NHS
Manchester University
NHS Foundation Trust

Board of Directors (Public)

Date: Thursday 30th July 2026
Time: 2:00pm – 5:00pm
Location: Main Boardroom, Cobbett House, Oxford Road Campus

Items marked with an asterisk have been discussed at the relevant Board Committee

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Interim Trust Chair	
2.	**Declaration of interest** (verbal)	Meeting admin	Interim Trust Chair	
3.	**Patient Story**		Deputy CEO / CNO	
4.	**Minutes of the previous meeting** (20th May 2026)	Meeting admin	Interim Trust Chair	
5.	**Action Log**	Discussion	Interim Trust Chair	
6.	**Matters Arising**	Discussion	Interim Trust Chair	
7.	**Trust Chair's report (verbal)**	Discussion	Interim Trust Chair	
8.	**Trust Chief Executive's report**	Discussion	Trust CEO	
9.	**Assurance Reporting**			
9.1	**Board Assurance Framework**	Discussion	Interim Deputy CEO	
9.2	**Integrated Performance Report***	Discussion	Executive Directors	
10	**Strategic aim 1: Work with partners to help people live longer, healthier lives**			
10.1	**Research, Innovation and Population Health Board Committee (19/06/26) escalation and assurance report**	Discussion	NED (MB)	
10.2	**North Manchester Board Committee (17/06/26) escalation and assurance report**	Discussion	NED (MG)	
10.3	**Strategic Development Update**	Discussion	Acting CSO	
11	**Strategic aim 2: Provide high quality, safe care with excellent outcomes and experience**			
11.1	**Quality, Safety and Performance Board Committee (30/06/26) escalation and assurance report**	Discussion	NED (JH)	
11.2	**Spinal Surgery Independent Patient Safety Investigation**	Discussion	JCMO	

11.3	**Annual Infection Prevention and Control report***	Discussion	Deputy CEO / CNO	
12	**Strategic aim 3: Be the place where people enjoy working, learning and building a career**			
12.1	**People Board Committee (30/06/26) escalation and assurance report**	Discussion	NED (AA)	
12.2	**Freedom to Speak Up Annual Report***	Discussion	Interim DCEO	
12.3	**Safer Staffing Report (nursing) ***	Discussion	Deputy CEO / CNO	
12.4	**Safer Staffing Report (midwifery and newborn services)***	Discussion	Deputy CEO / CNO	
13	**Strategic aim 4: Ensure value for our patients and communities by making best use of resources**			
13.1	**Finance Board Committee (01/07/26) escalation and assurance report**	Discussion	NED (TR)	
13.2	**Chief Finance Officer's report ***	Discussion	CFO	
13.3	**Audit and Risk Committee (23/06/26) escalation and assurance report**	Discussion	NED (SL)	
13.4	**Digital and Estates Board Committee (02/06/26) escalation and assurance report**	Discussion	NED (SL)	
Good Governance				
14.	**Any Other Business** (verbal)	Discussion	Interim Trust Chair	
15.	**Meeting Evaluation** (verbal)	Meeting admin	Interim Trust Chair	
Date of next meeting: Wednesday 30th September 2026 at 2:00pm				

Manchester University
NHS Foundation Trust

Board of Directors
(Public)

Wednesday 25th March 2026

Present:	Angela Adimora (AA) Mark Cubbon (MC) Vanessa Gardener (VG) Mark Gifford (MG) Nic Gower (NG) Jackie Hanson (JH) Sam Liscio (SL) Matt Makin (MM) Chris McLouglin (CM) Meera Nair (MN) Tom Rafferty (TRa) Trevor Rees (TR) Kimberley Salmon-Jamieson (KSJ) Sohail Munshi (SM) David Walliker (DW) Claire Wilson (CW)	Trust Non-Executive Director Trust Chief Executive Chief Delivery Officer Trust Non-Executive Director Trust Non-Executive Director Trust Non-Executive Director Trust Non-Executive Director Interim Joint Chief Medical Officer Trust Non-Executive Director Chief People Officer Chief Strategy Officer Interim Trust Chair Interim Deputy Chief Executive/ Chief Nursing Officer Joint Chief Medical officer Chief Digital and Information Officer Chief Finance Officer
In attendance:	Nick Gomm (NGo) Ursula Martin (UM) for item 11.2 Rachel Ferguson (RF) for item 12.2	Director of Corporate Business / Trust Board Secretary Chief Executive, Specialist Hospital Clinical Group Resident Doctor Peer Lead

Public questions

At the beginning of the meeting, TR explained that a petition had been received by the Trust from UNISON on behalf of some MFT staff affected by the national issue regarding Health and Social Care visas. TR summarised the ask from UNISON for the Trust to:

- Issue Certificates of Sponsorship regardless of the remaining time on an employee's visa; and
- Issue 5-year Certificates of sponsorship instead of the 3-years currently issued

Three members of staff attended the meeting and described their current circumstances and reiterated the requests in the petition.

Following their words, MN provided an overview of the Trust's position, the limitations due to national policy and legislation, and the support which has been provided to affected staff

TR thanked the members of staff for their contribution to the discussion.

1.	**Apologies for absence and confirmation of quoracy**

Apologies were received from Ashley Blom and Darren Banks

2.	**Declarations of Interest**

No interests were declared.

3.	**Patient Story**

KSJ introduced the story of Issa, a user of Community Falls service, and the support she has received. The care included structured exercises and regular physiotherapy visits over approximately ten weeks. Issa experienced a significant improvement in mobility and independence and restored confidence to undertake activities of daily living including walking, shopping, and travel. Issa offered high praise for staff, particularly regarding patience, encouragement, and rehabilitation support.

Board members highlighted that Issa's story demonstrated the impact of integrated care models and the value of community-based rehabilitation.

Decision	**Action**	**Lead**	**Complete / date for completion**
The Board of Directors noted the patient story.	None	n/a	n/a

4.	**Minutes of previous meeting held on 25th March 2026**

The minutes of the Board of Directors' (Board) meeting held on the 25th March were approved as a true record of the meeting.

5.	**Action Log**

All actions were either complete or were not yet due for completion.

It was confirmed that the outstanding item would be taken to a future Board seminar rather than being on the agenda for the June seminar.

6.	**Matters arising**

There were no matters arising.

7.	Trust Chair's Report

TR explained that there was no Chair's report at this meeting as he had only recently come into post. MC's report contains an overall update on key matters of interest.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the Trust Chair's report.	None	n/a	n/a

8.	Trust Chief Executive's Report

MC presented his report which provided an overview of activities at the Trust and operational delivery, and progress made on delivering the strategic aims and objectives. He drew attention to:

- Sustained improvements in urgent care performance with increased patient volumes and improved four-hour performance.
- Elective care improvements of approximately 12% compared to last year, with further improvement required to meet the 2026/27 targets.
- Cancer performance is ahead of plan with sustained improvement being seen
- Improvement in the Trust's NHS Oversight Framework ranking from to 65th.
- Launch of a new Culture and Staff Experience Forum with broad staff participation.
- Appointment of a contractor for the North Manchester General Hospital redevelopment.

Board members discussed:

- The positive Freedom to Speak Up developments and leadership visibility.
- The continued need to sustain improvements across key performance areas.
- The importance of staff engagement initiatives.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report.	None	n/a	n/a

9.1	Integrated Performance Report (IPR)

The Trust Executive Directors introduced the sections of the IPR relevant to their portfolios.

KSJ and SM introduced the Quality and Safety section and drew attention to:

- MRSA bacteraemia remains a significant concern, with 13 cases reported to date and ongoing issues relating to compliance with aseptic non-touch technique (ANTT) and training levels across clinical staff. Training compliance remained variable and a concerted programme of retraining was underway with a clear expectation of improvement by June.
- Missed opportunities in early treatment and pathway adherence were contributing factors to infections, particularly in relation to vascular access device management.

- Category 3 caesarean section data required further validation due to known data quality issues. The metric does not reflect actual time to theatre beyond 24 hours, and further refinement work was underway.
- Induction of labour performance was below the 24-hour standard, currently at approximately 60%, but safety checks for women and babies were maintained.
- VTE screening compliance has seen significant improvement since the digital hard stop has been introduced.
- Progress has been made on identifying and recording any health issue for patients on the Trust's waiting lists. GPs can now contact MFT directly if they observe any deterioration in the patient under their care. GP feedback has been positive about these arrangements.

Board members:

- Questioned the variation in infection performance, particularly the contrast between strong Clostridioides difficile results and poor MRSA performance. KSJ explained that MRSA and Clostridioides difficile are distinct conditions with different causes, controls and management approaches, explaining the contrasting performance levels.
- Emphasised the importance of ensuring mandatory training completion across all staff groups and suggested that stronger accountability mechanisms may be required where compliance remained low.
- Noted inconsistencies between performance indicators and accompanying commentary, particularly where metrics were rated as "no risk" despite being below target. It was agreed that clearer alignment between thresholds, risk ratings, and narrative interpretation was required in future to support effective assurance.
- Asked about progress with the demand and capacity review of caesarean sections. KSJ confirmed that the work was on track.
- Discussed the correlation of Alert/Advice/Assure status with delivery against the metrics. Executive Directors committed to reviewing the report in advance of presentation at the next Quality, Performance and Safety Board Committee meeting with clarity provided on the % patients with learning disabilities/autism metric.

VG introduced the operational performance section and drew attention to:

- There was strong delivery over 2025/26; we saw more patients more quickly and we are reducing very long waits - this now brings us in line now with national average and we continue to climb up the national rankings and benchmark quartiles.
- Over half a million patients were seen in urgent care pathways during the year, with approximately 14,000 additional patient attendances.
- In March 2026, 77.2% of patients were seen in 4 hours, representing a 7.5-percentage point improvement on April's 2025 position which was 1,500 more patients seen within 4 hours. Continued to reduce number of patients waiting over 12 hours in our emergency departments continued to reduce this year, Apr 25 was 4.16% and we finished March 26 at 2.73%.
- Our Care Closer to Home programme has demonstrated significant system impact across Manchester and Manchester Royal Infirmary including a 28% increase in patients managed through Hospital at Home pathways, a reduction of approximately 100 beds fewer beds used and 145 fewer patients entering long-term care resulting in a 14% improvement in delivery against the 4 hour standard.
- A 12% improvement in referral-to-treatment (RTT) performance.
- A 7,000 reduction in patients waiting over 52 weeks and 26,000 additional patients treated compared to the previous year.
- 13% improvement in the 62-day Cancer standard, resulting in 543 extra patients treated with a cancer diagnosis month on month.

- Quality, Safety and Performance Board Committee is retaining a focus on ADHD/Autism pathways as well as a focus on the cancer tumour sites that are challenged.

Board members:

- Welcomed the improved Hospital@Home occupancy levels, recognising the positive impact the service has across the whole system.

MN introduced the People section and drew attention to:

- Agency spend has reduced but is not yet at the required trajectory.
- Sickness absence decreased to 5.95%, the first time it has been below 6% in the last three years.
- Continued focus was required on staff wellbeing, absence prevention, and organisational culture interventions. [Board Jabr...recording | Meeting]
- Training compliance overall was reported as high, but variability remained in specific areas, requiring targeted improvement programmes.

Board members:

- Welcomed the reduction in sickness absence and acknowledged that further progress was required.
- The importance of culture, staff wellbeing, and training compliance as enablers of performance improvement was reinforced.

CW introduced the finance section, drawing attention to the achievement of the financial plan for 2025/26 and confirming that she would cover the detail of the metrics within the Chief Finance Officer's report later on the agenda.

SM introduced the research and innovation section and drew attention to:

- Good progress being made against the 150-day target.
- A new digital system will be developed to support data collection with a 3-6 month implementation period to enable all researchers to be trained on it.

MB questioned the proportion of commercial research compared to university research and asked about plans to increase the levels of commercial research. SM committed to confirming the issue at the Research, Innovation and Population Health Board Committee (RIPHBC).

DW introduced the digital section and drew attention to:

- Subject Access Request compliance is now at 100%.
- FOI performance has improved significantly and the Information Commissioner's performance notice has now been removed.

Board members:

- Thanked Executive Directors for the level of detail within all sections of the IPR, recognising its value in providing assurance.
- Welcomed the removal on the performance notice.

Decision	**Action**	**Lead**	**Complete / date for completion**
The Board of Directors noted the report.	SM to confirm proportion of commercial versus university research at the next meeting of the RIPHBC.	SM	July 2026

10.1	**North Manchester Board Committee (14/04/26) escalation and assurance report**

MG introduced the report from the first meeting of the Committee and drew attention to:

- The history of the site and the history of transformation change which had taken place over the years.
- The focus of the meeting included governance, programme scope, and redevelopment planning.
- Alignment with broader transformation objectives across the Trust and the local area was emphasised.
- A proposed amendment to include the Chief Digital Officer in the Committee membership had been supported.

Decision	**Action**	**Lead**	**Complete / date for completion**
The Board of Directors noted the report.	None	n/a	n/a

10.2	**Strategic Developments**

TRa introduced the report which provided an update to the Board on national, regional and local strategic developments relevant to MFT and drew attention to:

- The national Neighbourhood Health Framework had recently been published and set out a clear vision for the future of neighbourhood-based health services, emphasising prevention, early intervention, and community-based delivery. It defined key outcome metrics by which success would be measured, including reductions in hospital attendances, admissions, and lengths of stay. Particular focus is placed on priority cohorts, including people with frailty, long-term conditions, children, and young people.
- The Framework is strongly aligned with MFT's strategic direction and existing work within the Trust, particularly through the Local Care Organisation (LCO), was already consistent with the principles.
- Recruitment processes are underway for both the Chair and Chief Executive roles.
- Formal service change processes were progressing for cardiac and vascular services with positive feedback received through political and scrutiny processes. Public engagement was planned over the summer period, with a formal decision expected by the Integrated Care Board later in the year.

Board members:

- Recognised that services would increasingly need to identify individuals at risk earlier and intervene before deterioration occurred with the role of community teams and integration with hospital services identified as critical to achieving this model.
- Stressed the importance of ensuring that strategic planning reflected cross-boundary working and population flows, noting that, although MFT's primary relationships were with Manchester and Trafford, the Trust operated across multiple local authority boundaries with
- Acknowledged that changes in ICB leadership presented both risk and opportunity for influencing system direction.
- Emphasised the need for strong Board oversight to ensure that the scale of transformation required was fully understood and delivered effectively.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report	None	n/a	n/a

10.3 MFT Annual Plan

Review of 2025/26 delivery

TRa introduced the report which provided an overview of MFT strategy delivery during 2025/26. He drew attention to:

- The Trust had completed a formal annual assessment of delivery against its refreshed strategy, including a structured review of agreed performance metrics. The report incorporated a narrative summary of key achievements, outcomes, and programme delivery across all strategic aims.
- The strategy had been updated during the year, and a set of outcome measures had been established to assess delivery across key domains.
- Nine core metrics were in place to measure strategic delivery, with further metrics still under development.
- Five of these metrics had been fully achieved by year-end, demonstrating strong delivery in key areas.
- Three additional metrics were reported as slightly below target but showing positive improvement trends against baseline:
- Staff survey engagement scores had reduced, reflecting wider national trends and local organisational change.
- Further work is required to finalise a robust metric for Strategic Aim 1 (longer, healthier lives), particularly relating to population health and prevention.

Board members:

- Welcomed the impressive delivery in the context of a year of significant organisational change.
- Noted a potential additional metric regarding participant numbers for commercially sponsored trials.

Integrated Delivery Plan 2026/27

TRa introduced the report which presented the Integrated Delivery Plan for 2026/27, the requirement for which comes from the 2026/27 planning round. TRa drew attention to:

- The Integrated Delivery Plan (IDP) provides a forward-looking framework which translates the strategic objectives into deliverable priorities, actions, and measurable outcomes for the coming year.
- The plan includes a defined set of expected results and trajectories and key enabling initiatives required to deliver outcomes.
- The development process included consultation with the Council of Governors and refinement based on feedback from stakeholders.
- Some targets within the plan had recently been reviewed and may be increased in ambition, reflecting confidence in delivery capability.
- Particular attention was drawn to emergency care access, where increased utilisation of the single point of access was planned.
- The Plan will be published following Board approval.

Board members:

- Supported the alignment between the strategy and operational delivery plans.
- Emphasised that the organisation must maintain momentum and avoid complacency following a strong performance year.
- Supported the proposal to increase ambition where appropriate.
- It was noted that the Trust must balance ambition with deliverability to ensure continued success.
- Suggested that the published plan should be presented in a more accessible and visual format to improve engagement with the public.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report and approved the Integrated Delivery Plan for 2026/27.	None	n/a	n/a

11.1	**Quality, Safety and Performance Committee (QSPBC) (21/04/26) escalation and assurance report**

JH introduced the report and drew attention to:

- The update on the NHS England-led spinal surgery review. A combined action plan across all providers was in development with ongoing support arrangements were in place for affected patients and families. The final report will be brought through formal governance processes and presented to the Board in July.
- The discussion on the Paediatric ENT review which would be discussed later on the agenda. A further update was received on the paediatric ENT review, noting this as a significant and sensitive issue.
- Review of the 2026/27 capital plan and support for the risk-based prioritisation approach. It was noted that capital constraints required difficult decisions and that some schemes carried risks potentially outside the organisation's normal risk appetite.
- The Health and Safety Executive inspection relating to laser safety arrangements. It was confirmed that corrective actions had been implemented and governance arrangements strengthened.
- The Committee supported the Trust's Patient Safety Incident Response Plan which established a single, overarching approach to patient safety across the organisation.
- The Committee undertook detailed scrutiny of the Integrated Performance Report.
- Positive feedback was noted in relation to maternity performance, including confirmation of achievement of the Maternity Incentive Scheme requirements and positive national feedback.
- The Committee received multiple additional updates providing assurance including: mortuary services and human tissue authority compliance; implementation of the Fuller Inquiry Phase 2 recommendations; progress on genomics services; and learning from Prevention of Future Deaths reports.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report.	None	n/a	n/a

11.2	**Paediatric ENT review**

KSJ and UM presented the report which provided an overview of the background to the ENT review, the findings of the external review team, and the actions being taken in relation to the recommendations. KSJ recognised the harm caused to children and the wider impact on families and the seriousness of the issue and the organisation's responsibility. On behalf of the Trust, KSJ offered sincere apologies to all affected patients and families.

UM drew attention to:

- On discovering the issue, a comprehensive patient recall programme was initiated to ensure all affected children were reviewed.
- A full investigation had undertaken to identify and assess harm to patients.
- Follow-up care and surgical interventions were arranged where required.
- Direct communication was maintained with all families throughout the process.
- All recall clinics had been completed and the remaining surgical follow-up procedures would be completed by October, with delays due to patient and family preferences.
- Independent clinical reviewers and patient safety leads were commissioned to validate findings and ensure objectivity.
- A total of 15 cases of harm were identified with 11 cases categorised as moderate harm and 4 cases categorised as severe harm.
- In parallel with the clinical review, an independent learning review was commissioned to identify underlying causes and system issues with findings from the review were shared with affected families.
- The review resulted in 15 recommendations focusing on: professional practice and clinical standards; communication and team working; and organisational culture and behavioural issues.
- Immediate actions have been implemented with ongoing monitoring and auditing arrangements were in place to ensure sustained improvement.
- Governance arrangements within the clinical group have been strengthened'
- A broader quality management system is being implemented across the organisation.
- There has been reinforcement of patient safety culture, including escalation pathways and leadership oversight.
- The Trust has acted with full transparency, informing regulators including the CQC and ICB. Engagement with families will continue until closure was achieved for those affected.
- Additional external processes and reviews were ongoing.

Board members:

- Acknowledged the distress caused to patients, families, and staff.
- Emphasised the importance of maintaining openness, honesty, and empathy throughout the Trust's response.
- Commended the rapid implementation of recall clinics and patient review processes.
- Welcomed the involvement of independent reviewers as essential in providing credibility to the investigation.
- Noted the presence of team-level issues and how these may have contributed to patient safety risks, stressing the importance of identifying behavioural concerns early and not normalising poor practice within teams. It was highlighted that a key learning point was the need to proactively assess patient safety risks when concerns arise within teams.

- Gave detailed consideration to speaking-up arrangements, emphasising the need for staff to feel confident raising concerns and the importance of ensuring that concerns are acted upon promptly and effectively.
- Stressed the importance of triangulating multiple sources of intelligence, including staff feedback, patient feedback, performance data, and clinical outcomes. It was recognised that reliance on any single mechanism would not be sufficient to identify risks early.
- Sought assurance regarding current arrangements. UM described the improvements in governance structures, strengthening of clinical leadership arrangements, and increased focus on patient safety culture and escalation processes.
- Were reassured that there was no evidence of widespread systemic failure across the wider organisation.
- Acknowledged the pressures placed on staff involved in the service and investigation and welcomed the support being provided.
- Emphasised the importance of ongoing audit and assurance processes was highlighted.
- Concluded that, whilst the issue had been serious and concerning, the organisational response demonstrated transparency, accountability, and commitment to learning and improvement.
- Noted that continued oversight would be required through the Quality, Safety and Performance Board Committee.

MC and TR reiterated sincere apologies to the children and families affected.

Decision	**Action**	**Lead**	**Complete / date for completion**
The Board of Directors noted the report.	None	n/a	n/a

11.3	**Children and Young People Cancer Survey Report**

KSJ introduced the report which describes the results of the patient survey carried out in 2024 and published in November 2025. The report was discussed at the last QSPBC meeting. KSJ drew attention to:

- The results were broadly positive, with the Trust performing above the national average in a number of key areas relating to patient and family experience.
- A high level of confidence from parents and children in the care received, with approximately 96% rating care as 8 out of 10 or higher.
- Around 92% of children reported that they were very well looked after during their care.
- Strong performance in relation to: communication between staff, patients, and families; the ability for parents and carers to ask questions and receive clear responses; and patients being treated with dignity and respect throughout their care journey.
- Clear communication of treatment plans and understanding of care processes was highlighted as a particular strength.
- Areas identified for improvement included: communication at the point of diagnosis; physical environment and facilities; hospital food and catering services; and access to Wi-Fi.
- The Trust has clear and targeted improvement actions in place to address identified gaps.

Board members commended the positive improvement in the Trust's results and noted that the survey results had been discussed in detail at the Quality, Safety and Performance Board Committee.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report and supported the recommendations.	None	n/a	n/a

11.4	2025 Maternity survey results

KSJ introduced the report which summarised the 2025 national maternity survey results. It was discussed at the last QSPBC meeting. KSJ drew attention to:

- Overall improvement in performance across the majority of domains and improvements in 33 survey questions compared to the previous year
- High levels of patient satisfaction in relation to compassionate, respectful, and patient-centred care; and communication and involvement in decision-making.
- Strong performance in: community-based maternity care; mental health support for women; and involvement of partners and families in care processes.
- Areas identified for further improvement included: triage performance, particularly waiting times and patient experience within triage services; postnatal care, including aspects of support following birth; communication during labour; and involvement in decision-making at key points.
- No significant under-performance against benchmark Trusts.

Board members:

- Discussed the low scoring for triage despite the fact that the data shows the Trust is achieving 78% completion within 15 minutes. KSJ explained that the survey was carried out in 2024, prior to the new triage system being introduced.
- Noted the increase in use of triage services reflected a national trend and was a result of GPs referring directly to triage services.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report and supported the recommendations.	None	n/a	n/a

12.1	People Board Committee (PBC) (21/04/26) escalation and assurance report

AA introduced the report and drew attention to:

- Pilot testing of the GM Recruitment hub continues with some risks from a financial and people perspective.
- The discussion on workforce planning and the significant reduction in staff numbers required this year. The PBC will continue to scrutinise the work.
- The Trust's health and wellbeing services and the high number of referrals during 2025/26.
- Continued compliance with national safe staffing standards which are detailed in KSJ's report later on the agenda.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report.	None	n/a	n/a

12.2 Improving Resident Doctors' Working Lives

RF, MFT's Resident Doctors' Peer Lead, attended the Board for this item. MM introduced RF to the Board and explained that the report presented progress made since the beginning of the Improving Resident Doctors' Working Lives (IRDWL) programme.

RF drew attention to:

- Introduction of 24-hour access to food across hospital sites to support doctors working overnight and extended shifts. This development provides benefit to the wider workforce in addition to Resident Doctors.
- Improvements to facilities and the working environment including: installation of lockers; replacements of furnishings and fittings; and the ability for doctors to book accommodation or alternative transport home should they be unable to safely drive home following a tiring night shift.
- Improved work scheduling with a Standard Operating Procedure in place for escalation should forward-scheduling targets not be met.
- Ongoing issues with access to training places and the booking of annual leave and the impact this is having on resident doctors' financial security and health and wellbeing.
- The work underway to improve communication and engagement mechanisms for resident doctors across the Trust.

SL confirmed that she is the Non-Executive Director lead for the programme and explained that the Board would receive an update every 6 months with additional updates being presented to the PBC.

Board members:

- Welcomed the encouraging progress being made.
- Discussed the scale of overpayment/underpayment issues which seem to be a theme nationally. RF confirmed that it wasn't an issue which had been raised frequently with her and MN confirmed that a significant amount of work had been undertaken at the Trust over the last year to prevent it being an issue.

MC concluded the item by thanking RF for the work she is doing and recognising the value of hearing directly from her with regard to the issues being faced by resident doctors.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report.	None	n/a	n/a

12.3 Safer Staffing Report (nursing)

KSJ introduced the report and drew attention to:

- The report had been discussed in detail at the last PBC meeting.

- Overall compliance with safe staffing requirements remained strong with the majority of shifts were filled to planned staffing levels. Where gaps occurred, mitigation measures were implemented to maintain patient safety.
- Vacancy levels had improved compared to previous periods, reflecting successful recruitment activity.
- Turnover remained within expected levels, although continued monitoring was required.
- Sickness absence was improving, aligning with wider workforce trends reported elsewhere in the meeting.
- There was an ongoing focus on reducing agency reliance through substantive recruitment and improved workforce planning.
- The steps being taken to address the gaps in district nursing staffing in Trafford. TRa confirmed that the funding gap had now been closed following a meeting of the Trafford Locality Board.

Decision	**Action**	**Lead**	**Complete / date for completion**
The Board of Directors noted the report and supported the recommendations.	None	n/a	**n/a**

12.4	**Safer Staffing Report (midwifery and newborn services)**

KSJ introduced the report and drew attention to:

- The report had been discussed in detail at the last PBC meeting.
- The Trust remained compliant with national recommendations and Birthrate+.
- A new Birthrate+ assessment has been completed but the results are not yet known. The outcomes will be presented to the PBC.
- Actions being taken as a result of the Maternity survey.

Decision	**Action**	**Lead**	**Complete / date for completion**
The Board of Directors noted the report and supported the recommendations.	None	n/a	n/a

12.5	**2025 NHS Staff Survey**

MN introduced the report which presented of the 2025 staff survey and the action being taken to address themes or responses. MN drew attention to:

- The results were published in March 2026 and had been discussed in detail at the last PBC meeting.
- The Trust had experienced a reduction in response rates compared to previous years which was consistent with national trends but was nonetheless a concern in terms of staff engagement.
- Whilst improvements in some areas were evident, overall performance remained broadly aligned with national averages rather than significantly above them.
- The Trust demonstrated improvement in several key areas, including Freedom to Speak Up, with more staff reporting confidence to raise concerns, and flexible working, with improved staff perception of access and support.

- Areas identified for improvement include: staff engagement and morale, recognition and reward; and staff wellbeing.
- Organisational restructuring and service pressures during the year had likely impacted staff experience with many of the free text comments focusing on the organisational changes as a result of Phase 3 of the One MFT programme.
- Planned actions as a result of the feedback include: strengthening local team-level engagement to ensure feedback is understood and acted upon; improving communication with staff regarding changes and organisational priorities; enhancing recognition and reward initiatives; and continuing to embed a positive speaking-up culture across the organisation.

Board members:

- Discussed action being taken to improve the response rate for this year's survey including ensuring staff are aware of the actions being taken as a result of their feedback. MN explained that Clinical Groups are designing their own action plans and would be feeding back to their staff. Progress will also be communicated via the Culture and Staff Experience Forum.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report and supported the recommendations.	None	n/a	n/a

13.1	Finance Board Committee (23/04/26) escalation and assurance report

TR introduced the report and drew attention to:

- The current challenging cash position for the Trust.
- This year's Value for Patients programme and the progress being made.
- The discussion at the Committee meeting with the MRI Clinical Group Finance Director.
- An update on the Trust's work to identify commercial opportunities.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report.	None	n/a	n/a

13.2	Chief Finance Officer's report

CW introduced the M12 Chief Finance Officer's report and drew attention to:

- The Trust had delivered its financial plan for the year ending 31 March 2026, reporting a small surplus position as a result of the receipt of a £4.9m cash incentive payment from NHS England for successful delivery of the plan.
- The Trust delivered its full capital programme of approximately £155m which included core planned investment and additional in-year allocations of approximately £40m.
- For 2026/27 onwards, the underlying financial position remained a concern and the Trust had not fully achieved its desired underlying run-rate position by year-end.

- The Trust's cash position is a key risk with daily and monthly monitoring processes in place to manage liquidity and strengthened executive oversight of cash performance.
- Savings targets had been distributed across clinical groups and corporate services and delivery of these targets was essential to maintaining financial sustainability and protecting cash.

Board members noted that a full discussion of the Trust's continues to be discussed and scrutinised through the Finance Board Committee.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report and supported the recommendations.	None	n/a	n/a

13.3 Audit and Risk Committee (ARC) (07/04/26) escalation and assurance report

NG introduced the report and drew attention to:

- The Committee's support for the amended Standing Financial Instructions and Scheme of Reservation and Delegation.
- The 2025/26 Internal Audit Plan was close to completion.
- The Committee received a review of Pharmacy waste and noted that MFT had
- The Cyber Assessment Framework/Data Security Protection Tool had been self-

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report.	None	n/a	n/a

13.4 Delegate authority to Audit & Risk Committee (ARC) for Annual Report / Annual sign-off

CW introduced the report which sought Board approval for the delegation of the sign-off of the Annual Report and Annual Accounts to the ARC:

- The Trust has submitted its draft accounts to NHS England and the External Auditors with final submission to NHSE due on the 26th June.
- The request is for the sign-off of the final Annual Report and Annual Accounts to be delegated to the ARC.

Decision	Action	Lead	Complete / date for completion
The Board of Directors approved the delegation of the sign-off of the Annual Report and Accounts to the	None	n/a	n/a

Audit and Risk Committee.			

14.	**NHSE FT-Self Certification**

CW introduced the report which sought approval of the Trust self-certification for Provider License Condition CoS7(3). CW explained that this is a report which comes annually and the same certification status as previous years is being proposed.

Decision	**Action**	**Lead**	**Complete / date for completion**
The Board of Directors approved the proposed self-certification for CoS7(3) of the MFT license, confirming statement B.	None	n/a	n/a

15.	**Standing Financial Instructions / Scheme of Reservation and Delegation**

CW presented the report which sought approval of amendments to the Trust's Standing Financial Instructions and Scheme of Reservation and Delegation. CW drew attention to:

- The amendments are supported by the ARC who considered them at their meetings in February and April
- The main changes to the documents were the inclusion of specific delegation levels for the North Manchester redevelopment programme.

Decision	**Action**	**Lead**	**Complete / date for completion**
The Board of Directors approved the amendments to the Standing Financial Instructions and the Scheme of Reservation and Delegation.	None	n/a	n/a

16.	**Terms of Reference**

NGo introduced the report which sought approval for amendments to the terms of reference for three Committees the Board has established: NGo drew attention to:

- The NMBC ToR had been agreed at the Board in March but since then the Committee has met for the first time and has proposed the addition of the Chief Digital and Information Officer to its membership.
- The Remuneration and Nominations Committee met on the 7th May and reviewed its terms of reference.

- The Trust Leadership Team Committee has carried out a review of its effectiveness, the results of which are summarised in the report. A summary of the proposed amendments to its ToR are also included.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report and approved the recommended amendments to the terms of reference for the three Committees.	None	n/a	n/a

17.	Board of Directors' Register of Interest

TR presented the Register of Interests for the Board of Directors which is presented in public to the Board of Directors every six months.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report.	None	n/a	n/a

18.	Any Other Business

There were no further items of business.

19.	Meeting Evaluation

TR asked for any feedback regarding the meeting to be sent to him.

Date and time of next meeting: 22nd July 2026 at 2:00pm

Public Board of Directors
Action Log

Meeting Date	Action No	Action ID	Agenda Item	Action	Owner	Updates	Target Date	Status
	1	BOD-00000000-01		Analysis of national cost collection to be presented to a future Board Seminar session	Claire Wilson	on work programme for Board Seminar - exact date to be confirmed.	30/06/2026	In Progress
25/03/2026	1	BOD-25032026-01	9.1 Integrated Performance Report (IPR)	Proportion of commercial versus university research to be reported to the next meeting of the RIPHBC.	Sohail Munshi	Action Transferred to RIPHBC for update to meeting on 19 June 2026. Update given to the RIPHBC meeting on 19 June 2026.	30/07/2026	Complete

Manchester University
NHS Foundation Trust

Public Board of Directors
Thursday 30th July 2026

Paper title:	Trust Chief Executive Report	**Agenda Item 8**
Presented by:	Mark Cubbon, Trust Chief Executive	
Prepared by:	Leo Clifton, Senior Business Manager	
Meetings where content has been discussed previously	Trust Leadership Team Committee	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

The Trust Chief Executive has shared a report which provides an overview of activities at the Trust, an overview of operational delivery, and progress made on strategic aims and objectives. They have outlined issues of current interest to the Board and have shared their top three areas of concern.

Recommendation(s)

The Board of Directors is asked to note this report.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives

The work contained within this report contributes to the delivery of the following strategic objectives (see key below)

LHL objective 1	☒	LHL objective 2	☒
HQSC objective 1	☒	HQSC objective 2	☒
HQSC objective 3	☒	PEW objective 1	☒
PEW objective 2	☒	VfP objective 1	☒

VfP objective 2	☒	R&I objective 1	☒
R&I objective 2	☒	Good Governance	☒

Links to Trust Risks	The work contained within this report links to the following strategic, corporate or operational risks: • All strategic objectives in the Board Assurance Framework.	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Effective ☒ Responsive	☒ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • None.	

Main report

The purpose of this report is to provide a general update on matters that the Trust Chief Executive Officer (CEO) wishes to highlight to the Board since the last public board meeting. The report is divided into these sections:

Contents

Full content of the report is included as Appendix A.

1. Work with partners to help people live longer, healthier lives

Our Hospital, Our Future: Building a new North Manchester General Hospital

Delivery of the North Manchester General Hospital (NMGH) New Hospital Project continues to progress well. Since my last report to Board, a major milestone has been reached with the announcement of Bovis as the preferred Main Works Contractor (subject to approvals). The programme has also entered Royal Institute of British Architects (RIBA) Design Stage 1, with agreement of a proposed Preferred Route Forward.

The current proposal comprises a new acute hospital and a separate outpatient centre, delivered as a single integrated programme. The hospital will be one of the most digitally advanced in the country when it opens, providing the modern and effective care environments our population and teams deserve.

Trust teams are actively engaging colleagues in the development of RIBA Stage 1 designs. This phase focuses on establishing the site masterplan and defining how future accommodation requirements will be configured within the national New Hospital 2.0 model, helping to confirm scope, programme and affordability ahead of the Outline Business Case. July and August are critical months as design work is completed, reviewed and agreed with the national New Hospital Programme (NHP) team, maximising the benefits of early contractor involvement.

Alongside design development, opportunities for wider stakeholder engagement are increasing, with staff drop-in sessions and engagement events planned over the coming months. Continued support for the scheme was reinforced through a visit from Matthew Coats, Senior Advisor to the national New Hospital Programme, bringing together representatives from the MFT, NHP, DHSC, NHS GM and NHSE.

Micro-elimination of Hepatitis C

Manchester has successfully achieved Hepatitis C micro-elimination within its drug service (CGL), marking a significant public health milestone. Through strong collaboration between MFT Infectious Diseases, Hepatology, community partners and the Greater Manchester Hepatitis C network, 100% of service users were offered testing, over 98% of people with a history of injecting drug use were tested, and 97.4% of those diagnosed with Hepatitis C were successfully linked into treatment. This achievement demonstrates the impact of sustained outreach, partnership working and a commitment to improving outcomes for vulnerable populations.

Withington Community Diagnostic Centre opens

The purpose-built Manchester & Trafford CDC in Withington opened on 29 June and represents a major milestone in MFT's community diagnostics strategy. The centre is expected to deliver around 129,000 tests per year, providing seven-day access to a

comprehensive diagnostic offer for Manchester and Trafford residents while supporting earlier diagnosis, reduced acute-site demand and the care-closer-to-home agenda. As well as a range of imaging, pathology and physiological tests, the CDC offer includes new one-stop pathways, such as haematuria, neck lump, children & young people's asthma and audiology balance.

2. Provide high quality, safe care with excellent outcomes and experience

Operational Delivery

- **Urgent Care**

This year we aim to achieve 82% performance for the 4-hour target across all types by March 2027. For the month of June performance was 72.9% against a plan of 78.2%. In line with national increases in UEC demand, we saw 500 attendances higher than expected in our plan for June, leading to challenges with the time to be seen and hospital flow. We expect to realise improvements over the remainder of the year through our Care Closer to Home programme, which aims to reduce avoidable Emergency Department attendances and support more patients to access senior clinical advice, community alternatives, Same Day Emergency Care and Hospital at Home where appropriate.

Ambulance handover average time in June was 15.52 minutes against the Trust's plan for the month of 15 minutes. Focused work continues to improve care through effective handover processes, particularly during periods of high demand and for patients attending directly to our Cardiac Catheter Labs.

- **Elective Care**

The most recent reported data for elective care is for May, when the month end position for 18-week referral to treatment (RTT) showed 63.58% against our plan of 62.67%. We reported 1,518 patients waiting over 52-weeks for elective treatment against our plan of 1,737. Our overall waiting list size is currently above plan, with actions in place with the ICB where referral demand is exceeding expected levels. We are forecasting to be back on plan by July. Our Care on Time programme is making positive progress in areas such as Single Point of Access (SPOA), advice and guidance and outpatient transformation to improve clinic efficiency and reduce the number of unnecessary follow ups.

- **Cancer Care**

The latest data available for the Faster Diagnosis Standard (FDS) is for May, where performance was 83.04% against a trajectory of 80.01%. The 62-day standard for May reported 73.54% against a plan of 76.05%. Although below plan this represents an 8% improvement compared to May 2025.

There is significant focus on delivering improvement in the 62-day pathway at tumour site level with dedicated additional leadership resource commencing to drive transformation and pathway re-design.

- **Diagnostics**

Diagnostic waits and waiting list size continues to reduce with May reporting 8.68% of patients waiting >6 weeks against a plan of 8.65%.

National Oversight Framework Update

The latest data published represents delivery in Q4 25/26. MFT improved from segment 3 to segment 1. The previous ranking was 65/134 with an average metric score of 2.36 for acute providers, improving to 1.94, with the ranking of 19/134 Trusts. This improvement reflects sustained progress across a number of operational, financial and quality metrics, supported by strengthened executive oversight, clearer performance grip and targeted improvement work. It also reflects the benefit of aligning recovery programmes, quality priorities and productivity work through established governance routes, enabling a more consistent focus on delivery across the Trust.

Nottingham Maternity Enquiry

In June, both The Ockenden Report and Baroness Amos' National Maternity and Neonatal Investigation were published setting out findings, conclusions, local learning and immediate and essential actions arising from the independent reviews of maternity services. Both reports are deeply distressing and highlight failures including poor leadership and culture, lack of accountability, racism and discrimination, women and families being disbelieved or dismissed, and unlike previous maternity reports serious failings in post-death care causing further trauma to grieving families.

On 30 June 2026, all provider organisations were instructed to implement an urgent 100-day maternity and neonatal improvement programme centred on ten urgent priority areas. These include listening and responding to women, families and staff; strengthening real-time patient experience, Board reporting; addressing inequalities; strengthening governance and delivering safe effective homebirth and maternity triage services with learning from post-death care.

A briefing was provided to the Board of Directors during the first week of July. This plan will be treated as an immediate Board assurance priority rather than a narrow maternity action plan; with a further update once national expectations and any additional taskforce requirements are confirmed. In line with the Perinatal Quality Oversight Model (PQOM) Saint Mary's Managed Clinical Service (SMMCS) has established systems in place to support a responsive approach to the investigation findings.

Minimum Standards for Patients

NHS England has recently published a new set of mandatory Minimum Standards for Patient Experience for those waiting for elective treatment, establishing a consistent baseline of what patients should expect throughout their planned care pathway. The standards focus on improving communication, transparency and patient-centred care, including timely confirmation of referrals, provision of support while waiting, regular waiting list updates, reasonable adjustments for individual needs, advance notice of appointments, prompt rebooking following cancellations, and clear communication when care is complete. Trust Boards are required to provide assurance on compliance with these standards and publish their approach to implementation during 2026/27.

A workstream within our Elective Care on Time programme is focusing on patient experience and each Clinical Group are in the process of undertaking a baseline assessment against each requirement and developing improvement plans to ensure compliance with the national expectations. Further updates and assurance will be provided to the Board in due course as the work develops.

Corridor Care

Eliminating corridor care remains a key patient safety and system flow priority for MFT, supported by a strengthened governance framework aligned to NHSE and GIRFT expectations. Following the introduction of mandatory national reporting from 1 April 2026, the Trust implemented a Standard Operating Procedure for daily validation and reporting, alongside enhanced digital reporting and senior clinical oversight, to strengthen data quality, consistency and operational grip. This is complemented by system-wide actions to improve patient flow, reduce delays and minimise the use of non-designated care spaces, reflecting the Trust's ongoing commitment to eliminating corridor care and improving patient safety across urgent and emergency care pathways.

Hot Weather Events

During the recent period of sustained hot weather, MFT activated its established extreme weather response arrangements. A daily Tactical meeting was established with regular monitoring of operational pressures, estate infrastructure and clinical environments across all sites.

While we experienced some disruption for a small number of patients resulting from high temperatures and humidity affecting clinical areas, mitigation measures were implemented promptly to minimise impact on patients and maintain service delivery. We operated well established escalation processes in close collaboration between operational, clinical and Estates teams, and highlighted the importance of resilience measures to manage the increasing frequency and intensity of extreme weather events.

We will continue to review lessons learned from these events and incorporate them into future preparedness and business continuity planning.

3. Be the place where people enjoy working, learning and building a career

Resident Doctors' Industrial Action

A further period of Resident Doctors' industrial action was scheduled to take place from 15–19 June 2026. The Trust undertook significant planning to maintain patient safety, protect urgent and emergency care services, and minimise disruption to planned activity. Strategic, tactical and operational command structures were established, workforce and service continuity plans were developed, and communications arrangements were implemented across the organisation. However, the industrial action was stood down nationally on 13 June, two days before commencement, requiring a rapid transition to reinstate planned activity, amend rotas and communicate changes to staff and patients at short notice.

Since this, Consultant members of the BMA have voted in favour of Industrial Action. We continue to monitor the national position closely and are reviewing lessons from recent planning and stand-down arrangements to ensure ongoing preparedness and organisational resilience.

Resident Doctors' Conference

The Medical Directors' Leadership Fellows led a successful conference for Resident Doctors across the Trust at Wythenshawe Hospital on 15 July. The conference focused on leadership and aimed to give Residents an opportunity to hear from senior leaders on our individual leadership journeys and share their experiences on leadership development, engagement, resilience, challenges, and equality of opportunity.

The day also provided an opportunity for networking and poster presentations followed by deep dive workshops on effective Change Making, Improvement science, and Innovation in Healthcare. The event highlighted the importance of clinical leadership development and reinforced the benefits of MFT's move to becoming a clinically-led organisation following the OneMFT organisational change programme.

Digital and Data Academy Launch

I'm pleased to announce the launch of the Trust's new Digital and Data Academy, funded through the NHS Apprenticeship Levy, which will provide colleagues with access to a range of digital apprenticeships, learning opportunities and training materials, as well as enhancing the Trust's data and analytical capabilities. Staff do not need to be in a specialist role to benefit, with courses available for colleagues at every level, from foundation through to specialist and degree-level apprenticeships. The Academy represents a significant step forward in building a future-proofed workforce, equipping

colleagues with the skills and confidence to make more effective use of digital technology, data and automation in everyday practice.

Enrolment has begun to the initial eight course offering, which cover a range of topics including of Data, AI, Automation, Cybersecurity and Software Engineering. Further engagement is underway with Apprenticeship Learning Providers to customise learning programmes in line with the MFT Trust Digital Strategic requirements. This ensures content is relevant and appropriately tailored to learners' job roles, skill levels and responsibilities.

Volunteers' Week

In the first week of June, we celebrated the invaluable contribution of volunteers through site-based celebration events and awards across all our hospitals. The Chairman and Deputy Trust CEO joined events to personally thank volunteers and recognise their commitment, dedication and impact. The celebrations highlighted the vital role volunteers play in enhancing patient experience and supporting clinical teams, while communications issued over the course of the week showcased the breadth of volunteer roles and their positive contribution to patients, families and staff. Engagement activities also supported future recruitment, retention and the continued development of volunteering across the Trust.

Colleagues recognised in King's Honours

Two MFT colleagues were recognised in the King's Birthday Honours. Dr Maxine Power, MFT's Director of Improvement, was awarded the King's Ambulance Medal for her exceptional contribution to the North West Ambulance Service. Professor Gareth Evans, formerly Consultant in Genomic Medicine at MFT and Professor in Medical Genetics and Cancer Epidemiology at the University of Manchester, was awarded an MBE for services to cancer genetics.

Events and Celebrations

Two key events and celebrations have taken place over the period since our last meeting:

- **Secretary of State for Health and Social Care visits Wythenshawe Hospital –** on 11 June James Murray MP, Secretary of State for Health and Social Care, visited Wythenshawe Hospital's radiology department to see how artificial intelligence is supporting faster chest X-ray analysis and diagnosis. The visit highlighted MFT's role in deploying innovation to improve patient outcomes, including hearing directly from a patient whose AI-supported diagnosis enabled rapid treatment and recovery.

- **Afzal Khan MP Visit to Sickle Cell Unit –** on 19 June Afzal Khan MP visited the Manchester Sickle Cell Emergency Department Bypass Unit at MRI and the Sickle Cell and Thalassaemia Centre on Denmark Road, alongside MFT colleagues and John James OBE, Chief Executive of the Sickle Cell Society. The visit highlighted MFT's work to improve access, quality and equity of care for people with sickle cell disorder, including direct admission during crisis, patient co-designed improvement work and world-first gene therapy provision.

Ignite Festival of Events

Following the conclusion of the Ignite Festival of Events on 10 July, I would like to recognise what has been a fantastic programme and thank everyone who contributed to its success. Over the course of the month many of our staff engaged in a wide range of events, conversations and learning opportunities that celebrated diversity, inclusion and belonging across MFT.

Alongside hearing from respected national and international speakers in the field of inclusion, one of the most powerful aspects of Ignite has been hearing the stories of our own MFT staff, who generously shared their lived experiences and perspectives. These personal accounts have reminded us why this work matters and has reinforced the immense pride we have in our staff, whose openness, courage and commitment continue to make MFT a great place to work and provide care.

We were also delighted to formally launch and sign our Anti-Discrimination Pledge, developed following feedback from staff across the organisation, marking an important and lasting commitment to creating a workplace where everyone feels respected, valued and able to thrive.

Consultant Appointments

Since our last Board meeting in May, there have been 14 substantive Consultant appointments across the following specialties: Clinical Genetics, Community Paediatrics, Dermatology, Histopathology (Gynae), Colorectal Surgery and Benign Pelvic Floor Surgery, Infection, Neuro-Ophthalmology and Acute Ophthalmology, Respiratory Medicine, Acute Medicine, Plastic, Reconstructive and Hand Surgery, Trauma and Orthopaedics in Hip and Knee Surgery, and Glaucoma and Acute Ophthalmology.

MFT continues to attract exceptionally qualified candidates for consultant posts, reflecting the strength of our clinical services and the value placed on our established development programme for new consultants transitioning from Resident Doctor roles.

4. Ensure value for our patients and communities by making the best use of our resources

Financial Recovery and Productivity

To support delivery of the Trust's long-term financial recovery and address the underlying financial position, we are strengthening our focus on productivity as a key driver of sustainable improvement. While short-term measures remain important, our priority is to reduce the underlying cost of delivering care by improving the efficiency of clinical pathways, making better use of our workforce and estate, and embedding productivity improvement into day-to-day operational delivery.

Bringing together national benchmarking, local intelligence and operational performance data enables us to identify the areas with the greatest opportunity to improve both patient care and financial sustainability. This is providing a more targeted approach to our Value for Patients programme, with a particular focus on reducing unwarranted variation, improving patient flow, increasing elective productivity and making better use of our workforce and estate. The Trust is also developing enhanced productivity dashboards to support Clinical Groups with real-time benchmarking and performance improvement.

Our priority now is to translate operational improvement into recurrent financial benefit. Existing transformation programmes, including Care Closer to Home and Care on Time, are being further aligned with the Trust's financial recovery plans through clearer benefits realisation, quantified productivity measures and strengthened governance. This will ensure that improvements in flow, length of stay, theatre utilisation and outpatient pathways are converted into sustainable reductions in cost while maintaining high-quality patient care.

Value for Patients Programme

A key focus of the 2026/27 Value for Patients (VfP) programme is strengthening staff engagement and ownership of improvement through initiatives such as Share to Save. This newly launched engagement programme recognises that sustainable financial improvement cannot be delivered just through centrally directed schemes; it requires the active involvement of colleagues across clinical, operational and corporate teams in identifying opportunities to improve productivity, reduce waste and release resources for patient care.

Share to Save creates a mechanism for staff to contribute ideas and solutions drawn from their day-to-day experience of delivering services. This complements a wider shift across the Trust, where we are positioning VfP as a routine part of managing our services rather than a standalone financial exercise. To date c. 240 ideas have been shared, which will support our VfP programmes, and critically signal our ongoing efforts to engage colleagues closely with this requirement.

While VfP delivery remains challenging and a planning gap continues to exist against the £175m requirement, we are making good progress developing our plans, and maturing schemes ready for delivery throughout the year.

Ambient Voice Technology (AVT) Roll Out

Following a number of successful pilot cohorts taking place over 15 months, MFT's Ambient Voice Technology programme is now approaching a transition point into mobilisation for wider rollout. The third and final pilot completed in June and evaluated usage across 400 users (the second largest deployment of integrated AVT in the world), incorporating a range of specialities and clinical roles.

These findings have been developed into a robust investment case, which will be progressing through governance over the summer. In the meantime, the programme team is progressing with core readiness requirements including final clinical, cyber, information governance and operational assurance, in preparation to scale roll-out to 18 priority specialities and a greater range of professional groups by the end of October. These specialties have been prioritised based on expected benefit and clinical need.

The technology enables real-time generation of clinical documentation from the clinician-to-patient conversation, allowing clinicians to focus on the human interaction at the heart of healthcare. It reduces administrative burden, supports improved consultation quality and helps release clinical time, with positive impacts for patient experience. Initial models anticipate that at 50% adoption across all services, MFT RTT performance could improve to 78%, with a substantial reduction in long waits. Following successful rollout to priority specialties, expansion to remaining outpatient specialties is expected to complete by March 2027.

Hive EPR Implementation in our Local Care Organisations

In March, the Trust Board of Directors approved the expansion of the Hive Electronic Patient Record to MFT Community Health Services business case, which recommended replacing the existing core community EPR and moving MFT towards a single, unified patient record across acute and community care. The expansion covers Manchester and Trafford LCO community health services (spanning over 150 services) and will address challenges associated with the current fragmented digital landscape; delivering improved patient safety, better continuity of care, reduced duplication and administrative burden, improved discharge and referral flows, greater staff productivity and more effective use of community capacity.

Phase 0 of the programme completed in June, with pre-implementation mobilisation activities including establishing the programme governance, recruiting and onboarding the implementation team, and completing detailed programme planning. The programme has

now transitioned into the implementation phase, which will run until go-live, currently planned for October 2027. At the LCO EPR Programme Board in June, key leaders from across the LCO were asked to nominate Subject Matter Experts (SMEs) from across our services to provide expertise to inform the programme and system design.

SMEs are critical, as they connect the programme team to real workflows, current policies and frontline realities across services. They help define what will work in practice for staff and patients, shaping system requirements and design decisions, reviewing and validating the system as we build it, identifying risks early and ensuring decisions are communicated and embedded across the teams who will use it.

Successful MediCinema Launch

Manchester's first fully accessible in-hospital cinema officially opened on 25 June, welcoming children, young people and families from Royal Manchester Children's Hospital (RMCH) into the brand new MediCinema experience. To mark the occasion, young patients from RMCH were invited to a special screening of Minions & Monsters, ahead of its release in UK cinemas on 1 July. Patients and families also took part in film-themed activities and met James and Henry, two of the film's all-new Minion stars, before enjoying the first official screening together – the film's first screening in the UK.

The new MediCinema has been made possible through a partnership between BAFTA Award winning charity MediCinema, MFT and MFT Charity, following the successful completion of MFT Charity's Manchester MediCinema Appeal. The appeal raised £1.1 million thanks to the generosity of individuals, schools, community groups, charitable trusts and businesses across the region, and has enabled the creation of a purpose-built, fully accessible cinema for patients from across MFT's Oxford Road Campus hospitals, at no cost to the NHS.

The 50-seat facility will offer a year-round programme of films (a minimum of 260 screenings a year) which are free for patients and their families to attend, including the latest blockbusters, family favourites and much-loved classics. Alongside regular screenings, tailored sessions will be developed for specific patient groups such as youth mental health and dementia support groups, as well as for individual needs such as palliative care and end-of-life screenings, helping to ensure the experience is accessible to as many patients and families as possible.

5. Deliver world-class research and innovation that improves people's lives

Performance Against the 150 Day Target

MFT is continuing to shape its research set-up processes to support all staff in achieving and exceeding the 150-day study set-up target for all eligible studies. This includes implementing the EDGE digital transformation programme (to optimise study set-up

tracking, performance reporting and operational oversight) and Florence e-site files (to streamline documentation processes and increase efficiency and compliance across study sites) this summer. To date, MFT is at 100% for approval and first recruitment within 150 days for all eligible studies opened since February 2026.

Greater Manchester in Action – NHS Confed Expo Fringe Event

MFT welcomed over 100 health leaders and innovators from Greater Manchester (GM) and beyond to our inaugural NHS Confed Expo Fringe Event, delivered in partnership with the NHS Alliance (held the day before NHS Confed Expo 2026 in Manchester).

With a range of speakers from across the GM health and care ecosystem, the event focused on putting research into practice, innovation, and the power of partnerships, including MFT's leading collaborative role in discovering, developing and deploying health technology.

At the event, we announced a new partnership with the Medicines and Healthcare products Regulatory Agency (MHRA) and the National Institute for Health and Care Excellence (NICE). This partnership will explore the regulatory, evaluation and adoption complexities of digital, artificial intelligence (AI) and advanced technologies, enabling us to reach more patients and bring innovations to people sooner – safely, effectively and at whole-population level.

Greater Manchester Wearables and Remote Monitoring Innovation Cluster (GM-WIC)

We are leading an exciting new programme that will transform the way that wearable and remote monitoring technologies are researched, developed and deployed. The Greater Manchester Wearables and Remote Monitoring Innovation Cluster (GM-WIC) is a multi-million pound programme that will see MFT work closely with public sector, academic and industry partners to remove barriers and encourage investment, bringing the latest innovations and lasting impact.

Part of the UK Government's £500 million Local Innovation Partnerships Fund (LIPF), this new initiative will draw on the combined expertise of Greater Manchester's best institutions to accelerate the development of technologies to improve people's lives.

Launch of ADAMS Platform

MFT is introducing a new secure data analytics platform, ADAMS (Ask, Discover, Act, Measure and Share), in partnership with MDClone, building on our strong track record in research, innovation and digital transformation. This new tool will help colleagues use data to answer key questions, support quality improvement and improve patient care and outcomes. The system has been developed with input from digital, research and governance teams to ensure data is high quality, safe and easy to use. ADAMS includes

strong security safeguards and advanced features such as synthetic data, enabling teams to explore ideas and collaborate safely without identifying patients.

6. Strategic Updates and Policy Developments

There are several key updates I would like to bring to the Board's attention:

Cardiovascular Disease Modern Service Framework

The Government and NHS England have launched a new Cardiovascular Disease Modern Service Framework aimed at reducing premature deaths from heart disease and stroke by 25% over the next decade. The framework shifts the focus from reactive care to prevention and sets out priorities for local systems over the next three years, including identifying and proactively managing high-risk patients with hypertension, high cholesterol, diabetes, chronic kidney disease and heart failure, and improving rapid access to acute treatment for heart attack and stroke.

The programme is expected to prevent up to 2,400 premature deaths annually within three years, while helping to reduce health inequalities and demand on NHS services. The framework reflects national expectations around earlier diagnosis, moving to integrated cardiovascular-kidney-metabolic pathways, improved stroke and cardiac care performance, building rehabilitation capacity, and increased partnership working across neighbourhood, community and prevention services.

The Online NHS Trust

The Online NHS Trust was created on 1 June 2026 as the first national, digital-first NHS Trust. From 2027, the Online NHS Trust will provide patients with the option to receive planned specialist care through the NHS App, connecting them with clinicians across England for virtual appointments. Patients who choose the service will be able to access online consultations, receive advice and digital prescriptions, and book tests or treatments locally, while maintaining the option of traditional face-to-face care where preferred or clinically required.

The new service is intended to improve patient choice, speed up access to specialist advice and reduce waiting times by making better use of specialist clinical capacity across the NHS. Initially focusing on conditions such as glaucoma, inflammatory bowel disease, iron deficiency anaemia, prostate conditions and menopause-related care, the Online NHS Trust is expected to deliver up to 8.5 million appointments and assessments in its first three years, with all care delivered through existing NHS systems and linked to patients' GPs.

Care Quality Commission – Appointment of Chair

Baroness Julia Neuberger DBE has been named as the government's preferred candidate to be the next chair of the Care Quality Commission (CQC). The Department of Health and Social Care has invited Parliament's Health and Social Care Committee to hold a pre-appointment scrutiny hearing with Baroness Neuberger. Baroness Neuberger is a healthcare leader and cross-bench peer with a background in healthcare policy, regulation and organisational leadership. She is currently chair of Whittington Health NHS Trust and joint chair of University College London Hospitals NHS Foundation Trust.

Following the select committee hearing, expected to be in early September, the committee will set out its views on Baroness Neuberger's suitability for the role. The Secretary of State will then consider the committee's report before making a final decision on the appointment. Kay Boycott, a CQC non-executive director, will continue as interim Chair until the new Chair is appointed.

Advanced Foundation Trust Programme Policies and Guidelines

The 10 Year Plan for Health signalled an intention to introduce a new Advanced Foundation Trust (AFT) status for the best-performing NHS trusts, and earlier this year the first wave of AFTs were authorised. Based in part on learning through this process, NHS England has published an updated AFT policy framework and guide for applicants. Trusts will only be able to apply for AFT status if they can show strong performance, high-quality care, good value for money and excellent leadership. Successful trusts will get more freedom from national control, including a more strategic approach to planning, lighter oversight where performance is strong, and greater financial flexibility to invest in services.

On 10 June, NHS England published the policy framework underpinning the Advanced Foundation Trust Programme, alongside a guide for applicants that offers practical information for trusts seeking to apply. The policy framework sets out the overarching policy intent and principles of the Advanced Foundation Trust Programme, including details of the freedoms that advanced foundation trusts will benefit from. The guide for applicants details the eligibility and assessment criteria for advanced foundation trust status and provides practical information for trusts when applying to the programme.

As discussed at the Board seminar in June, the Trust will continue to carry out the necessary preparatory work to ensure that we are ready to apply for Advanced Foundation Trust status once the eligibility criteria are met.

NHS Staff Standards / Leadership and Management Framework

On 6 July, the Department of Health and Social Care and NHS England published a new set of NHS Staff Standards aimed at improving staff experience. The Standards apply to secondary care organisations (including community health care) and will be measured through the National Oversight Framework and wider assurance processes. They

complement existing local and national staff experience improvement initiatives such as the NHS people promise, providing a clear and measurable framework for action focusing on line management; health and wellbeing; violence prevention and reduction; tackling racism; championing sexual safety; and promoting flexible work.

Published to coincide with the new staff standards, the NHS Leadership and Management Framework sets expectations for all NHS leaders and managers and includes a code of practice and leadership and management standards. Organisations are required to begin embedding the Framework within development, appraisal, recruitment and talent processes, and to support leaders and managers to use the self-assessment as part of their normal appraisal and development conversations during 2026/27.

The work to ensure compliance with the Standards and the Framework will be led by the Chief People Officer and reported through to the People Board Committee.

7. Top concerns

The current top concerns I would like to highlight to the Board are:

Financial Position

The Trust has reported a position back in line with its financial plan in month 3 after it was able to recognise non recurrent income in the year-to-date position. However, the underlying financial challenge remains significant and reinforces the scale of delivery required over the remainder of the year. Our priorities continue to be the accelerated delivery of the £175m Value for Patients programme and strengthening our cash position. Whilst Value for Patients delivery is currently behind the straight-line profile, the programme has continued to strengthen month-on-month, with a growing pipeline of schemes progressing through assurance and implementation, supported by enhanced executive oversight, strengthened governance and much greater focus on cash-releasing recurrent benefits.

The above concern is reflected in strategic objective 8 in the Board Assurance Framework.

Extreme Weather Resilience

Extreme weather resilience is one of the Trust’s most significant emerging operational risks, reflecting the increasing frequency and severity of heatwaves and other climate-related events. The Trust is reviewing learning from recent periods of hot weather and developing a programme of work to strengthen organisational resilience, with a particular focus on estate infrastructure, clinical environment temperatures, business continuity arrangements and operational preparedness.

The above concern is relevant to strategic objective 9 in the Board Assurance Framework.

Manchester University
NHS Foundation Trust

Public Board of Directors

Thursday 30th July 2026

Paper title:	Board Assurance Framework	**Agenda Item 9.1**
Presented by:	Deputy Trust Chief Executive	
Prepared by:	Executive Directors Director of Corporate Business / Trust Board Secretary	
Meetings where content has been discussed previously	Quality, Safety, and Performance Board Committee People Board Committee Finance Board Committee Trust Risk Oversight Committee	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

The Trust's Board Assurance Framework (BAF) has been designed to provide Board members with assurance regarding progress in delivering the Trust's strategic aims and objectives. For 2026/27, the BAF has been updated following Board member feedback.

The BAF provides an update on progress in delivery of the priorities identified in the 2026/27 Annual Plan to deliver the Trust's strategic aims and details of the risks most likely to impede delivery of the strategic objectives (strategic risks).

The strategic risks have been discussed at the relevant Board Committees during June 2026.

The July BAF can be found in the appendix to the report.

Recommendation(s)

The Board of Directors is asked to discuss the contents of the BAF and the assurance provided

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives

The work contained with this report contributes to the delivery of the following strategic objectives (see key below)

LHL objective 1	☒	LHL objective 2	☒
HQSC objective 1	☒	HQSC objective 2	☒
HQSC objective 3	☒	PEW objective 1	☒

PEW objective 2	☒	VfP objective 1	☒
VfP objective 2	☒	R&I objective 1	☒
R&I objective 2	☒	Good Governance	☒

Links to Trust Risks	The strategic risks aligned to each strategic objective are included within the relevant sections of the BAF.	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Effective ☒ Responsive	☒ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • n/a	

Main report

1.1 A Board Assurance Framework (BAF) enables the Board of Directors to receive assurance on progress being made in achieving the organisation's strategic aims and objectives. MFT has five strategic aims, 11 strategic objectives, and 16 priorities which have been identified in the 2026/27 Annual Plan as the means to support delivery of the strategic aims. The format of the BAF has been amended for 2026/27 following the recent review and feedback from Board members.

1.2 The BAF for July can be found in Appendix A. It begins with a narrative overview of the current position for each strategic objective and a RAG rating provided by the lead Executive Directors. There are then five colour-coded chapters, one for each strategic aim. Within each chapter there is:

- An introductory page with details of how each strategic objective is led and overseen, the agreed 'Impact statement' for the strategic aim, the key metric(s) and the target for the end of the 2026/27.
- A section which lists the Annual Plan priorities aligned with the strategic aim, the key result sought for each priority, and an update on the current position.
- A final section which details the strategic risks associated with the strategic aim At each of their meetings, the Trust's Board committees discuss the strategic risks relevant to their scope and did so at their meetings in June 2026..

1.3 The Trust Risk Oversight Committee (TROC) approves the strategic risks which are included in the BAF and carries out deep dives into individual risks. At each meeting, the Audit and Risk Committee receives the minutes and the escalation report from the Trust Risk Oversight Committee in order to support their role in overseeing risk management processes within the Trust.

1.4 The BAF should be considered by Board members alongside the Integrated Performance Report and the other reports being presented at today's meeting, to assess progress being made in delivering the strategic aims of the Trust.

2. Recommendations

2.1 The Board of Directors is asked to discuss the contents of the BAF and the assurance provided.

BOARD ASSURANCE FRAMEWORK: SUMMARY

STRATEGIC AIM 1: WORK WITH PARTNERS TO HELP PEOPLE LIVE LONGER, HEALTHIER LIVES		
Strategic Objectives	**Overview**	**Rating**
We will work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.	Population Health Annual Report demonstrates successful delivery of projects to address wider determinants of health. Four out of the five lines of enquiry from NHSE's Statement of Health Inequalities met, final one to be met during 2026/27. Progress being made to meet Green Plan targets with recognition that significant investment will be required to meet GM 2040 target. No changes in related strategic risk scores.	
We will work with partners to redesign services so that more care is delivered in people's homes and neighbourhoods.	'Left shift' and 'Care Closer to Home' programmes progressing. Work ongoing with GMICB to test Lead Provider arrangements for Tier 2 services in five clinical pathways. LCOs and Integrated Neighbourhood Teams are well-established across Manchester and Trafford to deliver services identified in national Neighbourhood Health Framework. No related strategic risks.	

STRATEGIC AIM 2: PROVIDE HIGH QUALITY, SAFE CARE WITH EXCELLENT OUTCOMES AND EXPERIENCE		
Strategic Objectives	**Overview**	**Rating**
We will provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience wherever they are treated.	Improved National Oversight Framework rating reflects improvement in access to services. Productivity increases required to continue improvement as demand continues to increase. Transformation through the Care on Time and Care Closer to Home programmes continues to progress, supported by the embedding of a robust Delivery Oversight Framework. Progress being made with implementing PSIRF and strengthening patient involvement/ experience mechanisms. Improvement work underway to prevent Never Events and MRSA infections. Risk score for 'Harm whilst waiting for treatment' increased to 16.	
We will strengthen our specialised services and support the adoption of genomics and precision medicine.	Ongoing work with system partners to finalise design of GM Major Trauma service. Public consultation regarding cardiac and vascular services taking place in summer 2026. Contracts awarded for MFT to provide the North West Genomic Medicine Service and Rare Disease diagnostic Whole Genome Sequencing. No changes to related strategic risk scores.	
We will continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.	Work to disaggregate services at North Manchester General Hospital (NMGH) is nearing completion. Following confirmation from NCA colleagues that they do not wish to progress with Colorectal Cancer disaggregation, work is now underway to agree other routes through which a service could be established at NMGH. Work continues on the disaggregation of Vascular services as part of the wider Greater Manchester vascular service change process.	

STRATEGIC AIM 3: PROVIDE HIGH QUALITY, SAFE CARE WITH EXCELLENT OUTCOMES AND EXPERIENCE		
Strategic Objectives	**Overview**	**Rating**
We will make sure that our staff feel valued and supported by listening well and responding to their feedback. We will improve the experience of all our staff by embracing diversity and fairness, helping everyone to reach their potential.	New organisational arrangements following One MFT Programme continue to show benefits with programmes in place to support individual and team development. Profile of diversity and inclusion work raised by the success of the recent Ignite conference. Collective Leadership and Culture programme entering 'Design' phase. Freedom to Speak Up activity continues to increase indicating greater accessibility through expanded FTSU Champion network. Challenges remain with achieving the target headcount reduction for 2026/27 and reducing sickness absence following recent increase. Two new strategic risks replace the previous ones.	
We will offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here.	Progress continues in increasing opportunities to apprenticeship opportunities via the Widening Participation Programme, particularly in healthcare support. New Digital apprenticeship schemes launched with Trust-wide promotional activity. Band 5 nursing roles job evaluation delivery plan to be in place by end July 2026 to meet national requirements. New single platform for learning management and appraisal planned for go-live in November 2026.	

STRATEGIC AIM 4: ENSURE VALUE FOR OUR PATIENTS AND COMMUNITIES BY MAKING THE BEST USE OF OUR RESOURCES:		
Strategic Objectives	**Overview**	**Rating**
We will achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.	Plan in place to deliver a breakeven financial position for 2026/27 with a negative variance at M2. There are several areas of high risk – availability of cash, full delivery of the VfP programme, the impact of inflation to within funded levels, and the financial impact of any further industrial action, which is not budgeted for. Opportunities for improved productivity have been identified. A mismatch between priority capital funding requirements and availability of capital remains with an increased rating of the related strategic risk.	
We will deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships.	Digital developments are progressing well with piloting of risk stratification tools underway, Hive expansion to the LCO approved, and new cloud hosting arrangements for Hive supported. A Strategic Estates Plan is being developed with scenario-testing underway to reflect the Trust's ambitions for service redesign. The North Manchester New Hospital project is progressing, and a related risk has been added to the strategic risk register. Contractual issues with PFI provision continue to be worked on. To address the capital funding restrictions, alternative sources of external funding are being sought, including for the Wythenshawe Masterplan work.	

STRATEGIC AIM 5: DELIVER WORLD-CLASS RESEARCH AND INNOVATION THAT IMPROVES PEOPLE'S LIVES		
Strategic Objectives	**Overview**	**Rating**
We will strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part.	Key metrics show strong overall performance and positive national benchmarking with significant progress made over the last 12 months. An R & I Strategic Delivery Plan is being developed following recent external reviews with priorities increasing commercial opportunities through enhanced engagement with industry partners. No change to related strategic risk score.	
We will apply research and innovation, building on our position as a digital leader and embracing new technology such as artificial intelligence, to improve people's health and transform the services we provide.	AI innovation already in use across clinical and corporate services including Ambient Voice Technology, DNA predict and identification of patients with higher risk of lung cancer and skin cancer. Digital research programmes with the University of Manchester using Hive data are being planned. The potential for wearable technology data integration with MyMFT will support neighbourhood health development.	

Rating colour	Definition
	The evidence within the current BAF indicates that trajectories for delivery of the strategic objective are being met and any risks are well understood and managed.
	The evidence within the current BAF indicates that there is some deviation from trajectories for delivery of the strategic objective and some risk to delivering the plans in place.
	The evidence within the current BAF indicates that there is material deviation from trajectories for delivery of the strategic objective and significant risks to delivering the plans in place.
	The evidence within the current BAF indicates that there is material deviation from the planned trajectory for delivery of the strategic objective and no plans in place to recover the position.

STRATEGIC AIM 1	**WORK WITH PARTNERS TO HELP PEOPLE LIVE LONGER, HEALTHIER LIVES**	**GM mission**	Improve quality and safety and addressing inequalities	**Date of update**	July 2026	**Integrated Performance Report reference**	N/A

Linked Strategic Objectives	**We will work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.**	**We will work with partners to redesign services so that more care is delivered in people's homes and neighbourhoods.**
Lead Executive Directors	Joint Chief Medical Officer	Joint Chief Medical Officer Chief Delivery Officer Chief Strategy Officer
Board Committees	Research, Innovation and Population Health Board Committee Board	Digital and Estates Board Committee
Management Committee(s)	Population Health Management Committee	Digital Management Oversight Committee Delivery Oversight Management Committee

Impact statement	Key metrics for Strategic Aim	Target (March 2027)
More people being supported to live healthy lives in the community with fewer people needing to use healthcare services in an unplanned way	Admissions per 100,000 for ambulatory sensitive conditions	Target not yet confirmed (baseline data will be available for autumn 26 to inform the target)

ANNUAL PLAN DELIVERY

2026/27 priorities	Key result	Update
Support delivery of the GM Live Well programme. Increase public health interventions delivered across MFT to address both the major lifestyle drivers of illness and social determinants of health psychological safety and compassionate leadership.	Increase the number of referrals into the employment support programme by 100 referrals compared to 2025/26 levels by April 2027.	751 referrals into employment support programmes in Q1 though referral numbers have been lower than normal for both the WorkWell and Economic Activity Trailblazer programmes. Departments are being offered refresher meetings with external partners (MCC) to go through support offer. Work continues on the set up of Health and Wellbeing Hubs.
Increase the range of integrated services offered to people of all ages in the community, transforming outpatient services and moving care out of a hospital setting where possible	Deliver a diversion rate of at least 25% through implementation of advice and guidance pathways in high impact specialties, with pathways live from Q1.	5 specialties live with Single Point of Access. Diversion rate is currently above 25%. The Care on Time programme is overseeing the delivery of planned care reform
Deliver our integrated neighbourhood health plans – and develop the role of the Local Care Organisations – through place-based partnerships in Trafford and Manchester	Standardise case management across Integrated Neighbourhood Teams and introduce pro-active case finding in at least 1 neighbourhood by Q3	Manchester Neighbourhood operating model agreed through partner workshops. Integrated Neighbourhood Team standardisation in progress and on track. Business case in development for increased proactive case management. Plan agreed to further develop INTs in Trafford.
	Reduction of non-elective admissions for care of the elderly and end of life care by at least 2%.	Care Closer to Home is the Trust-wide programme for urgent and emergency care, with focus on admission avoidance, expanding community service provision and care in patients own home.

STRATEGIC RISKS

Strategic Risk	**INABILITY TO REDUCE HEALTH INEQUALITIES (MFT/008393)**	**Description**	If there a lack of agreed data sets, dashboards, leadership capacity and supporting governance, then priorities cannot be agreed, interventions designed and monitored, This could result in compromise progress being made on reducing health inequalities for our patients and their families with associated workforce, finance & reputational issues.
Lead Executive director	Joint Chief Medical Officer	**Management Committee**	Population Health Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
12	**12**	**9**	30/10/26	No change

Controls	Assurance
• Given this was a new Trust workstream the key risk was a lack of controls in place. Actions to introduce controls were agreed at the PHMC and the following have been introduced: • IPR Metrics were agreed and a dashboard has been built which includes: • Unplanned admissions for ambulatory care sensitive conditions (cardiology, respiratory, diabetes) • Missed appointments (DNAs) • New clinical leadership roles for population health in each CG with dedicated time, roles & responsibilities	• Governance: Population Health Management Committee with supporting groups: Health Inequalities & Prevention Group, Anchor Group, Green Plan Group, CPAG • Now that IPR has been launched and mandated data collection in place assurance is in place that issues of health inequalities can be identified and interventions agreed at Trust and Clinical Group level • Quarterly review of annal plan actions (Trust and Clinical Group)

Controls	Assurance
• Agreement of a full mandatory population health data set (to ensure questions e.g. ethnicity) are always asked when patients are registered/attend. (This then will improve the quality of the IPR data) • Strategic aims, objectives and actions. Population Health forms part of the Trust's Strategic aims. There are 2 aligned objectives with 8 actions. Each clinical groups and corporate team have specific supporting actions included as part of the annual planning process/governance • Race and Health Action Plan • Core20Plus self-assessment to identify gaps and Annual Plan actions • Elective and urgent care recovery plan • Staff wellbeing offer - such as staff health checks pilot at NMGH. • In summer 2026, Population Health Hubs are being opened at WTWA, MRI, NMGH and RMCH (The Hubs aim to provide holistic support to patients focusing on social barriers patients face to improving their health, as well as lifestyle factors. The Hubs will aim to embed prevention into routine clinical care and reduce downstream demand on services) • Social Determinants of Health Functionality in Hive. Prompts clinicians to discuss tobacco use, financial strain, stress, food insecurity etc and allows for referrals to be made to support patients	

Gaps in controls	Gaps in assurance
• Contracts and procurement processes at MFT require suppliers to confirm how they will support population health and this is reviewed at tender contract award. There is no systematic method for monitoring this resource/impact	• Estates Strategy that aligns to current MFT Annual Plan currently in development. • Actions outstanding relating to external estates reviews.

• Clinical Group Population Health Governance and structures and new and not fully developed	• No risk assessments in place on register relating to PFI risks to document formally. • E&F teams may not have full oversight of risks relating to infrastructure / estate to inform backlog maintenance allocation or to link with Estates Strategic; Corporate; or Operational risks

Action being taken to address gaps	Target date	Progress update
Review MFT procurement contracts to establish what social value/population health projects, funding etc has been contractually agreed by the supplier and put a process in place for ensuring delivery	31/07/26	Review of E&F Strategy against the Trusts current Annual Plan is in development by E&F SLT to create an E&F Strategic Delivery Plan. Links to actions identified in the Estates Review for Acute.

