:	C Sheard, Deputy Chief People Officer	Presented by:	J Mawrey, Chief People Officer/Deputy Chief Executive
--------------	---------------------------------------	---------------	---

1. Purpose

The paper sets out an assessment of the current management of attendance practices against published national standards and the principles of good governance. The broader determinants of staff health and well-being and the comprehensive actions in place are also considered, as well as the benchmarking of both activity in this area and comparative absence rates. Previous papers have focused on the key causes of short- and long-term absence and the support in place to address these and keep staff in work and/or facilitate an early return to work.

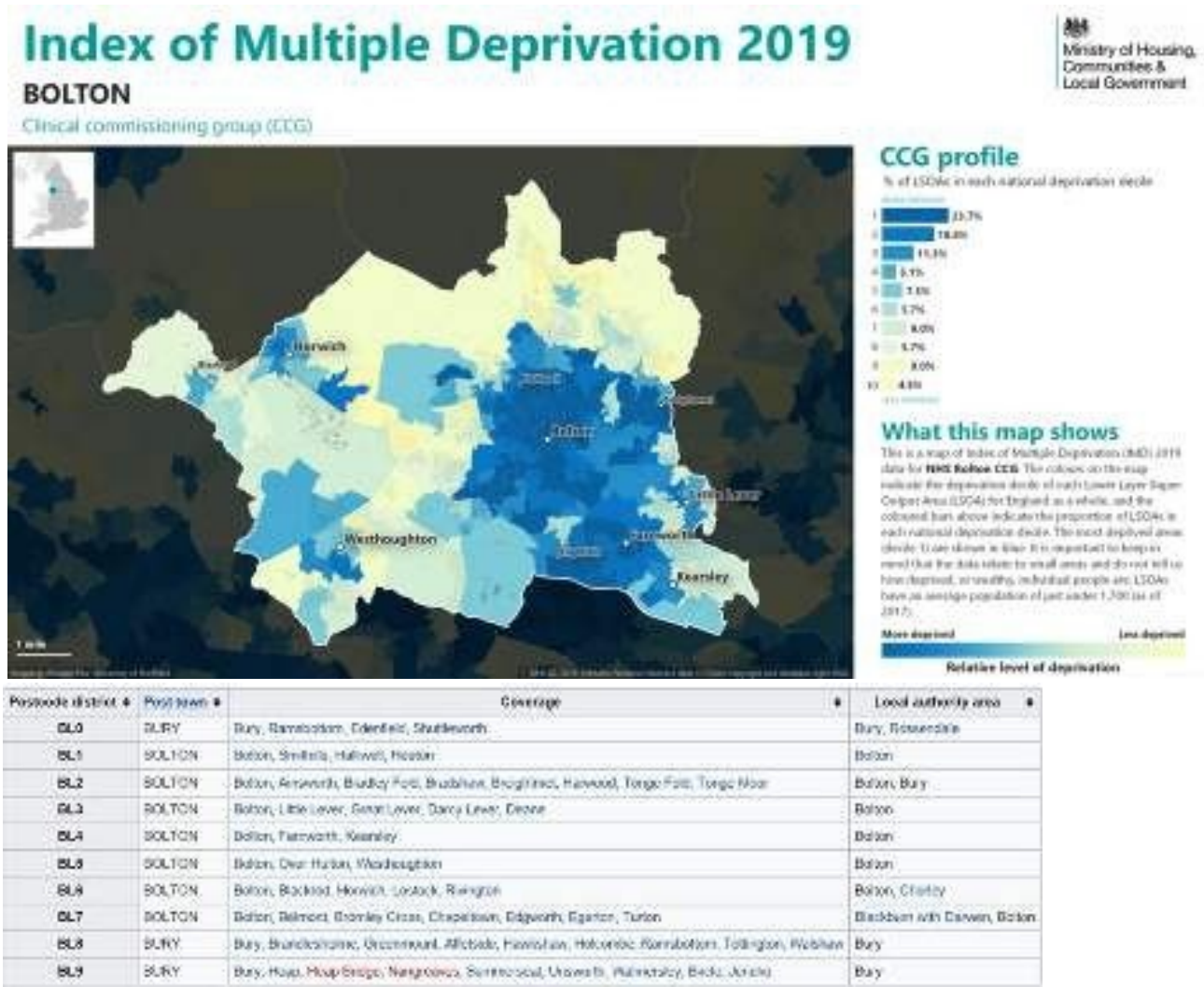
2. Introduction

The Trust mirrors the national position in that minor illness is the most frequent cause of short-term absence and mental health and stress, musculoskeletal and acute medical conditions (including heart conditions, cancer) are most commonly responsible for long term absence. Similarly mental ill health, nationally, across all sectors is increasingly prevalent, as a cause of both short- and long-term absence. When reviewing the local Bolton position the context of the health and well-being of the Bolton population, as an indicator of staff health is also considered.

The causes of sickness absence are influenced not only by individual health conditions but also by broader workforce and population factors, including deprivation, age, socioeconomic circumstances, workplace culture and access to wellbeing support. For this reason, sickness absence should be considered alongside wider indicators of workforce health and organisational performance.

3. The Broader Bolton Perspective

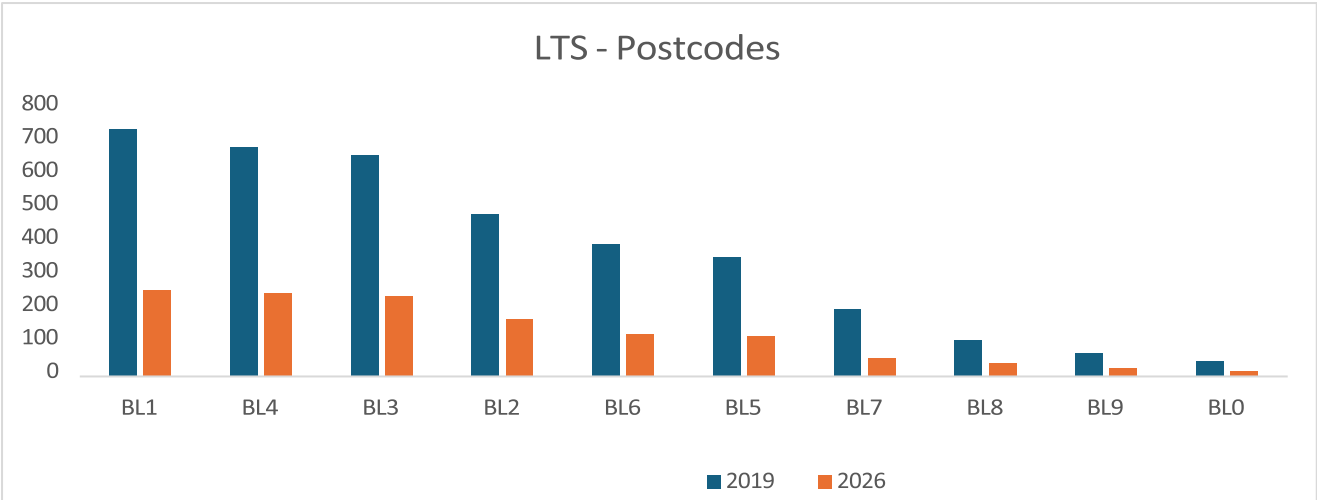
Bolton remains one of the more deprived local authority areas in England, with 47.3% of residents living within neighbourhoods ranked amongst the 20% most deprived nationally. Areas of greatest deprivation continue to be concentrated within Central Bolton and parts of Halliwell, Crompton, Rumworth, Tonge with Haulgh, Brightmet and Farnworth. The Borough's deprivation profile contributes to significant health inequalities and is an important factor influencing population health needs, demand for NHS services and workforce wellbeing.



LongTerm Sickness – BL Postcodes

Adjusted long-term sickness episodes have reduced by 65.3%, from 3,673 in 2019 to 1,274 in 2026. Reductions have been achieved across all postcode areas, particularly in BL1, BL4, BL3 and BL2. This improvement has been delivered despite a larger workforce, with staff numbers increasing by 4.1% over the period. The proportion of employees living within these postcode areas has also fallen from 59% in 2019 to 47.3% in 2026, demonstrating a changing workforce demographic alongside improved attendance outcomes.

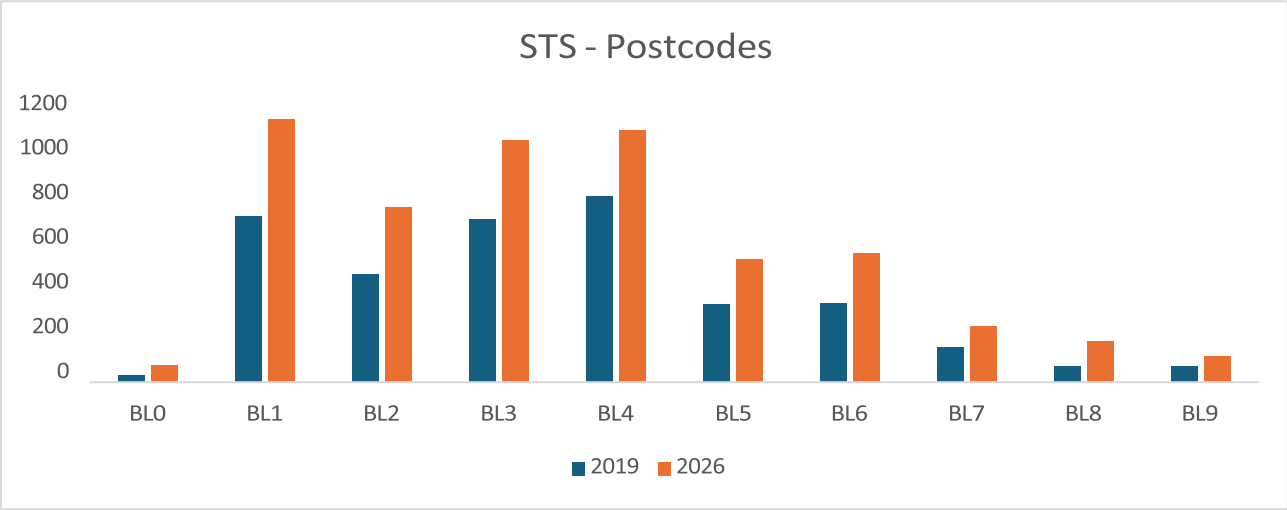
Improving care,
transforming lives...for a better Bolton



Short Term Sickness – BL Postcodes

The chart compares short-term sickness episodes with the geographical distribution of the Trust workforce. Staff living in BL2, BL3, BL4 and BL5 recorded higher levels of short-term sickness than expected, while BL6 and BL7 recorded lower levels, mirroring the pattern seen in long-term sickness.

Compared with 2019, the overall pattern remains similar, although the difference between workforce profile and sickness levels is less pronounced, suggesting a more even distribution of short-term sickness across postcode areas.

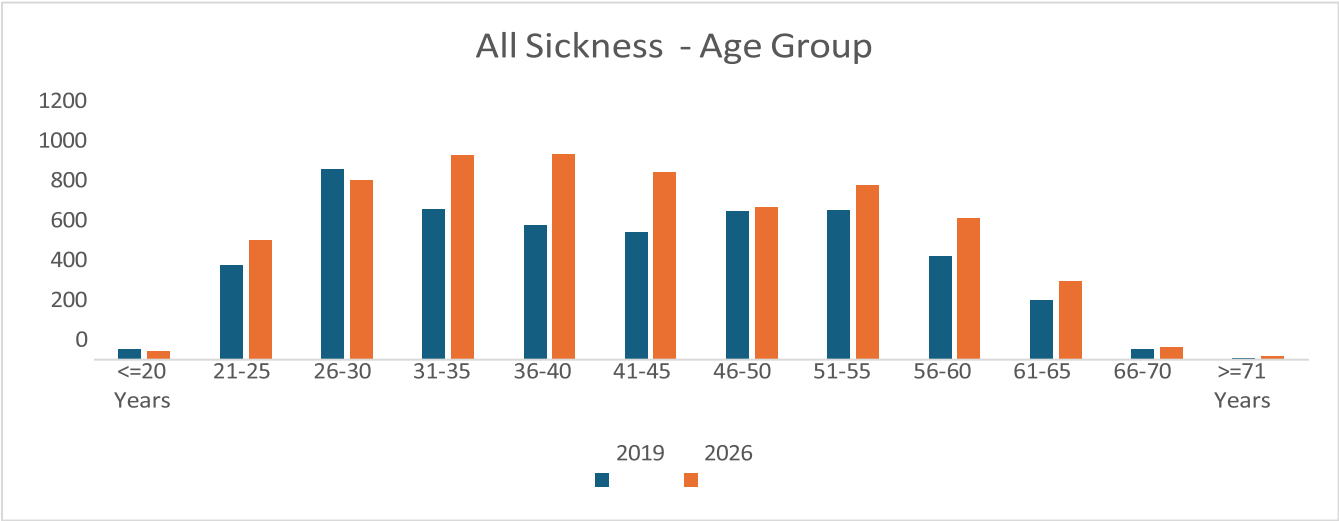


4. Staff age Profile and Sickness

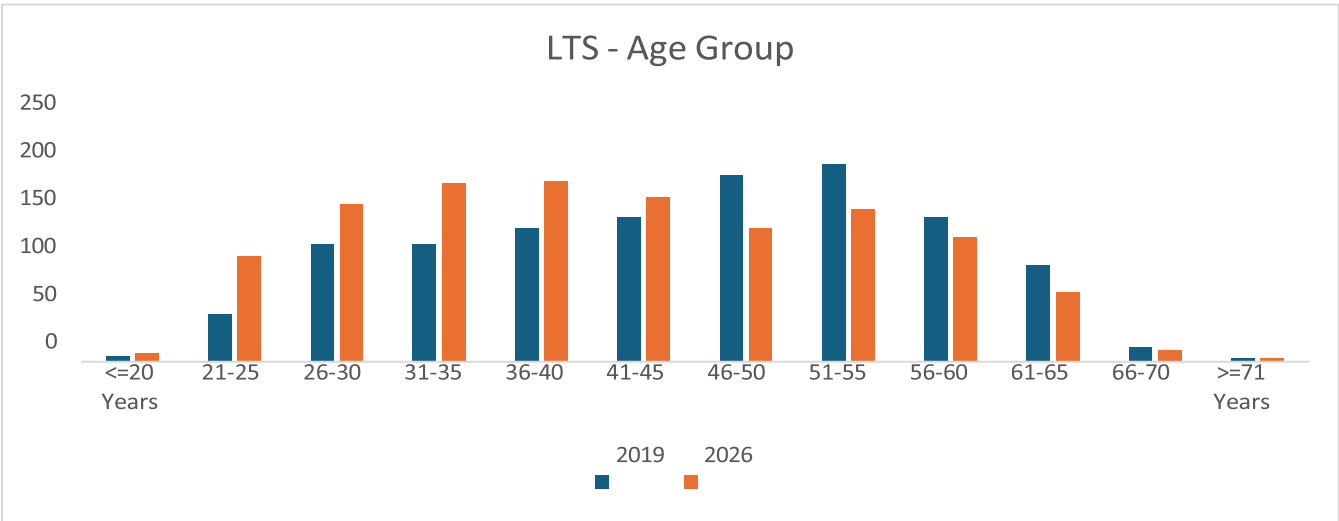
Long-term sickness episodes have increased across most age groups since 2019, with the largest rises seen in the 31-35 (+252.5), 36-40 (+338.4), and 41-45 (+284.8) age bands. The 36-40 age group now records the highest level of long-term sickness (977), followed by 31-35 (969) and 41-45 (891).

Despite a slight reduction in the ≤20 and 26-30 age groups, sickness levels have increased across almost all

other age bands, including older age groups. Overall, the data shows that long-term sickness is now more concentrated among working-age staff aged 31-45, with substantial growth compared to 2019.

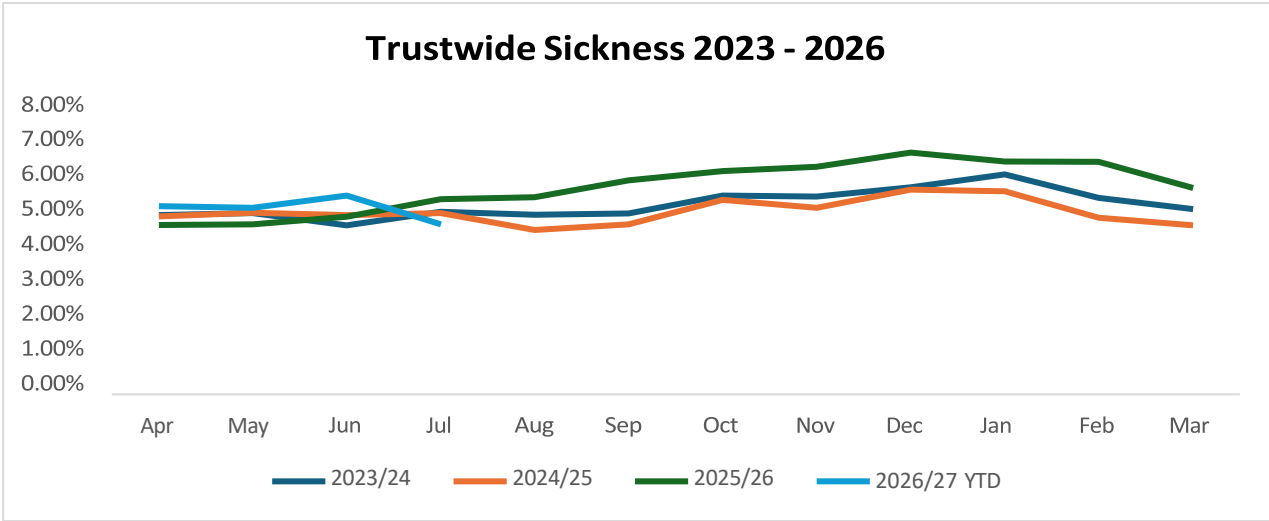


For long-term sickness episodes, the profile has shifted towards younger age groups compared with 2019. The largest increases were seen in the 21-25, 31-35 and 36-40 age bands, while long-term sickness episodes fell across most age groups aged 46 and over, particularly 46-50, 51-55 and 61-65. Overall, long-term sickness episodes are now more concentrated within the 26-45 age range, indicating a younger age profile than was seen in 2019.