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
MFT/001894: Patient Communication format - Accessible Information Standard	9	9 (All actions are completed and risk is being reviewed to establish if it can be closed)	30/07/26

Strategic Risk	DELIVERY OF GREEN PLAN (MFT/005752)	Description	If MFT do not deliver the Green Plan and embed sustainability criteria in decision making across the Trust then we will not achieve the 2038 net zero commitment or the legally binding 2040 NHS net zero requirement. Resulting in MFT contributing to climate change, exacerbating poor health, negative financial implications (such as levies & penalties) and damage to the Trust's reputation.
Lead Executive director	Chief Delivery Officer	Management Committee	Population Health Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
12	9	6	31/03/27	No change

Controls	Assurance
• Green Plan 2 Net Zero 2025-30 which sets out carbon reduction aims and priority actions was approved by the Board of Directors in May 2025. Green Plan Oversight Group is established and chaired by clinical group CEO. Attended by thematic leads for the ten areas of focus. Oversight by Population Health Management Committee. • Sustainability Team produce Annual Sustainability Report to demonstrate compliance with national requirements and progress towards targets. Annual reports are published on the MFT website. • Staff education provided through MFT Learning Hub. • Green Plan actions are linked to headline objectives across ten areas of focus, which have a senior thematic lead. These are tracked using the E&F assurance module and progress is reviewed by Green Plan Oversight Group.	• Green Plan Oversight Group meets bi-monthly. Meetings are recorded and minutes shared to group members. AAA reports are shared up to Population Health Management Committee. • Sustainability Annual Report currently being produced for publication in summer 2026. Statement for Trust Annual Report was provided in line with expectations. • Number of module completions is reviewed through the Sustainability Dashboard. • RAG reporting included in thematic reports for GPOG. • Levels of staff engagement are regularly reviewed by Sustainability Team and reported via Sustainability Management Group.

Controls	Assurance
• Staff behaviour change programmes are established and include monthly newsletter (opt-in), monthly webinars, project recognition programme (TimeToAct Awards), and the Green Rewards behaviour change tool. Network of engaged colleagues known as 'Sustainability Advocates' also embedded. • Sustainability, Energy and Waste team embedded within Estates & Facilities. Responsible for implementing and advocating for the activity described in the Green Plan.	

Gaps in controls	Gaps in assurance
• Training is currently voluntary. Lack of widespread staff awareness across MFT. • Use of Concerto is new to the Sustainability Team and being embedded. • Engagement is mostly through opt-in and therefore not universal. • Sustainability team provide monitoring and support across all ten areas of focus in the Green Plan but are not able to implement activity unilaterally.	• Thematic lead for “Workforce, Networks & System Leadership” is required. • Platform is now embedded and this control gap is now reduced.

Action being taken to address gaps	Target date	Progress update
To oversee and lead progress for the Digital Transformation, Research & Innovation thematic area within the Green Plan. Progress to be reported via the Green Plan Oversight Group.	31/03/2027	Ongoing
Share more accessible sustainability information by creating a Sustainability Dashboard with site-level sustainability metrics	31/03/2027	Dashboard in development with support from E&F Digital colleagues. Expect to share first version in Sept for review.

Action being taken to address gaps	Target date	Progress update
Increase coverage of energy-efficient lighting across MFT	31/03/2027	Ongoing installations as part of refurbishment projects. 2025/26 coverage: • WTWA: 95% • ORC: 22% • NMGH: 55%
Develop refreshed site-based understanding of required actions to meet decarbonisation plans	31/03/2027	Site based decarbonisation plans in development which include considerations for electrification of heat (NMGH through NHP) and district heating systems (ORC Octagon) and development of Deep Geothermal District Heat Network at Wythenshawe in partnership with other local large heat consumers.
Create a sustainability design guide to support delivery of capital projects in line with sustainability ambitions and objectives	31/03/2027	Draft document for consultation currently in preparation. Consultation expected from September 2026.
Increase understanding of reasons behind food waste through better monitoring.	31/03/2027	Food Waste Task & Finish group meets monthly to review monitoring data and the impact of interventions. Reports via Food & Drink Committee.
Establish local site management groups for the external areas to determine best practice management while promoting and increasing biodiversity	31/03/2027	This action is to be reviewed. Relationships being built at a more operational level; therefore, this may be overkill.
Nature-based or social prescribing activities to take place at MFT sites	31/03/2027	NHS Nature Recovery Ranger in post and completing activity risk assessment process. Activities expected from summer onwards.
Reduce the carbon intensity of inhalers by improving staff awareness of improved asthma control for patients through training on inhaler technique and adherence to NICE guidelines.	31/03/2027	Completion of inhaler eLearning module is reported through Sustainability Team. Pharmacy to spread awareness of eLearning to ensure staff compliance.
Roll out the "Your Medicines Matter" campaign to encourage patients to bring their medications into hospital to reduce unnecessary overprescribing & medicines waste.	31/03/2027	Your Medicines Matter is moving from launch to embedding: KPIs are now in local operational meetings; July site reviews will agree barriers and targeted actions. Also monitored via Pharmacy Management Committee.

Action being taken to address gaps	Target date	Progress update
Improve monitoring of supplier's social value commitments & carbon reduction plan progress	31/03/2027	Public Health Team is beginning to review and engage with Trust suppliers by spend to understand opportunities.
Investigate and enact further return and reuse programmes for suitable equipment	31/03/2027	National 'design for life' programme beginning in 2027 to address high volume items.
Expand the ward coverage of the inventory management system Genesis, to better manage consumables stock and reduce waste	31/03/2027	The point-of-delivery tracking software Genesis (which significantly improves analysis & action to avoid waste in consumables) is planned to expand to Audiology, Genomics & UDH. Coverage Trust wide is at ~80% of appropriate areas, and options are being explored for easier expansion of coverage to Endoscopy under current staffing pressures.
Engage with existing frameworks of quality improvement and transformation to incorporate sustainability and the "triple bottom line" value assessment. (e.g. Quality Improvement, Value for Patients, GIRFT)	31/03/2027	Greater collaboration between Sustainability and Improvement teams is taking place. Sustainability team providing training on carbon foot printing and sustainable healthcare and are attending Improvement Pioneers training.

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
There are currently no linked corporate risks.			

STRATEGIC AIM 2	PROVIDE HIGH QUALITY, SAFE CARE WITH EXCELLENT OUTCOMES AND EXPERIENCE	GM mission	Recover core NHS and care services	Date of update	July 2026	Integrated Performance Report reference	Pages 8 - 40

Linked Strategic Objectives	We will provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience wherever they are treated.	We will strengthen our specialised services and support the adoption of genomics and precision medicine.	We will continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.
Lead Executive Directors	Chief Nursing Officer Joint Chief Medical Officer Chief Delivery Officer	Chief Strategy Officer	Chief Strategy Officer
Board Committees	Quality, Safety and Performance Board Committee	Quality, Safety and Performance Board Committee	Quality, Safety and Performance Board Committee
Management Committee(s)	Quality and Safety Management Committee Delivery Oversight Management Committee	Service Strategy and Planning Management Committee	Service Strategy and Planning Management Committee

Impact statement	Key metrics for Strategic Aim	Target (March 2027)	
More people recommending MFT as a place to be treated	Summary Hospital-level Mortality Indicator (SHMI)	Within expected range	
	Deliver our performance standards	Referral to Treatment	65%
		4-hour Urgent/Emergency Care	82%
		62-day cancer	80%
	Friends and Family Test	Overall	95%

ANNUAL PLAN DELIVERY

2026/27 priorities	Key result	Update
Strengthen our culture of patient safety by empowering and supporting staff with human factors training, encouraging psychological safety and compassionate leadership.	A minimum of 175 Patient Safety champions registered with the network by end of Quarter 1.	190 patient safety champions registered with representatives across all Clinical Groups and a variety of professions.
	Deliver 50% reduction at least in the number of MRSA bacteraemia by Quarter 4.	There have been 0 MRSA bacteraemia reported in the last 2 months. There is a focus on a number of work programmes including Aseptic Non-Touch Technique training compliance. Senior Nurse Reviews are in place for all patients considered to be at risk of MRSA
Build a patient and carer experience framework to improve delivery of person-centred services, strengthening the way we obtain feedback and our approaches to co-production	Agree MFT's Patient and Carer Experience Framework by the end of Quarter 1.	A Trust Patient Experience Strategic Delivery Plan has been developed and is proceeding through approval processes with a Trust-wide launch date planned for Quarter 2.
Continue to reduce waiting times – for adults and children – in a way that is safe and equitable.	71.5% of people will be waiting less than 18 weeks for their treatment by the end of Q4.	RTT 18 weeks performance as at May was 63.6% in line with the Trusts delivery plan. Each Clinical Group has its own elective care delivery plan, underpinned by the Trust-wide planned care work programme - *Care on Time*.
	80.09% of people will wait for less than 62 days for their first cancer treatment by the end of Q4.	Performance against the 62-day cancer waiting time standard in May 26 was 73.5%. This is up 8% when compared to May 25 but 2.51% below plan. A work programme of pathway redesign and waiting time improvement is underway.
	82% of people will wait less than 4 hours in our Emergency Departments by Q4. 95% of children will wait less than 4 hours by the end of Q2.	Performance against the A&E 4-hour wait standard in June 26 was 72.9%. Performance is currently under plan, with focused actions and dedicated support from the Care Closer to Home programme for Urgent and Emergency Care.

2026/27 priorities	Key result	Update
		Performance against the A&E 4-hour wait standard for children and young people in June 26 was 85.3%. Focussed work is in place to drive improvements in waiting times including work to right size capacity.
	Increase the operating hours of our Single Point of Access (SPoA) for UEC to include evenings and weekends in Q1, routing 200 people each week away from our A&E departments and into more suitable services by Q4.	SPoA is now open evenings and weekends (10am–6pm, seven days a week), with plans to extend to 8am–8pm. The service receives an average of 31 calls per day and diverts around 12 patients per day from ED conveyance through a 63% deflection rate (approximately 84 patients per week).
Continue the development of Genomic Medicine across MFT and beyond, mainstreaming Genomics and building on our position as a national leader.	Launch Whole Genome Sequencing through the North West Regional Genomic Medicine Service by the end of Q2	Plans are in place for the implementation of distributed Whole Genome Sequencing by the end of Q2.

STRATEGIC RISKS

Strategic Risk	MENTAL HEALTH SERVICE CAPACITY AND DEMAND (Ref. TBC)	Description	If system-wide mental health demand and capacity pressures continue then, medically optimised patients with mental health needs will remain in ED and inpatient settings that are not designed to meet their needs, resulting in increasing risks to safety, absconsion, poor experience, delayed flow and reduced capacity, higher costs, and regulatory escalation.
Lead Executive director	Deputy Trust Chief Executive/Chief Nursing Officer	Management Committee	Quality and Safety Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
16	16	12	31/03/27	New risk

Controls	Assurance
• Mental Health Strategy 2023-26 in place with implementation through the Mental Health Improvement Plan, with 2026 addendum added. • Relevant policies are available to all colleagues on the Trust Policy Hub and includes oversight, quality assurance and escalation processes across the Trust. This includes the Mental Health Act Policy Suicide Prevention Policy, Environmental Ligature Risk Assessment Tool (ELRAT) and Ligature Incident Management Policy, Prevention and Management of Missing Patients Policy, Caring for persons of all ages who are experiencing distressed behaviours policy, Prevention and Management of Restrictive Interventions for Adults, Children and Young People policy, Enhanced Security Supervision Observation Policy, Rapid Tranquilisation Policy, Violence Prevention and Reduction Policy, Mental Health Section 136 SOP in place. • Delegation of statutory functions for all MFT colleagues in relation to patient's detained under the Mental Health Act is available on the Trust intranet.	• The IPR includes KPIs in relation to the Mental Health Act and is reported monthly to QSMC. • A quarterly assurance report on delivery of Mental Health Improvement Plan is presented to the Mental Health Subgroup. • Incident reporting, response and profile reported to Mental Health sub-group • Bi-monthly AAA reports are provided by the Clinical Groups to the Mental Health Subgroup regarding their delivery of the Mental Health Improvement Plan. • Assurance and audit programme in place overseen by the Mental Health subgroup. • Weekly missing patient meetings in place with Greater Manchester Police, Emergency Departments, Mental Health Liaison Team and Security Teams. • Compliance to Section 136 SOP reported to the RCRP Assurance Group.

Controls	Assurance
• Partnership working with Greater Manchester Mental Health Foundation Trust (GMMH) Mental Health Liaison Team (MHLT) to provide mental health care to people attending acute general hospitals via ED or via inpatient wards in line with the Core 24 Mental Health Liaison Service Operational Procedure – Manchester and Trafford Services. • Oversight and escalation processes in place relating to statutory and regulatory compliance. • Senior nurse review process in place for all patients in mental health distress or detained under the MH Act in ED and admitted to acute hospitals. • Daily, weekly and quarterly reporting of patients detained under the Mental Health Act provided to Clinical Group Directors of Nursing. • Mental Health Awareness training in place across the Trust with 90% compliance standard. • Positive Behaviour Support (PBS) training available to staff with 90% compliance standard.	• Daily reports via the security dashboard relating to application of Enhanced Security Supervision Observation Policy to provide assurance of application of policy within legislative framework. • Reporting of the application of the Violence Prevention and Reduction Policy to the Violence Prevention and Reduction Steering Group incorporating joint system workshop (May 2026) actions. • The MRI MHLT Plan accreditation by Royal College of Psychiatrists August 2025

Gaps in controls	Gaps in assurance
• Increasing demand of mental health patients admitted to general and acute beds within MFT despite continued partnership working. • delays in access to mental health assessment and care planning • limited availability of appropriate placements. • 90% compliance in mental health level 2 awareness training not met. • Limited capacity of Emergency Department Mental Health Interview rooms can mean that patients in ED are cared for in inappropriate environments.	• Mental Health Peer Review –49 of 62 recommendations have been implemented, with 13 in progress and 1 on hold (Liberty Protection Safeguards – awaiting DHSC consultation). Implementation of the remaining recommendations via the MH Strategic Plan (2026 addendum)

Action being taken to address gaps	Target date	Progress update
All recommendations of the Mental Health Peer Review to be implemented via the MH Strategic Plan (2026 addendum)	31/10/26	49 of 62 recommendations implemented to date with 13 outstanding and 1 on hold (Liberty Protection Standards). All actions on- track for completion by target date of October 2026.
Delivery of agreed actions arising from the May 2026 MFT and GMMH workshop, with shared accountability across MFT, GMMH, the ICB and Local Authority. Actions include strengthening data sharing, operational processes, escalation arrangements, workforce capability and system pathways to improve the management and flow of people with mental health needs presenting to acute care. Delivery and oversight are provided through the Mental Health Sub-Group.	28/11/27	May 2026 MFT/GMMH workshop completed. Multi-agency actions identified and incorporated into a consolidated action plan. The outline of the plan was presented to the Mental Health Sub-Group 8th June 2026 and will be reviewed 10th August 2026. This work will be progressed by a dedicated focus group with reporting aligned to the Mental Health Subgroup and TLTC at agreed intervals.
Trust-wide standard room specification and design guide to be finalised incorporating HSSIB recommendations and reported to MH T&F Group	30/08/26	The guide was shared at the MH subgroup on 8 June and consulted upon in June 2026. A final guide will be received for approval in August 2026.
Trust-wide process for temporary environmental modifications to be finalised and reported to the MH T&F Group	30/10/26	An update was received at MH subgroup on 8th June that this guide is currently in development. It will be received by MH subgroup in August 2026 for approval.
All Clinical Groups to report improvement plan to meet 90% compliance standard for Mental Health Awareness Training level 2 at MH subgroup in June 2026	30/06/26	COMPLETE: Trust wide training compliance at end of June 86.24%, (improving trajectory from May 2026 -85.57%) Improvement plans reported in Clinical Group AAA reports 8th June 2026.
Positive Behaviour Support Training plan for each Clinical Group to be reported alongside trajectory to MH Group	30/06/26	COMPLETE: All Clinical Groups have completed a Positive Behaviour Support Training Needs Analysis and are reporting training compliance with improvement plans to MH subgroup (8th June 2026).

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
Mental Health Waiting Times in the Emergency Department	16	4	01/09/26

Strategic Risk	**HARM WHILST WAITING FOR TREATMENT (MFT/009115)**	**Description**	If we are unable to consistently triage, prioritise and clinically review individuals waiting for first and follow up appointments across MFT then we will miss opportunities to maximise earlier intervention resulting in avoidable patient deterioration and potential harm whilst waiting for treatment.
Lead Executive director	Joint Chief Medical Officer	**Management Committee**	Quality and Safety Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
12	**16**	**6**	30/04/27	Current risk score increased from 12 to 16

Controls	Assurance
• Waiting list triage, prioritisation at referral and validation of waiting list processes. • Harm review processes circulated to all Clinical Groups from SIOG. • Ongoing prioritisation of waiting list. • Harm reviews in place for ENT, cancer, glaucoma (due to long waits) • Care on Time Programme in place • Data-led prioritisation tools programme – exploration of risk-based prioritisation (CoT) • GP process to re-escalate patients via the Local Medical Committee (LMC) on a monthly basis, with direct contact via service required for urgent escalations. GP led process for escalating patients potentially deteriorating whilst waiting.	• Oversight of harm resulting from waiting at SIOG • IPR reporting of mod+ harm resulting from waiting list delays and follow-up • Reporting provided to SIOG and Clinical Group • Executive oversight of waiting list programme. • Care on Time governance framework • PSOAG/ CG PSP

Controls	Assurance
• Incident reporting process in place for reporting and responding to incidents of harm	

Gaps in controls	Gaps in assurance
• Ongoing programme of work to reduce waiting list size, however it is acknowledged that this will take time and, whilst people are continuing to wait beyond NHS waiting time standards, there is an ongoing risk of harm.	• Formalisation of connection between Clinical Group harm review and reporting at SIOG

Action being taken to address gaps	Target date	Progress update
Review SIOG ToR to formalise reporting of Clinical Group harm review	31/08/26	Following implementation of a revised incident management structure, it has been agreed to defer updating the SIOG ToR to determine whether additional changes, learning from this approach, need to be incorporated. Date updated to End of August 2026
Plan to review and improve GP escalation review process, with elective single point of access go live planned	30/10/26	Go live planned for end October 2026.

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
N/A			

Strategic Risk	FAILURE TO DELIVER IMPROVEMENT STRATEGIC DELIVERY PLAN (MFT/008234)	Description	If MFT fails to embed improvement systemically as a key enabler, then it will be less likely to deliver its strategic aims and objectives which will impact the delivery of high quality, safe care to our patients, the experience of our staff and making the best use of resources. **(new description)**
Lead Executive director	Chief Delivery Officer	Management Committee	Delivery and Oversight Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
12	**12**	**8**	31/03/27	No change

Controls	Assurance
• Improvement Oversight Group oversees progress and provides assurance to Delivery Oversight Management Committee • Annual report completed. • Full risk review undertaken at Improvement Oversight Group • Senior Leadership Team in place to lead delivery of plan • Implementation of new Improvement Operating Model to better align resources to deliver the Improvement Strategic Delivery Plan: Improvement Academy; large scale change (transformation) and clinical group programme delivery (via CG PMO) • Improvement Faculty leadership established in each clinical group • Programme boards established for large scale change programmes (Care Closer to Home and Care on Time)	• Improvement Strategic Delivery Plan implementation monitored by improvement oversight group with risks escalated to DOMC. • Full risk articulation and actions approved at TROC 29th June 2026 • Assurance for Large Scale Change programmes reported through programme Governance processes • Standard reporting at improvement oversight group from clinical groups • Programme boards reporting to major programmes board bi-monthly

Gaps in controls	Gaps in assurance
• Improvement Dashboard for high level aims and accessibility of information for clinical groups • Clinical Group ownership of improvement activity to achieve the objectives in the Improvement Strategic Delivery Plan has not been formally agreed • Insufficient improvement leadership expertise at Clinical Group and Corporate level • Key gaps in improvement team capacity and capability • Improvement Training has capacity but isn't always fully utilised • No agreed standardised way of working within CG PMOs and nested Improvement personnel following implementation of the new operating model • No formalised Quality Management System	• Variable attendance at improvement oversight group from clinical groups due to competing operational pressures; workshop scheduled for October 2026 to review governance for improvement and plan for next phase of strategic delivery plan. • Training is reported in terms of numbers attended/completed but not currently reported in terms of utilisation rate • Progress is being made on a standard operating model for clinical group improvement personnel

Action being taken to address gaps	Target date	Progress update
Review of IOG quoracy, Terms of Reference/standing agenda to incorporate CG updates for elements which impact delivery of SDP such as training numbers	31/08/26	COMPLETE The Terms of Reference were reviewed and agreed at the Improvement Oversight Group meeting on 1 July 2026. October's meeting will be an extended face-to-face session and will focus on refining oversight arrangements, review of membership. governance review, advancing Quality Management Systems and the organisational co-production model.
Strengthen local improvement leadership through the launch of Clinical Group and Corporate Improvement Faculties	31/12/26	The first Clinical Group Improvement Faculty will be launched in August 2026 (WTWA). Plans for other clinical groups and corporate improvement faculties are underway.

Action being taken to address gaps	Target date	Progress update
Strengthen local improvement leadership through the launch of Advanced Improvement Programmes	31/03/27	The first cohort of Improvement Pioneers – a nine-month improvement training programme, launched in June 2026 with 12 teams from clinical groups/corporate teams participating. The second cohort will commence in September.
Build an advisory faculty of experts to advise MFT on a range of specialist topics and explore partnerships with innovation, improvement and university partners through the Improvement Academy	31/03/27	We have strengthened our networks through the IHI European Network and are building our expert faculty. We have met with Health Innovation Manchester and Aqua about refreshing partnerships.
Quality Management System task and finish group mobilised by CNO and CDO to develop the Manchester QMS framework	31/03/27	Steering group has met (x4) and had presentations from peers, reviewed evidence and agreed a framework for: defining quality and QMS. Next steps to review with clinical group leadership teams.
Develop and agree standard operating processes for nested Improvement teams with and Heads of CG PMOs	31/07/26	The standard operating process is currently in development and will be completed by 31 July 2026.
Dashboard of metrics to track improvement strategic delivery plan progress	30/09/26	Work is underway on a standard dashboard for our high-level aim; course attendance; course completion and learning outcomes (inc satisfaction)

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
N/A			

Strategic Risk	IMPACT OF UNDER-DELIVERY OF OUR ANNUAL PLANS (NEW RISK)	Description	If demand for services outstrips our capacity to deliver or we do not use our resources efficiently then we will not deliver on the performance commitments outlined in our plans resulting in the Trust not meeting the performance standards and ambitions around patient care and experience we have set ourselves, with potential for increased regulatory oversight, and poorer access to care and patient experience.
Lead Executive director	Chief Delivery Officer	Management Committee	Delivery Oversight Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
12	**12**	**8**	31/03/27	New risk

Controls	Assurance

• Delivery Oversight Framework
• Annual Planning Framework
• Patient Access Policy
• Insourcing contracts
• Capacity & Demand Modelling
• Validation of Waiting Lists
• Care Closer to Home including:
  • Implementing Single Point of Access
  • Regular Capacity & Demand Modelling
• Care on Time including:
  • Implementing Advice & Guidance
  • Improving Booking and Scheduling Digital HIVE workflows
	• Monthly IPR Reported at Clinical Group, DOFs, & DOMC, alignment with NOF scoring
	• Performance Assurance Dashboards
	• Internal Audit Reports
	• GIRFT Hub Accreditation
	• Care Closer to Home Programme Board Highlight Reports
	• Care on Time Programme Board Highlight Reports
	• Major Programme Board Highlight Reports

Controls	Assurance
• Implementing Advice & Guidance • Improving Booking and Scheduling Digital HIVE workflows • Implementing Single Point of Access	

Gaps in controls	Gaps in assurance
• Advice & Guidance – not currently implemented across all services • Integration of Advice and Guidance and eRS • Clinic Template optimisation against GIRFT standards • Single Point of Access requires further roll out • Roll out required of Cancer delivery programme • Delivery of Model ED programme incomplete • Effective management of patients with mental health presentation through UEC impacting ED, flow and length of stay • Roll out of cancer knowledge transfer to all operational and clinical teams	• Some assurance that transformation programmes are delivering expected capacity and productivity benefits. • Limited assurance that demand management schemes will deliver to the required levels in the contract • Some assurance that benefits realisation and performance outcomes are being consistently monitored and evidenced across programmes. • Limited assurance in improvement of patients presenting with mental health concerns

Action being taken to address gaps	Target date	Progress update
Care Closer to Home Programme Expansion: ((Phase 2 rollout, Single Point of Access development and further expansion)	Phase 2 launched: June 2026 Reduced bed demand demonstrated: Sept 2026 Further expansion approved: March 2027	Programme operating according to planned milestones.
Urgent and Emergency Care (UEC) Flow and Capacity Improvements	System collaborative operational model established: October 2026 Benefits realisation plan approved: Dec 2026	Model ED plans in place and mobilised with current delivery on track

Action being taken to address gaps	Target date	Progress update
Elective Care Transformation Programme (pathway redesign, GIRFT implementation, triage models, AI-enabled referral management, Booking & Scheduling)	Pathway redesign and programme plan: June 2026 Triage models operational: October 2026 AI-enabled referral management live: Dec 2026 Booking & Scheduling implementation: March 27	Fortnightly programme board in place reporting to Major Programmes Board. Benefits realisation board being set up in August 2026.
Cancer Improvement Plan	Cancer SDP refreshed: June 2026 Sustainability priorities delivered: Dec 2026 Cancer improvement plan in place and Cancer Community meetings in place quarterly.	SDP plan drafted for approval through July management committee
Cancer expertise and knowledge programme to be developed to support new staff members. Training / awareness sessions to be delivered with each CG	Training programme and SOPs: November 26. Awareness sessions to be completed with each CG: October 26	Training materials under development Sessions commenced June 26 as a programme across the organisation.
Referral monitoring in place with the ICB reviewing high referral areas.	Ongoing collaboration – meetings commenced July 26 and will be established to undertake a monthly review.	Deep dive underway in 3 specialty areas as an output from the initial meeting.
Daily enhanced working with GMMH including patient by patient review. Bi-annual MFT / GMMH workshop	Enhanced reporting on key challenges in place from July 26. Joint sign-off of winter plan actions – September 26	Daily meeting and revised escalations in place. Winter planning on track

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
Delays to diagnosis with patients waiting >6 weeks for diagnostic tests	12	6	31/03/27
Overcrowding in A&E and flow delays across Urgent Care pathways	12	8	31/03/27

Eliminating our longest waits for scheduled care admitted and non-admitted	16	6	31/03/27
Delays to diagnosis and treatment for patients on a Cancer Pathway.	12	6	31/03/27
Urgent and Emergency Care Capacity and Demand (Paediatric)	9	9	18/08/26
Mental Health Waiting Times in the Emergency Department	16	4	01/09/26

Strategic Risk	SAFE DISAGGREGATION OF COMPLEX SERVICES (MFT/007342)	Description	If disaggregation of NMGH catchment activity from the former PAHT and subsequent integration into MFT is not managed effectively, then patient safety could be compromised, patients could be lost between organisations or experience longer waiting times resulting in a negative impact on patient experience and safety, responsiveness of services, financial stability and health inequalities.
Lead Executive director	Acting Chief Strategy Officer	Management Committee	Service Strategy Planning Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
12	**12**	**8**	31/03/27	No change

Controls	Assurance
• Service Exit Plans • Commissioner approval process and documentation • Equality Impact Assessments (EQIA) • Quality Impact Assessments (QIA) • Governance structure with Executive oversight • Internal planning and mobilisation planning for colorectal disaggregation	• GM change management framework and defined commissioner approval process • Monitoring of exit plan delivery at the Joint (NCA/MFT) Disaggregation Group • Bi-monthly Assurance Reports to the Joint Delivery Board • Single Service Plans established for each service • Internal oversight of colorectal through SSMPC
Gaps in controls	**Gaps in assurance**
• Partner agreement to progress colorectal disaggregation The approach to move forward with service change for colorectal will be different to the tested process for other services	• No assurance currently NCA will engage with colorectal bipartite process

Action being taken to address gaps	Target date	Progress update
MFT approved Clinical Models for ENT, Urology T&O and Colorectal	**ENT:** Dec 2023 **Urology:** Dec 2023 **T&O:** Aug 2024 **Colorectal:** Sept 2026	**ENT:** Complete **Urology:** Complete **T&O:** Complete **Colorectal:** In progress
Commissioner & MFT approved plan for T&O colorectal cancer	**T&O**: Oct2023 **Colorectal**: Sept 2026	**T&O**: Complete **Colorectal:** In progress
Delivery of approved Service Exit Plans for ENT, urology, T&O and Colorectal	**ENT:** Apr 2024 **Urology**: Apr 2024 **T&O:** Apr 2024 **Colorectal:** Mar 2027	**ENT:** Complete **Urology:** Complete **T&O:** Complete **Colorectal:** Not yet started
Completion of 3-month post disaggregation review for T&O and colorectal	**T&O:** Aug 2025 **Colorectal:** July 2027	**T&O:** Complete **Colorectal:** Not yet started
Completion of 12-month post disaggregation review for T&O and colorectal	**T&O:** June 2026 **Colorectal:** Apr 2028	**T&O:** In progress **Colorectal:** Not yet started

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
N/A			

Strategic Risk	VASCULAR SERVICE CHANGES IN GREATER MANCHESTER (MFT/008406)	Description	If a single arterial site at MRI is not agreed and implemented to agreed timelines, then a sustainable service for GM may not be delivered resulting in MFT needing to vary its capacity, workforce or plans with an impact on cost, quality or sustainability of services.
Lead Executive director	Acting Chief Strategy Officer	Management Committee	Service Strategy Planning Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
12	**12**	**6**	31/03/27	No change

Controls	Assurance
• Engagement with ICB-led process • Production of MFT-owned outputs • Internal programme and planning arrangements • Engagement with Northern Care Alliance	• Regular reporting through MRI Strategy Sub-Committee and through Vascular Integration Board which includes representation across MFT. • Vascular integration retained as a standing agenda item for the committee. • Commissioner-led service change – 2nd Stage Clinical Senate completed with positive feedback and confirmation of MRI as a single arterial centre as the only viable option. The PCBC has been updated with Service Matter Expert queries addressed and feedback awaited from 2nd Stage NHSE assurance board. Public and Patient Engagement to commence from 1st July 2026. • Bipartite MFT and Northern Care Alliance arrangements established to support clinical pathways, workforce, finance and mobilisation planning. Good progress made to date • Key delivery risks identified, including theatre and ward capacity, specialist workforce recruitment, CSS dependencies and mobilisation timing. • In addition, key risks associated with potential delay in the implementation date identified with NCA colleagues and to address issues with ROH estate risk.

Gaps in controls	Gaps in assurance
• Internal programme plan for implementing the service change insufficiently robust • Low level of engagement with Oldham staff affected to date.	• Limited assurance that theatre, ward, CSS, estates and workforce capacity will be available within the required timescale. • Final bipartite position with Northern Care Alliance agreed across VIR, repatriation, diabetic foot, TUPE, finance and operational readiness. • Limited assurance that affected Oldham staff engagement is sufficiently progressed to support safe implementation. Further evidence required that the internal implementation plan is sufficiently robust to support the target delivery date.

Action being taken to address gaps	Target date	Progress update
To identify and manage the risks associated with the achieving the target deadline	15/10/26	• The programme continues to progress through the commissioner-led service change process. • The second Clinical Senate and second stage assurance process have provided helpful feedback and have strengthened the programme documentation.

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
N/A			

Strategic Risk	**RISK OF CONTINUING TO BE AN ADULT MAJOR TRAUMA PROVIDER (MFT/008405)**	**Description**	If Major Trauma pathways are reconfigured through the planned GM Single Major Trauma System there is a risk that this may result in a significantly different smaller adult major trauma provision at the MRI and over time renewed risk that it will no longer be designated as an adult major trauma provider.
Lead Executive director	Acting Chief Strategy Officer	**Management Committee**	Service Strategy Planning Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
12	**12**	**8**	31/03/27	No change

Controls	Assurance
• Engagement with ICB-led process for single GM Major Trauma system • Production of MFT inputs to process supporting MFT position. • Internal working arrangements. • Consistent MFT challenge to ensure the ICB direction of travel remains consistent with assurances regarding retaining current two site configuration and all the clinical considerations supporting this	• Regular reporting through Service Strategy Planning Management Committee. • MFT engagement in the ICB-led process for the GM Single Major Trauma System. • MFT executive and MRI senior leadership representation on the GM Major Trauma Single Service Planning Board. • Internal working arrangements in place to develop and maintain the MFT position. • Clinical lead appointed to support engagement with GM major trauma clinical and operational leaders. • MFT position continues to support retention of the current two adult major trauma centre configuration. • Current major trauma provision recognised as a strategic risk, with strengthened governance to maintain oversight of neurosurgery, spinal and interventional radiology risks.

Gaps in controls	Gaps in assurance
• Design process to be led by ICB. • Continued ICB leaning and national pressure towards a single adult MTC in GM. • Reliance on collaboration between the two providers will continue to • incentivise NCA to undermine the process as they hope to be designated as a single centre.	• Limited assurance that national or regional pressure for a single adult major trauma centre will not affect the final GM model. • Limited assurance that the emerging pathway and provision model will protect MRI's current role and designation as an adult major trauma provider. Further assurance required on provider alignment, pathway design, workforce resilience and the long-term sustainability of MRI's adult major trauma provision.

Action being taken to address gaps	Target date	Progress update
Plan and engage with design work on GM Single Major Trauma System by developing MFT position, confirming internal roles and mobilising clinical and other colleagues for maximum impact. MFT Execs and MRI SLT members on GM Major Trauma Single Service Planning Board. Clinical lead appointed and will commence work during June 2026 to engage with GM MT clinical and operational leaders to design new pathways and provision model.	31/10/2026	• Major Trauma remains recognised as a strategic risk for MFT and MRI. • Governance has been strengthened to maintain focus on the current risks and to support MFT engagement in the GM Single Major Trauma System design process. • MFT executives and MRI senior leaders are engaged in the GM Major Trauma Single Service Planning Board. • A clinical lead has been appointed and is expected to support engagement with GM major trauma clinical and operational leaders. • MFT continues to develop its position in support of the current two adult major trauma centre configuration. • The key unresolved issues remain neurosurgical provision, spinal recruitment, interventional radiology recruitment, pathway design and the future designation of MRI within the GM model. • The risk score remains unchanged at this stage, pending further assurance on the ICB-led design process and the developing clinical provision model.

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
N/A			

Strategic Risk	**GENOMICS CAPITAL INVESTMENT IMPACTS UPON PRODUCTIVITY (MFT/008409)**	**Description**	If there is insufficient capital funding and/or appropriate facilities available to support planned developments of Genomics services at MFT then the productivity of laboratory services will be limited resulting in an inability to meet growing demand, a loss of future income and reduced benefits to local patients of hosting a centre of excellence.
Lead Executive director	Acting Chief Strategy Officer	**Management Committee**	Service Strategy Planning Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
9	**9**	**6**	31/03/27	No change

Controls	Assurance
• ctDNA implementation in Citylabs 1.0 delivered in Nov 2025 • c. £6m in capital equipment secured in 25/26 to support Genomics developments including productivity. • 5th floor refurbishment capital requirements included in the 26/27 Strategic Capital Plan to support delivery of Whole Genome Sequencing • Formal review in-progress to review Liverpool site options	• Bi-monthly reporting and review through SHCG Strategy Committee • Monthly reporting through SHCG Management Board AAA • Bi-monthly reporting of risk through SSPMC • Monthly executive group review of Genomics developments

Gaps in controls	Gaps in assurance
• Potential funding for automation reliant on national capital bidding process in 26/27.	• Funding dependent on external review by NHSE Genomics Unit for capital funding available for all Genomic Medicine Services to bid against.

Action being taken to address gaps	Target date	Progress update
A business case is in development which explores procurement options for managed service automation system which uses revenue instead of capital funding. Implications for IFRS16 are being explored to understand the viability of this option. However, the revenue option is likely to require further investment, and it is understood that there is no new commissioned income for this service in 2025/26.	30/09/26	• MFT representatives continue to flag the risk of lack of capital to strategic commissioners to highlight the importance of capital to the national programme for genomic expansion, and MFT's ability to respond to this.
Establish a working group to oversee the various Genomics estates projects to support consolidation, including commissioning of Citylabs 1.0 site to support ctDNA, 5th Floor SMH works to accommodate Whole Genome Sequencing and Cytogenetics transfer and automation of both Manchester and Liverpool labs.	31/08/26	• Genomics Consolidation Steering Group provided oversight of the consolidation from 5 sites to 2 sites in 25/26. • Genomics Mobilisation Steering Group now established to oversee planned developments including WGS implementation.
NHSE Genomics Unit capital bid process launched in Q1 26/26 which includes automation, productivity and digital opportunities.	27/07/26	• NW GMS submission made for a range of developments including automation of laboratories. The NHSE GU review process is expected to conclude early July 26.

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
N/A			

ADDITIONAL CORPORATE RISKS RELATED TO STRATEGIC AIM

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
Adherence to the NHS EPRR Framework	12	8	31/03/27
Deprivation of Liberty Safeguards Authorisation Process	10	4	31/03/27
Implementation of Mental Capacity Act 2005	12	4	31/03/27
Use of Ligature(s) as a means to ending life through suicide/ form of self-harm	12	8	30/04/27
Safe and Secure Storage of Medicines	12	8	30/09/26
Application of the Mental Health Act 1983	12	6	30/04/27
Meeting recommendations from national maternity reports (3-year maternity and neonatal delivery plan, Maternity incentive scheme)	8	4	31/03/27
Potential failure of Cryo-storage facilities in DRM	16	10	03/07/26
CQC Recommendations Following Issuance of Section 29A Warning	20	8	04/09/26
Adult and Children Safeguarding Training at Level 3 is not meeting Trust wide standard of 90% of mapped workforce completing the training.	9	3	30/04/27
Safeguarding (Restraint Reduction Network (RRN) standards)	12	9	31/05/27
Patient safety processes	6	4	15/08/26
Inability to Monitor CSF biomarkers (amino acids, neurotransmitters, glucose) in Paediatric Metabolic Patients	12	2	Under review

STRATEGIC AIM 3	**BE THE PLACE WHERE PEOPLE ENJOY WORKING, LEARNING AND BUILDING A CAREER**	**GM mission**	Support our workforce and our carers	**Date of update**	July 2026	**Integrated Performance Report reference**	Page 41 - 50

Linked Strategic Objectives	**We will make sure that our staff feel valued and supported by listening well and responding to their feedback. We will improve the experience of all our staff by embracing diversity and fairness, helping everyone to reach their potential.**	**We will offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here.**
Lead Executive Directors	Chief People Officer	Chief People Officer
Board Committees	People Board Committee	People Board Committee
Management Committee(s)	Workforce and Education Management Committee	Workforce and Education Management Committee

Impact statement	Key metrics for Strategic Aim	Target (March 2027)
More people recommending MFT as a place to work	NHS Staff survey – staff recommending MFT as a place to work	65%

ANNUAL PLAN DELIVERY

2026/27 priorities	Key result	Update
Enable teams to create workplaces where people feel safe and well	Exceed the national average in the 'We are Safe and Healthy' domain in the National Staff Survey	This is an annual metric based on the national staff survey results. The Trust has confirmed "Safe and Healthy" as one of 3 priority areas for focus as a result of the Staff Survey, with a range of workstreams underway to address key issues including violence reduction, prevention and staff wellbeing, Health Care Support Workers, and reasonable adjustments for staff with disabilities and long-term health conditions.
	Reduce the percentage of people stating that they have personally experienced violence	This is an annual metric based on the national staff survey results. However, work to improve this metric continues with a range of workstreams underway to address key issues including a strengthened governance framework through the Violence and Abuse Compliance Group, practical safety measures such as body worn cameras, enhanced CCTV, improved access controls and lone worker protections, training and strengthened reporting.
	Increase the percentage of those who believe the organisation takes a positive interest in health and wellbeing.	This is an annual metric based on the national staff survey results. See updated provided above.

Enable teams to create workplaces where people feel safe and well	Reduce sickness absence to 5.4% by Q4.	Sickness absence rates continue to present a challenge and are recorded below. It is intended that the work outlined above will positively contribute to the achievement of the target. M03: Rolling 12M 6.0%, Single Month 6.0%
Enable people to develop the skills needed to deliver high quality care in the future, including digital and improvement skills. Ensure we are data-driven, providing people with the information they need to improve their services	Achieve 90% essential user personalisation in Epic by end of Q4 through delivery of the Thrive training offer	49% complete as at 22 June and on-track to deliver by Q4.
	Achieve 25% advanced user personalisation in Epic by end of Q4 through delivery of the Thrive training offer	13% complete as at 22 June and on-track to deliver by Q4.
	650 colleagues will have been enrolled in the Improvement Academy by Q4.	281 colleagues completed or enrolled on courses in Q1.
Embed our new, clinically-led operating model, continuing to build an inclusive, engaged organisation where everyone has a sense of value and belonging	Improve our response rate to the 2026 National Staff Survey by at least 10 percentage points and exceed the national average with our Staff Engagement score.	Significant work has been undertaken to support the Trust objective of increasing NHS Staff Survey participation. A phased “you said, we did” campaign is now underway, ensuring progress, feedback and positive change remain visible across Trust communications ahead of the 2026 Staff Survey launch.

STRATEGIC RISKS

Strategic Risk	**ABSENCE AND ENGAGEMENT (Ref. TBC)**	**Description**	If the Trust is unable to sustain a happy, supported and healthy workforce, including effectively managing sickness absence and workforce wellbeing, this will compromise the Trust's ability to deliver safe, high-quality patient care and its wider strategic objectives.
Lead Executive director	Chief People Officer	**Management Committee**	Workforce and Education Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
12	**12**	**8**	31/03/27	New risk

Controls	Assurance
• MSK Support • Mental Health Support • Fitness to work Support • Health Promotion • Sickness Absence Policy • CEO Led Staff Engagement & Culture Forum • Change Agent Infrastructure • What Matters to Colleagues Pilot • TJNCC • Staff Network Infrastructure • Leadership Summits	• Annual Performance Report • Empactis Policy Compliance Report • IPR Report – Sickness Absence • Staff Survey Results/Dashboard • Culture Corners • Network of Networks report through to TEDHRG • IPR Report – Turnover • Signed Sexual Safety Charter • Workforce Race Equality Scheme • Workforce Disability Equality Scheme • NHS England Workforce Oversight Meeting

Controls	Assurance
• Sexual Safety Group • Violence and Abuse Group	• National Sexual Safety Charter commitment

Gaps in controls	Gaps in assurance
• Accessibility of MSK support limited to certain sites • Mental Health Support does not meet the demand required • Sickness Absence Policy requires updating • Variation in application of sickness absence management across Clinical Groups • Some workforce plans dependent on reduction in sickness absence • Inconsistent staff engagement model across the Trust • Sexual Safety Policy does not align with NHS E template policy • No consistent Leadership Development Programme provision for MFT	• Absence due to Mental Health is the highest proportion of sickness • Empactis Policy Compliance Report highlights inconsistencies in compliance of application of the policy • Limited triangulation between workforce metrics and staff experience • Limited evidence of impact of wellbeing interventions beyond activity measures • Both WRES and WDES Data identify inequalities in experience

Action being taken to address gaps	Target date	Progress update
Develop and implement a Trust-wide sickness absence improvement plan	31/08/26	In progress – Initial draft submitted to TLTC and further work being undertaken to build up a full prevention strategy. Following review with TLTC agreed priority areas will be Women's Health, Mental Health, MSK and Cardiovascular. Additionally, MFT is engaged in early discussions with NHS England regarding the potential of hosting a regional Staff Treatment Hub which will form an integral part of our improvement plan.
Embed CEO Culture and Staff Experience Forum	31/10/26	In progress – initial meeting held

Action being taken to address gaps	Target date	Progress update
Draft and finalise new Sickness Absence Policy	30/09/26	
Develop a Culture Dashboard	31/01/26	In progress – request with Digital Services Team
Raise profile and visibility of MFT approach to Sexual Safety	31/07/26	Visual identify work in progress. Initial draft shared and awaiting finalisation.
Draft and finalise new Sexual Safety Policy	30/09/26	NHS E policy adapted into MFT template and shared with stakeholders
Agree and roll out a MFT Leadership Development Programme for Bands 5 to 8a	31/10/26	
Develop and implement Trust-wide WDES and WRES Improvement Plans	31/07/26	

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
TBC			

Strategic Risk	HEADCOUNT REDUCTION (Ref. TBC)	Description	If the Trust is unable to deliver the planned workforce reduction of 1,188 Whole Time Equivalents (WTEs) linked to the Value for Patients (VfP) programme, workforce costs will remain above plan and anticipated productivity improvements will not be realised. This will result in a failure to deliver required financial savings, a sustained financial deficit, and a reduced ability to maintain safe, high-quality patient care. Additionally, the management of headcount reductions may negatively impact staff morale, wellbeing and engagement, increasing the risk of reduced motivation, higher sickness absence and turnover, and reduced service resilience.
Lead Executive director	Chief People Officer	Management Committee	Workforce and Education Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
12	16	8	31/03/27	New risk

Controls	Assurance
• Workforce plan aligned to Value for Patients target of 1,188 WTE reduction • Vacancy control measures including restrictions on external recruitment • Workforce VFP programme governance (Wave stage-gate process) • Workforce Steering Group • Workforce Delivery Group • Clinical Group and Corporate workforce plans aligned to annual planning process	• Workforce performance to plan reporting (WTE vs plan via WAVE, ledger and dashboards) • Recruitment, vacancy and run-rate cost reports to Workforce Steering Group • Programme reporting on scheme maturity (L3+) and delivery risk • Monthly reporting through WEMC, Workforce Steering Group and finance governance • Finance reporting of savings delivery against VFP targets

Controls	Assurance
• Financial recovery and cost improvement plans linked to workforce reductions • Integrated workforce and finance planning processes • QIA process well established and aligned to Wave	• Triangulation between workforce, finance and operational plans • NHS England Provider Workforce Return (PWR) • GM ICB Led Provider Oversight Meetings (where progress reports are provided)

Gaps in controls	Gaps in assurance
• Insufficient identified WTE reductions to meet full 1,188 target (significant remaining gap) • High proportion of schemes not yet at delivery maturity (L3+) • Dependency on vacancy control and natural turnover rather than structural workforce change • Incomplete linkage between some schemes and quantified WTE reductions • Reliance on workforce reduction delivery within tight timescales	• Limited confidence in accuracy and alignment of WTE data across systems (WAVE vs ledger) • Limited real-time assurance on actual vs planned WTE reduction delivery • Inconsistent Clinical Group level assurance on delivery against plan • Data quality issues limiting confidence in reported VFP and WTE impact • Limited leading indicators to identify shortfall early in delivery cycle

Action being taken to address gaps	Target date	Progress update
Identify additional WTE reduction schemes to close gap to 1,188 target	31/07/26	
Accelerate progression of schemes to L3+ delivery maturity via Wave	31/07/26	
Maintain strengthened vacancy controls and recruitment governance across Trust	Ongoing	

Action being taken to address gaps	Target date	Progress update
Improve data quality and alignment between WAVE, ledger and workforce systems	30/06/26	COMPLETE: Through engagement with Clinical Groups the Performance to Plan pack format agreed which presents data in ways that reflect WAVE, Ledger and ESR.
Strengthen Clinical Group accountability for delivery of WTE reduction plans	31/10/26	
Align workforce, finance and operational reporting to provide single version of truth	30/08/26	
Continue with delivery and alignment of work in relation to the People Plan to ensure morale is maintained	Ongoing	
Implement effective communications plan to support VfP programme	Ongoing	Communications plan in place
Ensure robust Quality Impact Assessment (QIA) process is embedded to support any reductions have senior clinical oversight	30/06/26	COMPLETE: QIA process agreed. All schemes on Wave required sign off by Deputy Chief Nurse.

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
TBC			

STRATEGIC AIM 4	ENSURE VALUE FOR OUR PATIENTS AND COMMUNITIES BY MAKING THE BEST USE OF OUR RESOURCES	GM mission	Achieve financial sustainability	Date of update	July 2026	Integrated Performance Report reference	Pages 51 - 64

Linked Strategic Objectives	We will achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.	We will deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships.
Lead Executive Directors	Chief Finance Officer Deputy Trust Chief Executive	Chief Digital and Information Officer Chief Delivery Officer
Board Committees	Finance Board Committee	Digital and Estates Board Committee
Management Committee(s)	Finance and Commercial Management Committee Delivery Oversight Management Committee	Digital Management Oversight Committee Delivery Oversight Management Committee

Impact statement	Key metrics for Strategic Aim	Target (March 2027)
Make the biggest possible difference with the resources we have by delivering our financial plans	Delivery of our financial plan implied productivity	Target in development

ANNUAL PLAN DELIVERY

2026/27 priorities	Key result	Update
Improve our productivity and increase commercial income to deliver our financial plan	Increase the average cases per 4-hour theatre session in nationally benchmarked specialties to 2.2 by Q4.	The average number of cases per session for MFT at June 26 is 1.88 compared to 1.84 in Apr 26. Continued improvements in theatre utilisation, elective hub productivity and scheduling efficiency are increasing surgical capacity and supporting the reduction of long waiting times.
	Reduce DNAs to at least 7% by Q4.	Outpatient DNA rate at June 26, 9.4%. There are a number of key actions in place under the Care on Time programme to support reduction in DNAs, including patient self-scheduling.
	Reduce urgent and emergency care demand through an expansion of the Care Closer to Home programme to Wythenshawe and NMGH, releasing 120 beds by Q4.	Progress has been made in aligning complex discharge teams and processes across the system, establishing multidisciplinary review arrangements and developing a shared operating procedure. Oversight and improvement structures are now in place, supported by enhanced system visibility through new complex discharge reporting.
	Deliver £175m of Value for Patients schemes, with 75% as recurrent improvements by Q4.	At the end of Q1 we have identified c. £150m in plan against a target of £175m. Risk adjusted (reflecting maturity of schemes to deliver) this is c. £80m. Within Q1, c. £27m has been delivered against a target of £42m, reflecting a shortfall, whilst also offering a significant improvement on last years delivery. We remain on track for at least 75% of our delivery being recurrent. Work

		continues to progress scheme identification and delivery as we step into Q2.
Progress plans to redevelop the NMGH campus, delivering a refreshed Outline Business Case whilst making best use of existing estate across MFT	Develop the business case for the redevelopment of North Manchester General Hospital, achieving RIBA Stage 1 by the end of Q2 and Stage 2 by the end of Q4.	Good progress has been made on RIBA 1 for the main acute, and this is on-track for completion before end of Q2. The approach to design for the standalone outpatient building is now agreed with NHP – RIBA 1 for this facility will also complete before end of Q2. Planning has commenced for RIBA 2 according to the agreed programme plan.
Take forward plans to implement a digital solution for community services and to support digital integration with the wider system.	We will commence implementation of a new EPR for the Local Care Organisations by Q2, with system configuration finalised by Q4.	LCO EPR pre-implementation phase underway with formal programme commencing in July. Formal programme board in place, chaired by LCOD Chief Executive, with wider governance such as Rapid Decision Groups (RDGs) being established.

STRATEGIC RISKS

Strategic Risk	**IMPLICATIONS OF NATIONAL RESTRICTIONS ON CAPITAL RESOURCE (MFT/001791)**	**Description**	If we continue to experience restrictions to capital resource then we will be unable to invest in our infrastructure, medical equipment and digital assets resulting in adverse impacts on service delivery, the safety of our estate for staff and patients and our ability to deliver our strategic ambitions.
Lead Executive director	Chief Finance Officer	**Management Committee**	Finance and Commercial Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
6	**20**	**12**	31/03/27	Current score increased from 16 to 20

Controls	Assurance
• Engagement at national, regional and ICB level and application for other sources of funding e.g. TIF, CDC funding • At each annual planning round the Trust undertakes a robust prioritisation process covering estates, digital, and medical equipment capital requirements. • Prioritisation QIAs completed and risk assessment against programme and planning completed over multiple years to prioritise highest risk capital replacement spend.	• Capital reporting to CMMG and SCG, core capital and other in year funding requests reported alongside progress and spend against allocation. • Close monitoring of capital programme and associated risks re. funding and delivery of programme at Board level and Capital Management Monitoring Group (CMMG), which reports into Strategic Capital Group (SCG) which reports into FCMC.

Gaps in controls	Gaps in assurance
• Core allocations have seen increase in year but do not cover the backlog maintenance, medical equipment replacement needs and digital refresh backlog.	

Action being taken to address gaps	Target date	Progress update
Engagement in GM ICB process to ensure the funding requirements and priorities of MFT are clear and set out the consequences of not meeting these requirements.	31/03/27	This is ongoing as part of the annual planning, but also in year as specific funding allocations are made available at a regional and national level.
Capital Deep Dive to be presented to TROC.	29/06/26	Complete

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
N/A			

Strategic Risk	DELIVERING FINANCIAL SUSTAINABILITY IN THE MEDIUM TERM (MFT/005092)	Description	If we are unable to achieve our value for patients target, generate sufficient income or manage cost pressures then we would be unable to deliver financial sustainability in the medium term resulting in insufficient cash to meet expenditure obligations, without emergency cash support from NHSE.
Lead Executive director	Chief Finance Officer	Management Committee	Finance and Commercial Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
20	20	10	31/03/27	No change

Controls	Assurance
• Enhanced financial controls put in place including agency control, additional challenge and scrutiny on substantive recruitment and further discretionary spending controls. • At least monthly review of financial performance against revised Control Totals that reflect the revised financial regime, reviews now extended to include productivity and workforce. • An Executive led Vacancy Control Panel has been implemented. • Enhanced VfP reporting and scrutiny introduced in 2026/27 with bi-weekly meetings with Clinical Groups and SFO Deputy CE and VfP Programme Manager. This is focused upon maturing VfP scheme development and moving schemes to cash releasing status. • Monthly contract meetings with our main commissioners to monitor performance against income plan. • Daily cash management actions in place to increase cash preservation and ensure the Trust retains sufficient cash to pay its suppliers and payroll. • Working with Commissioners to identify income which can be paid in advance to the Trust to help mitigate any shortfall in cash releasing VfP delivery.	• Monthly reporting through Clinical Group Management Boards, FCMC, TLTC. FBC and Board reporting on a bi-monthly basis. • VfP reporting through FCMC, TLTC, and FPC and Board. Weekly reporting into NHSE Regional Team. • Monthly variance reporting to Clinical Group Management Boards, FCMC, TLTC. FBC and Board reporting on a bi-monthly basis. • Cash management and monitoring group chaired by CFO, which monitors actions. Bi-weekly update to TLTC and monthly updates to FCMC. B-monthly updates to FBC and Board.

Gaps in controls	Gaps in assurance
• Outstanding VfP delivery plan of approx. £110m which needs to be identified and converted to cash releasing savings.	• Weekly reporting of short-term actions on bank, agency, and ECL reductions in place, but requires embedding.

Action being taken to address gaps	Target date	Progress update
MFT will need to deliver finance balance in 26/27, including delivery of a £175m VFP. This includes a minimum reduction of 1,188 WTE headcount reduction compared to the exit run rate.	31/03/27	Schemes to the value of c£110m have been identified to date, with each CG and corporate areas tasked with rapidly improving the maturity of these schemes.
Continued monitoring of weekly reporting of short-term actions on bank, agency and ECL reductions.	31/08/26	Reporting implemented in May 2026, ongoing review and monitoring in place.

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
Risk of insufficient cash resources to fund Trust operational and strategic requirements in 2026/27 and beyond. (MFT/008655)	16	2	31/03/27
Commissioner Affordability Constraints for MFT Activity Related Income delivery (MFT/008897)	20	20	31/03/27

Strategic Risk	**INABILITY TO PROVIDE A FULLY COMPLIANT ESTATE RELATING TO ESTATES INFRASTRUCTURE AND SERVICES AND FULLY COMPLY WITH STATUTORY SAFETY LEGISLATION (MFT/008283)**	Description	If we do not have sufficient funding and appropriately qualified and experienced workforce then we will not have a fully compliant and safe estate resulting in a deterioration in the condition of the estate, financial implications, impact on staff, patient and public health, safety and wellbeing and experience and an increase in regulatory involvement.
Lead Executive director	Chief Delivery Officer	Management Committee	Delivery Oversight Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
20	**20**	**10**	31/03/30	No change

Controls	Assurance
• Estates and Facilities (E&F) Strategy in place. • E&F Capital allocation (backlog maintenance and equipment allocation received annually and reviewed using Department of Health/Trust risk methodology • Six facet /condition surveys (NHS property appraisal) take place every 5 years across MFT to identify condition of properties. • External estates review commissioned of the MFT Estate - commenced September 2024. • Annual Authorised Engineer/Independent Advisor audits carried out on Health Technical Memorandum (HTM)/safety disciplines on an annual basis.	• Condition audits outcomes are fed into site spreadsheets on infrastructure list noting risk and reviewed against annual capital backlog and NHSE safety fund allocation. • Estates reviews carried out for Community and Acute. LCO/UDHM reviewed and LCO/UDHM Delivery Team picked up community opportunities, delivered against early wins and have a medium / long term strategy in development. • Computer Aided Facility Management Software and Service Helpdesks are in place across all sites for scheduling/monitoring planned preventative maintenance and reactive works.

Controls	Assurance
• Planned Preventative Maintenance (PPM) Program in place with process for following up non-compliances. • Governance Framework in place to ensure all clear processes in place for HTM/Safety compliance.	

Gaps in controls	Gaps in assurance
• Current Estates and Facilities Strategy does not fully align to 'One MFT' and current MFT Annual Plan. • Currently awaiting final confirmation of MFT Capital funding allocation for estates equipment and backlog maintenance and NHSE Safety Fund allocation for backlog/safety for 26/27 year. • Currently no formal internal audit programme within E&F in place to review 'helpdesk' jobs to identify closure per priority rating or items closed without being resolved • Not all jobs logged on the 'helpdesk' as reactive jobs may be actioned upon as per the priority rating or may be closed on the system without the issue being resolved. • A number of E&F related risks on the risk register owned by Clinical Groups may not be visible to E&F and vice versa. • CCTV footage viewing currently relies on security team to support and review CCTV does not cover all areas. • MFT H&S e-learning has switched to the national NHS H&S e-learning module and uncertain if built environment section is still included	• A new Estates & Facilities Strategic Delivery Plan is in draft for consideration by Delivery Oversight Management Committee in August 2026. • Actions outstanding relating to external estates reviews. • No risk assessment in place on register relating to PFI Wythenshawe risks to document formally. PFI ORC risk now on risk register as strategic risk • E&F teams may not have full oversight of risks relating to infrastructure / estate to inform backlog maintenance allocation or to link with Estates Strategic; Corporate; or Operational risks

Action being taken to address gaps	Target date	Progress update
Review current Estates strategy against Trust 'One MFT', current Annual Plan and other Trust strategies and develop a E&F Strategy delivery plan (this may be part of the Trust strategic delivery plan)	31/07/26	Review of E&F Strategy against the Trusts current Annual Plan is in development by E&F SLT to create an E&F Strategic Delivery Plan. Links to actions identified in the Estates Review for Acute.
Review of current backlog maintenance allocation and programme take into account any changes in funding or priority by E&F SLT.	30/06/26	COMPLETE
Review significant risks relating to E&F equipment to ensure the risk assessments are developed and documented on the risk register by E&F SLT	31/05/26	COMPLETE
Review/audit of ORC helpdesk jobs closed to determine if jobs are closed on system without solving and if non-compliances exist	30/09/26	Not started. Revised date and action owner noted in previous BAF report updated on risk register.
Review/audit of WTWA helpdesk jobs closed to determine if jobs are closed on system without solving and if non-compliances exist	30/09/26	Not started. Revised date and action owner noted in previous BAF report updated on risk register.
Review/audit of NMGH helpdesk jobs closed to determine if jobs are closed on system without solving and if non-compliances exist	30/09/26	Not started. Revised date and action owner noted in previous BAF report updated on risk register.
E&F CRaG Team work with Trust Clinical Governance / Risk Management Team to identify E&F related risks currently 'owned' by CGs to ensure they reflect the current status of risk and correct actions for E&F are captured and agreed with E&F	30/09/26	As of end 25/26 year there were over 360 Clinical Group 'owned' risks (searched under 'Infrastructure' and 'H&S'). Further work underway with Trust Deputy Director of Clinical Governance/Risk Management as part of wider Risk Management Strategy review. Awaiting dates from Clinical Groups for E&F Compliance Managers to begin to attend CG risk meetings.
Review lifecycle plans for PFI Wythenshawe to develop risk register assessment - EH as action owner as NM unable to be added on system	30/09/26	Not yet started – target date not met. Revised target date identified. COBP progress reviewed and risk associated with lifecycle to be added onto register following E&F Governance process for risk management.
Ensure E&F workforce & development group is included in the updated E&F Divisional Governance Framework Policy for June 2026 EFMG ratification and begins in Q2 2026/27.	30/09/26	To be further discussed with new Director of E&F upon appointment. Chair required as E&F do not have a dedicated HR Director / SLT member for Workforce & Development. Currently included in Divisional Governance

Action being taken to address gaps	Target date	Progress update
		Framework meeting structure as agreed with SLT given importance of this and size / varied workforce. Revised completion date to end of Q2 to enable meeting to be re-established.

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
MFT/008419: Management of asbestos	16	8	31/12/26
MFT/005527: Failure of Reinforced Autoclaved Aerated Concrete	15	5	31/03/27
MFT/008818: Security Management	20	4	31/03/27
MFT/007067: Fire safety management and building compliance	15	5	30/12/27

Strategic Risk	NORTH MANCHESTER NEW HOSPITAL DEVELOPMENT (MFT/009206)	Description	If the North Manchester New Hospital project fails to deliver its planned investment objectives and defined benefits, the operational capability and provision of safe and adequate care for patients and staff will be significantly compromised, with reduced capacity to meet demand, limited service transformation, increased financial and estate risk, potential scope reduction and reputational impact.
Lead Executive director	Chief Finance Officer	Management Committee	NMGH Strategic Programme Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
20	20	15	31/03/28	New risk

Controls	Assurance
Project Governance • Project governance processes reviewed, updated and implement in April 2026. Annual review process implemented to support the review of governance processes to include independent programme of assurance. • New structure of reporting, approvals and delegated authorities implemented 01 April 2026. • Integrated Project Plan (IPP) jointly developed with NHP, Trust and Trust design team specialists with clear set of assumptions and covering all key workstream activities.	**Project Governance** • Regular reporting of project matters through established project governance processes. • Project resource gaps being addressed i.e. recruitment of staff progressing. **Clinical & Transformation** • Outpatients Transformation Working Group established at NMGH. **Technical Design and Construction** • Technical design assurance processes in place.

Controls	Assurance
• Project Resources Plan established to support delivery through to FBC with phased appointment of resources through to commencement of RIBA Stage 2. **Clinical & Transformation** • Demand and Capacity Model jointly agreed with NHP and Health Economy partners. • Right-sized Schedule of Accommodation (SoA) jointly developed and approved by NHP. • Demand mitigation measures identified and to be developed throughout the OBC development stage with the Transformation Project. **Technical Design & Construction** • Experienced Technical Design Team onboarded. • Technical design processes established to support delivery throughout RIBA Design Stages. • Robust change control processes to be implemented. • NHP TEMS process incorporated within the Integrated Project Plan (IPP). • Processes in place to secure approval of technical derogations if and where required. • SRF established with MCC from a Town Planning Framework. • Stakeholder Engagement Plan to plan communication and engagement of key stakeholders aligned to design development process. **Digital/Equipment** • Digital/Equipment Plans in place to support current stage of the Project. • Digital Strategy established, updated and realigned. • Equipment Strategy established to define future planning. **Financial, Legal and Commercial** • Financial procedures and controls established. • 7-Year Financial & Resources Plan established to support delivery of the New Hospital Project. • New Project Financial Controls implemented from 01 April 2026.	• Evidence of staff engagement in the development of the design solution. • Regular progress updated to develop the design solution presented through Project Governance arrangements. **Digital and Equipment** • Digital design deliverables submitted and reviewed through Project governance arrangements. **Financial, Legal and Commercial** • Monthly financial reporting against plans and other capital metrics e.g. inflation. • External Legal advice in place to provide assurance. **Communications and Engagement** • Effectiveness review of governance arrangements to be completed.

Controls	Assurance
• Robust Change Control Processes. • Key contracts agreed and NHP agreement in place **Communications & Engagement** • Communication & Engagement processes and established. • Project Communications & Engagement Strategy and reporting process established supported by an Annual Plan and Quarterly Plan with progress reported to the Project Board monthly basis.	

Gaps in controls	Gaps in assurance
Project Governance • Governance arrangements not fully implemented with some groups continuing to be established. • Internal and external resourcing gaps remaining within the Team necessary to fully support RIBA Stage 2 commencement. • Programme Planning assumptions remain to be agreed with NHP. **Clinical & Transformation** • Continue work to define, establish and fully resource the Transformation Project as part of the NMGH Redevelopment Programme is continuing. • Stakeholder Partnership Group involving Health economy partners to be established to support future approvals. **Technical Design & Construction** • Define and agreed baseline technical design solution • Agree Construction, Buildability and Enabling Works Strategy **Digital/Equipment** • Monitoring and reporting process to be implemented to support achievement of equipment transfer assumptions.	**Project Governance** • Effectiveness review of governance arrangements to be completed. **Technical Design & Construction** • Technical design assurance for future stages (beyond the current stage) planned but not fully implemented. • Assurance surrounding deliverability of programme planning assumptions. **Digital/Equipment** • Assurance information surrounding the introduction of POLAN.

• POLAN – design is currently being progressed based upon an NHP mandated system that requires further evidence-based testing. • Alternative medical and non-medical equipment funding solutions to be identified. • Site equipment information held has gaps and not fully reliable. **Financial, Legal and Commercial** • Early revenue and benefit assessment work remains to be completed, and commitments nationally remain to be confirmed to understand affordability of the Project. • Scope assumptions not fully defined until completion and agreement of RIBA Stage 1. • Route to affordability not fully defined and agreed. **Communications & Engagement** • Resource constraints potentially limiting breadth and depth of communication and engagement activity.	

Action being taken to address gaps	Target date	Progress update
Finalise implementation of Project governance arrangements	18/09/26	Key components of governance arrangements established and operating
(Continue full-time recruitment but continue to appoint external specialists to meet gaps in resourcing.	31/07/26 & Ongoing	
Agree a plan with NHP to confirm acceptance or otherwise to Programme Plan Assumptions	10/07/26	Call held with NHP on 09/07/26. NHP holding Commercial Meeting to review and confirm.
Complete effectiveness review of governance arrangements	27/11/26	
Complete definition of Transformation Project	18/08/26	Deep dive into Transformation Project at NMBC scheduled for 18/08/26
Stakeholder Partnership Group to be established by 18/09/26	18/09/26	Stakeholder Partnership Group ToRs and membership approved at Project Board – June 2026

Action being taken to address gaps	Target date	Progress update
Finalise RIBA Stage 1 for Acute and OPD to provide a clear technical framework to support acceleration forwards.	31/07/26	On plan to complete RIBA Stage 1 (Acute and OPD) by 31/07/26
Finalise Construction, Buildability and Enabling Works Strategy	31/07/26	On plan to complete by 31/07/26. Meetings to be scheduled with Bovis following 3 August
Confirm equipment transfer and scope assumptions and establish internal monitoring processes	31/07/26	Preliminary plan to be established for 31/07/26 to be progressively developed.
Review NHP POLAN implementation trial and complete MFT operational risk assessment	25/09/26	Update report to be presented to New Hospital Project Board mid-August 2026.
Identify opportunities for alternative funding strategies for medical and non-medical equipment	31/12/26 & Ongoing	
Work with MFT to define and agree a baseline of equipment information for NMGH.	31/12/26 & Ongoing	
Obtain and assess NHP assurance surrounding POLAN implementation.	25/09/26	Update report to be presented to New Hospital Project Board mid-August 2026.
Complete preliminary revenue and benefit assessment work	28/08/26	
Finalise RIBA Stage 1 and baseline scoping and responsibility assumptions	31/07/26	On target to complete by 31/07/26
Work with NHP to define a route to affordability	31/07/26	Meeting held with NHP on 09/07/26 and affordability information sent to NHP as requested. Letter issued to Natalie Forrest / Matthew Coats
Review communications and engagement opportunities from Stage 2 and develop an aligned resourcing strategy	28/08/26	

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
N/A			

Strategic Risk	**PATIENT RECORDS**	**Description**	If there are insufficient systems, processes, controls and assurance to manage the use of the patient record then key clinical information, including diagnostics, results and follow-up actions, may not be consistently recorded, reviewed or acted upon in a timely manner resulting in patients being lost to follow-up (including following DNAs), delays to diagnosis and treatment, increased risk of patient harm, deterioration in clinical outcomes, and adverse impacts on quality, performance and patient experience.
Lead Executive director	Chief Digital and Information Officer	**Management Committee**	Digital Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
20	**20**	**8**	Under review	New risk

Controls	Assurance
• Validation and harm review: Systematic clinical validation and risk stratification of cohorts • Governance strengthening: Integration of SIOG, Data Quality Steering Group, and quality governance, with clearly defined ownership, controls, and measurable thresholds for acceptable performance • Process standardisation: SOPs, training, and pathway management improvements for both digital and non-digital record keeping processes • Digital fixes and controls: Workflow improvements and monitoring mechanisms	• Data visibility and dashboards: Development of Trust-wide patient safety dashboards • Incident management & assurance: Weekly Incident Management Groups and Patient Safety Oversight Panels

Gaps in controls	Gaps in assurance
• Reliance on manual validation rather than automated controls • Lack of sustained workforce capability and training in digital workflows • Gaps in links into Quality and Safety governance.	• Gaps in real-time patient-level visibility across all pathways

Action being taken to address gaps	Target date	Progress update
Service review of existing issues, scale and high-risk patient cohorts	31/07/26	In progress with update at next Serious Incident Oversight Group meeting
Update Patient Access Policy and review compliance	31/07/26	Oversight through Delivery Oversight Management Committee
Training needs analysis for EPR workflows and non-digital record keeping workflows	31/07/26	Digital Management Committee oversight for digital workflows, Quality & Safety Management Committee oversight for non-digital workflows
Mandatory registration training and smart cards	31/07/26	Oversight through Workforce and Education Management Committee
Close validated / completed issues	31/07/26	Oversight through Digital Management Committee
Stratify and prioritise remaining validation cohorts	31/07/26	Oversight through Digital Management Committee (stratification) and Quality & Safety Management Committee (prioritisation)
Clarity and formalise governance relating to digital patient safety – including updated Terms of Reference and escalation processes.	31/07/26	Updated Terms of Reference to be to be reviewed/approved at Quality and Safety Management Committee in July 2026.
Deliver Hive deficiency dashboard to support ongoing oversight	31/07/26	Oversight through Digital Management Committee

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
N/A			

Strategic Risk	**CYBER SECURITY RISK - TRUST IT (MFT/000363)** **(Risk overseen through Digital and Estates Board Committee)**	**Description**	If the security for the IT infrastructure including IT network, IT hardware and software is not robust or not kept up-to-date, then there may be vulnerabilities to allow a malicious or cyber-security attack resulting in loss of access to systems, or loss of data, or unauthorised access to data which will cause harm to individuals (patients and staff) and will impact on patient care, compliance / regulatory risk, financial and reputational damage.
Lead Executive director	Chief Digital and Information Officer	**Management Committee**	Digital Management Committee

Strategic Risk	**LOSS OR INSTABILITY OF DIGITAL INFRASTRUCTURE (MFT/008780)** **(Risk overseen through Digital and Estates Board Committee)**	**Description**	If critical findings, actions and vulnerabilities from digital infrastructure design and audit activities are not resolved, then there may be loss or instability of digital infrastructure. Resulting in loss of access to clinical and business applications which will cause harm to individuals and will impact on the provision of safe and high quality patient care, the productivity and efficiency of the workforce, and the potential for reputational damage and adverse publicity.
Lead Executive director	Chief Digital and Information Officer	**Management Committee**	Digital Management Committee

STRATEGIC AIM 5	**DELIVER WORLD-CLASS RESEARCH AND INNOVATION THAT IMPROVES PEOPLE'S LIVES**	**GM mission**	Improve quality and safety and addressing inequalities	**Date of update**	July 2026	**Integrated Performance Report reference**	Pages 65 - 69

Linked Strategic Objectives	**We will strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part.**	**We will apply research and innovation, building on our position as a digital leader and embracing new technology such as artificial intelligence, to improve people's health and transform the services we provide.**
Lead Executive Directors	Joint Chief Medical Officer	Joint Chief Medical Officer
Board Committees	Research, Innovation and Population Health Board Committee	Research, Innovation and Population Health Board Committee
Management Committee(s)	Research and Innovation Management Committee	Research and Innovation Management Committee

Impact statement	Key metrics for Strategic Aim	Target (March 2027)
More people benefitting from world-class research and innovation	Weighted annual total number of participants recruited to non-commercially sponsored research studies	1,245,500
	Nature index ranking	6

ANNUAL PLAN DELIVERY

2026/27 priorities	Key result	Update
Make it easier for people to take part in research and innovation, growing the volume and value of our R&I activity	Increase number of research studies hitting 150-day target by 50% by August 2026.	Set up times have decreased for commercial and non-commercial sponsored projects from 150 and 125 mean days in August 2025, to 50 and 80 days in April 2026. First recruit times have decreased for commercial and non-commercial sponsored projects from 30 and 125 mean days in August 2025 to 10 and 20 days in April 2026. This shows significant progress towards maintaining average performance below the target days by August 2026.
Develop our digital infrastructure and embrace technology, including AI and wearables, to drive new models of care, improve quality and productivity across the organisation	By Q1 we will have undertaken an AVT (Ambient Voice Technology) pilot and Evaluation across 2 platforms for up to 600 users.	There were 406 users of AVT across MFT as at 2 July. An investment case for further roll-out is in development
	Using MyMFT, we will increase remote hypertension monitoring and other telehealth services in maternity by 5% by the end of Q3.	There has been a 26% increase in number of patients enrolled in MyMFT for hypertension from 680 patients in March to 860 in June.
Improve the strategic alignment between MFT and our academic and industry partners	Finalise a partnership agreement and programme of work with the University of Manchester by the end of Quarter 2	There has been a 26% increase in number of patients enrolled in MyMFT for hypertension from 680 patients in March to 860 in June. Work with the University of Manchester remains on-track, with a draft partnership agreement in development.

STRATEGIC RISKS

Strategic Risk	**HOSTING OF MULTIPLE NATIONAL INSTITUTE FOR HEALTH AND CARE RESEARCH (NIHR) INFRASTRUCTURE CENTRES (MFT/008648)**	**Description**	If MFT failed in a bid to host NIHR infrastructure then there could be a reduction in our reputation as an organisation trusted to deliver high quality R&I services resulting in a negative impact on applications to other research funders and wider perceptions of MFT.
Lead Executive director	Joint Chief Medical Officer	**Management Committee**	Research and Innovation Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented
12	**12**	**12**	01/06/2027	Change to target date

Controls	Assurance
High quality of existing performance and strength of partnership working across the multiple NIHR infrastructure centres MFT hosts on behalf of the wider system.	Annual reporting by all hosted NIHR infrastructure centres have been completed on time and received positive feedback for demonstrated high performance.

Gaps in controls	Gaps in assurance
N/A	N/A

Action being taken to address gaps	Target date	Progress update
Complete all annual reporting requirements on time for NIHR by all infrastructure centres.	30/09/26	Reporting underway
Processes are established for strong partnership working of MFT with University of Manchester and other Greater Manchester/North West NHS Trusts drawing on talented individuals across the system. This varies depending on nature of the infrastructure centre. Next funding round for NIHR Biomedical Research Centre has been announced, with details for timelines to follow.	06/7/26	COMPLETE
Application for an MFT hosted NIHR Manchester Biomedical Research Centre to be undertaken led by Director of the MBRC	18/09/26	New Action

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
N/A			

Manchester University
NHS Foundation Trust

Public Board of Directors

Thursday 30th July 2026

Paper title:	Integrated Performance Report (IPR)	**Agenda Item 9.2**
Presented by:	Chief Delivery Officer Chief Nursing Officer Joint Chief Medical Officers Chief Finance Officer Chief Digital Information Officer	
Prepared by:	Director of Clinical Governance (Quality and Safety) Director of Performance and Planning (Performance) Deputy Chief People Officer (Workforce) Deputy Director of Financial Reporting & Planning (Finance) Managing Director, R&I Deputy Digital Information Officer	
Meetings where content has been discussed previously	Board Committees	
Purpose of the paper Please check **one** box only:	☐For approval ☐For support ☒For discussion	

Executive summary / key messages for the meeting to consider

Members of the Board are requested to note the updates provided in the Trust Integrated Performance Report (IPR)

Recommendation(s)

The Board of Directors is asked to:

- Note the performance assurance provided.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐**Yes** (please set out in your report what action has been taken to address this) ☒**No**

Relationship to the strategic objectives

The work contained with this report contributes to the delivery of the following strategic objectives (see key below)

LHL objective 1	☐	LHL objective 2	☐
HQSC objective 1	☐	HQSC objective 2	☐
HQSC objective 3	☐	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☐

VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: • All strategic risks	
Care Quality Commission domains Please check **all** that apply	☐Safe ☐Effective ☐Responsive	☐Caring ☒Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • N/A	

Main report
Please see attached Integrated Performance Report.

NHS
Manchester University
NHS Foundation Trust

MFT Integrated Performance Report

July 2026

Measuring our performance

Manchester University NHS Foundation Trust

Risk Status	Board Focus	Definition
Alert	Measures which require Board attention	Measures which are consistently falling short of the target, showing deteriorating performance or show increasing risk
Advise	Measures to note	Measures which are improving, with risk being actively managed
Assure	Measures for assurance	Measures which are in control and on target

Variation			Assurance			Compliance against plan		
								
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates Inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates Consistently (F)alling short of the target	Target (MFT plan for the month) being met	Target (MFT plan for the month) not met	For information, no target set or target not due

Using the SPC rules, we use an **Alert, Advise and Assure** risk model to ensure appropriate escalation and Board focus of risks and improvements associated with performance. Risks identified through the assessment of and assurance associated with any element of performance that may have an impact on the delivery of the Trust's strategic objectives are reflected within the Board's Assurance Framework

Section 1:
Executive Summary

Updated NOF segmentation Q4

Manchester University NHS Foundation Trust

For quarter 4 MFT improved to **segment 1** from **segment 3** of the NHS oversight framework (NOF). The previous ranking was 65/134 with an average metric score of 2.36 for acute providers. The average metric score is now 1.94, with the ranking of 19/134

Domain	Domain Score (March Q4)	Segment	Direction of Travel since last segmentation	Previous score (January Q3 Segmentation)
Effectiveness and experience of care	1.93	2	↔	1.89 / Segment 2
Patient safety	2.27	2	↔	2.32 / Segment 2
Access to services	1.78	1	↑	2.58 / Segment 3
People and workforce	2.96	3	↑	3.08 / Segment 4
Finance and productivity	1.35	1	↔	1.68 / Segment 1

Executive Summary:

Manchester University NHS Foundation Trust

Strategic Domain	NOF Domain	Measures requiring Board attention
Quality and Safety	Effectiveness & Experience of Care	*The Trust continues to see cases of E. coli, Klebsiella and Pseudomonas above the standard, introducing a risk of the NOF segmentation being impacted, and work continues to implement improvement and recovery plans, overseen by the Trust Infection Prevention and Control Committee. Incidents of single sex compliance breaches continue to occur, with continued focus on timely escalation and intervention.*
	Patient Safety	*A Never Event was reported relating to a retained vaginal swab - a total of 13 Never Events have been reported since April 2025 (12 in 2025/26, 1 in 2026/27 to date). Incidents of care for patients in the corridor were reported above the standard of 0 - each case is incident reported with a harm review completed.*
Operational Performance	Access to services	*No measures require attention at month 2 but UEC and cancer 62 standards have increased oversight in place.*
Workforce	People & Workforce	*R12M sickness absence has increased slightly, moving performance away from the 5.4% target by March 2027, and requiring continued focus to restore the improvement trajectory. AfC appraisal compliance has declined for five consecutive months, indicating a need to strengthen oversight and re-establish consistent delivery.*
Finance	Finance & Productivity	*The Trust is reporting a year-to-date deficit to plan of £19.5m, primarily due to under-delivery of cost improvements through the VfP programme and unmitigated, unfunded costs of Resident Doctor's industrial action taken in April 2026. NOF score recently uplifted to 1 from 3 based on submission of a compliant breakeven plan and a breakeven forecast outturn.*
Digital	N/A	*Overall strong performance against Digital key performance metrics, with cyber risks requiring continued capital prioritisation.*
Research & Innovation	N/A	*No measures require attention and time to recruitment for new studies continues to show an upward trend.*

Quality IPR

Patient Safety NOF Scores 2025/26

Manchester University NHS Foundation Trust

Quality and Safety remained Segment 2 across Q1 – Q4 against NHS oversight framework (NOF). The previous ranking was 81/131 with an average metric score of 2.32 for acute providers. The average metric score is now 2.27, with the ranking of 28/131

	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
MFT Segment	3	3	3	1
MFT Average Segement Score	**2.41**	**2.5**	**2.36**	**1.94**

Patient safety	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Segment	**2**	**2**	**2**	**2**
Average Score	**2.37**	**2.37**	**2.32**	**2.27**
NHS Staff survey - raising concerns sub-score	2.31	2.31	2.31	2.13
Number of MRSA bacteraemia cases (12 months)	3.98	3.98	3.91	3.96
Proportion of C. difficile infections	1	1	1	1
Proportion of E. coli bacteraemia	2.29	2.3	2.09	2.24

Measures requiring Board attention

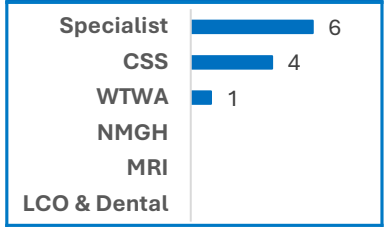
Never Events

Accountable Executive: Kimberley Salmon-Jamieson and Sohail Munshi Accountable Group: Quality & Safety Performance Board Committee
NOF: N/A | NHS England Reportable

Actual	Standard / Plan	Variance
1	0	+1

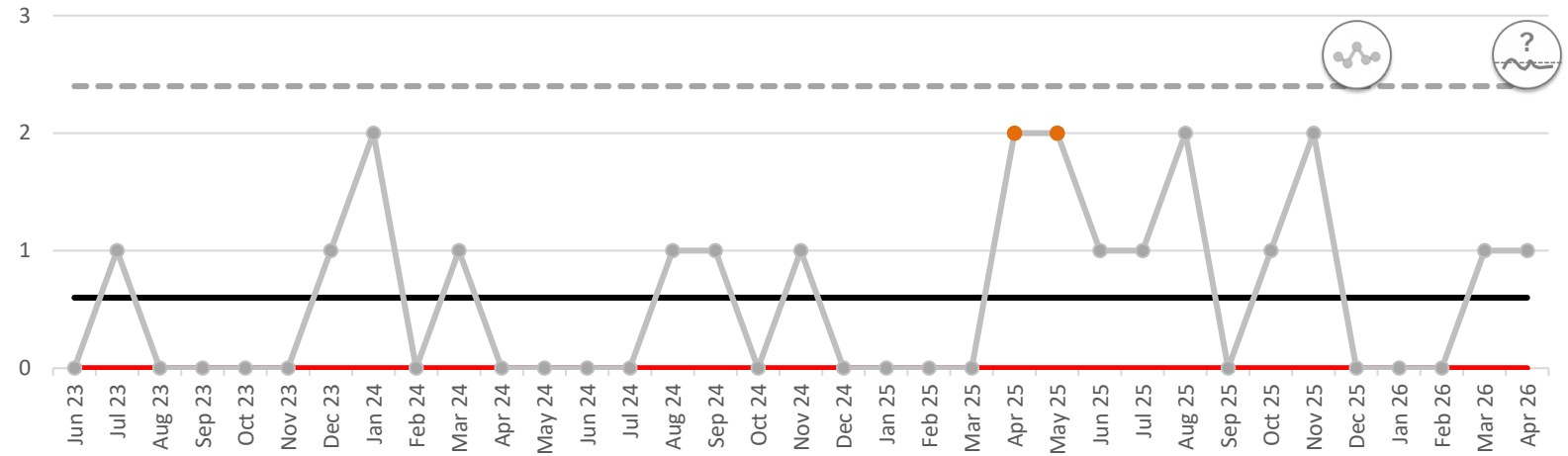
Compliance	Variance	Assurance	Actions
✗	~	?	👁

Clinical Group breakdown (12 months)



Never Events

Alert



Understanding the performance

One Never Event (NE) reported in April 2026 by SHG regarding retained swab. 11 Never events reported over last 12 months. Governance processes in place.

Risks and controls

Oversight of individual NEs is via Clinical Group Quality & Safety Groups. Trust Oversight via Trust Patient Safety Oversight & Assurance Group and QSMC.
Interventional Procedures Safety Group leading Trust wide work on human factors, implant and equipment storage, patient safety observations, and safety checklist design and use.

Actions and timescales

ISPG actions:
Observation tool rolled out June 2026.
Enhanced patient safety training due to commence Q2.
Improvement plan for checklist due be implemented by August 2026.
Patient Safety Network implementation due Q3.
Storage workstream actions due April 2027.

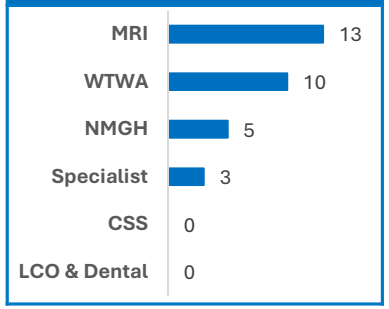
Gram negative infection – *E. Coli*

Accountable Executive: Kimberley Salmon-Jamieson| Accountable Group: Quality, Safety & Performance Board Committee
NOF: 2.11 | Rates of Healthcare Associated Infection (MRSA, C-Difficile and E-Coli)

Actual	Standard / Plan	Variance
31	<24.8	+ 6.2

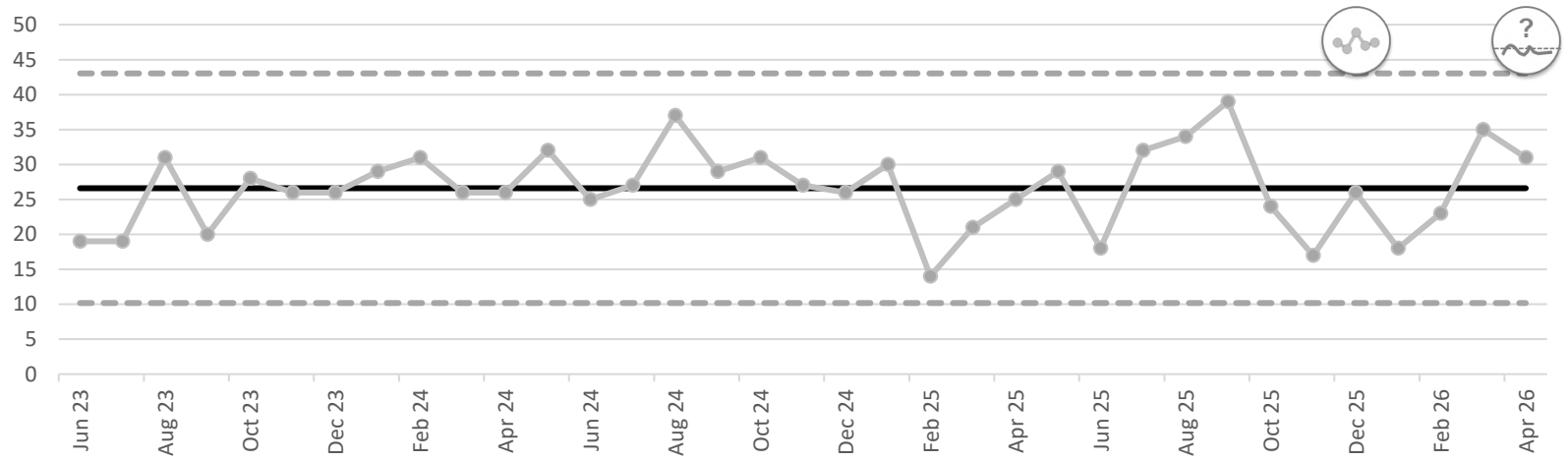
Compliance	Variance	Assurance	Actions
✗	~	?	👁

Clinical Group breakdown



Gram negative infection – E. Coli

Alert ⚠



Understanding the performance

April recorded 31 cases against a threshold of <24.8, variance +6.2. Cases reduced by 4 overall, with MRI +1, NMGH -5, SHG -2 and CSS -1 compared to previous month.

Cases linked to catheter and vascular access device (VAD) care with each case incident reported and reviewed.

Risks and controls

Clinical Group (CG)improvement plans for VAD and CAUTI (catheter associated urinary tract infection) in place and overseen and owned by CG IPC Committees.

Live Antimicrobial Stewardship dashboard in Hive to help ensure review of all patients receiving antimicrobial therapy.

Actions and timescales

Hive programme of work to improve documentation, including completion of the catheter passport and easier access for clinicians due July 2026.

Significant focus on CAUTI – regular audit programme in place.

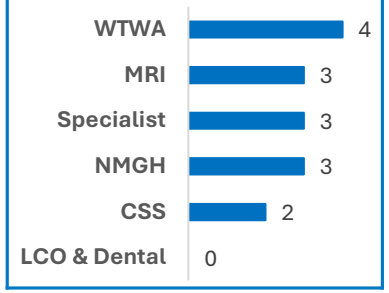
Gram negative infection – *Klebsiella sp.*

Accountable Executive: Kimberley Salmon-Jamieson Accountable Group: Quality, Safety & Performance Board Committee
NOF: N/A | NHS England Reportable

Actual	Standard / Plan	Variance
15	<10.9	+4.1

Compliance	Variance	Assurance	Actions
✗	~	?	👁

Clinical Group breakdown



Gram negative infection – Klebsiella

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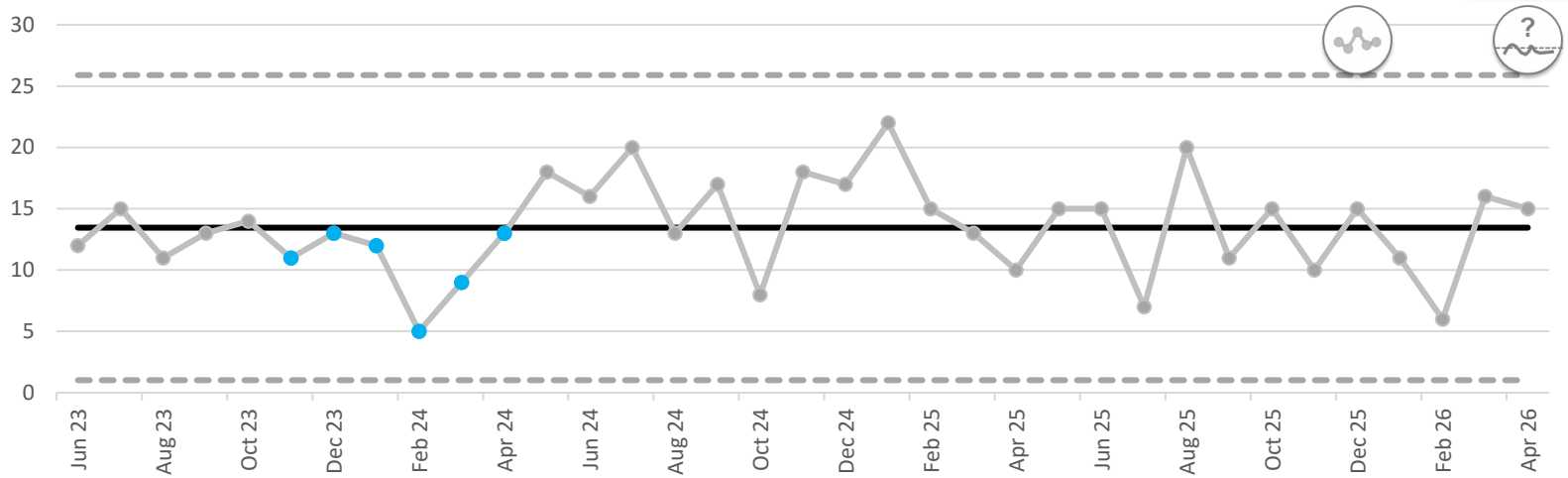


Understanding the performance

April recorded 15 cases against a threshold of <10.9, variance +4.1. Cases reduced by 1 overall, with NMGH +3, CSS +2, WTWA -2 and MRI -4 compared to previous month.

Cases linked to catheter and vascular access device care with each case incident reported and reviewed.

Risks and controls

Clinical Group improvement plans for VAD and CAUTI in place and overseen and owned by CG IPC Committees.

Live Antimicrobial Stewardship dashboard in Hive to help ensure review of all patients receiving antimicrobial therapy.

Actions and timescales

Hive documentation improvements, including completion of the catheter passport and easier access for clinicians due July 2026. Audit schedule in place.

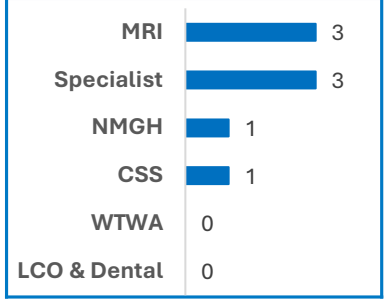
Gram negative infection – *Pseudomonas sp.*

Accountable Executive: Kimberley Salmon-Jamieson| Accountable Group: Quality, Safety & Performance Board Committee
NOF: N/A | NHS England Reportable

Actual	Standard / Plan	Variance
8	<2.4	+5.6

Compliance	Variance	Assurance	Actions
✗	H	?	👁

Clinical Group breakdown



Gram negative infection – Pseudomonas

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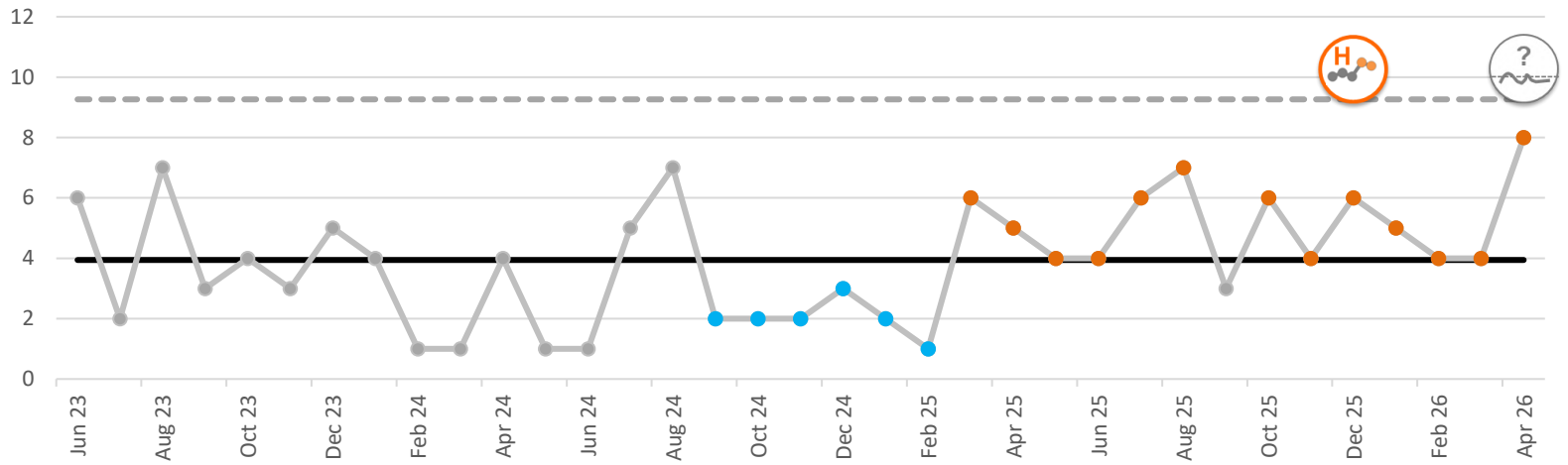


Understanding the performance

April recorded 8 cases against a threshold of <2.4, variance +5.6. Cases increased at MRI +1, SHCG +2 and CSS +1 compared to previous month.

Cases relate to complex haematology and oncology patients.

Risks and controls

Clinical Group improvement plans for VAD and CAUTI in place and overseen and owned by CG IPC Committees.

Live Antimicrobial Stewardship dashboard in Hive to help ensure review of all patients receiving antimicrobial therapy.

Actions and timescales

Hive documentation improvements, including completion of the catheter passport and easier access for clinicians due July 2026.

Antimicrobial stewardship is also progressing as part of 2026/27 NMAHP priorities.

Category 3 Caesarean sections not performed within 24 hours

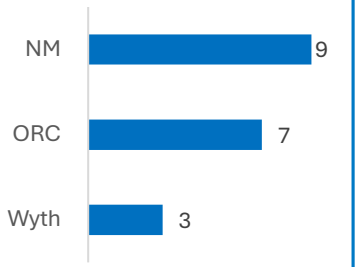
Manchester University NHS Foundation Trust

Accountable Executive: Kimberley Salmon-Jamieson| Accountable Group: Quality & Safety Management Committee
NOF: N/A | Internal Measure

Actual	Standard / Plan	Variance
19	<10	+9

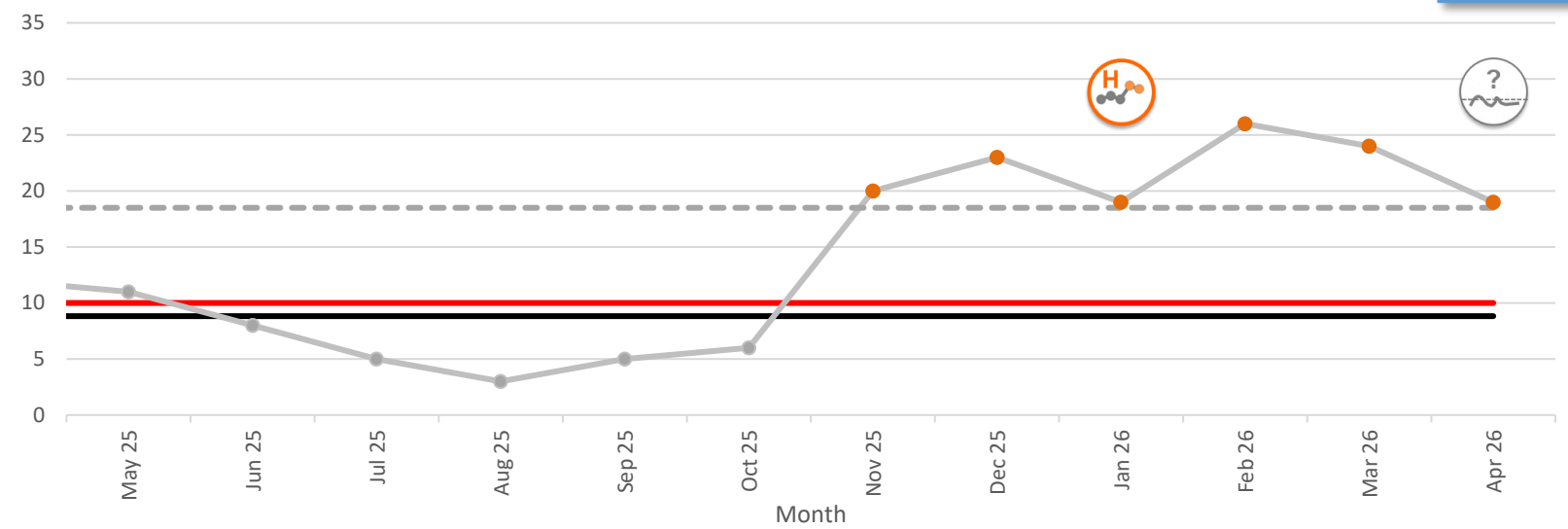
Compliance	Variance	Assurance	Actions
✗	H	?	✗

Clinical Group breakdown



Category 3 Caesarean sections not performed within 24 hours

Alert



Understanding the performance

Manual review of data continues pending digital solution for robust validation process.

North Manchester are limited in additional emergency theatre capacity, which impacts on the ability to undertake category 3 caesarean sections within 24 hours.

Risks and controls

There is increasing demand for non-emergency caesarean sections.

Activity continues to be monitored at the twice daily flow meetings and action taken to reduce delays.

Actions and timescales

Demand and capacity review completed (May 2026) and submitted to SLT that proposes additional theatre lists are required each week.

Initial assessment time (Maternity Triage)

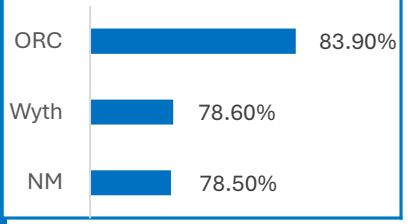
Manchester University NHS Foundation Trust

Accountable Executive: Kimberley Salmon-Jamieson | Accountable Group: Quality & Safety Management Committee
NOF: N/A | Internal Measure

Actual	Standard / Plan	Variance
81.0% (15') **96.7% (30')**	>90%	+9.0% (15') +6.7% (30')

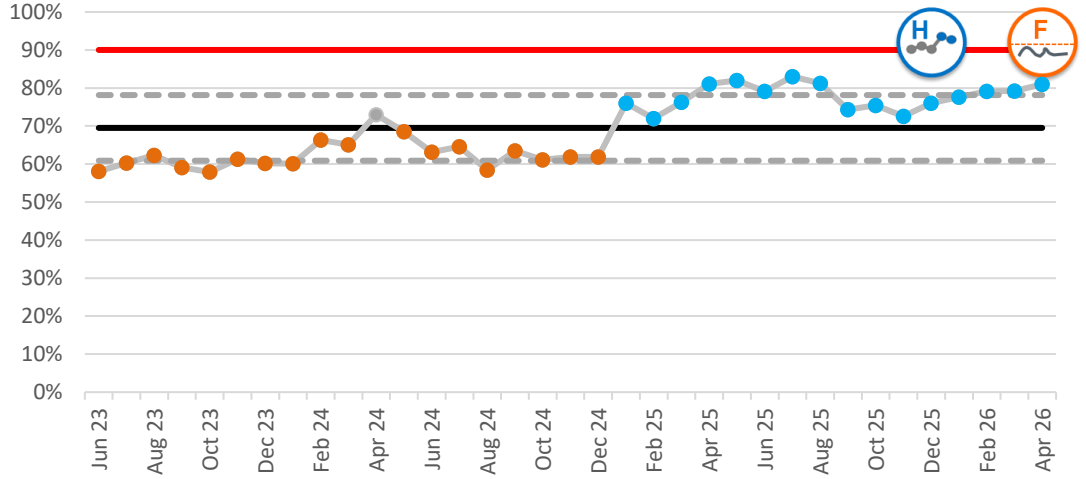
Compliance	Variance	Assurance	Actions
✗	H	F	✓

Clinical Group breakdown



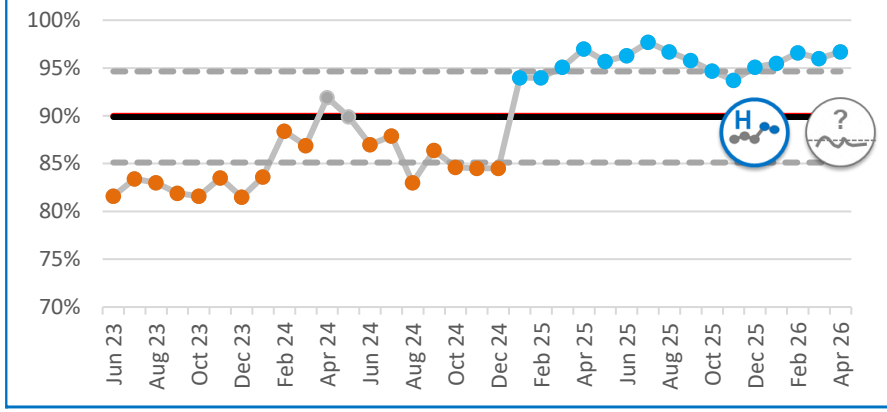
Initial assessment time (Maternity Triage -15 mins)

Alert



Initial assessment time (Maternity Triage -30 mins

Assure



Understanding the performance

Performance for assessment within 15 minutes improved and exceeded the GM LMNS 80% target.
Target not met for North Manchester and Wythenshawe due to increased activity.

Performance for assessment within 30 minutes and appropriate categorisation have been consistently maintained above 90% since January 2025.
No poor outcomes identified in relation to initial assessment times.

Risks and controls

Increased activity continues (4107 attendance April 2026 compared to 3431 in April 2024 – 19.7% increase).

Twice daily flow meetings in place. GM LMNS target for assessment within 15' is 80%.

Actions and timescales

Demand and capacity assessment completed May 2026 and presented to SLT.

Single Sex Compliance Breaches

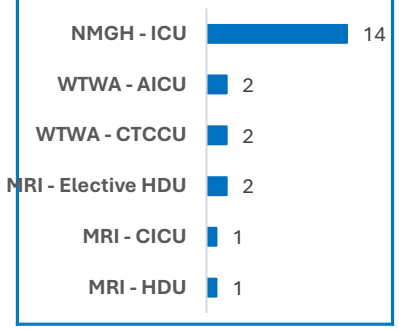
Manchester University NHS Foundation Trust

Accountable Executive: Kimberley Salmon-Jamieson| Accountable Group: Quality, Safety & Performance Board Committee
NOF: N/A | NHS England Reportable

Actual	Standard / Plan	Variance
22	0	+22

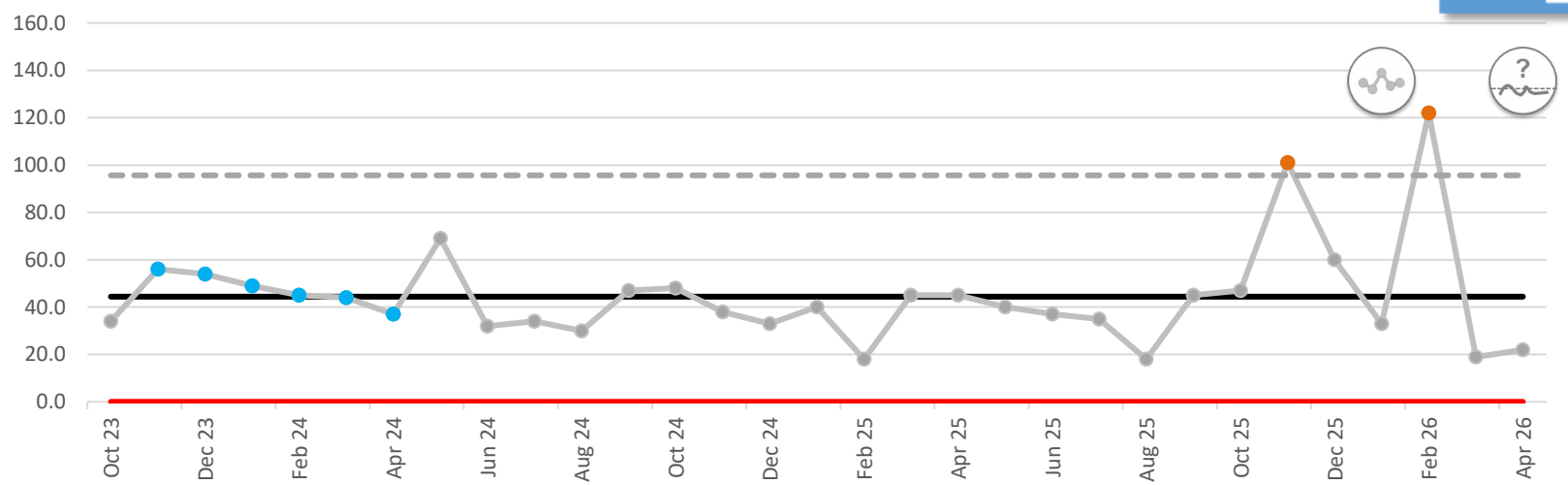
Compliance	Variance	Assurance	Actions
✕	~	F	👁

Clinical Group breakdown



Single Sex Compliance Breaches

Alert



Understanding the performance

Overall increase of 15.8% from previous month isolated to ICU and HDU. Increases in incidents at NMGH – ICU (5) and MRI – HDU (1).

Risks and controls

Breaches occur when demand exceeds capacity resulting in delays to patient flow. Controls focus on timely escalation, intervention, and ward transfer.

Clinical Groups will continue to evaluate the efficiency of step-down processes.

Actions and timescales

Further work on patient flow underway.

Eliminating Corridor care in Emergency Departments

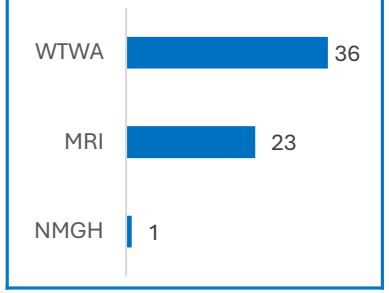
Manchester University NHS Foundation Trust

Accountable Executive: Kimberley Salmon-Jamieson| Accountable Group: Quality, Safety and Performance Board Committee
NOF: N/A | NHS England Reportable

Actual	Standard / Plan	Variance
60	0	60

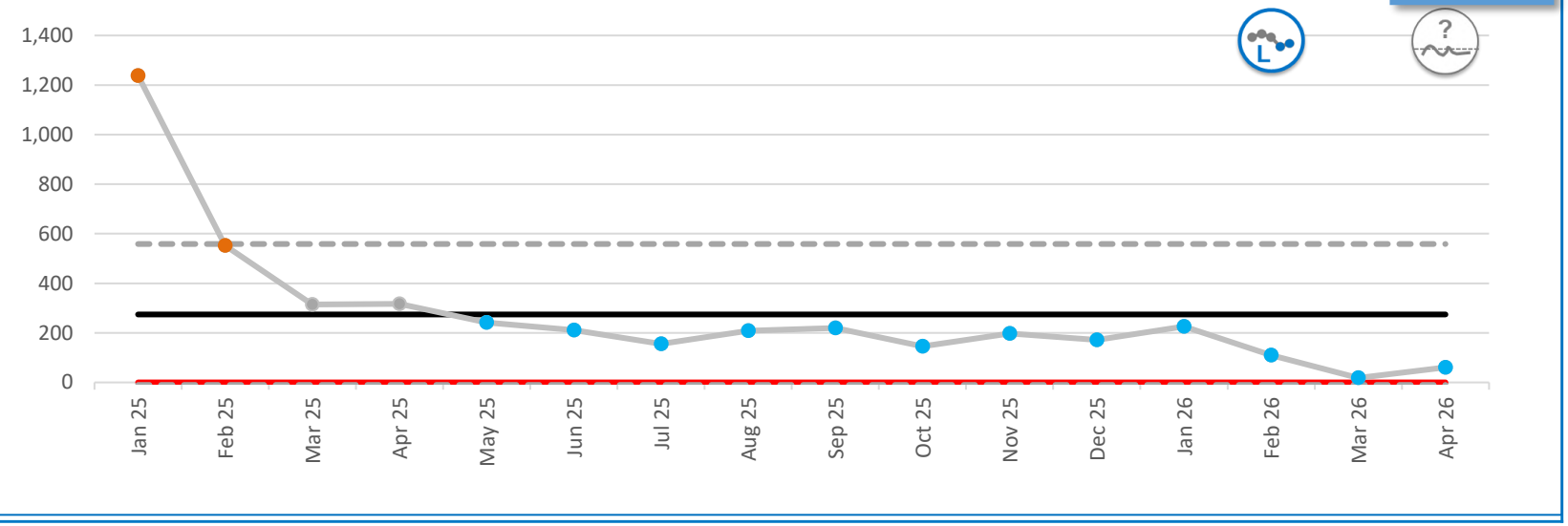
Compliance	Variance	Assurance	Actions
✗	L	?	👁

Clinical Group breakdown



Corridor care in Emergency Departments

Alert ⚠



Understanding the performance

Incidents of corridor care increased for WTWA (3) and MRI (12) and decreased for NMGH (3).

Risks and controls

Key risks are patient safety, privacy and dignity, and lack of dedicated bed or cubicle space.

Controls in place include patient risk assessment, dedicated nurse and senior nurse oversight, patient information and follow-up, incident reporting for each occurrence, and harm review process.

Actions and timescales

Urgent and Emergency Care " Get it Right First Time" GIRFT standards implementation group established.

Integrated plan in place alongside GMHH for patients requiring mental health support.

Measures to note

Measures to note

Manchester University NHS Foundation Trust

Key Oversight Performance Metrics							
Focus	Compliance	Variation	Assurance	Action status	Performance	Plan / standard	Indicator
Infection Prevention & Control					0	0	Trust attributable methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia
					13	<22.2	Trust attributable Clostridioides difficile (C-Diff) infection
Complaints			N/A		178	N/A	Number of formal complaints opened
			N/A		0	N/A	Number of PHSO complaints
Learning from Deaths			N/A		80.78	N/A	Hospital Standardised Mortality Ratio (HSMR)
			N/A		3.33%	N/A	Crude mortality (rolling 12 month)
			N/A		120.36	N/A	Summary Hospital-level Mortality Indicator (SHMI)
					0	0	Prevention of Future Death reports impacting the Trust
Maternity			N/A		0	N/A	Number of incidents accepted for Maternity and Newborn Safety Investigations (MNSI)

Measures to note

Infection Prevention and Control:
0 MRSA Bacteraemia reported in month, and C-Diff reported within threshold set. Continued oversight in place due to previous performance above standards set.

Complaints: Decrease of 3 complaints and 0 PHSO complaint received since previous month.

Learning from Deaths: Mortality metrics continue to be stable and in line with or better than Shelford peers. 0 PfD reports were received in month.

Maternity 2 term stillbirths met the criteria for MNSI with both families declining MNSI investigation.

Measures for assurance

Measures for assurance

Key Oversight Performance Metrics							
Focus	Compliance	Variation	Assurance	Action status	Performance	Plan / standard	Indicator
Patient Experience					97.41%	95%	Patient Experience Survey (Overall Performance Score)
Complaints					92.8%	90%	Complaints closed in agreed timescales
Maternity					1.27	<4/1000	Neonatal deaths per 1000 live births
					5.5	<6/1000	Stillbirths per 1000 live births (excluding termination of pregnancy)
			N/A		0	N/A	Number of maternal deaths
					3	<4	Number of maternity incidents with moderate harm and above
					5.7%	<6	Term admissions to the Neonatal Unit
					96.7%	>90%	Initial assessment time in maternity triage – 30 minutes
					81%	60%	Induction pathway – transfer to intrapartum area within 24 hours
					0%	<20%	Augmentation of labour pathway delays
					3	<4	Births outside of intrapartum birth setting
					0	<0.75	Number of babies with suspected hypoxic-ischemic encephalopathy grade 2/3
					0	0	Maternity related concerns (Maternity and Newborn Safety Investigations (MNSI) / NHS Resolution (NHSR) / Care Quality Commission (CQC) / Prevention of Future Deaths (PFD)
					4.5%	<5% MCS <6% ORC	Post partum haemorrhage >1500ml and <2500ml

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Operational Performance – IPR May 2026

Access to Services NOF Scores 2025/26

Manchester University NHS Foundation Trust

Access to Services improved to **segment 1** in Q4 from **segment 3** Q3 and following being **segment 4** in Q2 of the NHS oversight framework (NOF). The previous ranking was 81/131 with an average metric score of 2.58 for acute providers. The average metric score is now 1.78, with the ranking of 28/131

	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
MFT Segment	3	3	3	1
MFT Average Segement Score	**2.41**	**2.5**	**2.36**	**1.94**

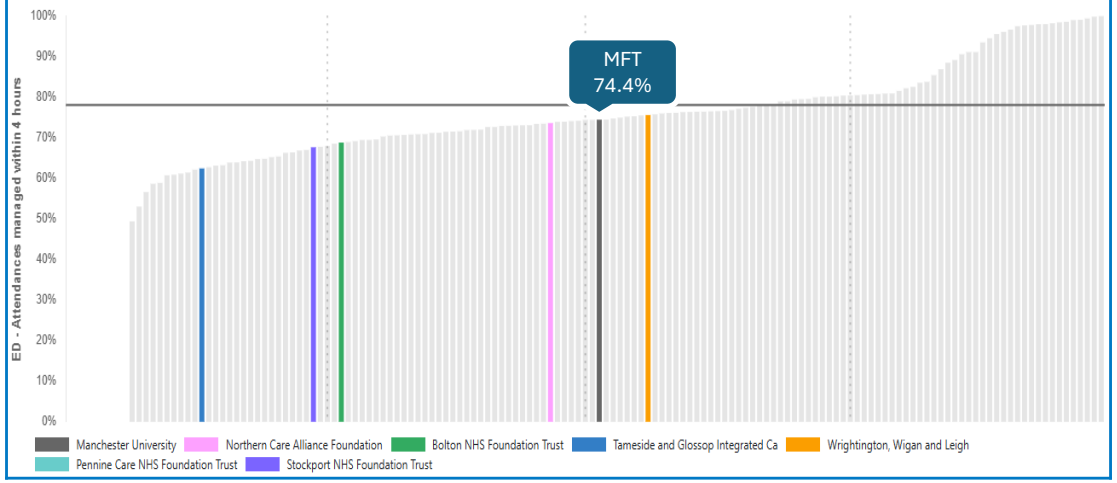
Access to services	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Segment	3	4	3	1
Average Score	**2.68**	**2.85**	**2.58**	**1.78**
Annual change in the number of children and young people accessing NHS-funded MH services	2.61	2.52	2.65	2.61
Difference between planned and actual 18 week performance	1	2.58	2.48	1
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	3.82	3.75	3.4	2.98
Percentage of emergency department attendances admitted, transferred or discharged within four hours	3.11	3	2.82	2.66
Percentage of emergency department attendances spending over 12 hours in the department	1.84	1.69	1.59	1.57
Percentage of patients treated for cancer within 62 days of referral	3.34	3.53	3.01	2.2
Percentage of patients waiting over 52 weeks for community services	2	1.88	2.21	1
Percentage of patients waiting over 52 weeks for elective treatment	3.64	3.55	2.99	1
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	2.79	3.11	2.03	1

Benchmarking of National Oversight Framework (NOF) Indicators (1 of 2)

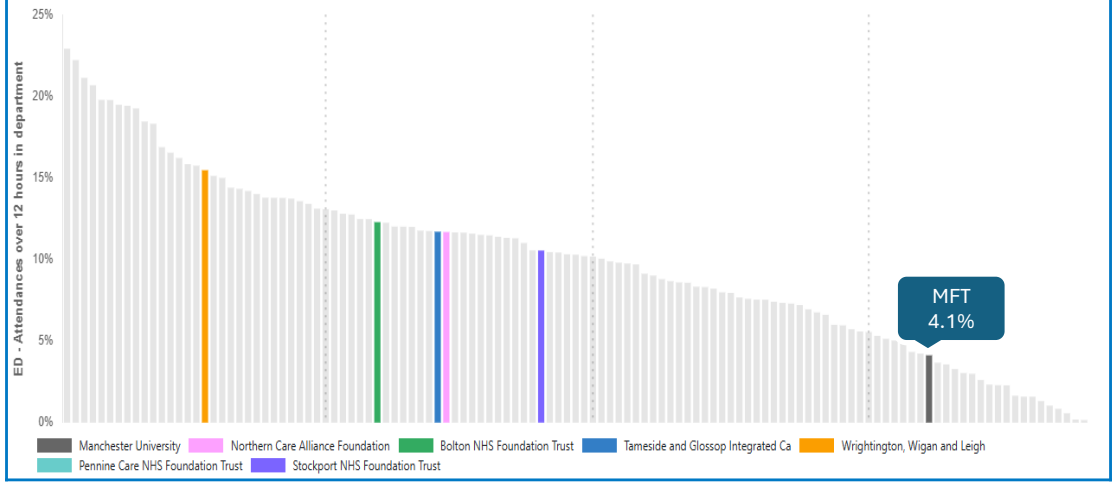
Manchester University NHS Foundation Trust

Q1 shows overall improvement in RTT, with 52-week waits remaining (1.00 → 1.00) and 18-week performance (3.00 → 2.88) improving. A&E 4-hour performance (2.16 → 2.48) and 12-hour waits (1.49 → 1.54) show worsening performance.

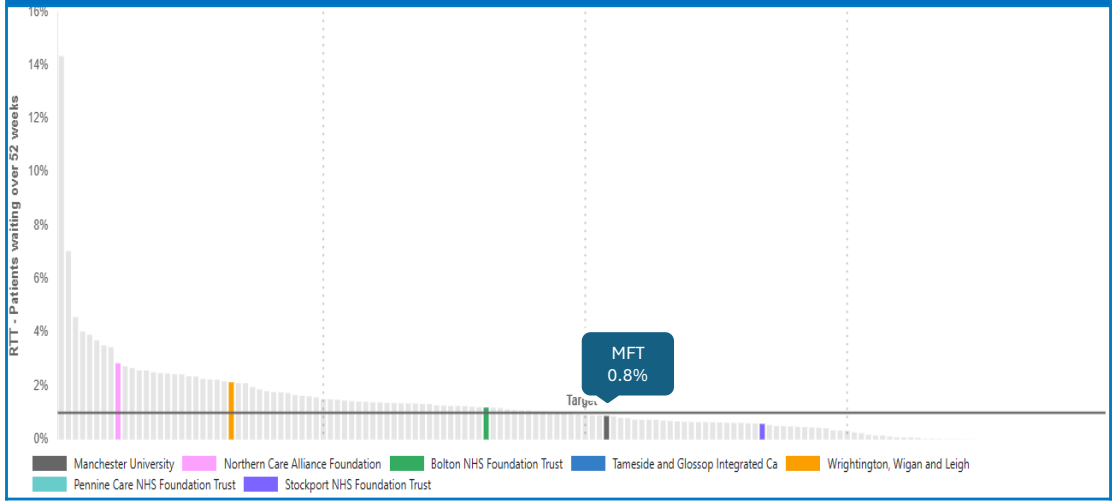
A&E - 4 Hour Standard - May



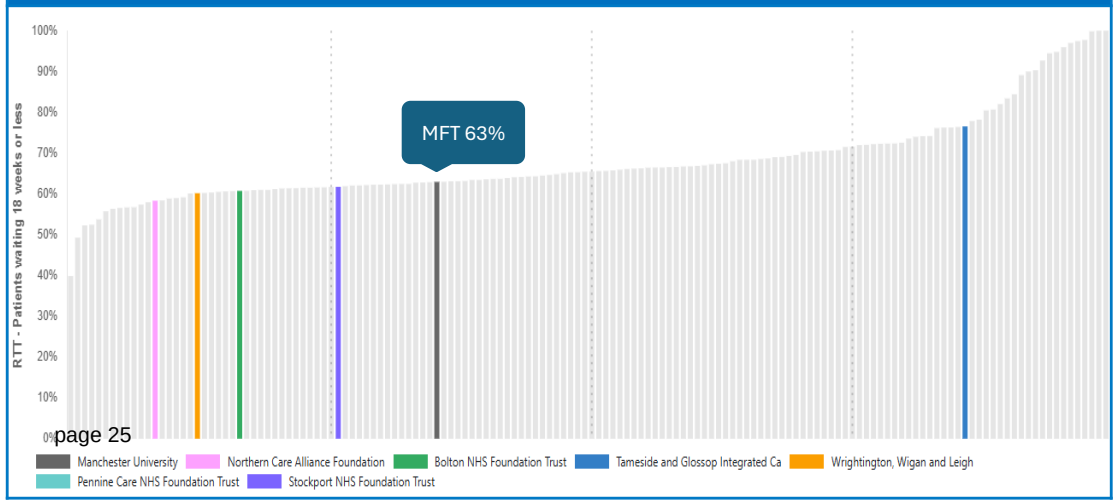
A&E - 12 Hour Standard - May



RTT Incomplete 52 Weeks - April



RTT Incomplete 18 Week Standard - April

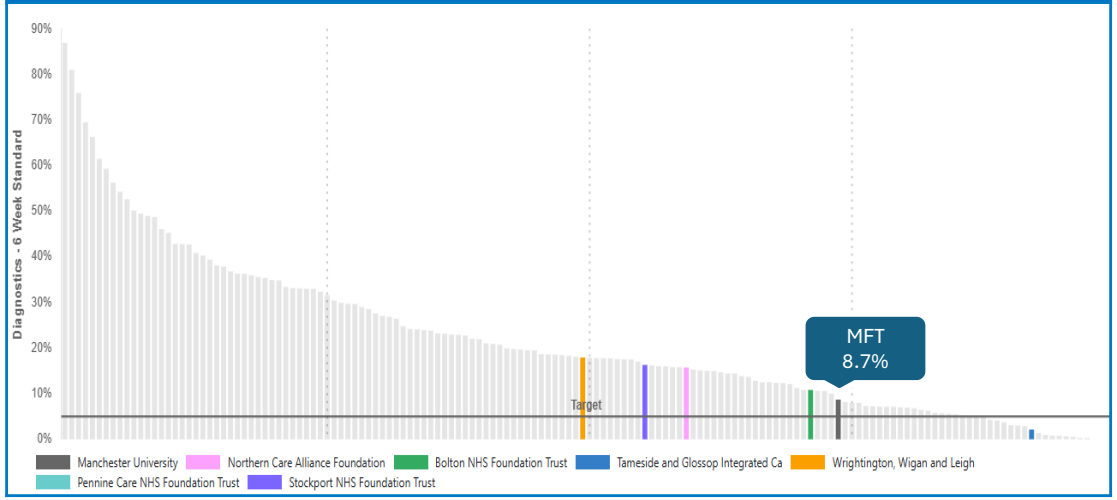


Benchmarking of National Oversight Framework (NOF) Indicators (2 of 2)

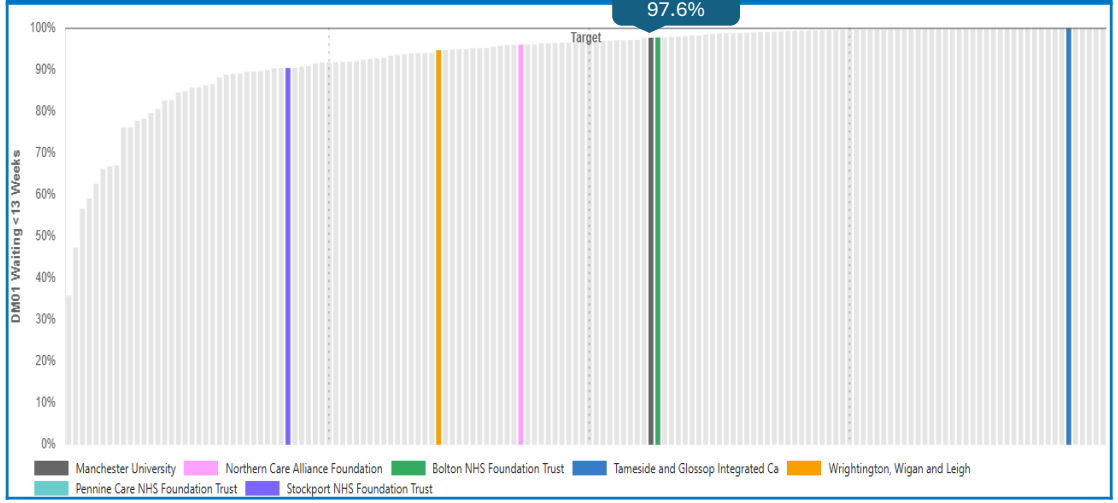
Manchester University NHS Foundation Trust

Cancer performance improved in Q1, with reductions in 62-day treatment (2.19 → 1.00), while 28-day Faster Diagnosis (1.00 → 2.25) show worsening performance.

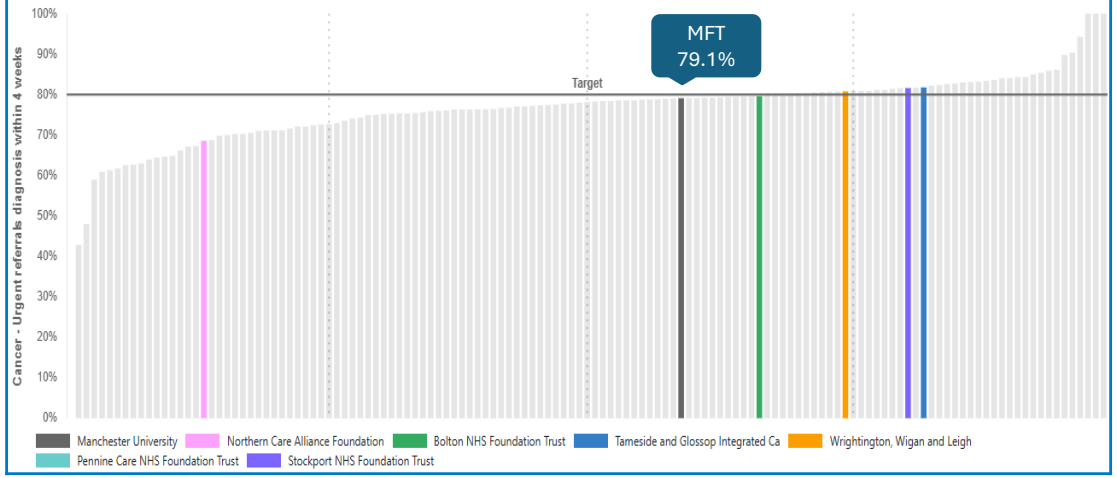
Diagnostics - 6 Week Standard - April



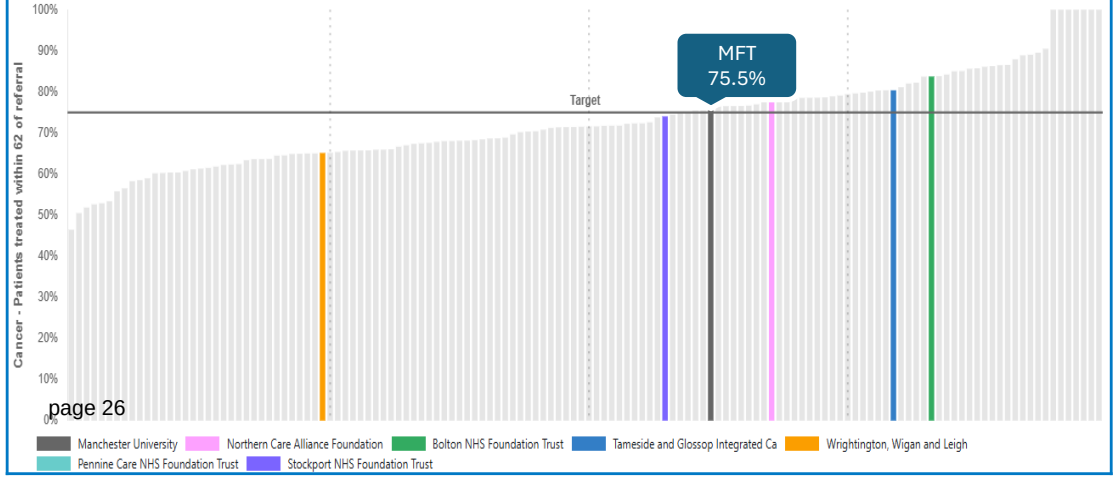
DM01 Waiting <13 Weeks – April



Cancer 28 Day Faster Diagnosis – April



Cancer 62 Day All Routes - April



Section 3:
Measures to note

Urgent & Emergency Care (UEC)

Accountable Executive: Vanessa Gardener | Accountable Group: Quality and Safety Board Committee
NOF: Access to Services | 'Percentage of emergency department attendances admitted, transferred or discharged within four hours'

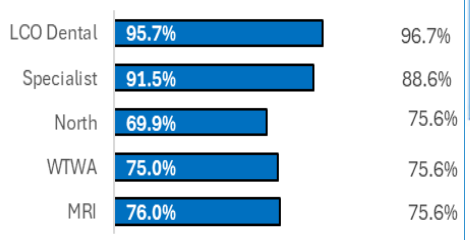
NHS Manchester University NHS Foundation Trust

Advise

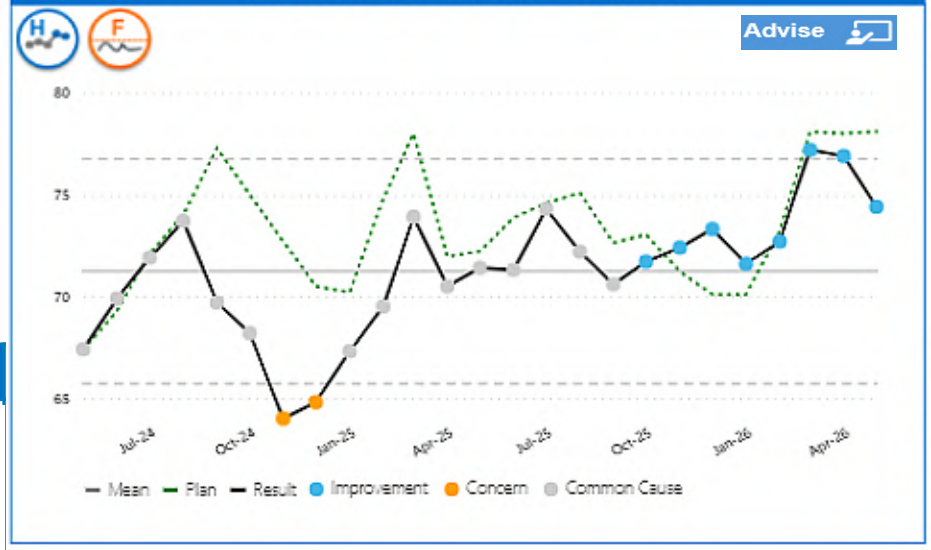
May-26		
Actual	Plan	Variance
74.4%	78.1%	-3.7%

Compliance	Variance	Assurance
✖	H	F

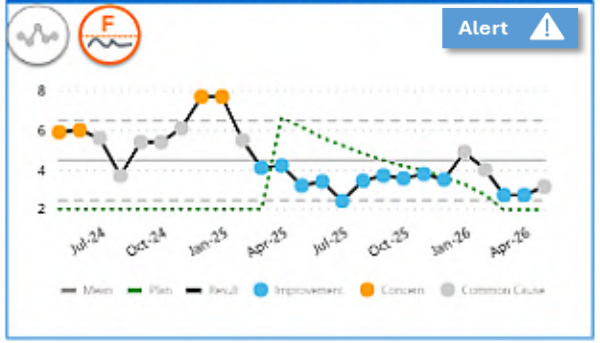
Clinical Group Overview



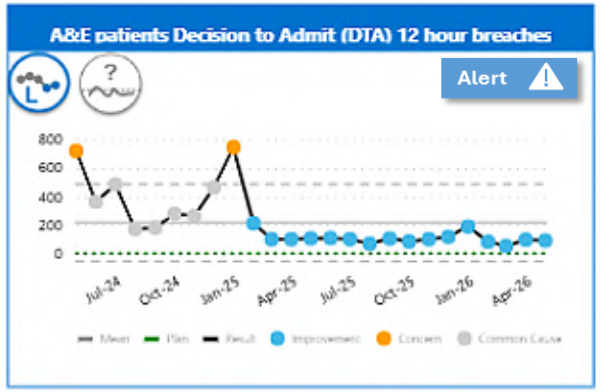
A&E patients stays less than 4 hours (Type 1 2 3)



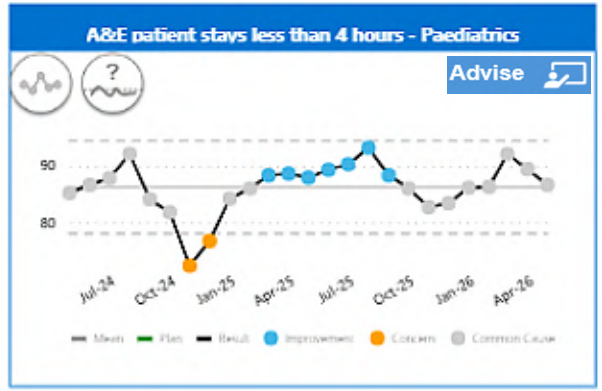
Proportion of patients spending over 12 hours in A&E



A&E patients Decision to Admit (DTA) 12 hour breaches



A&E patient stays less than 4 hours - Paediatrics



Understanding the performance

May reported below plan (-3.7pp) with variation across Type 1 EDs. Attendances were broadly in line with plan (47,290 patient attendances versus a plan of 46,996). Non-admitted, non-referred (NANR) performance saw a decrease in May to 85.7% from 87.9% in April; this remains 9.8% below the Trust target of 95%.
Sustained improvement in patients with a Decision to Admin (DTA) beaching 12 hours, and those waiting 12 hour in department.

Risks and controls

Attendance above plan, the wait to be seen, patient flow and discharge are key risks.

Hospital @ Home capacity in place to support timely discharge and patient flow. Delivery Oversight Framework in place.

Actions and timescales

Action plans are in place and are being led by the UEC Improvement Group and senior leadership teams to improve performance to above 82%. This includes enhanced modelling to strengthen non-admitted, non-referred (NANR) performance and support delivery of agreed targets. The UEC plan is being delivered through the Board Committee, with a focus on Model Emergency Department, the First 72 Hours in Hospital programme, and the successful expansion of the Care Closer to Home programme to WTWA and NMGH. A Single Point of Access (SPOA) optimisation programme is also in place.

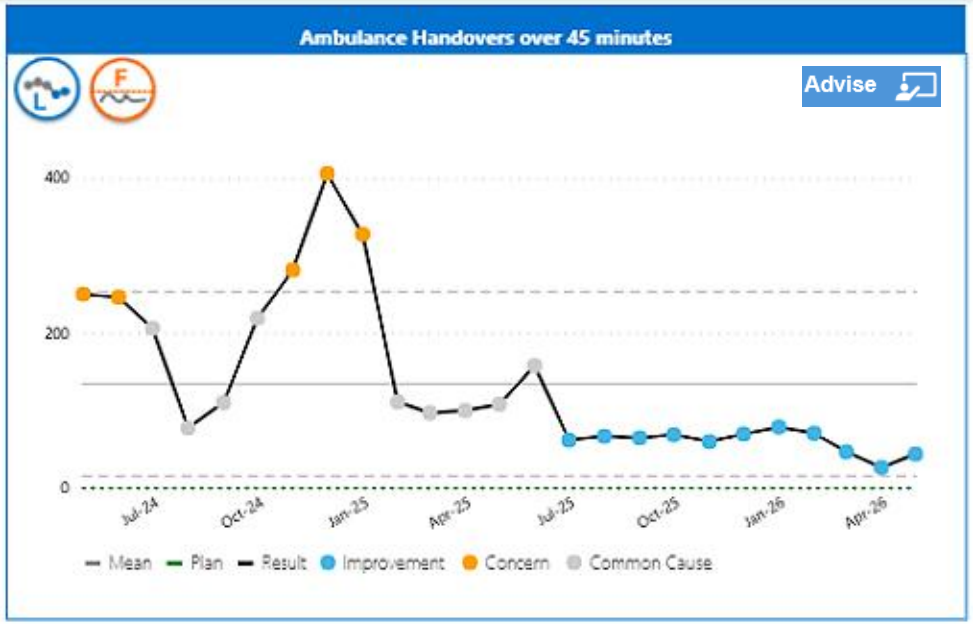
Ambulance Handover

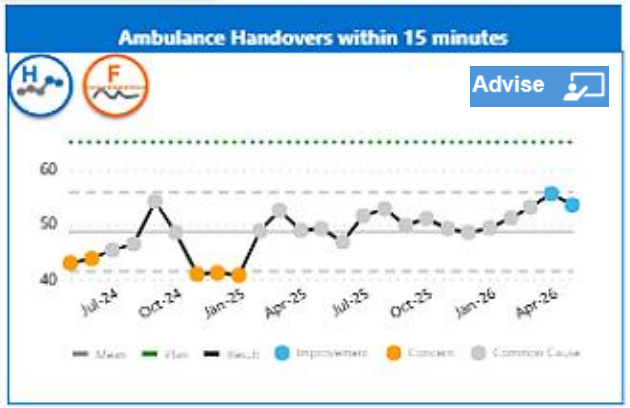
Accountable Executive: Vanessa Gardener | Accountable Group: Quality and Safety Board Committee

Advise

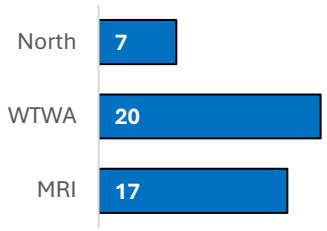
May-26		
Actual	Plan	Variance
44	0	44

Compliance	Variance	Assurance
✖	L	F





Clinical Group Overview



Understanding the performance

In May 26, there were 44 patients handed over beyond 45 minutes. This compares to 27 in April 26. Performance against <15 min handovers remains below standard (65%) at 53.5%. Average turnaround increased to 24.45 minutes (24.4 in April), and average handover time also increase to 15.45 minutes from 15.23 minutes. Patient handovers over 45 min equates to 0.7% of ambulance attends during May. Upon validation 79% of breaches were identified as not true breaches with the majority of these being 'delayed pinning out" by ambulance crews.

Risks and controls

Risk of continued inaccuracies in pin-out recording, which is falsely inflating reported breaches. There is also an ongoing risk of breaches during periods of peak pressure and in cath labs.

Regular review of discrepancies and shared learning with NWAS are in place. Action plans are in place across all sites and are monitored through the UEC Improvement Group, with a focus on eliminating breaches. Progress is tracked through the weekly performance report and Delivery Oversight Framework.

Actions and timescales

Communication with NWAS crews and Clinical Groups on timely pin-outs continues, with PCI handovers and the pin-out process remaining key priorities for both organisations.

The weekly programme group is maintaining momentum, supported by ongoing performance reviews, and the data shows a clear step-change since this work began.

Diagnostic Waiting Times

Accountable Executive: Vanessa Gardener | Accountable Group: Quality and Safety Board Committee

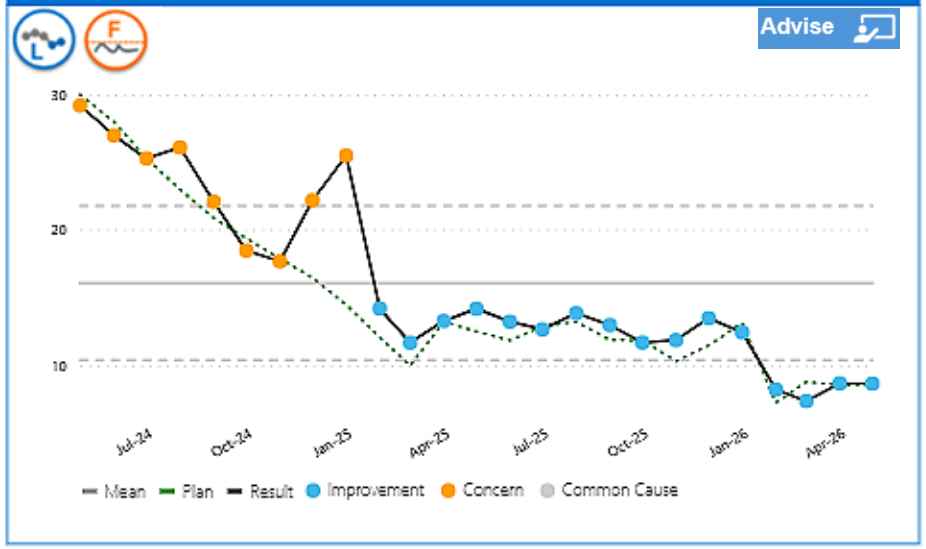
NHS Manchester University NHS Foundation Trust

Advise

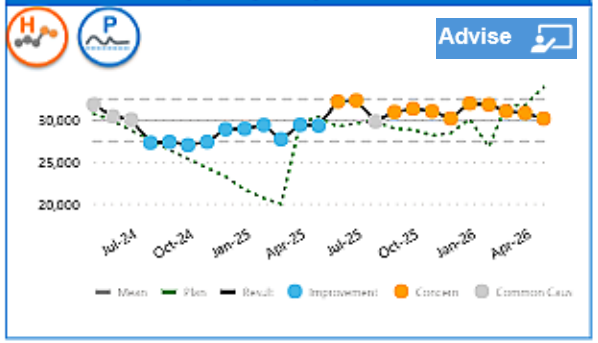
May-26		
Actual	Plan	Variance
8.68%	8.65%	0.03%

Compliance	Variance	Assurance
✖	L	F

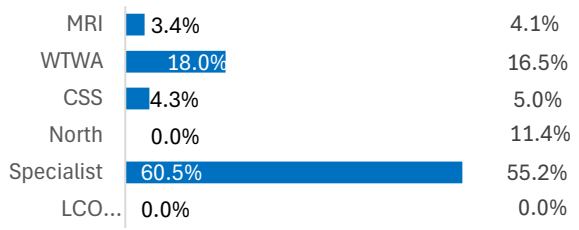
Percentage of Patients Receiving their Diagnostic test within 6 weeks



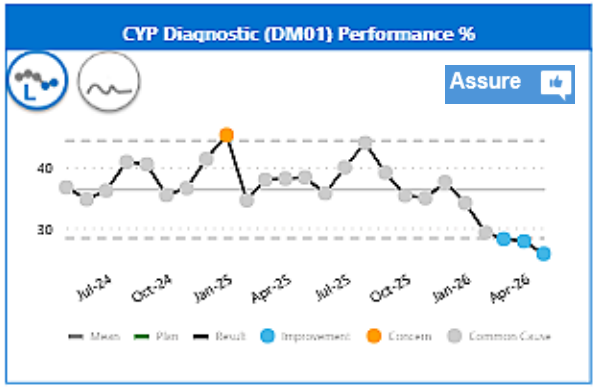
Diagnostic (DM01) Total List Size



Clinical Group Overview



CYP Diagnostic (DM01) Performance %



Understanding the performance

DM01 performance was 0.03% above plan in May at 8.68% (plan 8.65%). The waiting list was better than plan at 30,074 patients (plan 33,763) but shows concerning variation; MRI, NMGH and CSS were better than plan. Specialist and WTWA were worse than plan in May. For CYP, MR, Sleep, and Gastroscopy remain the main drivers of underperformance, with MR scanning accounting for 50.6% of all waits over six weeks.

Risks and controls

DM01 delivery remains at risk for the remainder of Q1 due to greater breach numbers driven by the Q4 RTT sprint and less new clock starts as indicated by the wait list size.CYP performance remains constrained by limited clinical resource for MR sedation lists and theatre access for sedated endoscopy, affecting gastroscopy performance.

Sleep demand increased since January with increase to breaches.

CG level plans in place, along with associated monitoring.

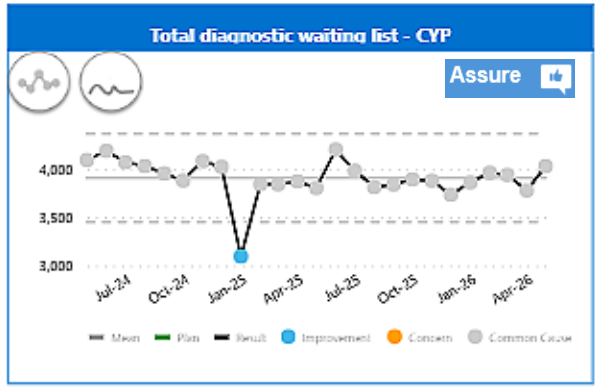
Actions and timescales

For CYP we continue to maximise all available capacity to support the position and rising demand in addition to utilising an additional scanner to support backlog reduction.

Order wisely work programme and planned care transformation programmes in place.

Weekend insourcing in place for Gastroscopy and a business case for Sleep in development for August.

Total diagnostic waiting list - CYP



Elective Referral to Treatment (RTT) standards

Accountable Executive: Vanessa Gardener | Accountable Group: Quality and Safety Board Committee
NOF: Access to Services | 'Percentage of cases where a patient is waiting 18 weeks or less for elective treatment'

NHS Manchester University NHS Foundation Trust

Advise

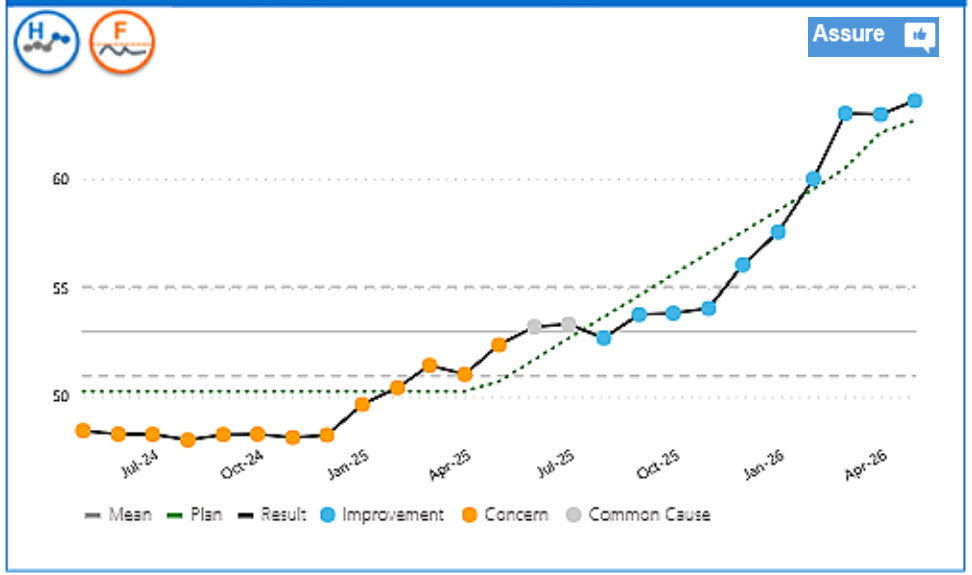
May-26		
Actual	Plan	Variance
63.6%	62.7%	0.9%

Compliance	Variance	Assurance
✓	H	F

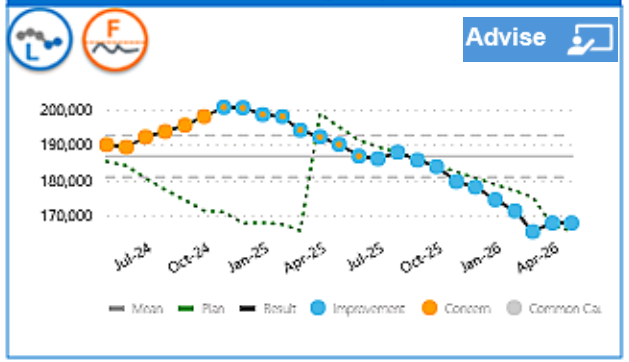
Clinical Group Overview

MRI	32,122	32914
WTWA	38,054	37347
CSS	4,768	4113
North	27,742	27494
Specialist	52,880	51814
LCO Dental	11,631	11669
Unallocated	783	352

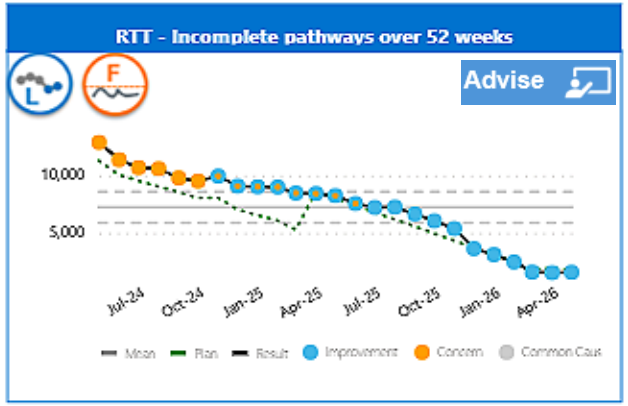
Percentage of patients on the RTT waiting list less than 18weeks



RTT - Total incomplete pathways



RTT - Incomplete pathways over 52 weeks



Understanding the performance

RTT performance continues to be better than plan, with 18-week performance rising to 63.58% in April, 0.88pp above plan.

The 52-week wait cohort continues to reduce over time, with May finishing 115 below the plan of 1,633 (0.9%).

The overall PTL size remained off plan in May. Missing the planned PTL size of 165,703 by 2,277 pathways. This was due to an increase in under 18 week pathways.

Risks and controls

RTT performance for 18w and 52w is currently ahead of plan with maintenance of this supported by our annual plans.

A risk remain around PTL size, currently this is higher than plan for the number of <18w pathways. The number of pathways >18w weeks is currently at our planned level. The growth in <18w could negatively impact future months if demand is not managed.

Growth areas identified and recovery plans in place.

Actions and timescales

Regular forecasting and monitoring of the position in place with the ability to review leading and supporting measures to predict future performance or risks.

Insights shared with Clinical Groups along with targeted lists to optimise validation.

The Care on Time programme continues to drive pathway transformation and sustainable PTL reduction, supported by strengthened validation approaches.

Trust SPC, Multipl...