5. Sickness comparison by year

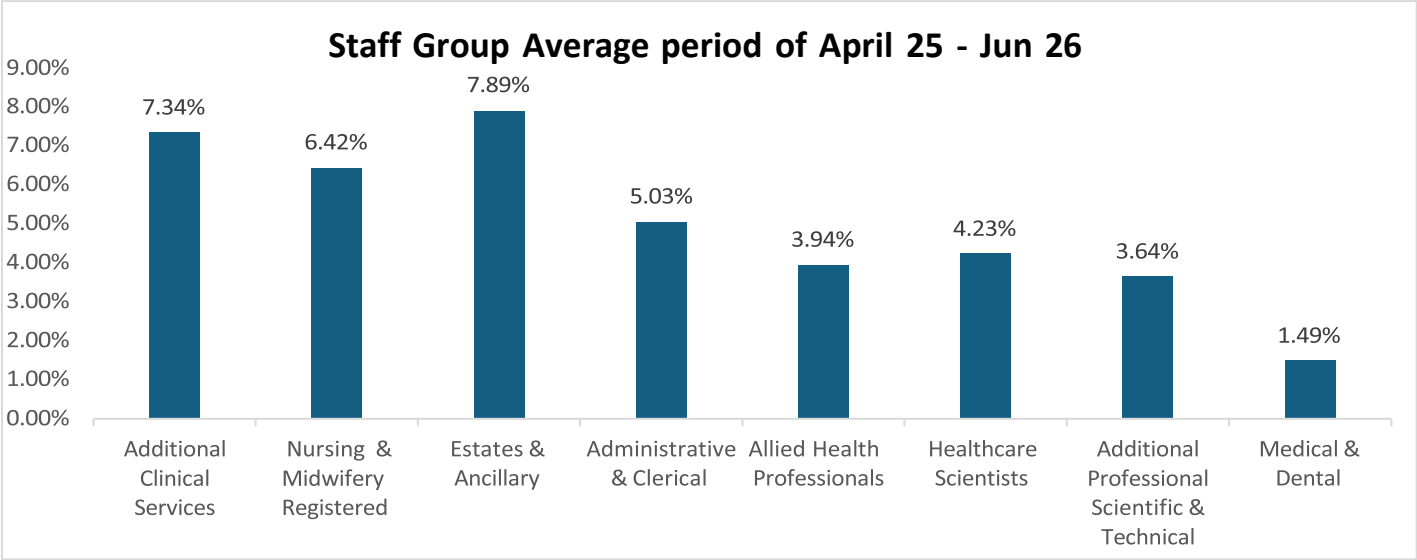
The following analysis presents sickness absence trends across the Trust from April 2023 to July 2026, showing the overall Trust sickness absence rate.



Trust-wide sickness absence remained relatively stable during 2023/24 and improved slightly in 2024/25. However, 2025/26 saw a significant deterioration, with absence rates exceeding 6% throughout much of the winter period and peaking at 6.69% in December 2025. Year-to-date performance in 2026/27 indicates some recovery, with an average absence rate of 5.14%, although performance remains above the level achieved in 2024/25. The data continues to demonstrate a strong seasonal trend, with sickness absence increasing during the winter months.

A Divisional breakdown for Apr 2025 to June 2026 can be found in appendix 1.

The chart below presents the average sickness absence rate by staff group over the period April 2025 to June 2026.



Over the period April 2025 to June 2026, Estates & Ancillary (7.89%), Additional Clinical Services (7.34%), and Nursing & Midwifery Registered (6.42%) recorded the highest average sickness absence rates. In contrast, Medical & Dental staff maintained the lowest average absence rate at 1.49%. Administrative & Clerical staff averaged 5.03%, while Allied Health Professionals, Healthcare Scientists, and Additional

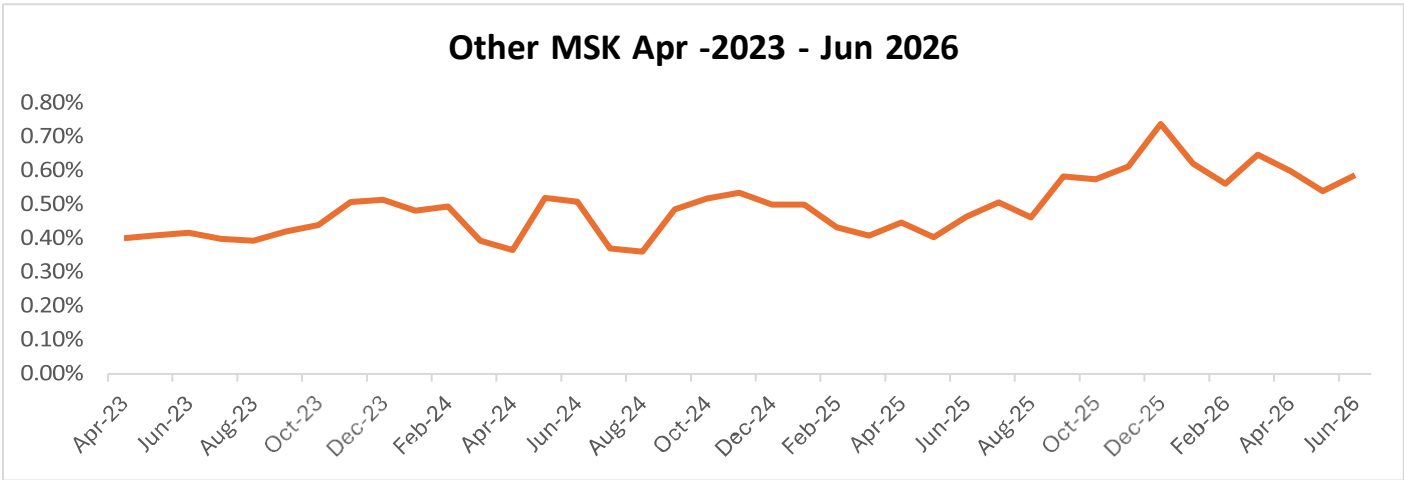
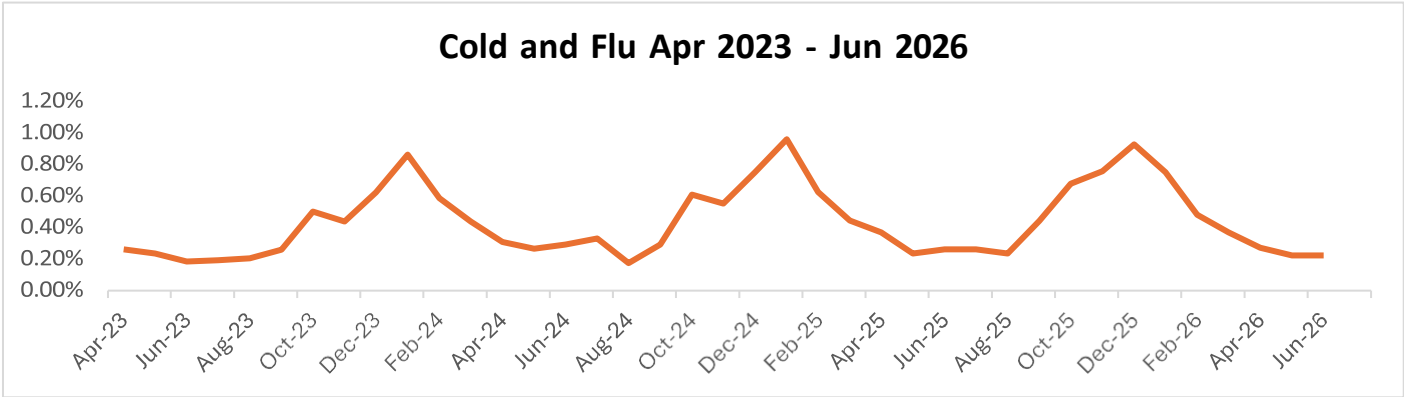
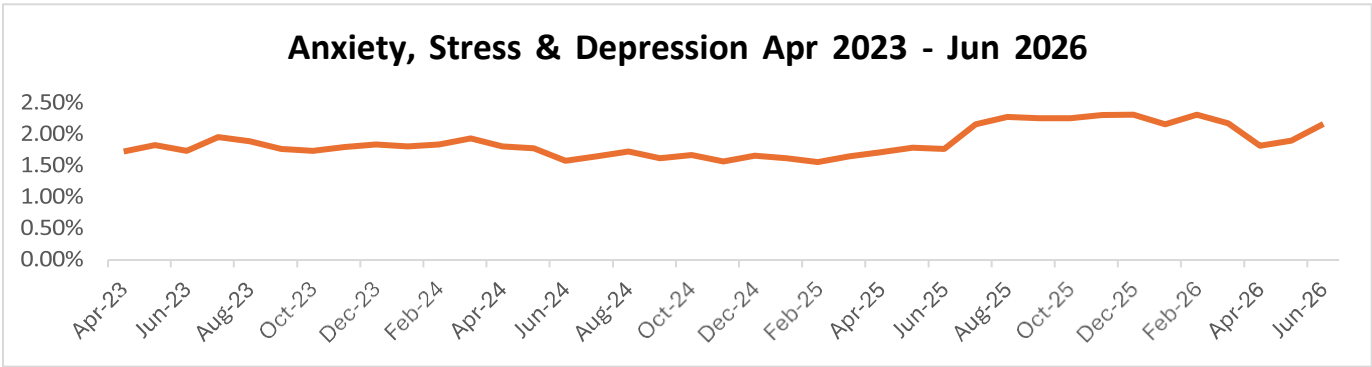
Professional Scientific & Technical staff remained below 4.5% on average across the period.

6. Reasons

There are a range of factors contributing to sickness absence across the NHS, encompassing both short-term and long-term conditions. National evidence from the CIPD Health and Wellbeing at Work Survey 2025 identifies minor illness as the most common cause of short-term absence, whilst mental ill health remains the leading cause of long-term absence. Stress, musculoskeletal disorders and other chronic health conditions also continue to be significant contributors to absence levels.

Appendix 4 shows the most common causes of absence as per the CIPD health and wellbeing survey 2025

Analysis of Trust sickness absence data between April 2023 and July 2026 identified anxiety, stress and depression, cold, cough and flu, and musculoskeletal (MSK) conditions as the three leading causes of absence. The following charts show the trend for each of these absence categories over time.



7. Workforce Wellbeing and Attendance Management

National evidence suggests that organisations are increasingly adopting strategic wellbeing approaches, with more employers recognising the relationship between employee wellbeing, engagement, retention and attendance. The CIPD Health and Wellbeing at Work Survey 2025 found that 57% of organisations now have a standalone wellbeing strategy and that employee wellbeing has become a significant leadership priority.

Bolton FT recognises that attendance management and workforce wellbeing are two sides of the same coin. Consistent with the NHS People Promise, the Trust is increasingly focusing on the wider factors that influence

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

attendance, including wellbeing, engagement, inclusion, leadership and workplace culture. Whilst sickness absence remains an area of focus, it is considered alongside a broader set of workforce indicators to provide a more comprehensive assessment of organisational health and staff experience.

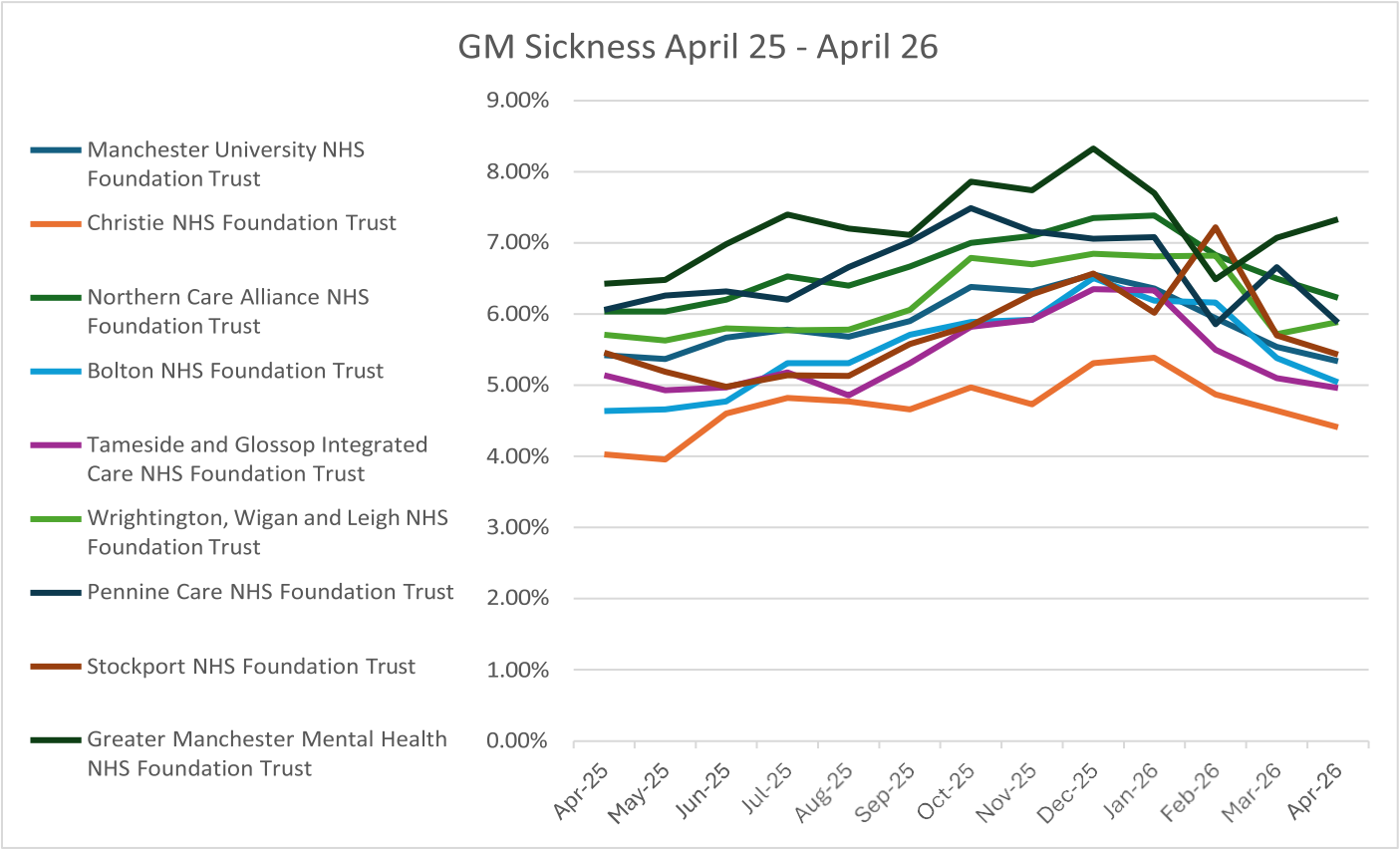
The recent CIPD Health and Wellbeing at Work Survey 2025 does not have a definitive list of the ‘top 10’ list of managing sickness, but the research from NHS England guidance, the NHS People Promise and CIPD consistently points to the same core principles as before. (see Appendix 2)

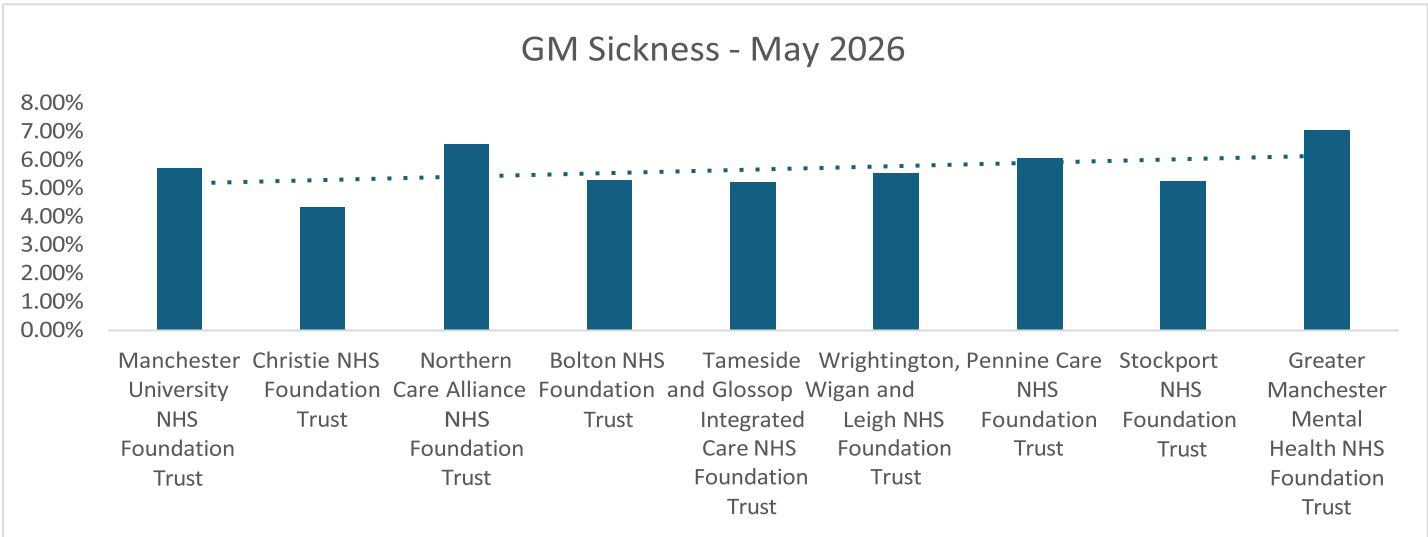
8. Benchmarking

GM Benchmarking

Benchmarking demonstrates that Bolton FT performs favourably compared with many Greater Manchester provider trusts, with sickness absence levels consistently below several comparable organisations throughout 2025/26. Whilst absences increased during the winter period, this trend was evident across all Greater Manchester providers, suggesting wider system pressures and seasonal factors contributed to increased absence levels.

(Figures for charts below can be found in Appendix 3)



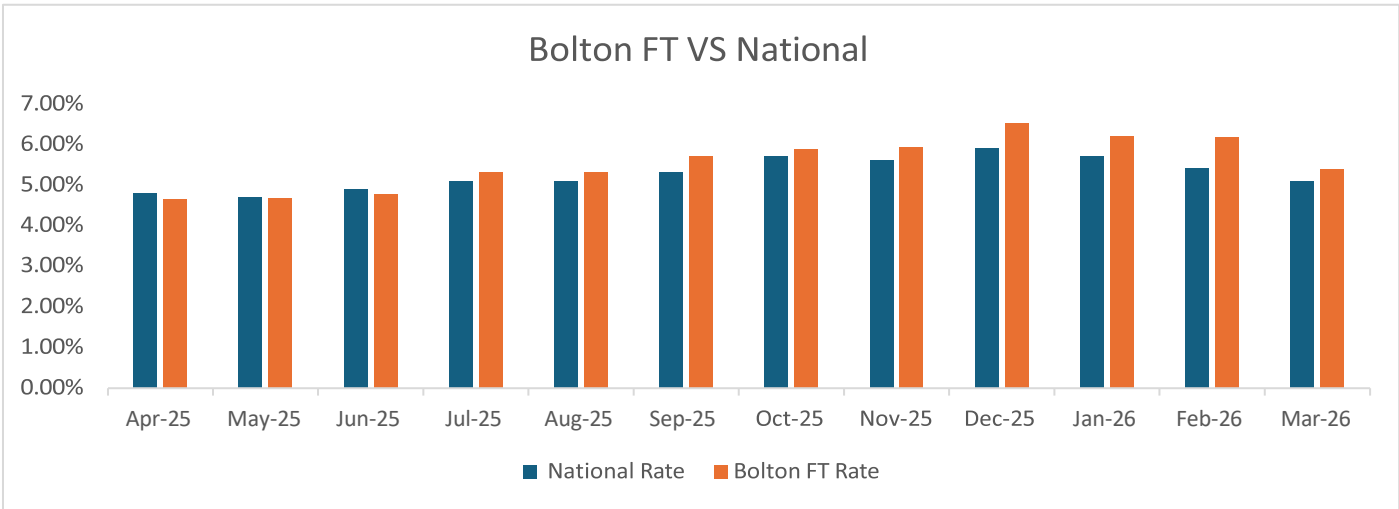


At 5.28%, we sit below the group average and perform better than several neighbouring trusts, including Manchester University NHS Foundation Trust (5.70%), Pennine Care NHS Foundation Trust (6.07%), Northern Care Alliance NHS Foundation Trust (6.56%), and Greater Manchester Mental Health NHS Foundation Trust (7.04%).