Cancer Standards

Accountable Executive: Vanessa Gardener | Accountable Group: Quality and Safety Board Committee
NOF: Access to Services | 'Percentage of patients treated for cancer within 62 days of referral'

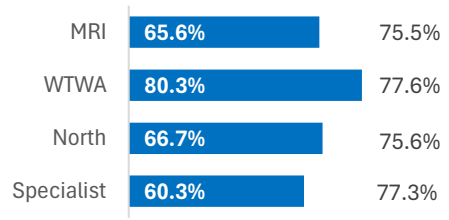
NHS Manchester University NHS Foundation Trust

Advise

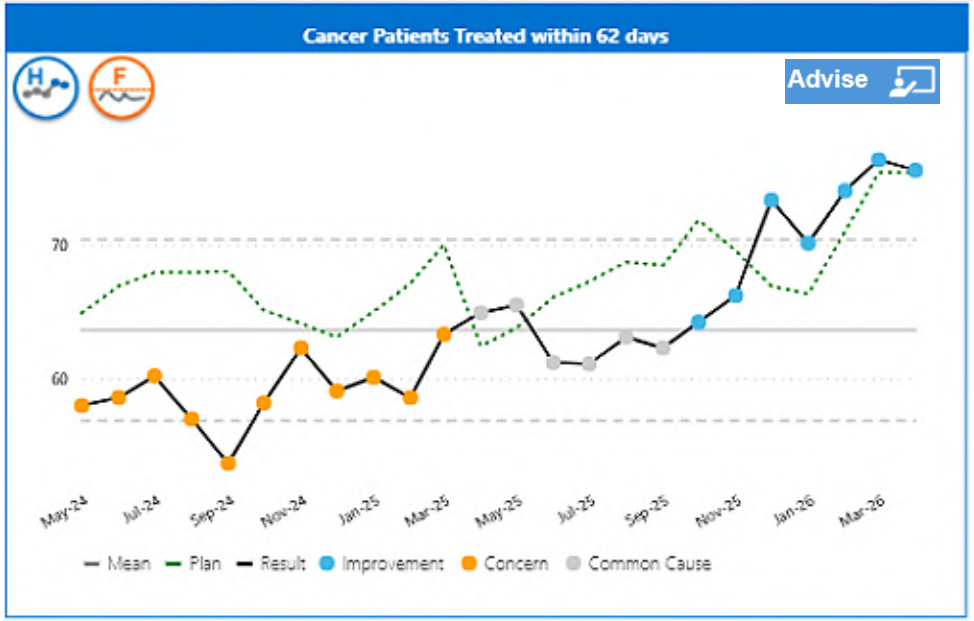
Apr-26		
Actual	Plan	Variance
75.51%	75.65%	0.14%

Compliance	Variance	Assurance
✖	H	F

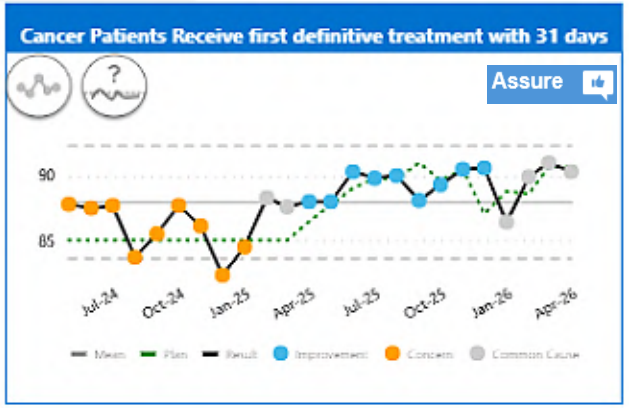
Clinical Group Overview



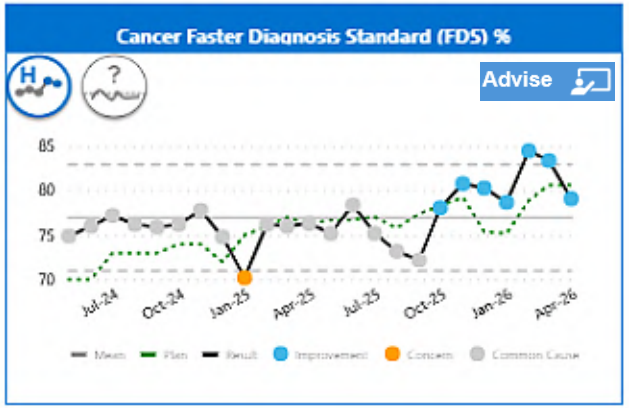
Cancer Patients Treated within 62 days



Cancer Patients Receive first definitive treatment with 31 days



Cancer Faster Diagnosis Standard (FDS) %



Understanding the performance

The % of patients treated within 62 days had been above plan since January and was only 0.14% below plan for April. However, this is not yet at a level where performance can be assured consistently and without intense operational and clinical input on a patient-by-patient basis. The highest volume of accountable patient pathways which were treated over 62 days were in Urology (22,WTWA), Lung (19, WTWA 17, NMGH 1 and MRI,1), LGI (14.5, WTWA 3.5, NMGH 3.5 and MRI 9.5) and Breast (12.5,WTWA). However, Breast, Lung and Urology were above performance plans.

Risks and controls

The volume of patients tipping into the backlog each week remains too high to assure performance.
The volume of patients being diagnosed with cancer late in the pathway (past day 28) is not reduced to the required level to assure performance and is also leading to late referrals to other treating centres.
The ability to treat patients referred into MFT later in the pathway to an expedited timescale (24 days) is also a risk.
GM PET waits escalated.

Actions and timescales

Clinical leads review of MFT pathways against the National/Regional best practice timed pathways and improvement plans being developed – meeting July 26.
RCA deep dive ongoing in Breast. Gynae intensive improvement initiative June 26.
Review of pre op/anesthetic review provision.
Continue weekly oversight meetings with operational teams. Operational and booking staff education sessions in June.

Patient Flow

Accountable Executive: Vanessa Gardener | Accountable Group: Quality and Safety Board Committee

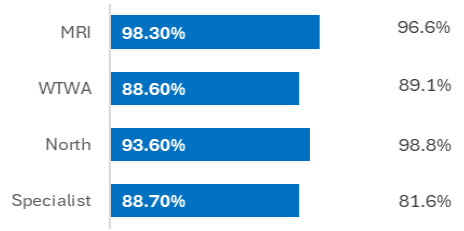
NHS Manchester University NHS Foundation Trust

Advise

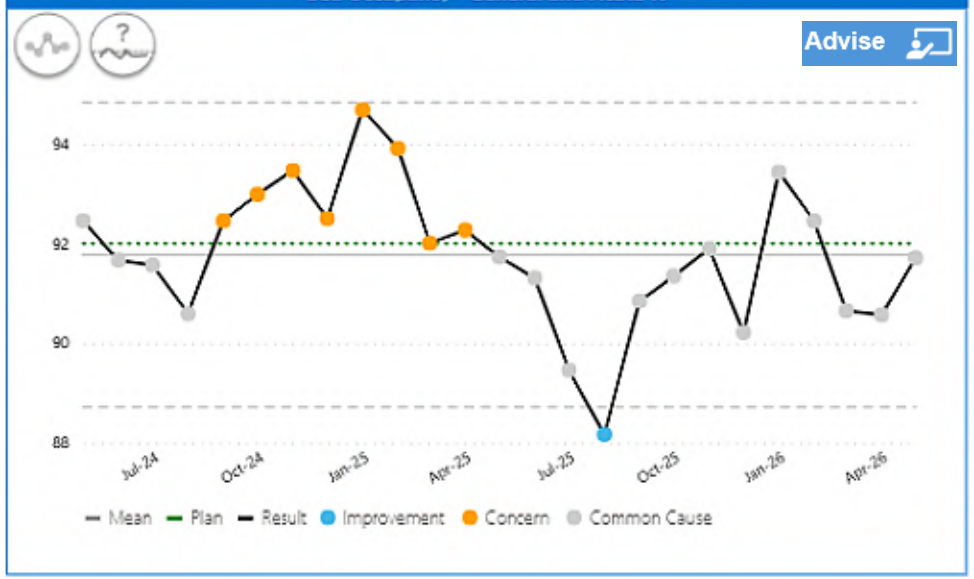
May-26		
Actual	Plan	Variance
91.7%	92.0%	-0.3%

Compliance	Variance	Assurance
✓	~	?

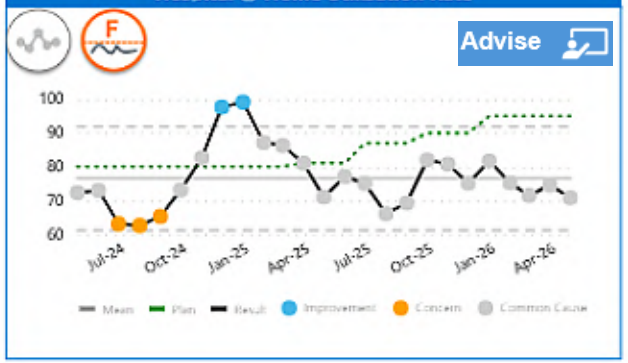
Clinical Group Overview



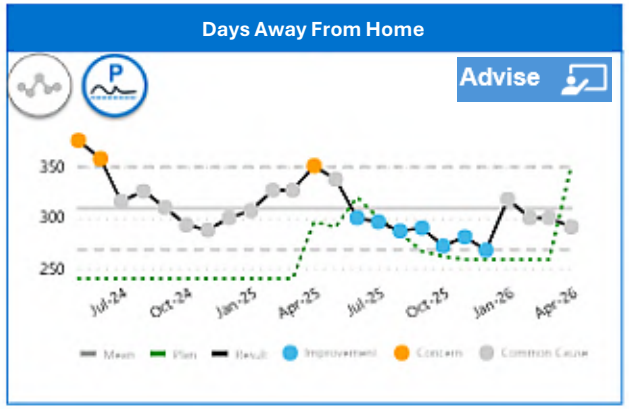
Bed Occupancy - General and Acute %



Hospital @ Home Utilisation Rate



Days Away From Home



Understanding the performance

G&A occupancy remains below plan across MFT, with site variation but overall common cause variation. Days Away From Home averaged 279 NCTR patients per day in May, despite ongoing reablement and MDT improvements. Hospital at Home performance dipped following expansion to 200 beds, which are as yet still not fully utilised. Overall impact on releasing G&A capacity is improving but not yet at scale.

Risks and controls

Higher than plan attendance, high ED acuity. limited rehab and care-home capacity and NCTR performance are the key risks.
Hospital at Home continues to face staffing gaps in South Community, though work to increase referrals across adult and paediatric services is ongoing to support flow.

Strong oversight of performance in place.

Actions and timescales

Oversight of Care Closer to Home will continue to drive actions to improve G&A occupancy and expand capacity. Local Authority representation agreed for the silver and gold improvement cycles. Bedded (P2-3) & Pathway 1 MDTs established across all three acute sites. Bury & Trafford Adult Social Care data pipeline plan with a temporary solution in place to share data around long-term outcomes.

Elective Waiting Times in the Community

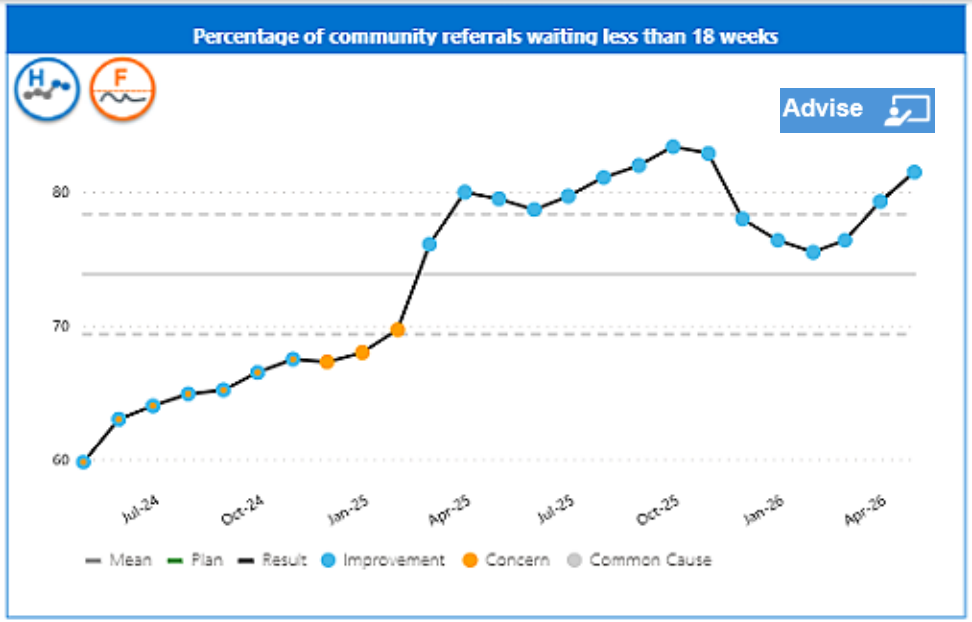
Accountable Executive: Vanessa Gardener | Accountable Group: Quality and Safety Board Committee
NOF: Access to Services | 'Percentage of patients waiting over 52 weeks for community services'

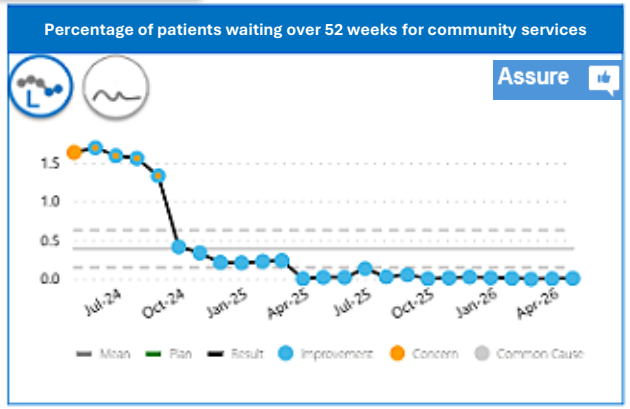
Manchester University NHS Foundation Trust

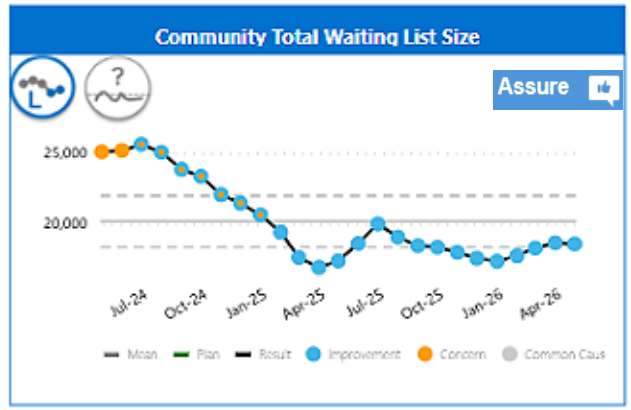
Advise

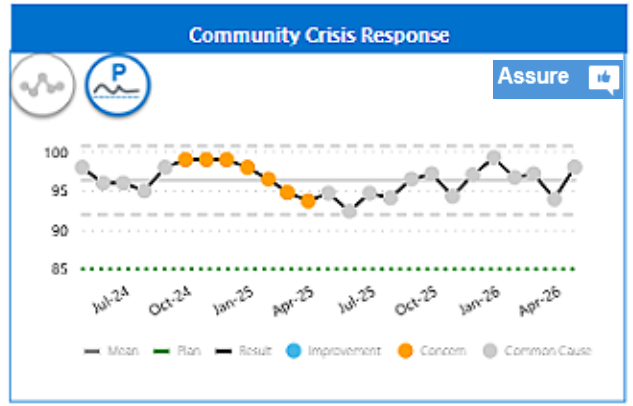
May-26		
Actual	Plan	Variance
81.5%	82.6%	-1.1%

Compliance	Variance	Assurance
✖	H	F









Understanding the performance

The CHS SitRep reportable waiting list has slightly reduced compared to the previous month (-0.4%). Significant increase in waiters for Podiatry compared to the previous month (+7.4%). 18-week performance is exceeding the national 26/27 ambition of 78%. 2 reportable 52-week breaches in May with work underway to manage 52-week risk. Crisis performance continues to be above the national average.

Risks and controls

Pressure on the Trafford ADHD pathway continues with action plan in place to mitigate immediate capacity shortfalls. Bladder and Bowel capacity outstripping demand within the Trafford system with non comparable funding to Manchester.

Actions and timescales

ADHD pathway is being closely monitored by the management team, awaiting confirmation of non-recurrent funding envelope available in June to support interim activity to reduce long waits. Full business case submission expected in July. Bladder and Bowel recovery plan in place with short term test of change to monitor new ways of working to support care and outcomes.

Neurodiversity waiting times

Accountable Executive: Vanessa Gardener | Accountable Group: Quality and Safety Board Committee

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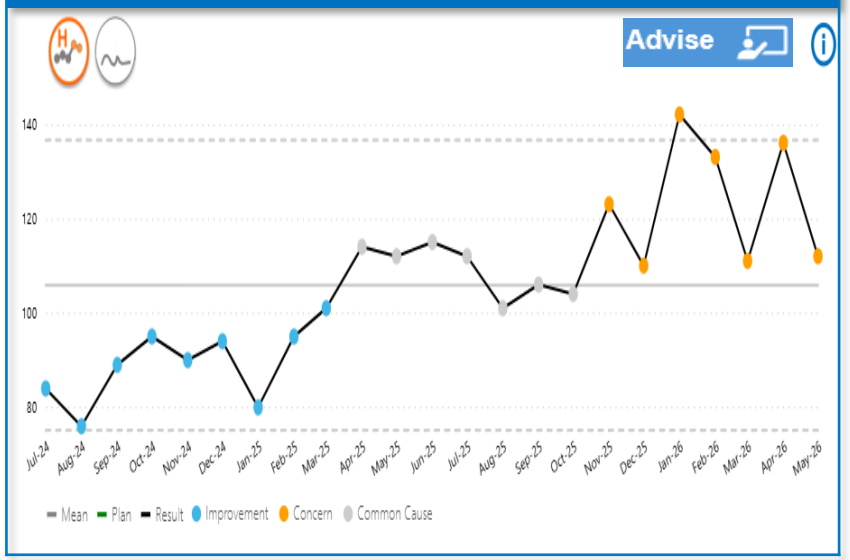
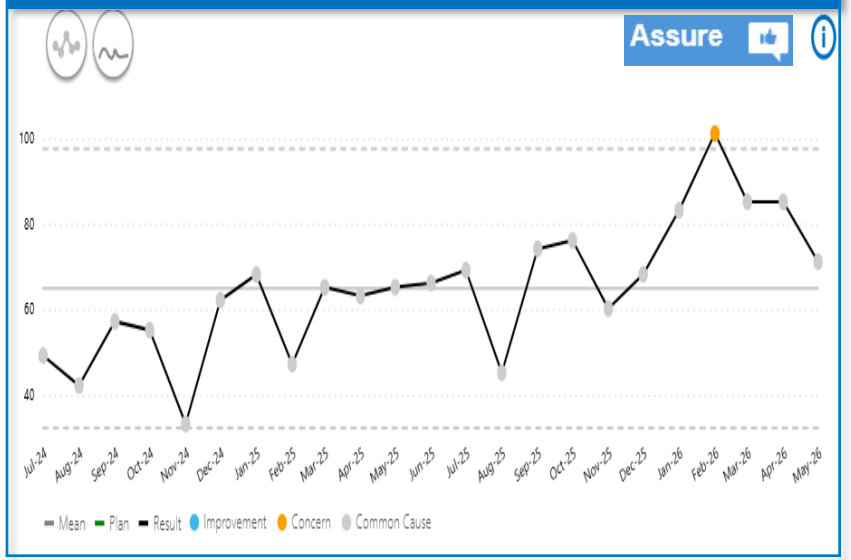
	May- 26	Plan
Autism	110.7	-
ADHD	68.7	-

	Compliance	Variance
Autism		
ADHD		

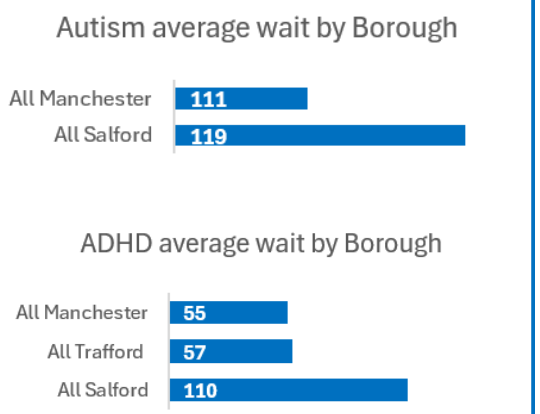
Autism Waiting Times for First Assessment (weeks)



ADHD Waiting Times for First Assessment (weeks)



Overview – May 26



Understanding the performance

Patients awaiting autism assessment, shows concerning variation, with waits averaging 111 weeks for first assessment, in May, and remaining above the median (106), although an improvement from April (136). The longest waits were in Salford (189 weeks).

ADHD assessment waits shows common cause variation, averaging 69 weeks for first appointment (above the median of 65), with the longest waits in Salford at 109.5 weeks.

Risks and controls

There is growing demand for neurodevelopmental assessments across both ADHD and autism pathways; however, CAMHS is not structured or funded to meet this demand. This is resulting in long waiting times, increased pressure on resources, and poor patient experience, with challenges evident across both pathways but impacting ADHD and autism services separately.
Monitoring in place.
From Jan 2026, CAMHS only accept referrals for ADHD or Autism with co-occurring mental health needs. Although, all Greater Manchester CAMHS services have been asked by the ICB to remain flexible as the new system-wide care model continues to evolve and be implemented. As part of this, CAMHS will be required to adhere with the co-occurring mental health and neurodevelopmental conditions pathway to April 2027.

Actions and timescales

Demand for neurodevelopmental assessments (Autism and ADHD) continues to exceed CAMHS capacity and funding, with a shared approach in place including MDT triage, £525k retriage funding, and "one MFT" oversight.
Autism pathway redesign through the Demand & Capacity collaborative (pending approval).
ADHD-only referrals will cease. Backlog reduction focused on 78+ weeks.
ND Needs Led Model
New triage Model official launch will be on 16th July at North Star (Manchester). Engagement events taking place with young people and parent carers.
With a 'One MFT' single pathway being agreed across MLCO and CAMHS.

Outpatient Productivity

Accountable Executive: Vanessa Gardener | Accountable Group: Quality and Safety Board Committee

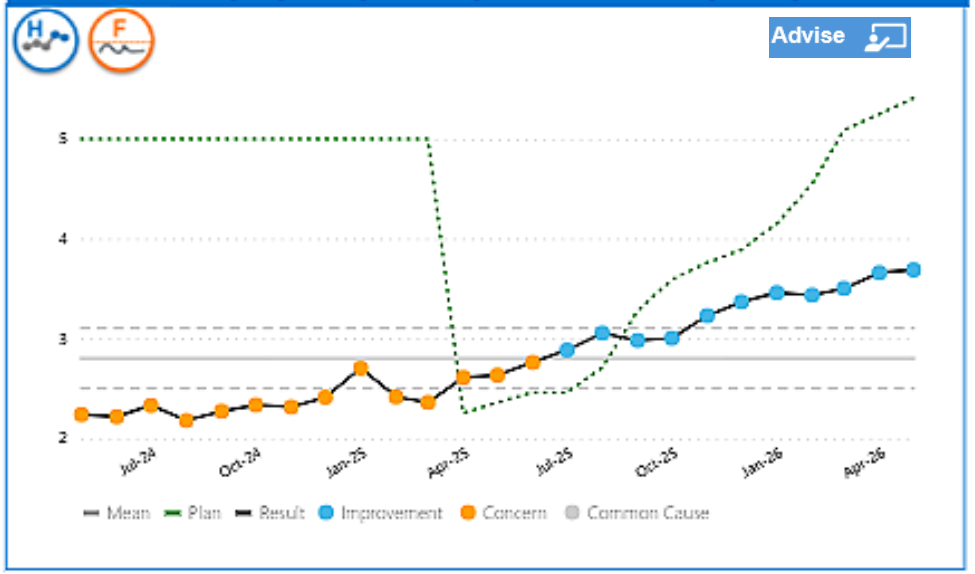
Advise

NHS Manchester University NHS Foundation Trust

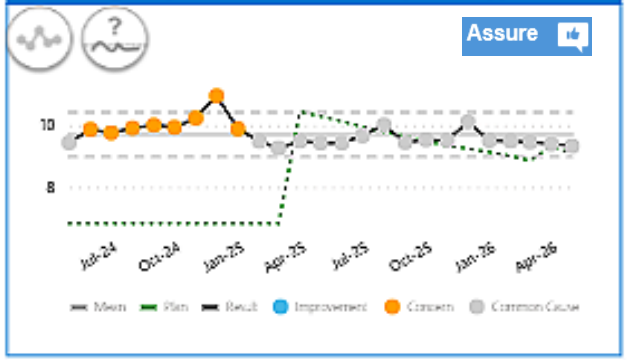
May-26		
Actual	Plan	Variance
3.7%	5.4%	-1.7%

Compliance	Variance	Assurance
✖	H	F

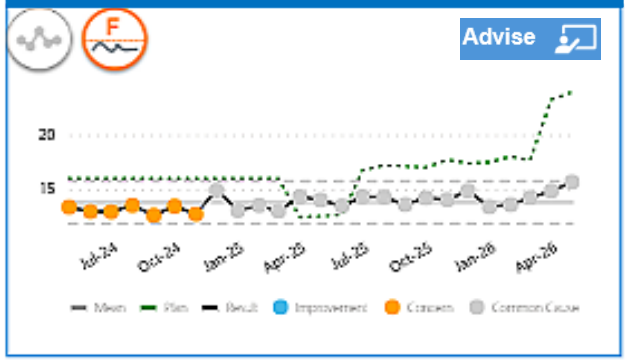
Percentage of patients placed on a patient initiated follow up waiting list



Percentage of patients that DNA an outpatient appointment



Percentage of patients receiving Advice and Guidance following referral



Understanding the performance

PIFU performance continues to show improving variation although remains below plan at 3.7% in May against the 5.4% plan (-1.7pp).

Risks and controls

There is continued risk to under delivery and as a result additional follow up demand created.
CG level productivity targets and delivery within annual plan.
Monitoring and visibility in place.

Actions and timescales

Mitigate through proactive clinical identification to increase uptake, strengthened tracking/reporting of PIFU cohorts, and consistent pathway management to convert demand.

Single Point of Access to be implemented for 10 specialties from Q3 to optimise advice and guidance use.

Theatre Productivity

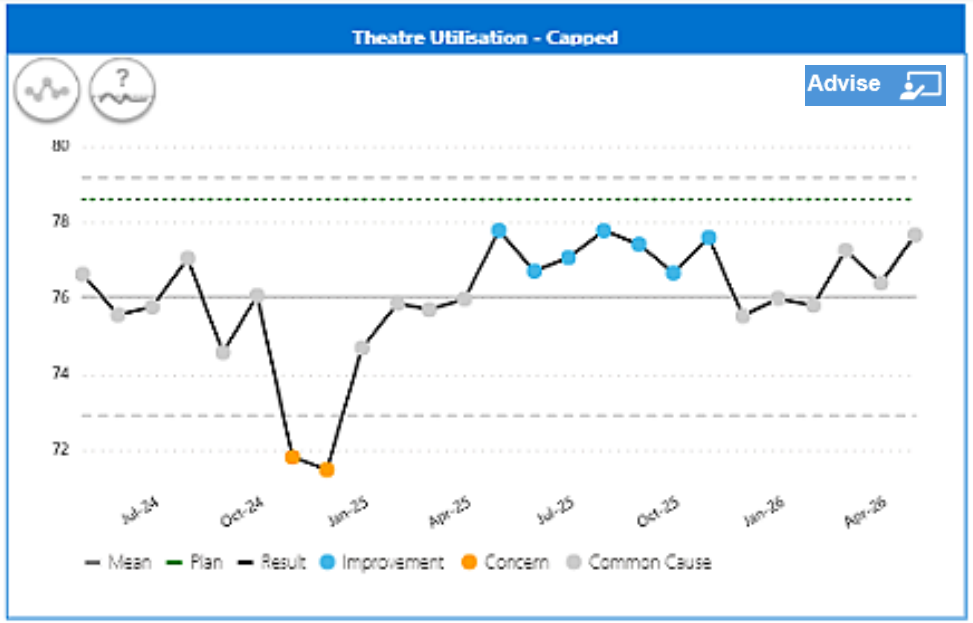
Accountable Executive: Vanessa Gardener | Accountable Group: Quality and Safety Board Committee

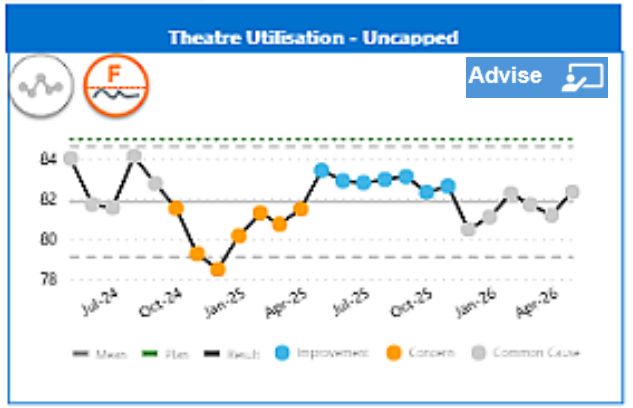
Manchester University NHS Foundation Trust

Advise

May-26		
Actual	Plan	Variance
77.7%	78.6%	-0.9%

Compliance	Variance	Assurance
✖	~	?





Understanding the performance

Theatre utilisation remains statistically stable, with May delivery at 77.7% against a 78.6% plan (-0.9pp). Performance is above the current mean (~76%) and consistent with recent months, but not yet reliably at plan.

Trafford Elective hub delivered 86.4% utilisation in May, an improvement from April (84.5%).

RMCH delivered 80% utilisation and Withington 79.9% in May, all other clinical groups delivering below the standard.

Risks and controls

Theatre lists not optimised resulting in activity levels below plan or at additional cost, and non delivery of RTT performance and productivity requirements.

Improving Theatre Productivity is a key focus for the care on Time Programme – Theatre improvement workstream. The plan for 26/27 will focus on best practice scheduling, daily operational oversight, complimented by strong governance and quarterly 'SPRINTS' to test and embed improvements.

Actions and timescales

Embed Gold Standards for Theatre Booking and Scheduling for all elective theatre lists. Gold Standard Proposal to be finalised by July 2026 Implementation across all Clinical Groups planned for September 2026 .

Ensure there are robust on the day operational process in place to support theatre flow. Gap analysis underway against 'what a good day looks like'. This will enable development of robust escalation processes. Daily operational huddles to commence from July 2026.

Quarterly Elective Theatre Focus Weeks. Focus weeks to run in line with GIRFT Hub Optimisation Week on each theatre site.

Trust SPC, Multipl...

Measures for assurance

Activity

Accountable Executive: Vanessa Gardener | Accountable Group: Quality and Safety Board Committee

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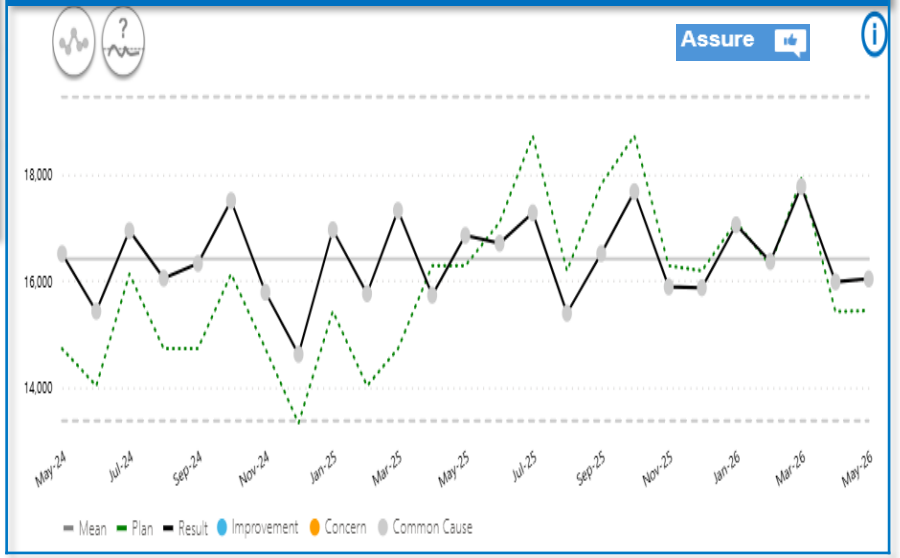
NHS Foundation Trust

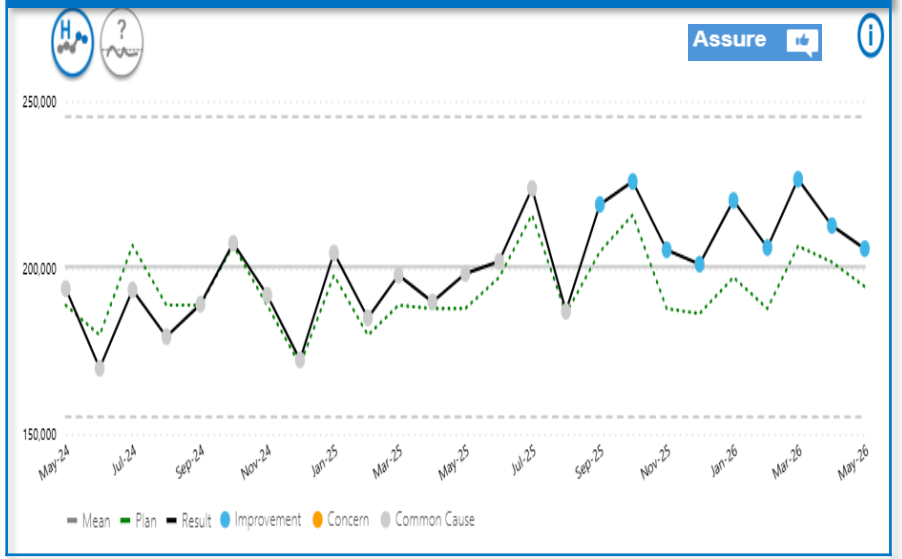
May - 26	Actual	Plan	Variance
Inpatient	16,036	15,595	595
Outpatient	205,758	194,377	11,381

	Compliance	Variance	Assurance
IP	✓	~	?
OP	✓	H	?

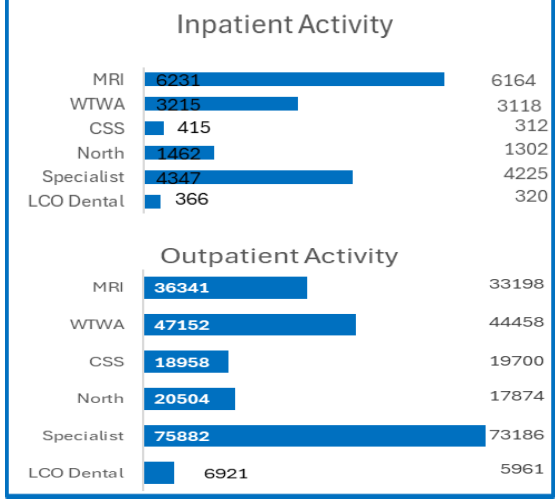
Elective Inpatient and Daycase Activity



Elective Outpatient Activity



Overview – May 26



Understanding the performance

Inpatient activity shows common cause variation for delivered activity in inpatients and daycase elective treatment. May Performance delivered better than plan +595.

Outpatient activity also shows improving variation for delivered activity in outpatients. May Performance delivered better than plan +11,381.

Over 18 week RTT cohort is on plan, suggesting that overperformance has been due to keeping up with RTT demand plus any non-RTT additionality.

Risks and controls

Variation to plan creates a risk in operational performance delivery and contractual issues.

Risk of future disruption from industrial action remains; however, clinical groups are experienced in implementing mitigations to reduce impact and maintain delivery wherever possible.

CG activity plans in place and monitoring in place.

Actions and timescales

Ongoing demand and capacity planning, supported by strengthened activity monitoring, underpins delivery against agreed trajectories and provides in-year oversight with commissioners.

Sexual Assault Referral Centre waiting times

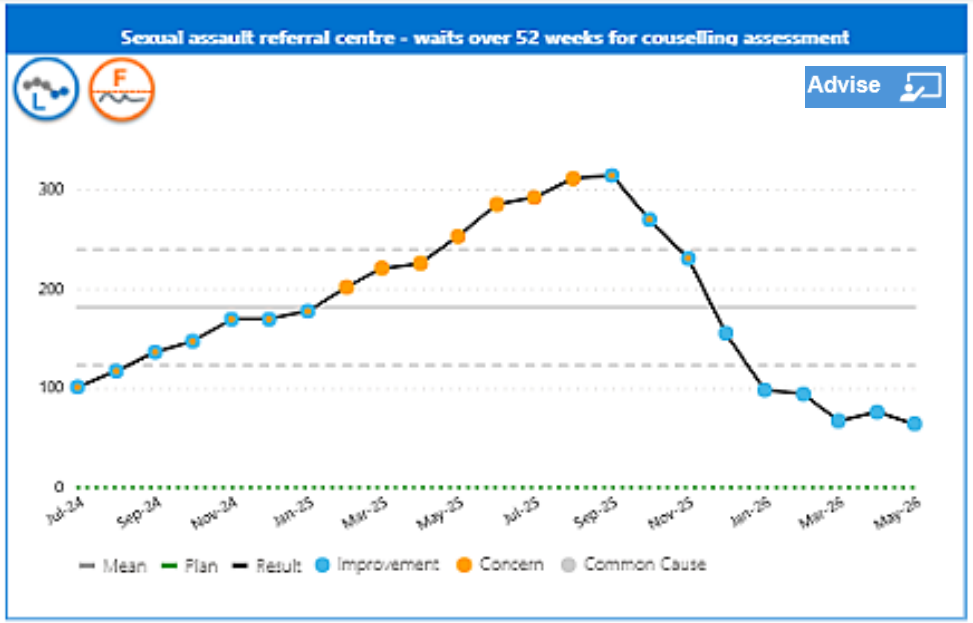
Assure

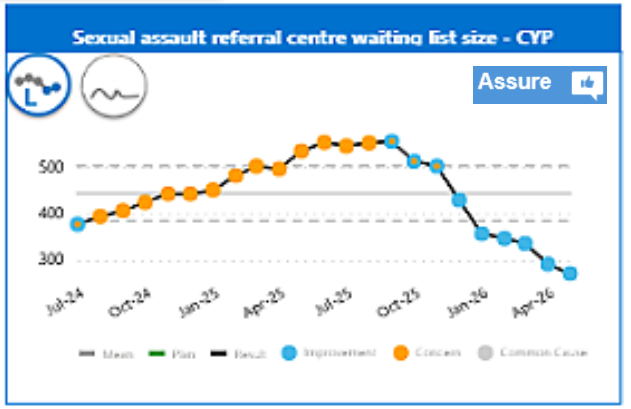
Accountable Executive: Vanessa Gardener | Accountable Group: Quality and Safety Board Committee

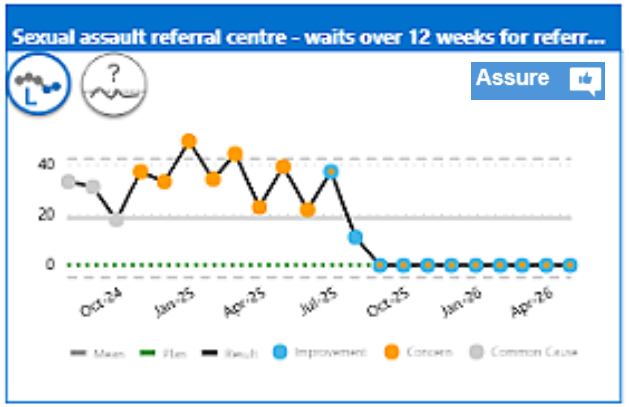
NHS Manchester University NHS Foundation Trust

May-26		
Actual	Plan	Variance
64	0	64

Compliance	Variance	Assurance
✖		F







Understanding the performance

The wait time for Counselling has reduced this month with the longest waiter being at 64 weeks (compared to 76 weeks in April).
The changes in referral criteria has also reduced the number of child counselling referrals in May.
The average wait for a counselling assessment in May was 40 days.

Risks and controls

Staff are experiencing signs of burnout and vicarious trauma, which risks continued delivery of the service.

Full wellbeing support in place.

Actions and timescales

From June we expect to see an accurate reflection in our data of how the new referral criteria will impact the data going forwards.
An urgent staff meeting is to be held next week to discuss the staff wellbeing in the children's team.

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Workforce - IPR
May 2026

People & Workforce NOF Scores 2025/26

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People and Workforce improved to **segment 3** in Q4 from **segment 4** Q1/2/3 of the NHS oversight framework (NOF). The previous ranking was 113/134 with an average metric score of 3.08 for acute providers. The average metric score is now 2.96, with the ranking of 103/134

	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
MFT Segment	3	3	3	1
MFT Average Segement Score	**2.41**	**2.5**	**2.36**	**1.94**

People and workforce	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Segment	4	4	4	3
Average Score	**3.18**	**3.09**	**3.08**	**2.96**
NHS staff survey engagement theme sub-score	2.92	2.92	2.92	2.69
Sickness absence rate	3.44	3.26	3.25	3.22

Measures requiring Board attention

Rolling 12 month (R12m) Sickness Absence

Accountable Executive: Meera Nair| Accountable Group: People Board Committee
NOF: People and Workforce| 'Sickness Absence Rate' |Q4 score: 3.22 (Below Average)

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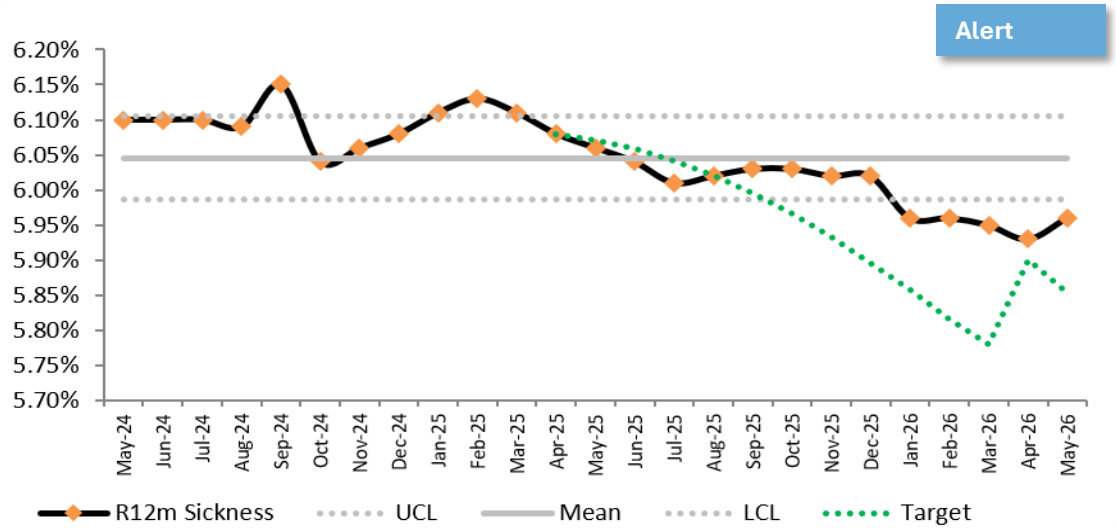
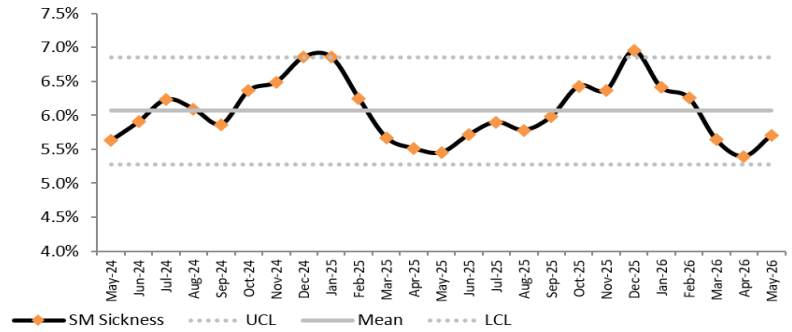
May-26	Target
SM 5.7%	4.8%
R12M 6.0%	5.9%

Compliance	Variance	Assurance	Actions
✗	L	F	✗
✗	L	F	✗

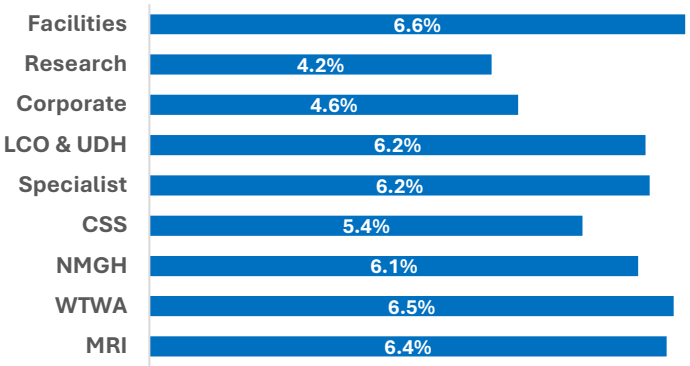
R12M Sickness Absence %



Single Month Sickness Absence %



Clinical Group breakdown (R12m)



Understanding the performance

Rolling 12-month sickness absence is 6.0% (5.95%) for May 2026 which is slightly above target. Return to Work and Callback compliance via Absence Manager is 60.5%, against expectations of manager contact within 48 hours of absence notification and a return-to-work meeting within 24 hours of closure.

Risks and controls

Sickness Absence management programme continues with five core workstreams led by the Clinical Group Directors of Workforce. Improvements to absence manager system notifications and policy surveillance reporting have been implemented to provide managers with clearer tools and data to manage sickness absence more effectively

Actions and timescales

1. Policy review to support management of absence.
2. Widespread communications campaign and monitoring of absence management training.
3. Empactis system deep dive data pilot.
4. Policy Surveillance monitoring report to move from monthly to weekly (Q2 – 26/27)

Appraisal: AfC and Medical

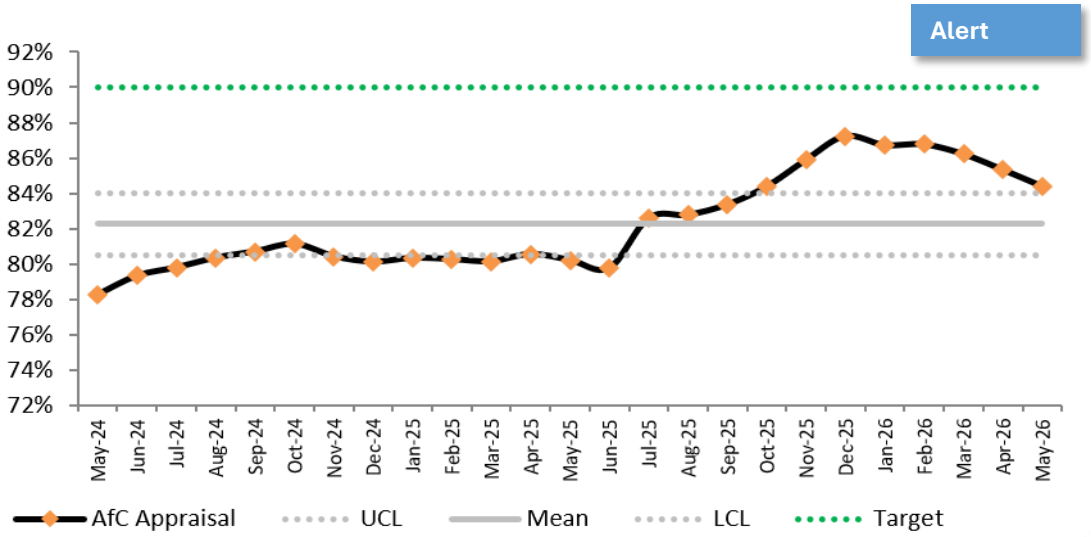
Accountable Executive: Meera Nair | Accountable Group: People Board Committee

Manchester University NHS Foundation Trust

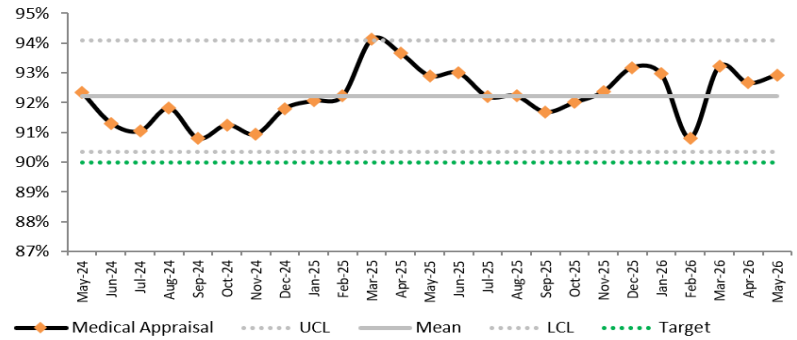
May-26	Target
AfC 84.4%	90.0%
Med 92.9%	90.0%

	Compliance	Variance	Assurance	Actions
AfC	✗	H	F	✓
Med	✓	~	P	⇄

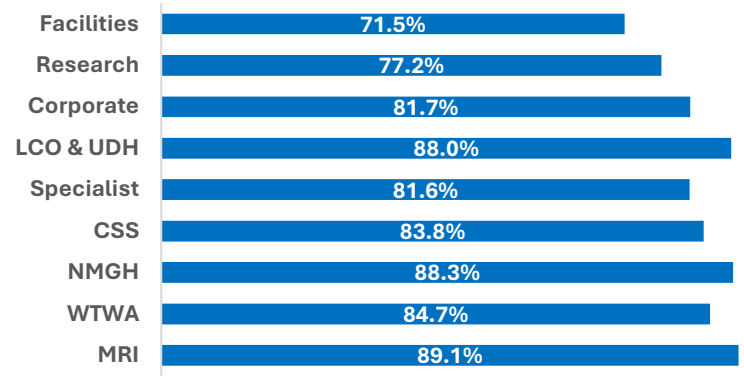
AfC Appraisal



Medical Appraisal



Clinical Group breakdown (AfC)



Understanding the performance

In May 2026, MFT reported 84.4% compliance with AfC appraisals, below the Trust target of 90%. AfC appraisal compliance is 4.2% higher than the same reporting period last year. Compliance has reduced consecutively for AfC appraisals for the last 5 months.

Risks and controls

Delays in appraisal completion, particularly in frontline services, are likely linked to ongoing operational pressures and competing priorities. An investigation is currently underway to ensure the accuracy and integrity of the underlying data and reporting processes.

Actions and timescales

1. Integration of appraisal completion into performance and development reviews.
2. Targeted support and training for line managers

Measures to note

Mandatory Training: Level 1 and Level 2 & 3

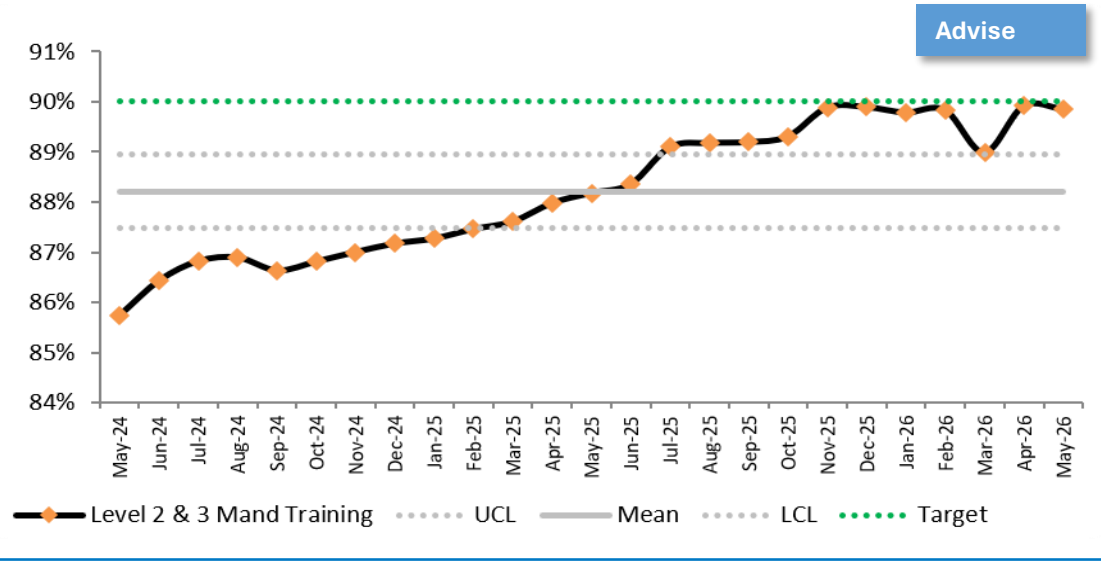
Accountable Executive: Meera Nair | Accountable Group: People Board Committee

Manchester University NHS Foundation Trust

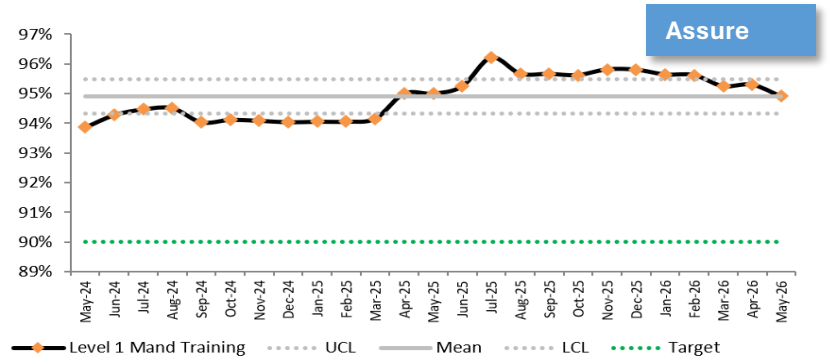
May-26	Target
Lvl 1 94.9%	90.0%
Lvl2&3 89.9%	90.0%

	Compliance	Variance	Assurance	Actions
Lvl 1	✓	~	P	⇄
Lvl2&3	✗	H	F	✓

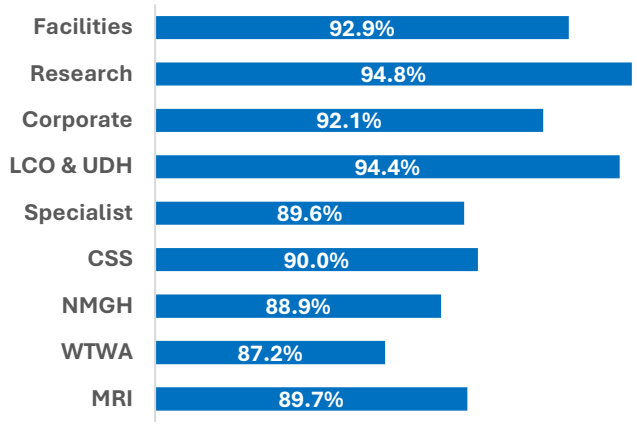
Level 2 & 3 Mandatory Training



Level 1 Mandatory Training



Clinical Group breakdown (Level 2 & 3)



Understanding the performance

In May 2026, MFT reported 89.9% compliance with Level 2 and 3 mandatory training, slightly below the Trust target of 90%. However, performance has improved steadily over the past two years, reflecting continued focus on mandatory training compliance.

Risks and controls

Compliance remains inconsistent, with notable variation across staff groups and clinical areas. Operational pressures and competing priorities are likely contributing to lower completion rates in some parts of the organisation.

Actions and timescales

1. Targeted communications to reinforce the importance of mandatory training.

Measures for assurance

Staff WTE: Substantive, Bank and Agency

Accountable Executive: Meera Nair| Accountable Group: People Board Committee

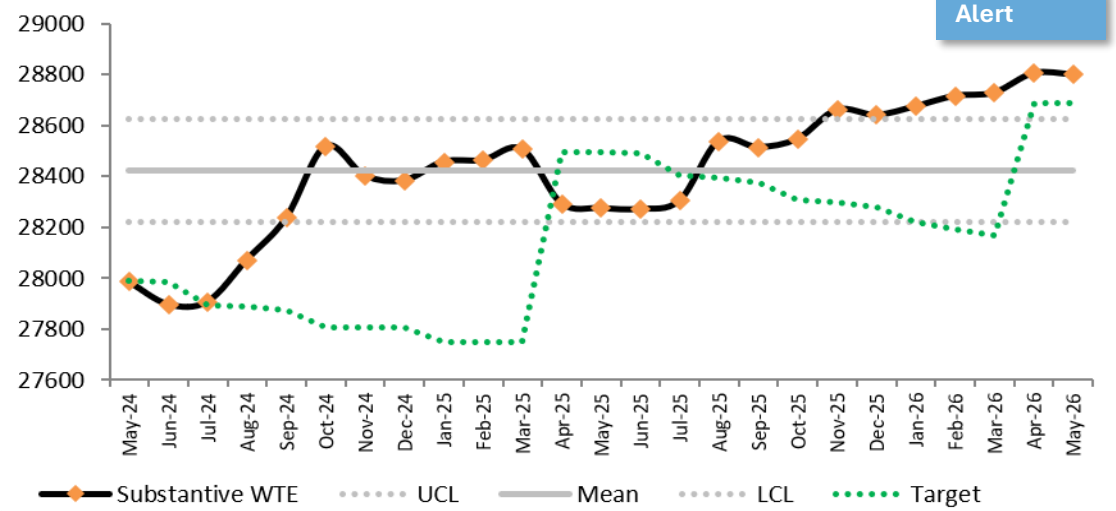
Manchester University NHS Foundation Trust

May-26	Target
29,794	30,154

Compliance | Variance | Assurance | Actions

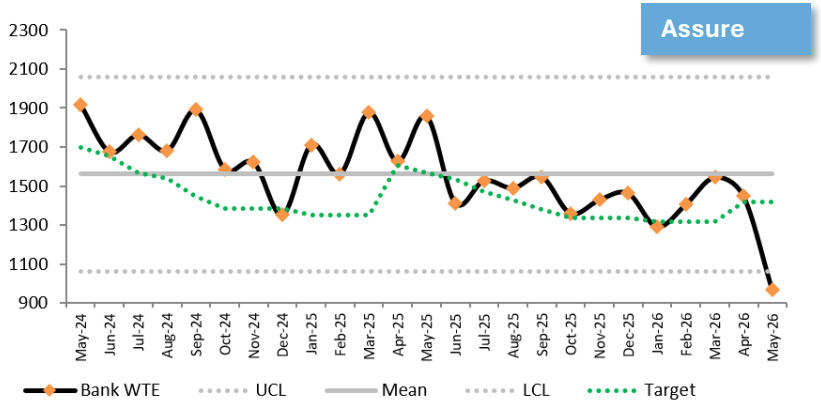
Substantive WTE

Alert



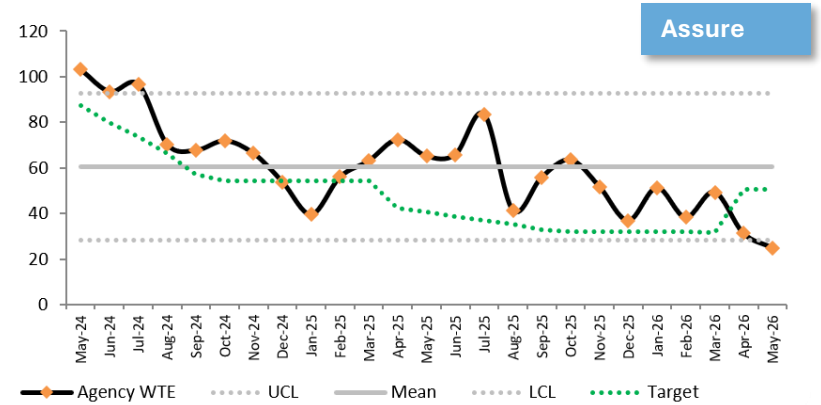
Bank WTE

Assure



Agency WTE

Assure



Understanding the performance

Total staffing WTE is 360 below the Annual plan for May 2026. This variance is predominantly driven by temporary staffing with bank (-446 WTE) and agency (-26 WTE) usage exceeding expectations for this reporting month.

Substantive WTE remains above plan by +112 WTE, although this has reduced slightly by 5 WTE month-on-month, indicating early signs of stabilisation.

Risks and controls

A proportion of the WTE increase reflects funded service changes—such as the implementation of Single Hospital Services—which appropriately expanded the workforce during the year. These additional posts were not included in the original WTE plan and account for approximately 200 WTEs across both substantive and Bank staffing.
Low turnover rate of 8.0% impacts on organisational churn / reduction.

Actions and timescales

1. Enhanced scrutiny of agency bookings through workforce dashboards (Q1 – 26/27)
2. Ongoing work continues with triangulation of income back changes and potential growth relative to 2026/27 annual planning.

Turnover

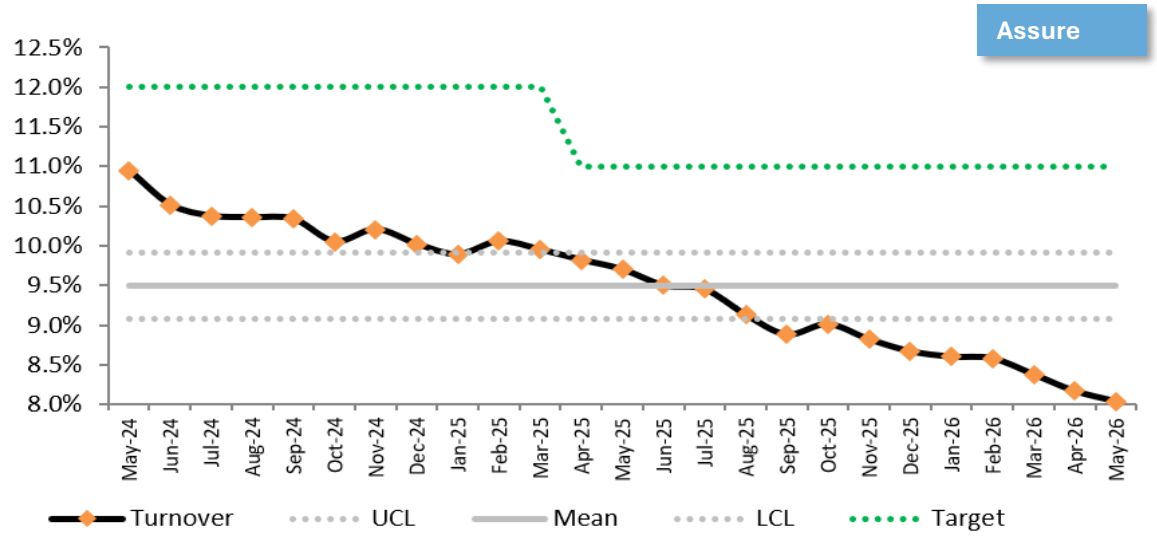
Manchester University
NHS Foundation Trust

Accountable Executive: Meera Nair| Accountable Group: People Board Committee

May-26	Target
8.0%	11.0%

Compliance | Variance | Assurance | Actions

Turnover



Understanding the performance

Turnover for May 2026 is 8.0%, continuing the sustained downward trend observed over the past two years and remaining well below the 11.0% target. Performance has steadily improved from 10.9% in May 2024 to the current level, with particularly consistent reductions throughout 2025 and into 2026.

Risks and controls

Actions and timescales

NHS
Manchester University
NHS Foundation Trust

Finance - IPR 26-27 M2

Finance and Productivity NOF Scores 2025/26

Manchester University
NHS Foundation Trust

Finance and Productivity reaming in **segment 1** in Q4 of the NHS oversight framework (NOF). The previous ranking was 21/134 with an average metric score of 1.68 for acute providers. The average metric score is now 1.35, with the ranking of 9/134

	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
MFT Segment	3	3	3	1
MFT Average Segement Score	**2.41**	**2.5**	**2.36**	**1.94**

Finance and productivity	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Segment	**1**	**2**	**1**	**1**
Average Score	**1.28**	**1.79**	**1.68**	**1.35**
Combined finance	1	2	1	1
Implied productivity level	1.56	1.59	2.35	1.7
Planned surplus/deficit	1	1	1	1
Variance year-to-date to financial plan	1	3	1	1

Measures requiring Board attention

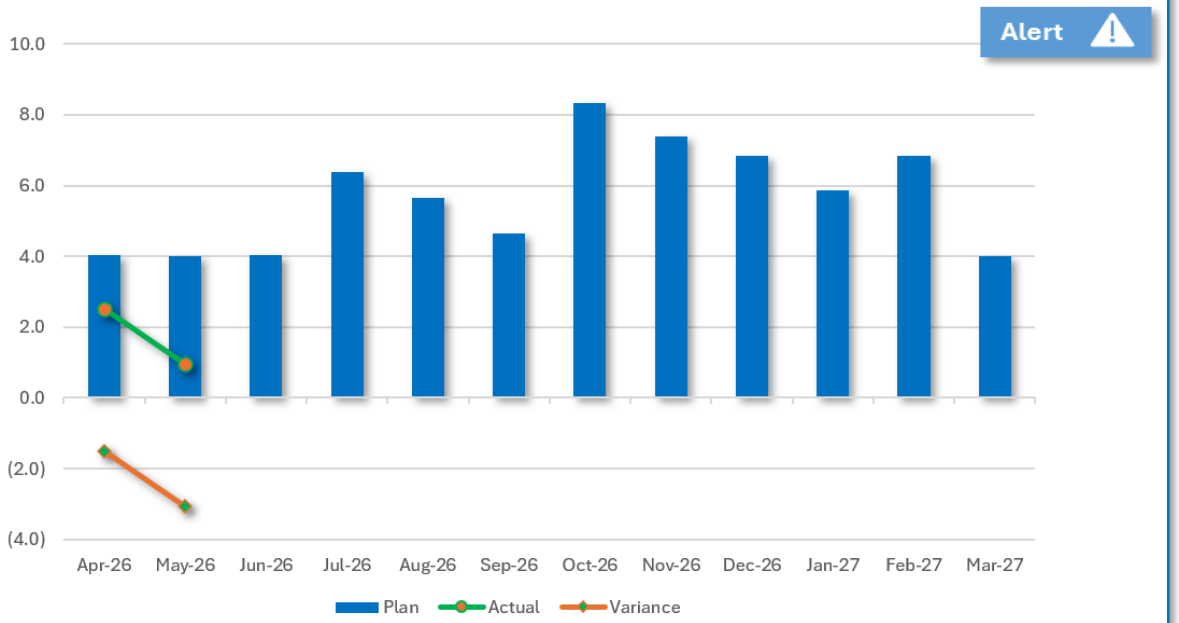
Liquidity – Operating Expenditure Days

Accountable Executive: Claire Wilson | Accountable Group: Finance Board Committee

May-26		
Actual	Plan	Variance
Days	Days	Days
0.9	4.0	(3.1)

Compliance	Variance	Assurance	Actions
✗	L	F	✗

Liquidity – year to date operating expenditure days



Understanding the performance

The YTD deficit to the I&E plan of £19.5m impacts the cash balance – more outgoings than planned.
Planned £36m of revenue support was not drawn down.
Active management of working capital gives a £30m benefit.

Risks and controls

Key risk is there will be insufficient cash flow to meet operational commitments.
To mitigate, there is robust cash-flow forecasting, monitor daily liquidity positions, and regularly reconcile forecasts against actual cash movements. Early escalation of potential shortfalls is made to finance leadership.

Actions and timescales

Progress on delivery of the VfP programme is essential to holding sufficient cash to pay suppliers and payroll.
Significant focus continues on maximisation of the Trust's cash position through management of payments and maximising income.

Financial performance against budget YTD (£m)

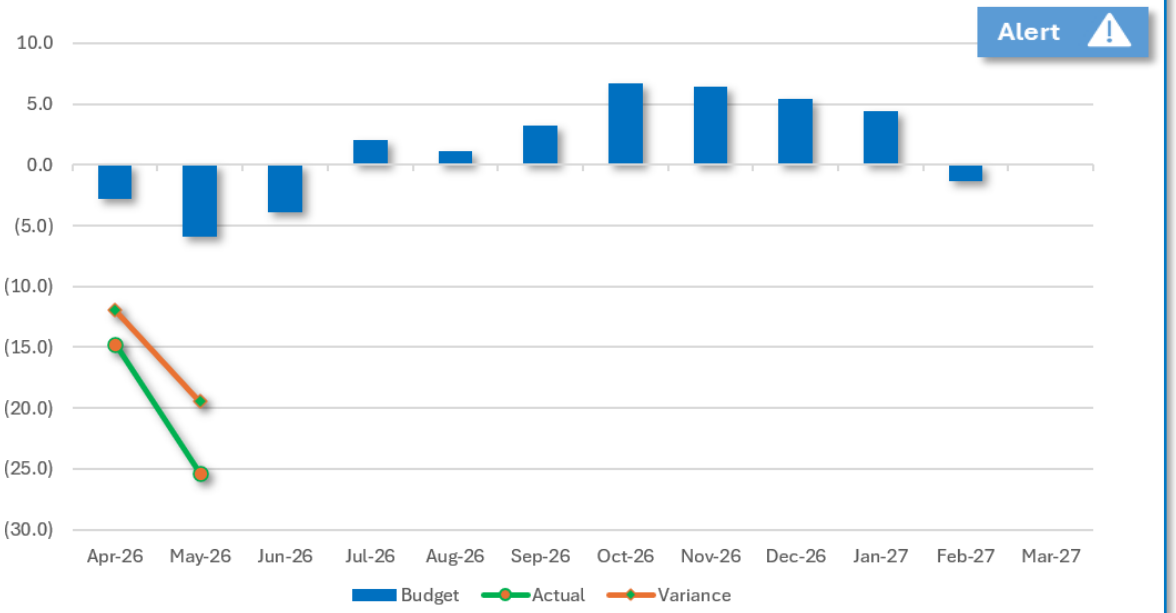
Accountable Executive: Claire Wilson | Accountable Group: Finance Board Committee

NOF: Variance year-to-date to financial plan| Q1 score: 1.0

May-26		
Actual	Plan	Variance
£m	£m	£m
(25.34)	(5.88)	(19.46)

Compliance	Variance	Assurance	Actions
✕	L	F	✕

Financial performance against budget YTD (£m)



Clinical Group breakdown

Rank	Clinical Group	YTD Value £m
1	NMGH	(0.01)
2	LCO & Dental	(1.73)
3	WTWA	(3.21)
4	MRI	(3.98)
5	CSS	(5.05)
6	SHCG	(6.74)

Understanding the performance

YTD under-delivery of the VfP programme by £17.2m plus unmitigated and unfunded costs related to the April Resident Drs industrial action of £2.7m have driven the adverse variance to plan.

NOF score recently uplifted to 1 from 3 is not representative of YTD performance but based on breakeven plan and forecast outturn,

Risks and controls

Key risk is the failure to achieve the planned full year breakeven position.
To mitigate, there is monthly spend monitoring, detailed variance analysis, executive review of financial performance, and implementation of recovery plans where adverse variances are identified.

Actions and timescales

Accelerated identification and implementation of VfP schemes is required to avoid the YTD deficit getting worse.
All CGs and Corporate areas will need to begin identification of mitigations in order to recover the YTD deficit and the IA costs.

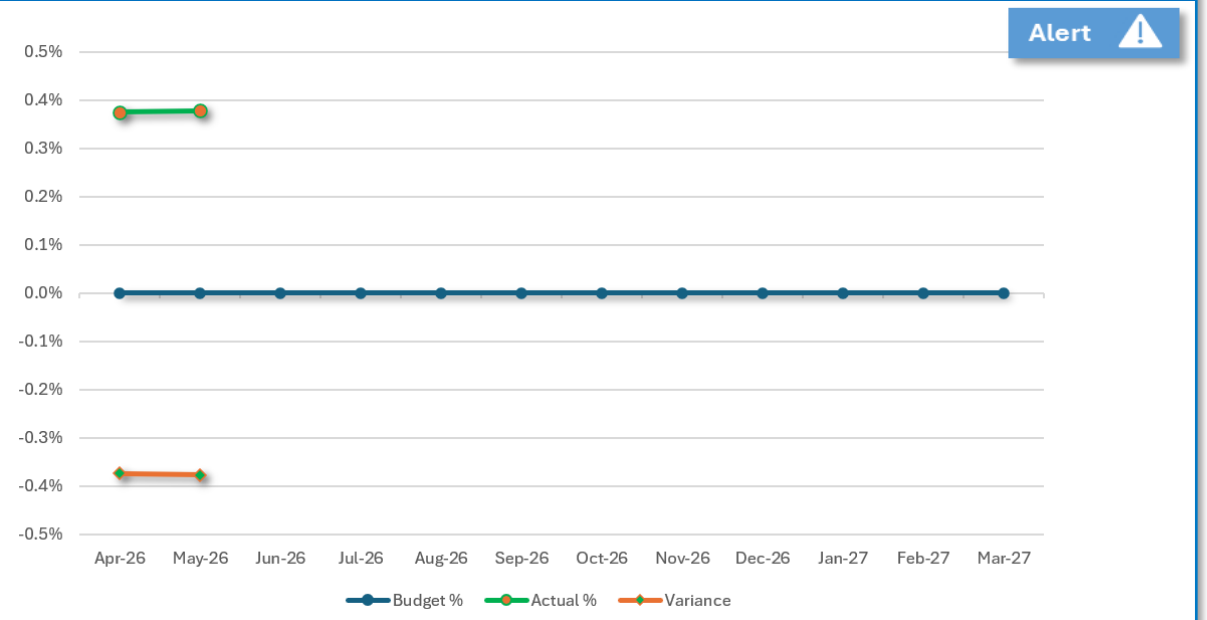
Agency expenditure as a proportion of total pay expenditure YTD

Accountable Executive: Claire Wilson | Accountable Group: Finance Board Committee

May-26		
Actual	Target	Variance
%	%	%
0.4	0.0	(0.4)

Compliance	Variance	Assurance	Actions
✗	~	F	✗

Agency expenditure as a proportion of total pay expenditure YTD (%)



Clinical Group breakdown

Rank	Clinical Group	YTD Value %
1	LCO & Dental	0.1%
2	SHCG	0.2%
3	WTWA	0.3%
4	MRI	0.5%
5	CSS	0.6%
6	NMGH	0.7%

Understanding the performance

YTD expenditure on agency staffing is £1.3m against an internally set target of £0. This equates to less than 0.4% of total pay expenditure.

The externally set annual cap for MFT is £6.4m. Pro-rata to month 2 this would be £1.1m, so the Trust is adverse to this by c£0.2m.

Risks and controls

Key risks around clinical scientists in CSS and Consultants in paediatric services where recruitment to substantive positions is extremely difficult and there is no bank staff available.

Actions and timescales

All NHS organisations are required to eliminate agency staff usage before the end of March 2029. There is a reducing cap each year. Internal target has been set at zero useage for 2026/27 but key issues remain to be resolved.

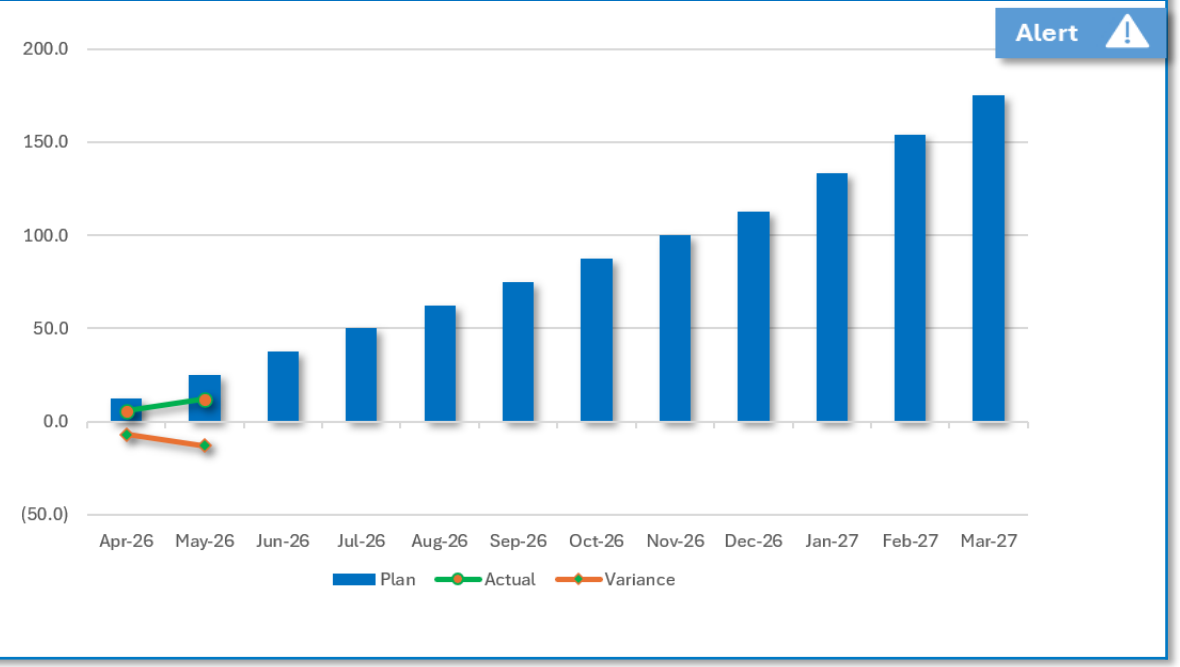
Value for Patients variance to plan (£m)

Accountable Executive: Claire Wilson | Accountable Group: Finance Board Committee

May-26		
Actual	Plan	Variance
£m	£m	£m
11.96	25.00	(13.04)

Compliance	Variance	Assurance	Actions
✗	L	F	✗

Value for Patients variance to plan YTD (£m)



Clinical Group breakdown

Rank	Clinical Group	YTD Value £m
1	NMGH	0.76
2	LCO & Dental	(1.42)
3	MRI	(3.62)
4	WTWA	(3.62)
5	CSS	(3.86)
6	SHCG	(4.54)

Understanding the performance

- 26/27 programme has identified £148.1m against a target of £175m (£61.4m risk adjusted).
- Financial planning continues, although minimum £26.9m additional is required to reach the £175m target.
- YTD actual delivery £12.0m against a target of £29.2m (variance to target £17.2m).

Risks and controls

- Month-end reconciliation ensures Wave and the Financial ledger are consistent.
- Workstreams report progress to the Value for Patients Team Management Group, which meets monthly.
- Fortnightly meetings track progress between clinical leaders and finance heads.

Actions and timescales

- The primary objectives are to enhance the recurring value of VfP delivery for 26/27 and to improve the cash position in the 1st quarter.
- Ongoing efforts will focus on identifying and developing new opportunities, progressing the maturity of existing schemes to rapidly start.
- Additional measures to improve operational grip include revised month-end processes, senior check-in meetings to support issue resolution and prioritisation, and leveraging workstreams for Trust-wide read-across.

Measures for assurance

Measures for assurance

Key Oversight Performance Metrics							
Focus	Compliance	Variation	Assurance	Action Status	Performance	Plan	Indicator
Finance and Commercial					3.91	0.0	Income including Elective - variance to income in finance plan (£m)

NHS
Manchester University
NHS Foundation Trust

Digital - IPR

Measures requiring Board attention

Measures to note

Advise

Key Oversight Performance Metrics: April 2026						
Compliance	Variation	Assurance	Action status	Performance	Plan	Indicator
✗	~	?	◉	87%	90%	Freedom of Information Requests (FOIs)
✗	~	?	◉	15hr20min	15hr	Clinical and Operational Downtime

Measures to note

FOI: FOIs received continues to increase, with a 10% increase for period Jan 2026 - Apr 2026 against the same period in 2025. AI tools are being piloted to assist FOI administration process. Month-on-month, performance improved slightly on the 83.78% compliance achieved in March 2026. The performance improvement delivered in recent months continues to satisfy ICO expectations with ongoing positive engagement.