Among the trusts shown, Christie NHS Foundation Trust reports the lowest sickness rate at 4.35%, while Greater Manchester Mental Health NHS Foundation Trust reports the highest at 7.04%. Overall, Bolton's sickness rate is broadly in line with comparable organisations and is lower than a number of Greater Manchester peers. However, we remain off target against the 4.8% forecast in the medium term plan.

National/Regional Benchmarking

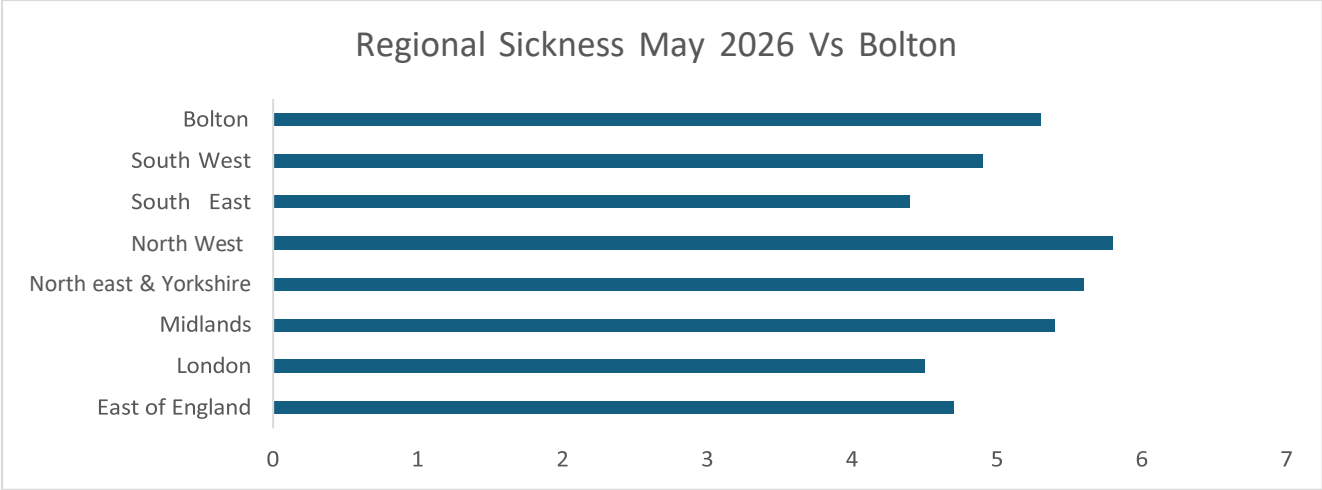
Bolton FT started 2025/26 with sickness absence below the national average. Although rates increased during autumn and winter, peaking at 6.51% in December 2025, the Trust saw a strong recovery in the final quarter, reducing absence by 1.13 percentage points by March 2026. The year ended at 5.38%, just 0.28 percentage points above the national average and among the stronger performers within Greater Manchester. (Figures for charts below can be found in Appendix 4)



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

At 5.3%, Bolton's sickness absence rate is below the North West average (5.8%) and North East & Yorkshire (5.6%), but above all other regions. This places Bolton broadly in the middle of the regional comparison, performing better than the wider North West position while remaining above the national best-performing regions, particularly the South East (4.4%) and London (4.5%).

A Month by month view cover April 25 – May 26 can be seen in appendix 5.



9. Oversight and Governance –Absence Management

A review of absence management against the key pillars of corporate governance is detailed below:

Board of Directors and Committees

As members are aware, health and well -being updates are provided to People Committee in line with the work plan and via AAA reports to the Board. Formal action taken under the Attendance Management process is included as part of the Employee Relations summary to People Committee and via AAA report to the Board.

Legal and Regulatory Framework

The Attendance Management Policy and processes are aligned to the legal and regulatory framework as well as best practice as evidence by the CIPD professional body.

A recent MIA internal audit has evidenced the application of the Trust Attendance Management Policy achieving ‘Moderate’ assurance with the one high risk recommendation being related to evidence of paperwork to support trigger escalation and retention of fit notes, both held at Divisional level. Actions to address the recommendations have been agreed and will be overseen by Audit Committee.

Monitoring and Internal Control

There is monitoring and internal control against the application of the policy, triggers and return to work interviews and recording both via MIA internal audit and local hot spot audits. These are reviewed on a monthly basis through the unavailability meetings.

Transparency and Accountability

The Divisional process, the detailed monthly reporting and the individual case management of long-term sickness cases ensure the transparency and accountability of the absence management process.

10. Actions

The updated Trust wide sickness absence action plan is included at Appendix 6.

Further information is eagerly awaited on the NHS Staff Regional Treatment hubs which, it is understood, will focus on mental health and MSK.

The changes to the national offer for emergency mental health provision is also welcomed as improvements in access to services and hence population health, will impact on staff health.

Following discussion at the unavailability meetings a series of focus groups across Divisions including staff side, managers, HR and Occupational Health will take place to identify any further insights or actions that can address the current levels of sickness absence.

At place level the Trust has also recently hosted Bolton Council in promoting access to well-being services through the local authority including talking therapies, well-being training and well-being walks.

Planning is also underway for this year's flu vaccination campaign building on the excellent uptake last year.

11. Conclusion

Sickness absence remains a key workforce challenge for Bolton NHS Foundation Trust and should be viewed within the wider context of workforce wellbeing, population health and organisational performance. The analysis demonstrates that sickness absence rates were relatively stable during 2023/24 and 2024/25 before increasing significantly during 2025/26, reflecting both local and national trends. Encouragingly, year-to-date performance for 2026/27 indicates a recovery from the elevated levels experienced during the previous winter period.

The review identified anxiety, stress and depression, cold, cough and flu, and musculoskeletal conditions as the leading causes of absence across the Trust. Nursing & Midwifery Registered and Additional Clinical Services continue to account for the highest levels of sickness absence, whilst postcode and age profile analyses suggest that wider determinants of health, including deprivation, health inequalities and an ageing workforce, may influence attendance patterns.

Benchmarking demonstrates that Bolton NHS Foundation Trust continues to compare favourably with many Greater Manchester provider organisations and remains broadly aligned with national trends, despite experiencing increased absence levels during the winter months. The Trust has comprehensive attendance management processes, wellbeing initiatives and governance arrangements in place which are consistent with recognised best practice and the NHS People Promise. Work is underway to map the new NHS standards including Health and Well-Being against existing practice to identify any gaps and actions required.

Continued focus is required to sustain progress, particularly in relation to mental health, musculoskeletal health, winter resilience and targeted support for staff groups and localities experiencing higher levels of

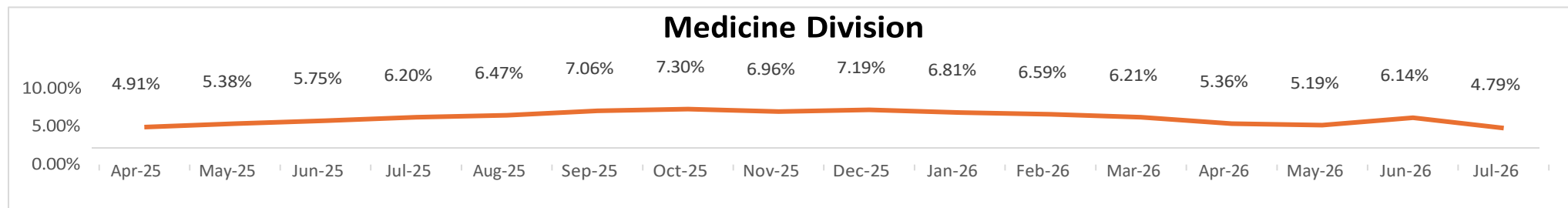
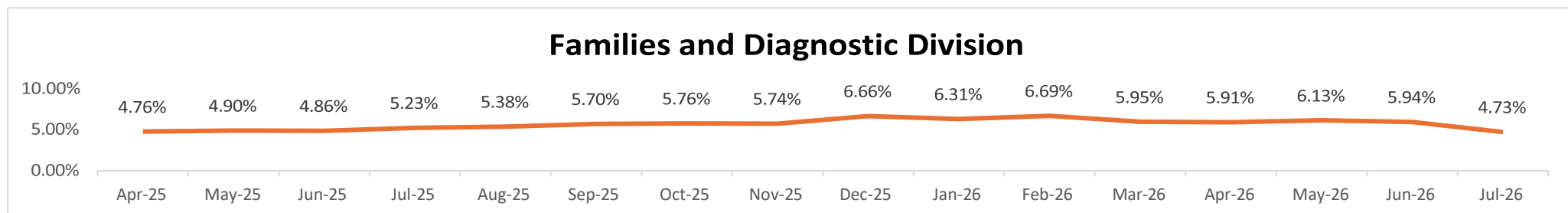
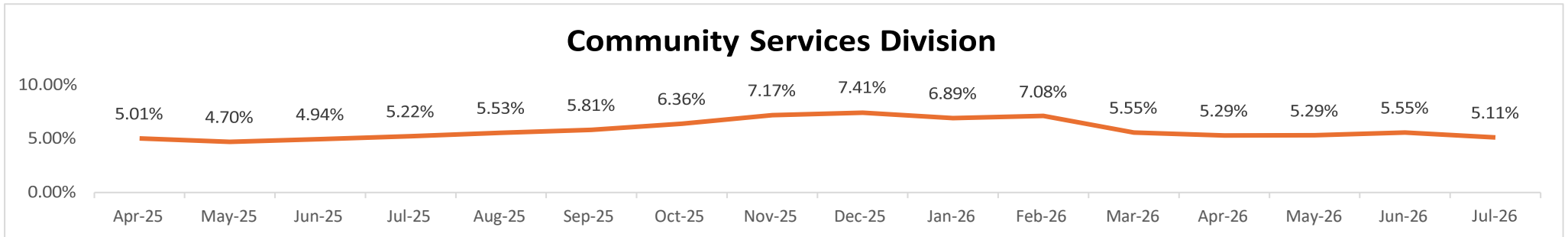
absence. By combining effective attendance management with a proactive wellbeing approach, the Trust is well placed to further improve attendance, support employee health and wellbeing, and maintain high- quality patient care.

12. Recommendation

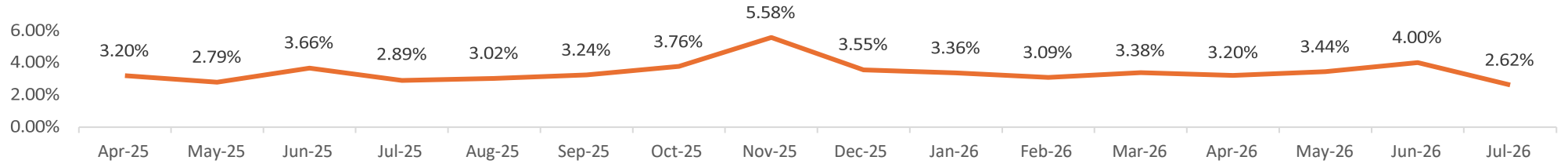
The Board is asked to receive the Staff Attendance report.

Appendix 1

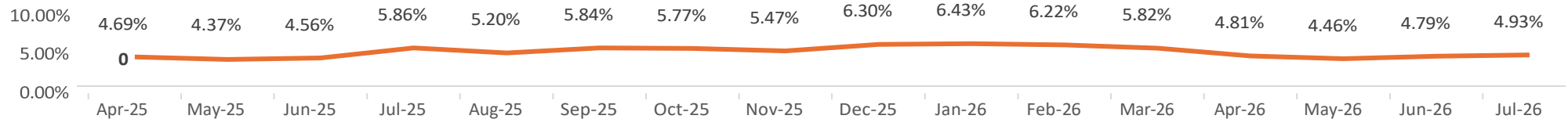
Divisional sickness April 2025 – July 2026



Corporate



Surgery Division



Appendix 2 - CIPD standards

Approach	Purpose	What are we doing?
Return to work Interviews	Review reasons for absence, identify support needs and reduce repeat absence.	RTW compliance monitored. App to make recording easier being explored.
Regular manager contact during absence	Maintain engagement and support employees during periods of sickness.	Within guidance and policy.
Trigger point monitoring	Identify patterns of absence requiring intervention or additional support	Trigger processes and reporting in place and subject to audit.
Occupation Health referrals	Obtain specialist advice on fitness for work, adjustments and rehabilitation.	OHS service in house provision and contracted in OH Physician capacity. SEQOSH accredited
Phased returns to work	Support employees returning from long-term absence safely and sustainably.	Phased rtw regularly agreed as part of the absence review process
Workplace Adjustments	Enable staff with health conditions or disabilities to remain in work.	On -going work with the health and long term conditions staff network and the reasonable adjustments passport.
Employee Assistance Programmes	Provide counselling and wellbeing support.	EAP 24/7 in place and counselling capacity through OHS
Mental Health and Wellbeing Initiatives	Address stress, burnout and psychological wellbeing.	Review of well-being offer I light of NHS staff standards and regional NHS Staff treatment centres
Management Training	Improve managers' confidence and capability in managing attendance and wellbeing.	On- going support and training via HR
Case management panels/review meetings	Review complex or long-term cases and coordinate support.	Monthly review of LT and complex cases as well as through individual 1:1's

Appendix 3

Trust	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Manchester University NHS Foundation Trust	5.42%	5.37%	5.67%	5.78%	5.68%	5.90%	6.38%	6.32%	6.56%	6.36%	5.94%	5.54%
Christie NHS Foundation Trust	4.03%	3.96%	4.60%	4.82%	4.77%	4.66%	4.97%	4.73%	5.31%	5.39%	4.87%	4.64%
Northern Care Alliance NHS Foundation Trust	6.04%	6.04%	6.20%	6.53%	6.40%	6.67%	7.00%	7.10%	7.35%	7.39%	6.83%	6.50%
Bolton NHS Foundation Trust	4.64%	4.66%	4.77%	5.31%	5.31%	5.71%	5.89%	5.92%	6.51%	6.19%	6.16%	5.38%
Tameside and Glossop Integrated Care NHS Foundation Trust	5.14%	4.93%	4.97%	5.18%	4.86%	5.31%	5.82%	5.92%	6.35%	6.33%	5.50%	5.10%
Wrightington, Wigan and Leigh NHS Foundation Trust	5.71%	5.63%	5.80%	5.77%	5.78%	6.06%	6.79%	6.70%	6.85%	6.81%	6.82%	5.72%
Pennine Care NHS Foundation Trust	6.06%	6.26%	6.32%	6.20%	6.66%	7.02%	7.49%	7.16%	7.06%	7.08%	5.86%	6.66%
Stockport NHS Foundation Trust	5.46%	5.19%	4.98%	5.14%	5.13%	5.58%	5.84%	6.28%	6.57%	6.02%	7.22%	5.70%
Greater Manchester Mental Health NHS Foundation Trust	6.43%	6.48%	6.98%	7.40%	7.20%	7.11%	7.86%	7.74%	8.33%	7.70%	6.49%	7.07%

(figures for charts benchmarking against GM)

Figures taken from published sickness data: [NHS Sickness Absence Rates - NHS England Digital](#)

Figures taken from published sickness data: [NHS Sickness Absence Rates - NHS England Digital](#)

Trust	Apr-26
Manchester University NHS Foundation Trust	5.34%
Christie NHS Foundation Trust	4.41%
Northern Care Alliance NHS Foundation Trust	6.23%
Bolton NHS Foundation Trust	5.04%
Tameside and Glossop Integrated Care NHS Foundation Trust	4.96%
Wrightington, Wigan and Leigh NHS Foundation Trust	5.89%
Pennine Care NHS Foundation Trust	5.88%
Stockport NHS Foundation Trust	5.43%
Greater Manchester Mental Health NHS Foundation Trust	7.33%

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

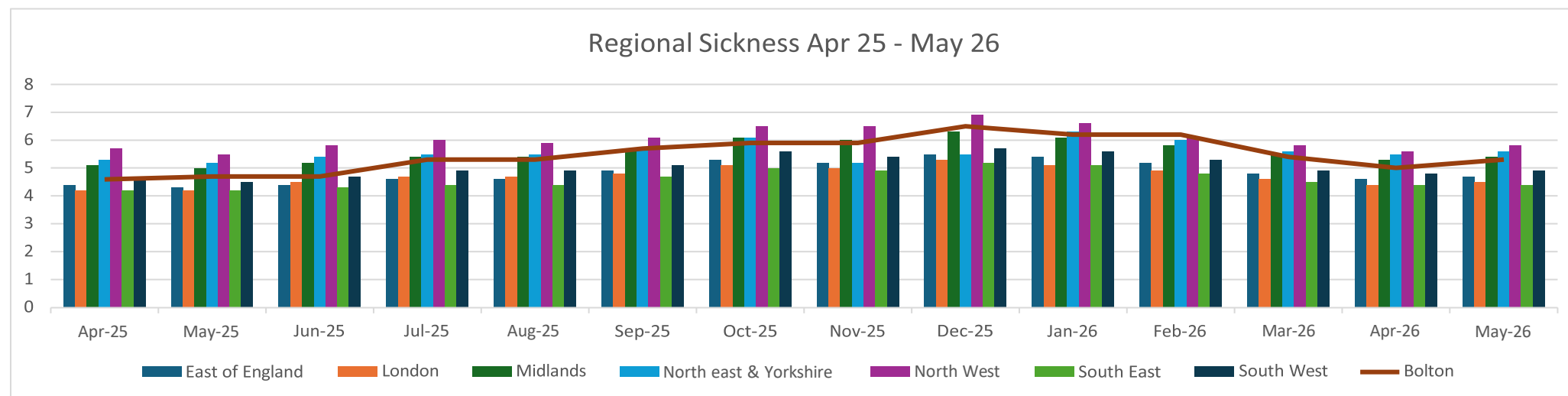
Appendix 3

(figures for charts benchmarking against national average)

Figures taken from published sickness data: [NHS Sickness Absence Rates - NHS England Digital](#)

Rate	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
National Rate	4.80%	4.70%	4.90%	5.10%	5.10%	5.30%	5.70%	5.60%	5.90%	5.70%	5.40%	5.10%
Bolton FT Rate	4.64%	4.66%	4.77%	5.31%	5.31%	5.71%	5.89%	5.92%	6.51%	6.19%	6.16%	5.38%

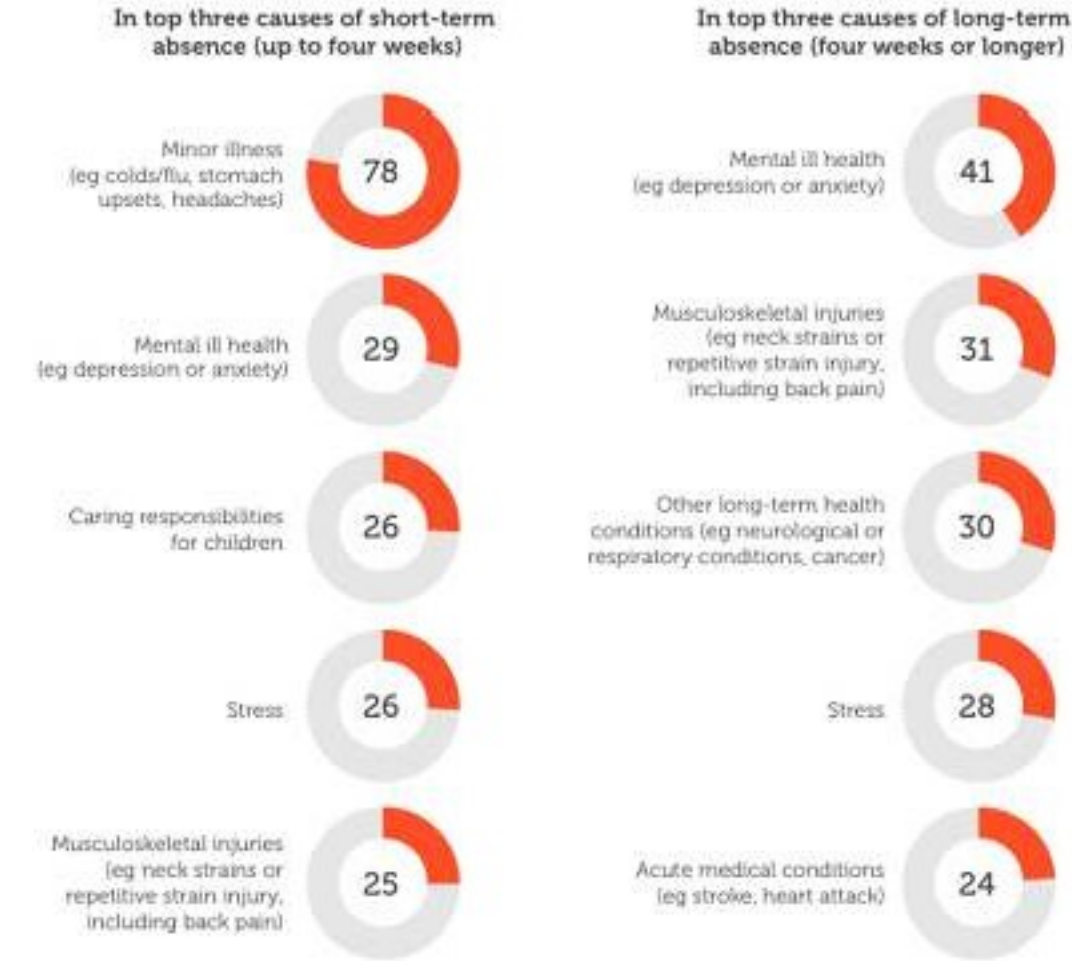
Appendix 4



Appendix 5

CIPD Health and Wellbeing Survey 2025 – Reasons for absence data taken from [Health and wellbeing at work 2025](#)

Figure 4: The most common causes of absence (% of respondents who include in their top three causes)



Base: n=1,101 (all respondents)

Sickness Absence and H&WB Action Plan - Updated August 2026

Ref No	Charter Focus	Actions for each category of work	Lead	Planned Start date	Proposed completion date	Revised Finish date	Action Status	Commentary
							B - Completed R - Not on Track - Exception report required A - Issues raised - G - On Track - no issues of note	Brief update on progress or description of issues
	Oversight	Set up monthly unavailability meetings	CW	01/03/2026	30/03/2026		B	Completed - Each Division now has a monthly meeting set out for remainder of calendar year
		Set consistent template for the above	CW	01/10/2024	30/04/2026		B	Original template being re-worked, to be used from end of April 2026 meetings
		Provision of assurance to people committee	CW	01/03/2026	Ongoing		B	Quarterly reports to be provided alongside updates from this action plan
		Benchmark current sickness rates - internally and externally	CW	01/09/2026	07/09/2026		B	Complete -PC report Sept 2026
		Provide MIA audit report to Div People Groups and WPF	CW	01/09/2026	07/09/2026		G	Complete
1	Policy and Process	Review of current policies	HR	01/07/2026	Ongoing		G	Focus on Attendance and Stress at Work Policies. Both policies are due for review in 2027 however will commence review earlier with support of staffside
		Sickness hotspot reviews	HR	01/04/2026	Ongoing		G	To identify initial hotspot areas in each Division. Set template to be completed and reviewed through unavailability meetings
		RTW audit schedule	HR	01/04/2026	Ongoing		G	Rolling programme of reviews to be confirmed in conjunction with hotspot audits
		Review of current provisions within 'Other leave'	HR	01/04/2026	30/04/2026		B	Review of volume of approved leave completed. To review entitlements and approval process (set action below). Also a review of Disability leave provision (interlinks with passport).
		Establish Trust SOP for approval of other leave	HR	01/04/2026	30/04/2026		B	Roll out standard SOP across all divisions - Initially based on unpaid leave to be approved by a panel.
		Review use of NHS England sickness toolkit	HR	01/04/2026	30/06/2026		B	Recently published toolkit under review. Majority of actions already in place but will build in further best practice
		Update reasonable adjustment passport and actions to support attendance	HR	01/04/2026	30/10/2026		G	Updated passport being finalised and to be re-launched along with additional guidance. Scope widened to include digital offer and network involvement
		Update all template letters to support managers	HR	01/04/2026	30/05/2026		B	Initial review of template letters and documents completed. Further review to support timely use for managers. To be uploaded to a manager portal for ease of access
		Review digital options for forms	HR	24/8/26	30/11/26		G	Exploring if more forms can be digital to improve completion and visibility
		Review 10x Stage 3 hearing packs -number of extensions	HR	01/09/2026	30/09/2026		G	Include in Oct unavailability meetings
2	Occupational Health & Welbeing	Review current referrals and consent timeframes	OHS	20.4.26	Ongoing		G	Ongoing management of KPIs within OH
		Ensure current provision meets KPIs	OHS	01/04/2026	Ongoing		G	All activity within KPIs for M referral nurse/ Pre placement
		Review project of initial call and support for all LT absences	OHS	30/04/2026	30/06/2026	30/11/2026	A	Work needs to be done to scope/Bcase
		Review current VivUp offer and other local welbeing offers	OHS	01/04/2026	30/06/2026	30/11/26	G	Ongoing - Links created with Local Authority and Work Well. Submitting external bid for additional funds for MSK work.
		Plan vaccination timetable for winter	OHS	01/04/2026	30/08/2026		G	Complete plan in place 7 day working
		Secure additional OHP capacity from Stockport	OHS	13/04/2026	30/04/2026		B	Complete need more formal plan CS looking at this
		Review opportunity for Day 1 input	OHS	30/04/2026	30/06/2026	30/11/2026	A	In planning will need investment to pilot and BC
		Update referral process	OHS	24/8/26	30/11/26		G	Update referral form to support managers, consider embedding guidance documents

Sickness Absence and H&WB Action Plan - Updated August 2026

Ref No	Charter Focus	Actions for each category of work	Lead	Planned Start date	Proposed completion date	Revised Finish date	Action Status B - Completed R - Not on Track - Exception report required A - Issues raised - G - On Track - no issues of note	Commentary <i>Brief update on progress or description of issues</i>
3	Manager Training	Update current manager guides to support management of sickness	HR	01/04/2026	30/06/2026		A	Further version being reviewed, plans to re-launch with updated templates
		Produce additional training and support tools for use on Blendid learning platform	OD	01/04/2026	30/06/2026		G	Additional training and video produced. Working on next training and roll out
		To establish bespoke training for hotspot areas	HR/OD	01/04/2026	Ongoing		G	Areas are identified and supported with bespoke training. Ongoing review through monthly unavailability meetings
4	Data and Monitoring	Review current sickness recording - including recording of D&V	HR		30/04/2026		B	External benchmarking completed. No change to current process however exploring options to support duties where possible.
		Roll out use of sickness dashboard	HR		30/05/2026	30/11/26	A	Digital dashboard developed and being trialled. Plan to roll out wider access to live sickness data
		Audit current actions and outcomes	HR	01/05/2026	Ongoing		G	quarterly audit
		Conduct deep dive in to sickness themes and tailor the above	HR	01/05/2026	Ongoing		G	Ongoing and reported through people Committees
		Review recording of annual leave during sickness	HR	01/05/2026	30/05/2026		B	Update SOP which currently pays for periods of leave in place of breaking sickness.

Report Title:	Medical Appraisal and Revalidation Report - 2025-2026 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 2026		Discussion	✓
Executive Sponsor	Medical Director		Decision	✓

Purpose of the report	The purpose of this report is to provide assurance that governance systems for appraisal and revalidation and professional standards for non-training grade medical staff are in place and fit for purpose.
-----------------------	---

Previously considered by:	The People Committee reviewed the report before it was submitted to the Board of Directors.
---------------------------	---

Executive Summary	The 2025-26 Annual Submission to NHS England North West under the Framework for Quality Assurance and Improvement (FQAI) provides assurance that Bolton NHS Foundation Trust has effective arrangements in place to meet its statutory responsibilities for medical appraisal, revalidation, professional standards and clinical governance. The Trust has maintained robust appraisal and revalidation processes throughout the year, supported by an updated Medical Appraisal and Revalidation Policy and completion of a peer review, the findings of which have informed a programme of continuous improvement. A key challenge remains the continued growth in the medical workforce, with a 57% increase in doctors connected to the Responsible Officer since 2013. Combined with financial constraints and limited administrative capacity, this has increased pressure on appraisal and revalidation services. To address this, appraisal and revalidation budgets have been centralised, a business case for additional appraiser capacity has been approved, and recruitment of new appraisers is underway. During 2026-27, the Trust will further strengthen governance arrangements by improving the incorporation of complaints, serious incidents and clinical outcomes into appraisals and by implementing enhanced quality assurance processes for responding to concerns about doctors. This will include the development of a Standard Operating Procedure to support fair, proportionate and bias-free decision-making.
-------------------	---

	Separate submissions are included for Bolton NHS Foundation Trust and Bolton Hospice, reflecting the Responsible Officer role held across both designated bodies.
--	---

Proposed Resolution	The Board of Directors is asked to approve the Medical Appraisal and Revalidation Report for submission to the Board of Directors to allow completion of section 4 – Statement of Compliance, prior to submission to NHSE by 30th October 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	No	
Legal/ Regulatory	Yes	Statutory annual return
Health Inequalities	No	
Equality, Diversity and Inclusion	No	
Is a Quality Impact Assessment Required	No	

Prepared by:	Nicola Caffrey, Corporate Business Manager for the Medical Director and Joanne Warburton, Medical Education Manager	Presented by:	Dr Rauf Munshi, Medical Director
---------------------	---	----------------------	----------------------------------

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

A&R	Appraisal and Revalidation
----------------	-----------------------------------

Bolton NHS Foundation Trust Submission

2025-2026 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required
to be submitted electronically to NHS England North
West at

england.nw.hlro@nhs.net

by **30 October 2026**

As this is a national deadline, failure to submit by this
date will result in a missed submission being recorded.
We are unable to grant any extensions.

2025-2026 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Bolton NHS Foundation Trust
What type of services does your organisation provide?	Acute District General Hospital providing NHS Healthcare Services

	Name	Email
Responsible Officer	Dr Rauf Munshi	Rauf.Munshi@boltonft.nhs.uk
Medical Director	Dr Rauf Munshi	Rauf.Munshi@boltonft.nhs.uk
Medical Appraisal Lead	Dr Wyn Price	Wyn.Price@boltonft.nhs.uk
Appraisal and Revalidation Manager	Joanne Warburton	Joanne.Warburton@Boltonft.nhs.uk
Additional Useful Contacts	Rabeya Rashid (Senior Admin)	Rabeya.Rashid@Boltonft.nhs.uk
	Lynne Hardy (Admin)	Lynne.Hardy@boltonft.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes/No No

If yes, who is this with?

Organisation:
Please describe arrangements for Responsible Officer to report to the Board:
Date of last Responsible Officer Report to the Board:
Action from last year:

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

- Section 1 – Qualitative/narrative
- Section 2 – Metrics
- Section 3 - Summary and conclusion
- Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of:
Bolton NHS Foundation Trust
can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	The new RO, Dr Rauf Munshi, came into post in January 2026 following the retirement of Dr Francis Andrews.
Comments:	New Medial Director/Responsible Officer in post.

Action for next year:	No action required.
-----------------------	---------------------

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Business case for funding to increase administrative support for A&R.
Comments:	Currently on hold due to the financial challenges.
Action for next year:	Reassess financial situation and potential for business case submission.

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	No action required.
Comments:	The Trust utilises the Premier IT appraisal and revalidation system to maintain accurate records. Information on new starters is obtained from multiple sources, including ESR new starter reports, induction registers, pre-employment revalidation checklists and GMC Connect notifications.
Action for next year:	No action required.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	None – policy next due for review in May 2027.
Comments:	Policy available on the Trust intranet.
Action for next year	Policy review due May 2027.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	No
Action from last year:	Work on actions from the peer review which took place in March/May 2024.
Comments:	Actions taken forward from the review include private practice declarations and change to quality assurance process for appraisals. Arrangements for locally employed doctors is an ongoing action.
Action for next year:	Continue to refine arrangements for locally employed doctors.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	None

Comments:	For locum doctors, there is a specific induction process in place. Responsibility for maintaining CPD, participating in annual appraisal, and engaging with the revalidation process remains with the individual doctor and their locum agency or designated body. For locally employed doctors, information relating to appraisal and revalidation processes is provided within the Trust's welcome email, and training and support are available to assist doctors in meeting their requirements. The Trust continues to experience a significant shortage of trained appraisers, which can present challenges in arranging appraisals within the desired timescales. Consequently, it is not always possible to complete the appraisal process for doctors employed on short term contracts before they leave the organisation.
Action for next year	None

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	None
Comments:	The Trust utilises the Premier IT appraisal system for the management of medical appraisal and revalidation activity. The appraisal portfolio is compliant with current national appraisal and revalidation requirements and is aligned to the principles and domains set out in the GMC's Good Medical Practice framework. A private practice declaration is incorporated within the appraisal process to support transparency and appropriate governance. Information relating to clinical performance, including complaints, serious incidents and outlying clinical outcomes, is considered as part of the appraisal process where relevant information is available. However, due to the administrative burden associated with collecting and transferring this information, it is not currently incorporated into the appraisal documentation.

Action for next year:	The Trust recognises the value of such information in supporting reflective practice and continues to review opportunities to strengthen the inclusion of governance information within the appraisal process.
-----------------------	--

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	Additional support will be offered to doctors new to the UK in the form of a meeting with the Clinical Lead and/or and accessible presentation which is now available on our intranet, to help educate on the importance of appraisal and revalidation. This is in addition to the existing introduction email that is sent to all new starters.
Comments:	Special circumstances and postponements may be agreed in accordance with Trust policy. Examples include periods of long term sickness absence, maternity or parental leave, or delays arising from a shortage of available appraisers. For doctors who do not meet the criteria and who fail to engage, a formal escalation process is outlined within the Appraisal and Revalidation policy.
Action for next year:	Audit organisation wide compliance with the Clinical Lead meetings for doctors new to the UK for consistency across specialities

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	None
Comments:	Ratified and uploaded to Trust intranet in May 2024.
Action for next year:	Policy due for update in May 2027.

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	No
Action from last year:	The RO and CL for A&R are progressing plans to centralise funding and retain experienced appraisers approaching retirement through bank staff arrangements.
Comments:	There has now been agreement for the centralisation of the A&R budget and 19 additional appraisers have expressed an interest in joining the appraiser pool.
Action for next year:	Continued oversight of appraiser pool, with a greater focus on ensuring appraisal quality

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	Yes
Action from last year:	None
Comments:	Appraisers complete their initial training through an external provider. Appraiser network meetings are held every six months to promote consistency, maintain quality standards, and provide updates. Feedback on appraiser performance is routinely collected and shared with individual appraisers as part of their

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	own appraisal process. Quality assurance is supported through the use of the PROGRESS document and formal MIAD training.
Action for next year:	Continue as above.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	None
Comments:	The A&R team hold monthly meetings with the RO to review issues, risks and areas of concern. Delivery of the A&R action plan and appraisal performance metrics are monitored and overseen by the People Committee.
Action for next year:	Continue as above

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	None
Comments:	We are compliant with protocols.
Action for next year:	Continue as above

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	None
Comments:	Doctors are kept fully informed throughout the revalidation process, particularly where a deferral or non-engagement recommendation is being considered. All doctors are encouraged to obtain patient and colleague feedback in the second year of their revalidation cycle to support timely revalidation.
Action for next year:	Continue as above

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	A process for SUI's and Never Events for uploading to doctors portfolios is in place when needed.
Comments:	The RO plays a key role in clinical governance, including membership of the Quality Committee and involvement in PSIRF. Each directorate has an active Clinical Governance Lead to support and promote effective governance practices. However, due to inadequate admin resource this has further delayed this implementation and the lack of maternity cover of the A&R officer further exacerbated the issue.
Action for next year:	Establish robust quality and information reporting for SUI's and Never Events for uploading to doctors portfolios, following the

	same process as the complaints report and enhance process for recording events is not declared by doctor.
--	---

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	To strengthen inclusion processes within appraisal documentation.
Comments:	Information from appraisals, complaints, incident reporting, external agencies, and direct reports to the Medical Director team is systematically reviewed to identify concerns, inform decision making, and ensure appropriate actions are taken. A process is in place for adding information to appraisal if deemed appropriate by Responsible Officer.
Action for next year:	Following best practice recommendations, a RO Assurance governance group will be established, triangulating conduct and professional standards with A&R requirements and combining the management of performance and Revalidation into regular meetings. Furthermore, a new reporting system is being implemented to support management of casework to support triangulation of practice and standards

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	RO to discuss with Director of Quality Governance to set up a system to receive these reports.
Comments:	HED data is available to consultants on request and is provided as a downloadable PDF report. Complaints reports, including all nil returns, are uploaded for all doctors. Patient and colleague feedback is collected through the electronic system and

	automatically uploaded to individual appraisal portfolios. The implementation of routine reporting for PSIRF and Never Events has been delayed due to staffing constraints.
Action for next year:	Establish the full process and oversight for engagement with the GIRFT NCIP (National Consultant Information Programme) which will allow reporting of performance in surgery with full oversight from the RO, with the ability to extract consultant level compliance and outcomes for adding to portfolio's.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	None
Comments:	Robust processes are in place for the management of concerns, underpinned by the Capability, Conduct and Remediation Policy and the Disciplinary Policy. Decisions are made in accordance with the GMC's fair decision-making framework. A pool of trained investigators is maintained to undertake investigations and support effective management of cases. There are currently six trained investigators, and the new Medical Director is undertaking the NHS England North West Responsible Officer training
Action for next year:	Increased the number of trained investigators, and ensure all the Divisional Medical Directors, and Associate Medical Directors are all trained

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	To establish a quality assurance process to report into People Committee.
Comments:	All concerns raised with the RO are discussed with the deputy director of people and the PPAS to ensure a fair and proportionate response. We follow the 10 recommended practices in the GMC best practice document Principles of a good investigation
Action for next year:	Following best practice recommendations and the change of RO, a RO Assurance governance group will be established, triangulating conduct and professional standards with A&R requirements. This will ensure oversight of all concerns and will include information relating to numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	None
Comments:	An agreed process is in place with the Medical Workforce Business Partner to ensure that relevant information is provided for both incoming and outgoing doctors.