Clinical and Operational Downtime: Performance represents an aggregate of all types of downtime at individual service level across the Trust. It equates to seven incidents, for which all impacts were minimal, with no Business Continuity required. Performance of clinical and operational downtime continues to be actively monitored as part of a suite of new KPI measurements.

Measures for assurance

Measures for assurance

Key Oversight Performance Metrics: April 2026						
Compliance	Variation	Assurance	Action status	Performance	Plan	Indicator
				99.7%	90%	Subject Access Requests (SARs)

NHS
Manchester University
NHS Foundation Trust

Research & Innovation – IPR – May 2026

Measures for assurance

IPR Metric Assurance Summary

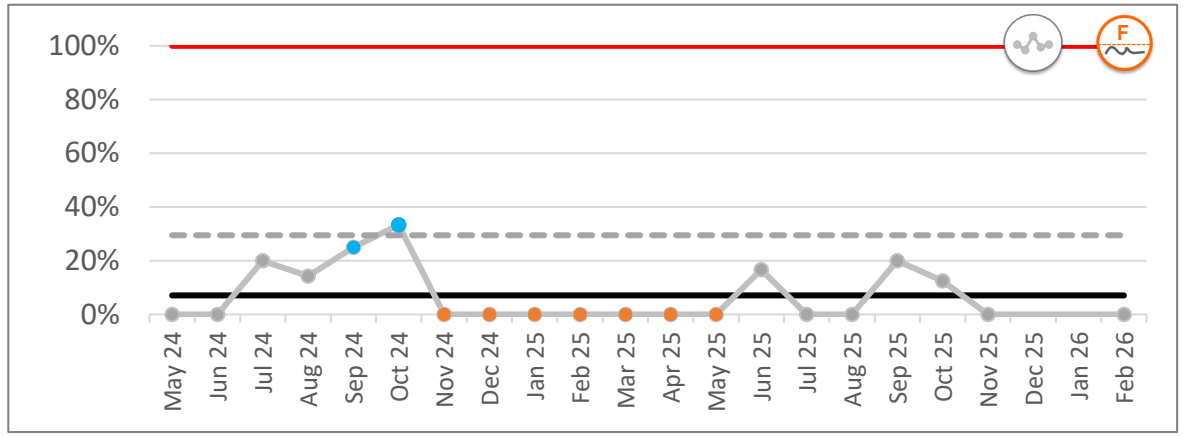
NHS
Manchester University
NHS Foundation Trust

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Weighted (by type) total monthly recruitment	Apr 26	72779	118375			114494	28290	200697
MFT-sponsored, NIHR Portfolio-adopted research studies on track for recruitment to time and target	Apr 26	93%	80%			92%	Not applicable yet	Not applicable yet
HRA approval to actual start date within 60d- NIHR commercial studies	Feb 26	0%	100%			7%	-15%	29%
HRA approval to actual start date within 60d- NIHR all studies	Feb 26	50%	100%			10%	-16%	36%
Actual start date to first patient within 30d- NIHR commercial studies	Mar 26	0%	100%			30%	-54%	114%
Actual start date to first patient within 30d- NIHR all studies	Apr 26	100%	100%			48%	-1%	96%

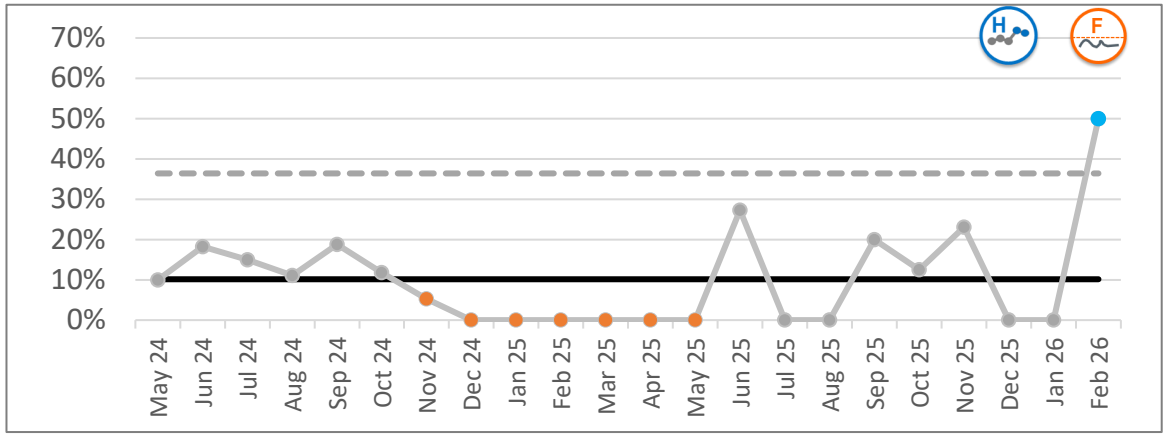
Metric Summary

NHS
Manchester University
NHS Foundation Trust

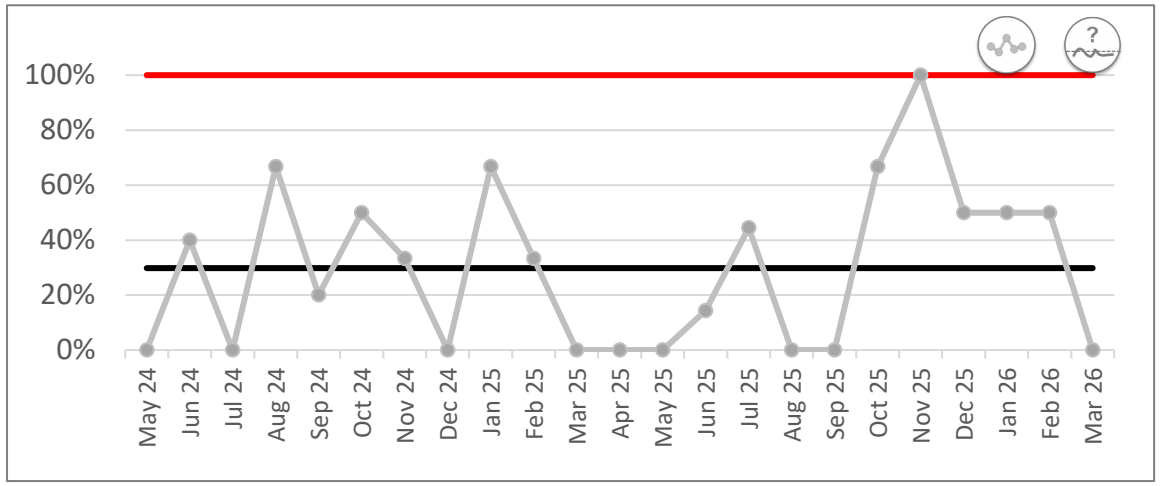
HRA approval to actual start date within 60d- NIHR commercial studies



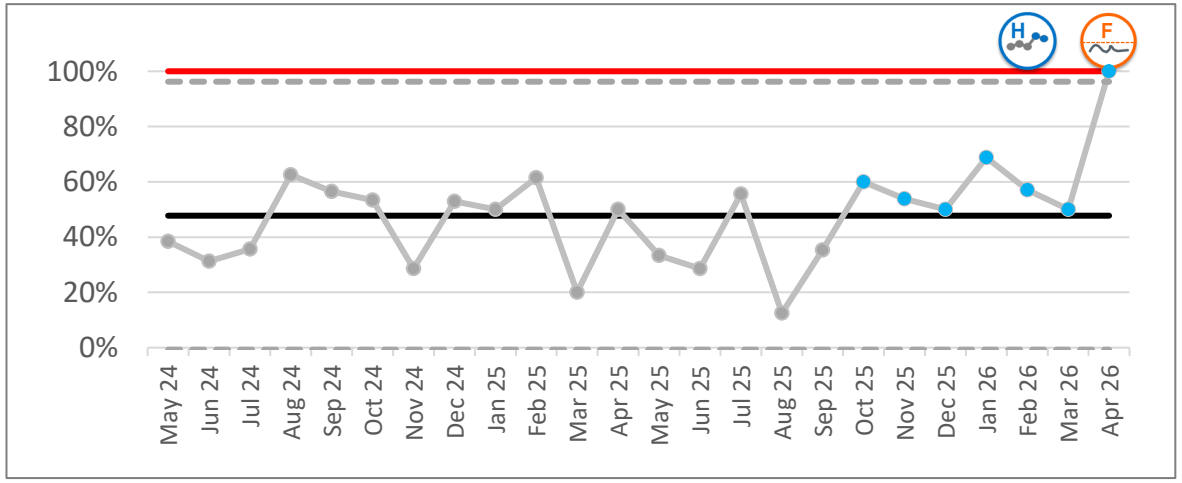
HRA approval to actual start date within 60d- NIHR all studies



Actual start date to first patient within 30d- NIHR commercial studies



Actual start date to first patient within 30d- NIHR all studies



National Overview – 2025/26

Trust name	Median days - to first partipant first visit (in days)	Studies that reported FPFV at the trust	Studies with FPFV within 90 days	Studies with FPFV after 90 days
University Hospitals of Leicester NHS Trust	74	85	46	39
Manchester University NHS Foundation Trust	77.5	90	59	31
Barts Health NHS Trust	79	120	67	53
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	82	117	64	53
University Hospital Southampton NHS Foundation Trust	92	125	61	64
University Hospitals Birmingham NHS Foundation Trust	107	91	37	54
University College London Hospitals NHS Foundation Trust	114	90	39	51
Oxford University Hospitals NHS Foundation Trust	117	105	34	71
Leeds Teaching Hospitals NHS Trust	208	110	24	86
Guy's and St Thomas' NHS Foundation Trust	219.5	126	20	106

Top 10 Trusts sorted by number of studies that reported FPFV in 2025/26. MFT is 8th for study numbers reporting FPFV in 2025/26 and 2nd for median days (77.5) compared with peer organisations.

MFT 5th for overall recruitment nationally and 2nd Trust for commercial recruitment nationally for 2025/26.

Manchester University
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Escalation and Assurance Report
Research, Innovation and Population Health

Report to: Board of Directors
Report from: Matt Bonam, Non-Executive Director
Date of meeting(s): 19 June 2026

Key escalation and discussion points from the meeting
Alert
The were no matters to alert to the Board.
Advise
The **Population Health Integrated Performance Report** outlined the continued development of population health metrics. Discussion focused on the importance of aligning reporting with the emerging Neighbourhood Health Framework and strengthening the ability to demonstrate outcomes and impact at neighbourhood level. Members emphasised the need for greater granularity within future reporting, including variation between neighbourhoods and cohorts, to support local improvement activity and clinical engagement. The Committee reviewed the **Research and Innovation Integrated Performance Report**, noting continued strong overall performance and positive national benchmarking. Discussion focused on areas requiring improvement, including study start-up times and weighted recruitment performance, both of which were considered advise metrics. The Committee welcomed the significant progress achieved over the previous 12 months and requested future benchmarking against Shelford Group organisations. Members also supported development of future reporting to better demonstrate diversity of research participation, the impact of research activity on population health outcomes, and comparative performance. The **2025/26 Population Health Annual Report**, which reflected progress delivered through the Population Health Management Committee and the contribution of initiatives supporting vulnerable communities, was received by the Committee. Discussion progressed in respect to alignment with the Greater Manchester Live Well agenda, opportunities to further promote achievements externally, development of analysis relating to waiting list inequalities and access to care, and the importance of evidencing the impact of interventions that support prevention and the shift from hospital to community-based care. The Committee received the **Sustainability Annual Report Submission,** which forms part of MFT's Annual Report, and noted continued progress across the Green Plan programme, including a reported 5% reduction in carbon emissions during 2025/26 and national recognition of MFT's Green Plan. Discussion focused on the challenge of achieving the longer-term carbon reduction trajectory, opportunities to strengthen staff engagement with sustainability initiatives, and the importance of ensuring that sustainability reporting accurately reflects both progress and future delivery assumptions.

A verbal update was provided on the development of the **Research and Innovation Strategic Delivery Plan**, which is being developed in response to recent strategic reviews and aligned to MFT's strategy. Emerging priorities include strengthening research infrastructure, supporting research-active staff, increasing commercial opportunities and maximising the translation of research into improved patient outcomes.

The Committee received an update on progress against recommendations arising from recent **external reviews of Research and Innovation** activity. Members noted work underway to strengthen commercial research opportunities through enhanced engagement with industry partners, development of an external prospectus and establishment of a new industry contact route. The Committee welcomed progress made and noted that recommendations from the external reviews are being incorporated into the wider Research and Innovation Strategic Delivery Plan and delivery programme.

An overview was provided on the preparation underway to secure future **NIHR Biomedical Research Centre funding opportunities**, including the development of collaborative proposals across the North West and participation in wider regional research initiatives.

Assure

The **Research and Innovation Integrated Performance Report** outlined the following R&I metrics as assure:

- Active Studies - Number of studies by study types which inform RRDN funding.
- Recruitment - Weighted (by type) total monthly recruitment
- Study Delivery - MFT-sponsored, NIHR Portfolio-adopted research studies on track for recruitment to time and target.
- All Clinical Trial Study Initiation Set-up - HRA approval to actual start date within 60d- NIHR all studies
- All Clinical Trial Study Initiation Recruitment - Actual start date to first patient within 30d- NIHR all studies

Risks discussed at the meeting

The Committee reviewed the **Strategic and Corporate Risks** within its remit and received assurance regarding the management of strategic risks relating to Research, Innovation and Population Health. Assurance was provided regarding the extensive programmes of work supporting population health improvement, prevention, neighbourhood working and the wider left-shift agenda. The Committee emphasised the importance of ensuring consistent metrics and reporting across Board Committees to demonstrate the collective impact of these programmes on admissions, demand and wider system outcomes.

Report approved by: Matt Bonam, Non-Executive Director.

Agenda:

Manchester University NHS Foundation Trust

Research, Innovation and Population Health Board Committee

Date: Friday 19th June 2026
Time: 2:00pm – 4.00pm
Location: via MS Teams

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	2.00pm
2.	**Declaration of interest** (verbal)	Meeting admin	Chair	
3.	**Minutes of the previous meeting** (3rd March 2026)	Meeting admin	Chair	
4.	**Action Log**	Discussion	Chair	
5.	**Matters Arising / Hot Topics**	Discussion	Chair	
6.	**Assurance Reporting**			
6.1	Strategic and Corporate Risks	Discussion	JCMO	2:10pm
6.2	Integrated Performance Report 6.2.1 Population Health IPR 6.2.2 Research and Innovation IPR	 Discussion Discussion	 JCMO Deputy Managing Director (Research)	 2.20pm 2.35pm
7.	**Strategic aim 1: Work with partners to help people live longer, healthier lives**			
7.1	2025/26 Population Health Annual Report	Noting	JCMO	2.50pm
7.2	Sustainability - Annual Report Submission	Noting	CDO / Associate Director of Sustainability	3.00pm
8.	**Strategic aim 5: Deliver world class research and innovation that improves people's lives**			
8.1	2026-27 Research and Innovation Strategy (Verbal)	Discussion	JCMO	3:10pm
8.2	Update on external reviews and R&I commercial activity	Discussion	JCMO / Deputy Managing	3:20pm

	Item	Purpose	Lead	Time
			Director (Research)	
Committee business				
9.	**Escalation report**	Approval	Chair	3.30pm
10.	**Workplan Review**	Meeting admin	Chair	
11.	**Any Other Business** (verbal)	Discussion	Chair	
12.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	
Date of next meeting: Tuesday 1st September 2026, 2:00pm – 4.00 pm				
Papers for Information • Research and Innovation Management Committee Escalation Report (s) • Population Health Management Committee Escalation Report (s)				

Agenda Item 10.2

Manchester University
NHS Foundation Trust

Escalation and Assurance Report
North Manchester Board Committee

Report to: Board of Directors
Report from: Mark Gifford, Non-Executive Director and Chair of North Manchester Board Committee (NMBC)
Date of meeting: 17 June 2026

Key escalation and discussion points from the meeting
Alert:
The Committee received a report on the **initial contractual arrangements with the Main Works Contractor** relating to the New Hospital Programme. The Committee was assured by the legal and financial due diligence undertaken that the proposed contract represented a low-risk commitment for the Trust at this stage. Independent legal advice confirmed that appropriate safeguards and termination provisions were incorporated within the agreement. The Committee supported the recommendation to delegate authority to the Chief Finance Officer to conclude negotiations on call-off arrangements and proceed with contract execution within the agreed parameters, noting a further discussion was to take place at the forthcoming Board Seminar.
Advise:
The Committee received an overview on the **New Hospital Programme** and noted the significant progress that has been made since the previous meeting. The Committee noted that work continues with the New Hospital Programme team to identify opportunities to address the current funding gap and ensure the scheme remains deliverable ahead of submission of future business cases. The Committee highlighted the importance of maintaining clear oversight of programme-level risks and ensuring alignment between individual project risks and overarching programme governance arrangements. The Committee considered the **Integrated Programme Plan for the New Hospital Programme** and agreed it as the framework against which future progress will be monitored. Members were assured that clear milestones, stage-gate approvals and programme controls are in place and that the plan will continue to evolve as the programme develops. The Committee noted the importance of maintaining momentum in the programme and highlighted the potential impact that delays in national approvals processes could have on scheme affordability and delivery timescales. The Committee received a detailed update on the progress of the **New Hospital design work** currently being undertaken through RIBA Stage 1. Members were encouraged by the significant progress achieved in developing the hospital design, undertaking engagement with clinical teams and planning the operational, digital and logistical requirements for the new facilities. The Committee received positive feedback regarding engagement with staff and clinical groups and noted widespread support for the emerging design proposals. Members were further assured that programme risks relating to design development, construction logistics and digital requirements are being actively managed. The Committee reviewed progress on the **North Manchester Masterplan** project and received assurance that positive progress is being made in developing the Healthy Neighbourhood programme. The Committee welcomed the extensive engagement being undertaken with housing providers, community partners and

public sector stakeholders and noted the opportunities presented by the development of affordable and key worker accommodation. Members also noted the need to continue monitoring the availability of external regeneration funding and the associated delivery risks. The Committee noted that future decisions regarding land use, development arrangements and delivery partners will be brought through the appropriate governance processes for consideration and approval.

An update was received on the **Transformation project** associated with the North Manchester redevelopment. The Committee was assured that substantial work is underway to validate demand and capacity assumptions, understand future service requirements and identify the changes necessary to support operation of the new outpatient and hospital facilities. Clinical engagement has commenced and governance arrangements for the programme are being developed. The Committee discussed the importance of ensuring that service transformation is delivered at sufficient pace to accommodate projected population growth and future demand pressures.

Assure

Overall, the Committee agreed that there was clear evidence of progress, effective leadership, impactful engagement, and strong programme management across all workstreams. It was noted that governance arrangements would need to remain sufficiently flexible and responsive as the programme develops over the coming years – this includes the need to clarify the roles of other Board Committees within assurance processes.

Report approved by: Mark Gifford, Non-Executive Director and Chair of the NMBC.

Agenda:

NHS
Manchester University
NHS Foundation Trust

North Manchester Board Committee

Date: Wednesday 17 June 2026
Time: 1:00pm – 3:00pm
Location: via MS Teams

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	1:00pm
2.	**Declaration of interest** (verbal)	Meeting admin	Chair	1:00pm
3.	**Minutes of the previous meeting** *(14th April 2026)*	Meeting admin	Chair	1:00pm
4.	**Action Log**	Discussion	Chair	1:05pm
5.	**Matters Arising**		Chair	1.10pm

6. Strategic Aim 4: Ensure value for our patients and communities by making best use of resources				
6.1	NMGH Programme Report: ▪ NMGH New Hospital Project Update ▪ NMGH Masterplan Project Update ▪ NMGH Transformation Project Update	Discussion	CW TRa VG	1.15pm
6.2	NMGH New Hospital Project: Main Works Contractor Call-Off Contracts	Assurance/ Approval	CW/MB	1.30pm
6.3	NMGH New Hospital Project: Integrated Programme Plan (IPP)	Assurance/ Approval	CW/MB	1.45pm
6.4	NMGH New Hospital Project: RIBA Stage 1 Progress Update	Discussion	CW/MB	2:00pm
6.5	NMGH Masterplan Project: Deep-Dive Briefing	Discussion	TRa/MH	2:15pm
Committee Business				
7.	**Escalation Report**	Discussion	Chair	2.40pm
8.	**Workplan Review**	Meeting admin	Chair	2:45pm
9.	**Any Other Business** (verbal)	Discussion	Chair	2.50pm
10.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	2.55pm
Date of next meeting: Tuesday 18th August at 2:00pm – 4:00pm, Conference Room, 2nd Floor, North Manchester House, NMGH				

Manchester University
NHS Foundation Trust

Public Board of Directors
Thursday 30th July 2026

Paper title:	Strategic Development Update	**Agenda Item 10.3**
Presented by:	Tom Rafferty, Acting Chief Strategy Officer	
Prepared by:	Caroline Davidson, Director of Strategy	
Meetings where content has been discussed previously	Service Strategy and Planning Management Committee	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

This paper provides an update to the Board of Directors on national, regional and local strategic developments relevant to MFT. Key developments covered are:

National Developments

- **Consultation on Contracting Models to Support Neighbourhood Health:** NHS England has launched a national consultation on proposed Multi-Neighbourhood Provider (MNP) and Single Neighbourhood Provider (SNP) contracting models which are an important part of to develop neighbourhood health and care.
- **NHS England Specialised Commissioning Service Development Policy:** NHS England has published a new policy which sets out how it will decide which nationally commissioned specialised services, should be introduced, changed or routinely funded.
- **Advanced Foundation Trust Programme Policy Framework:** NHS England published its policy framework for the Advanced Foundation Trust Programme which describes the overarching policy intent and principles and guidance for Trusts wishing to apply to the programme.

Regional and Local Developments

- **Specialised Commissioning**: Changes to regional specialised commissioning arrangements are underway, with NHS England functions moving to a new North West OPIC and a new health inequalities strategy in place. MFT is reviewing compliance against a range of updated service specifications.
- **Vascular and Cardiac Service Change Assurance Process**: work continues following positive feedback and support from the Clinical Senate for the proposed single arterial centre at MRI, as well as changes already made to the provision of cardiac services across MFT. There are a number of key dependencies, including Project RED estate works. Business case development continues and public consultation will conclude this summer.

MFT Developments

- **Left Shift Programme Update:** The Left Shift Programme has made early progress in establishing an MFT approach to shifting care upstream. A programme board to oversee this work is in place. Work continues on funding models to support the shift in care.
- **MFT Masterplans**: the North Manchester Healthy Neighbourhood and Wythenshawe programmes are progressing. Bids to the GM Combined Authority have been submitted to take forward both workstreams. The focus with Wythenshawe is planning for early enabling works, including demolition of aged estate, plans for a multi-storey car park and other infrastructure, as well as the development of a funding strategy. The North Manchester Healthy Neighbourhood work is at a more advanced stage with the focus on the first phase of development including affordable housing and key worker accommodation. Feasibility studies and design works are planned for this first phase.
- **Multi-Year Planning**: Preparation for the 27/28 planning round has begun. We are taking a three phased approach; preparing the foundations, activity, finance and workforce planning and the development of the narrative/actions plans. This early start reflects our move towards making planning a year-round exercise, in line with NHS England approach and guidance.

Recommendation(s)

The Board of Directors is asked to:

- Note the updates on strategic developments nationally and regionally, and the key MFT strategic programmes of work set out in this report.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☐ **No**

Relationship to the strategic objectives

The work contained with this report contributes to the delivery of the following strategic objectives (see key below)

LHL objective 1	☐	LHL objective 2	☐
HQSC objective 1	☐	HQSC objective 2	☐
HQSC objective 3	☐	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☐
VfP objective 2	☐	R&I objective 1	☐

R&I objective 2	☐	Good Governance	☒
Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: •		
Care Quality Commission domains Please check **all** that apply	☐ Safe ☐ Effective ☐ Responsive	☐ Caring ☒ Well-Led	
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: •		

Main report

1. Introduction

The purpose of this paper is to update the Board of Directors in relation to strategic issues of relevance to MFT.

2. National Developments

2.1 National consultation on contracting models to support neighbourhood health

NHS England has launched a national consultation on proposed Multi-Neighbourhood Provider (MNP) and Single Neighbourhood Provider (SNP) contracting models, which form a key component of the Government's 10 Year Health Plan and its ambition to strengthen neighbourhood health services. The consultation seeks views on new contractual arrangements designed to support more integrated, population-based care, with MNPs coordinating services across multiple neighbourhoods and SNPs enabling primary care and neighbourhood teams to deliver enhanced services for defined local populations.

The proposals would not replace core GP contracts but would provide local systems with additional commissioning options to support neighbourhood health delivery, integrated neighbourhood teams and greater focus on prevention, proactive care and reducing health inequalities. NHS England has indicated that feedback from the consultation will inform the development of more detailed proposals later this year, with the potential for implementation from 2027/28. For MFT, the consultation aligns closely with our ongoing work on neighbourhood health, Local Care Organisation development and population health delivery models across.

2.2 NHS England specialised commissioning service development policy

Each year, NHS England makes decisions about which new specialised services to routinely commission and which existing specialised services need to be changed or updated. New services could include new medicines, medical devices or other sorts of interventions. In May NHS England published a new policy setting out its approach to making these decisions. The policy applies to nationally commissioned specialised services and is intended to ensure that limited NHS resources

are invested fairly, transparently and consistently, while meeting legal duties on equality, reducing health inequalities and involving patients and the public in decision-making.

The policy sets out a three-stage decision-making process. First, a Clinical Build phase assesses the clinical case for a new policy or service specification, including review of evidence, patient impact and equality considerations. Second, an Impact Analysis phase evaluates financial, operational and service implications, undertakes stakeholder engagement and, where necessary, public consultation. Finally, a Decision Phase determines whether a proposal should be routinely commissioned. Proposals that are cost-neutral or cost-saving are assessed primarily on clinical benefit, while proposals requiring additional investment are subject to a more formal prioritisation process. Urgent commissioning policies can be introduced where there is an immediate clinical need.

This policy is important for MFT because it influences future provision of treatments, new technologies and service developments in specialist areas where we provide many services, such as cardiovascular, renal, respiratory, rheumatology, endocrinology, ophthalmology, haematology services and clinical genomics and rare diseases.

2.3 Advanced Foundation Trust Programme Policy Framework

In June NHS England published its policy framework for the Advanced Foundation Trust Programme. This set out the overarching policy intent and principles, and guidance for Trusts wishing to apply to the programme.

Advanced foundation trust status will be the new marker of excellence used for high-performing trusts which pass an updated assessment process and benefit from additional freedoms and flexibilities. Advanced Foundation Trust status will be available only to organisations that demonstrate strong performance, high-quality care and excellent leadership, assessed through the NHS Oversight Framework, CQC ratings and a Provider Capability Assessment.

The programme is built around three main freedoms. First, greater local discretion over delivery and less routine intervention from NHS England in relation to planning. Second, greater operational freedom and more time to resolve issues before formal intervention, while maintaining accountability for quality, financial performance and delivery. Third, enhanced financial flexibilities, including the ability to retain and reinvest surpluses in capital projects and transformation programmes, together with increased autonomy over capital investment decisions. NHS England's intention is to reduce unnecessary performance management and create greater local management capacity for innovation and improvement.

The framework signals a future direction in which organisational capability, governance quality and system leadership determine autonomy and access to investment freedoms. Advanced Foundation Trusts will be expected to perform well internally as well as providing leadership across systems and working with partners to improve population health, tackle health inequalities and deliver the three national shifts: hospital to community, analogue to digital, and sickness to prevention.

The current criteria for applying to be an Advanced FT are:

- In the top 2 segments of the National Oversight Framework for the last 2 consecutive quarters
- Rated as "good" or "outstanding" by the Care Quality Commission in the most recent trust level CQC assessment, with no site or service rated inadequate by CQC

- A score of 3 or better in the quality domains within the NHS Oversight Framework (currently these are the effectiveness and experience of care domain and patient safety domain) for the last 2 consecutive quarters.
- Not subject to support from the Maternity and Neonatal Improvement Support team.
- Have excellent leadership, measured by having a provider capability score of at least amber-green.

NHS England's longer-term ambition is that all trusts will achieve Advanced Foundation Trust status by 2035. Our planning for 27/28 will be based around achieving the criteria to apply for Advanced Foundation trust status.

3. Regional and Local Developments

3.1. *North West Specialised Commissioning Update*

The arrangements for the commissioning of specialised services at the regional and local level are to change. NHS England's direct commissioning function is to transfer to newly created Offices for Pan-ICB Commissioning (OPICs). For the North West the OPIC will be hosted by Lancashire and South Cumbria ICB. In addition to this North West Specialised Services Committee has recently approved a new health inequalities strategy which will shape their future agenda. Areas of focus within the strategy of particular relevance to MFT include cardiac and vascular service change, major trauma, neonatal critical care and gynaecology and cardiac surgery.

NHS England has established a rolling programme for updating national specialised service specifications. Following publication of these amended specifications, providers are required to assure commissioners that services are meeting the updated specification. Within the MFT specialised services contract there are ten specifications that have been amended and published. MFT Clinical Groups have reviewed requirements and, whilst no significant issues with compliance have been identified, action plans have been developed to ensure services fully meet the specifications.

3.2. Vascular and Cardiac Service Change Assurance Process

Service change proposals for vascular and cardiac services across Greater Manchester made substantive progress through external assurance with support from the Clinical Senate for the preferred service models. These include the proposed creation of a single arterial centre model at Manchester Royal Infirmary, alongside continued network provision across GM, as well as changes already made to the provision of cardiac services at MFT. The programme has now moved into a delivery assurance phase and public consultation whilst work continues to ensure implementation readiness.

There are a number of key dependencies that are being actively managed, including ongoing estates works as part of Project RED and recruitment to specialist roles. Teams across MFT continue to work closely with partners at the NCA, GM ICB and the regional NHS England team as part of the process.

4. MFT Strategic Developments

A number of key local strategic developments are covered in the report from the Trust Chief Executive Officer to the Board of Directors earlier on the agenda, including:

- Neighbourhood Health and Place-based Care
- University Dental Hospital of Manchester development

Details of further local developments are set out below:

Left Shift Programme Update

The Left Shift Programme has made early progress in establishing a coherent, organisation-wide approach to shifting care upstream. A Programme Board has been established to oversee delivery and partnership working across primary care, community services and wider stakeholders.

Examples of the progress that is being made across a range of areas as described below:

- A community gynaecology model is being mobilised, supported by ICB funding, with approximately 30% of referrals expected to be managed within community settings, improving patient experience, access and waiting times.
- Additional funding has been made available through the ICB to support the expansion of the MFT Tier 2 Ear, Nose and Throat (ENT) service, through which GPs with enhanced roles and advanced nurse practitioners provide care for people who would otherwise have been seen by hospital teams.
- A new pathway has been approved that will enable people receiving established treatment for heart failure to be cared for under the Hospital@Home service, enabling more people to receive hospital care in their own home.
- An evaluation of the Respiratory Left Shift Pilot has completed. The initiative identified over 17,500 people at increased risk of COPD, resulting in 119 new COPD diagnoses and 42 new asthma diagnoses through proactive case finding and community-based intervention.
- Planning work continues around left shift opportunities in palliative and end of life care, as well as diabetes services.

MFT Masterplans – WTWA & NM Healthy Neighbourhoods

Progress across the MFT masterplans has continued with both the North Manchester Healthy Neighbourhood and Wythenshawe programmes transitioning from planning into early delivery phases.

In North Manchester, plans to develop the Healthy Neighbourhood zone are now moving into delivery. The next phase of work will focus on early development opportunities around affordable housing and key worker accommodation, with design works and market testing planned.

Plans for Wythenshawe are at an earlier stage, and part of the work over the remainder of the current year is the production of a funding strategy for the development. The current focus is on planning for early enabling works including commencement of the decant of legacy buildings and the development of proposals for a multi-storey car park, which would help to ready the site for future development.

Bids to the Greater Manchester Combined Authority have been submitted in order to take forward both workstreams.

Multi-year planning 27/28

Preparation for the 27/28 planning round has begun. Last year the annual planning process was brought forward by approximately 3 months and we intend to work to the same earlier deadlines for 27/28. This should result in a more resilient process overall and ensure that we have plans in place that are ready to go as soon as we enter into the new year.

We are taking a three phased approach. Preparing the foundations over the summer in phase one. This will include setting up the governance and developing the guidance and templates. The next phase will focus on activity, finance and workforce planning and the completion of the NHSE numerical templates and will take place over the period September to December. The final phase will be the development of the narrative/actions plans from January to March.

The process will bring together activity, financial and workforce planning and be aligned with capital planning, job planning, contracting negotiations and the development of our plans for improving quality, increasing our use of digital technology and transforming our services in line with the NHS 10 Year Plan.

This early start reflects our move towards making planning a year-round exercise, in line with NHS England approach and guidance.

5. Recommendations

The Board of Directors is asked to note the updates on strategic developments nationally and regionally, and the key MFT strategic programmes of work set out in this report.

Manchester University NHS Foundation Trust

Escalation and Assurance Report
Quality, Safety and Performance Board Committee

Report to: Board of Directors
Report of: Jackie Hanson, Non-Executive Director and Chair of QSP Board Committee
Date of meeting: 30 June 2026

Key escalation and discussion points from the meeting
Alert
The Committee supported an amendment to its **Terms of Reference**, to include the Chief Digital and Information Officer as a named member of the Committee. The Board is asked to approve this change. Members were informed that a review of MFT's position in respect to recommendations arising from the **Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust** and **Baroness Amos' independent investigation into maternity and neonatal services** was underway**.** Reassurance was provided that previous work undertaken in response to national maternity reviews provided a strong foundation. Noting NHS England's request for a Board Assurance Statement confirming that arrangements to care for people after death were in place and had been robustly tested, the Committee acknowledged that previous updates provided in respect to the Fuller Inquiry Phase 2 actions would inform the submission. The Committee received an update on feedback provided by the **Human Tissue Authority (HTA),** following their visit on 26 June 2026. The HTA reviewed MFT's Donor and Transplant records management action plan, which outlines that all required actions are due to be completed by September 2026, and will further strengthen governance and records management arrangements. Preliminary feedback from the HTA was positive and further feedback is awaited. The Committee agreed that delivery of the Donor and Transplant records management action plan should remain under close scrutiny and continue to be reported through Board governance arrangements. Associated risks were noted. The refreshed **Quality and Safety** chapter of the **Integrated Performance Report** alerted 23 measures for the Committee attention. Particular focus was given to learning from never events, harms arising from delays, Category 3 Caesarean section performance and deteriorating compliance with timely medical review in sepsis pathways. Further deep-dive review and assurance activity has been requested. The remaining measures, 23 for note and 17 to assure, were noted. The Committee received the **Transfusion Service Annual Report** which outlined key achievements during 2025/26, priorities for 2026/27 and the revised governance arrangements through Clinical and Scientific Services into Trust-level governance. An overview of the significant digital transformation in the service to further improve safety, traceability and standardisation, was provided. The operational challenges identified during roll-out and the programme of work to ensure full traceability, including updating records where it had not been possible to undertake digital scanning at the bedside, was described. A further update regarding blood traceability compliance and continued implementation of digital system improvements was requested by the Committee. The update on the **Patient-Led Assessment of the Care Environment (PLACE)** programme noted that 2025/26 performance was below national average across all assessed domains. An overview of the strengthened governance arrangements in place, supported by a dedicated task and finish group, revised

operational processes and a programme of PLACE-Lite assessments was provided. The Committee welcomed progress made and noted that PLACE-Lite findings will inform improvement planning ahead of the 2026 assessment cycle.

Advise:

The **Operational Performance** chapter of the **Integrated Performance Report** presented 10 advisory measures for the Committee to note and two assure measures. The Committee noted that productivity measures remained under constant review given the pace and trajectory to be delivered and external factors, such as industrial action and the climate, that impact demand, flow and operational delivery.

The Committee received the regular **Maternity Safety and Assurance Report** and the first **Integrated Thematic Learning Report** developed in response to Maternity Incentive Scheme Year 8 requirements and welcomed evidence of a strong learning culture, improved patient feedback mechanisms and continued progress against national maternity safety requirements. Common learning themes identified through incidents, investigations and mortality reviews highlighted communication, personalised care, escalation processes and listening to women and families as areas for focus.

Assurance was provided on the progress made in respect of **Community Learning Disability Services**. Significant improvements have been made to governance, leadership oversight, workforce arrangements and service delivery, following the external review, with only a small number of recommendations remaining in progress. The Committee was assured that current mitigations adequately manage patient safety risks and agreed that routine reporting to QSPBC could cease unless future escalation is required.

The Committee received an update on progress across **Child and Adolescent Mental Health Services**, including delivery against the Galaxy House improvement plan following CQC inspection. Whilst noting continued progress and successful acquisition of additional system-level investment for children's mental health services, the Committee discussed the ongoing challenge of neurodevelopmental waiting times and the impact this has on children, young people and their families. Members welcomed the development of the needs-led model and the work underway with partners to provide support whilst children await assessment and intervention. The Committee also noted ongoing discussions regarding prescribing and shared-care arrangements across the Greater Manchester system and requested that oversight of these challenges continue through established governance arrangements.

An update on current **service developments** confirmed that progress continues across a number of programmes, including the Manchester Lung Institute and major service reconfiguration programmes. The Committee noted that delivery of several initiatives remains dependent on wider system partners and external governance processes. Discussion focused on pathology collaboration, vascular and cardiac service reconfiguration, and the potential implications of service changes across Greater Manchester. Members emphasised the importance of ensuring that any future re-configuration of services, must deliver improved outcomes for patients across the system and that services remaining at existing locations continue to operate safely and sustainably.

The Committee received the **Infection Prevention and Control Annual Report** and noted continued strong performance across a number of priority areas, including surgical site infection rates, vaccination uptake and compliance with key infection prevention programmes. An update was provided on the actions being taken to address current MRSA bacteraemia performance and catheter-associated urinary tract infection compliance, where performance had not met the 2025/26 annual trajectory. The Committee noted the extensive improvement programme underway.

The Committee was reassured by the Trust's strong participation in **national clinical audit programmes**, increasing engagement from 54 audits in 2025/26 to 72 audits in 2026/27, with MFT’s performance reported above or within national benchmarks. Action plans are in place for the two negative

outlier areas. Governance arrangements are continuing to mature, with a stronger focus on ensuring learning translates into measurable improvement.

An update on the continued improvement in **cancer performance**, including progress against Faster Diagnosis and 62-day pathways was provided. Members welcomed the use of pathway deep-dives to support improvement, increase visibility and monitoring of patient waiting lists to reduce harm associated with long waits. This approach will be continued moving forward.

The Committee received an update on the Trust's engagement with the national **Getting It Right First Time (GIRFT)** programme. Members welcomed external recognition of MFT's governance arrangements, which have been identified nationally as exemplar practice. It was confirmed that arrangements are in place to support implementation of GIRFT recommendations and maintain oversight of delivery through established governance structures. A further update will be provided later in the year to demonstrate progress against improvement actions.

The Committee noted the substantial progress against the **Mental Health Improvement Plan** which confirmed that the majority of actions were now closed with open actions, relating to ongoing monitoring, transitioning into management committee governance arrangements. The proposal to revise the strategic risk description, to better reflect the system-wide capacity and demand challenges affecting mental health services more accurately, was supported.

Assure

The Committee noted the Trust's improved position under the **National Oversight Framework**, including achievement of Segment 1 status for Quarter 4 2025/26. Members recognised the significant effort undertaken across the organisation to achieve this improvement and highlighted the importance of maintaining performance as the revised national methodology is implemented. The recently published changes to the National Oversight Framework were also noted.

The Committee reviewed the Trust's draft **Quality Account** which provided an accurate reflection of MFT’s quality improvement activity and performance during 2025/26, whilst meeting applicable regulatory requirements. Subject to inclusion of updated year-end performance information, the Committee received the report on behalf of the Board of Directors.

The Committee received the **Patient Safety Annual Report** and was assured by the progress made in strengthening patient safety culture, establishing the patient safety team and development of patient safety networks, and implementation of PSIRF including continued embedding of learning across the Trust. The recent internal audit review of MFT’s compliance with PSIRF standards provided a significant assurance.

Risks discussed at the meeting

In discussing the **strategic and corporate risk** position, the Committee noted:

- an increase in the strategic risk score relating to harm while waiting for treatment from 12 to 16.
- closure of the strategic PSIRF risk and opening of a more relevant operational risk
- closure of the mental health strategy risk and inclusion of a new strategic risk relating to mental health capacity and demand
- addition of a new strategic risk relating to under delivery of the annual plan.
- revision of the Strategic Delivery Plan risk descriptor.

Report approved by: Jackie Hanson, Non-Executive Director and Chair of QSP Board Committee

Manchester University NHS Foundation Trust

Quality, Safety and Performance Board Committee

Date: Tuesday 30th June 2026
Time: 10:00am – 13:00pm
Location: MS Teams

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	10:00am
2.	**Declaration of interest** (verbal)	Meeting admin	Chair	
3.	**Minutes of the previous meeting**	Meeting admin	Chair	
4.	**Action Log**	Discussion	Chair	
5.	**Matters Arising / Hot Topics**	Discussion	Chair	10:05am
6.	**Assurance Reporting**			
6.1	Strategic and Corporate risks	Discussion	Trust Board Secretary	10:15am
6.2	Integrated Performance Report 6.2.1 Operational Performance 6.2.2 Quality and Safety	Discussion	Executive Directors and Director of Nursing and Midwifery	10:25am
6.3	Maternity Safety Reporting 6.3.1 Maternity Safety and Assurance Report 6.3.2 Maternity Learning from Incidents Thematic Report	Discussion Discussion	DCE / Chief Nursing Officer Director of Nursing and Midwifery	10:40am
7.	**Strategic aim 2: Provide high quality, safe care with excellent outcomes and experience**			
7.1	Update on service developments (strategic objectives 4 and 5)	Discussion	Acting Chief Strategy Officer	10:55am
7.2	Community Learning Disability Services Report	Discussion	Chief Executive Officer, MTLCO/D	11:05am

7.3	CAMHS Update	Discussion	CEO Specialist Hospitals, SHHG	11.15am
7.4	Transfusion Service Annual Report	Support	Director of Nursing CSSCG	11.25am
7.5	Patient Safety Annual Report	Support	Director of Clinical Governance	11.35am
7.6	Annual Infection Prevention and Control (IPC) Report	Approval	DCE / Chief Nursing Officer	11:45am
7.7	Update on Completion of National Audits	Discussion	Director of Clinical Governance	11.55am
	BREAK (5 mins)			
7.8	Quality Account	Approval	Director of Clinical Governance	12:00pm
7.9	Update on the Patient-Led Assessment of the Care Environment (PLACE)	Discussion	DCE / Chief Nursing Officer	12.15pm
7.10	Update on Cancer Delivery (including how diagnostic improvements have impacted on performance)	Discussion	Chief Delivery Officer	12.25pm
7.11	GIRFT Update	Discussion	Chief Delivery Officer	12:30pm
7.12	Mental Health Improvement Plan Update	Discussion	DCE / Chief Nursing Officer	12.45pm
Committee business				
8.	**Escalation report**	Approval	Chair	12.55pm
9.	**Workplan Review**	Meeting admin	Chair	
10.	**Any Other Business** (verbal)	Discussion	Chair	
11.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	

Date of next meeting: 25 August 2026, at 10am, main Boardroom, ORC

Papers for Information:

- QSMC Escalation Report – May 2026

Manchester University
NHS Foundation Trust

Public Board of Directors
Thursday 30th July 2026

Paper title:	Spinal Surgery Independent Patient Safety Investigation	**Agenda Item 11.2**
Presented by:	Dr Sohail Munshi, Joint Chief Medical Officer	
Prepared by:	Ursula Martin, Specialist Hospitals Clinical Group CEO Rachael Barber, Specialist Hospitals Clinical Group MD	
Meetings where content has been discussed previously	RMCH Quality and Safety Committee May & June 2024 Quality Safety Management Committee June 2024 Trust Research Governance Committee June 2024 Specialist Hospitals Clinical Group SLT meeting May 2026 Trust Leadership Team Committee May 2026	
Purpose of the paper Please check **one** box only:	☐ For approval ☒ For support ☒ For discussion	

Executive summary

Concerns were raised regarding the spinal surgery practice of a former consultant surgeon ('Consultant Surgeon A'), whose work spanned multiple provider organisations across the Northwest, including Royal Manchester Children's Hospital (RMCH) until 2011. Between 2022 and 2025, a series of locally commissioned reviews and spinal safety lookbacks were undertaken by individual providers, including RMCH. While these reviews were conducted in good faith, patients, families, staff and external stakeholders consistently expressed concern that they were not sufficiently comprehensive and did not fully review all patients under the care of Consultant Surgeon A.

In March 2025, following sustained concerns being raised, the Secretary of State for Health requested that NHS England commission an independent review to assess whether earlier investigations were adequate and to advise on whether further action was required. NHS England subsequently commissioned *Niche Consulting* to undertake this review. The *Niche* review was not a reinvestigation of individual clinical cases; instead it focused on assessing the adequacy, consistency and assurance of previous reviews, triangulating findings and recommendations, and determining whether further patient review or lookback activity was required.

The *Niche* review concluded that earlier provider led investigations were inconsistent in methodology, use of clinical records, definitions of harm and approaches to patient engagement. As a result, assurance was partial and uneven across organisations, and confidence among some patients and families remained low. Key themes arising from earlier reviews focused primarily on deficits in Consultant Surgeon A's clinical practice, alongside identified weaknesses in departmental governance and incident reporting culture. The *Niche* review also identified gaps in prior recommendations, particularly around benchmarking clinical outcomes, strengthening post-operative consultant follow up and improving transparency of service performance.

Specific feedback relating to RMCH highlighted that, while governance structures were in place, specialty level assurance within spinal services had not been consistently embedded, especially during periods of leadership change. Since the review, governance arrangements have been strengthened, and improved oversight has identified that the RMCH spinal service is currently fragile, with significant capacity constraints and requiring transformation in line with Getting It Right First Time (GIRFT) recommendations. The Trust invited GIRFT to come in and complete a review of paediatric spinal services in RMCH in 2026 and a consolidated safety, recovery and improvement action plan is in place, with oversight through Clinical Group and Trust governance structures.

The *Niche* review makes six recommendations, including the development of a combined cross provider action plan, strengthened measurement of impact and assurance, improved post-operative care processes, enhanced incident reporting, and the introduction of a spinal surgery quality and safety dashboard. The review also recommends offering face to face reviews, on request, for any patient treated by Consultant Surgeon A for a minimum of three years. The Board is asked to note the review findings and recommendations and to receive ongoing assurance through the Quality, Safety and Performance Board Committee on delivery and Trust wide learning.

Recommendation(s)

The Board of Directors is asked to:

- note the findings and recommendations of the NHS England Independent Patient Safety Diagnostic Review of Spinal Surgery (April 2026)
- note the Trust's approach to developing a consolidated spinal surgery action plan and strengthened Board level assurance
- seek ongoing assurance through the Quality, Safety and Performance Board Committee regarding delivery, impact and learning

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives

The work contained with this report contributes to the delivery of the following strategic objectives (see key below)

LHL objective 1	☒	LHL objective 2	☒
HQSC objective 1	☒	HQSC objective 2	☒
HQSC objective 3	☒	PEW objective 1	☒
PEW objective 2	☒	VfP objective 1	☐
VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: • a corporate risk is included regarding the paediatric spinal service	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Effective ☒ Responsive	☒ Caring ☒ Well-Led

Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report:
	• Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended)
	  o Regulation 12: Safe Care and Treatment
	  o Regulation 17: Good Governance
	  o Regulation 18: Staffing
	  o Regulation 20: Duty of Candour
	• Patient Safety Incident Response Framework (PSIRF), governing proportionate investigation, learning, and system improvement following patient safety incidents
	• General Medical Council (GMC) – Good Medical Practice (2024), setting professional standards for doctors, including patient safety, documentation, openness, accountability, and raising concerns
	• NHS England National Patient Recall Framework	

Main report

1. Background and context

Longstanding concerns were raised about the spinal surgery practice of a former consultant surgeon ('Consultant Surgeon A'), whose work spanned multiple organisations, including NHS and independent sector providers in the Northwest. This included RMCH, where Consultant Surgeon A worked until 2011.

Between 2022 and 2025, a series of reviews and lookback exercises were undertaken by individual provider organisations including MFT (RMCH Spinal Safety Lookback review published February 2024 (https://mft.nhs.uk/rmch/spinalreview/).

However, patients, families, staff and external stakeholders continued to express concern that these reviews had not been comprehensive enough, as they had not reviewed *all* patients under the care of Consultant Surgeon A.

In March 2025, following ongoing correspondence and public concern, the Secretary of State for Health asked NHS England to commission an independent review, to assess whether earlier investigations were adequate and to advise on any further action required and NHSE commissioned *Niche Consulting* to undertake this review.

2. Purpose and scope of the independent review

The *Niche* review was explicitly stated to not be a reinvestigation of individual clinical cases rather its purpose being to:

- use appreciative enquiry to actively engage with patients, their families and stakeholders to understand their concerns about the reviews already undertaken and their request for a more detailed lookback
- to review the previous Terms of Reference, and the methodology and timelines from existing reviews for the purpose of identifying any new cohorts of patients to be reviewed clinically or have an alternative lookback process
- to review, triangulate and thematically review the recommendations from all four previous reviews, undertaken to establish if any new recommendations emerge
- to determine the level of assurance for each provider organisation on the delivery and governance associated with the recommendations
- to develop Terms of Reference for any future reviews/lookbacks needed

3. Overall findings

i. Adequacy of prior reviews

The review concluded that earlier provider investigations were undertaken in good faith and represented substantial organisational effort. However, it concluded that across the organisations:

- methodologies varied widely
- clinical records were often incomplete and considered unreliable
- definitions of harm were inconsistent
- approaches to patient engagement differed significantly

As a result, assurance was considered partial and uneven, and some patients and families remained unconvinced that their concerns were fully understood or addressed.

ii. Thematic review of recommendations made

The key themes from the lookback reviews were largely about the deficits in Consultant Surgeon A's clinical practice. These included:

- poor surgical technique
- poorly planned surgery
- high blood loss
- poor communications with patients and their families
- failures to be open and honest
- poor consenting processes, including not sharing risks with patients
- poor documentation, often inaccurate or inconsistent with the records of other healthcare professionals
- unprofessional behaviours

The individual provider reviews also identified a small number of failings at departmental level, including poor culture of incident reporting and suboptimal governance practices.

Some key gaps in the recommendations of all four reports were identified including:

- the need to regularly benchmark a range of clinical indicators in spinal surgery, such as surgical site infections, metalwork failure rates, misplaced screws and post-operative neurological deficits, as well as metrics of patient satisfaction and feedback. This information should be visible to all staff delivering the service so that they can see how well the service is performing

- improved post-operative consultant (and other medical) follow up of patients. This included patients in hospital, during ward rounds, dealing with own complications, giving explanations to patients about their procedures, and post-discharge follow up care and rehabilitation through outpatients and handover to GP care

4. Specific feedback on RMCH lookback review

The *Niche* review identified that Royal Manchester Children's Hospital (RMCH) had established governance and oversight arrangements in place; however, at the time of review assurance and visibility at specialty level, particularly within spinal services, had not been consistently embedded. This was largely attributed to periods of leadership change across the Division and Hospital between 2022 and 2024, which impacted clarity of accountability and routine governance oversight for some specialist services.

Specific findings included constraints within consultant job plans that limited consistent attendance at Morbidity and Mortality (M&M) and Multidisciplinary Team (MDT) meetings, and the variable use of benchmarking and comparative data to support learning and service improvement. Full and routine submission to the British Spine Registry commenced in early 2025; while systems for data submission are now in place, the review concluded that the systematic use of this data to drive local governance and assurance was still developing at the time of the review.

Incident reporting within spinal services was identified as lower than expected, with limited contemporaneous reporting in relation to historical cases involving serve harm. The review highlighted the need to strengthen the reporting culture, improve early identification of risk, and ensure timely escalation and learning.

Positive practice was identified in relation to family engagement, with RMCH offering meetings to all affected families and holding multiple meetings where required, to ensure concerns were fully explored and addressed. This aspect of engagement has since been strengthened and more clearly articulated.

Since the review, RMCH has implemented strengthened governance arrangements, including clearly divisional accountability, and the establishment of a weekly spinal improvement meeting, chaired by Specialist Hospitals Clinical Group Medical Director. By having this weekly meeting, a number of issues have been identified relating to the spinal service, with workforce capacity constraints impacting on activity, performance, and financial sustainability. As well as the *Niche* review, the service invited the National Getting It Right First Time (GIRFT) team in 2026. Significant transformation is required in line with

GIRFT recommendations, including improved pathways, reduced length of stay, and strengthened governance. Workforce capacity remains a key risk, limiting the ability to deliver additional activity, with increased demand and a significant backlog of patients requiring follow up. A consolidated recovery and safety action plan is in place, with escalation and assurance through Clinical Group and Trust governance structures.

5. Delivery and oversight of existing review recommendations for RMCH

Further to the initial RMCH lookback review, a number of actions were identified, which have been progressed over time, through Divisional and Hospital governance structures. All initial actions are now completed as outlined below and have been benchmarked for ongoing oversight and assurance purposes, against the newly developed action plan, in response to the *Niche* review report.

Theme	Action	Status
Communication with patients and families	All patients and families to be sent summary letters outlining the outcome of their review with an offer of a meeting fulfilling Duty of Candour responsibilities	**Complete**
Communication with stakeholders	Copy of report to be shared with external stakeholders including NCA/NHSR/GMC/Spire/Surgeon A and their RO	**Complete**
Opportunities for further learning	The Trust will consider whether further reviews are required for other patients who received care from Consultant Surgeon A outside the time period included in the initial review. The Terms of Reference for the lookback will also be applied to any families who contact the Trust following publication. In addition, a small number of legal claims that were not captured within the review had been identified and will be subject to further examination	**Complete**
Shared learning	Assurance should be provided that all actions have been completed through Hospital QSC and the Board level QSPBC	**Completed**
Governance process across spinal services	The clinical governance structures and processes within the paediatric spinal service will be reviewed to ensure full alignment with PSIRF, with formal assurance provided through RMCH Quality & Safety Committee and the Trust Quality, Safety and Performance Board Committee (QSPBC). It is recognised that the original action	**Completed**

	was high level and did not fully articulate the multiple clinical governance components requiring consideration. A SHCG Spinal Improvement Group has been in place since July 2025 and was enhanced in April 2026 to provide specific oversight of the *Niche* review findings and the implementation of GIRFT recommendations. Completion of British Spine Registry (BSR) data submissions is now established and embedded	
Use of data to determine effectiveness and safety across the service	RMCH will review the clinical indications for, and implications of, dual operating within the paediatric spinal service and benchmark current practice against national standards and comparator UK centres. The SHCG Spinal Improvement Group has progressed this work	**Completed**
Trust Research Governance Committee to oversee and investigate research governance around clinical trial	Detailed investigation reported findings June 2024. Comprehensive summary of controls in place to ensure Good Clinical Practice maintained in trials	**Complete**

6. 2026 *Niche* review action plan

Further to the recommendations made in the *Niche* review, a comprehensive action plan (appended) has been developed, that takes into account any previous actions that require ongoing oversight and assurance to be in place, with newly developed actions arising from the *Niche* recommendations also being incorporated. The action plan will have Divisional Hospital and Clinical Group oversight through Quality, Safety and Performance Committee structures, with overall assurance into the SHCG Management Board and Trust Board assurance structures.

7. Conclusion and next steps

The *Niche* review made six specific recommendations:

Recommendation 1: All three organisations should develop a single and combined action plan that incorporates all the learning from previous review work (i.e. lookback reviews, CQC, GIRFT)
There must now be a clear focus on the impact of actions taken, driven by defined measurement strategies for each action. Clear assurance reporting routes must also be agreed. Consider whether project support is needed to drive these plans forward.

Recommendation 2: Once each organisation has developed a combined action plan, it should be shared with the other providers to ensure that each plan is complete, with all relevant learning and improvement ideas are captured
Each site could benefit and learn from the action plans of the other two sites.

Recommendation 3: The NCA and RMCH must review all actions from their respective reports to a) ensure that all have been delivered in full and b) that their impact has been measured and embedded
If recommendations remain open, they should be transferred to the combined action plan recommended above.

Recommendation 4: The NCA should review any potential gaps in recommendations from the Breen Report and the SPSLBR to assess whether further action is required
If it is determined that no further action is necessary, the reasons must be formally documented and shared at the forums responsible for overseeing the action plans.

Recommendation 5: When developing a combined action plan, include actions to improve the processes for:
- post-operative inpatient follow up by the responsible surgeon
- ward round effectiveness (including communication between medical staff, nursing colleagues and allied health professionals)
- outpatient support after spinal surgery
- the quality of incident reporting

Recommendation 6: Introduce a spinal surgery quality and safety dashboard in each organisation to regularly benchmark performance on, for example, surgical site infections, metalwork failure rates, misplaced screws, post-operative neurological deficits, and metrics of patient satisfaction and feedback
This information should be visible to all staff delivering the service so they can see how well the service is performing. Discussions are ongoing with NHSE regarding the potential for GM to pilot a national dashboard which will need discussions with Royal College of Surgeons/British Association of Spinal Surgeons.

Further patient review/lookback:

The review used a robust scoring matrix to consider the potential options for a further patient recall. It recommends that face-to-face reviews should be available to all patients who request it for a minimum of three years, even if no harm has been identified by previous reviews. This should be open to any patient who has had surgery by Consultant Surgeon A at any time, at any of the organisations where he worked. A more extensive recall was not felt feasible given the time that has elapsed and the limited scope for further learning.

MFT will communicate and advertise this offer with the support of NHSE and the ICB to ensure that Consultant Surgeon A's patients are aware that they have a three-year window to request a review.

Additional investigative review (Phase 2)

A follow up recommendation relates to an independent feasibility study to be undertaken to establish what information is required/availability of information within NCA/SRFT to establish what was known about these matters historically and at what points could different actions have been taken.

8. Communications

The full report was published on NHSE website 28 May 2026. Organisations have provided links directly to the NHSE website.

MFT will support the offer of further lookback for patients of Consultant Surgeon A for the next three years.

Since the publication of the report, two contacts from the public have been made, requesting further information on their individual reviews. These contacts were resolved immediately.

9. Recommendations

The Board of Directors is asked to note the update, the *Niche* independent review and the accompanying recommendations and actions, and to gain ongoing assurance through the Quality, Safety and Performance Board Committee, that the Committee will maintain continued oversight, scrutiny and reporting to the Board on full implementation of the recommendations and Trust wide learning.

10. Additional links and appendices

Spinal Surgery Independent Patient Safety Investigation Phase 1 April 2026 – https://www.england.nhs.uk/north-west/our-work/publications/ind-investigation-reports/

RMCH SPSLBR 2024 RMCH-Spinal-Safety-Look-Back-Review-Report-23-Feb-2024.pdf

Appendix 1 – Specialist Hospitals Clinical Group – Combined Spinal Services Action Plan incorporating *Niche* review and GIRFT recommendations

Appendix 1 – Specialist Hospitals Clinical Group – Combined Spinal Services Action Plan incorporating *Niche* Review and GIRT Recommendations

Commencement from June 2026

Assurance / Oversight

No	Theme/Intended Outcome	Recommendation	Lead	Start Date	End Date
1	Implementation of recommendations and good governance principles	Establish a shared multi-organisation action plan, mapping all existing recommendations into one consolidated tracker with clear ownership and measurable outcomes	Clinical Group Medical Director	01/06/2026	30/09.2026
2	Implementation of recommendations and good governance principles	Develop and embed outcome-based metrics for each action, including clinical outcomes, audit measures, and compliance indicators and report into Divisional/Hospital QSP monthly	Clinical Head of Division	01/06/2026	30/09/2026
3	Implementation of recommendations and good governance principles	Define and formalise governance structure for reporting (including committees and reporting frequency) ensuring escalation of risks and progress tracking	Clinical Head of Division	01/06/2026	31/07/2026
4	Implementation of recommendations and good governance principles	Undertake a comprehensive review of all previous recommendations, confirming completion status and either closing with evidence or migrating to current plan	Clinical Head of Division	01/06/2026	Complete
5	Implementation of recommendations and good governance principles	Conduct structured gap analysis comparing partner organisation reports against current action plan, documenting any additional	Clinical Head of Division	01/06/2026	31/07/2026

No	Theme/Intended Outcome	Recommendation	Lead	Start Date	End Date
		required actions or confirming no further action required			
Spinal Pathways					
6	Redesign of spinal pathways based on GIRFT recommendations	Review and implementation of updated GIRFT back pain referral pathway with General Paediatrics and GP communication processes	ADOP	01/06/2026	31/08/2026
7	Redesign of spinal pathways based on GIRFT recommendations	Development of a shared consultant imaging workflow within Hive to improve visibility and management of imaging results	ADOP	01/06/2026	31/08/2026
8	Redesign of spinal pathways based on GIRFT recommendations	Implementation of updated referral triage pathway to redirect patients to Alder Hey or Stoke based on geographical criteria	ADOP	01/06/2026	31/08/2026
9	Redesign of spinal pathways based on GIRFT recommendations	Implementation of PIFU pathways for appropriate patients to reduce follow up waiting list pressures	Clinical Lead / Divisional Manager	01/06/2026	31/08/2026
10	Redesign of spinal pathways based on GIRFT recommendations	Completion of GIRFT PIFU rate review to inform service benchmarking and pathway development	Clinical Lead / Divisional Manager	01/06/2026	31/08/2026
11	Redesign of spinal pathways based on GIRFT recommendations	Review of active monitoring patients for suitability and transition to PIFU pathways	Consultant team	01/06/2026	30/09/2026
12	Redesign of spinal pathways based on GIRFT recommendations	Achievement of NHS and MFT PIFU target rate of 5% in line with the annual plan	Clinical Lead / Divisional Manager	01/06/2026	31/10/2026
13	Redesign of spinal pathways based on GIRFT recommendations	Completion of review with Salford and development of an operational SOP for transition of patients aged 16-18 years and over to adult services	Clinical Lead / Divisional Manager	01/06/2026	30/09/2026
14	Redesign of spinal pathways based on GIRFT recommendations	Implementation of the ‘Ready, Steady, Go’ transition pathway in line with GIRFT and NICE guidance	Clinical Lead / Divisional Manager	01/06/2026	30/09/2026

No	Theme/Intended Outcome	Recommendation	Lead	Start Date	End Date
15	Redesign of spinal pathways based on GIRFT recommendations	Reduce cancellations due to medical unfitness through strengthened pre-operative readiness processes	Head of Nursing	01/06/2026	31/08/2026
16	Redesign of spinal pathways based on GIRFT recommendations	Achieve and maintain ≤0.8% on the day cancellation rate	Operational Manager	01/06/2026	31/08/2026
17	Redesign of spinal pathways based on GIRFT recommendations	Develop clear guidance on dual surgeon operating	Clinical Lead	01/06/2026	30/08/2026
18	Redesign of spinal pathways based on GIRFT recommendations	Review and standardise post-operative inpatient follow up processes, including responsibilities, documentation standards, and review timelines	Clinical Lead	01/06/2026	30/09/2026
19	Redesign of spinal pathways based on GIRFT recommendations	Develop and implement a standardised ward round model including clear documentation, MDT attendance expectations, and communication processes	Clinical Lead	01/06/2026	31/08/2026
20	Redesign of spinal pathways based on GIRFT recommendations	Implement structured communication tools (e.g. MDT huddles, standardised handover processes) to ensure consistent information sharing across teams	Clinical Lead	01/06/2026	30/09/2026
21	Redesign of spinal pathways based on GIRFT recommendations	Review outpatient pathway and implement standardised follow up support, including clear patient communication and escalation pathway	Clinical Lead	01/06/2026	31/08/2026
Outcomes / Data					
22	Develop a quality management system dashboard	Dashboard will bring together patient experience, incidents, risks, complaints, PALs, M&M themes, audit outcomes and action plan progress, with monthly review through divisional governance meetings and assurance into Hospital and Clinical Group	Head of Performance / Associate Director of Clinical Governance	01/06/2026	30/09/2026

No	Theme/Intended Outcome	Recommendation	Lead	Start Date	End Date
		Quality, Safety and Performance intelligence			
23	Full Engagement and Compliance of BSR	Ensure all eligible patients are registered on BSR at the point of surgical listing	Consultant team / Nursing team / Operational team	01/06/2026	30/09/2026
24	Full Engagement and Compliance of BSR	Achieve full clinical engagement with BSR (including consent at pre-op and completion of procedure forms at time of surgery)	Consultant team / Operational team	01/06/2026	30/092/2026
25	Full Engagement and Compliance of BSR	Implement robust administrative follow up processes to maximise completion of BSR outcome data	Consultant team / Operational team	01/06/2026	30/09/2026
26	Full Engagement and Compliance of BSR	Ensure team data is reviewed quarterly at Divisional Board and complications / outcomes compared against national data for both individuals and team	Clinical Lead / CHoD	01/06/2026	30/09/2026
27	Full Engagement and Compliance of BSR	Explore potential to develop more extensive national database with improved visibility of spinal surgery outcomes with NHSE/GIRFT	Clinical Group MD / Clinical Lead	01/06/2026	01/02/2027
28	Full Engagement and Compliance of BSR	Achieve and sustain >50% associated tariff through improved BSR compliance	Consultant team / Operational team	01/06/2026	30/09/2026
Future Planning					
29	Business Case / Investment	Develop and present business cases to support service capacity and pathway improvements including recruitment of additional surgeons / pre-op capacity	Associate Director of Operations	01/06/2026	31/03/2027
30	Business Case / Investment	Progress development of navigation system to support pathway efficiency and patient flow	Associate Director of Operations	01/06/2026	31/03/2027
31	Business Case / Investment	Develop business case for larger laminar flow theatre to enable safe use of C-arm	Associate Director of Operations	01/06/2026	31/10/2027

No	Theme/Intended Outcome	Recommendation	Lead	Start Date	End Date
Governance					
32	Patient Safety / Clinical Governance	Review governance processes across Spinal services and support the ongoing development of a patient safety culture	Clinical Head of Division / Associate Director Clinical Governance	01/06/2026	30/09/2026
33	Patient Safety / Clinical Governance	Undertake a focused review of M&M processes, incident report profile, risk, complaints and PALs	Clinical Head of Division / Associate Director Clinical Governance	01/06/2026	30/08/2026
34	Patient Safety / Clinical Governance	Implement a planned teaching session with the spinal team, specific to PSIRF principles and the development of a robust patient safety culture	Clinical Head of Division / Associate Director Clinical Governance	01/06/2026	30/09/2026
35	Patient Safety / Clinical Governance	Monitor for evidence of an increased culture of learning actions across the service. Ensuring expected levels of incident reporting and that department level risk registers are in place, are visible and demonstrate that risks are being appropriately escalated and managed	Clinical Head of Division / Associate Director Clinical Governance	01/06/2026	31/03/2027

Manchester University NHS Foundation Trust

Public Board of Directors
Thursday 30th July 2026

Paper title:	Infection Prevention and Control Annual Report 2025/26	**Agenda Item 11.3**
Presented by:	Kimberley Salmon-Jamieson, Deputy Chief Executive, Chief Nursing Officer/ Director of Infection Prevention and Control	
Prepared by:	Michelle Worsley, Associate Director of Nursing Infection Prevention and Control/Tissue Viability.	
Meetings where content has been discussed previously	Trust Infection Control Committee 26th May 2026	
Purpose of the paper Please check **one** box only:	☒ For approval ☐ For support ☐ For discussion	

Executive summary / key messages for the meeting to consider

This annual report outlines progress and achievements over the past year, with Infection Prevention and Control (IPC) remaining a key priority within the NHS Standard Contract. Our commitment to safe, high-quality care is reflected in continued improvements in reducing healthcare-associated infections and strengthening IPC practice across all services.

Position

Over the past year, MFT has sustained infection prevention and control standards and remained compliant with national frameworks and contractual requirements. Despite the pressures of emerging infectious, for risks example Mpox and Hanta viruses and seasonal demands, we have continued to prioritise the safety of patients and colleagues. IPC governance arrangements have also been further strengthened to support ongoing oversight, timely risk mitigation, and a swift response to outbreaks.

Improvements

In support of the NHS Standard Contract's quality and safety objectives, we have implemented targeted interventions to strengthen IPC across the Trust. Key improvements include:

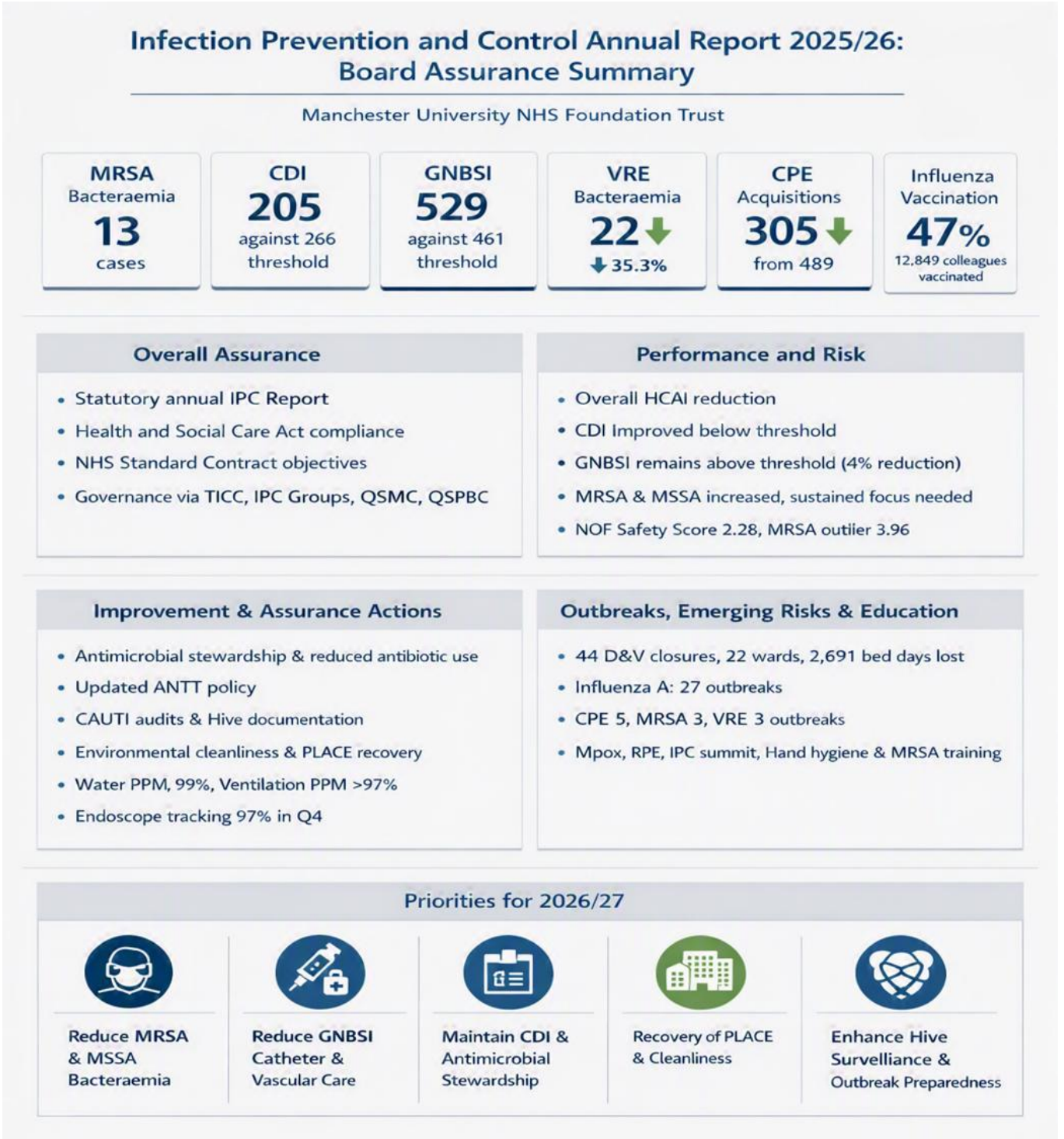
- Ongoing monitoring of IPC compliance programmes
- Updated cleaning and environmental decontamination protocols
- Advanced surveillance and reporting systems to support real-time infection monitoring
- Expanded staff training on IPC best practice to ensure clinical and non-clinical colleagues meet mandatory competencies
- Stronger antimicrobial stewardship to help reduce the impact of antimicrobial resistance

Highlights

- Overall infections decreased compared with the previous year; however, MRSA bacteraemia increased by 44% in reportable cases 13 cases reported in total
- Performance remains above the Standard Contract threshold for Gram-negative infections 529 cases reported above the 461-case threshold
- Good progress in antimicrobial stewardship has contributed to a reduction in cases of *Clostridioides difficile* infection 205 cases reported with an annual threshold of 266 cases, a reduction of 89 cases from the previous year (2024/25)
- Mandatory reporting of surgical site infections shows that, although surgical activity has increased in both knee replacement (from 316 to 663 cases) and hip replacement (from 234 to 475 cases), the infection rate remains low with only 2 patients readmitted due to or reporting a surgical site infection.
- Environmental cleanliness has continued to receive focused oversight across all Clinical Groups, with ongoing action in place to address challenges in specific areas.
- The seasonal influenza vaccination target was achieved, including the required 5% increase.

- The National Oversight Framework (NOF) patient safety score for March 2026 was 2.28; MRSA bacteraemia remains an outlier within this domain at 3.96.
- This report demonstrates the Trust's continued commitment to strengthening infection prevention and control measures and reducing healthcare-associated infections. While progress has been made, ongoing challenges continue to be actively managed through sustained focus and clear strategic direction.

MFT will continue to invest in IPC innovation, workforce development and patient engagement by involving patients in education, feedback and collaboration to further reduce infection risks and maintain the highest standards of safety and quality.



Recommendation(s)
The Board of Directors is asked to: • Consider the matters set out in the Executive Summary; and • Accept the Infection Prevention and Control Annual Report for 2025/26.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)			
LHL objective 1	☒	LHL objective 2	☐
HQSC objective 1	☒	HQSC objective 2	☐
HQSC objective 3	☒	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☐
VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒
Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: • Relevant risks are noted within the report		
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Effective ☐ Responsive	☐ Caring ☒ Well-Led	
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • Health and Social Care Act 2008		

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

The Infection Prevention and Control Annual Report 2025/2026

Executive summary table

Infection Prevention and Control (IPC) Annual Report 2025/2026

1. Executive Summary

The Trust has a statutory responsibility to be compliant with the Health and Social Care Act 2008 Department of Health, 2014)[1]. Under this Act, the Board of Directors must receive an Annual Report from the Director of Infection Prevention and Control (IPC). The Director of Infection Prevention and Control is the Deputy Trust Chief Executive and Chief Nursing Officer.

The purpose of the Annual Report is to inform the Board of Directors how the Trust's Infection Prevention and Control team (IPCT) has engaged in Health Care Associated Infection (HCAI) Prevention and Control during the period 2025/2026.

2. Purpose

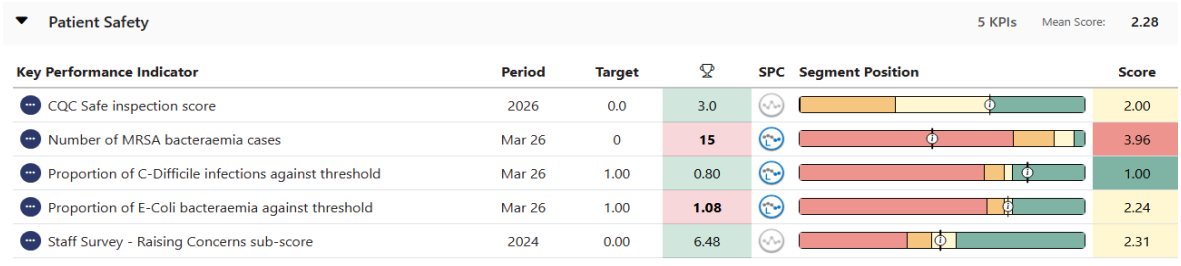
The IPC Annual Report details activity from April 2025 to March 2026, outlining key achievements, and seeks to provide assurance on our progress against the annual programme which is set against the 10 criteria of the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections. The Code was updated in December 2022 to reflect changes to the Act itself and the role of IPC including cleanliness in optimizing antimicrobial use and reducing antimicrobial resistance and considering changes to the IPC landscape and nomenclature that have occurred since the COVID-19 pandemic.

3. Financial Implications

It is widely accepted that healthcare acquired infections carry both a human and financial cost including the increased cost of environmental decontamination and bed losses during ward outbreaks and extended length of patient stay.

4. NHS National Oversight Framework

The NHS National Oversight Framework (NOF) is a comprehensive system deigned to assess how NHS Trusts are performing across various measures. It includes financial, operational and patient safety measures including IPC. NHS England uses these indicators to compare Trusts and determine what oversight or support may be needed. The framework aims to support improvement, ensure accountability and promote effective use of resources. It is important to note the NOF scoring is based upon a 12-month rolling data set and is updated quarterly so does not reflect the total number of cases reported April 25- March 26.