Action for next year:	Continue as above
-----------------------	-------------------

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Yes
Action from last year:	To continue existing processes supported by the development of a clear SOP to support these arrangements.
Comments:	The Trust Capability and Conduct for Medical Staff Policy incorporates the principles of the NHS England Just Culture Guide, promoting a fair, consistent, and supportive approach to managing concerns. A second independent opinion is obtained before cases progress to formal investigation. Responsible Officer, case managers and investigators are required to complete EDI mandatory training.
Action for next year:	The policy in agreement with the BMA will be reviewed and the inclusion of the available Fairness and Proportionality framework and resources will be added into the next step review so its up to date.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	To provide assurance to People Committee following relevant national reports and reviews
Comments:	This process is undertaken by the Medical Director, but there is a need to provide a response to the People Committee after review

	of relevant national reports for assurance. Learning from the RO Networks, the GMC Liaison officer and the A&R regional groups received relevant updates for incorporation into organisational information.
Action for next year:	Strengthen the process for sharing national reviews, reports and enquiries information, to be managed through a standing item on the RO Assurance Group meeting

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	None
Comments:	The Trust has embedded principles of collaborative leadership and organisational values through its leadership development initiatives, including 'Our Leaders' leadership programme and 'Our Voice' change programme. The RO chairs the DEI Assurance Group and managers are accredited through CMI. There is a unified FABB appraisal system. Robust arrangements are in place for senior appointments including NED, and talent attraction and recruitment for hard to fill areas.
Action for next year:	Continue as above

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	To continue existing process to ensure that all doctors from overseas training programmes undertake the GMC 'Welcome to UK Practice' and implement results of recent quality scoring trial.

Comments:	TRAC electronic system is in place for completion of all pre-employment checks in line with NHS Employment Check Standards for all substantive staff, bank medical staff and foundation doctors before employment. All agency medical staff are sourced through accredited agency partners, through NHS framework agreements.
Action for next year:	Ensure processes are in place and working

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	None
Comments:	There is comprehensive clinical governance including clinical audit committee and Quality Assurance Committee and sub groups to monitor excellence in clinical care.
Action for next year:	None

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	None

Comments:	The Trust 'Our Voice' programme supports compassion, fairness, respect, diversity and inclusivity. There is a focus on all Clinical Leads to attend the Our Leaders programme.
Action for next year:	None

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	None
Comments:	'Our Voice' programme, extensive Freedom to Speak Up guardians and champions embedded and monitored through the People Committee.
Action for next year:	None

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	These processes will be reviewed by the Medical Director.
Comments:	These mechanisms are incorporated into our capability, conduct, remediation, and disciplinary policies. Appropriate consultation is carried out during review of these policies. These include access to formal complaints and grievance procedures, Freedom to Speak Up arrangements, Medical Staff

	Committee and Local Negotiating Committee representation, appraisal feedback processes and established appeal mechanisms within Maintaining High Professional Standards (MHPS) procedures.
Action for next year:	To continue under review from the Medical Director

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Yes
Action from last year:	None
Comments:	A small number of formal capability and disciplinary cases are undertaken each year. Information relating to protected characteristics is reported annually, and a report is submitted to the People Committee to enable analysis of cases and identify any trends or disparities.
Action for next year:	None

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	None

Comments:	The RO and A&R team attends and contributes to network meetings. A peer review programme was completed in May 2024 with WWL NHS Trust.
Action for next year:	Continue as above

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	456
Total number of appraisals completed	371
Total number of appraisals approved missed	37
Total number of unapproved missed	48
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	51
Total number of late recommendations	2
Total number of positive recommendations	37
Total number of deferrals made	14
Total number of non-engagement referrals	5
Total number of doctors who did not revalidate	0
Total number of trained case investigators	6
Total number of trained case managers	1
Total number of concerns received by the Responsible Officer ²	5
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March (working days)	160
Median duration of concerns processes closed (working days) ³	113
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	1
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of new doctors joining the organisation	131
Total number of new employment checks completed before commencement of employment	131
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld ⁴	0

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
• Appointment of Dr Rauf Munshi as Medical Director and Responsible Officer in January 2026, ensuring continued leadership and oversight of appraisal, revalidation and professional standards. • The current A&R lead is retiring and an advert for their replacement is currently out to advert • The Medical Appraisal and Revalidation Policy has remained in place and compliant with national requirements, with the next scheduled review due in 2027. • Continued utilisation of the Premier IT appraisal system with ongoing quality assurance processes and regular oversight meetings between the Responsible Officer and the Appraisal and Revalidation Team. • Progress made against actions arising from the Appraisal and Revalidation Peer Review, including enhancement of quality assurance arrangements and the introduction of private practice declarations within appraisal documentation. • Agreement secured to centralise appraisal and revalidation budgets, improving organisational oversight and management of appraiser activity across divisions. • Work undertaken to address appraiser capacity challenges, with 19 doctors expressing an interest in undertaking the appraiser role, supporting future sustainability of the appraisal process. • Continued provision of complaints information, colleague feedback and patient feedback within appraisal portfolios to support effective reflection and triangulation of information. • Ongoing application of robust processes for managing concerns relating to doctors' conduct, capability and professional performance, with support from trained investigators and established governance arrangements.

- Continued embedding of Just Culture principles within professional standards processes to support fair, proportionate and learning-focused approaches to managing concerns.
- Mechanisms remain in place to enable doctors to provide feedback on professional standards processes, including formal complaints procedures, grievance processes, Freedom to Speak Up arrangements, Medical Staff Committee representation and appraisal feedback mechanisms.
- Progress made in strengthening equality, diversity and inclusion considerations within professional standards and workforce governance processes.
- Financial constraints and limited administrative capacity continue to present challenges, particularly in relation to expanding appraisal support arrangements and further developing automated clinical governance reporting to support appraisal and revalidation.

Actions still outstanding

- Complete a review of arrangements for incorporating outlying clinical outcomes, serious incidents and complaints data into appraisal documentation to strengthen triangulation of information and support appraisal quality.
- Develop and implement a formal quality assurance process for responding to concerns about doctors, including routine reporting and oversight through the People Committee.
- Develop and approve a Standard Operating Procedure (SOP) to provide assurance that processes for responding to concerns are fair, proportionate and free from bias and discrimination.
- Continue recruitment and training of new appraisers from the cohort of interested clinicians to improve organisational resilience and appraisal compliance.
- Further strengthen arrangements for locally employed doctors, ensuring consistent access to appraisal, support and governance processes.
- Explore opportunities to improve the automation of clinical governance information available within appraisal portfolios, reducing manual processes and improving efficiency.

- Review administrative support requirements for the Appraisal and Revalidation function in light of continued growth in the medical workforce and ongoing capacity pressures.
- Continue to embed and monitor equality, diversity and inclusion considerations within professional standards processes, including the collection and review of relevant workforce data.
- Strengthen mechanisms for obtaining and reviewing feedback from connected doctors regarding appraisal, revalidation and professional standards processes to support continuous improvement.
- Monitor the impact of the centralised appraisal and revalidation budget arrangements and ensure they deliver sustainable appraiser capacity across all divisions.

Current issues

- The incumbent A&R lead is retiring and the post is out to advert.
- Appraiser Capacity: There remains an insufficient number of trained appraisers to meet organisational demand, however there has now been approved for the centralised budget and identification of 19 more appraisers.
- Medical Workforce Growth: The significant increase in the number of doctors connected to the Responsible Officer since 2013 continues to increase workload and demand on appraisal, revalidation and governance processes.
- Administrative Capacity: Financial constraints have limited the ability to increase administrative support, creating challenges in maintaining and developing appraisal and revalidation services.
- Clinical Governance Information: Further work is required to improve the systematic incorporation of complaints, serious incidents and outlying clinical outcomes into appraisal documentation.
- Responding to Concerns Assurance: Formal quality assurance arrangements and reporting mechanisms for concerns relating to doctors' practice require further development to meet the enhanced FQAI requirements.

- **Equality and Inclusion Monitoring:** Additional work is needed to strengthen assurance that professional standards processes remain fair, proportionate and free from bias and discrimination.
- **Sustainability of Appraisal Services:** Ongoing monitoring is required to ensure the centralised budget arrangements and appraiser recruitment initiatives deliver sufficient long-term resilience.
- **Resource Pressures:** Continued financial and workforce pressures may impact the pace of implementing quality improvement initiatives within appraisal, revalidation and professional standards functions.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

- Complete a review of how complaints, serious incidents, clinical outcomes and other governance information are incorporated into appraisal documentation to strengthen reflection and triangulation of information.
- Develop and implement a quality assurance framework for responding to concerns about doctors, including regular reporting and oversight through the People Committee.
- Develop and embed a Standard Operating Procedure (SOP) to provide assurance that processes for managing concerns about doctors are fair, proportionate, transparent and free from bias and discrimination.
- Increase appraiser capacity through recruitment, training and support of new appraisers to ensure sustainable delivery of appraisal requirements across the organisation.
- Complete a business case for additional appraiser administrative resource, informed by the continued growth in the medical workforce and appraisal demand.
- Monitor and evaluate the effectiveness of the centralised appraisal and revalidation budget arrangements to ensure equitable and efficient deployment of appraisal resources across divisions.
- Continue to strengthen appraisal arrangements for locally employed doctors, ensuring consistency of support, governance and regulatory compliance.

- Enhance the quality and accessibility of clinical governance information available to appraisers and appraisees through further system development and process improvements.
- Strengthen mechanisms for obtaining and reviewing feedback from connected doctors regarding appraisal, revalidation and professional standards processes to support continuous improvement.
- Further embed equality, diversity and inclusion principles within appraisal, revalidation and professional standards processes and develop reporting mechanisms to support ongoing assurance.
- Review administrative support requirements for appraisal and revalidation services to ensure arrangements remain effective and sustainable in the context of increasing workforce numbers and organisational pressures.
- Maintain compliance with GMC and NHS England requirements through ongoing monitoring, quality assurance and continuous improvement of appraisal, revalidation and professional standards processes.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

With the retirement of the current A&R Lead, responsibility for progressing the next phase of development will transfer to the newly appointed postholder.

The Trust continues to demonstrate a strong commitment to maintaining high standards of medical professionalism, appraisal and revalidation, supported by effective governance arrangements and a culture of continuous improvement.

Significant progress has been made during the year, including implementation of peer review recommendations, strengthening quality assurance processes and securing agreement to centralise appraisal and revalidation budgets. However, challenges remain in relation to appraiser capacity, workforce growth and administrative resources. During 2026-27, the Trust will focus on strengthening assurance processes, improving appraisal capacity, embedding equality and inclusion principles and ensuring continued compliance with GMC and NHS

England requirements while supporting high-quality patient care and professional development.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists))]

Official name of the designated body:	
---------------------------------------	--

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

2025-2026 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required
to be submitted electronically to NHS
England North West at
england.nw.hlro@nhs.net
by **30 October 2026**

As this is a national deadline, failure to submit by
this date will result in a missed submission being
recorded. We are unable to grant any extensions.

2025-2026 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Bolton Hospice
What type of services does your organisation provide?	Palliative and end of care services for adults

	Name	Email
Responsible Officer	Rauf Munshi	Rauf.Munshi@boltonft.nhs.uk
Medical Director	Aurelia McCann	ellie.mccann@boltonhospice.org
Medical Appraisal Lead	Wyn Price	wyn.Price@boltonft.nhs.uk
Appraisal and Revalidation Manager	Lynne Hardy	lynne.hardy@boltonft.nhs.uk
Additional Useful Contacts	Jenny Short	jenny.short@boltonhospice.org

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes/ No

yes

If yes, who is this with?

Organisation: Bolton Hospital NHS Foundation Trust
Please describe arrangements for Responsible Officer to report to the Board: updates via Bolton Hospice Medical Director
Date of last Responsible Officer Report to the Board: n/a
Action from last year: n/a

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

- Section 1 – Qualitative/narrative
- Section 2 – Metrics
- Section 3 - Summary and conclusion
- Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of:

Bolton Hospice

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	yes
-----	-----

Action from last year:	No actions
Comments:	The RO is the current Medical Director at Bolton Hospital NHS Foundation Trust
Action for next year:	Continue appraisal and revalidation processes as established on the SLA; ensure timely appraisal and revalidation for all doctors employed by Bolton Hospice; timely report any outstanding issues to the Board of Trustees

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	yes
Action from last year:	No actions
Comments:	We have a valid SLA with Bolton Hospital NHS Foundation Trust
Action for next year:	Review and agree SLA terms and conditions timely

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	yes
Action from last year:	Form B designated body details completed and returned to NHSE and RO
Comments:	
Action for next year:	Make sure that Form B is accurate and up to date

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	yes
Action from last year:	none
Comments:	Policies sit with the RO and the NHS Trust as per SLA
Action for next year	RO to forward copy of NHS Trust policy for medical revalidation

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Appraisal and revalidation recommendations are currently sitting with Bolton NHS foundation trust; Bolton Hospice follows their appraisal and revalidation processes.
Action from last year:	n/a
Comments:	none
Action for next year:	n/a

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	yes
Action from last year:	n/a
Comments:	This is part of HR processes (induction, CPD, governance, mandatory training) Short-term placement trainees have permanent staff as clinical supervisors, we have regular teaching, we complete clinical assessments (DOPS, mini-CEX)
Action for next year	Ongoing monitoring

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	yes
Action from last year:	none
Comments:	All annual appraisal completed timely or deferred in special circumstances according to policy
Action for next year:	Continue good practice

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	yes
Action from last year:	n/a
Comments:	Updated information is circulated to managers re: deferred appraisals with reasons and deadlines
Action for next year:	Continue good practice

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	yes
Action from last year:	n/a
Comments:	The medical appraisal policy sits with the Bolton NHS trust, who conducts all our appraisals and it is agreed locally by the NHS Trust Board
Action for next year:	n/a

1B(iv) Our organisation has the necessary number of trained appraisers⁵ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	yes
Action from last year:	n/a
Comments:	No concerns about the Trust's ability of conducting appraisals timely by trained appraisers; this will continue to be monitored
Action for next year:	none

1B(v) Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	yes
Action from last year:	n/a
Comments:	No concerns about the Trust's ability of conducting appraisals timely by trained appraisers

⁵ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action for next year:	n/a
-----------------------	-----

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	yes
Action from last year:	n/a
Comments:	The quality assurance process is embedded into the Trust policies and procedures; each appraisee has the opportunity to feedback regarding the quality of appraisal
Action for next year:	n/a

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	yes
Action from last year:	n/a
Comments:	Local protocols in place at the NHS Trust

Action for next year:	n/a
-----------------------	-----

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	yes
Action from last year:	n/a
Comments:	Confirmation cascaded through to Medical Director and HR at the hospice
Action for next year:	n/a

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	yes
Action from last year:	n/a
Comments:	Governance systems in place at local level, policies and procedures in place

Action for next year:	Keep policies and procedures relevant and up to date
-----------------------	---

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	yes
Action from last year:	n/a
Comments:	1:1 meetings, activity reviews including case reviews, OP clinical activity/caseload reviews, locality MDT, CPD/study and professional leave and training opportunities, monitoring of clinical incidents via Vantage reporting systems, Freedom to Speak Up guardian, separate management and leadership appraisals
Action for next year:	Continue best practice

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	yes
Action from last year:	n/a

Comments:	Appraisal systems monitored and reviewed at Bolton Hospital NHS Foundation trust level, training given in the use of the appraisal tool
Action for next year:	Continue to monitor

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	yes
Action from last year:	n/a
Comments:	Policy local and at Trust level, disclosure form completed by line manager prior to appraisal
Action for next year:	Monitor performance according to existing policies and procedures

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	yes
Action from last year:	None
Comments:	Discussions at clinical governance meetings, reporting via Vantage systems, escalating concerns to line managers and HR as appropriate
Action for next year:	Monitor performance according to existing policies and procedures

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	yes
Action from last year:	n/a
Comments:	Reporting and sharing via managers/ Medical Director
Action for next year:	Monitor performance according to existing policies and procedures

--	--

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	yes
Action from last year:	n/a
Comments:	Local policies in place
Action for next year:	Monitor performance according to existing policies and procedures

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	yes
Action from last year:	n/a
Comments:	NCEPOD reviews and national guidance disseminated via clinical training and email
Action for next year:	Continue best practice

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Y/N	yes	
Action from last year:	n/a	
Comments:	professional standards reviewed as part of ongoing commitment to outstanding care, part of 1:1 and peer review	
Action for next year:	continue best practice	

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	yes
Action from last year:	n/a
Comments:	HR and interviews
Action for next year:	Continue best practice and adherence to policy

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	yes
Action from last year:	n/a
Comments:	Vantage reporting Clinical supervision, training, reflective practice
Action for next year:	Continue to monitor

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	yes
Action from last year:	n/a
Comments:	Hospice values EDI committee
Action for next year:	Monitor best practice

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	yes
Action from last year:	n/a
Comments:	Freedom to speak up guardian role extensively advertised, in induction booklets
Action for next year:	Monitor best practice

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	yes
Action from last year:	n/a
Comments:	Part of induction process, freedom to speak up guardian, exit interviews
Action for next year:	Monitor and address any concerns

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	yes
Action from last year:	n/a
Comments:	EDI group
Action for next year:	Continue to monitor

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	yes
Action from last year:	n/a
Comments:	Professional and study leave, Locality MDT, regional training
Action for next year:	Monitor performance according to existing policies and procedures

--	--

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	5
Total number of appraisals completed	3
Total number of appraisals approved missed	1
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	3
Total number of late recommendations	0
Total number of positive recommendations	3
Total number of deferrals made	0
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	0
Total number of trained case managers	0
Total number of concerns received by the Responsible Officer ⁶	0
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March (working days)	0
Median duration of concerns processes closed (working days) ⁷	0
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	1
Total number of new employment checks completed before commencement of employment	1

⁶ Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

⁷ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld ⁸	0

⁸ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
This will be the first report to the Board
Actions still outstanding
none
Current issues
One doctor has a deferred appraisal due to maternity leave
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
None at present, continue to monitor and adhere to the principles of best practice
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Bolton Hospice has a stable medical workforce, is fully staffed for full capacity (16 beds); the challenges for next 12 months are related to service development, especially in outpatients and education/training (external component).

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists))]

Official name of the designated body:	Bolton Hospice
---------------------------------------	----------------

Name:	Dr Leigh Vallance
Role:	CEO
Signed:	<i>Leigh Vallance</i>
Date:	07/08/2026

Name of the person completing this form:	Dr Aurelia McCANN
Email address:	Ellie.mccann@boltonhospice.org

Report Title:	Finance & Investment Committee AAA Chairs' Reports			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 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 report from the Chair of the Finance & Investment Committee provides an overview of matters discussed at the meeting held on 16 September 2026. 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 is asked to receive the Finance and Investment Committee Chair Report from the meeting held on the 16 September 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, Finance and Investment Committee Chair	Presented by:	Sean Harriss, Finance and Investment Committee Chair
---------------------	--	----------------------	--

ALERT | ADVISE | ASSURE (AAA)

Key Issues Highlight Report

Name of Committee:	Finance and Investment Committee	Reports to:	Board of Directors
Date of Meeting:	16 September 2026	Date of next meeting:	21 October 2026
Chair	Sean Harriss	Meeting Quoracy	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- | | |
|--|---|
| <ul style="list-style-type: none"> • Cost Improvement Programme • Sustainability Plan 2026-29 • Month 5 Finance Report • Revenue Provider Support • Digital Programme Update • Health Innovation Bolton Update | <ul style="list-style-type: none"> • CRIG Terms of Reference • Installation of New Electrical Substation 11 • Gas Contract Renewal • Main Entrance Update • Contract Award Recommendation for the GM Hip, Knee and Complex Arthroscopy contract. |
|--|---|

ALERT

<u>Agenda items</u>	<u>Action Required</u>
<u>Cost Improvement Programme</u> The Trust reported a planned PYE of £32.32m against a total target of £38m. Risk-adjusted savings, taking into account the governance rating of each individual scheme, were £26.08m, with 12% of schemes at Plans in Progress (amber), 40% at Fully Developed (green) and 44% now Delivered. Combined reported savings for M1 to M5 were £5.97m year to date, which was above plan. <u>Month 5 Finance Report</u> • The Trust had a cumulative accounts deficit at Month 5 of £13.7m favourable to plan by £37k. • The in-month deficit was £2.4m, favourable to plan by £5k. • The planned deficit for the year was £7m. Delivery of the annual plan required a surplus of £6.7m for the next seven months combined. • The underlying deficit at the end of 2025/26 was judged to be £25.4m. Income was £2.8m adverse to plan year-to-date. • Variable Activity Income was £5.1m below plan, although the contractual impact of this was £4.2m. • Capital spend to date was £3.5m, below plan by £9.3m. The capital plan for the year was £37m including £17.8m of RAAC. <u>Revenue Provider Support</u> The Committee supported an application for Provider Revenue Support to manage forecast cash requirements during November and December. The required amounts were £5.7m for November and £1.6m for December, though the Committee was advised that some elements could change before the submission date of 30 September 2026.	The full target had not yet been identified and work continued across several themes to address this.

ADVISE

Digital Programme Update

The Committee received an update on key digital priorities, including progress with the Maternity EPR programme with go live in quarter 3, implementation of a new Digital KPI Framework to strengthen performance oversight, the appointment of Rosie Connor as Associate Director of Digital to enhance delivery capacity, and early work to assess future Patient Administration System (PAS) options. Together, these developments support the Trust's digital strategy, strengthen governance and performance management, and maximise the value of digital investment to improve services for patients and staff.

Health Innovation Bolton Update

The Committee received an update on the Health Innovation Bolton Programme, including a timeline, next steps and an understanding of the upcoming milestones and expectations. The Committee asked for clarification around the alignment of this with the Trust Board and also the implications of the MOU.

ASSURE

Sustainability Plan 2026-29

The Committee was advised of the Trust's route to achieving underlying financial balance by 2028/29. It reflected a strategic shift from short-term financial recovery measures to a productivity-led transformation programme focused on improving operational performance, releasing capacity and maximising income.

The plan recognised that workforce controls alone will not deliver sustainable financial balance. Future improvement must also come from increasing productivity, improving flow, reducing unwarranted variation, optimising workforce deployment and improving income capture. The focus therefore moves from expenditure control towards redesigning pathways and improving what existing resources deliver. Delivery would be structured across three phases. The plan acknowledged the risks, with suggested mitigations including targeted external expertise during Q3 and a review of delivery capacity and capability to support large-scale change.

The Committee noted that the next stage of recovery represents a fundamental shift from workforce and expenditure controls towards productivity, pathway redesign and organisational transformation, and that future success will depend on improving how effectively existing resources are deployed, supported by robust governance, strong delivery capability and system-wide partnership working.

Capital and Revenue Investment Group (CRIG) Terms of Reference

The CRIG Terms of Reference had been updated to clarify the role of CRIG and its powers. The Committee approved the revised CRIG Terms of Reference.

Installation of a New Electrical Substation (Substation No 11)

The Committee approved the utilisation of the GM Fund allocation to deliver Substation 11, a new on-site electrical substation required to address future capacity and resilience requirements and enable the Trust's planned estate and clinical developments.

Gas Contract Renewal

The Committee was advised that IFM Bolton's existing gas supply arrangements required renewal from 01 April 2027. Following a review of the available procurement routes with the Government Commercial Agency and benchmarking of the Trust's gas portfolio, the Committee approved IFM Bolton entering the GCA Gas Basket from 01 April 2027 and the NHS England Energy Basket from 1 April 2029.

Main Entrance Update

The Committee discussed the final contractual arrangements for the Main Entrance scheme and approved the proposal in principle, noting that any CDEL investment would be further discussed following approval of the capital pipeline and agreed at a later date.

Contract Award Recommendation for the GM Hip, Knee and Complex Arthroscopy contract

The Committee approved the award of a four-year Greater Manchester collaborative contract for the supply of hip, knee and complex arthroscopy products across the Bolton Group. The contract will be awarded through the NHS Supply Chain Total Orthopaedic Solutions 3 Framework, subject to completion of the relevant procurement and governance requirements.

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	Committee Chair	✓	✓	✓	✓	✓	✓	✓	✓		
Andy Chilton	Operational Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓		
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	✓	A		
Ian Williamson	NED	✓	A	✓	A	✓	A	✓	A		
✓ = In attendance A = Apologies											

Report Title:	Audit and Risk Committee Chair's Report			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 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 on 9 September 2026.
-----------------------	---

Previously considered by:	The matters included in the Chair's reports were discussed and agreed at the Audit and Risk Committee held in September.
---------------------------	--

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 09 September 2026. It outlines the Committee's oversight activities and deliberations across a range of financial, governance, assurance, and risk-related areas. This report forms part of the committee's formal assurance framework and supports the Board in discharging its responsibilities for effective governance and oversight.
-------------------	---

Proposed Resolution	The Board of Directors is asked to receive the Audit and Risk Committee Chair's Report.
---------------------	--

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

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

Prepared by:	Sean Harriss, Non-Executive Director	Presented by:	Sean Harriss, 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:	09 September 2026	Date of next meeting:	02 December 2026
Chair	Sean Harriss, Non-Executive Director	Meeting Quoracy	Yes
AGENDA ITEMS DISCUSSED AT THE MEETING			
- External Auditor’s Annual Report 2025/26 - Internal Audit Update - Counter Fraud Progress Report - Losses and Special Payments Report		- Waivers Report - Risk Management Framework - Senior Information Risk Owner (SIRO) Report	
ALERT			
Agenda items		Action Required	
There were no matters to be escalated to the Board of Directors.			
ADVISE			
Internal Audit Update - The Committee received the Internal Audit progress report and four final audit reports. Three reviews received Moderate Assurance: Data Quality, Outpatient Outcomes; Cyber Assessment Framework aligned to the Data Security and Protection Toolkit; and Sickness Absence Management. Committee Effectiveness received Substantial Assurance. Members agreed that the final Data Quality, Outpatient Outcomes and Sickness Absence Management reports would be shared with the relevant committees. The Committee also noted progress against previous audit recommendations and agreed that recommendations relating to Cancer Follow-Up Quality Spot Checks would be raised at the Quality Assurance Committee. Waivers Report - The Committee received the Group Waivers Report for April to August 2026/27 and noted the level and value of waivers, including retrospective waivers. The Committee considered the risks associated with non-competitive spend and received assurance that recurring requirements had been incorporated into the 2026/27 procurement work plan, with strengthened oversight intended to reduce future reliance on waivers.			
ASSURE			
Counter Fraud Progress Report - The Committee received the Counter Fraud Progress Report covering activity undertaken between May and August 2026. The report provided assurance on the Trust’s continued compliance with counter fraud standards, including an overall Green rating for the 2025/26 Counter Fraud Functional Standard Return. Updates were also received on prevention activity, awareness sessions, fraud alerts and investigation progress. The Committee was assured that work continued to strengthen fraud prevention arrangements. Losses and Special Payments Report - The Committee received the Losses and Special Payments Report for the period 01 April to 31 July 2026. The Committee noted that iFM Bolton reported no losses or special payments during the period.			

- **Risk Management Framework** - The Committee received the draft Risk Management Framework which set out the Trust's approach to risk management, including the introduction of Level 1 principal risks and Level 2 risk categories, and the development of risk appetite statements to support consistent risk assessment and management. The Committee noted that work continued to socialise the framework with operational teams and align the Risk Management Policy and risk management system accordingly.
- **Senior Information Risk Owner (SIRO) Report** - The Committee received the SIRO Annual Report, which provided assurance on Information Governance and cyber security arrangements for 2025/26, including continued alignment with the DSPT and NHS England's CAF. The Committee noted that an improvement plan had been accepted and was being implemented to address areas requiring further development across information governance and cyber resilience. Information Governance training compliance met the 95% target and reported incidents reduced during the year. The Committee was assured that incidents were reviewed, managed and reported in accordance with relevant requirements.
- **Risk Management Group Chair's Reports** - The Committee received the Chair's Reports from the Risk Management Group meetings held on 14 July and 11 August 2026. No matters were escalated for alert. The Committee received assurance that key operational risks relating to waiting-list management, follow-up capacity and clinical correspondence were subject to active oversight, with mitigating actions in place. Assurance was also received in relation to the Trust's Fraud Risk Strategy and compliance with national fraud prevention requirements.

New Risks identified at the meeting: None

Review of the Risk Register: N/A

Meeting Attendance						
Members		Feb	May	June	Sept	Dec
Tony Allen	Committee Chair	✓	✓	A	A	
Alan Stuttard	NED					
Sean Harriss	NED	✓	A	✓	✓	
Fiona Taylor	NED	✓	✓	✓	A	
In Attendance		Feb	May	June	Sept	Dec
Tiri Mutambasere	Associate NED	✓	✓	✓	✓	
Gita Bhutani	Associate NED				✓	
Annette Walker	Chief Finance Officer	✓	✓	✓		
Sharon Katema	Director of Corporate Governance	✓	✓	✓		
✓ = In attendance A = Apologies NA = no longer a member						

Report Title:	Trust Winter Plan 2026/27			
Meeting:	Board of Directors	Action Required	Assurance	✓
Date:	24 September 2026		Discussion	✓
Executive Sponsor	Chief Operating Officer		Decision	✓

Purpose of the report	The report sets out the key actions and approach that the Trust will be taking to manage winter demand for 2026/27, whilst maintaining patient experience, clinical quality and operational performance.
------------------------------	--

Previously considered by:	The report is scheduled for discussion at the Quality Assurance Committee and has been reviewed at the Performance and Transformation Group (September 2026)
----------------------------------	--

Executive Summary	This paper sets out Bolton NHS Foundation Trust's Winter Plan for 2026/27 and describes the actions being taken to maintain safe, high-quality care, patient experience and operational resilience during the winter period. The plan has been developed through early divisional and corporate partner planning, informed by learning from last winter and aligned to the Trust's three Operational Improvement Plans. It is structured around five key priorities: 1. Safe urgent care, 2. Improved patient flow, 3. Infection prevention, 4. Workforce and wellbeing, 5. System working. Divisional plans identify practical schemes to support alternatives to admission, reduce length of stay, improve discharge flow, strengthen infection prevention arrangements and maintain visible operational leadership. Additional inpatient ward capacity may be opened if required, with Wards A4 and B2 identified as potential capacity within the Trust's current run-rate position; any further escalation, including potential use of F6, would require data-led review and Executive Triumvirate approval.
--------------------------	--

	The plan also includes a coordinated communications and engagement approach, a comprehensive colleague wellbeing and vaccination offer, and clear governance arrangements for monitoring, escalation and Board assurance. At present, no additional financial implications are anticipated, and delivery will be overseen through established operational and executive governance routes.
--	--

Proposed Resolution	The Board of Directors are asked to receive and approve the Winter Plan and in particular approve the <i>Board assurance statement</i> prior to submission by 30 September 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	No	Plans are based on delivery through existing budgets, with escalation decisions to be managed through established governance.
Legal/ Regulatory	No	No specific legal or regulatory implication identified within the source documents.
Health Inequalities	No	The plan includes a One Bolton communications approach, targeted winter health advice and promotion of access to appropriate services.
Equality, Diversity and Inclusion	No	No specific EDI impact has been identified in the source documents; continued engagement and communication will support inclusive access to winter messages.
Is a Quality Impact Assessment Required	Yes	

Prepared by:	Michelle Cox, Director of Operations	Presented by:	Rae Wheatcroft, Chief Operating Officer
---------------------	--------------------------------------	----------------------	---

Glossary

Acronym	Definition
UEC	Urgent and Emergency Care
LoS	Length of Stay
SDEC	Same Day Emergency Care
IPC	Infection Prevention Control
IFM	Integrated Facilities Management
UCR	Urgent Community Response
ITOCH	Integrated Transfer of Care Hub
DOD	Director of the Day
SMOD	Senior Manager of the Day
NWAS	North West Ambulance Service
OPAT	Outpatient Parenteral Antimicrobial Therapy
IV	Intravenous
RSV	Respiratory Syncytial Virus
NHS	National Health Service
COVID-19	Coronavirus disease 2019
GM	Greater Manchester
NHSE	NHS England
PR	Public Relations
TV	Television

Bolton NHS Foundation Trust Winter Plan 2026/27

1. Introduction

This paper describes the key actions and approach Bolton NHS Foundation Trust is taking to manage winter demand during 2026/27, whilst maintaining patient experience, meeting clinical quality indicators and sustaining performance through the winter period.

Winter planning has been developed with an emphasis on early preparation, consistent decision-making and visible operational support. Planning recognises that winter pressures are predictable and include increased urgent care attendances and admissions, respiratory illness, capacity constraints and workforce pressure.

Why planning for winter matters

- Demand increases through more urgent care attendances and admissions.
- Flu, COVID-19, norovirus and other infections increase pressure on services.
- High occupancy and delayed flow reduce flexibility.
- Sickness, fatigue and vacancies require visible workforce support.

2. Winter priorities and visible changes

Five priorities guide winter decision-making:

1. Safe urgent care
2. Improving patient flow
3. Infection prevention
4. Workforce and wellbeing
5. System working.

These priorities are intended to support the right patient, in the right place, at the right time, reduce delays and length of stay, minimise the impact of winter illness, support colleagues through pressure and maintain a One Bolton response with partners.

Colleagues should experience six visible changes through winter:

1. Visible senior presence and operational support during busy periods.
2. Planned and consistent messages about what is happening and why.

3. Clearer understanding of Director of the Day (DOD) / Senior Manager of the Day (SMOD,) on-call and operations roles in escalation.
4. Reduced duplication, delay and waste where this supports care.
5. Earlier intervention to support flow, safety and colleagues.
6. Use of colleague feedback and ideas to improve practical delivery.

3. Actions every colleague can take

The staff-facing message is deliberately simple and practical. Every colleague can contribute by getting their flu vaccination, washing hands at the right moments, and speaking up to raise concerns or share ideas that improve flow, safety and care. Communication plans have been pre agreed for staff and service users to ensure consistent and timely messaging is available throughout winter. Key pre winter engagement has been agreed and winter plans will be shared and explained at:

- October's All Staff Briefing
- Trust Management Committee – September 2026

4. Planning approach and governance

The winter plan continues to be overseen through established operational governance, including review through Performance and Transformation Group and Quality Assurance Group before Trust Board consideration.

Operational monitoring and escalation will be via the four daily site meetings, operational improvement group meetings and monthly performance and transformation group with emerging issues escalated through the Director of Operations as required.

5. Review of previous winter

The creation of this year's winter plan builds on learning from previous winter planning, including the importance of cross-divisional planning, system partner involvement, bed occupancy as a driver of emergency department waits, and the need for flexible escalation options. Previous winter learning also highlighted the value of early capacity planning and collaborative delivery across clinical, operational, estates, digital, business intelligence and support teams. Key Takeaway Messages from Winter Feedback Session

- ✓ **Strong foundations to build on:** Effective command structures, sustained elective activity, STU, POCT in Paediatrics and pharmacy initiatives all supported winter performance.

- ✓ **Simplify and prioritise:** Too many concurrent initiatives reduced impact; focus on a small number of high-value priorities with clear ownership and accountability.
- ✓ **Discharge and flow remain the biggest challenge:** Therapy capacity, failed discharges, NCTR processes and community flow constraints all contributed to longer lengths of stay.
- ✓ **Stronger escalation and IPC planning needed:** Clear triggers, OPEL dashboards, risk management processes and IPC escalation plans should underpin winter response arrangements
- ✓ **Earlier preparation and communication are critical:** Deliver winter training, staff briefings, wellbeing support and pre-planned communications before winter pressures begin.

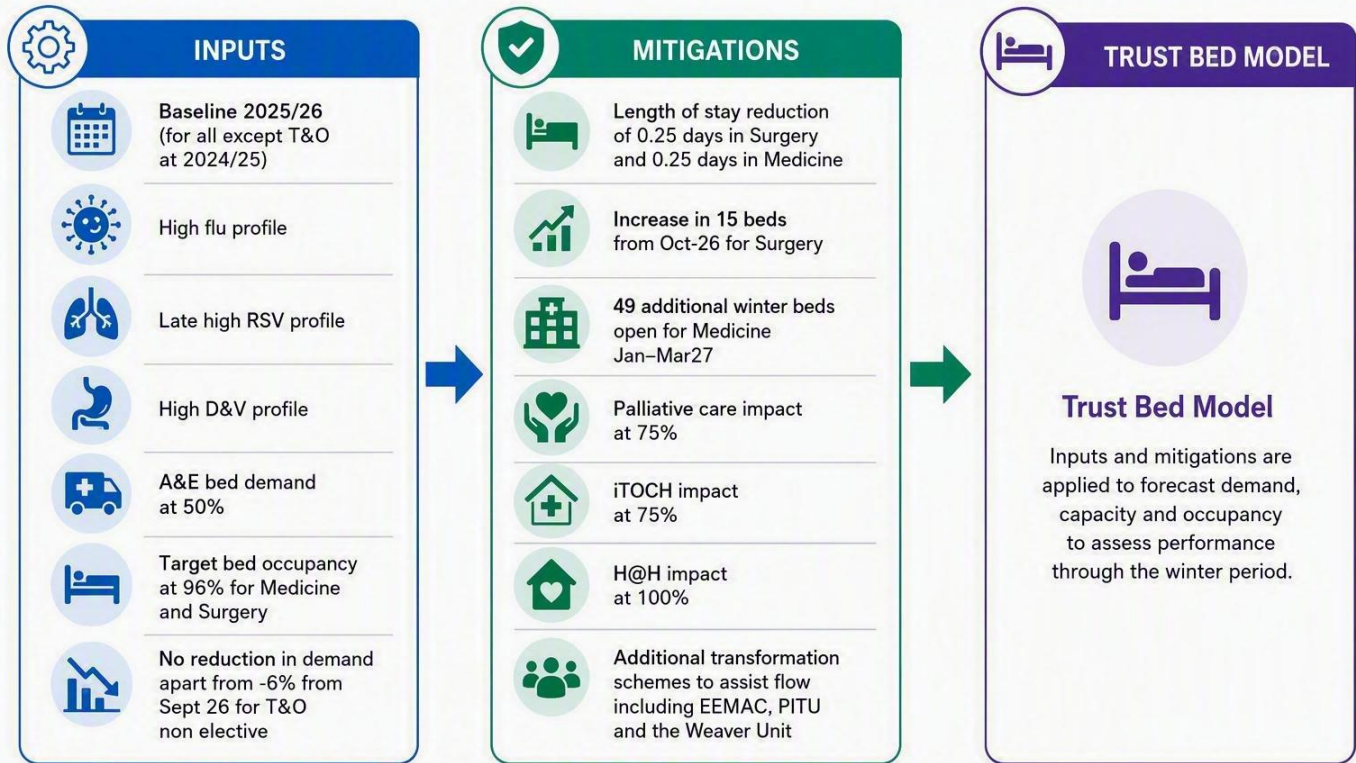
6. Winter bed modelling and intelligence

The bed model uses 2025/26 activity and performance data as its baseline, with divisional assumptions relating to demand, capacity, flow and performance manually applied to model potential scenarios for 2026/27. Two winter scenarios have been modelled: a “Bad Winter” scenario, reflecting increased orthopaedic attendances and admissions similar to those experienced during winter 2024/25, and a “Mild Winter” scenario, reflecting orthopaedic demand more consistent with winter 2025/26. Current long-range forecasting indicates a strong El Niño effect during winter 2026/27, which is associated with an increased likelihood of wetter, stormier conditions across the UK and North West Europe during autumn and early winter, although the precise impact on local healthcare demand remains uncertain. [\[metoffice.gov.uk\]](https://www.metoffice.gov.uk)

It is important to recognise that this is a planning tool designed to test assumptions and support operational decision-making, rather than a definitive forecast of future bed requirements, and should therefore be interpreted and used accordingly.