Patient Safety — 5 KPIs — Mean Score: 2.28

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
CQC Safe inspection score	2026	0.0	3.0			2.00
Number of MRSA bacteraemia cases	Mar 26	0	15			3.96
Proportion of C-Difficile infections against threshold	Mar 26	1.00	0.80			1.00
Proportion of E-Coli bacteraemia against threshold	Mar 26	1.00	1.08			2.24
Staff Survey - Raising Concerns sub-score	2024	0.00	6.48			2.31

Fig.1. Patient Safety domain NOF indicator of quarterly NHS organisational delivery score (12-month rolling data set)

[1] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Health and Social Care Act 2008: code of practice on the development and control of infections and related guidance. Updated December 2022

5. Risk

The Trust Infection Prevention and Control Committee (TICC) provides executive oversight of the Trust's IPC programme, reporting to the Quality and Safety Management Committee with infection prevention and control matters that have been reviewed during 2025/2026 and monitored at Hospital/MCS/LCO level. Risks are managed through the Trust Infection Control Committee, chaired by the Trust deputy Chief Executive Officer and Chief Nursing Officer and deputised by the Deputy Director of Infection Prevention and Control. and a continued focus is required on the controls in place to mitigate the risks associated with healthcare acquired infections. IPC risks are further described in section 11.11.

6. Communication and Involvement

The Annual Report has been developed by the Associate Director of Nursing, Infection Prevention and Control in conjunction with the Clinical Groups. Review, assurance and actions where agreed are undertaken at Clinical Group/Hospital/MCS levels where required and monitored through Trust Committees.

7. Summary of Infection Prevention & Control Activity

The following sections provide a summary of activity and performance during 2025/2026 that are detailed in full in the Trust Annual Report.

7.1 Governance

7.1.1 The Trust Infection Prevention & Control Committee (TICC) has responsibility for monitoring Infection Prevention and Control activities, as laid out in the key 10 commitments. During 2025/2026 the TICC met six times during the year and is chaired by the Deputy Trust Chief Executive Officer/Chief Nursing Officer/Director of Infection Prevention Control, Deputy Chair is the deputy DIPC, Associate Medical Director, IPC and Clinical head of Laboratory Medicine. The TICC Terms of Reference are provided at Appendix 1.

7.1.2 The Deputy Chief Executive Officer/Chief Nursing Officer/Director of Infection Prevention Control (DIPC) reviews are held with each Director of Nursing supported by their Senior Leadership team including medical colleagues who have delegated responsibility for IPC in the Hospitals/MCS/LCOs, regularly throughout the year.

7.1.3 An End of Year review meeting with each Clinical Group provided an opportunity to focus on activity and performance, risks posed, with mitigations and improvement streams of work in place to support ongoing patient safety.

7.1.4 The Trust Integrated Performance Review (IPR) monitors a range of healthcare related infections attributed to the Trust which are reported externally to the UK Health Security Agency Mandatory Data Capture System (UKHSA DCS) and is reported to the Quality and Safety Management Committee for oversight and assurance.

7.1.5 Risks associated with Infection Prevention & Control are monitored through Hospital/MCS/LCO IPC meetings and TICC and where escalation occurs, through the Quality and Safety Management Committee.

7.2 Seasonal Respiratory viruses

On the 1st of April 2023 changes were made to existing national COVID-19 testing policy and MFT policy towards an overall theme of moving to a broader strategy of managing seasonal respiratory viral infections, including COVID-19 but also other infections such as Influenza and Respiratory Syncytial virus (RSV) with an emphasis

on local decision making around patient pathways and risk management. A Respiratory Risk Assessment (RRA) was produced to support ward and departmental managers in understanding the wider risks associated with seasonal respiratory viral infections, by integrating IPC measures into the risk assessment process to enhance patient and staff safety.

7.3 Healthcare Associated Infections (HCAI)

HCAI figures are considered against nationally calculated thresholds which are set by NHS England except for Carbapenemase-producing Enterobacterales where no threshold is applied.

Organism	2023/24	2024/25	2025/26	Threshold	Trend
Meticillin Resistant Staphylococcus aureus (MRSA) **bacteraemia**	20	9	13	0	
Clostridioides difficile Infection (CDI)	275	292	205	266	
Gram-negative Bloodstream Infections (GNBSI)	490	551	529	461	
Vancomycin-resistant Enterococci (VRE)	34	34	22	N/A	
Carbapenemase-producing Enterobacterales (CPE) **acquisition**	572	489	305	N/A	
Carbapenemase-producing Enterobacterales (CPE) **bacteraemia**	17	10	4	N/A	

Fig.2. Year on year reportable organisms and 2025/26 thresholds

7.4 Antimicrobial Stewardship

7.4.1 The Antimicrobial Stewardship Committee (AMC) oversees the stewardship of antimicrobials in line with the MFT AMS vision, reporting to the Medicines optimisation Board and TICC.

7.4.2 The AMC met each quarter during 2025/2026, in April, July, December and March. In June 2023 the AMS-operational group was convened to operationalise the objectives and priorities of the AMC, Dr Katherine Ajdukiewicz was appointed as Chair, and the group meets every two months. The Guideline Development Group (GDG), Education and Training and Quality Improvement and Research groups became subgroups of AMS- operational group. In Q.4 2025/26 the national action plan for AMR set an ambitious target, to ensure the organisation is on track to meet AMR targets and complete the following action- 'to agree and publish three priority areas for AMR improvement within the organisation'. Each priority must;

- Define specific, measurable objectives.
- Assign executive-level accountability.
- Establish timelines and reporting mechanisms.
- Progress should be reviewed quarterly, with a formal update to the board at least annually

7.4.3 Key Achievements of Antimicrobial Stewardship Committee

- Expansion of audit coverage to include Emergency Departments.
- Ongoing development of digital stewardship tools to support prescribing and monitoring.
- Progress in reviewing both adult and paediatric antimicrobial guidelines.
- Delivery of comprehensive education programmes across the organisation.
- Successful piloting of penicillin allergy de-labelling initiatives.

7.5 Surgical Site Infection Surveillance (SSI)

The Trust is required to submit a minimum of one quarter of data per year to comply with mandatory reporting for Orthopaedic implant surgery. Data was submitted for both hip and knee replacement surgery for routine surgery performed at Trafford Campus. Across MFT in 2025/26 **663** knee replacement procedures and **475** hip replacement procedures were conducted during the previous four quarters in which surveillance was undertaken, with **2** patients readmitted due to or reporting an SSI, both patients were high risk relating to co-morbidities, learning from infections is discussed at Trauma and Orthopaedics management meetings.

7.6 Cleanliness

Environmental cleanliness remains a significant IPC priority and a core component of patient safety assurance. Assurance is provided through established monitoring processes across all sites, external review, implementation of the National Standards of Healthcare Cleanliness 2025, and oversight through established governance routes. An external review in August/September 2025 confirmed that improvement has been made, but further work is required to achieve consistent standards. Targeted action plans remain in place and are monitored through established governance routes to reduce residual risk and embed sustained improvement. Throughout 2025/26, the following actions were completed:

- A comprehensive review of the revised 2025 standards was undertaken to ensure compliance and improve cleanliness standards and related reporting.
- The Trust Cleaning Policy has been reviewed by a multidisciplinary team.
- Education sessions on the NSoHC have been delivered to colleagues across the Trust.
- Progress against Clinical Group action plans was reported through Clinical Group Infection Prevention Committees, with escalations raised to the Trust Infection Prevention and Control Committee.

7.7 Outbreak of Infection Management

The management of outbreaks of diarrhoea and vomiting requires swift, coordinated action to contain spread and protect patients and staff. Once an outbreak is identified, affected patients are isolated or cohorted promptly to prevent transmission and, where necessary, patient bays or whole wards may be closed. Enhanced infection prevention measures, including strict hand hygiene, appropriate personal protective equipment (PPE), and intensified environmental cleaning with effective disinfectants, are implemented in affected areas. Colleague education and clear communication support early recognition of symptoms and adherence to control measures. Surveillance is increased to identify new cases, and visitor restrictions or notifications are introduced where appropriate. Outbreaks are managed in partnership with the

Infection Prevention and Control team and microbiology/virology services to identify the causative organism, implement targeted interventions, and achieve safe, timely resolution. The IPC service also supports outbreak meetings for infections other than diarrhoea and vomiting, including VRE, MRSA, and seasonal viral infections. In addition, the IPC team contributes to wider regional groups to support horizon scanning for emerging infection risks.

7.7.1 In 2025/26 there were ward or bay closures due to outbreaks of diarrhoea and vomiting (D&V) where either Norovirus or Rotavirus or no confirmed organism was found. The total numbers of bed days lost are detailed below.

Clinical Group	Full ward & bay closures	Ward closures	Lost bed days (ward & bay closures)
WTWA	20	6	1244
ORC	10	7	868
NMGH	12	8	472
LCO	2	1	107
Total	**44**	**22**	**2691**

Fig.3 Numbers of bed days lost due to outbreaks of gastrointestinal infections

7.7.2 There were also outbreaks of CPE (5), and Influenza A (27) between April 2025 and March 2026. There were also outbreaks of MRSA (3) and VRE (3).

7.7.3 There were some periods of increased incidence (PII) of Clostridioides difficile (15), although no outbreaks during 2025/2026. There were no outbreaks of Extended Spectrum Beta Lactamase (ESBL) organisms during 2025/2026

7.8 Water Safety

7.8.1 Site Water Safety Groups (WSGs), chaired by Compliance Management team and report to the Estates and Facilities Management Group, meet quarterly to monitor any risks, issues, positive samples, remedial works, reactive works, derogations, and lifecycle works. Emerging risks and issues that required escalation were taken to the site Technical Boards and the E&F Compliance, Risk and Governance (CRaG) Oversight Committee to determine further actions and/or escalations as required. Water Safety Plans are in place for ORC, NMGH and WTWA and will be reviewed and revised as required in 2026/27.

7.8.2 The review of areas classified as Augmented Care for sampling for Pseudomonas took place across the ORC, WTWA and NMGH sites and were agreed by the Water Safety Groups. Sampling continued in accordance with HTM04-01 Part C.

7.9 Ventilation Systems

The management of Ventilation Systems was undertaken in accordance with HTM 03-01 Specialist Ventilation for Healthcare Premises and HSG 258; this includes the design, maintenance, and operation of ventilation systems. Where other non-specialised ventilation systems are installed, they are maintained in accordance with manufacturers recommendations and any required standards.

7.10 Decontamination

The decontamination services within the Decontamination Services Department (DSD) at Oxford Road Campus (ORC) transferred across to the Hospital Sterilization and Disinfection Unit (HSDU) at North Manchester General Hospital (NMGH) and the STERIS facility based in Wythenshawe in July 2021, for the DSD at ORC to undergo a life cycling refurbishment program which is being undertaken through the Trust's PFI partner Equans. The new Decontamination Services Department reopened in

2023 on the ORC site.

7.11 External Service Level Agreements (SLA)

The (SLA) provision of IPC advice and guidance to Moya Cole Hospice across the three North West Hospice sites through a Service Level agreement (SLA)

- The Neil Cliffe Centre (based at Wythenshawe Hospital);
- Heald Green; and,
- Little Hulton

7.12 Professional Development

7.12.1 The Infection Prevention and Control nursing team have focused on providing Respiratory Protective Equipment training (RPE) within the Trust throughout 2025/2026. The IPC team have also celebrated eventful days within the year such as `World Hand Hygiene Day`, `Leg Matters` week, `Stop the Pressure` week, 'Free Floating Feet', in addition to bespoke training sessions for wards as required. The IPC team have supported Clinical Group education with ward/departmental managers and senior leadership education days and hosted the annual IPC Summit.

7.13 Digital Implementation

7.13.1 In September 2022, the EPIC Electronic patient record (EPR) system Hive, was implemented. The IPC team have continued to develop functionality to improve practice and communication between IPC and clinical teams to facilitate patient care.

7.13.2 During 2025/26, Hive was used to complete two Trust-wide CAUTI audits. The number of patients with urinary catheters included in the audits increased year on year. Compliance exceeded 95% for documented indication for catheterisation and correct drainage bag position. Areas requiring further focus include provision of patient information, use of fixation devices, timely catheter removal, and documentation of catheter care. Results were shared with Clinical Groups, and a CAUTI Oversight Working Group, chaired by the Associate Director of Nursing IPC, was established to support improvement. Significant work has been undertaken to strengthen catheter care documentation within Hive, improving access for clinical teams and supporting consistent recording of care provided. Further work is underway to enable more regular auditing and provide assurance that improvements are being made. Clinical Group action plans are included in escalation reports and reported to TICC bi-monthly.

7.14 Vaccination Program

7.14.1 This year seasonal influenza vaccine programmes were delivered in accordance with national guidance. Vaccination rollout commenced in September 2025.

7.14.2 Final administration rates for seasonal influenza vaccine programme:
47% (12,849 vaccines) of MFT colleagues received the vaccination achieving the required 5% increase set by GM

7.14.3 As with the previous year vaccine hesitancy, health inequalities, operational challenges and communication barriers has had an impact on uptake rates in 25/26 and this is reflected in regional and national uptake rates, as well as at MFT.

8. Infection Prevention and Control Arrangements

The Director of Infection Prevention and Control (DIPC)

Kimberley Salmon-Jamieson Deputy Trust Chief Executive/Chief Nursing Officer and designated DIPC for MFT appointed in April 2024 and has been employed as Chief Nursing Officer and DIPC at a former NHS

Trust since 2017.

The Infection Prevention and Control Team (IPCT)

Dr Rajesh Rajendran Associate Medical Director/Deputy DIPC for IPC. Rajesh was appointed as Regional IPC Doctor and Medical Microbiologist from July 2021 and in November 2021 became Clinical Head of Division Director of the Division of Laboratory.

Mrs Michelle Worsley is the Associate Director of Nursing (ADN) for IPC/TV. Michelle started working at the Trust in 1990 and has substantial experience in both adult, neonatal nursing, Michelle was appointed as an IP&C specialist nurse in 2007 and was appointed to the Lead Nurse position IPC team in 2020 following her clinical leadership experience before becoming ADN in May 2022.

Dr Nicholas Machin Consultant Virologist, Clinical Lead for Virology maintained his role as an Infection Control Doctor (ICD). Consultant Virologist, Head of Service/Clinical Director for Manchester Medical Microbiology Partnership. Dr Machin is also an Infection Control Doctor for MFT and currently leads on IPC for RMCH, St Mary's and the Eye and Dental hospital.

Dr Shazaad Ahmad Consultant Virologist continued his role as an Infection Control Doctor. Shazaad helped to set up the Data Science Unit at MFT in the field of infection data which has been used to inform regional and national decision-making regarding COVID-19.

Dr Eamonn Trainor, Consultant Medical Microbiologist, joined MFT in February 2023 and is the Infection Control Doctor for North Manchester General Hospital. He has nearly 10 years' consultant experience in infection prevention and control and has recently contributed to Healthcare Infection Society national guidance on managing norovirus outbreaks.

Mrs Lorraine Durham was appointed as Head of Nursing for IPC in February 2023. Lorraine has substantial experience in Intensive Care Nursing, prior to moving to Infection control and Tissue Viability over 20 years ago, having worked across GM hospitals for 32 years.

Dr Tristan Banks, Consultant in Infectious Diseases and Microbiology, joined MFT in December 2024 after completing training in the Northwest. He is an IPC doctor for Wythenshawe Hospital and works in the Specialist Regional Infectious Diseases Centre at NMGH, supports the inpatient infection consults service at Oxford Road Campus, and runs specialist clinics in HIV, viral hepatitis and chronic pulmonary aspergillosis.

Dr Prasun Chakravorty, Consultant in Medical Microbiology and Infectious Diseases, Infection Control Doctor for Wythenshawe Hospital, joined MFT in December 2024. Prasun has an interest in Diabetic Foot infections, and undertakes specialist clinics involving patients with HIV, Chronic Hepatitis B and Chronic Pulmonary Aspergillosis.

8.1 Microbiology and Virology Laboratory Services

Microbiology and Virology Laboratory services were provided on-site at the Oxford Road Campus (ORC) by the Manchester Medical Microbiology Partnership (MMMP). Virology services were provided across the region as well to the Trust.

8.2 The Infection Prevention and Control (IPC)/Tissue Viability (TV) Team

All IPC services are managed within the Clinical and Scientific Services (CSS). The Medical members of the IPC Team are in the Division of Laboratory Medicine. The NursingTeam is in the CSS Clinical Group. Recruitment and succession plans are in place for both the medical and nursing team, to ensure that the IPC team develops its workforce.

An organogram demonstrating an overview of the structure of the IPC/TV Nursing Team can be found in Appendix 2.

8.3 The Trust Infection Prevention and Control Committee (TICC)

The Trust Infection Prevention and Control Committee has corporate responsibility for overseeing the implementation of Infection Prevention and Control activities. The TICC met six times during the year chaired by the Deputy Chief Executive Officer/Chief Nursing Officer/DIPC and co-chaired by the Deputy DIPC. The TICC reported to Quality and Safety Management Committee and to the Board of Directors via the Quality, Safety & Performance Board Committee.

8.4 Framework for IPC

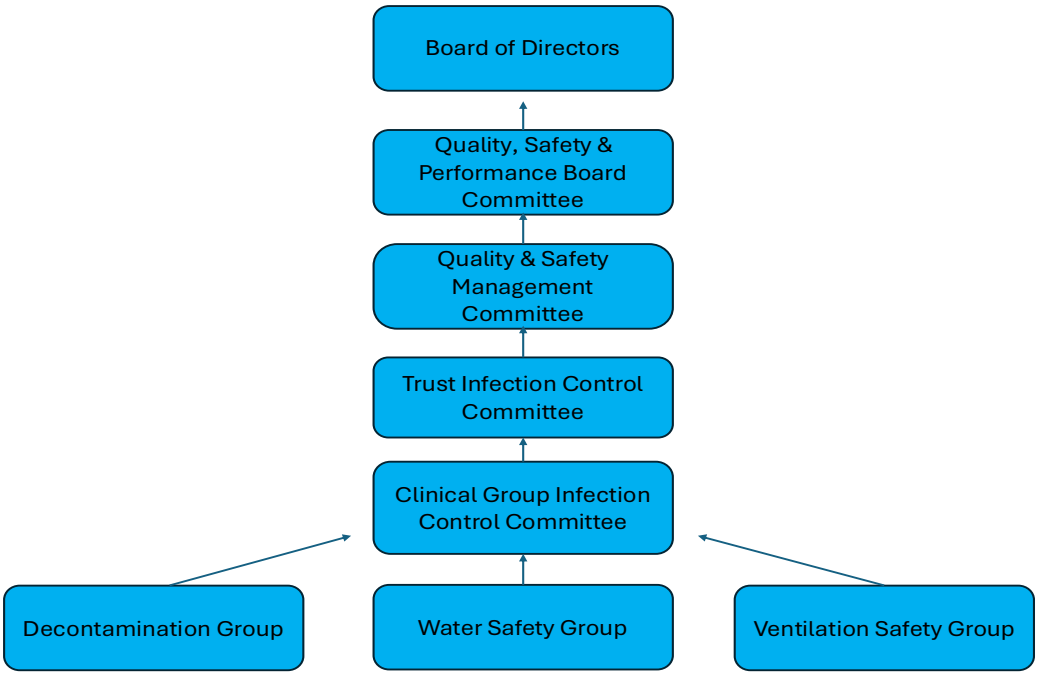


Fig.4. MFT IPC Governance framework organogram

8.5 Infection Prevention and Control Structure within the Hospitals/Managed ClinicalServices (MCS)/Local Care Organisation (LCO)

8.5.1 Infection Control Committees are in place within each Hospital/MCS and LCO (Clinical Groups). The day-to-day management for IPC was delegated to the Directors of Nursing by the Deputy Chief Executive Officer/Chief Nursing Officer/DIPC. Each Hospital/MCS/LCOs appointed a Clinical Medical Lead to support IPC policy and practice across professional groups and represent the Hospitals/MCS/LCO at the Trust Infection Control Committee (TICC).

8.5.2 Each Hospital/MCS/LCO present their Infection Control Assurance reports including any escalated issues or concerns. Attendance at the hospital/MCS/LCO meetings includes designated IPC nurses and Infection Control Medical colleagues.

8.6 Service Level Agreement (SLA) with Moya Cole Hospice

The Trust IPC/TV Team were asked to renew the Service Level Agreement (SLA) provision for IPC advice and guidance to Moya Cole Hospice and include Tissue Viability across the Northwest Hospice sites:

- The Neil Cliffe Centre (based atWythenshawe Hospital);
- Heald Green
- Little Hulton

9. Seasonal Viruses

Healthcare management of seasonal viral infections, including Influenza and COVID-19, involves a multi-layered approach aimed at reducing transmission, minimizing illness severity, and protecting vulnerable populations. Key strategies include vaccination programs to provide immunity and reduce disease burden, rigorous infection prevention and control measures such as effective hand hygiene, use of personal protective equipment (PPE), and respiratory etiquette. Early identification and isolation of symptomatic patients are critical to preventing outbreaks within healthcare settings. Clinical management focuses on supportive care, antiviral treatments where appropriate, and careful monitoring for complications. Additionally, the implementation of surveillance and reporting protocols to track infection trends and inform responses. Colleague education and collaboration between multidisciplinary teams ensured preparedness and resilience during seasonal peaks of these viral infections.

Influenza

The Acute Respiratory Infection (ARI) report was circulated throughout the winter months (Oct-Mar) and will be reinstated for the next Influenza season. Healthcare worker vaccination strategy and outcomes are detailed in section 11. In total there were 27 outbreaks of Influenza A during 2025/26.

SARS-CoV-2

Data is no longer required to be submitted via the national database however any individual cases are managed in line with local policy and periods of increased incidence or outbreaks are managed in line with the outbreak policy.

9.1 The MFT Acute Respiratory Infection Report

The report was circulated October 25- March 26 on a weekly basis to provide a summary of acute respiratory attendances and hospital admissions for the purpose of informing healthcare delivery. The report was produced on behalf of the Manchester Medical Microbiology Partnership and the MFT IPC Surveillance Team. The following

charts detail both adult and paediatric attendances and admissions due to respiratory illness in comparison to the previous four years.

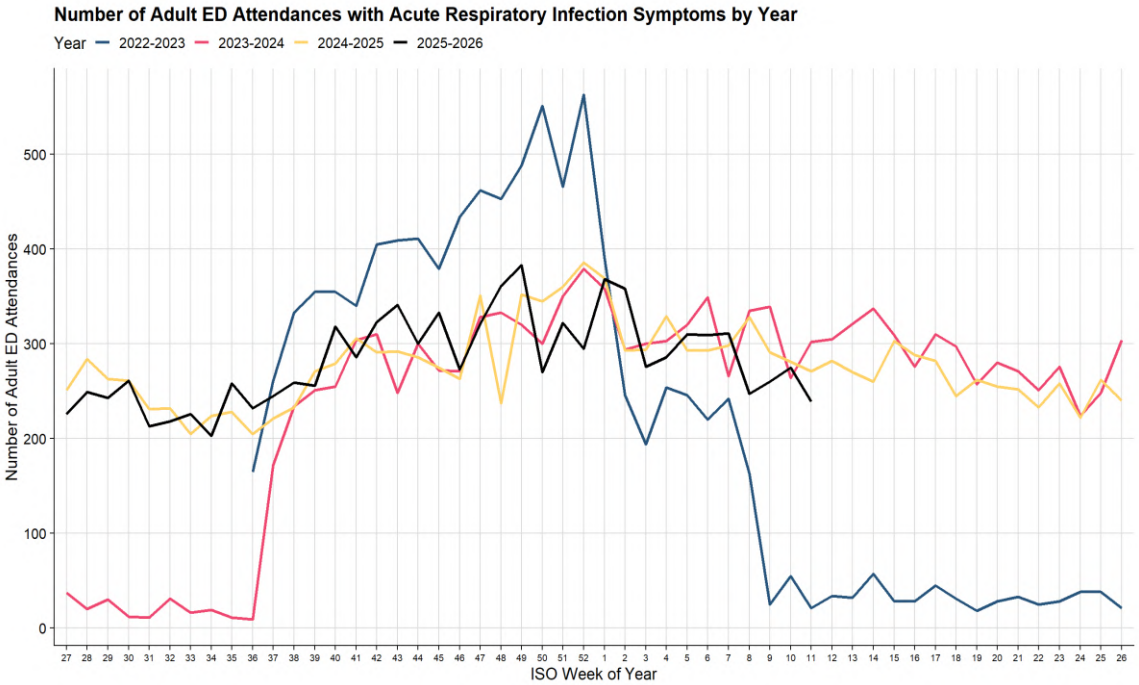


Fig.5. Non elective adult attendances to MFT with fever, breathlessness, respiratory distress, cough or sore throat

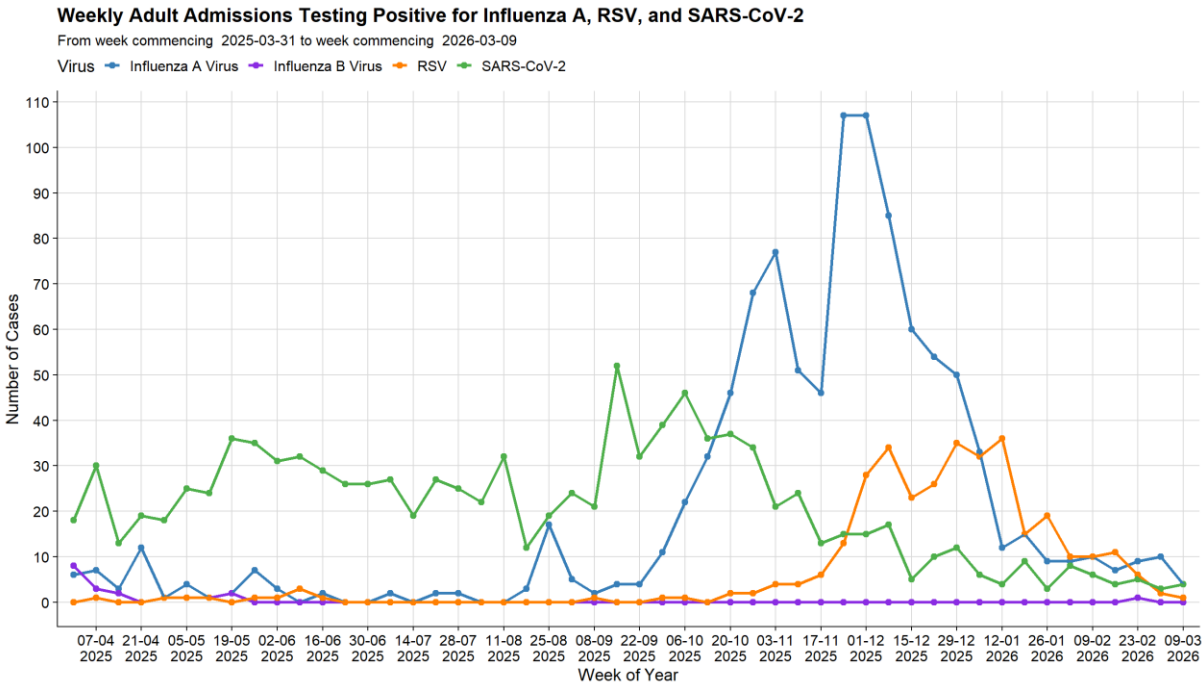


Fig. 6. Weekly adult admissions testing positive for Influenza, RSV and Sars-CoV-2

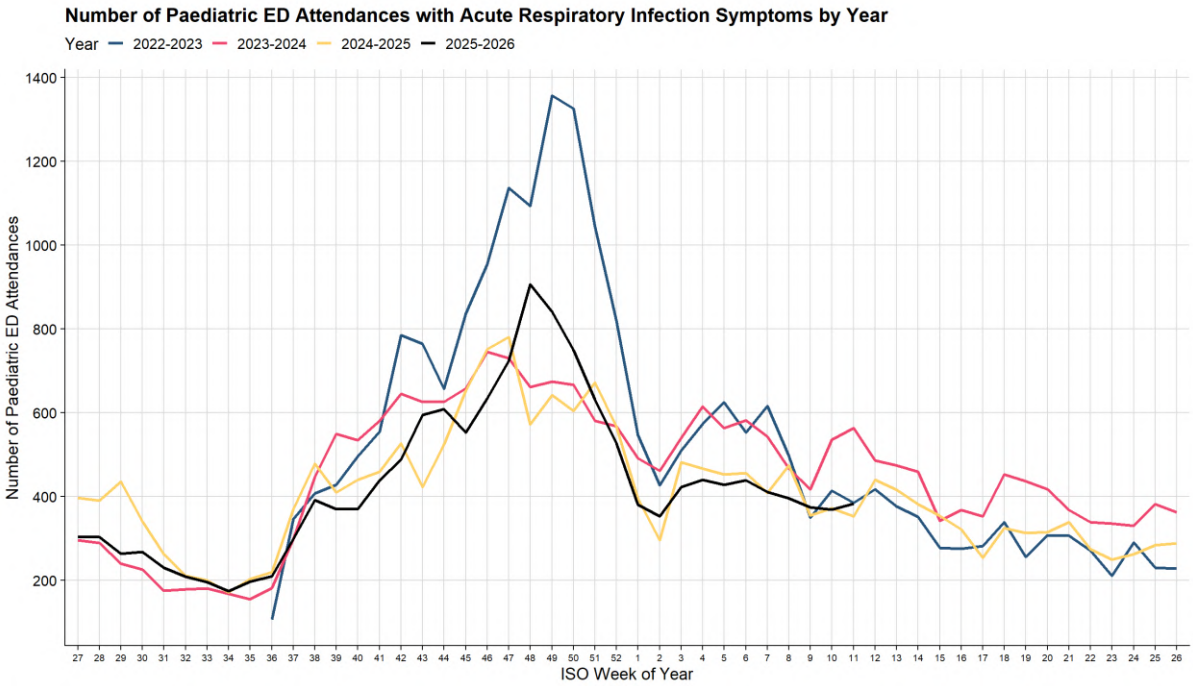


Fig.7 non-elective paediatric attendances to MFT with fever, breathlessness, respiratory distress, cough, or sore throat.

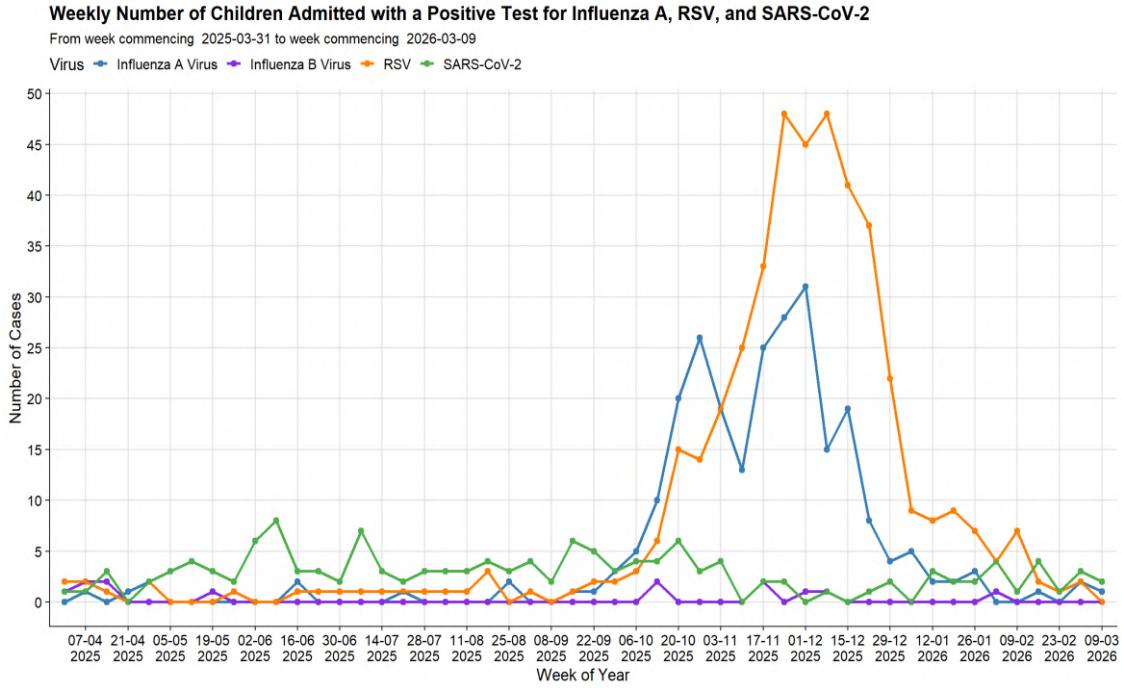


Fig.8. Weekly numbers of children admitted with a positive test for Influenza, RSV and Sars-CoV-2

9.2 Respiratory Risk Assessment

9.2.1 Implementation of Respiratory Risk Assessment (RRA)

The RRA was introduced to ward and departmental managers in May 2023 for implementation across the organisation. The Directors of Nursing have oversight of the risk assessments which are monitored at the hospital/MCS Infection Control Committees (ICC) and reported to TICC by exception. Information posters were circulated with the RRA so wards and departments can display the requirement to wear FRSM within the area if required. The RRA are to be regularly reviewed including

at ward level during respiratory outbreaks.

9.2.2 **Personal Protective Equipment (PPE)**
The National Infection Control manual (NIPCM) recommendations are followed regarding the application of Standard IPC precautions and Transmission based precautions depending upon the organism and route of transmission.

10. Health Care Associated Infections (HCAI)

All charts are included in Appendix 3**.** Over the past year, our hospitals have made notable progress in reducing the overall incidence of healthcare-associated infections (HCAIs) including CDI, GNBSI, VRE and CPE bacteraemia, demonstrating the positive impact of ongoing infection prevention and control (IPC) initiatives. Enhanced colleague training, IPC process compliance, and strengthened environmental cleaning protocols have contributed to a downward trend in several key HCAI indicators.

However, despite these achievements, we have observed an increase in infections caused by certain organisms, including MRSA and MSSA. The rises emphasise the continuing challenges posed by evolving microbial threats and highlight areas where targeted efforts must be intensified including screening, decolonisation therapy compliance and aseptic non-touch technique (ANTT) assessment compliance.

Moving forward, our focus will be on deepening surveillance, refining antimicrobial stewardship, and reinforcing multidisciplinary collaboration to address these emerging risks. By building on our successes and addressing current gaps, we remain committed to improving patient safety and minimizing the burden of HCAI across the hospital.

10.1 Meticillin-resistant Staphylococcus aureus (MRSA)

There have been 13 hospital-onset MRSA bacteraemia reported for the 2025/2026 year which represents an increase based on the previous year's performance of 9 cases. There have been 286 MRSA acquisitions for the 2025/2026 which is an increase of 15 from the previous year position (271). Actions to reduce occurrence include.

- Implementation of decolonisation protocol within Hive including adult, paediatric and neonatal populations.
- Senior Nurse reviews of all complex patients including development of senior nurse review report within Hive
- Targeted colleague education and training in high-risk groups i.e. Neonatal patients, renal patients
- Colleague screening pilot in high-risk areas (NICU)
- Updated screening policy in line with national recommendations
- Colleague education in the use of decolonisation therapy
- Targeted ANTT assessment compliance action plans within Clinical Groups

10.2 Clostridium difficile Infection (CDI)

There has been a total of 214 healthcare associated CDI cases reported for 2025/26 (205 Trust / 9 GP), against a trajectory of 266. This represented a reduction from 294 cases reported for the previous year. Lessons learned data is being determined retrospectively upon review: there are currently 123 instances for lessons learned in 2025/2026. Actions to reduce occurrence include.

- Antimicrobial stewardship
- Risk assessment updates within Hive
- Targeted education around timely sampling techniques
- In depth review of all CDI cases
- Implementation of Patient Safety Framework to understand learning themes

- Ribotyping of cases in periods of increased incidence
- Education and training in environmental hygiene standards

10.3 Gram Negative Blood Stream Infections (GNBSI)

There was a total of 529 healthcare associated Gram-Negative Bloodstream Infections reported for the last financial year, which is over the NHSEI trajectory of 461 and represents a 4% reduction on last year's position (551) for the same period. Actions to reduce occurrence include.

- MFT wide vascular access device and urinary catheter audit undertaken July 2025 and January 2026, results shared with Clinical Groups and action plans for improvement developed.
- MFT wide Urinary Catheter Care audit in July 2025 and January 2026 results shared with Clinical Groups and action plans for improvement developed.
- GNBSI risk factor proforma developed and added to the Ulysses incident reporting system to provide themes and further areas for action.
- Updated Vascular Access Device policy

10.4 Meticillin-sensitive Staphylococcus aureus (MSSA) bacteraemia

A total of 113 hospital onset MSSA bacteraemia cases have been reported for 2025/2026, compared to 96 cases for 2024/2025. There is currently no target associated with MSSA bacteraemia incidence. Actions to reduce occurrence- please see 10.1

- MSSA swarm review trial implemented at NMGH which will then be implemented across the Clinical Groups throughout 2026/27.

10.5 Carbapenemase-producing Enterobacterales (CPE)

There is a total of 305 CPE acquisitions recorded for 2025/2026, compared to 489 cases for 2024/2025. There have been 4 hospital-onset CPE bacteraemia recorded for 2025/2026, compared to 10 cases recorded during 2024/2025. Actions to reduce occurrence include.

- Increased screening protocol to support identification and placement of patients
- Outbreak and control management within clinical areas
- Review of environmental decontamination and use of advanced technologies to reduce bio burden
- Education and training in environmental hygiene standards

10.6 Vancomycin-resistant Enterococci (VRE)

A total of 22 hospital-onset bacteraemia cases has been reported for 2025/2026, with a total of 513 acquisitions. Based on last year's performance (34 bacteraemia, 600 acquisitions), we have seen a reduction of 35.3% in VRE bacteraemia and a reduction of 14.5% in total VRE acquisitions.

- Increased screening protocol to support identification and placement of patients which highlighted the increase in acquisitions specifically in vascular and haematology/oncology patient cohorts.
- Clinical Group action plans and improvement processes in place to address areas with sustained VRE transmission
- Trust Leadership Team Committee received an update paper on Clinical Group action plans to address VRE transmission.
- Outbreak and control management within clinical areas
- Review of environmental decontamination and use of advanced technologies to reduce bio burden
- Education and training in environmental hygiene standards
- Genetic Ribotyping of VRE cases indicated there were several strains in circulation

10.7 Mpox

Background on mpox

Mpox is an infectious disease caused by the MPXV virus. There are two main genetic clades (types) of MPXV: Clade I (formerly Central African or Congo Basin), which is associated with more severe illness, and Clade II (formerly West African), which has largely driven outbreaks since 2022 and is often associated with milder symptoms and lower mortality.

Current global outbreak context

Since May 2022, human cases of mpox have been reported in multiple countries where MPXV had not previously been identified in animal or human populations, including the UK. The ongoing outbreak has been caused predominantly by clade IIb, lineage B.1, and has spread mainly through sexual contact.

Recent local presentations

Since February 2026, four patients have presented to Emergency Departments across WTWA, MRI, and NMGH and were subsequently diagnosed with mpox. These cases, presenting atypically, resulted in significant exposure incidents affecting both staff and patients.

Response and key messages

In response to these incidents, the Virology, Infectious Diseases, and Infection Prevention and Control teams supported Clinical Groups outbreak meetings, advising and supporting risk assessments and subsequent actions, developed and disseminated communications to Medical Directors, Directors of Nursing, and Emergency Departments. These communications emphasised the following points:

- The increasing prevalence of mpox in the community
- The need for appropriate use of PPE for all patients presenting with a rash
- Visual guidance, including photographs of typical mpox lesions, to support early recognition and safe triage

10.8 Catheter Associated Urinary Tract Infection audit (CAUTI)

Two Trust-wide CAUTI audits were completed using Hive in July 2025 and January 2026, reviewing 348 and 350 patients with urinary catheters respectively. Findings are informing local action plans across hospitals, MCSs and LCOs to address areas of non-compliance and strengthen CAUTI prevention and management.

Action plans are monitored through local Infection Prevention Committee meetings to support accountability and continuous improvement. Direct year-on-year comparison is limited because previous audits used different methods and sample sizes. Overall compliance remains below the expected 95% standard, except for indication for catheterisation and drainage bag position. Further focus is required on patient information and explanation of care, documented daily catheter review, fixation device use, daily catheter care documentation, and recording the expected date of removal. The CAUTI Working Group has implemented changes within Hive to improve access to catheter care documentation, with system reminders now supporting updated care plans and documentation of care provided. Further work is underway to enable regular monthly catheter care audits, providing assurance that improvements are being made and identifying areas requiring continued focus.

10.9 Peripheral blood culture trends

The monthly rates for ages under 16 years are 1.8% overall for latest 12 months and those 16 and over 2.2% overall for latest 12 months. Both are set against a trajectory/threshold of <3%. Aggregated rate for the Trust for the latest 12 months is 2.1%. Management and monitoring of Aseptic Non-Touch Technique (ANTT) compliance is imperative to maintaining this standard. The IPC team updated the MFT ANTT policy including education, training and compliance recording components and continue to monitor Trust wide ANTT compliance.

10.10 IPC Risks

Throughout 2025/26 the IPC risk register was reviewed and updated. There are currently four risks on the MFT Risk Register relating to Infection Prevention and Control, the risks are monitored monthly and are reported to the TICC bi- monthly and include any updated actions and mitigations currently applied. The risks include.

- MFT/000987 Outbreak of HCAI and isolation management
- MFT/000989 Compliance with IPC policies and procedures
- MFT/0001122 Infection Control targets
- MFT/007792 Condemned mattress replacement programme

10.11 Shelford Group Comparison

The Shelford Group comparison charts in 2025/2026 are included within Appendix 3.

11. Employee Health and Wellbeing Service: IPC and Vaccination Programmes

The Employee Health and Wellbeing (EHW) Service delivers a comprehensive range of Infection Prevention and Control (IPC) programmes, including seasonal influenza vaccination and other relevant occupational vaccination programmes in line with the Green Book. These programmes are designed to protect staff from vaccine-preventable illness, reduce the operational impact of sickness absence and associated costs, and minimise the risk of infection transmission to both staff and patients. Occupational vaccination provision includes Hepatitis B, MMR, Varicella, Pertussis, Mpox, Diphtheria/Tetanus/Polio (DTP) and other role-specific laboratory vaccines. EHW also support infectious disease outbreak management and contact tracing exercises, providing advice on prophylaxis, vaccination and workplace exclusions where indicated.

11.1 Seasonal Influenza Vaccination Programme

The rollout began in September 2025 and concluded end of March 2026. The percentage of frontline healthcare workers vaccinated this campaign rose to 47%, achieving the 5% target increase set by GM. The 5% increase was comparable with increases nationally.

11.2 Seasonal Influenza Vaccination Programme Limitations

Vaccine hesitancy, health inequalities, operational challenges, limited dedicated resources, and communication barriers continue to play a part and impacted uptake rates at MFT during 2025–2026. Lower uptake was particularly evident among vulnerable groups and some ethnic minority colleague groups, highlighting the need for more targeted and inclusive engagement approaches.

Nationally, factors such as perceptions of disease risk, confidence in vaccine safety, healthcare provider recommendations, and longstanding immunisation inequalities have continued to influence uptake. Collectively, these factors contributed to the overall vaccination rates observed during this period and underline the importance of addressing disparities to improve equitable access and uptake.

11.3 Other Vaccinations

In addition to routine business-as-usual (BAU) vaccination programs, the EHW Service continues to offer additional vaccine recommendations from the Green Book, and UKHSA national guidance, including the provision of Pertussis vaccines to high-risk groups and the scoping and planning for pre-exposure Mpox vaccines. These efforts will require further operational adjustments and resource allocation beyond routine activities, to ensure high-risk populations receive timely immunisation in line with evolving public health guidance. Currently colleagues joining the organisation

working in specific job roles are offered these vaccinations, further work and resourcing is needed to vaccinate larger colleague cohorts i.e. ED, NICU, Maternity.

11.4 Training

To support vaccination delivery, the EHW Service trained and enabled over 100 peer-to-peer vaccinators across all hospital/MCS) facilitating wider access to the seasonal influenza vaccination programme. This approach supported increased coverage by improving convenience and staff engagement. Ongoing delivery of the programme is dependent on maintaining sufficient trained workforce capacity and dedicated support.

11.5 Contact Tracing

The increasing frequency of contact tracing exercises for colleagues exposed to infectious diseases has placed sustained pressure on existing EHW resources. Activity has risen markedly, from 5 exercises in 2023 to 91 in 2024, 159 in 2025. Jan to April 2026 there have been 44 reported already.

This consistent upward trend reflects a growing demand that exceeds current service capacity. It also highlights the need for strengthened local risk management measures, including appropriate use of personal protective equipment (PPE), alongside enhanced education and training. The EHW Service continues to work collaboratively with Infection Prevention and Control (IPC) and local management teams to support operational resilience while maintaining colleague safety.

11.6 Outbreak Response

The EHW Service will support meningococcal outbreak management and has been a key stakeholder in developing the outbreak response framework, including the provision of ciprofloxacin chemoprophylaxis under an agreed Written Instruction during EHW service hours. Out-of-hours provision will be managed in collaboration with Infection Prevention and Control (IPC), the Emergency Department (ED), and Pharmacy.

11.7 Compliance

Ensuring compliance with vaccination and immunisation programmes, both at pre-employment screening and through required periodic reviews is essential to maintaining a safe healthcare environment. Current compliance levels indicate scope for improvement, underlining the need for clearer guidance and strengthened accountability among candidates, colleagues, and managers.

Embedding vaccination compliance within organisational culture and policy frameworks will support the Trust in safeguarding patients and healthcare workers while ensuring alignment with national health requirements. The EHW Service has identified gaps within recruitment and onboarding processes and is working collaboratively with recruitment and workforce system teams to strengthen compliance at the point of entry.

12. Antimicrobial Stewardship Committee

12.1 Overview

During 2025–26, the Antimicrobial Management Group (AMG) placed a strong emphasis on reinforcing governance structures, delivering on national priorities for antimicrobial resistance (AMR), and addressing ongoing challenges related to antimicrobial use.

12.2 Governance and Organisational Developments

Governance arrangements were improved through the consolidation of Antimicrobial Stewardship Operations (AMS-ops) and AMG, streamlining decision-making and oversight. This restructuring aimed to enhance the group's effectiveness in leading

stewardship initiatives.

12.3 Antibiotic Consumption and Prescribing Patterns

Notably, there was a reduction in total antibiotic consumption throughout the year. This positive trend coincided with an increase in Access (narrow spectrum) antibiotic prescribing, a shift that reflects updated guidelines recommending reduced use of broad-spectrum antibiotics.

12.4 Performance and Monitoring

Trust-level targets for switching from intravenous (IV) to oral antibiotics continued to be achieved. The rollout of live digital dashboards within the Hive system provided valuable support for monitoring this process. Despite this, prescribing audits revealed varied performance across standards, with duration of therapy consistently identified as the weakest area. This standard remains a significant contributor to unnecessary antimicrobial exposure.

12.5 Benchmarking and National Comparison

National benchmarking indicated some improvement in performance; however, overall antibiotic use and carbapenem prescribing rates remained above the national average. This highlights the need for continued focus and targeted interventions.

12.6 Ongoing Challenges

Several challenges persist and will shape stewardship priorities for 2026–27. These include difficulties in accessing meaningful antibiotic consumption data at the specialty level, limited workforce capacity for conducting guideline reviews, and the pressures of rising regional AMR trends and widening health inequalities.

13. Maintaining a Clean Environment

13.1 The Role of the Infection Prevention and Control Team

The Infection Prevention and Control Team have worked in conjunction with the Trust Estates and Facilities Teams, Clinical Groups, Sodexo and internal providers to ensure cleaning standards are met across the Trust and any changes required following the pandemic were consistently implemented.

13.2 Contracting Arrangements:

The Trust cleaning services were provided by both internal and external contractors/teams.

13.2.1 Sodexo Healthcare are the main contractor for domestic cleaning services across the Oxford Road Campus (ORC), including the Dental Hospital, and at Wythenshawe Hospital. In addition to the core domestic service Sodexo provide HPV and UVC decontamination services at both sites.

13.2.2 North Manchester, Withington, Trafford and Altrincham Hospitals and the Intermediate Care Units all had domestic services provided by in-house teams. The inhouse teams provide HPV decontamination services at North Manchester and Trafford.

13.3 National Standards of Healthcare Cleanliness (NSoHC) 2025

13.3.1 The Estates and Facilities Team in collaboration with PFI partners continues to work to the National Standards Healthcare Cleanliness (NSoHC) and has carried out a comprehensive review of the revised 2025 standards to ensure compliance. The NSoHC provides a consistent approach to cleaning across the NHS and aims to deliver improvements in cleanliness standards and reporting of these.

13.3.2 The Trust Cleaning Policy has undergone a multi-disciplinary review to ensure it not only reflects the National Standards of Healthcare Cleanliness but also reflects the

Trust approach to ensuring cleanliness across the Trust.

13.3.3 To promote an ethos where cleanliness is everybody's responsibility education sessions relating to the NSoHC have been delivered to colleagues across the Trust.

13.4 Monitoring Arrangements:

13.4.1 The National Standards of Healthcare Cleanliness 2025 audit regime includes 3 levels of audit:

- Technical audits, which check and score cleanliness outcome against the safe standard
- Efficacy audits which check the effectiveness of the cleaning at the point of delivery.
- External audit provides quality assurance and checks both the technical audit and the efficacy audit.

13.4.2 The Trust have a monitoring schedule in place across all the Clinical Groups. Monitoring is undertaken by trained monitoring officers, employed by the Estates and Facilities department and Sodexo. Nursing colleagues join NSoHC audits as they are conducted to ensure a multi-disciplinary approach.

13.4.3 Technical audits have been carried out in line with the frequencies set out in the NSoC and the efficacy audits were carried out as muti-disciplinary management audit on an annual basis. Assurance around the completion of these audits is provided at Clinical Group Infection Prevention committees which feed into the Trust Infection Control Committee.

13.4.4 The Deputy Trust Chief Executive Officer/Chief Nursing Officer/Director of Infection Prevention Control commissioned an independent expert to complete an external audit of the processes and procedures that the Trust has in place in relation to cleaning. The findings of this audit were presented in a report with Trust and Clinical Group specific actions. Task and finish groups were formed to address findings of this audit.

13.4.5 Updates on progress in relation to Clinical Group action plans were reported through Clinical Group Infection Prevention Committees with escalations being reported at the Trust Infection Prevention and Control Committee. Clinical Group Infection Prevention Committees receive a monthly report outlining the domestic performance across the group. This report highlights any areas that have not achieved 4* or above ratings and the issues that have been identified through the escalation planner.

13.5 Commitment to Cleanliness Charters and Star Ratings

13.5.1 As required by the new NSoHC Commitment to Cleanliness Charters are publicly displayed in all clinical and public facing circulation areas, these have replaced the cleaning schedules. Star ratings are displayed in all patient facing wards, departments and circulation areas to demonstrate the standard of cleaning delivered in these areas.

13.5.2 The Trust Infection Control Committee receives any escalations from the Clinical Groups in relation to cleaning standards

13.6 Infection Prevention and Control Training for Domestic Staff:

All new employees attended a generic induction which included the principles of Infection Prevention and Control.

13.7 Patient Led Assessment of the Care Environment (PLACE):

13.7.1 The PLACE assessments were completed across October and November 2025

across all qualifying sites. PLACE 2025 results, published in February 2026, showed a decline across all domains, with Trust performance below the national average in every area. Delivery of the assessments was affected by difficulties recruiting patient assessors, which led to some assessments being rescheduled and highlighted the need for a stronger recruitment and training plan.

13.7.2 The was some variation across the organisation and some sites i.e. Trafford and NMGH showed some improvement, although performance remained below benchmark. Dermot Murphy and Buccleuch Lodge exceeded the national average across all domains.

13.7.3 The main areas of concern were privacy and dignity, dementia, and disability, alongside broader underperformance across the Trust. Governance has been strengthened through a PLACE Task and Finish Group, with oversight provided through the Patient Experience Oversight Group and relevant specialist forums and reported to the Quality, Safety and Performance Board Committee.

13.7.4 Overall, Trust-wide performance has declined against national standards. However, strengthened governance, targeted action planning, and interim PLACE Lite reviews are in place to support recovery and ongoing monitoring.

- PLACE Lite reviews in May 2026 to monitor progress and emerging risks
- Detailed action plans were presented in March 2026
- A progress update to Trust Leadership Team Committee (TLTC) scheduled for June 2026

14. Water Safety

14.1 Water Safety Risks

The Trust risk register, managed under the Estates and Facilities Division, contains several entries associated with water safety. These risks are systematically monitored and reviewed to ensure effective management and mitigation at IPC committees across the organisation with escalation where required to the TICC.

Estates and Facilities Division (E&F)
MFT/002980: Augmented Areas – identification and review of areas requiring enhanced water safety measures.
Oxford Road Campus (ORC)
MFT/002980**:** Infection risk to patients in augmented care areas via water outlets, specifically from Pseudomonas aeruginosa. This risk is currently accepted and subject to ongoing monitoring.
MFT/002979: Potential for Legionella bacteria to develop within water systems on site. This risk has been reopened and is being actively monitored.
MFT/008665: SS3 Cold Water Main (Leak).

Wythenshawe Hospital (WTWA)
MFT/001456: Opportunist pathogens, including Legionella and Pseudomonas.
MFT/004822: Never event: scalding.
MFT/006962: Loss of water supplies.

North Manchester General Hospital (NMGH)
MFT/006397: NMGH Water systems.

The following risks relating to water safety are reported onto the risk register system and monitored through Water Safety Groups; Estates and Facilities Management Group and relevant Clinical Group Management Board/risk meetings.

MFT/007836 UDHM dental hospital water tanks:

Risk score 16. Actions are in place to mitigate the risk. Replacement of the tanks is planned for 2026/27 and funding has been secured. Mitigations will remain in place and be monitored through the ORC Water Safety Group, Estates and Facilities Management Group, and UDHM/LCO Clinical Group management and risk meetings until the works are complete.

MFT/002390 OSM cold water storage tanks (and general building condition risk):

Ongoing discussions are taking place on future building use with OSM SLT and Estates and Facilities. Risk score 15. A new facet survey has been commissioned, with completion targeted for June 2026.

In addition to the risks on the E&F Risk Register, Clinical Groups own several water-related risks. From 2026/27, the Head of Risk and Patient Safety will produce a monthly report on these risks for the E&F Compliance, Risk and Governance Team to review at the relevant site safety meetings.

14.2 Management of Risk for Legionella:

Water sampling for Legionella and control of Legionnaires' disease continues across Trust sites in line with COSHH Regulations (2002), Approved Code of Practice L8, Health Technical Memoranda (HTM 04), and Health and Safety Guidance (HSG) 274. No positive Legionella or Pseudomonas *aeruginosa* samples were identified at WTWA or NMGH during 2025/26. At ORC, there were no positive Legionella samples, but a small number of Pseudomonas *aeruginosa* positives were identified in both six-monthly sampling rounds, accounting for 2.84% of samples in May and 2.62% in November. All affected outlets were fitted with point-of-use (POU) filters while the Estates Team carried out remedial works. The team continues to resample, monitor, and report issues through the Water Safety Group for ongoing management.

14.3 Management of Pseudomonas aeruginosa from Water Outlets in Higher-Risk Clinical Areas

The review of augmented care areas for Pseudomonas sampling was completed across ORC, WTWA and NMGH and agreed by the Water Safety Groups. Sampling continued in line with HTM04-01 Part C. At ORC, routine water sampling for Pseudomonas *aeruginosa* also continued in 2025/26 through an external contractor.

The IDEXX Pseudalert system continues to be used at WTWA and NMGH for rapid testing of Pseudomonas *aeruginosa*. It provides definitive results within 24 hours, enabling a faster response to positive samples. Samples also continue to be sent to the laboratory alongside Pseudalert testing.

Off-campus and community premises continue to undergo quarterly Pseudomonas sampling at Community Macular Treatment Centres linked to intravitreal injections. This will continue throughout 2026/27.

A procedure setting out the actions required at all MFT augmented care units (ACUs) following a positive Pseudomonas or Legionella water sample was drafted by the Head of Compliance, Risk and Governance – E&F, approved by IPC, and shared with Water Safety Group members.

14.4 2026/27 Water Safety Management

Estates & Facilities, alongside clinical teams, identified and assessed Arjo baths no longer in use, continuing to explore compliant alternative uses for these bathrooms. Clinical areas are confirming new room purposes to determine the costs of removing Arjo baths and repurposing the space.

The E&F Teams at Wythenshawe and ORC are collaborating with IPC and Physiotherapy to update the Hydrotherapy Pools Standard Operating Procedure, following ATACP and PWTAG guidelines; this will be reviewed by Water Safety Groups by June 2026.

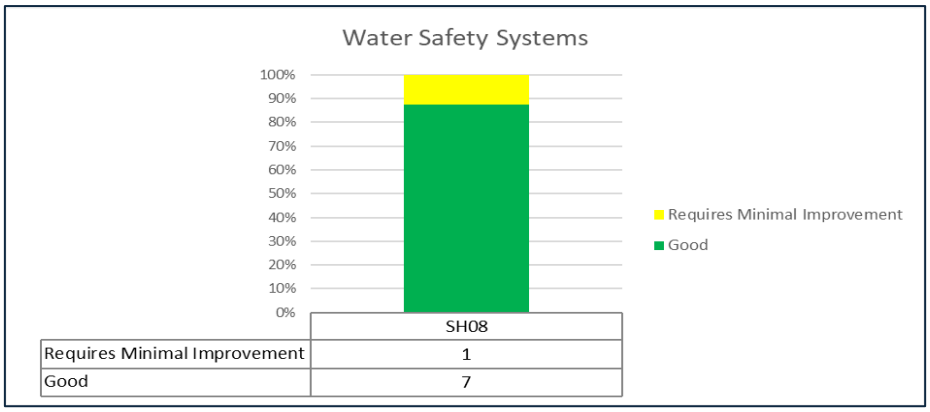
In 25/26, 9,375 Water Safety Planned Preventative Maintenance tasks were scheduled, with 9,308 completed on time—a 99% completion rate. PPM data will

remain part of the Water Safety AAA report.

14.5 Assurance Reporting

Assurance of all Estates technical services/disciplines under HTM guidance (including water safety and ventilation) is recorded through the Estates and Facilities Assurance Module (via Concerto Platform). The questions within the E&F module are a duplicate to the questions within the NHS Premises Assurance Model (PAM) to allow external annual reporting.

The data below in figure 9, represents the position recorded on the Assurance Module on the 25th February 2026. Since then, the model has been replaced with a new version that reflects the substantial changes to NHS PAM for 2026, which is in the process of being populated at the time of writing. In addition to the AAA reports and attendance at TICC by Estates and Facilities, monthly meetings between Estates and Facilities, the Associate Medical Director – Infection Control and Microbiology, and Associate Director Of Nursing IPC/TV continued to be held in 2025 to discuss water and ventilation outside of TICC and site safety groups, although these were limited in quarter 4 of 2025/26 year.



SAQ Title	List Of Qs	Question	Trust NHS PAM Score
Water Safety Systems	SH08-1	Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Good
	SH08-2	Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Good
	SH08-3	Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	Good
	SH08-4	Are assets, equipment and plant adequately maintained? (Note 1)	Good
	SH08-5	Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Good
	SH08-6	Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Requires Minimal Improvement
	SH08-7	Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Good
	SH08-8	If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.	Good

Fig.9. the position recorded on the Assurance Module

15. Ventilation

15.1 Ventilation System Management

15.1.1 Compliance and Maintenance Standards

The management of Ventilation Systems continues to be carried out in line with HTM 03-01 Specialist Ventilation for Healthcare Premises and HSG 258. This encompasses the design, maintenance, and operation of ventilation systems throughout the estate. In cases where non-specialised ventilation systems are present, these are maintained according to manufacturers' recommendations and any relevant standards.

15.1.2 **Verification and Commissioning**

All new installations and refurbishment projects are required to provide verification reports, which include commissioning information and any derogations relating to the introduction of new systems or their connection to existing plant.

15.1.3 **Safety Group Oversight**

The Authorising Engineer (AE) continues to attend quarterly Ventilation Safety Group (VSG) meetings at the site, alongside Authorised Persons and representatives from Infection Prevention and Control (IPC). These groups monitor risks, issues, failed verifications, remedial works, reactive maintenance, derogations, and lifecycle works. Matters requiring escalation are brought to the site Technical Boards and the Estates and Facilities Management Group for further action.

15.1.4 **Audit and Action Management**

Annual ventilation audits in accordance with HTM standards were completed by the Authorising Engineer (Ventilation) during 2025/2026 for ORC, WTWA, and NMGH sites. Actions arising from these audits are reviewed and monitored through quarterly site Ventilation Safety Groups. The Estates Operational teams are tasked with completing the identified actions, all of which require sign-off by the AE before closure.

15.1.5 **Planned Preventative Maintenance (PPM)**

Ventilation Safety Planned Preventative Maintenance (PPM) information continues to be provided to the Trust Infection Control Committee. In 2025/26, a total of 4,846 PPM tasks were scheduled, with 4,686 completed on time, resulting in an overall completion rate of over 97% for the year. PPM data will remain a key component of the Ventilation Safety AAA report going forward.

15.2 Ventilation Safety Risks

Ventilation safety risks are owned by Estates and Facilities and are detailed on the risk register relating to ventilation. These are monitored through Ventilation site safety groups and items for escalation raised through Estates and Facilities Management Group and TICC.

In addition to the risks owned on the Risk Register by E&F there are several ventilation related risks that are owned by Clinical Groups. From 2026/27 a monthly report of these risks will be produced by the Head of Risk and Patient Safety, and issued to the Compliance, Risk and Governance Team within E&F for discussion at the relevant site safety meetings.

Risk relating to ‘cleaning of ventilation grilles in patient areas’ identified during the external cleaning review was further reviewed by the Head of Compliance, Risk and Governance, Estates and Facilities in 2025. A Task & Finish group has been established with key stakeholders (including facilities and IPC) and is working to identify gaps in the Trust cleaning schedules against the requirements of the National Standards of Healthcare Cleanliness 2025. The resources and costs required to meet the standards, and the associated risks will then be presented to TICC.

15.3 Ventilation Safety Guidance Update

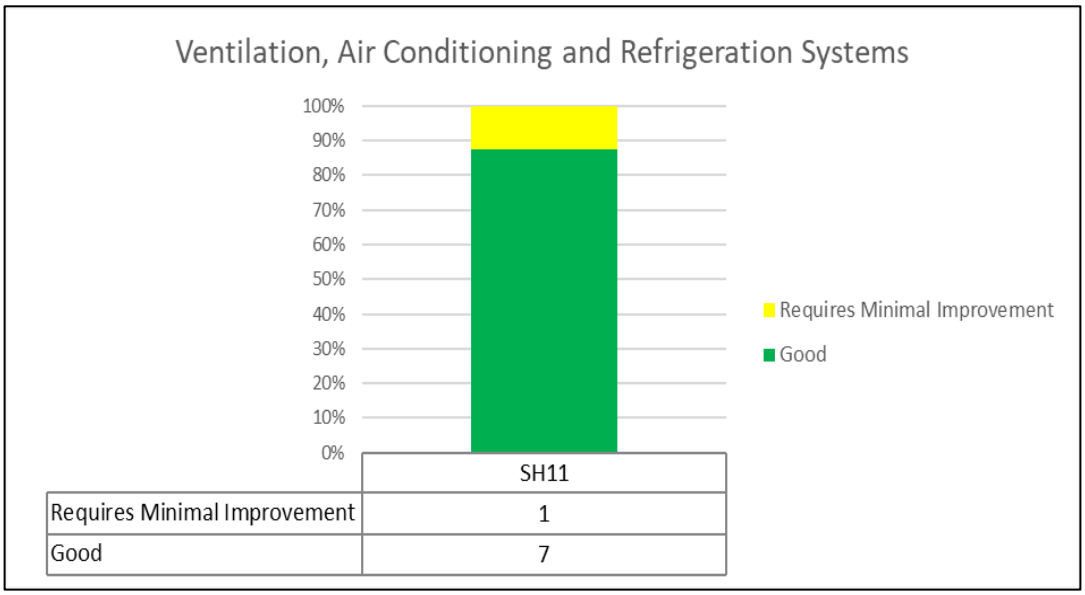
The AE Vent reported that it had been identified nationally there has been a rise in infections associated with the cleaning of Ultra Clean Ventilation (UCV) perforated screens in theatres. National guidance is being drafted and is expected to be released at a date yet to be confirmed in 2026.

15.4 Assurance Reporting

Assurance of all Estates technical services/disciplines under HTM guidance including

ventilation is recorded through the Estates and Facilities Assurance Module (via Concerto Platform). The questions within the E&F module are a duplicate to the questions within the NHS Premises Assurance Model (PAM) to allow external annual reporting.

The data below in figure 10. represents the position recorded on the Assurance Module on the 25th February 2026. Since then, the model has been replaced with a new version that reflects the substantial changes to NHS PAM for 2026, which is in the process of being populated at the time of writing.



	SH11
Requires Minimal Improvement	1
Good	7

SAQ Title	List Of Qs	Question	Trust NHS PAM Score
Ventilation, Air Conditioning and Refrigeration Systems	SH11-1	Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Good
	SH11-2	Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Good
	SH11-3	Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Good
	SH11-4	Are assets, equipment and plant adequately maintained?	Good
	SH11-5	Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Good
	SH11-6	Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Requires Minimal Improvement
	SH11-7	Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Good
	SH11-8	If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.	Good

SAQ Title	List Of Qs	Question	Trust NHS PAM Score
Ventilation, Air Conditioning and Refrigeration Systems	SH11-1	Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Good
	SH11-2	Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Good
	SH11-3	Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Good
	SH11-4	Are assets, equipment and plant adequately maintained?	Good
	SH11-5	Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Good
	SH11-6	Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Requires Minimal Improvement
	SH11-7	Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Good
	SH11-8	If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.	Good

Fig.10 position recorded on the Assurance Module

16. Decontamination

16.1 Sterile Services

All MFT Sterile Service departments are Certified to ISO 13485:2016 Medical

Devices Quality Management Systems and UK Medical Device Directive. All PPMs, machine validation, environmental monitoring and ISO quality compliance for the two internal Sterile Services departments have been suitably managed and compliant for 2025/26.

16.1.1 **Oxford Road Campus (ORC) Decontamination Services Department (DSD)**

The ORC DSD continued to provide satisfactory, compliant, and accredited levels of service to all sites. All DSD staff are fully trained and competent with all systems and equipment within the unit. DSD's overall production figures increased by 4.6% with 400,358 trays and supplementary items processed. On average 83% of items were turned around within 24 hours. Which is an improvement on 2024/25 performance of 75%.

DSD has maintained a defect rate below the 0.2% target for 2025/26 averaging 0.15%.DSD had an unannounced Audit in February 2026 and passed with zero corrective actions.

16.1.2 **North Manchester General Hospital (NMG) Hospital Sterilisation & Disinfection Unit (HSDU).**

The Hospital Sterilisation and Disinfection Unit (HSDU) at North Manchester General Hospital (NMGH) continues to operate well within its capacity.

An annual review of plant equipment, including analysis of breakdowns and maintenance reports, has confirmed that while the current equipment is approaching the end of its expected lifecycle, it has been exceptionally well maintained. Risk Assessments indicate that the existing equipment remains fit for purpose.

Throughout 2025/26, the HSDU consistently maintained a defect rate below the 0.1% target, averaging an impressive 0.09%. In late November 2025, the unit underwent a vigilance audit, which it passed successfully with only one minor corrective action.

16.1.3 **Wythenshawe, Trafford and Withington (WTWA) Sterile Services (Steris)**

WTWA Hospitals continued in the Northwest Sterile Service partnership (NWSSP) the independent decontamination services provider, from their facility in Wythenshawe. with the Christie and Warrington hospitals to receive their sterile services provision from Steris. This contract was renewed May 2025 for a seven-year term.

Steris defect rate is over target for 2025/26, at 0.25%, in addition only 56% of items are returned within 24 hours, both underperforming metrics are addressed monthly via the contract service review meetings. Refurbishment of the decontamination machines is planned for late 2026, expected to support improving defect figures.

16.2 Endoscope Decontamination Units (EDUs)

The EDUs across the Trust continued to provide satisfactory, compliant, and accredited levels of service to all sites. All Endoscope Decontamination Staff are fully trained and competent with all new systems and processes (verified as part of the JAG Audit and the Independent Authorising Engineer (Decontamination) (AE(D) Institute of Healthcare Engineering and Estates Management (IHEEM) Annual Compliance Audit process). Certification remains in place with the Joint Advisory Group (JAG).

Endoscope to patient tracking was identified as a risk July 2025 with 67% compliance across MFT. Tracked through the Trust Decontamination Group and escalated to the Trust Infection Control Committee, a working group has been created and in Q4 a significant improvement has been realised, averaging 97% compliance across all sites. A further awareness campaign and including scope tracking into the theatre

EPR op time module is planned to see greater compliance.

16.2.1 **ORC EDUs (MRI, OPD, ETC & Endoscopy)**

The washers, driers and Reverse Osmosis systems for these units are supplied on a lease and maintained by Getinge and Envirogen, the two machine manufacturers. Getinge also provides validation and water sample testing for these services. This has been a successful contract with all machines maintained and regular timely water sample reports.

16.2.2 **WTWA EDUs (Withington, Wythenshawe & Trafford)**

Wythenshawe was designated a centre of excellence for Endoscope decontamination in January 2024 by Gentige Ltd serving a primary reference site. Withington EDU is the only EDU with different washers and Reverse Osmosis (RO) water system than the rest of MFT, the water system has again been challenging during 2025. The WCH management team have attempted to address concerns with the supplier. However poor performance is still experienced leading to a project to install a new water system from an alternative supplier. This has been reviewed by the Trust Decontamination Lead and Senior Leadership Team for WTWA Theatres. The plan is to replace the current system with a smaller in-situ RO, aligning with the main supplier for MFT who provides exceptional service levels. The in-situ system will increase reaction time by operational staff. A capital bid has been submitted as a cost saving over the reliance on single use Cystoscopes.

16.2.3 **NMGH EDU**

The unit has continued to perform well under MRI management. There was an isolated incident of a contaminated scope being used to treat a patient. This was thoroughly investigated following the HILA process and several recommendations have been identified for all Endoscope Decontamination facilities.

16.3 Pathology & Laboratories

The laboratory Sterilisers for ORC and Wythenshawe hospital were regularly tested and validated accordingly. However, HSE reported concerns with the CBS1 steriliser tests at ORC early 2025. This was reviewed by the Decontamination Lead and Authorising Engineer (Decontamination). New test protocol enacted and issues highlighted by HSE now resolved.

16.4 Domestics & Room Decontamination

MFT operates two methods of room decontamination supplied by Inivos a commercial provider. These methods are Vaporised Hydrogen peroxide (HPV) and UltraViolet light (UVc).

16.5 Local Decontamination (TV/TOE Probes & In-situ decontamination)

Cardiac TOE probes: At Wythenshawe CTCCU, these are decontaminated using an automated UVc system. MRI Echo Hub, MRI Theatres and NMGH Cardiology currently use a wipe-based system. Cardiology SLT has been advised to consider automated decontamination and is exploring this option.

Ultrasound and Gynaecology TV probes: These currently follow a three-step wipe decontamination process, approved as an improvement in early 2025. The Senior Leadership Team (SLT) is considering a business case for an automated UVc cabinet for TV and TOE probes.

Expansion of UVc units: Following the success of the three UVc decontamination cabinets installed at NMGH in 2024, ENT has installed a further six units across the Trust.

16.6 Laundries

MFT uses two external linen providers: Ellis (serving ORC and Wythenshawe) and Synergy Linen Management Services (serving NMGH, Trafford Hospital, Withington

Community Hospital, and Altrincham Hospital).
Both providers comply with HTM01-04 and BS EN 14065:2016 standards for linen decontamination and microbiological quality. MFT receives and reviews monthly reports from each provider through the Facilities management team.

16.7 LCO Dental Practices

Decontamination is limited to community dental practices, using benchtop washer disinfectors and sterilisers. In 2025, equipment failures posed challenges, but capital investment was approved and replacement began. By Q4, all sterilisers and a third of the washer disinfectors were replaced. The risk score dropped from 20 to 16, remaining until full equipment replacement.

16.8 Training & Competency

In May 2024 NHSE released the technical bulletin (NETB/2024/1) version 2.0
. MFT continues to work towards compliance with this bulletin and is on track to satisfy the requirements by the 2029 deadline.

16.9 Regulation Compliance

The Trust Decontamination Group (TDC). Continues to oversee risks, incidents and policies related to Decontamination on behalf of TICC. The group is a strategic level group to govern Decontamination compliance and processes across MFT, it is well represented by all DoNs, is chaired by the Trust Decontamination Lead and supported by the Deputy DIPC and Associate Medical Director and ADN, IPC/TV.

16.10 Risks

MFT/002842 Decontamination risk remains under TDC review.
MFT/007404 Instrument tracking and traceability increased to 16 after endoscope tracking gaps. Q4 improvements may support reduction in Q1.
MFT/006680 TOE probe decontamination remains constrained by limited automation. Additional systems are being pursued. Ultrasound has moved to a three-step wipe process as an interim control pending automation. Business case approval is outstanding.
MFT//007893 DSD instrument wash checks were escalated following a patient harm incident. Staffing redeployment is planned.
MFT/006251 Obsolete dental decontamination equipment, replacement is in progress and due by end of Q2.

17. Training and Education

17.1 Respiratory Protective Equipment (RPE) Training

In line with IPC Board Assurance Framework requirements, local Hospitals/MCS maintain fit-testing records on the central Kallidus Learning Hub, where competencies are also recorded. During 2025/26, the IPC team delivered quarterly fit-test trainer sessions, with additional training at all MFT hospital sites provided by external accredited companies and recharged to Clinical Groups. National guidance requires all staff who use FFP3 respirators to be fit tested every two years on at least two different mask types to avoid reliance on a single brand.

17.2 Infection Prevention and Control policies

The team updated infection prevention policies and education programs to strengthen patient safety and support the healthcare organisation in maintaining high standards of care. This included reviewing current guidelines, aligning procedures with evidence-based best practices, and introducing updated protocols for hand hygiene, aseptic non-touch technique (ANTT) cleaning procedures, and infection surveillance. Education sessions, workshops, and refresher training were delivered to improve awareness and ensure consistent compliance across all departments. The IPC team also developed accessible educational resources and provided ongoing support to

colleagues, helping to promote a culture of accountability, reduce healthcare-associated infections, and ensure the organisation remained compliant with regulatory and accreditation requirements.

17.3 Focus on practice

17.3.1 The IPC/TV team participated in the World Health Organisation's Hand Hygiene Day on 5th May and visited clinical areas across the Clinical Groups during that week with the lightbox, encouraging both staff and visitors to participate. This formed part of a sustained year-round focus on hand hygiene, with ongoing promotion of correct hand hygiene practice, reinforcement of the 5 Moments for Hand Hygiene, and continued education and visibility campaigns across clinical areas to support safe care and reduce infection risk**.**

17.3.2 International Infection Prevention Week ran from 19-25th October 2025, where general IPC practices were the focus including – 'Gloves off' campaign updates, information on healthcare associated infections and quizzes. Feedback for both events was positive from both colleagues and visitors across the organisation.

17.3.3 Various organisation-wide events were held throughout 2025/26, including ward and departmental managers' study days, healthcare support workers' study days, and the annual IPC summit, 'Strengthening IPC: Lessons Learned, Success Stories, and Future Challenges'. This also included delivery of MRSA-specific education and sharing of education on decolonisation therapy to strengthen assurance around targeted prevention, support consistent practice in high-risk areas, and reduce the risk of MRSA transmission and bacteraemia.

17.3.4 IPC mandatory training modules were revised to reflect national guidance and support a consistent approach across the organisation. This has strengthened alignment with current standards and provided clearer direction for colleagues in meeting required training expectations. Ongoing oversight will help ensure compliance levels are maintained and any further updates are implemented in a timely way.

17.4 Additional Training and Education

17.4.1 The IPC/TV team provided induction training to new starters across the organisation and provides e-learning annual updates developed in line with national standards. In addition to these, bespoke sessions in both IPC and TV were also delivered, including

- Internship programme students
- Student nurses
- Spoke days for student nurses
- Bespoke sessions in response to increased incidence of HCAI's, outbreaks or as required
- IPC and Tissue Viability study days
- Planned IPC updates arranged locally
- Care home colleagues
- Practice nurses and GP's
- Age UK staff
- Activity camp children
- General public within a library setting

17.4.2 Delivery of the MFT IPC and TV education strategy is assisted by representatives from companies whose products are used across the Community and Acute MFT settings. Their support is integral to MFT delivering local and national strategies for IPC and TV through both induction of new colleagues to the organisation or ongoing support of existing MFT employees.

17.5 Infection Prevention and Control and Tissue Viability Team Development

17.5.1 In addition to the training and education that the IPC/TV team provide across MFT, we also recognise the importance that we invest within our own team. By strengthening our own knowledge and skills we can ensure our education and training delivery across the organisation aligns with national standards thereby supporting the organisation to deliver safe and effective care to our patients and their families.

17.5.2 Examples of types of education and training undertaken by the team include a wide range of wound care and infection prevention conferences and study days, leadership and management courses and Masters modules and pathways. These have been delivered by both internal and external providers across the community, acute and higher education establishments and supports the dissemination of relevant research-based practice.

17.6 Hive Update

Digital systems play a crucial role in supporting IPC across the organisation. Hive is integral to service delivery, and our focus is on continually developing functionality to help clinical teams deliver quality care, including IPC Dashboards, infection reports, internal messaging systems direct to clinical teams and HCAI surveillance.

17.7 Clinical Group Review

The Hospital/MCS/LCO have prepared and submitted an overview of Infection prevention activities undertaken within each of the Clinical Groups this year, meetings with the DIPC were facilitated throughout April 2026.