The diagram below summarises the key assumptions, demand drivers and mitigating actions incorporated within the Trust's winter bed model, demonstrating how baseline activity, anticipated winter pressures and planned operational interventions have been applied to assess bed demand, capacity and occupancy requirements throughout the winter period.

Middle Case: Option A - bad winter



Key Findings

- The most significant change between the two models is the available bed base. Across the year, the 2026/27 model assumes between 17 and 80 fewer beds compared with the 2025/26 model. The largest variance occurs in December, where the modelled bed base is 433 beds compared to 513 beds in 2025/26, a reduction of approximately 80 beds.
- This reduction is largely attributable to wards being unavailable within the model assumptions, including B2, B4, AMU1, AAU2, N3 and
- The modelled operational gaps at their peak are:
 - Bad Orthopaedic Winter scenario:** additional 81 beds required in January.

- **Mild Orthopaedic Winter scenario:** additional 55 **beds** required in January
- Given the scale of the bed base reduction, these figures suggest that the mitigations and service assumptions incorporated into the model are making a significant contribution to reducing bed demand.

Winter Pressure Outlook

- Under the **Bad Winter** scenario, the model shows bed pressures increasing significantly through autumn and peaking in winter, with additional beds required rising from **40 in December** to **81 in January** and **79 in February**.
- Under the **Mild Winter** scenario, pressures are lower but still material, requiring an additional **31 beds in December**, **55 in January**, and **42 in February**.

Overall Conclusion

The comparison demonstrates that the 2026/27 model is operating with a substantially smaller bed base than the equivalent 2025/26 model, particularly during the winter period. While this explains much of the increase in modelled bed demand, the mitigations embedded within divisional plans appear to offset a significant proportion of this pressure. Nevertheless, the Acute Medicine position remains a key area of risk, with a requirement for additional capacity even after mitigation assumptions have been applied. The model should therefore be viewed as a tool for understanding risk and testing operational assumptions rather than a definitive forecast of future bed occupancy.

Summary of bed modeling outputs

Bolton NHS Foundation Trust
Bed Model Comparison: 2025/2026 & 2026/2027
Model Outputs

			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/2027	Option A: Bad Winter	Bed Base (Model)	515	491	477	455	442	419	436	436	433	487	479	484
		Expected Beds Required (at Target Occupancy)	513	501	493	480	507	485	484	467	473	568	558	552
		Increase (+) / Decrease (-) Beds Required	-2	10	16	25	65	66	48	31	40	81	79	68
2026/2027	Option B: Mild Winter	Bed Base (Model)	515	491	477	455	442	419	436	436	433	487	479	484
		Expected Beds Required (at Target Occupancy)	533	504	480	469	488	475	467	457	464	542	521	531
		Increase (+) / Decrease (-) Beds Required	18	13	2	14	46	56	31	21	31	55	42	46
2025/2026	Middle Case	Bed Base (Model)	532	532	498	498	498	490	490	490	513	513	513	513
		Expected Beds Required (at Target Occupancy)	498	494	502	497	498	477	486	487	524	534	531	523
		Increase (+) / Decrease (-) Beds Required	-34	-38	4	-1	0	-13	-4	-3	11	21	18	10
Bed Base Comparison: 2026/2027 Model vs. 2025/2026 Model			-17	-41	-21	-43	-56	-71	-54	-54	-80	-26	-34	-29

Negative indicates fewer Beds in 2026/2027 vs. 2025/2026. Positive indicates a higher number of Beds.

Actual Beds Required

2025/2026	Middle Case	Actual Beds Required (Utilised)	530	498	475	470	484	477	482	494	496	536	527	523
		+/- Difference Actual Required vs. Bed Base (Model)	-2	-34	-23	-28	-14	-5	0	4	-17	23	14	10
		+/- Difference Actual Required vs. Expected Beds	32	4	-27	-27	-14	-1	-4	7	-28	2	-4	0
2026/2027	Middle Case	Actual Beds Required (Utilised)	501	493	488	473								
		+/- Difference Actual Required vs. Bed Base (Model)	-15	2	11	18								
		+/- Difference Actual Required vs. Expected Beds (Option A)	-13	-7	-5	-7								
		+/- Difference Actual Required vs. Expected Beds (Option B)	-33	-10	9	4								

Data includes Acute Medicine, Surgery, Gynaecology and All Trauma & Orthopaedic (Elective, Semi and Non-elective).

Recommended Planning Assumption

Whilst both scenarios provide a useful range within which winter demand may sit, it is recommended that the Trust adopts the Middle Case model as the primary planning assumption for Winter 2026/27. This approach provides a balanced and credible assessment of likely demand, recognising the uncertainty associated with both winter severity and the impact of planned mitigations. The Middle Case reflects the significant reductions in available bed capacity compared with 2025/26, whilst also recognising the anticipated benefits of improvement initiatives such as length of stay reduction, additional winter capacity, Hospital at Home, iTOCH and other flow schemes. Planning against the Middle Case will enable the Trust to develop realistic operational and contingency plans, while maintaining visibility of the risks presented by the higher-demand scenario. The Bad Winter scenario should continue to be used as a stress-test and trigger framework for escalation arrangements, ensuring that additional actions can be mobilised rapidly should demand trends begin to track towards the upper range of modelled activity.

7. Divisional capacity planning

Divisional plans set out practical schemes to support alternatives to admission, discharge flow, reduced length of stay, infection prevention, workforce resilience and operational support services over the winter period. The plans include a mixture of schemes already in progress and schemes with implementation milestones ahead of or during winter 2026/27. The aspiration is to build on long-term improvement plans as set out in the Trust's three Operational

Improvement Plans, to deliver incremental and sustainable improvement as opposed to focusing solely on increasing capacity in winter to meet demand.

A winter plan has been created for each division and selected corporate partners, building on feedback from last year and the improvement initiatives already established through the Trust's three Operational Improvement Plans. These plans have been reviewed monthly at organisational level since April, enabling a coordinated approach to planning, refinement and assurance ahead of winter. The following section provides a summary of the key winter initiatives identified by each division and corporate partner.

7.1 Community Services

Scheme / focus area	Action, impact or current position
Call before you convey	Move to a seven-day business-as-usual model with NWAS, supported by an assigned paramedic and a target of six deflections per day.
Bardoc overnight pathway	Extend overnight case-holding for over-65s in their own home, with expected two to three referrals per night.
OPAT / IV and Hospital at Home	Expand OPAT / IV capacity and establish Hospital at Home capacity to 58 beds, sustaining occupancy above 80%.
Urgent Community Response	Optimise 2-hour UCR in line with operational planning standards, supported by pathway development and promotion.
Palliative and discharge flow	Establish specialist palliative care rapid response / Hospital at Home model and implement the full ITOCH model with triage and tracking.
Children and young people	Promote flu / RSV vaccination, develop a resilient paediatric respiratory offer and increase utilisation of ICPS pathways.
Staff wellbeing and winter offer	Maintain divisional leadership visibility, weekly communication routes and a CSD winter offer communication package.

7.2 Families and Diagnostics

Scheme / focus area	Action, impact or current position
---------------------	------------------------------------

Diagnostics and POCT	Use POCT on E5 from October 2026 to enhance isolation protocols and reduce waiting times for RSV and flu results.
Discharge support	Enhance the discharge lounge pharmacy trial from November to February and establish an outpatient discharge pathway for inpatients requiring scans.
Paediatric capacity	Open additional capacity on E5 as required and step down paediatric electives for four weeks in November 2026.
Imaging support	Provide additional inpatient imaging porter capacity between 09:00 and 17:00 from November to February.
Vaccination and workforce	Service-level flu / COVID vaccination rollout plans and maternity vaccination programme from September 2026.
Leadership and escalation	Use weekly DLT oversight of the winter plan and strengthen winter training and communication between divisions.

7.3 Medicine

Scheme / focus area	Action, impact or current position
Majors, ED and IPC	Roles guidance, EEMAC rollout and Majors IPC planning. Corridor controls complete; SOPs and OPEL escalation cards embedded.
AAU and workforce	AAU pull model agreed; PITU and bed-priority reset remain enablers. Recruitment for 3 WTE consultants is underway, supported by locums.
LOS and discharge	Weekly LOS oversight established; criteria-led discharge underway. KPIs: NEL LOS 3.5 days; discharge by 12 - 40%; by 4 - 60%; admitted - 50%.
Flow and community	Planned Investigation TU ready pending EEMAC and nursing release; Frailty/Elderly Medicine H@H SOP and ward challenge process underway.

Site management and BI	Revised site staffing, H@N/GM reporting and Minerva dashboard refresh.
Escalation capacity	Escalation-ward staffing under CNO discussion; ward-in-a-cage capability in development.

7.4 Surgery

Scheme / focus area	Action, impact or current position
Length of stay and escalation	Implement standardised escalation processes, ward flow management and monthly reliability checks to reduce average surgical length of stay.
Surgical Triage Unit Phase 2	Develop a full business case for virtual clinics and a daily surgical hot clinic within a seven-day SDEC model.
Surgical urgent care pathways	Review and reconfigure the surgical bed base to support urgent care pathways, with a focus on orthopaedics.
Elective protection	Identify a ring-fenced cold elective ward and expand day case working to support reduced bed reliance.
Trauma and orthopaedics	Review the T&O medical model and undertake focused work on OOA / NCR orthopaedic trauma patients.
Staff wellbeing and communication	Increase divisional visibility, strengthen SLT communication and support flu rollout through focused communications.

7.5 Infection Prevention and Control

Scheme / focus area	Action, impact or current position
Training and support	Provide additional training and support for site managers to strengthen decision-making during winter incidents.

SBAR and outbreak assurance	Redesign IPC SBARs with the flow team and duty managers, and embed daily assurance checklists for ward outbreaks.
ED and isolation support	Support business cases for more isolation spaces in ED Majors and air scrubbers in the ED trolley handover area.
Flow mapping	Undertake flow mapping in ED with the ED matron to understand and improve infection-related flow risks.
Enteric PCR	Support business case development for enteric PCR to improve outbreak identification and management.

7.6 IFM

Scheme / focus area	Action, impact or current position
Portering	Place porters in key areas to support patient movement and support rollout of the new porter system.
Domestic services	Review staffing after 16:00 to support faster turnaround of deep cleans, including consideration of fogging / UVC with IPC.
Ward opening and closing	Ensure staff availability and equipment preparedness for ward opening and closing.
Visible leadership	Protect SLT time; avoid meetings before 10:00 from November to January and ensure SLT presence at bed meetings.
Estates, heating and gritting	PAT test radiators, maintain trade staff on-call for snow events and ensure gritting rotas and stock are in place.

7.7 Communications, Charity and Wellbeing

Scheme / focus area	Action, impact or current position
---------------------	------------------------------------

Staff communications	Communicate rest facilities, occupational health and wellbeing offer, flu vaccination offer and winter operational updates.
Recognition	Promote good news and developments through all key channels.
Partner support	Share content about accessing services and alternative services through system and community channels.
Media and spokespeople	Agree spokespeople, prepare responses to typical winter scenarios and develop proactive PR for initiatives.
Charity support	Enhance staff and patient wellbeing over winter through increased provision of white goods, targeted wellbeing initiatives, and a patient-focused donation campaign.
Flu offer	Support an expanded flu offer that covers twilights through October, with vaccinations available from 07:30 to 02:00.

8. Communications and engagement plan

The communications approach is a single Bolton winter communication and engagement plan covering winter health advice, access to services and emergency preparedness. It includes messages on staying warm, managing chronic conditions, flu prevention, how and when to use NHS 111, pharmacies and urgent care, and how to access urgent care during extreme weather or high patient demand.

Partnership working will amplify reach through alignment with NHS GM and NHSE campaign assets, translation into top languages, tailoring for Bolton, a locality communications cell and broader access to audiences through digital, broadcast, traditional and community channels.

Key messages have been prewritten and fall into the themes below:

- **Patient safety remains our top priority** during periods of sustained winter pressure, with services prioritised according to clinical need.
- **People should use NHS services appropriately**, including NHS 111, pharmacies, GP services and urgent care options where suitable, so emergency services can focus on those most in need.
- **Longer waits may occur in urgent and emergency care**, but patients will continue to be assessed and treated based on clinical urgency, with the sickest patients seen first.

- **Some services, appointments or procedures may be disrupted** due to operational pressures, outbreaks, industrial action or estates issues; affected patients will be contacted directly.
- **Infection prevention and safe visiting remain important**, and anyone who is unwell or has symptoms of an infectious illness should avoid visiting until symptom-free.
- **The Trust is working closely with system partners** to maintain services, minimise disruption, support staff, and keep patients, visitors and colleagues safe throughout winter.

9. Colleague wellbeing and vaccination

The Trust's Winter 2026 Wellbeing Offer provides a comprehensive package of support designed to help colleagues remain healthy, resilient and supported throughout the winter period. Staff have access to 24/7 wellbeing and counselling support through Vivup, including mental health, physical health and financial wellbeing resources, self-help guides, menopause support and manager assistance. The offer is complemented by a wide range of internal services including Occupational Health, physiotherapy, the on-site gym, cycle-to-work schemes, wellbeing walks, fatigue-rest facilities and health promotion activities. Mental wellbeing support includes the ShinyMind app, Headspace, GM Resilience Hub, Schwartz Rounds, the Keeping Everyone Safe and Supported (KESS) programme, suicide prevention resources and wellbeing campaigns. Additional support is available through financial advice services, staff discounts, chaplaincy services, meditation sessions, choir activities, menopause awareness and coaching sessions, and dedicated support for staff involved in incidents.

To protect both staff and patients during the winter period, the Trust's annual flu vaccination programme will launch from 1 October 2026, using a flexible roving model and targeted clinics to make vaccination easily accessible across all sites, departments and shift patterns, helping maximise uptake and workforce resilience throughout the winter months

10. Winter Ward capacity

To support operational resilience during the winter period, the Trust is planning to open additional inpatient ward capacity, subject to ongoing demand and capacity modelling. The current proposal is to utilise Wards A4 and B2 (for Medical Patients) for up to three months each, likely from the Christmas and New Year period through to March. This provides a total of six months of additional ward capacity and is accommodated within the Trust's existing baseline budget position, with no associated cost pressure currently anticipated. In addition, the use of F6, ranging from half a ward to a full ward, will be used for further surgical escalation. Following the F6 QEIA review and the output of the bed model, the Surgery Division plan to reintroduce flexible surgical capacity within the former F6 estate from November 2026 to strengthen winter resilience, address bed capacity and flow risks, and retain the majority of planned CIP savings. Ahead of opening additional Medicine ward capacity, operational data will be reviewed through

the four-times-daily bed meetings to assess demand, flow, occupancy, staffing and escalation status. If the Trust experiences a sustained period of OPEL 4 and there is no clear plan to de-escalate, a conversation should be initiated with the Chief Operating Officer, Chief Nursing & Quality officer and the Medical Director to consider whether additional capacity should be opened in line with the winter plan. Any decision to open extra wards, including the wards identified within this plan, must be supported by the available data and formally signed off by the Executive Triumvirate. Divisional Nursing Directors are working collaboratively to develop and implement a safe staffing model to support any additional ward capacity that is required over the winter period, ensuring services can be expanded safely while maintaining the quality of patient care.

11. Financial implications

At present, no additional financial implications are expected during the winter period. The additional winter ward capacity described within this plan, providing up to six months of capacity across Wards A4 and B2, is already reflected within the Trust's existing budget baseline position.

Following completion of the QEIA review associated with the closure of Ward F6, it has become evident that the revised bed model does not provide sufficient capacity or flexibility to consistently meet demand. Key challenges include limitations in managing mixed-sex accommodation requirements, insufficient non-elective capacity, an increase in elective procedure cancellations, and prolonged patient stays within the Surgical Triage Unit beyond the intended 23-hour model. Through the QEIA review process, and in preparation for winter pressures, the Surgery Division has worked with key stakeholders to develop a revised bed model. This will be implemented ahead of winter and will utilise the former F6 estate to provide additional capacity and operational resilience. The model has been designed to minimise workforce growth, enabling the Division to retain the majority of the planned F6 cost improvement programme savings while addressing the clinical and operational risks identified following implementation of the original model. This flexible surgical capacity will be live from November 2026, following the move of intermediate care into the weaver unit.

12. Governance

The Urgent Care Transformation Board will oversee and monitor progress against the winter plans which will be a standard agenda item. The Urgent Care Programme Manager will monitor the winter plan and will escalate issues through to the Director of Operations. The winter plan will be submitted to the Trust Board in September 2026 for approval following review at Performance and Transformation group and Quality Assurance Committee.

Bolton system's winter plan will also be tested through Exercise Aegis in September 2026, which aims to:

- Test winter response plans against three demand scenarios for a base case, moderate and extreme winter surge.
- Ensure that individual organisations have tested internal arrangements to respond to increasing levels of pressure from winter virus outbreaks, with effective measures to maintain patient safety and minimise risk.
- Assess system leadership arrangements. Ensure that organisations will collaborate under pressure, with a shared understanding of the relative risk and impact of individual actions on partners.
- Use lessons learned during the exercise to finalise and sign off winter plans through Board assurance.

In addition, a winter planning 26/27 board assurance statement (BAS) requires Board approval by Board ahead of submission to NHS England at the end of September 2026 (see appendix A for completed submission for Board approval.)

13. Recommendations

The Board is asked to:

- Note and agree the key actions within the proposed Winter Plan 2026/27.
- Note the monitoring and escalation process for delivery through winter.
- Support continued divisional and system partner delivery against the winter priorities.
- Review and approve appendix 1 'Board assurance statement' for approval of submission

Appendix A - Board assessment templates – completed document for national return 30/09/26

[BAS Self Assessment Template 20260703 V1.11 TRUST Bolton final submission](#)

Appendix B – QEIA

[2026-2027 Winter Plan QEIA](#)

Winter Planning 26/27

Board Assurance Statement

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust is off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please include the Trust / Provider name at the top of the tab.