18. Conclusion

In summary, this year's Infection Prevention and Control activities have shown progress in protecting patients, meeting national standards, and promoting continuous improvement. Performance indicators remain aligned with best practice, and the effective management of both routine and emerging risks highlights the strong commitment of staff and leadership to delivering high-quality care.

Looking ahead, the focus will be on proactive risk management, strengthening data-led surveillance, and embedding learning from incidents and audits into routine practice. Key priorities include improving antimicrobial stewardship, enhancing colleague training and engagement, optimising environmental hygiene, focussed education to support MRSA reduction and further integrating IPC within organisational resilience planning.

The Public Board of Directors can be assured that infection prevention remains a priority, supported by robust governance, evidence-based practice, and a forward-looking approach to improving patient and colleague safety.

18.1 Recommendations

Note the information provided in the Executive Summary and
Accept the Infection Prevention and Control Annual Report for 2025/2026.

Strategic objectives (Key)

Work with partners to help people live	**LHL objective 1**	Work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.

longer, healthier lives	**LHL objective 2**	Improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so people are cared for in the most appropriate place
Provide **high quality, safe care** with excellent outcomes and experience	**HQSC objective 1**	Provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience and outcomes wherever they are seen.
	HQSC objective 2	Strengthen our specialised services and support the adoption of genomics and precision medicine
	HQSC objective 3	Continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.
Be the place where **people enjoy working**, learning and building a career	**PEW objective 1**	Make sure that all our colleagues feel valued and supported by listening well and responding to their feedback. We will improve staff experience by embracing diversity and fairness, helping everyone to reach their potential
	PEW objective 2	Offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here
Ensure **value for our patients** and communities by making best use of our resources	**VfP objective 1**	Achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.
	VfP – objective 2	Deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships
Deliver world-class **research & innovation** that improves people's lives	**R&I – objective 1**	Strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part
	R&I – objective 2	Apply research & innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide
Good governance	**GG**	Deliver a safe, legally compliant and well run organisation

Appendix 1 TRUST INFECTION PREVENTION & CONTROL COMMITTEE TERMS OF REFERENCE

1. CONSTITUTION

The Quality, Safety and Performance Board Committee has established a committee to be known asthe Trust Infection Prevention and Control Committee. The committee is an executive committee and holds the powers delegated to it in these terms of reference. The Trust Infection Control Committee is chaired by the Deputy Chief Executive/Chief Nursing Officer/Director of Infection Prevention and Control.

2. Membership

2.1 Membership of Trust Infection Control Committee shall consist of:

- Deputy Trust Chief Executive Officer/Chief Nursing Officer/DIPC (CHAIR)
- Associate Medical Director Infection Control/Deputy DIPC (Deputy Chair)

- Deputy Chief Nursing Officer
- Assistant Chief Nurse, IPC & TV
- Consultant Virologists/Consultant Microbiologists (IPC medics)
- Clinical Group Directors of Nursing
- Head of Nursing IPC
- Lead Nurses Infection Prevention and Control
- Hospital/MCS Clinical Leads for Infection Control
- Consultant in Communicable Disease (Public Health England)
- Lead Antimicrobial Pharmacist
- Director of Estates and Facilities
- Assistant Director, Employee Health & Wellbeing
- Chair of Antimicrobial Stewardship Committee

2.2 The Committee may require the attendance of any Trust employee (or agent of the Trust) as required.

2.3 A quorum shall consist of a minimum of ten members including the Chair or Deputy Chair; four Clinical Group Leads and either the Deputy Chief Nursing Officer or Assistant Chief Nurse (IPC/TV)

3. ATTENDANCE AT MEETINGS

Members are expected to attend at least five meetings per year.

4. FREQUENCY OF MEETING

The Committee will meet every two months (six times a year) but may be convened at other times as deemed necessary. With prior agreement from the chair, well briefed deputies may attend by exception.

5. OVERVIEW

The Committee will set the strategic direction for infection prevention and control and seek assurance on an exception or as required basis

The Committee is responsible for developing the group organisational strategy and clinical standards for infection prevention and control in line with national/international evidence-based practice and standards.

6. SCOPE AND DUTIES

The scope and duties of the Committee are

6.1 To provide strategic leadership for infection prevention and control, including identifying priorities and setting performance targets

6.2 Develop the strategy and agree the clinical standards for infection prevention and control across all the Trust sites

6.3 Approve the programme of work of the Trust Infection Prevention and Control committee

6.4 Receive Clinical Group/MCS IPC escalation and assurance reports

6.5 Receive, review and ratify Trust policies, clinical pathways and reports including the Annual Infection Control report

6.6 Approve the annual audit calendar to provide assurance that standards are met and any changes to practice, systems and processes are delivered.

6.7 To report to the Quality, Safety and Performance Board Committee on performance against infection control indicators and audits, including any actions taken to address areas of improvement.

6.8 To determine and commission programmes of work required to deliver the work programme of the committee

6.9 Oversee the Trusts involvement in and response to internal and external assessments and inspections

6.10 Agree the education and training framework for infection prevention and control for the Trust, ensuring compliance with the infection prevention and control standards

6.11 Approve the Trusts annual Infection prevention and Control annual report

6.12 To describe, review and monitor the principle significant risks related to Infection control on behalf of the Trust and present these with a plan to the Quality, Safety and Performance Board Committee and Quality and Safety Management Committee.

6.13 The Committee will receive escalation and assurance reports from the Clinical Groups/MCS Infection Control leads.

6.14 The Committee will receive at each meeting a report including

- Policy and pathway development
- Infection Control group activity
- Any changes to national/local strategy
- Any Trust wide themes from adverse incidents or events

7. AUTHORITY

The committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

8. REPORTING

The committee will report to the Quality, Safety and Performance Board Committee and will provide assurance to the Board of Directors in relation to infection prevention and control. Minutes and escalation reports will be provided as requested.

9. REVIEW

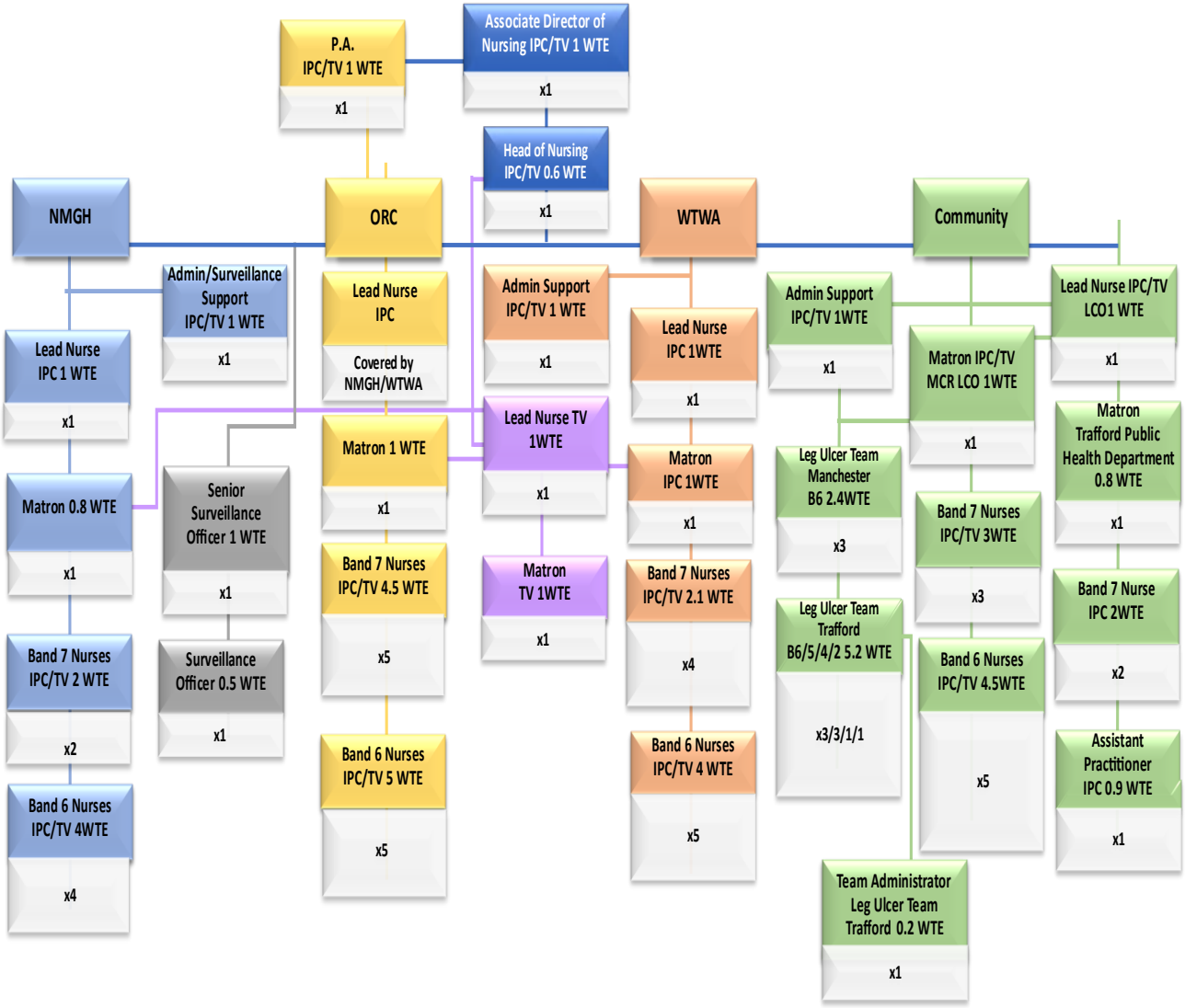
These Terms of Reference will be reviewed annually

10. Key Performance Indicators

These Terms of Reference will be considered against the following key performance indicators

- 75% attendance of all listed members or nominated deputies
- Presentation of the Infection prevention and Control Annual Report

Appendix 2 MFT IPC/TV Nursing Team Structure 2025/26 including whole time equivalent (WTE)



Appendix 3 Health Care Associated Infections Positional Charts

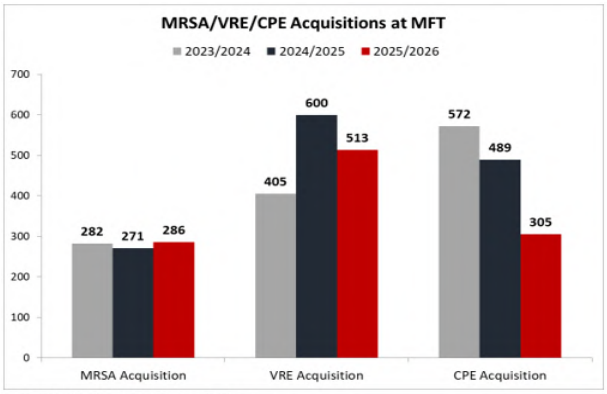


Chart 1: MRSA/VRE/CPE Acquisitions

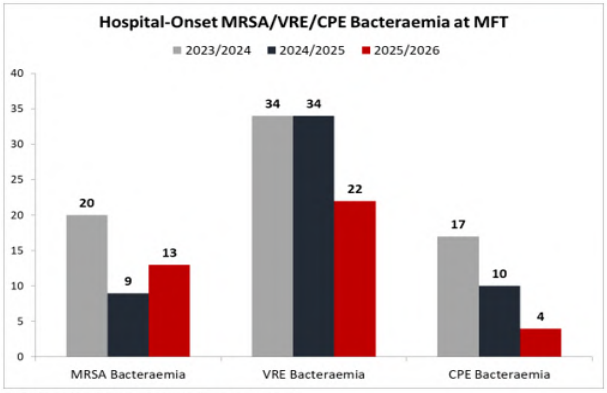


Chart 2: MRSA/VRE/CPE Bacteraemia cases

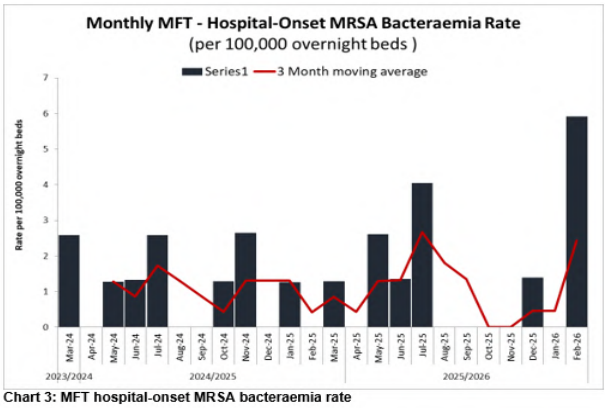


Chart 3: MFT hospital-onset MRSA bacteraemia rate

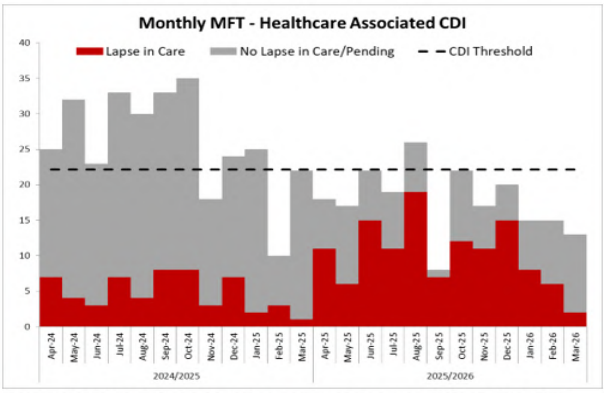


Chart 4: Monthly healthcare-associated CDI with Lapse in Care status and trajectory

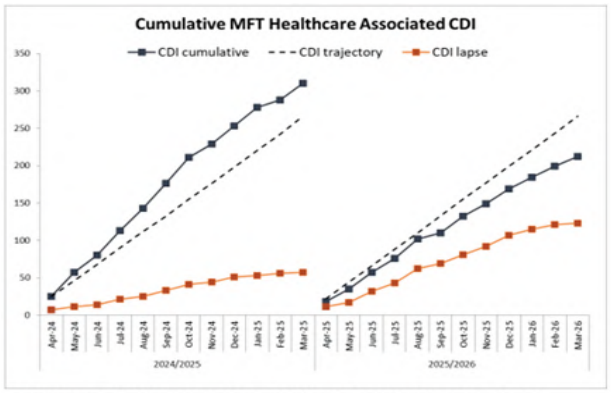


Chart 5: Cumulative healthcare associated CDI with lapse in care and trajectory

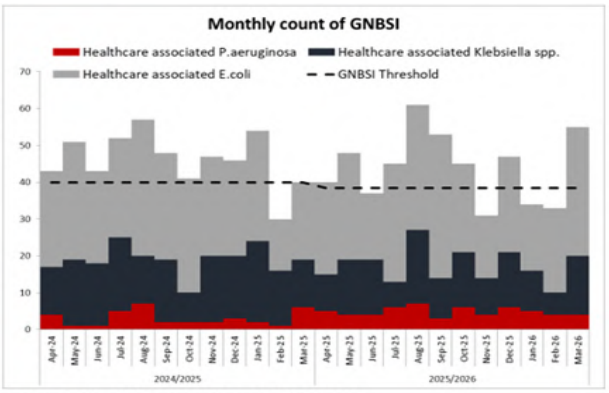


Chart 7: Monthly healthcare associated GNBSI cases

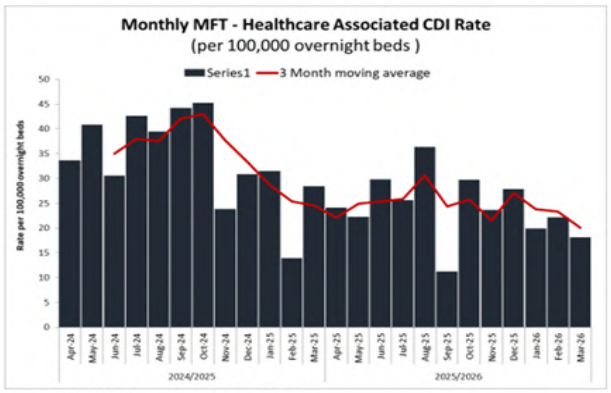


Chart 6: MFT healthcare-associated CDI rates

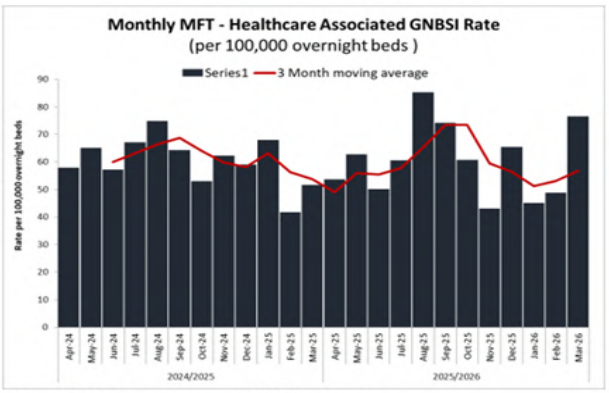


Chart 8: MFT healthcare associated GNBSI bacteraemia rates

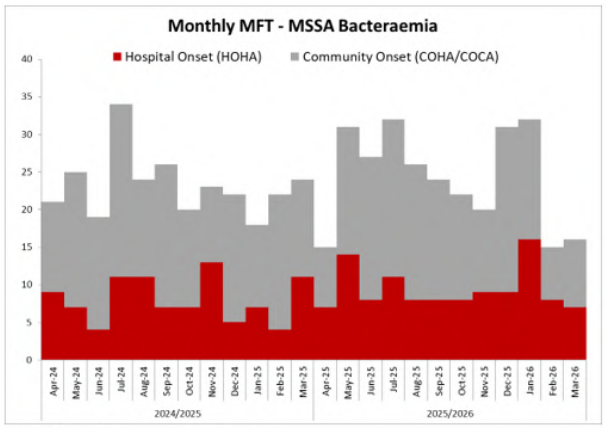


Chart 9: Monthly MSSA cases by onset

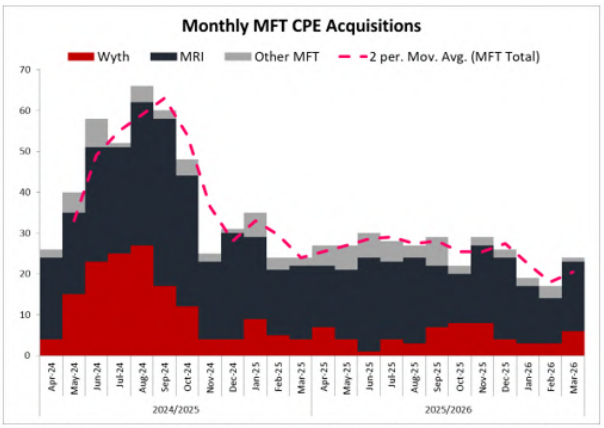


Chart 11: Monthly CPE acquisitions for MRI, Wythenshawe Hospital and other MFT

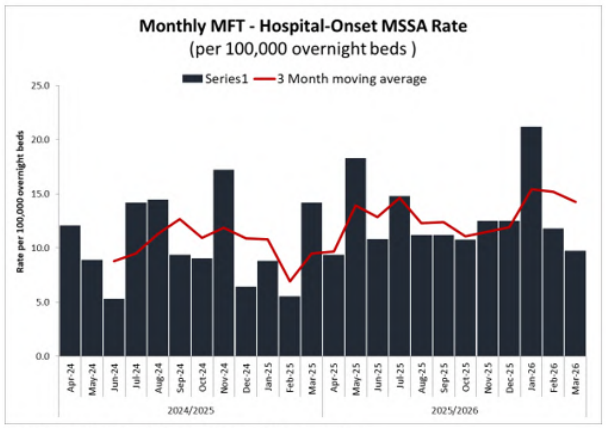


Chart 10: MFT hospital-onset MSSA bacteraemia rate

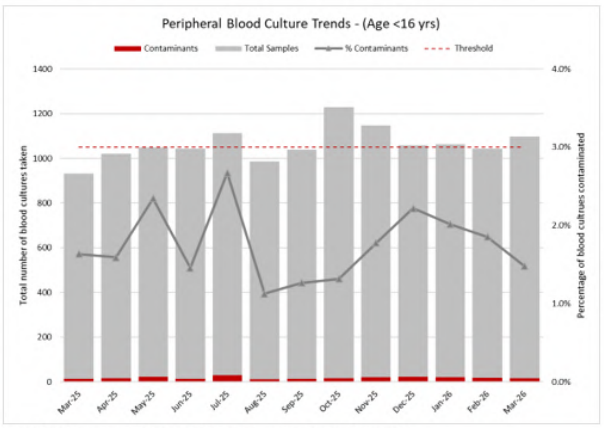


Chart 12: MFT-wide peripheral blood culture trends (<16 yrs)

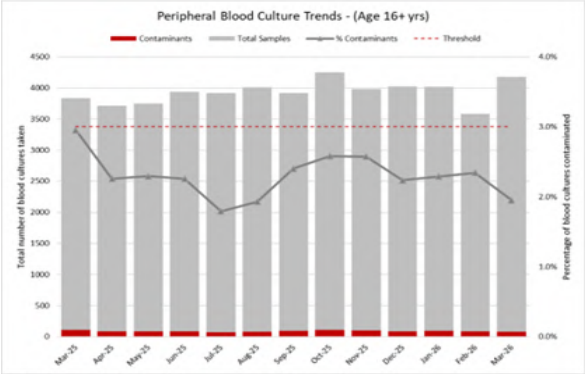


Chart 13: MFT-wide peripheral blood culture trends (>16 yrs)

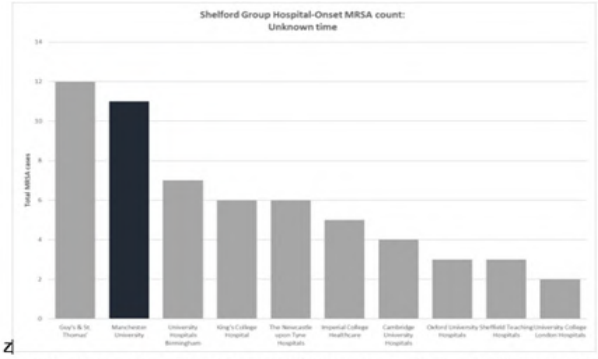


Chart 15 – Shelford Group hospital-onset MRSA bacteraemia rates (per 100,000 overnight beds)

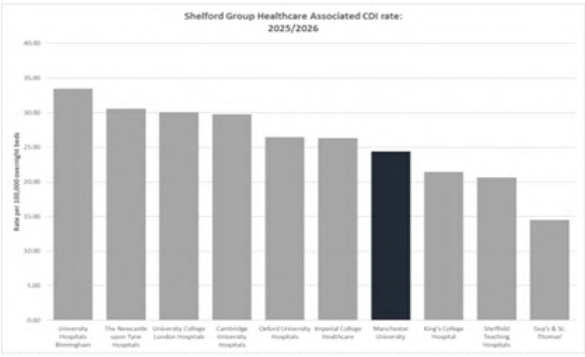


Chart 14 – Shelford Group healthcare associated CDI rates (per 100,000 overnight beds)

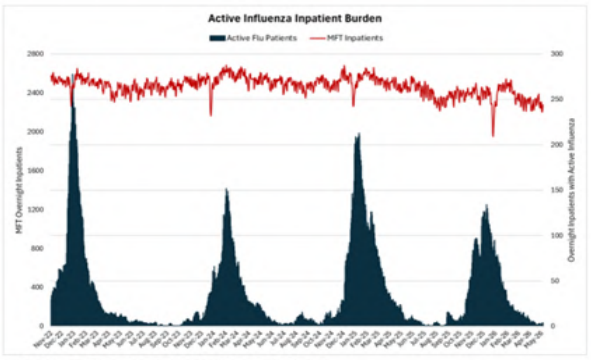


Chart 16 – MFT Population vs Active Flu Patients

Manchester University NHS Foundation Trust

Escalation and Assurance Report
People Board Committee (PBC)

Report to: Board of Directors
Report from: Angela Adimora, Non-Executive Director and Chair of PBC
Date of meeting: 30/06/26

Key escalation and discussion points from the meeting
Alert
The Committee received the Integrated Performance Report noting that the **Trust's staff sickness absence** had increased to 6%, following the previous positive downward trend outside of winter pressures. Clinical group monitoring continues to provide appropriate staff support, with work being trialled in North Manchester to further strengthen sickness absence management support. The continual decline in the **Agenda for Change staff appraisal** compliance rates, was also reported relating to frontline operational pressures. The Trust is progressing a new learning management system and appraisal platform to support a simpler appraisal process, alongside engagement with the developing NHSE appraisal framework.
Advise:
The Committee received the Integrated Performance Report noting that **Levels 2 and 3 mandatory training** compliance continues to improve at 89.93% however remains slightly below the 90% target rate. Key improvement areas include resuscitation, moving and handling and Aseptic Non-Touch Technique, with further reporting to TLTC and continued clinical leadership support required to support consistent compliance. The **Substantive WTE** position was also reported with the need for clearer assurance on baseline figures, in-year changes and alignment with previous planning projections being requested. A detailed workforce performance-to-plan pack will be reported at the next Committee meeting to further support understanding of the baseline WTE position and any funded service changes. **Chief People Officer's report:** The Committee noted updates on the Lord Mann Review, the Equality and Human Rights Commission draft Code of Practice on the definition of sex, NHSE Workforce Oversight meeting and the Trust's positive position in comparison to other Foundation Trusts, SEQOSH accreditation being successfully achieved for the Trust's Employee Health and Wellbeing service, forthcoming immigration policy changes and the ongoing success of the Trust's Ignite - Equality, Diversity and Inclusion (EDI) conference. Recommendations on the Lord Mann Review will be submitted to the Board of Directors for formal decision. **Collective Leadership and Culture programme:** The Committee noted progress with the programme, including the launch of the Culture and Staff Engagement Forum, development and progress of the 22 culture recommendations, continued support of the Change Agent Network and the clinical group cultural elements focused on psychological safety, autonomy and leadership visibility/accountability. Future updates will include digital and alternative engagement channels, links with Ignite EDI event learning and how culture work translates into patient outcomes. **Maternity culture and national reports:** Following further cultural work (October 2025), early outputs include workforce metric improvements in turnover and vacancy rates, with St Mary's Managed Clinical Service continuing to embed leadership and culture work into normal clinical practice with regular Senior Leadership walkarounds being undertaken to talk to staff and discuss working practice/environments.

Committee noted the need to map assurance routes and timescales for maternity culture work, including Ockenden and Baroness Amos gap analysis, across QSPBC and People Board Committee to support appropriate assurance processes.

Workforce operations: The Committee received updates on Payroll, Recruitment, Employee Relations and Job Evaluation. Payroll performance remains within service level agreements, with cost per payslip improvements being realised and overpayments reduced. Recruitment activity remains high, with approximately 12,500 vacancies and 6,600 conditional offers being managed over the previous 12 months, with the Greater Manchester Collaborative Recruitment Hub continuing to be an important programme of work being progressed. Future Payroll reporting will include underpayments and resolution timelines, with future Job Evaluation updates including the ongoing phasing and progress against the 11,500 nursing and midwifery job role review programme. The Trust has published anonymised employee relations data to support openness, fairness and transparency in relation to casework themes and outcomes with the Trust's Employee Relations Oversight Group ensuring processes remain fair and equitable to all staff.

Employee Wellbeing: The Committee noted progress on the preventative wellbeing strategy and the mapping of vaccination, immunisation and infection management processes. Assurance was received that necessary infection management actions are being undertaken, with improvement recommendations being progressed through the Workforce Education and Management Committee.

Rewards and Recognition: The Committee noted the development of the Trust-wide Recognition Framework and proposed MFT Annual Staff Awards Event. Further work will map existing local staff recognition activity and consider developing categories linked to innovation, sustainability and research.

Freedom to Speak Up: The Committee received the Quarter 4 and the Annual Freedom to Speak Up (2025/26) reports, noting 123 concerns received in Quarter 4 which is in keeping with the Trust's size, with an overall total 382 concerns received during 2025/26. The continued increase in speaking up activity, the 99.4% initial response rate within two working days, strengthened reporting by protected characteristic and further work to improve oversight of detriment and concern resolution times was reported.

Guardian of Safe Working: The Committee noted the Quarter 4 Guardian of Safe Working report, which included increased exception reporting following national changes introduced in February 2026. There were 24 immediate safety concerns relating to 18 shifts, the vast majority being linked to additional hours and addressed through pay or time off in lieu. A comprehensive update on the Obstetrics and Gynaecology NMGH review and NHSE monitoring position will be provided at the next meeting.

Learning and Development: The Committee noted progress with implementation of the Trust's new learning management system and appraisal platform. Mandatory training Levels 2 and 3 compliance was 89.93% (June 2026) and continues to improve, remaining slightly below the 90% target rate. Future updates will include National Education and Training Survey (NETS) improvement actions and potential innovation in data capture, accuracy and participation.

Improving Resident Doctors' Working Lives: The Committee noted progress against the NHSE 10-point action plan, following detailed consideration by the Board of Directors. The programme continues to be tracked through the relevant governance routes with regular updates being provided to the Committee.

Assure:

The Committee received assurance through the Integrated Performance Report that **Trust-level Level 1 mandatory training** compliance remains above 95%. **Bank WTE** has reduced significantly following grip and control work, with impact assessments informing future requirements. The Committee noted that this reduction is not expected to be fully sustainable and provides a useful basis for future optimisation. **Agency WTE** use had reduced to a small number of long-term agency workers, with clear exit strategies in place and specific departmental requirements identified in relation to Maxillo-facial and Biomedical Sciences. **Turnover** continues to decrease, reaching 8%, which was a positive position in comparison with Greater Manchester benchmarks.

Bi-annual safer staffing report – nursing and Allied Health Professionals: The Committee received the bi-annual safer staffing report and was assured that nursing services across the Trust remains compliant with national safer staffing guidance. The annual comprehensive establishment review confirmed that safer staffing establishments had been maintained across all inpatient ward areas, following the realignment of funded establishments within clinical groups. Progress was also noted with the revised Trafford District Nursing workforce model, including completion of the service reconfiguration in February 2026 and the commencement of a two-phased recruitment process for an additional 16.33 WTE. The Committee noted the potential risk of an annual pay bill increase of between circa. £9m and circa. £12.3m, arising from the review of Band 5 job descriptions during 2026/27.

Bi-monthly safer staffing report – midwifery and newborn services: The Committee received the Specialist Midwifery, Maternity and Neonatal report in line with national safer staffing guidance and was assured of continued compliance. Supernumerary labour ward coordinator compliance remained at 100%, and one-to-one care in labour continued to be maintained at just under 100%. The Committee noted the changes required in line with MIS Year 8, continued compliance with relevant MIS safety actions, and progress towards QIS compliance, particularly on the Oxford Road Campus site. The actions being taken to improve sickness and absence performance were also noted.

Risks discussed at the meeting

Workforce Strategic and Corporate risks: The Committee reviewed the updated workforce risks, including the new strategic risk relating to workforce experience, wellbeing and engagement and the strategic risk relating to delivery of the 1,188 WTE workforce reduction. The workforce systems risk reclassified to the Corporate Risk Register was noted and that Board Assurance Framework alignment had been strengthened. The Committee discussed the current level of assurance on the 1,188 WTE reduction, noting that approximately 500 WTE reductions had been identified to date and that further scheme maturity is required with future reports to provide an updated assurance position including delivery maturity.

Sickness absence and wellbeing: The Committee noted sickness absence as an area of ongoing risk, including the increase to 6% (Integrated Performance Report) and the higher anxiety, stress and depression sickness absence rate reported in maternity services. A further review will be undertaken to consider whether additional staff wellbeing support is required in the context of national scrutiny and forthcoming gap analysis reports (Ockenden and Baroness Amos).

Report approved by: Angela Adimora, Non-Executive Director and Chair of the People Board Committee

Manchester University NHS Foundation Trust

People Board Committee

Date: Tuesday, 30th June 2026
Time: 2:00pm – 4:00pm
Location: Virtual – MS Teams

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	2:00pm
2.	**Declaration of interest** (verbal)	Meeting admin	Chair	
3.	**Minutes of the previous meeting** Tuesday 21st April 2026	Meeting admin	Chair	
4.	**Action Log**	Discussion	Chair	
5.	**Matters Arising**	Discussion	Chair	
6.	Staff story (film)	Discussion	Chief People Officer	2:05pm
7.	**Assurance Reporting:**			
7.1	Integrated Performance Report.	For noting	Deputy Chief People Officer	2:10pm
7.2	Strategic Risks	Approval	Deputy Chief People Officer	2:15pm
Strategic aim 3: Be the place where people enjoy working, learning and building a career				
8.	Chief People Officer report	Discussion	Chief People Officer	2:20pm
9.	Collective Leadership and Culture programme.	Discussion	Director of OD & Inclusion	2:30pm
10.	Maternity culture work update.	Discussion	DCE / Chief Nursing Officer	2:40pm
11.	Workforce operations: 11.1 Payroll 11.2 Recruitment 11.3 Employee Relations 11.4 Job Evaluation	Discussion	Director of Workforce Transactional Services- 11.1 &11.2 Director of People 11.3 & 11.4	2:50pm

12.	Employee Wellbeing	Discussion	Director of People	2:55pm
13.	Rewards and Recognition	Discussion	Deputy Chief People Officer	3:00pm
14.	Freedom to Speak Up 14.1 FTSU Quarterly Report (Q4) including Communications Strategy update. 14.2 FTSU Annual Report	Discussion	Freedom to Speak Up Guardian	3:15pm
15.	Guardian of Safe Working Quarterly Report (Q4).	Discussion	Chief of Staff	3:20pm
16.	Learning and Development Update	Discussion	Director of Learning and Development	3:30pm
17.	Improving Residential Doctors' working lives - 10-point plan.	Discussion	Chief of Staff	3:35pm
18.	Bi-annual safer staffing report (Nursing and AHP).	Discussion	DCE / Chief Nursing Officer	3:40pm
19.	Bi-monthly 'Safer Staffing' report (midwifery and newborn services).	Discussion	DCE / Chief Nursing Officer	3:45pm
Committee business				
20.	**Escalation report.**	Approval	Chair	3:50pm
21.	**Workplan review.**	Meeting admin	Chair	3:55pm
22.	**Any Other Business** (verbal).	Discussion	All	3:55pm
23.	**Meeting Evaluation** (verbal).	Meeting admin	Chair	3:55pm

Date of next meeting: Tuesday, 25th August 2026 at 2.00pm – format to be confirmed.

Papers for Information

- Workforce Education and Management Committee Escalation Report

Manchester University
NHS Foundation Trust

Public Board of Directors
Thursday 30th July 2026

Paper title:	Freedom to Speak Up (FTSU) Annual Report	**Agenda Item 12.2**
Presented by:	Darren Banks, Interim Deputy Chief Executive	
Prepared by:	Andrew Lloyd, Head of FTSU Zakira Takolia, FTSU Guardian	
Meetings where content has been discussed previously	People Board Committee 30 June 2026 Workforce Education & Management Committee 3 June 2026	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

This report provides an overview of the Freedom to Speak Up (FTSU) service at Manchester University NHS Foundation Trust (MFT) for the period 1 April 2025 to 31 March 2026. The service continues to play a critical role in enabling colleagues to raise concerns, contributing to improved patient safety, worker experience, and organisational learning.

During 2025/26, 382 concerns were raised through the service, representing an 8.9% increase on the previous year and sustained growth over recent years. This reflects prior investment in the service and increased engagement activity, bringing reporting levels closer to expected benchmarks for organisations of comparable size.

Worker Safety and Wellbeing remained the most frequently reported theme, followed by inappropriate attitudes and behaviours, and bullying and harassment. These themes highlight the continued impact of workplace culture, leadership behaviours, and organisational pressures. Concerns often described the cumulative effect of incivility, workload pressures, and the emotional impact of raising concerns locally without perceived resolution.

The FTSU Champion network has continued to expand, with 161 active Champions exceeding the Trust target ratio. Engagement has increased significantly, with over 140 events delivered to improve accessibility and awareness across the organisation.

While MFT staff survey results concerning Speaking Up remain above national averages, there has been a slight decline year-on-year, reinforcing the need to strengthen leadership capability, improve feedback mechanisms, and embed a culture of psychological safety.

Priorities for 2026/27 focus on improving consistency, enhancing anonymous reporting, strengthening inclusion, and ensuring that concerns lead to timely and meaningful action.

Recommendation(s)

The Board of Directors is asked to:

- Consider the contents of the report.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)			
LHL objective 1	☐	LHL objective 2	☐
HQSC objective 1	☒	HQSC objective 2	☐
HQSC objective 3	☒	PEW objective 1	☒
PEW objective 2	☐	VfP objective 1	☒
VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic/corporate or operational risks: • N/A	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☐ Effective ☒ Responsive	☒ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • N/A	

Main report
Please see attached report.

MFT Freedom to Speak Up Annual Report 2025/2026

Freedom to Speak Up Executive Lead foreword

Our Freedom to Speak Up (FTSU) Annual Report for 2025/26 gives a clear view of the experiences of colleagues across MFT, and the progress we are making to build a culture where people feel able and supported to Speak Up.

Over the past year, we have strengthened the visibility and reach of the FTSU service across the organisation. As a result, more colleagues are coming forward, and we continue to see a steady increase in concerns raised. This is positive. It reflects growing confidence that Speaking Up will lead to action and brings us more in line with expectations for organisations of our size.

The report also shows how important FTSU insight is in helping us understand where we need to improve. Themes around leadership, culture, and day-to-day experience remain consistent, underlining the need for compassionate, responsive leadership at every level.

We are also seeing more colleagues tell us they have experienced negative consequences after Speaking Up. This is a concern, and one we take seriously. While the FTSU team does not investigate these cases, the insight is shared in a structured way with senior leaders so we can understand the issues, learn from them, and take action to reduce the risk of this happening.

We have continued to strengthen our governance, with more regular engagement between FTSU Guardians and senior teams, clearer reporting through Trust committees, and improved oversight of open concerns. This helps ensure that emerging issues are visible early and addressed promptly.

We are also improving how we understand who is using the service, so we can ensure it is accessible and inclusive for all colleagues.

Creating an environment where people feel safe to Speak Up is essential to delivering safe, high-quality care. I would like to thank our FTSU Guardian team for the professionalism, care and commitment they show to everyone who comes forward, and to the 160 FTSU Champions across MFT who contribute to safe environments for our colleagues and patients each day.

Darren Banks, Executive Lead for FTSU
and Trust Interim Deputy Chief Executive

Head of Freedom to Speak Up Introduction

This report reflects a year of significant operational progress within the Freedom to Speak Up (FTSU) service, alongside continued learning from the experiences shared by colleagues across Manchester University NHS Foundation Trust (MFT).

The previous expansion of the FTSU service has enabled a more proactive and accessible approach to engagement. Increased presence across clinical and corporate areas has supported greater awareness of the service and how it can be accessed. As a result, more colleagues are choosing to Speak Up, and we have seen a continued rise in concerns received over the past year.

From a service perspective, this increase is an important indicator. It reflects not only growing awareness but also trust in the impartiality and confidentiality of the FTSU function. It also provides a richer understanding of colleagues' experiences, enabling more informed conversations and learning at both local and organisational levels.

A key development this year has been how learning is recorded and shared. Feedback from colleagues emphasised the importance of receiving feedback after raising concerns, which informed the launch of the 'Follow Up' virtual workshop in 2025. Building on the 'Listen Up' workshop introduced in 2024, this session supports leaders to develop their practice while reflecting on anonymised feedback shared with the service.

Learning from concerns has also informed strategic discussions at Trust-level groups focused on improving colleague experience, including the Sexual Safety Steering Group and Safety and Risk Panels.

The development of a diversity monitoring approach is also improving our understanding of who engages with the service, both as a service user and team member. Anonymised data, voluntarily provided by service users, FTSU Champions and attendees at FTSU virtual training workshops, helps the team assess how well the service reflects the workforce, improve accessibility, and reduce barriers to Speaking Up.

As a confidential and impartial service, our role is to ensure colleagues' voices are heard. This report brings those voices together to support reflection, learning and continuous improvement across the Trust.

I would also like to thank the entire FTSU team, the 160 FTSU Champions, and all who work with FTSU to help make Speaking Up part of everyday practice across MFT.

.

Andrew Lloyd, Head of Freedom to Speak Up

1.0 Purpose of Report

1.1 The purpose of this report is to provide an overview of the work of the Manchester University NHS Foundation Trust (MFT) Freedom to Speak Up (FTSU) Team over the period 1st April 2025 to 31st March 2026.

2.0 Context/Background

2.1 The roles of FTSU Guardians and the National Guardian's Office (NGO) were established in 2016 following events at Mid Staffordshire NHS Foundation Trust and the subsequent public inquiry by Sir Robert Francis QC.

2.2 FTSU Guardians help protect patient safety and the quality of care, improve the experience of workers, and promote learning and improvement. They do this by ensuring that workers are supported in Speaking Up and that concerns raised are used as opportunities for learning and improvement. They work within their organisations to help ensure that barriers to Speaking Up are addressed and a positive culture of Speaking Up is fostered.

3.0 FTSU Team update

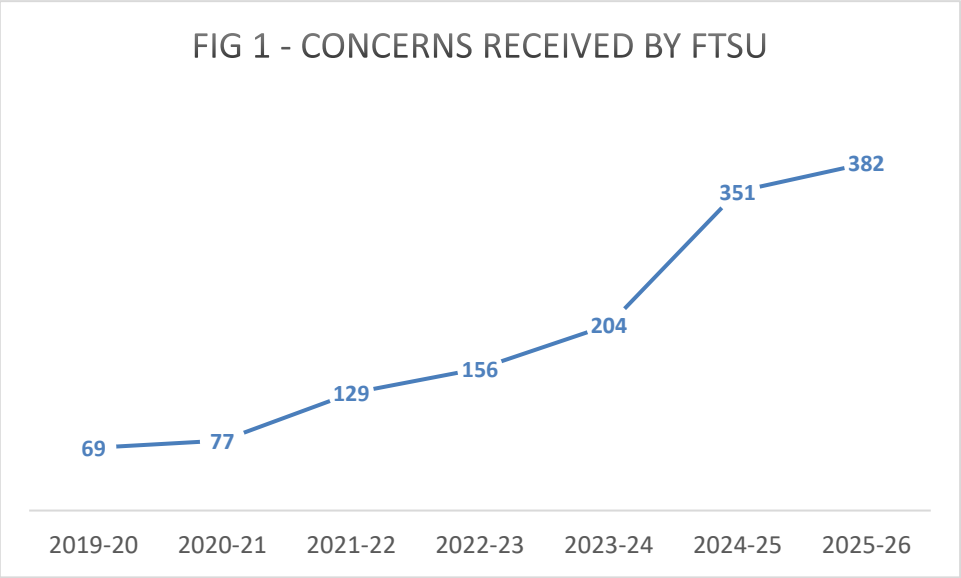
3.1 In January 2025, a member of the FTSU Guardian team left the organisation, prompting recruitment for a replacement. The post was filled through the Trust's redeployment process, and the new Guardian started in July 2026.

In December 2025, Mark Gifford was appointed as the new Non-Executive Director for FTSU, succeeding Angela Adimora, to whom the team extends its thanks for her contribution.

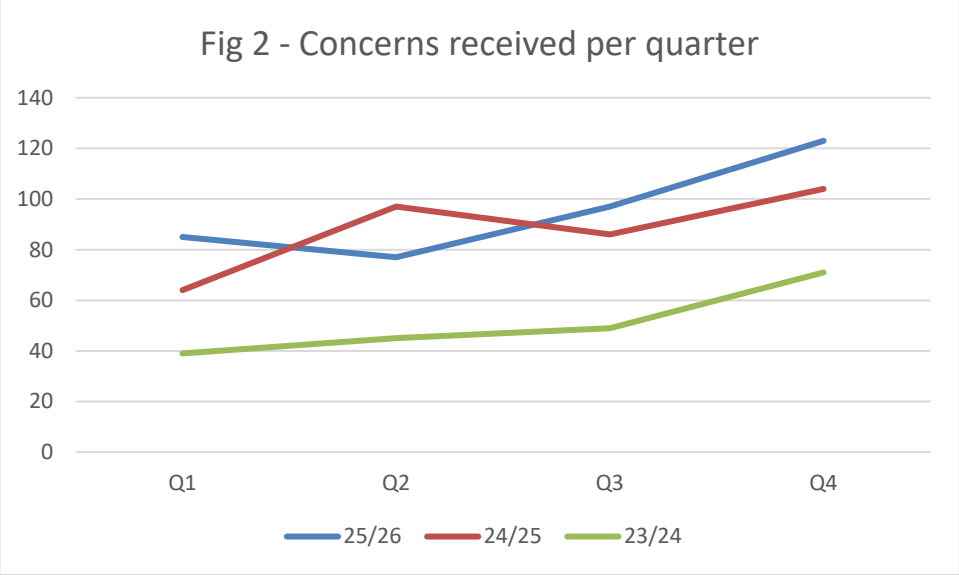
4.0 Assessment of Cases raised via the FTSU Team (Guardians & Champions)

4.1 During 2025/26 there has been an increase in the number of concerns raised via FTSU. As detailed in figure one, 382 concerns were reported to the FTSU Team during this period, an 8.9% year on year increase and 454% increase over the past 6 years.

4.2 The expansion of the service in 2024, and associated engagement activity that this enabled now sees the organisation closer to the average number of concerns received by Shelford Group colleagues. Based on Shelford Group averages, an organisation of MFT's size receives 401 concerns per year.



4.3 Figure 2 illustrates the number of concerns which were reported to FTSU each quarter over a three-year period.:



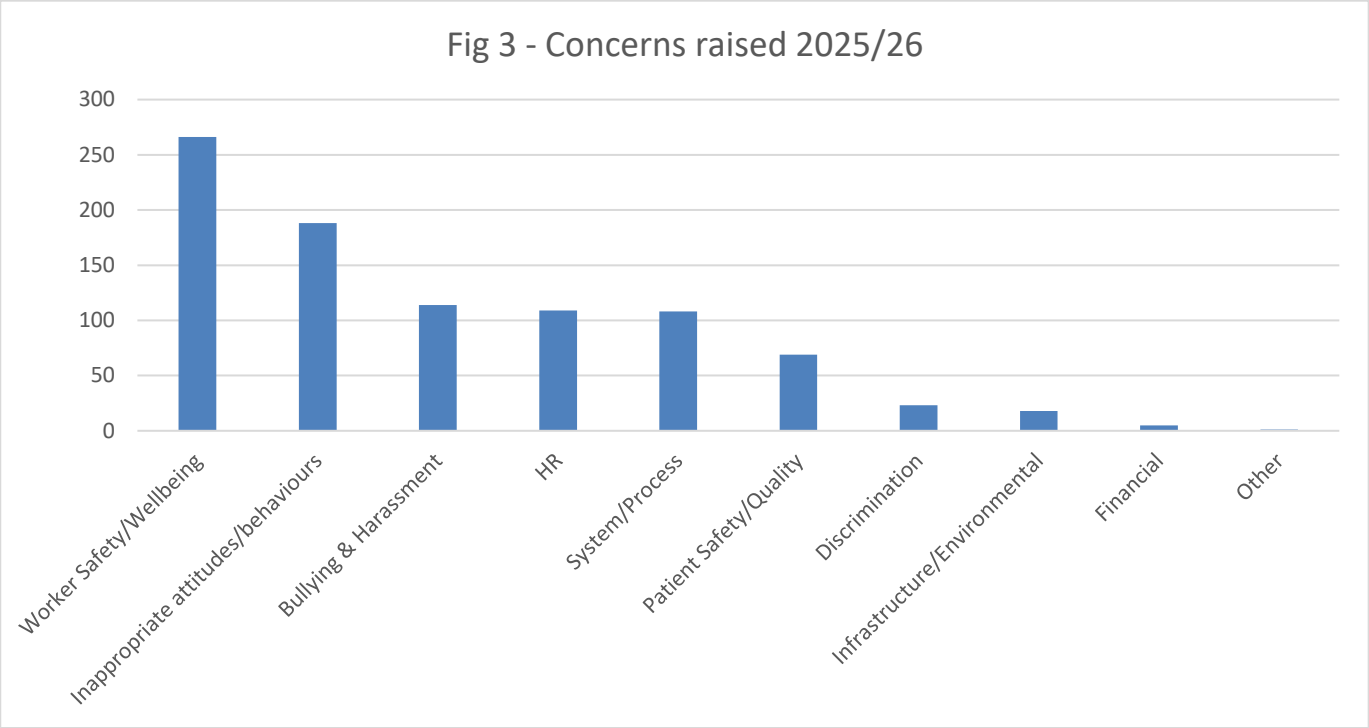
4.4 Of the 382 concerns received this year, 47 were received by FTSU Champions (12% of concerns compared to 15% in 2024/25).

4.5 When a colleague raises a concern with a FTSU Guardian, it is recorded against up to three themes given by the National Guardian's Office (NGO). The examples below reflect the perspective of the person who raises the concern.

For example, a colleague may share that the attendance management policy was applied to them more strictly after they had spoken up locally about an issue. This could be recorded as a bullying and harassment concern with possible detriment following them Speaking Up. Although the two may not be directly linked, FTSU records the concern based on the worker's account and understanding of the

situation.

Figure three shows the numbers of concerns that include each theme for 2025/26.



4.6 Worker Safety and Wellbeing remains the most reported theme, with inappropriate attitudes/behaviours and bullying & harassment remaining the second and third most reported themes.

A comparison of theme prevalence can be seen in table one.

Table 1: Comparison of thematic data 2025/26 vs 2024/26

	2025/26 Theme	%	2024/25 Theme	%
1	Worker Safety & Wellbeing	29.5%	Worker Safety & Wellbeing	26%
2	Inappropriate Attitudes/Behaviours	20.9%	Inappropriate Attitudes/Behaviours	19.3%
3	Bullying & Harassment	12.7%	Bullying & Harassment	16.8%
4	HR	12.1%	Patient Safety/Quality	10.7%
5	System/Process	12.0%	HR	10.7%
6	Patient Safety/Quality	7.7%	System/Process	9.6%
7	Discrimination	2.6%	Discrimination	4.3%
8	Infrastructure/Environment	2.0%	Financial	2.1%
9	Financial	0.6%	Infrastructure/Environment	0.5%
10	Other	0.1%		

Worker Safety & wellbeing

Across all four quarters, colleagues most often describe the impact of workplace experiences on their mental wellbeing, confidence and a sense of psychological safety, particularly where local Speaking Up had not led to meaningful change. Most colleagues who Speak Up to FTSU do so as their values and those of the Trust are challenged, which they often describe as impacting on their wellbeing.

Colleagues reported themes including:

- Unprofessional behaviours and leadership approaches leaving colleagues feeling undervalued, anxious or unsafe at work
- Workload pressures, staffing gaps, long hours, rota changes and the risk of burnout
- Stress linked to organisational change and perceived inconsistency in the communication and process
- The personal toll of raising concerns repeatedly, including the emotional impact of re-telling experiences when Speaking Up locally, and then again to FTSU where resolution was not found locally
- The impact of leadership behaviours and/or follow up to concerns raised affected their health and wellbeing (including needing clinical support).

Inappropriate attitudes and behaviours

A consistent theme was conduct that colleagues felt did not align with Trust values or expected leadership behaviours. This is often related to how teams/individuals were treated day-to-day, and the cumulative effect of incivility.

Colleagues reported themes including:

- Incivility and disrespectful interactions, including being spoken to inappropriately or dismissed when asking for help
- Micromanagement and management styles perceived as aggressive or counterproductive to workplace morale
- Concerns about fairness and transparency in decision making (e.g. annual leave decisions, role changes)
- Reasonable adjustments not being upheld, particularly when leadership changed, or when adjustments weren't formally recorded
- Confidentiality/professionalism concerns – for example, confidential information discussed openly in front of other colleagues.

Bullying & Harassment

Across the year, colleagues continue to report bullying behaviours and harassment which can be directed towards a particular group, or individual who identifies as having a protected characteristic.

Colleague reported themes including:

- Bullying behaviours by people in positions of authority and/or senior colleagues as well as those in more junior positions with a long length of service
- Feeling treated unfairly after Speaking Up, including being singled out or experiencing a deteriorating local relationship
- Use (or perceived misuse) of formal processes in ways colleagues described as punitive or unfair
- Harassment linked to protected characteristics (with overlap into discrimination themes)
- Concerns that inappropriate behaviour was not addressed locally, allowing it to continue without consequence.

FTSU have noted that this year, behaviours that occur outside of MFT have impacted colleagues in the workplace. An example being behaviours shown to those from a specific country, or religion in the community or online being normalised, and reflected in the workplace

HR

Colleagues raised concerns around how workforce policies were applied locally and how formal employee relations processes were managed. When Speaking Up, colleagues highlighted their concerns around the timeframes, lack of communication, and perceived impartiality of these processes.

Colleagues reported themes including:

- Recruitment and selection concerns (including transparency, ringfencing of roles, and perceived fairness)
- Pay and payroll issues (delays, discrepancies, back pay)
- Absence management and how processes were applied, contributing anxiety
- Timelines and communication during investigation/grievance; colleagues describing slow progress and limited updates
- Request for FTSU support in meetings, suggesting reduced confidence in local impartiality for some colleagues who use the service.

System & Process

Reports of system and process issues increased in the later quarters of the year, particularly in relation to how organisational changes were implemented and the perception of inconsistent, and at times absent, feedback colleagues received about both those changes and their wider concerns.

Colleagues reported themes including:

- Incident reporting system and feeling processes were ineffective without feedback
- Unclear service reviews/operating models and lack of clarity around processes
- Allocation issues – for example overtime, shift allocation perceived unfair

- Colleagues report the human cost/impact when matters are taking longer to resolve or investigate. The delay for some leads into extended periods of sickness or leaving the Trust
- Lack of clarity as to how feedback is collated and shared for learning when a colleague leaves the Trust.

Patient Safety

Patient Safety concerns featured throughout the year and were often linked with culture and staffing pressures, where colleagues felt unable to raise issues locally without fear or retribution.

Colleagues reported themes including:

- Staffing gaps and rota changes impacting safe and consistent care
- Culture and behaviours (described by colleagues as toxicity/incivility) reducing the likelihood of colleagues raising safety concerns
- Concerns around the lack of feedback after reporting safety issues through the Trust incident reporting system
- Pressures and targets influencing colleague behaviours and potentially increasing risks to the quality of care provided.

Discrimination

Discrimination-related concerns were present throughout the year and sometimes intersected with bullying, inappropriate attitudes and behaviours, and wellbeing. Reports also noted themes affecting Overseas Trained Workers and colleagues with a protected background.

Colleagues reported themes including:

- Racist behaviours and differential treatment impacting teams and individual wellbeing
- Overseas trained colleagues reporting harsher treatment and less support navigating processes
- Lack of support for reasonable adjustment linked to protected characteristics
- Perception of unequal development opportunities and fairness in career progression.

Infrastructure/Environmental

Although smaller in volume, colleagues raised practical concerns about the working environment that affected day-to-day experience and, at times, the ability to deliver care.

Colleagues reported themes including:

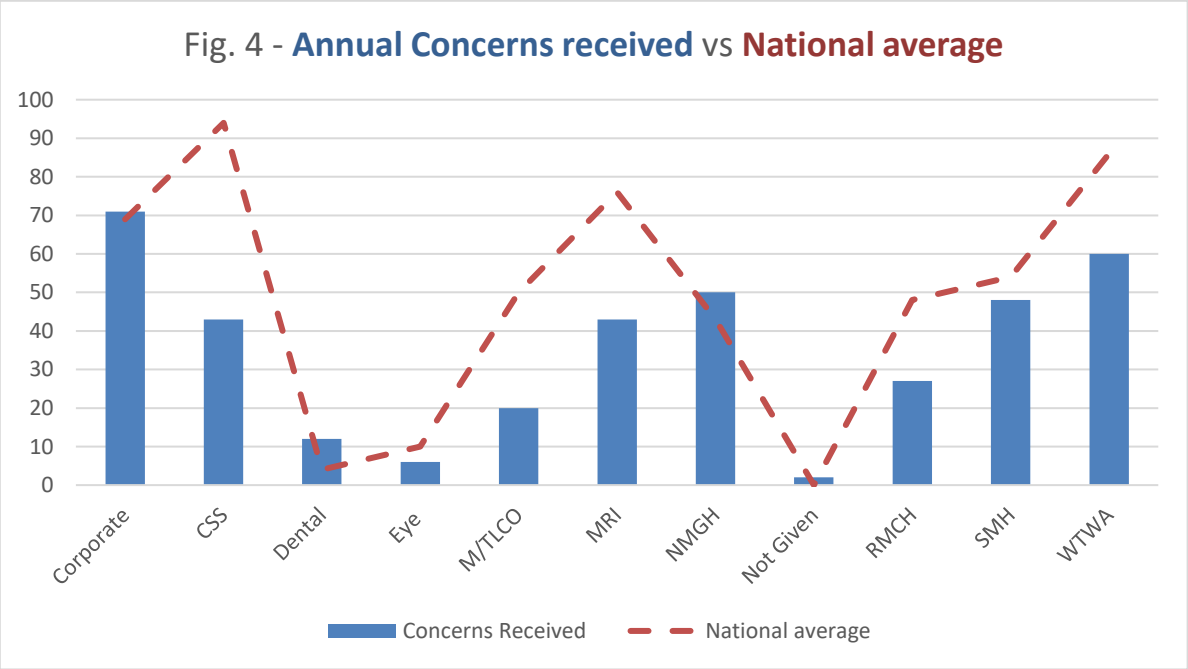
- Poor workplace facilities, such as lack of rest facilities, hot water, and general building inefficiency
- Delays with uniform/equipment availability
- Unsuitable working conditions and environmental issues

Financial

Colleagues reported themes including:

- Incorrect pay following recruitment, previous NHS experience not recognised, impacting on positions on banding scales
- Colleague's mis-using NHS time which impacts on the departmental output, which was described as inappropriate use of NHS monies. When such themes are reported, the FTSU Guardian may refer the theme to the counter-fraud team if appropriate.

4.7 Figure four illustrates where contacts have been made across MFT and compares this with an average number of concerns received for an NHS organisation of a comparable number of Whole Time Equivalents (WTE).



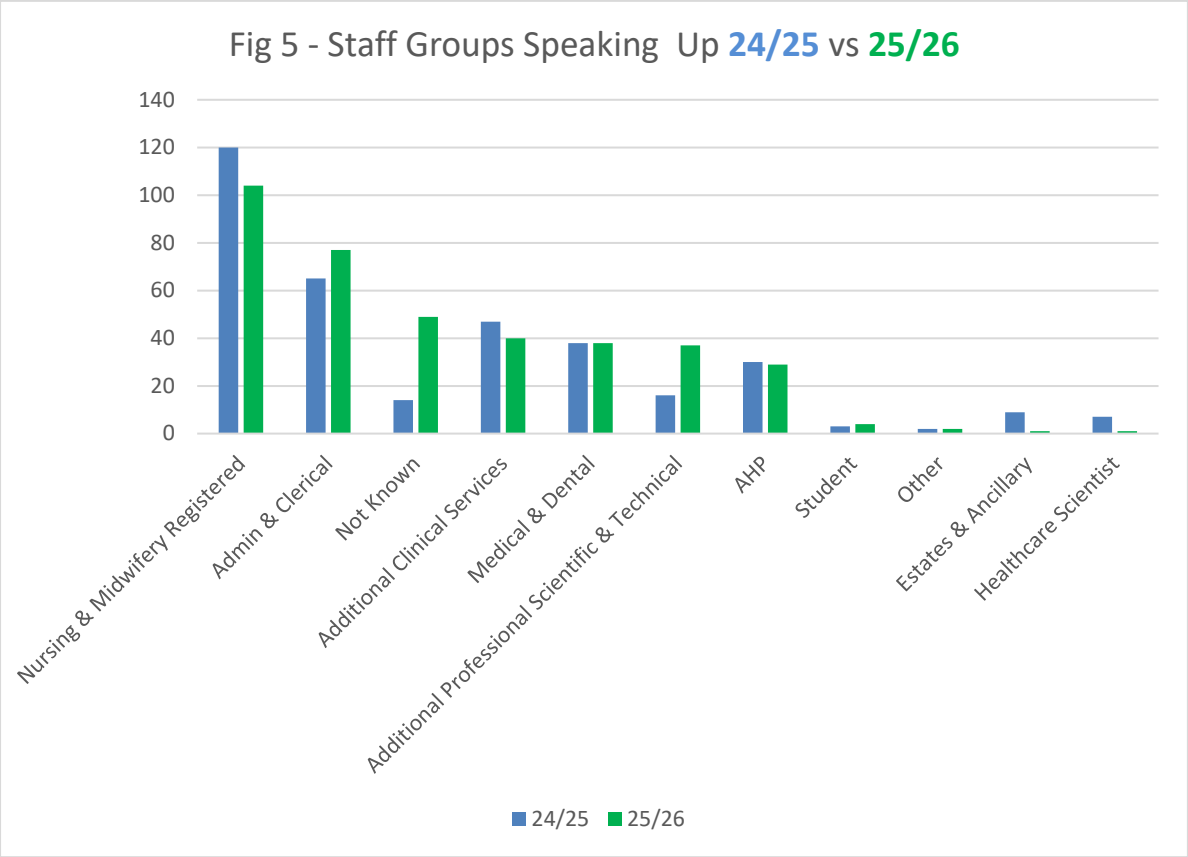
It is important to note that each member of staff who approaches FTSU is recorded as one concern. Therefore, if several members of a team approach the service about the same concern, they are each recorded individually to highlight the impact a situation can have on colleagues. This helps to highlight where multiple workers share similar concerns, while ensuring that each colleague's desired outcomes are considered and managed on an individual basis.

Comparison to national data allows us to look at average numbers of concerns raised at other organisations with a similar whole time equivalent (WTE). The comparison allows FTSU to look at areas with reported concern numbers that are not proportionate to national averages and work with Senior Leadership Teams to understand this difference.

A good example is St Mary's Hospital, which reported fewer concerns than the average for a similar-sized organisation. FTSU has worked closely with the Practice Midwife Advocate team, which supports midwifery colleagues and listens to their

concerns. Together, FTSU and the PMA team have piloted an approach in which PMAs code support conversations using FTSU themes, enabling data triangulation between the two teams and strengthening the overall worker's voice. While these numbers are not included as FTSU concerns, they are shared as part of the quarterly reporting process to the Clinical Group.

4.8 Figure 5 highlights the professional groups using the FTSU service over the last two years.



4.9 Nursing & Midwifery colleagues continue to be the staff group most likely to approach the service. However, only 4.5% of concerns raised by this group came from Saint Mary's Hospital Clinical Group who employ the midwifery workforce. While this reflects an increase of 1.5% year on year, representation of midwifery voices continues to be lower than other colleagues. From April 2026, FTSU will separate Registered Nurses and Registered Midwives to better understand who is Speaking Up, and to support more targeted engagement.

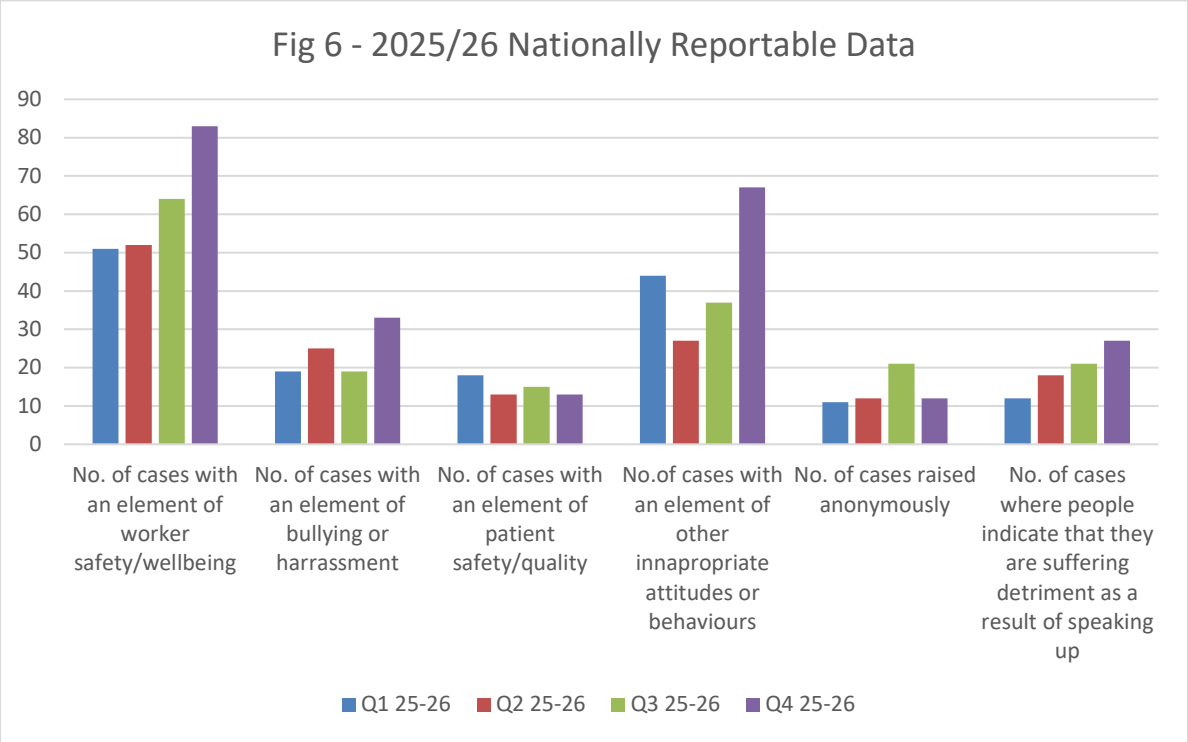
4.10 The increase in 'not known' staff group is reflective of the increase in anonymous concerns received, where FTSU are unable to engage further with colleagues.

5.0 Nationally Reportable Data

5.1 The National Guardians Office (NGO) requires Trusts to report specific data each quarter. NGO data consists of concerns where colleagues directly approached a FTSU Guardian and excludes contacts with FTSU Champions.

5.2 Figure 6 illustrates the data for the nationally reportable elements of the cases raised

to FTSU each quarter at MFT during 2025/2026. Note that each concern may have up to three themes attributed.



Comparing Nationally reportable data

MFT has robust processes in place to ensure that Freedom to Speak Up (FTSU) data reported nationally is subject to local audit and verification, providing assurance that information is recorded consistently within the organisation. However, there is currently no national audit or assurance framework for FTSU data, which limits the ability to validate the consistency of reporting across NHS organisations.

To address this challenge, MFT is working collaboratively with Northwest FTSU colleagues to promote greater standardisation in data recording and reporting practices. This will support more meaningful benchmarking and improve the reliability of comparative data in the future.

In the absence of a national FTSU data assurance programme, this report does not include comparisons with other organisations, as differences in local recording practices could lead to inaccurate conclusions and potentially misleading interpretations of performance.

5.3 Anonymous concerns

Fifty-five concerns were received by the FTSU Guardians anonymously during 2025/26 (16.4% in comparison with 7.4% in 2024/25). MFT does not currently have an anonymised system through which colleagues can raise concerns. Colleagues raise anonymous concerns through phone calls to the service, emails from pseudo email addresses, or anonymised letters.

This can create challenges as the team is unable to provide further information or provide further feedback when colleagues choose to remain anonymous and do not leave their contact details. The absence of contact details restricts follow-up, limiting the ability to fully investigate concerns, evidence of learning, and provide assurance that appropriate action has been taken.

Research suggests that certain demographics of colleagues (such as 18–34-year-olds) prefer raising concerns anonymously[1]. Further research highlights that cultural norms in some professions such as surgery can mean that colleagues are less likely to Speak Up about some themes openly[2].

To improve the process of receiving anonymised concerns, the FTSU team are currently scoping potential systems that would enable a consistent approach to receiving concerns anonymously.

5.4 Detriment

As with the thematic coding of concerns, FTSU Guardians record experiences described by colleagues at face value. If a colleague says they believe they were treated negatively after Speaking Up, this is recorded as detriment. FTSU does not investigate whether detriment occurred; their role is to record and highlight the worker's experience as described. Because fear of detriment can prevent colleagues from Speaking Up, it is important for the Trust to understand which behaviours colleagues perceive as detrimental.

Colleagues reported that they are suffering detriment following Speaking Up locally on 79 occasions during 2025/26 (24%) in comparison to 48 occasions in 2024/25 (13.6%).

Detriment is mainly reported to FTSU Guardians when colleagues have spoken up at a local level, and experienced negative behaviours for doing so. An example of this could be speaking up to a manager, and then not receiving NHSP shifts, or feeling excluded from a group.

To help reduce the number of concerns including detriment, the FTSU team introduced virtual workshops in October 2024 which are an alternative to the 'Listen Up' eLearning course. During the session, we discuss creating psychologically safe spaces where colleagues feel safe to Speak Up and the impact that detriment has on the culture.

To assess if colleague's experience detriment after Speaking Up through the FTSU service, the team survey colleagues three months after their concern has been closed (this is further noted in section seven).

[1] https://public-concern-at-work.s3.eu-west-1.amazonaws.com/wp-content/uploads/images/2025/06/20155004/25-06-Protect-Attitudes-to-Whistleblowing-Briefing.pdf

[2] Hopkins, C. (2024) 'Time to toughen up against sexual harassment in surgery', *Bulletin of the Royal College of Surgeons of England,* 106(2), pp. 56–57 Available at: 10.1308/rcsbull.2024.23

5.4.1 Detriment data and Staff Survey comparison

The numbers of colleagues reporting detriment to FTSU are one way to measure the confidence that colleagues have in Speaking Up.

This year the National NHS Staff Survey results for MFT highlighted that colleagues are more confident to Speak Up about both clinical and other concerns than the national average.

Colleagues also shared that they are more confident that MFT would act on their concern than the national average, which could suggest a positive improvement in worker appetite to raise concerns, either through FTSU or at a local level.

Further details on the NHS Staff survey can be seen in section nine of this report.

6.0 FTSU concern resolution feedback

Once each concern is closed, all colleagues are asked to give their feedback on the service received by the FTSU team in an anonymised survey. This year 380 concerns were resolved, and 46 of those colleagues completed the survey (12%).

6.1 When asked if colleagues would Speak Up again after using the service, 70% answered “yes”, 19% answered “no” and 11” answered “maybe”.

Of those who answered “no”, service users cited local management action as the main reason for not wishing to Speak Up again. Delays in receiving responses, and disappointment in the response received (or no response) also contributed to their decision not to Speak Up again.

Lack of clarity of the role of the FTSU Guardian was a contributing factor to those colleagues who responded “maybe”, with the service received from the Guardian rated high, and a lack of action locally, or inability of the Guardian investigate an issue was cited as a reason for their response.

The learning from this feedback has been incorporated into the “Follow Up” virtual workshops launched by the FTSU Guardian team in 2025, complementing the existing “Listen Up” sessions. While attendance remains low, the team has engaged Clinical Group leaders to include these sessions within leadership development plans and has also delivered targeted face-to-face workshops to selected teams.

6.2 All survey responses can be found in Appendix A.

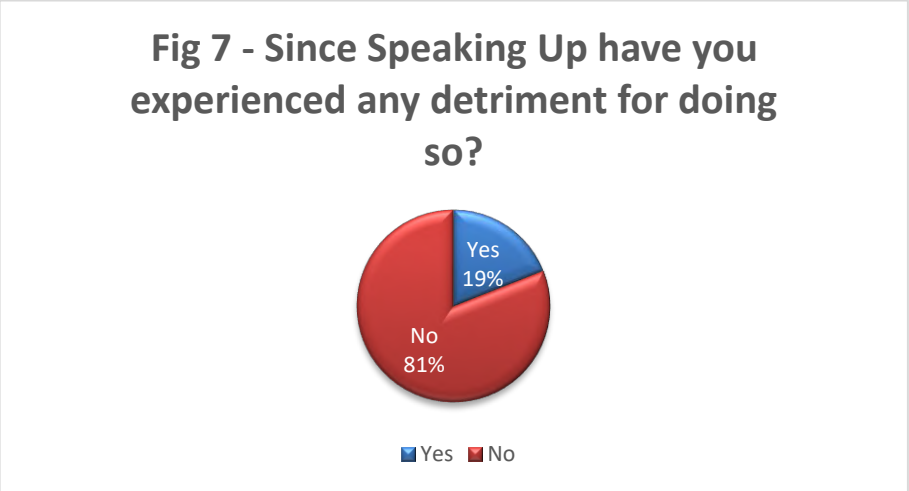
7.0 3-month post-resolution feedback

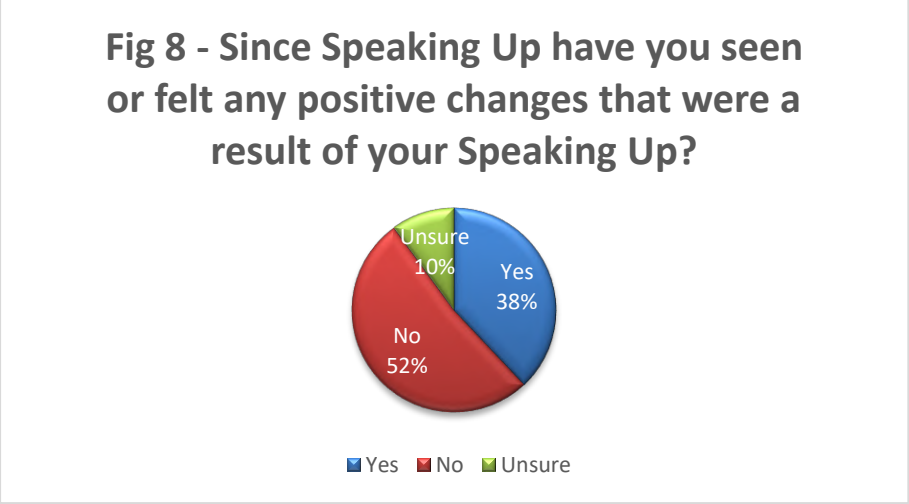
7.1 To ensure that the service continues to meet the needs of colleagues Speaking Up, all service users receive an anonymous email three months after their concern has

been closed. This is to monitor any positive or negative outcomes from their Speaking up. Where detriment has occurred following their Speaking up, colleagues are given the option to add their email for the FTSU team to contact them.

7.2 Of the 380 concerns which were resolved in 2025/26, 21 colleagues completed the optional survey (5.5%).

7.3 Figures 7 and 8 show the responses to the survey.





7.4 Examples of behaviours that colleagues describe as detriment include:

- Management making the colleague aware that they had been to FTSU, where the colleague felt they disapproved of them doing so. The colleague felt like they were being punished for using FTSU.
- A colleague shared that they felt harassment had increased from the manager since they had been made aware that someone had Spoken Up about their behaviour.

Examples of positive changes described to FTSU Guardians include:

- A full review of the service to ensure equality across all sites
- Salary issues resolved, including the payment of arrears
- Local management appearing “visibly supportive”
- A potential danger to staff being “resolved in a manner that would prevent it fully”
- Improvement of representation on interview panels
- Changes to leadership approach
- “(*managers name*) was great, she really listened to my concerns, and I feel like she is doing everything she can to help. Unfortunately, I think time and resources are stretched and this issue isn’t seen as a high priority”.

7.5 To enable the learning culture of FTSU, the FTSU Guardians commenced a new process in April 2026 to record the behaviours described by colleagues at each report of detriment.

This will highlight at what stage of the Speaking Up journey the reported detriment occurred, and a clear example of the behaviour described. This information will be shared through the Trust People Board Committee each quarter, and at each FTSU Clinical Group Senior Leadership Bi-monthly meeting.

8.0 Equality Monitoring

8.1 To ensure that the service reaches all colleagues throughout MFT, in 2025 the FTSU Guardians began to monitor diversity information for all colleagues who use the service to Speak Up, attend FTSU training, or volunteer as a FTSU Champion.

8.2 Initial data received from FTSU Champions who have completed the survey (approximately 70% of the team) highlights the wide range of diversity among the Champion group, which is representative of the MFT workforce. The data has highlighted that there is still work to be done, especially in recruiting Champions who are working in roles that reflect a band 3, 4 and 5 to ensure all colleagues feel that they are represented by the group. Full diversity information can be found in Appendix B.

8.3 Diversity data on those who Speak Up is limited, with the process being launched in November 2025. Of those colleagues who completed the survey, data shows that the majority of services users are female aged between 30 and 49. Service users share that they are in roles which attract a banding range between band 4 and 8a. Further service user diversity information can be found in Appendix C.

8.4 Diversity data for those who attend FTSU training courses is still being gathered and will be shared through the FTSU reports to the Trust People Board Committee.