This section gives Trust the opportunity to describe the approach to have been considered.

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is c

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September**

(BAS)

Just Boards has oversight that all key considerations have been met. It should

s)

o creating the winter plan, and demonstrate how links with other aspects c

covered in their 2026/27 Winter Plans.

mber 2026.





uld be signed

of planning



Winter Planning 26/27

Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):
If Other, write Provider/Trust Name:

Contact details (email, phone number):
Date:

Bolton Foundation Trust

Michelle Cox (Director of Operations) michelle.cox@boltonft.nhs.uk

25/08/2026

Please complete these sections					
Assurance statement			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes	The Trust Winter Plan 2026/27 has been developed through a structured planning programme involving all clinical divisions and corporate functions. All winter schemes and service changes are subject to the Trust's established governance processes for assessing quality, safety and equality impacts. The winter planning process includes review of service risks, patient safety considerations, workforce implications and quality impacts. The Trust's Winter Plan has been developed collaboratively with internal divisions and system partners, including community services, urgent care partners and the Integrated Care Board. The planning process has incorporated schemes focused on admission avoidance, discharge improvement, community alternative to admission and neighbourhood and scenario exercises. Structured scenario planning has been undertaken as part of the winter planning programme, including testing of moderate, severe and extreme pressure scenarios. Learning from previous winters and the Chief Operating Officer is the Executive Sponsor for the Trust Winter Plan and has overall accountability for winter preparedness, operational delivery, escalation arrangements and assurance. The planning process is supported through executive oversight and divisional leadership.	N/A
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes		N/A
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes		N/A
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes		N/A
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes		N/A
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes	The Trust has established governance and escalation arrangements to support operational delivery throughout winter. These include a structured winter planning programme, executive oversight, divisional accountability, agreed escalation processes, operational leadership rotas, OPEI monitoring	N/A

Winter Planning 26/27

Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Section B: 26/27 Winter Plan checklist			Please complete these sections		
			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: - the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; - that both walk-in and bookable appointments are available; - that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and - the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	A comprehensive staff vaccination programme will commence from 1 October, supported by an expanded delivery model that includes a roving vaccination service operating from 07:30 to 02:00 (to include out of hours access), alongside continued access through fixed vaccination clinics. Robust arrangements are in place to ensure timely recording and assurance, with all flu vaccinations uploaded daily to both RAVS and ESR. Staff vaccination activity is maintained throughout the year; delivery is being focused in October to maximise uptake at the earliest opportunity and build on the Trust’s strong vaccination performance across Greater Manchester.	N/A
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	The Board is assured that comprehensive plans are in place to support frontline staff vaccination, respiratory virus prevention, and workforce health and wellbeing throughout the winter period. A targeted vaccination programme, including an extended roving vaccination service and fixed-site provision, has been established to maximise staff uptake and protection. Vaccination activity is supported by robust monitoring arrangements, with uptake recorded and reviewed routinely, alongside wider infection prevention and respiratory virus mitigation measures to protect patients, staff and service continuity.	N/A
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	Yes. Plans are in place to offer seasonal flu and COVID-19 vaccinations to eligible long-stay inpatients (21 days and above) and to inpatients being discharged to care homes. Clinical teams assess each patient’s suitability for vaccination as part of routine care planning, and vaccinations are prescribed and administered according to individual clinical requirements through a Patient Specific Direction (PSD). These arrangements support timely access to vaccination for vulnerable patients and help reduce the risk of respiratory illness and associated complications.	N/A
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	The Trust is working with system partners to use population health intelligence, risk stratification and shared data to proactively identify vulnerable residents and rising-risk cohorts, enabling earlier intervention before needs escalate. This approach is embedded within neighbourhood working, proactive MDT development, admission avoidance schemes and winter planning arrangements, ensuring targeted support for those most at risk during periods of increased demand and winter pressure.	N/A
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	Yes. A full review of the community bed base has been completed, with reconfiguration expected to be complete by the end of September 2026. A full review of performance against the national standards has been undertaken and further improvement initiatives have been agreed to address known challenges, in collaboration with Bolton Council and the ICB.	N/A

	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: • Coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. • Executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. • Targeted operational actions to reduce long discharge delays. • Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes	Yes. The Board can be assured that model discharge pathway arrangements are in place to support seven-day discharge and patient flow across acute, community and social care services. Escalation and coordination processes are well established, with daily system escalation calls, regular out-of-area reviews, and twice-weekly senior escalation meetings focused on patients with No Criteria to Reside (NCTR). During periods of increased demand, system escalation arrangements are enhanced to enable additional capacity to be mobilised and support operational resilience. Executive oversight is provided through the role of the Director of the Day overseeing the four-times-daily site and bed management meetings (with clear escalation routes to the executive management team) which monitor occupancy levels, bed availability, discharge performance, and the number of patients awaiting discharge across pathways 1 to 3, including those experiencing prolonged delays. Targeted operational actions are in place to reduce long discharge delays, and a multi-agency Rapid Improvement Event is scheduled for September 2026 to accelerate improvements in discharge flow. This work will focus on reducing reliance on pathways 2 and 3, increasing pathway 0 and 1 discharges, and shortening the time between patients becoming medically fit and returning home. The Trust and its locality partners continue to embed a Home First approach through effective Discharge to Assess pathways, ensuring assessment takes place outside of hospital wherever possible. These arrangements are supported by integrated escalation processes across health and social care partners to maintain patient flow and maximise discharge capacity. Progress and ongoing development are monitored through the Community Services Operational Improvement Programme.	N/A
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	Yes. The Board is assured that robust plans are in place to support occupancy reduction ahead of the Christmas and holiday period. These arrangements are embedded within the Trust's winter bed modelling and delivery plans and include a dedicated pre-festive capacity programme designed to optimise bed availability and resilience before the onset of peak winter demand. In addition, the wider Winter Plan incorporates a comprehensive range of initiatives to improve patient flow, reduce avoidable bed occupancy, strengthen discharge processes, and maximise inpatient capacity, ensuring the organisation is well positioned to respond to anticipated seasonal pressures.	N/A
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	The Board can be assured that established Same Day Emergency Care (SDEC) pathways are in place across both medical and surgical specialties to support admission avoidance and ensure patients receive timely assessment and treatment without the need for an inpatient stay where clinically appropriate. Referrals are accepted from a range of sources, including the Emergency Department, General Practice, North West Ambulance Service (N WAS), and other specialty teams, enabling direct access to ambulatory care pathways and reducing unnecessary hospital admissions. The Trust continues to optimise these pathways through ongoing service development and pathway refinement, aligned to the implementation of the Emergency and Elective Management Access Centre (EEMAC) model within Medicine. This work is focused on maximising the number of patients managed on a same-day basis, improving patient flow, and ensuring capacity is used effectively to support both urgent and elective care demand.	N/A
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	The Board can be assured that frailty pathways have been reviewed and are operating effectively to support admission avoidance and deliver care closer to home wherever clinically appropriate. A comprehensive 72-hour frailty model assessment has been completed, with identified improvement opportunities incorporated into the Urgent Care Improvement Plan to support continued pathway optimisation. A single point of access is in place across community services, providing coordinated access to frailty, Hospital at Home, and admission avoidance services. This enables timely assessment and intervention in the community, reducing the need for unnecessary hospital admissions. For patients who do require acute assessment, the Home First team supports early discharge and ongoing community	N/A
Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	The Board is assured that workforce resilience assumptions have informed development of the Trust Winter Plan 2026/27 and are supported by divisional and corporate workforce plans. The plan includes consideration of safe staffing requirements, workforce availability, vacancy and absence assumptions, escalation capacity, operational leadership arrangements and business continuity planning. Divisional plans identify specialty-specific staffing risks and mitigating actions, including recruitment initiatives, flexible deployment of staff, utilisation of bank staffing where required, and management of additional winter capacity. Workforce wellbeing has been embedded through dedicated staff wellbeing and support initiatives, recognising the importance of maintaining workforce resilience during periods of sustained operational pressure. The Trust has also established escalation processes, executive oversight arrangements and regular review mechanisms to monitor workforce pressures throughout the winter period and implement additional mitigations where required.	N/A

	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	The Board is assured that all specialty services have arrangements in place to ensure access to senior clinical decision-makers at all times through established rota and on-call arrangements. Divisions have confirmed that robust workforce and operational procedures are in place to manage short-notice absences and maintain appropriate senior clinical oversight. During periods of heightened operational pressure, services have defined escalation plans to manage workload and prioritise activity, ensuring senior decision-making capacity is maintained for urgent and emergency care. Where necessary, elective activity can be reduced or re-prioritised to create capacity for emergency admissions and support patient safety. The Trust also operates specialty-specific escalation protocols, including within Obstetrics, and adheres to Greater Manchester system escalation arrangements. In the rare event that senior clinical decision-maker cover cannot be secured at short notice, established system protocols enable the safe diversion of patients or service pressures to maintain continuity of care and minimise clinical risk.	N/A
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Yes. The Board is assured that robust plans are in place to deliver elective recovery and performance trajectories as set out within the Trust's Operating Plan. Following a recent business continuity incident, involving the unplanned closure of five theatres to facilitate essential estates remedial works, the level of risk associated with delivery of these plans has increased. However, a comprehensive recovery plan has been implemented and is actively being progressed to mitigate the impact and support recovery of activity. Progress against recovery actions and performance trajectories is subject to ongoing executive oversight, with assurance provided to the Integrated Care Board (ICB) through monthly Performance Oversight Meetings (POM) and other established assurance forums.	N/A
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	Yes. The Board has reviewed and approved the Trust's 4-hour, 12-hour and RTT trajectories and is assured that the Winter Plan supports delivery against these commitments. Seasonal demand and capacity pressures were fully incorporated into the 2026/27 planning assumptions as part of the Trust's Medium Term Plan. Performance against agreed trajectories and achievement of key access standards are reviewed and scrutinised by the Trust Board on a bi-monthly basis, providing ongoing oversight and assurance that delivery remains on track and that any emerging risks are identified and managed proactively.	N/A
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	Yes. Significant investments have been made in Community Services to enable continued utilisation of the Urgent Community Response (UCR) pathways. The service operates 7 days a week and daily triage is led by a senior advanced clinical practitioner to ensure those requiring our services most are prioritised. The progress of this offer and continued development is tracked through the Community Services Operational Improvement programme.	N/A
	Flow				
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	The Board is assured that emergency department crowding mitigations have been reviewed and strengthened, with the elimination of corridor care recognised as a key patient safety priority. Refined escalation cards have been developed and embedded across the organisation, providing clear safety thresholds, defined escalation triggers, and agreed operational actions to manage periods of increased demand and maintain patient dignity, privacy, and safety. The Trust has refreshed and embedded it's OPEL 4 escalation arrangements, ensuring timely and coordinated responses when system pressures increase. In addition, the site management team and command-and-control approach (including Senior Manager and Director of the day and on call structures) are now fully embedded, providing real-time oversight of patient flow, capacity, and escalation measures across the hospital. These arrangements support proactive management of crowding risks, reduce the potential for corridor care, and provide executive oversight of operational pressures and associated patient safety risks.	N/A
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	The Board is assured that deliverable plans are in place to improve ambulance handover performance, supported by established operational arrangements and clear escalation processes. Ambulance handover delays are actively managed through the Trust's escalation framework, with defined actions incorporated within the refreshed escalation cards and OPEL arrangements to ensure a timely and coordinated response during periods of increased demand. Improving ambulance handovers is a key component of the Urgent Care Phase 3 Operational Improvement Plan, with targeted actions focused on reducing delays, improving patient flow, and maintaining ambulance availability across the wider system. The Trust recognises the critical relationship between ambulance handover performance, emergency department occupancy, and overall system capacity, and therefore ambulance handover metrics form an integral part of operational oversight, escalation processes, and OPEL assessments. These arrangements provide executive visibility of emerging risks and support timely intervention to maintain safe and effective patient flow.	N/A

	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	The Board is assured that the Winter Plan has been developed in conjunction with system partners and includes a range of initiatives to support admission avoidance, discharge optimisation and patient flow across health and care services. Plans incorporate community alternatives to admission, urgent community response services, Hospital at Home, discharge pathways and system escalation arrangements, with operational oversight through established winter governance structures and regular system engagement. Robust escalation and coordination arrangements are in place across the Bolton health and care system to support timely transfers of care and maintain patient flow. Through the Strategic Cell System Pressures Group, partners including Bolton NHS Foundation Trust, NHS Greater Manchester (Bolton), Primary Care, Adult Social Care, Mental Health Services, BARDOC and GP representatives meet regularly to review system pressures, share intelligence, jointly assess risks and agree coordinated actions. The group provides both strategic and operational oversight, enabling organisations to work collectively to identify solutions, deploy resources effectively, address barriers to discharge and ensure services remain responsive to patient needs. This collaborative, whole-system approach supports resilience across the health and social care economy and facilitates safe, timely movement of patients through care pathway	N/A
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	The Board is assured that plans are in place to implement the requirements of both the Model Emergency Department and Model Discharge frameworks ahead of winter. A comprehensive review against the relevant standards has been completed, with any identified gaps or opportunities for improvement incorporated into the Trust's Urgent Care Operational Improvement Plan. Delivery of these requirements is being progressed through a coordinated approach with system partners, recognising that the Model ED and Model Discharge standards extend beyond urgent and emergency care and require whole-system implementation across acute, community, primary care and social care services. Progress is subject to ongoing oversight through established system governance arrangements to ensure readiness for winter and continuous improvement in patient flow, discharge performance and emergency care delivery.	N/A
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	The Board is assured that plans, governance arrangements and operational processes are in place to support the safe reconfiguration of clinical areas, the creation of additional capacity, and the implementation of patient cohorting measures during periods of increased demand or infectious disease transmission. A dedicated Norovirus Management Standard Operating Procedure (SOP) has been developed and is scheduled for approval through the Infection Prevention and Control (IPC) Committee on 26 August 2026. The SOP aligns with the national guidance Norovirus: Managing Outbreaks in Acute and Community Health and Social Care Settings and sets out clear arrangements for patient cohorting, outbreak management, escalation processes, and safe staffing requirements. These arrangements are supported through established IPC governance structures and provide a framework for the safe management of infectious disease outbreaks, ensuring that patient safety, operational resilience, and infection prevention requirements can be maintained while responding to changing demand and capacity pressures.	Opportunities to plan further for additional clinical capacity are limited due to physical space constraints
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	Deputy DIPC has been engaged in the Trust winter planning process. The winter plan will be reviewed at a number of governance meetings including Quality assurance committee at which the DIPC is a member	N/A
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	The Trust retains a discrete fit testing service and there is capacity to scale up testing if required supported by certified fit testers in ED and critical care as required.	N/A
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	As per 5.1. Briefing sessions planned in for August and September to go through planning in advance of anticipated winter pressures related to seasonal infections.	N/A
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	The Board is assured that operational leadership and escalation arrangements are in place to support the Trust throughout the winter period. The Winter Planning Programme has reviewed on-call arrangements, operational leadership rotas and escalation processes, including Director and Senior Manager on-call arrangements. These arrangements provide access to senior clinical, nursing and operational leadership to support decision-making during periods of heightened demand. Winter planning exercises, scenario testing and previous winter learning have informed the refinement of these arrangements to ensure effective operational oversight and escalation	N/A
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	The Board is assured that the Trust has established monitoring and escalation processes aligned to the OPEL framework. Winter planning actions have included development of OPEL dashboards, review of escalation processes and incorporation of OPEL-related reporting within operational management arrangements. Real-time operational pressures will be monitored through daily operational processes, escalation meetings and executive oversight mechanisms, enabling timely response to emerging risks and capacity pressures	N/A
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	The Board is assured that the Winter Plan has been developed as part of a wider system approach to winter preparedness, involving collaboration with system partners and regional planning processes. Escalation arrangements include the ability to work collaboratively across organisations to manage periods of increased demand and capacity pressures. Mutual support arrangements form part of established system escalation and resilience processes and can be enacted where operationally required.	N/A

	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	The Board is assured that business continuity forms a core component of winter preparedness planning. Winter plans across divisions and corporate services incorporate service resilience, escalation arrangements and contingency planning, supported by scenario-based exercises and lessons learned from previous winter periods. These reviews have informed local and corporate actions designed to maintain critical services during periods of sustained operational pressure. An audit of all BCPs was complete in July 2026, following a trust wide update of all plans	N/A
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed and remain in place through the Trust's Adverse Weather Policy and supporting business continuity arrangements. The policy sets out clear escalation processes, organisational response arrangements, service continuity measures, and contingency plans for adverse weather events, including flooding, severe snow, ice, storms, heatwaves and associated transport disruption. Services have locally reviewed business continuity plans, ensuring plans maintain essential service delivery, and actions to mitigate risks to patients, staff and operational performance	N/A
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes	The Board is assured that industrial action contingencies have been reviewed and are supported by a comprehensive command and control framework designed to maintain patient safety and service resilience during periods of industrial action. The Trust has established a formal Gold, Silver and Bronze command structure, supported by dedicated strategic, tactical and operational leads, divisional escalation arrangements, workforce deployment processes, and daily Incident Command Centre meetings to oversee risk, capacity, workforce impacts and patient flow. Comprehensive business continuity arrangements are in place across all divisions, with clear escalation routes to senior decision-makers and regular situation reporting to identify and mitigate emerging risks. Industrial action delivery meetings review clinical safety, staffing, operational pressures, patient flow impacts and system escalation requirements, ensuring timely decision-making and coordinated responses throughout any period of disruption. The Trust's arrangements are integrated with wider Greater Manchester and NHS England resilience structures, including defined escalation pathways, incident coordination arrangements and processes for major incident response and derogation requests should exceptional circumstances arise. These measures provide assurance that industrial action risks have been fully considered, rehearsed through established EPRR arrangements, and are subject to ongoing executive oversight to protect patient safety and continuity of care	N/A
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	Staff welfare is embedded within the Trust's winter planning arrangements. Occupational Health and Wellbeing colleagues are engaged in planning and delivery, with a range of support mechanisms in place to promote staff wellbeing, resilience and attendance during periods of increased operational pressure.	N/A
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.		N/A	N/A
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.		N/A	N/A
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.		N/A	N/A

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name: Bolton NHS Foundation Trust

Provider CEO name: Fiona Noden

Date reviewed: 24/09/2026

Provider Chair name: Niruban Ratnarajah

Date reviewed: 24/09/2026

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Rae Wheatcroft - Chief Operating Officer.
Internal: 145449 External: (01204) 390449
rae.wheatcroft@boltonft.nhs.uk

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Confirmed this has been reviewed and approved by the COO (as SRO) and Trust board

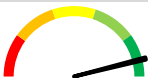
Please confirm date reviewed

24/09/2026

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance



		Rating
Section B	Prevention	5 - Full assurance
	Flow, occupancy and discharge	5 - Full assurance
	Capacity and community	5 - Full assurance
	UEC Flow	5 - Full assurance
	Infection Prevention and Control (IPC)	5 - Full assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	Awaiting assessment