9.0 Staff Survey Responses

9.1 The NHS Annual Staff Survey asks colleagues four questions under the ‘we each have a voice that counts’ section.

9.2 Table one shows an increase in colleagues feeling safe to Speak Up and that the Trust would address their concerns.

Table 1: Staff Survey Speaking Up questions

Question	***2025***	***2024***	***Annual MFT Variance***	***2025 National average***
I would feel secure raising concerns about unsafe clinical practice.	***71.63%***	*72.06%*	*-0.43%*	*71.10%*
I am confident that my organisation would address my concern.	***57.16%***	*57.86%*	*-0.7%*	*55.49%*
I feel safe to speak up about anything that concerns me in this organisation.	***61.74%***	*62.02%*	*-0.28%*	*60.29%*
If I spoke up about something, I am confident my organisation would address my concern.	***48.97%***	*50.01%*	*-1.04%*	*47.59%*

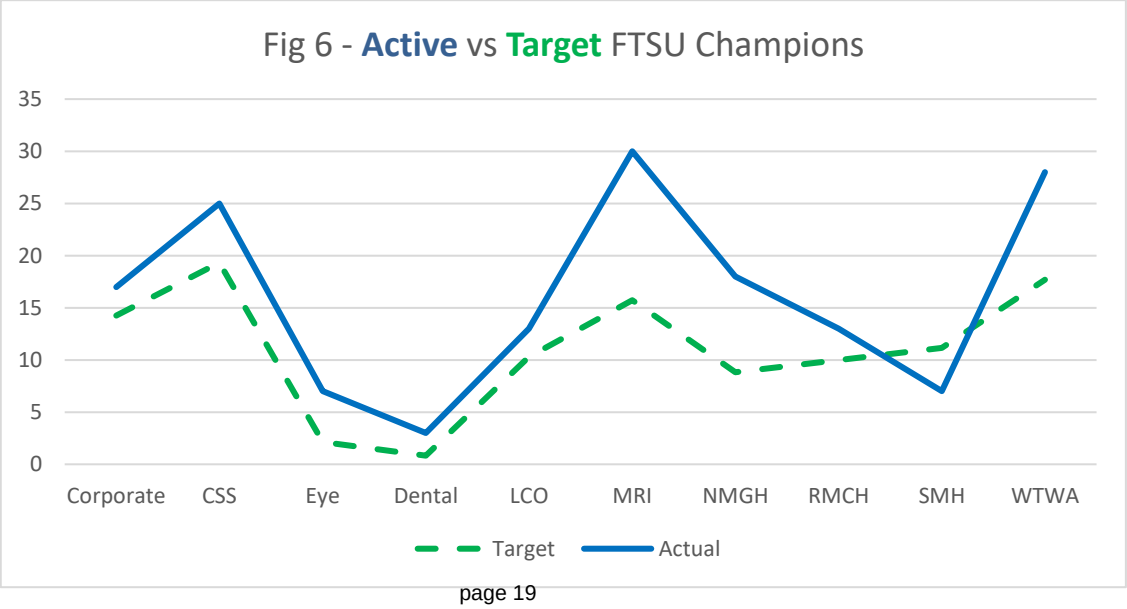
9.3 Although the Trust's 2025 results are slightly lower than 2024, the change is modest and broadly reflects the National picture across the NHS. MFT's results are higher than National results for these questions, which may suggest a greater confidence in Speaking Up, and in the organisations approach to addressing concerns.

We continue to improve this score through leadership development workshops that FTSU offer around psychological safety, and the importance of feedback when colleagues Speak Up.

10.0 FTSU Champion expansion and development

10.1 The drive to recruit FTSU Champions across the Trust has continued throughout 2025/26, with the overall ration of FTSU Champion to WTE exceeding the 1:250 Trust target and 161 active FTSU Champions.

10.2 The team has worked with areas of historic lower FTSU Champion representation to engage and drive recruitment, which has seen all Clinical Groups across MFT having at least one FTSU Champion for every 250 staff members



10.3 The team has continued to develop the role and support available to FTSU Champions including:

- A dedicated SharePoint page for Champions highlighting best practice, training opportunities, and meeting details.
- A simplified online way for Champions to share the themes of the concerns they receive locally
- An annual 'keep in touch' process for all Champions to ensure all information is up to date
- A streamlined meeting schedule to make meetings more efficient
- A guest speaker at each FTSU Champion meeting to share best practice or updates. Speakers include Senior Leaders from across MFT, and other key colleagues such as Safeguarding, and Sexual Safety experts.
- Terms of Reference for the Champion Network has been formalised
- A buddying programme to support new FTSU Champions has been launched.

11.0 Engagement

11.1 To ensure that colleagues are aware of the option of using FTSU, the team ensure that regular engagement activities are planned throughout each month. These range from departmental walkabouts, specialized team training, and attendance at developmental sessions across the Trust.

11.2 Throughout 2025/26, the FTSU Guardian team attended over 140 engagement events to heighten the understanding of FTSU across MFT.

11.3 Work is ongoing with Clinical Group Senior Leadership Teams to ensure that engagement continues to reach all areas of the workforce, with additional weekend and night visits planned throughout 2026/27.

12.0 Annual FTSU Conference

12.1 A key date in the 2025/2026 engagement calendar was the FTSU Champion Conference. Building on the success of the 2024 event, a full-day conference was held in February 2026 to celebrate the contribution of the FTSU Champion team and share best practice from around the Trust.

Speakers including Senior leaders, FTSU Service users, FTSU Champions, Patient Safety leads, Equality, Diversity & Inclusion colleagues. The event also featured a Q&A session with the Trust Chair and Chief Executive highlighting the importance and impact of Speaking Up across the organisation.

12.2 Attendees were surveyed to assess the effectiveness of the day, and feedback was overwhelmingly positive, with an overall rating of 4.79 out of 5.

An overview of the conference and all feedback can be found in appendix D.

The team plan on holding a larger event in 2027 which will be open to all Trust

colleagues to attend.

13.0 Reflection of the service

13.1 Successes this year

- When colleagues reached out to the service, the FTSU Guardians responded to 99.4% of concerns within two working days.
- Engagement reached its highest level in Q4 (123 contacts), aligning with national expectations and demonstrating appropriate use of FTSU routes
- Sustained growth in engagement across the year, including a 12.8% increase from quarters two to three, supported by targeted visibility initiatives
- FTSU Champion network expanded from 137 to 161 Champions, exceeding the target ratio and strengthening local access to speaking up support
- Continued progress in ensuring equitable Champion representation across sites, professions and protected characteristics
- High worker satisfaction in Q1–Q3 (8.9–9.35), reflecting strong trust, psychological safety and positive user experience
- Evidence of tangible organisational change resulting from Speaking Up, including service reviews, improved leadership behaviours and more inclusive recruitment practices
- Increased leadership capability through improved training uptake and introduction of the ‘Follow Up’ workshop
- Learning from concerns actively embedded into training and organisational development approaches
- Monitoring of experiences of 'Overseas Trained Workers' following on from learning from National Guardian's Report. This will enable FTSU to report on any variation in experience that Overseas Trained Workers have against the general working population.
- SharePoint page created for Senior Leaders, highlighting pertinent information on FTSU, best learning from other organisations and MFT data
- Completion of 'FTSU Reflection & Planning Tool by all Clinical Groups and Trust level to enable action plans for improvement for 2026-2028
- Collaboration with Practive Midwife Advocates to ensure midwifery voices are recorded and understood
- Continued development of Senior Leadership Teams and staff Governors

13.2 The year ahead

Reflecting on the learning achieved in 2025/26, the Freedom to Speak Up (FTSU) service will continue to focus on strengthening workers experience, improving consistency of response, and embedding a culture where concerns lead to visible and meaningful action.

Projects planned for 26/27 include:

- Strengthen feedback processes to ensure timely and meaningful responses to colleagues who Speak Up

- Oversight at TLTC on open concern numbers and lengthy concerns

- Report on specific protected characteristics where harassment is identified as a theme, in order help the Trust create targeted improvement projects to minimise such discrimination
- Detriment recording process to enable detailed examples of detriment to be shared at a Clinical Group and Trust level
- Embed a consistent “Follow-Up” culture, with clear accountability for action at all leadership levels
- Enhance leadership capability through targeted training on responding to concerns and creating psychologically safe environments
- Improve workers experience by reducing delays and variation across services, and report delays in concerns to the Trust Leadership Team while protecting the confidentiality of colleagues who Speak Up
- Increase visibility and engagement in areas with lower levels of Speaking Up activity
- Develop and implement improved anonymous reporting options to support wider access
- Strengthen inclusion by identifying and addressing barriers for underrepresented staff groups
- Expand and sustain the FTSU Champion network, focusing on engagement, diversity and active participation
- Expansion on the FTSU conference to be delivered in February 2027
- Collaborate with other teams to embed the importance of building psychological safety in teams, as well as providing meaningful feedback to colleagues who Speak Up locally
- Include FTSU Reflection & Planning Tool action plans in regular meetings with Clinical Groups to ensure progress.

14.0 Learning from FTSU concerns

To highlight the impact that FTSU has on teams, two case studies can be found in appendix E.

Case Study 1 highlights how concerns raised by Social Workers identified significant gaps in professional infrastructure, including limited access to supervision, lack of clear management structures, and insufficient oversight of professional standards. In response, senior leadership engagement led the co-design of a structured improvement plan, including the proposal of a dedicated professional lead role. This proactive approach strengthened engagement between staff and leadership, ensured that concerns were understood at a senior level, and translated staff feedback into tangible organisational change.

Case Study 2 provides insight into the experience of service users engaging with FTSU and reflects the importance of listening to and learning from feedback, particularly where this is critical of the service. Anonymous feedback highlighted challenges relating to role clarity, expectations of the service, and perceptions of independence and impact. This feedback has enabled the FTSU team to reflect on its approach, strengthen communication with service users, and improve transparency around escalation routes and service limitations.

15.0 Training Compliance

15.1 The National Guardian's Office supplies three modules around creating a speaking up culture:

- Speak Up – currently mandated for all staff in MFT
- Listen Up – designed for all managers, not currently mandated
- Follow Up – designed for senior leaders, not currently mandated.

15.2 In October 2024, a virtual workshop was created as an option for staff completing the 'Listen Up' training, giving staff either an eLearning module or virtual classroom option to complete the training. This has helped to drive completions of this module.

The FTSU team deliver the virtual classroom sessions several times each month and have received excellent feedback from staff who have completed the course with 80% of delegates sharing that they would feel confident in applying the skills learned during the session.

15.3 A 'Follow Up' session for managers was launched in September 2025, which is aimed at senior leaders, and highlights the importance of honest feedback to colleagues who Speak Up.

15.4 Compliance of the mandated Speak Up module as of 31 March 2025 is 82.24%, an improvement of 17.16% on 2023/24 data.

15.5 As of 31st March 2025, 615 staff have completed the 'Listen Up' training module and 230 have completed the 'Follow Up' training module, which are not currently mandated.

Table 2: FTSU training completion

Competence	2025/26	2024/25	Variance
Speak Up	86.33	82.24%	+4.97%
Listen Up	791	615	+28.6%
Follow Up	280	230	+21.7%

16.0 Conclusion

This report demonstrates the continued value of the Freedom to Speak Up service in providing a safe and confidential route for colleagues to raise concerns, with 382 concerns received during 2025/26 and sustained growth in engagement across the organisation.

The themes raised by colleagues this year highlight that workplace culture and behaviours remain central to the experiences shared with the service. Concerns relating to worker safety and wellbeing, inappropriate attitudes and behaviours, and bullying and harassment continue to feature most prominently, often describing the cumulative impact of day-to-day interactions, leadership behaviours and organisational pressures.

A notable feature of this year's data is the increase in colleagues reporting experiences of detriment following Speaking Up, alongside a rise in anonymous concerns. These patterns

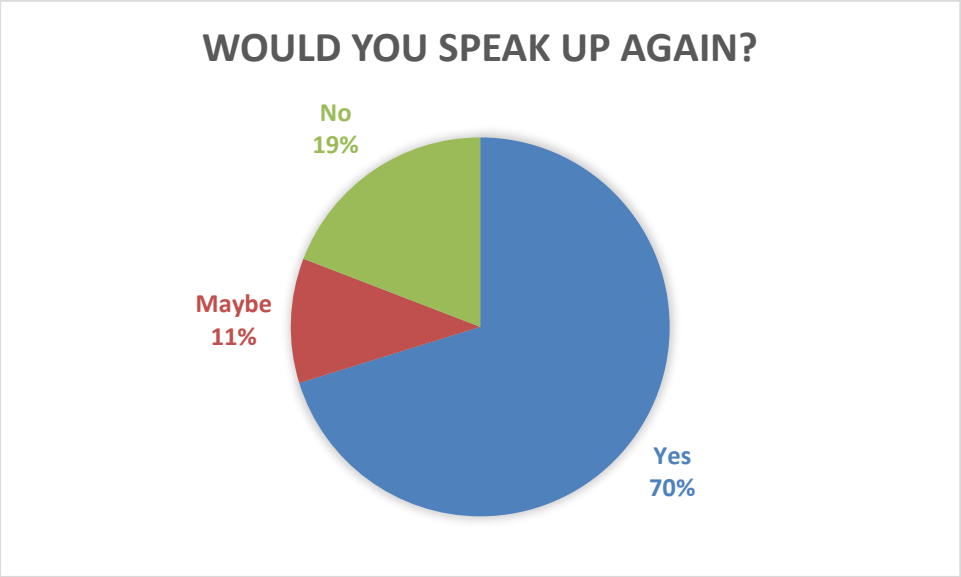
may indicate that, for some staff, there remain barriers to speaking up openly and with confidence, particularly where previous experiences have not led to visible or timely change. To help guide any future Trust initiatives around leadership behaviours when listening to concerns, FTSU is now noting each case of detriment shared with a FTSU Guardian and will include anonymised examples in the quarterly reports to the board. This is in addition to the FTSU Listen Up and Follow Up virtual workshops delivered by the team to develop leaders across MFT.

In addition, the themes identified through concerns relating to leadership behaviours, inclusion, and equality continue to provide important insight into the lived experiences of different staff groups across the organisation, including those with protected characteristics and overseas trained workers.

As an independent and impartial service, Freedom to Speak Up does not determine findings or direct organisational action. Instead, the role of the Guardian is to ensure that the voices of workers are heard and that the themes arising from concerns are visible to the Trust, supporting reflection, learning, and continuous improvement.

Appendix A – FTSU Service feedback

Q1. Given your experience of using the FTSU service, would you Speak Up again?



Q2. Please explain your response to question one.

Yes, I feel I have a responsibility to advocate for patients and the public
I always spoke to the same person so there was continuity. I always felt heard. I was thanked for coming forward. I was offered support throughout.
I was made to feel like I was in a safe and secure environment to discuss my concerns from the very beginning. My FTSU guardian was great at reassuring me and listening to my concern whilst also validating what I was feeling was correct. She clearly explained the potential next steps in great detail and was sure to remind me that nothing would be done unless I asked. She also explained how I would stay anonymous and looked into ways to continue my anonymity going forward. If I ever have more concerns, I know I can raise them through FTSU
Speaking up isn't easy, but the FTSU process makes it feel safer and less intimidating than going through HR or management directly.
I have used FTSU twice now and on both occasions the team have taken the time to listen and really understand my concerns, advocate and escalate on my behalf, and resolve the issues both times
FTSU guardians were very supportive & helpful but other than that the experience of raising a concern was very disappointing. Managers seemed to want to avoid meeting with us in the first instance, then didn't follow up with a response in agreed time frame,

FTSU guardian had to chase multiple times to get any response or up date. Multiple questions were raised and we only received a one line response when we eventually got a response. A further meeting face to face didn't provide any more detailed answers.
No because it was useless speaking up.
Staff listened and was understanding and made me feel valued
The session gave me the confidence to revisit issue in my department
In some circumstances, speaking up is important, as it is better to discuss the matter with the internal team.
Warm and considerate concern for my issue
"I would not speak up again due to how HR, management and my colleagues treated me when i spoke up.
However the only help i recieved was from FTSU and they were extremely kind "
Andrew was very approachable and explained different options I could use
Yes I would speak up because I was listened to
Concerns were taken on board and acted upon
My concerns were taken seriously and listened to
She also kept me updated on the progress of things
Freedom to speak up was the last option in a hard battle I feel more training and work needs to be done with senior management and HR to show the effects of not listening to staff and going ahead with concerns raised and make the people speaking lives change for ever due to not thinking as the impact it has on us due to their negligence and lack of training and knowledge that the impact it could have on us could be life changing
The Freedom to Speak Up person took the process as far as they could but the senior managers within the [redacted] didn't action the agreed plan. Ultimately those staff brave enough to raise concerns were made to feel like trouble makers. It was an awful experience. I feel traumatised. It is difficult to score "the service" because the FtSU person was really helpful but ultimately the process failed the employees, patients and research as a whole. Several people have left the team in the past 8 months but the root causes of the problems have not been properly explored, investigated or effectively resolved or managed.
"I feel raising my concern to FTSU has definitely contributed to resolve my issue much quicker. I was struggling for last four years to get this issue fixed. But I was totally depending on [redacted] to resolve the problem. They were also trying their best but nothing was happening. But when I contacted FTSU not long ago, they activated the whole process and finally my problem is solved.

I felt listened to and supported without threat of reprisal
Andrew was supportive, empathic but importantly pragmatic in helping define the concern I was raising and ensuring I had appropriate points of escalation to seek resolutions
I felt listened to and not pressured to pursue.
The FTSU programme has proven itself as a fast, effective and professional way of getting problems looked into away from the usual routes confidentially.
My issue was resolved quickly and efficiently
I don't really know what the FTSU guardian does. I was desperate to find someone who would listen, but unfortunately the FTSU guardian can't do anything, or stop a disaster from happening when you warn them about it, they just log it and the disaster happens anyway. Hopefully the audit trail is useful if the person involved in the disaster needs it!
It was a very easy process and Zakira was very helpful
Yes since my details were kept confidential, I feel I can speak up again
It has been a good experience and given an opportunity for concerns to be raised to managers who have ignored complaints to line managers under their seniority
Zakira was really approachable and supportive. There was no pressure to proceed with anything if you didn't want.
Yes, I would speak up again because it helps resolve problems and encourages positive change.
Supportive, maintained confidentiality and directed me to Protect.
It was simple, quick and straightforward
I don't feel my claim was taken seriously, I wasn't updated and there were no actions taken from the issue I raised
I believe in the importance of speaking up and raising concerns in the interests of patient safety and staff wellbeing. However, my experience left me uncertain about whether the Freedom to Speak Up process would provide the support and psychological safety I expected. As a result, I would not use the service again.
I felt validated and supported
Felt process stressful and not helpful
The Freedom to Speak Up provided me with an avenue to go to confidentially and anonymously to address an incident that was of concern.
The loyalty of FTSU seems to be to MFT and not the individual who has come to them. Ultimately it feels like FTSU will protect an abuser if they are valuable or higher banding.

I found the advice given was very helpful
I felt supported and had every step of the way explained clearly. I was provided updates when I asked
During the process of raising concerns, there was direct contact with Executive Lead within the Freedom to Speak Up route.
The experience was not handled appropriately and resulted in feeling silenced rather than supported
It raised serious concerns about whether the Freedom to Speak Up process provides a safe and protective environment for staff to raise issues."
It was an easy process and gave me the confidence to put forward my concerns

Q3. Were you satisfied with the service from the FTSU team?

Speak Up Guardian was very helpful and supportive, and it felt like a safe space to raise concerns
Organised, approachable service.
Excellent
Although FTSU Guardians and Champions remain objective, they made me feel genuinely supported and heard. They helped me reflect on the situation and guided me toward a positive resolution.
The team's advocacy got the result we needed to ensure patient safety
FTSU guardians were very supportive, knowledgeable & helpful.
Nothing was done about the situation
I felt at ease and did not feel uncomfortable talking
The session was relaxed and my champion gave me the confidence to talk about my issues but also gave me really good impartial advice
I felt better after speaking up and got some ideas about it.
i took advice and management have responded
I had spoke to someone from the FTSU team named Zakira Takolia and she was absolutely fantastic, so patient, kind and helpful all the way through
Unfortunately, I didn't speak to FTSU until I had already raised my concerns with the matrons. This was due to not knowing at the time that this was something I could do. Once I had spoken with them, they were extremely helpful and reassuring. They were

able to help organise meetings with [redacted] and also directed me to the speaking up scheme which was life changing.
There was only so much Freedom to speak up could do in my situation but I appreciated his help nethertheless
Excellent interaction
I was satisfied
"I was listened to and Zakira could relate to what I was trying to explain and my concerns.
I also felt given the cultural similarity, she better understood my emotional aspect as well.
Speaking with someone higher up in FTSU we got listened to and more options came our way but the local hospital ones may need more training in routes staff can take to be heard
FTSU person was a good listener, kind, made themselves available to staff, was empathetic when listening but also managed to stay neutral with regard to the situation. Hence score of 8. Timescales seemed protracted at times and ultimately there was no action by the [redacted] that made a noticeable difference to the staff who had raised concerns. All but one person who raised concerns have left the team.
I am totally satisfied with their service. They listened to my problem patiently and suggested what can be done. Every time they took my consent before taking any action. They kept me updated about the whole situation. I felt I'm not alone, somebody is on my side. That's a great feeling. Thank you FTSU.
Although my issue was addressed, I got the impression by the response given from the senior manager via email to all staff in the department that what it said was lip service to appease the situation risen by the FTSU Guardian and the shrinking of the role I perform is continuing using stealth.
Andrew was available and provided regular updates and subsequently checked in
I was given a range of options what I could do next but felt in this case not to pursue it as I've managed to secure another role in the organisation.
I received an appointment in a timely manner and Sarah was great to talk to and actively listened while I explained the problem I was experiencing. She then quickly took action and had my problem passed onto the relevant teams who are now resolving the issue.
Nice but powerless to do anything.
Quick response from Zakira, very helpful and a follow up which I did not expect.
Every help possible was offered
Keep informed and given suggestions to resolve issues

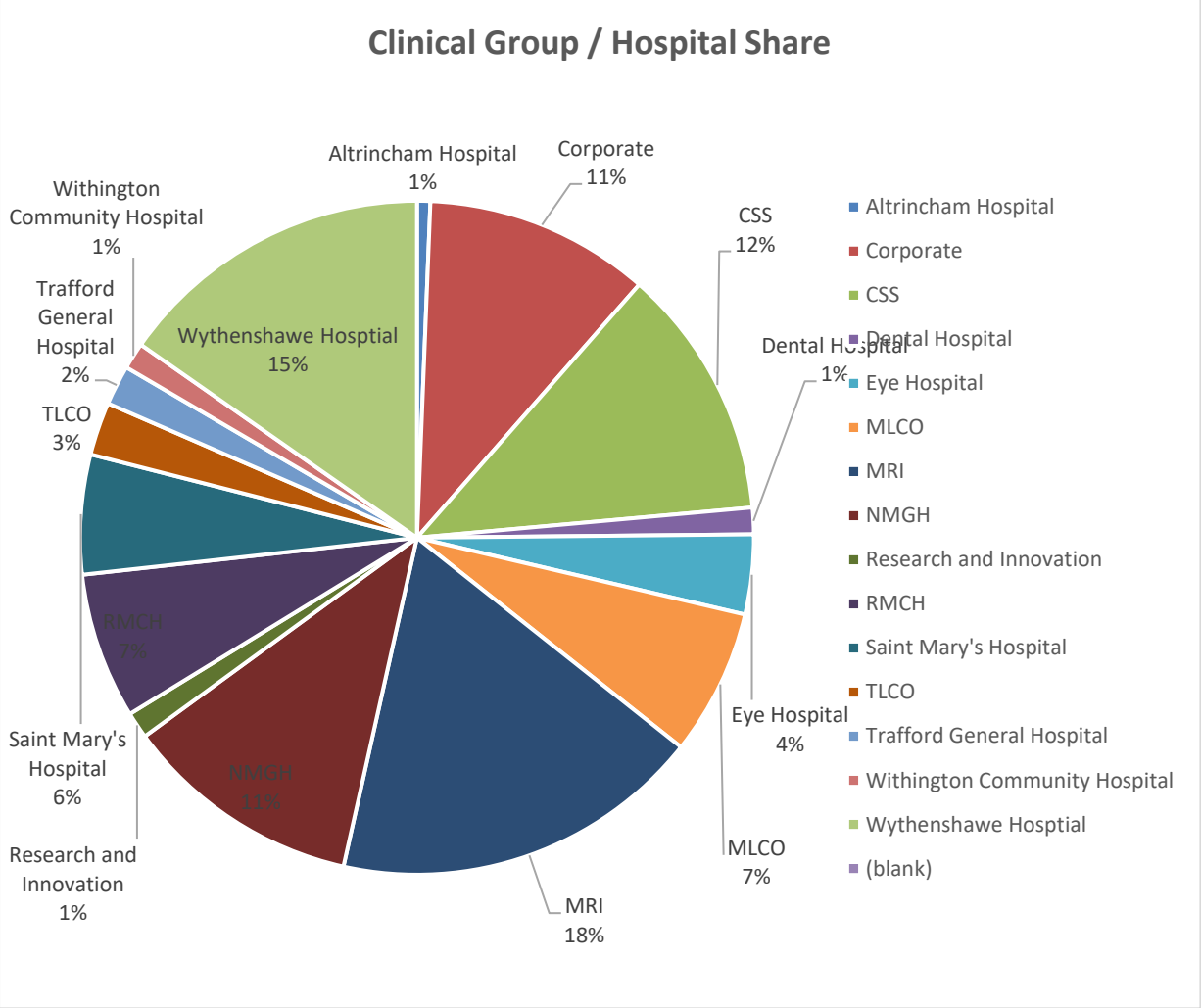
As above and also good that Zakira was there in person to support me at the meeting and then followed up to check in I was okay and satisfied with the response I had
I felt supported and reassured that my matter was taken seriously. The team listened to my concerns and treated them with importance, which helped me feel confident in speaking up.
I was not provided with any updates automatically I had to follow them all up myself
"I approached Freedom to Speak Up seeking support and reassurance to raise concerns safely. Instead, I felt discouraged from taking my concerns forward and was given advice that went beyond the remit of the service, including HR and legal advice that conflicted with guidance I had already received from my union and HR.
I made it clear that I was not seeking legal or HR advice, but support to speak up. The conversation left me feeling uncomfortable and silenced rather than supported. As a result, I did not feel able to pursue my concerns through Freedom to Speak Up and instead had to raise them directly with HR, where my concerns were later found to be valid.
This experience undermined my confidence in the service and raised concerns about whether staff are being appropriately supported to speak up."
I felt validated and supported. Information surrounding my options was clear.
Felt pressured throughout situation
Helpful, reassuring, supportive and confidential. I am so pleased the confidentiality and anonymity was kept. I was nervous around this.
It was very slow. It felt like because they knew I was [redacted] that they were hoping I [redacted] before they would need to do anything
Andrew was very supportive and helpful.
Helpful and polite. made me feel supported
"The service did not operate in line with its stated purpose.
The response received did not reflect a safe, independent or supportive process for raising concerns.
The handling of the situation reduced trust and confidence in the service."
I felt listened to and supported

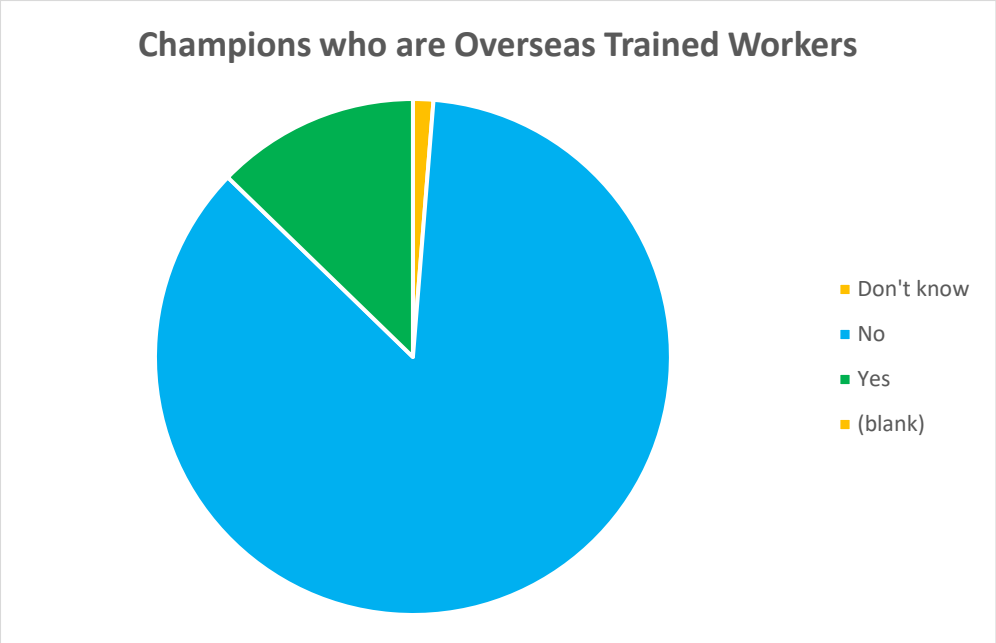
Q4. On a scale of 1-10, how would you rate the service you received from FTSU?

Average rating 8.4

Appendix B – Champion Diversity monitoring data

Staff Group	% of Champions
Registered Nurse	41.4%
Admin and Clerical	22.9%
Allied Health Professional	14.6%
Medical/Dental	7.6%
Additional Clinical Services	6.4%
Healthcare scientist	3.2%
Registered Midwife	2.5%
Additional Professional Scientific	0.6%
Estates & Ancillary	0.6%




Champions who are Overseas Trained Workers
Don't know
No
Yes
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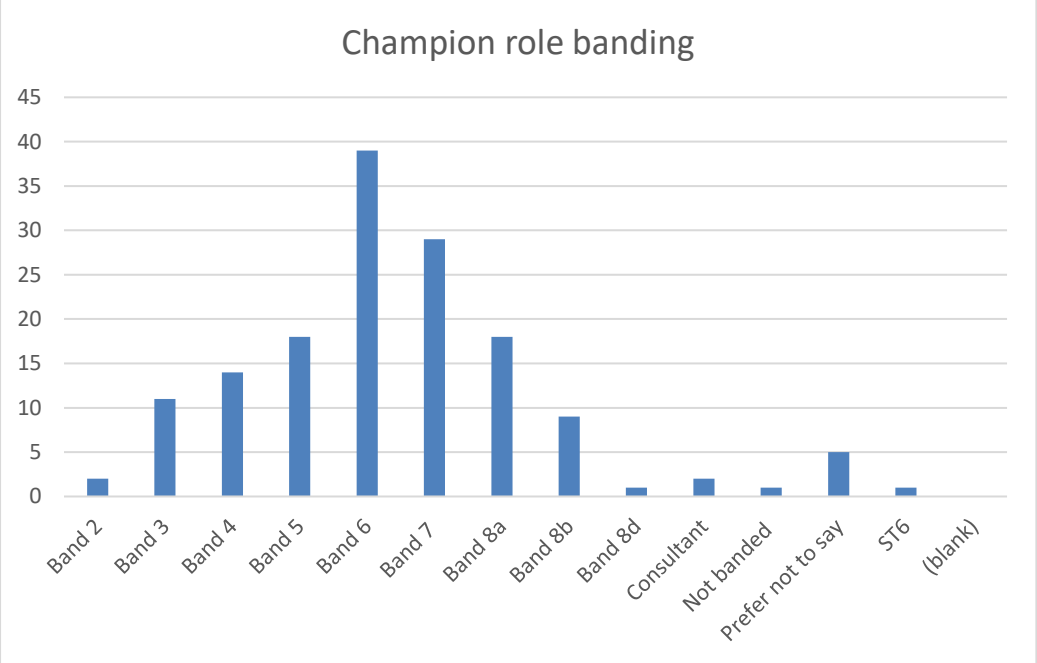
Champion role banding
45
40
35
30
25
20
15
10
5
0
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8a
Band 8b
Band 8d
Consultant
Not banded
Prefer not to say
ST6
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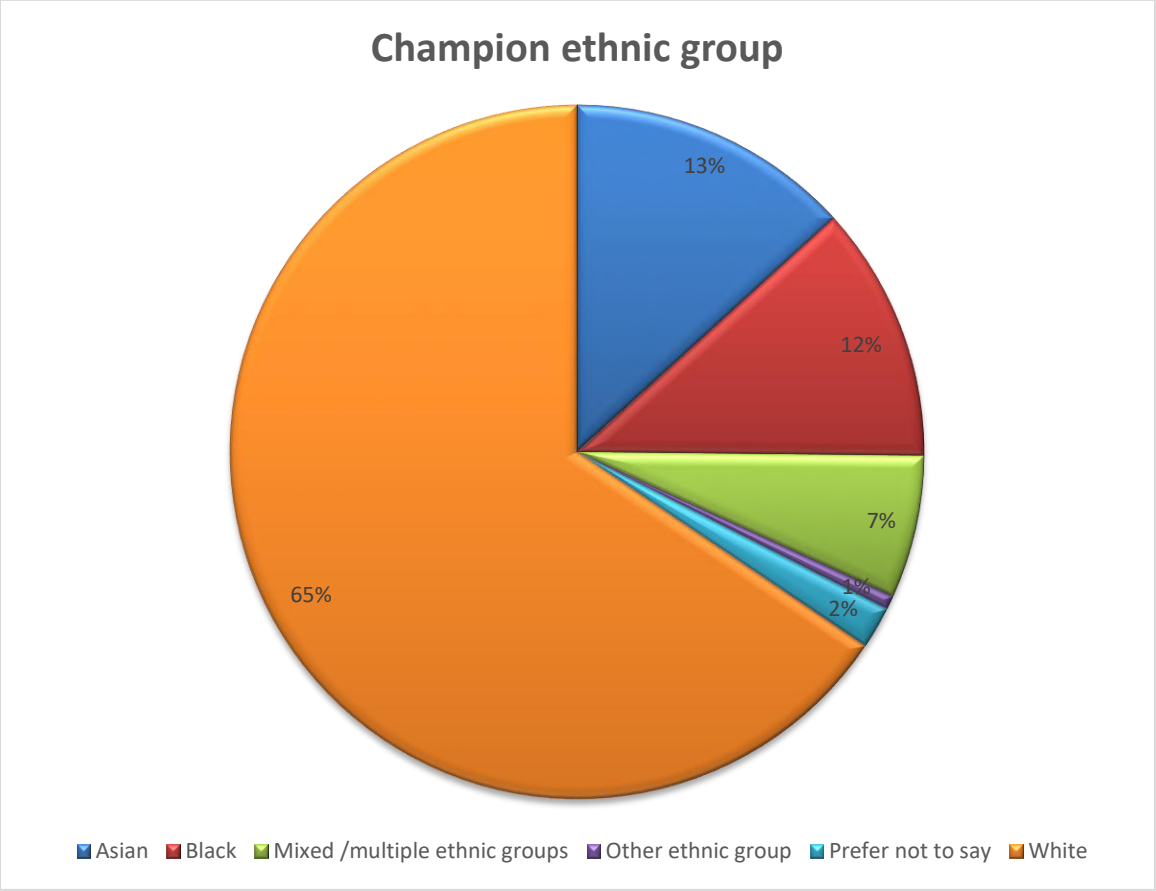
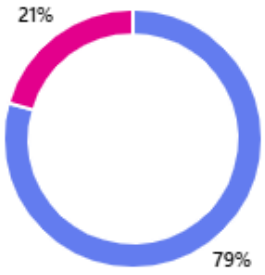

Champion ethnic group
13%
12%
7%
1%
2%
65%
Asian
Black
Mixed /multiple ethnic groups
Other ethnic group
Prefer not to say
White

Appendix C – Client Diversity monitoring

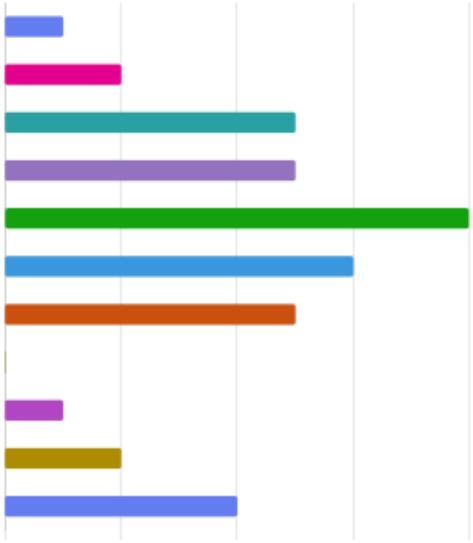
1. What is your sex?

Female	31
Male	8
Intersex	0
Prefer not to say	0



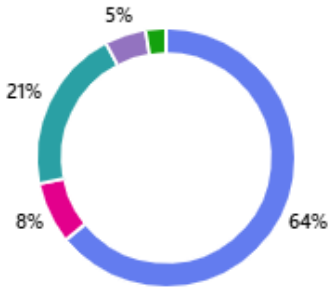
What is your job banding

Band 2	1
Band 3	2
Band 4	5
Band 5	5
Band 6	8
Band 7	6
Band 8a	5
Band 8b	0
Band 8c	1
Prefer not to say	2
Other	4



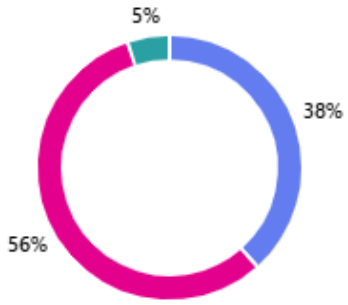
What is your ethnic group

White	25
Black	3
Asian	8
Mixed/multiple ethnic group	2
Other	1



Do you consider yourself to be a disabled person or have a long - term heath condition

Yes	15
No	22
Prefer not to say	2



Appendix D – Feedback from FTSU Conference 2026

Q1. What part of the conference did you find most valuable and why?

The stories – sharing of people's experience were most impactful. They reminded me why I chose to become a FTSU
The true stories, which actually broke our hearts, to see staff have even committed suicide. No one should lose their life because of bullying or lack of support. This tells us the system has still not faced up to the dangers of some staff suffering. *To hear a few community nurses raising their concerns and even overseas staff nurses – afraid to share their concerns as they may loose their jobs.* *That some staff suffered badly from sexual harassment.* *We need to move forward with what Mark Cubbon said 2-3 years ago to encourage all staff in management to learn and watch Professor Michael West Masterclasses "Compassionate Leadership".* *The bigger the organisation becomes the bigger the danger. Thankfully, I know some managers have amazing people and leadership skills and others need to be trained to the high level.*

Q2. Which session or speaker resonated with you?

The session with Mark (Cubbon) and Kathy (Cowell) really stood out for me. It was the first time I had the opportunity to hear them speak, and they delivered their message with genuine heart, compassion, and authenticity. *Their commitment to supporting and championing Freedom to Speak Up was impactful for me.* *It was inspiring to see leaders at the very top not only recognising the importance of FTSU Champions but actively valuing and promoting the role.* *Their openness, humility, and sincerity resonated with me – it was wonderful to see and even better to hear.*
Andrew and Zakira have become people that are approachable and inspire more people to speak up. *The ex-police officer (Nick Bailey) & Doctor (Darya Ibrahim) from sexual safety saying we need to be alert about dangers some patients and staff are going through.* *It was good to meet 4 or 5 others to mingle and chat (to learn about) what they or their departments are going through.* *Staff being honest that still in 2026 – some staff are fearful to speak up for fear of being*

bullied, harassed, or under pressure.
All actually, every aspect spoke to the reason and purpose for the freedom to speak up course
I felt I learned the most from the speaker representing the overseas workers (Jismy Vellakunathu Kunjachan) *Hearing their perspective really made me want to change how I engage with some of our diverse communities.*
All excellent
It was great to hear Mark (Cubbon) speaking about the Trust commitment to FTSU
Dr Kate Lenton, as I feel paediatric voices are lost a lot of the time

3. Do you have any final thoughts?

Overall excellent conference, well organised and really well thought topics. Like the poster idea… thanks for involving and making us feel important and acknowledging our work
I really enjoyed the day. I think I went through every emotion which is a clear sign that it was a great conference. Well done team, you nailed it.
It was a very good experience for thank you
I feel that a better understanding of what freedom to speak up actually is, before the conference I thought it was another way to form a complaint like whistleblowing which can be daunting especially when you have had a previous poor experience but knowing its somewhere for your voice to be heard whether a positive or negative experience makes it more open .
The conference was much more engaging than Teams meetings
During new staff induction can a foreign trained worker be co-opted to the FTSU slot to give a 10 or so minutes charge on how to overcome barriers and found your voice to speak up. The lady that gave the talk on foreign trained workers if she will be available

would be a good choice or any other champion with lived experience.
The conference was exceptionally well planned, with excellent speakers. It was informative and interesting day, and good to meet other FTSU Champions in person.
To keep reminding top management that an organisation to be truly honest and open means that the concern especially of the voiceless (more lower staff) needs to be recognised. There is tension in teams with pressures. That the NHS should place caring for Patient and Staff at the highest level. This is a people organisation and with hurting people leads to greater problems if they are not resolved.
A huge well done to the FTSU team. Your commitment, honesty and openness was clear to see throughout the session. Having authentic leaders in senior FTSU roles truly matters, and you showed exactly why. You've given me greater confidence to address any issues going forward, knowing that the organisation, right up to the very top, is supportive, responsive, and taking meaningful action.
Would like to see if some of these real-life experiences are shared at the board level and how these have been used to make changes at strategic level in policies
Thank you to all the Guardians for the continued hard work and for making a difference to patients and staff
Just wanted to email you both to tell you that I found the conference inspiring and very positive. I gained so much from it. The stories were so powerful, and it was great to see everyone hold the same values. *Look forward to the next one*
Just wanted to say what a fantastic conference yesterday. All the talks were amazing and so personal and thought provoking. *I have been a bit distant from FTSU over the last few years which has been partly due to clinical commitments. However, I have to admit to also being very disillusioned about how one of my concerns was delt with in the past. This was before either of you were guardians.* *However, I am so pleased that I attended yesterday- it has really renewed my faith and belief in the FTSU process.*


FREEDOM TO SPEAK UP
Freedom to Speak Up
SPEAK UP
FOLLOW UP
LISTEN UP
Freedom to Speak Up


FREEDOM TO SPEAK UP
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Appendix E – FTSU Case Studies

CASE STUDY 1

The FTSU service was approached by locally employed Social Workers at the Trust, who highlighted several systemic concerns. Key themes included the absence of a clear professional management reporting structure, inconsistent access to clinical supervision, limited opportunities for career progression, and insufficient oversight of professional registration and regulatory compliance. Social Workers were supported by local management in the Trust but felt that dedicated Social Worker leadership would be better placed to understand their professional needs.

Action Taken

- The concern was escalated to the Chief Nursing Officer of the Trust, wo met colleagues from the Social Worker team to fully understand their concerns.
- The Chief Nursing Officer thanked the colleagues for raising the concerns, and with their permission, asked the Deputy Chief Nurse to investigate the current situation, and possible future actions
- Workshops were convened with social workers and partners at Manchester City Council to co-design a sustainable operating framework.
- A proposal was created to establish a Trust-wide professional leadership role through the uplift of an existing Band 7 social worker to a Band 8a position (0.4 WTE) on a 12-month secondment basis.
- This role will provide professional leadership, ensure oversight of Social Work England registration requirements, and deliver formal clinical supervision aligned to regulatory standards.
- Additional actions include strengthening access to peer supervision, improving data capture and registration monitoring, enhancing links with Manchester City Council for learning and development, and progressing work to raise the profile of social work across the organisation.

Key Insights

- The concerns raised through FTSU highlighted a gap in professional infrastructure for social workers within the Trust. In the absence of dedicated leadership and consistent supervision, there were risks relating to compliance, safeguarding practice, and staff wellbeing
- By working with the team to build the proposal, the Chief Nursing Officer and Deputy Chief Nurse strengthened connections with the Social Worker team at the Trust, to fully understand the support that they needed
- This work demonstrates how FTSU intelligence can inform strategic workforce decisions, driving improvements in culture, safety, and organisational effectiveness.

CASE STUDY 2

For each concern shared with the FTSU Guardian, a closure email is sent to the service user. The purpose of this feedback is to understand their experience of using the service and to use that insight to drive improvement and learning, not only for the FTSU service, but for the wider organisation. All feedback is collected anonymously to encourage honest and candid responses, and to minimise any fear of detriment.

The feedback received in quarter four for the service has been difficult to hear, but has provided an opportunity for reflection and learning:

Client's feedback:

"I don't really know what the FTSU guardian does. I was desperate to find someone who would listen, but unfortunately the FTSU guardian can't do anything, or stop a disaster from happening when you warn them about it, they just log it and the disaster happens anyway. Hopefully the audit trail is useful if the person involved in the disaster needs it!"

"I believe in the importance of speaking up and raising concerns in the interests of patient safety and staff wellbeing. However, my experience left me uncertain about whether the Freedom to Speak Up process would provide the support and psychological safety I expected. As a result, I would not use the service again."

"The loyalty of FTSU seems to be to MFT and not the individual who has come to them. Ultimately it feels like FTSU will protect an abuser if they are valuable or higher banding."

Initial engagement with the FTSU Guardian:

As all feedback is anonymised, it has not been possible to follow up directly with the individuals. The FTSU team has therefore undertaken collective reflection on the themes raised.

Key considerations included:

- Are we clearly explaining our role and scope to those who raise concerns?
- How effectively are we managing expectations about what the service can and cannot do?
- In addition to sharing their feedback, is there a clear accessible mechanism for individuals to raise a complaint about the service, to provide reassurance, accountability, and confidence.

Action taken by the FTSU service:

- All quarter four feedback has been discussed and evaluated by the FTSU Guardian team
- Further discussions on managing expectations and setting clear boundaries will be incorporated in team development days
- Escalation routes within the FTSU service are highlighted on the FTSU intranet pages
- Link to the Trust FTSU policy shared with all new service users, which highlights internal and external escalation routes that workers may use

- Full information on how service users can escalate any concerns they have about the service received from FTSU is now included in our initial emails to all colleagues who Speak Up, highlighting the Head of Service, and Executive and Non-Executive Director lead details.

Key insights:

- Role clarity is not landing consistently. This therefore might suggest the “offer” of the service which includes listening, facilitating and providing an escalation route is not always understood
- The feedback indicates a misconnect between what the service user hopes will happen and what the process can realistically deliver. Management of expectation matters as it could result in a loss of confidence of the service
- Perception of the impartiality and independence of the service
- The feedback shared is an opportunity for wider learning; fear of hierarchy, a belief that some colleagues being “protected” and low confidence that raising concerns lead to change.

NHS
Manchester University
NHS Foundation Trust

Public Board of Directors
Thursday 30th July 2026

Paper title:	Bi-annual safer staffing comprehensive establishment review report (Nursing and AHP) (data for March and April 2026)	**Agenda Item 12.3**
Presented by:	Kimberley Salmon-Jamieson, Deputy Trust Chief Executive / Chief Nursing Officer	
Prepared by:	Mark Keegan, Corporate Director of Nursing – Workforce and Education; Jemma Haines, Trust Chief Allied Health Professionals	
Meetings where content has been discussed previously	Workforce and Education Committee on 3rd June 2026 People Board Committee 30th June 2026	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

The annual safer nurse staffing establishment review, triangulating the Safer Nursing Care Toll (SNCT) census recommendations, patient outcomes and using the "Professional Judgement Framework", was completed by the WTWA, MRI, NMGH and SH Clinical Groups during Quarter 2 2025/26. From the 84 wards reviewed, there has been a recommendation to increase the funded establishment in 7 and the reduce the funded establishment in 8 with those changes being transacted within the Clinical Groups by realigning funded establishments.

Following a comprehensive redesign and targeted investment in Trafford's adult core and specialist community nursing services, with £659,703 recurrent investment delivering an additional 16.33 WTE, implementation is progressing as planned. The reconfiguration of District Nursing services was completed in February 2026 and the first phase of recruitment into the specialist services has commenced with the second phase due to commence in the quarter 2 of 2026/27.

Registered nursing vacancies have reduced overall to 104.8wte (1.1%) in April 2026 which is significantly less than the current national vacancy rate at 5.2%, which is attributed to an overall increase in contracted wte and improved turnover rates.

Nursing Assistant turnover rate has reduced from a high of 12% in May 2025 to 10.2% in April 2026, compared to a national average of 10.2%, and the rolling average sickness rate has reduced from of 10.2% in May 2025 to 9.5% in April 2026, compared to a national average of 7.9%.

At the end of the financial year 2025/26, nursing and midwifery bank spend was 13.8% (£8.9m) lower than 2024/25 overall, against the NHSE target of 10%.

The national programme to review of all nursing and midwifery job descriptions against revised national job profiles has commenced with the review of Band 5 roles commencing in July 2026 and anticipated to be completed by end quarter 3 2026/27. The Royal College of Nursing's (RCN) position is that nursing is a band 6 profession and that the percentage of nurses in band 5 positions should align with the benchmark in the AHP workforce of 20%, with 46.4% of the nursing workforce at MFT at band 5 level. The potential worst-case impact on the annual wage bill, of band 5 colleagues being uplifted to band 6, is an increase of between c£9.0m and c£12.3m. National funding to support pay uplift is yet to be confirmed by NHSE.

Recommendation(s)

The Board of Directors is asked to:

- Receive this report as assurance that MFT remains compliant with the national guidance (NQB 2026; DWS 2018) in relation to safer nurse staffing.
- Note the report was received and discussed at the People Board Committee on 30th June 2026.
- Receive assurance of safe nurse staffing as described in sections 5, 6, 7, 8 and 9.
- Receive the outcome of the annual safer staffing comprehensive establishment review which shows that safer staffing establishments have been maintained across all in-patient ward areas following realignment of funded establishments within respective Clinical Groups.
- Receive assurance of the revised workforce model in Trafford District Nursing service with service reconfiguration completed in February 2026 and commencement of a two phased recruitment to the additional 16.33 WTE.
- Note the risk of between c£9m and c£12.3m increase in the annual pay bill as a consequence of the review of band 5 job descriptions taking place during 2026/27.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)			
LHL objective 1	☐	LHL objective 2	☐
HQSC objective 1	☒	HQSC objective 2	☐
HQSC objective 3	☐	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☒

VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: •	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☐ Effective ☐ Responsive	☐ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016) • CQC's fundamental standards – staffing; safety; good governance • Developing workforce safeguards - Supporting providers to deliver high quality care through safe and effective staffing; NHSE; 2018	

Main report

1. Introduction

This bi-annual safer staffing establishment review report provides assurance that MFT remains compliant with the national guidance in relation to safer staffing for nursing with data up to April 2026. In the absence of no validated framework for Allied Health Professional (AHP) safe staffing, this report utilises advisory standards for assurance. A midwifery safe staffing report is provided separately.

2. Background

The National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016), states 3 expectations of the Trust Board of Directors. These are endorsed by the NHS Improvement (NHSI) Developing Workforce Safeguards (DWS) Guidance (2018) (Appendix B).

A report of the comprehensive establishment and skill mix review for nursing and AHPs is presented twice a year.

In between these reports, the bi-monthly safe staffing report provides assurance that the Trust remains compliant with the national guidance in relation to safer staffing for nursing and AHPs.

3. NMAHP Workforce Productivity

The Chief Nursing Officer is accountable for the NMAHP Workforce VfP programme. The Director of Nursing (Workforce and Education) leads the programme and provides regular updates through the NMAHP Professional Advisory Forum and Workforce VfP Steering Group.

At the end of the financial year 2025/26, nursing and midwifery bank spend was 13.8% (£8.9m) lower than 2024/25 overall, against the NHSE target of 10% (appendix A), mainly a result of removing enhanced pay rates and several measures implemented to increase efficiency of rosters. The two largest reductions were noted in Specialist Hospitals CG (£3.1m) and Clinical Scientific Services CG (£2.1m). Nursing related agency usage was eliminated from April 2025.

Nursing and midwifery premium overtime was 52.6% (£148k) lower in 2025/26 compared to 2024/25, (appendix A). The average premium bank spend of c£9k per month (0.02% of the monthly budget of £45m) is mainly due to supporting overruns in Theatre units.

Demand for AHP premium overtime spend was 27.1% (£398k) higher in 2025/26 compared to 2024/25, mainly attributed to additional clinical activity (appendix A). 99.8% is utilised in Clinical Scientific Services (imaging services 81.6% and AHP services 18.2%). NMAHP corporate team are supporting CSS CG with a programme of work to migrate imaging staff to NHSP bank contracts. LCOD AHP Therapy services have stopped all premium overtime spend.

AHP agency spend has decreased by 10% compared to previous financial year, equivalent to £216k, attributed to successful migration of colleagues to NHSP bank (appendix a). AHP agency colleagues are provided by framework agencies sourced via NHS Professionals Bank, and those sourced through outsourcing arrangements directly managed by CSS Clinical Group. A review of outsourcing arrangements has been identified as the priority for the VfP AHP programme in 2026/27.

4. Nursing and Midwifery National Job Profiles

On 23 April 2025 the Secretary of State for Health and Social Care made a Statement to Parliament stating the government would take forward the recommendation in the 2023 AfC Deal relating to improving local job evaluation practice, and on 1st April 2026 Annex 31 was added to the NHS Terms and Conditions of Service handbook to provide clarity and support the application of the Job Evaluation Scheme.

In June 2025 the NHS Staff Council published a revised suite of nursing and midwifery Job Profiles and provided guidance to inform and support the local review of job documentation for nursing and midwifery. On 11th February 2026 the Government announced a series of measures to recognise the significant value of the nursing profession including a commitment to reviewing the roles and pay bands of every Band 5 nurse. This was followed up on 2nd June 2026 in a letter to NHS Trusts from Duncan Burton, Chief Nursing Officer for England and Danny Mortimer, Director General, People at NHSE setting out how the review of the roles and pay bands of every Band 5 nurse should proceed.

In October 2025 the MFT N&M Job Profiles Oversight Group was established by the Workforce and Education Management Committee (WEMC) with Corporate Workforce team and NMAHP Workforce team working in partnership with Staff-side colleagues. A comprehensive programme plan has been developed following the guidance laid out by the NHS Staff Council. Following extensive preparatory work, the review of all band 5 job descriptions has been scheduled to commence in July 2026.

On 18th May 2026 Patricia Marquis, Director, Royal College of Nursing (RCN) wrote to all NHS Trust Chief Nursing Officers which laid out the RCN's position that nursing is a band 6 profession and that the percentage of nurses in band 5 positions should align with the benchmark in the AHP workforce of 20%. RCN believe that progression to Band 6 after 2 years post registration would bring nursing in line with other average progression in comparable professions.

46.4% of the nursing workforce at MFT are at band 5 level which is just above the mean average for the Shelford Group of Trusts of 46.2%, with MFT ranked 5th from highest to lowest from the 10 Shelford Trusts (appendix 1). The highest percentage amongst Shelford Trusts is 56% and the lowest 35%.

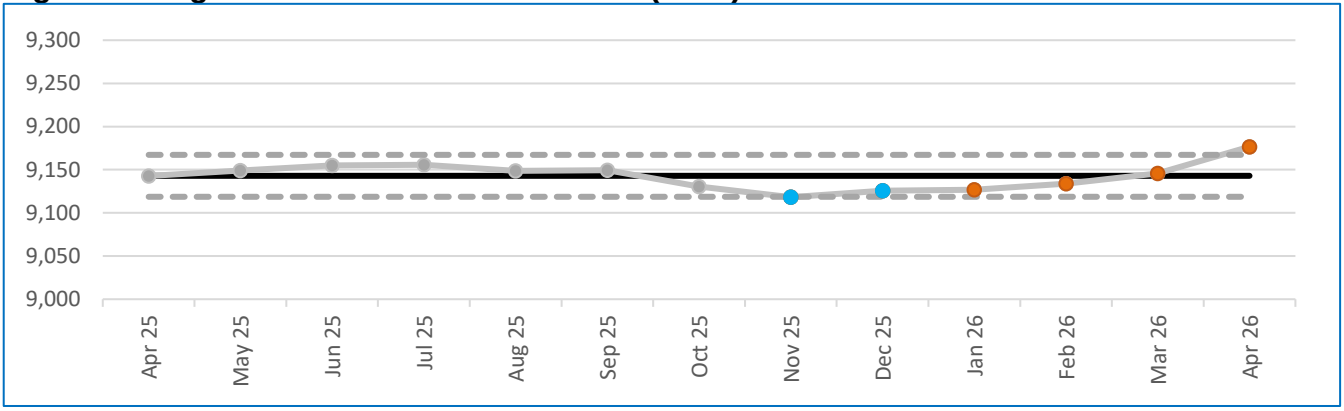
The potential worst-case impact on the annual wage bill, of band 5 colleagues being uplifted to band 6 as a result of the job profiles programme, could be an increase of between c£9.0m and c£12.3m. National funding to support pay uplift is yet to be confirmed by NHSE.

5. Achieving the set establishment

Registered Nursing

The registered nursing establishment for roles band 5 in April 2026 is 9,176.6wte (figure 1). The increase in March 2026 and April 2026 is related to the increases in establishment by 38wte within LCO CG to support the investment in adult community nursing in Trafford, and by 28wte in Gastroenterology service at MRI CG to support elective recovery.

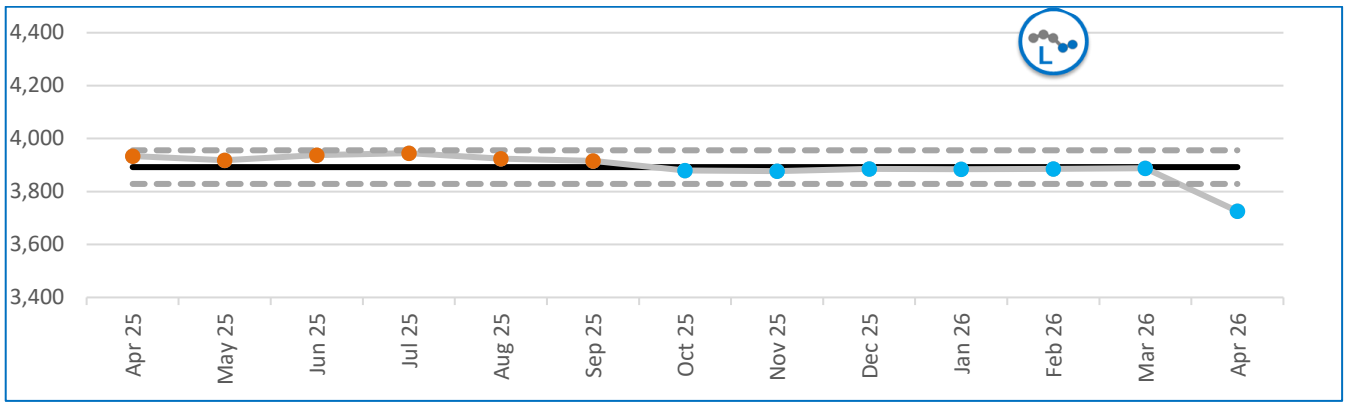
Figure 1: Registered Nurse Establishment (WTE) - All MFT



Support to Nursing

The current support to nursing establishment in April 2026 was 3726.0wte (figure 2). Establishment has reduced by a total of 159.2wte into the new financial year. Within specific Clinical Groups there has been a planned reduction in line with care closer to home programme due to bed closures.

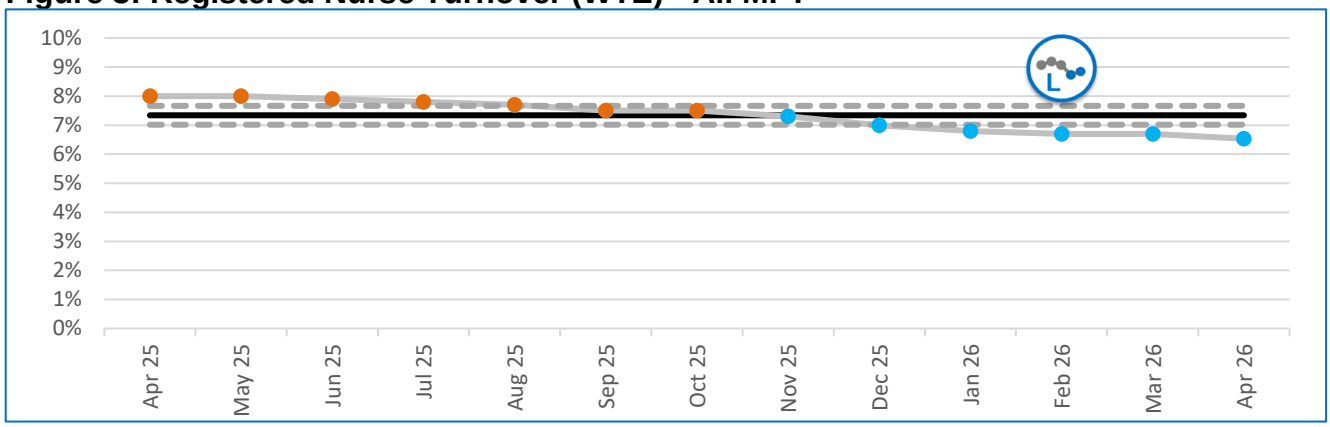
Figure 2: Support to Nursing Establishment (WTE) - All MFT



Registered Nursing

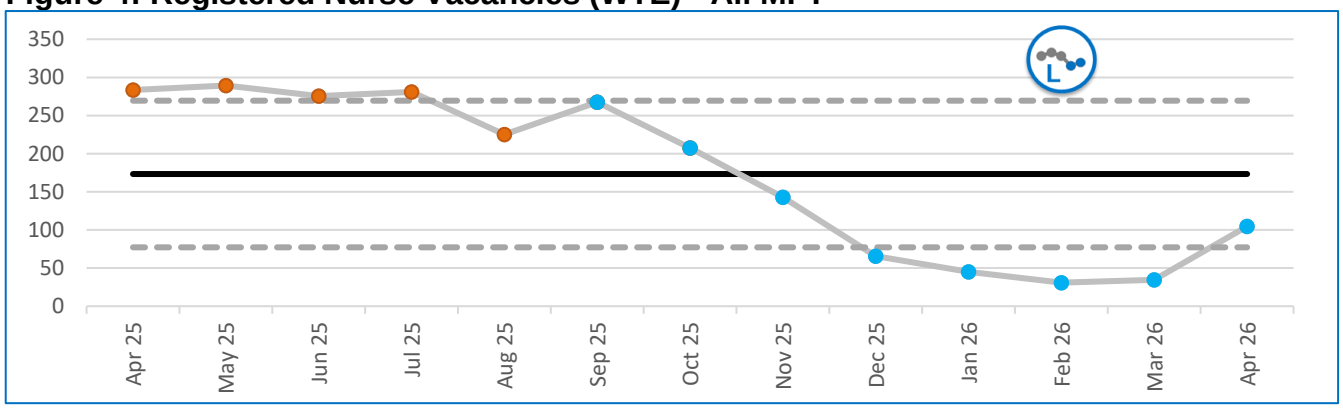
Continued improvement has been noted in registered nursing turnover rates, which have decreased month on month since April 2025 (Figure 3). The current MFT rate is down to 6.5% compared to the national turnover rate currently reported at 6.6%.

Figure 3: Registered Nurse Turnover (WTE) - All MFT



Registered nursing vacancies have reduced overall to 104.8wte (1.1%) in April 2026 which is significantly less than the current national vacancy rate at 5.2%, which is attributed to an overall increase in contracted wte and improved turnover rates (Figure 4). Detailed breakdown of current registered nursing vacancies by Clinical Group and speciality can be found in Appendix C.

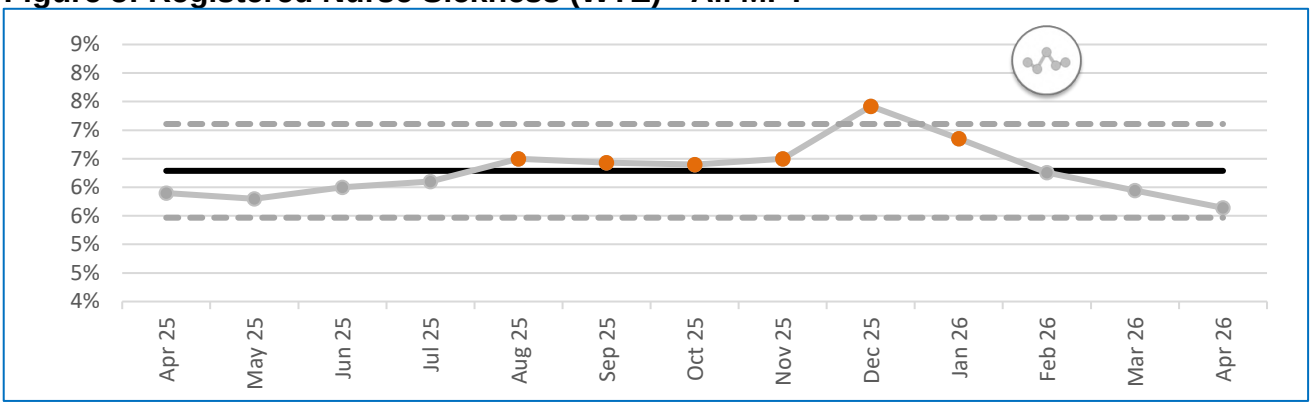
Figure 4: Registered Nurse Vacancies (WTE) - All MFT



Additional factors impacting the availability of registered nurses are sickness and maternity leave. Sickness rate for registered nurses has seen improvement in the last two months down

to 5.6% in April 2026 (Figure 5). There is currently an unbudgeted pressure on nursing workforce due to maternity leave of 452.1wte (4.7%). Further details and breakdown of registered nursing workforce metrics by Clinical Group can be found in Appendix C.

Figure 5: Registered Nurse Sickness (WTE) - All MFT

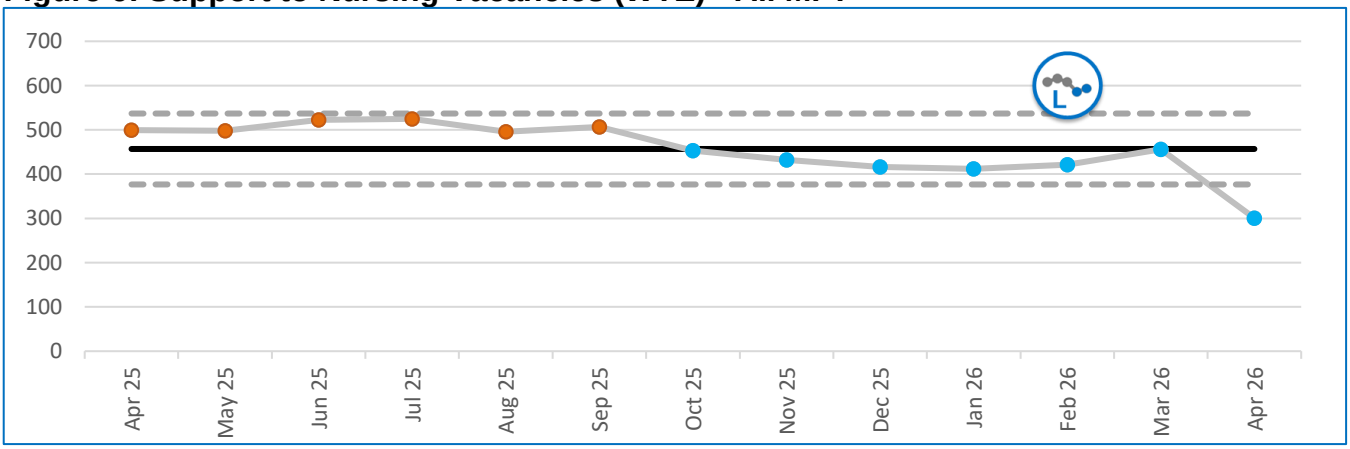


Support to Nursing

There has been a reduction in nursing assistant vacancies down from a mean average for the year 2025/26 of 457wte to 300.7wte (8.1%) in April 2026 **(Figure 6)** consistent with the reduction in funded establishment. Detailed breakdown of current support to nursing vacancies by clinical group can be found in **Appendix C.**

The Nursing Assistant Attraction, Recruitment and Retention improvement programme is established to reduce vacancies by increasing the recruitment pipeline whilst reducing the turnover rates. The turnover rate has reduced from a high of 12% in May 2025 to 10.2% in April 2026, compared to a national average of 10.2%, and the rolling average sickness rate has reduced from of 10.2% in May 2025 to 9.5% in April 2026, compared to a national average of 7.9%.

Figure 6: Support to Nursing Vacancies (WTE) - All MFT



Clinical Groups have established recruitment trajectories and are actively involved in local recruitment drives to attract and recruit applicants supported by the talent attraction team with a range of approaches including promoting through social media several short videos with nursing assistants talking about their role and connecting with a range of community groups including colleges.

The first pilot cohort of the Nursing Assistant Apprenticeship programme commenced in February 2026. As part of the attraction campaign, the Nursing Assistant Apprenticeship was advertised on the Find an Apprenticeship website, which initially received over 380 applications. 53 candidates met the strict criteria for the entry-level apprenticeship pathway and were shortlisted for interview during June 2026, with the remaining 143 shortlisted for direct recruitment into nursing assistant roles.

A comprehensive programme approach to absence prevention and attendance management is underway through the MFT Absence Management Improvement Plan, with a specific workstream related to absence amongst nursing assistants.

A pilot of 1:1 supportive conversations for nursing and midwifery (N&M) assistants was launched in September 2025 with an aim for planned roll out across all wards and departments on completion of the pilot in January 2026. The pilot was extended to March 2026 to allow for improvements to process and record keeping following feedback from colleagues.

A total of 223 colleagues were included across 13 pilot areas within five clinical groups. Over 90% of colleagues have completed their 1:1 discussions. RMCH, REH, SMH and MRI have successfully completed discussions for all staff in the pilot areas. N&M support colleagues responded positively to the 1:1 support conversations and valued to opportunity. The key themes identified from the pilot findings included increased workload, lack of opportunities for colleagues' progression and feeling undervalued within the team.

During June/July 2026 the 1:1 support conversations for N&M assistants will be implemented across the trust through a programmed approach, with launch events across each Clinical Group led by the Chief Nursing Officer.

6. Managing Staff Shortfalls

SafeCare

SafeCare is part of the established e-roster system used across MFT that facilitates the measurement of acuity and dependency needs of patients within inpatient areas to determine the hours of care required by the patient occupying the bed. It helps teams to proactively highlight and address risks before they lead to patient safety incidents through early identification and management of staffing pressures and effective workforce deployment.

Following a programme of education and support for ward teams the overall compliance with use of the system has improved from 50% in 2024 to 87% in April 2026 against a target is 90%.

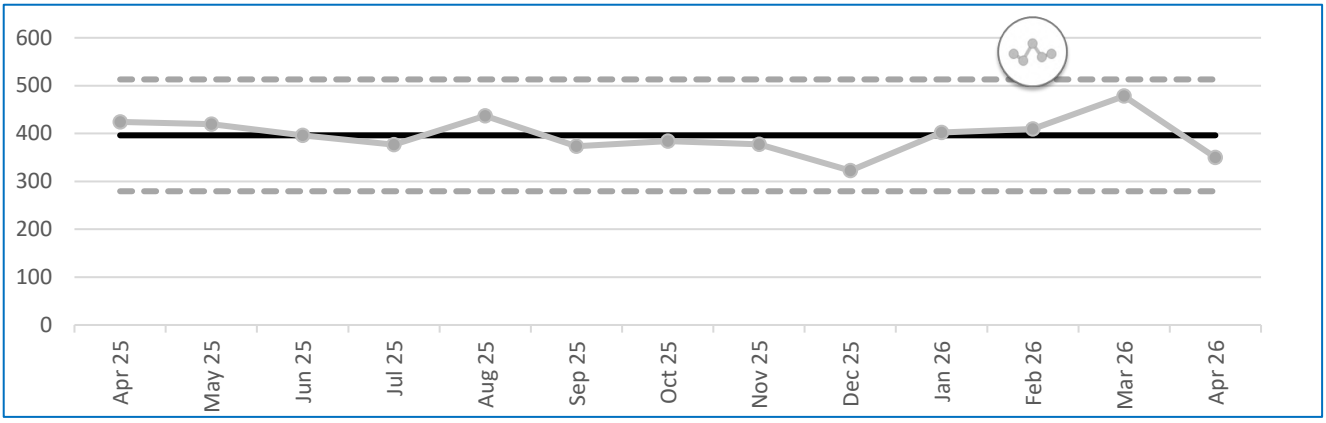
MRI Clinical Group have opted to undertake the first full roll out of SafeCare to support their daily nurse staffing oversight processes during July 2026, subject to initial analysis and configuration requirements.

Temporary Staffing

Temporary staffing resource is provided to the Trust by NHS Professionals (NHSP) to cover shortfalls in the nursing workforce. The nursing bank at MFT is well established, primarily by a large proportion of substantive staff who are registered with NHSP to undertake bank additional hours, with an average fill rate of 84%. A further detailed overview of nursing NHSP bank fill can be found in Appendix D.

The volume of registered nursing filled shifts increased in March and then resumed back to normal variation from April 2026 down to 349.9wte (Figure 7). Fill rates for each individual Clinical Group are provided in appendix E.

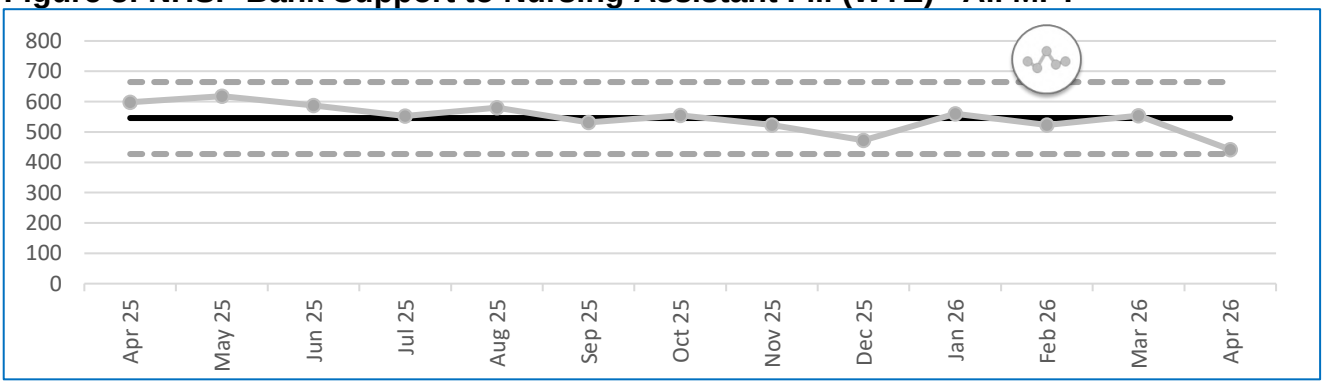
Figure 7: NHSP Bank Registered Nursing Fill (WTE) - All MFT



In the last two months, support to nursing usage has reduced by 81.3wte (Figure 8). 23.4% of support to nursing bank usage during this period was to support Enhanced Therapeutic Observations and Care (ETOC) across the Clinical Groups. The remaining filled shifts are to support gaps associated with vacancies, sickness and maternity leave.

Fill rates for each individual Clinical Group are provided in appendix F.

Figure 8: NHSP Bank Support to Nursing Assistant Fill (WTE) - All MFT



<u>Enhanced Therapeutic Observations and Care (ETOC)</u>

Patients require an enhanced level of therapeutic care and observation when they are at high risk of harm, self-harm, falls, removing essential medical devices or experiencing acute distress. This can be due to a risk of suicide or where they lack the mental capacity to maintain their own safety, such as patients living with dementia or experiencing delirium. Therapeutic interventions, including communication, distraction techniques, and meaningful activities, alongside maintaining the safety of individual patients through continuous or intermittent observation.

During the 2024/2025 financial year, the average NHSP filled WTE to support ETOC requirements was 178wte per month. Since the introduction of the ETOC improvement programme, there has been an average monthly reduction of 42wte. This equates to a cost saving of £35,402 per month.

A Research Intern commenced in post in August 2025, in collaboration with the University of Manchester, and a Delphi study has commenced to capture views from a range of stakeholders about what needs to be incorporated into the risk assessment tool. The Delphi study is open to other Trusts involved in the national ETOC Collaborative to support the development of a tool that is representative across the NHS. This research is supported by academic partners and is aligned to the improvement programme in practice. NHSE have endorsed the development of the risk assessment tool as a potential national standard, subject to validation, recognising its potential to provide a consistent approach across the NHS.

Falls data demonstrates there has not been a statistically significant increase in falls since commencement of ETOC improvement programme. This provides an indication that the de-escalation of ETOC provision, when supported by targeted interventions and the introduction of technological solutions, has not adversely impacted patient safety.

Enhanced Supervision Security Service

MFT has an Enhanced Supervision Security Policy, which supports the care of patients within adult and children's ward settings who demonstrate a high risk of aggression and/or self-harm to others. The patient must have an identified named nurse who is responsible for the care provided, and either undertakes or allocates direct therapeutic care and observation of the patient to an appropriate nursing assistant colleague. All patients requiring ESSO have had a nursing assistant assigned to their direct care since August 2025.

The approval of ESSO deployment is via the Director of Nursing within the Clinical Group to ensure that ESSO is used as per the current trust policy.

The average number of patients receiving ESSO has remained within normal variation for the last 11 months at 12 patients per week. Patient detained under the Mental Health Act (MHA) features as the most common reason (51%) for use of ESSO, with patients deprived of their liberty under a Deprivation if Liberty Safeguard (DoLS) accounting for the other substantial reason (31%).

Positive Behaviour Support (PBS) training provides evidence-based approaches to supporting individuals with challenging behaviours, aiming to provide therapeutic care and minimise restrictive practices. Clinical Groups have completed a training needs analysis and have identified a plan for delivery of PBS training to targeted and priority areas, and progress is reported to the Mental Health Subgroup. PBS training is delivered in 3 stages with plans to convert the first stage from face-to-face to e-learning in quarter 2 2026/27 to increase accessibility for colleagues.

CQC guidance requires that security staff used for enhanced observations must be properly trained, supervised, and vetted, focusing on person-centred care rather than just physical control. Security staff must support a therapeutic environment, with providers ensuring they are fit, competent, and authorized to work with vulnerable individuals. All Security Officers have completed the Trust's Level 3 PBS training prior to delivering ESSO.

The Chief Nursing Officer has committed to remove the deployment of ESSO, and Clinical Group Directors of Nursing for MRI, WTWA and NMGH have implemented plans which will be monitored at the NMAHP Professional Advisory Forum.

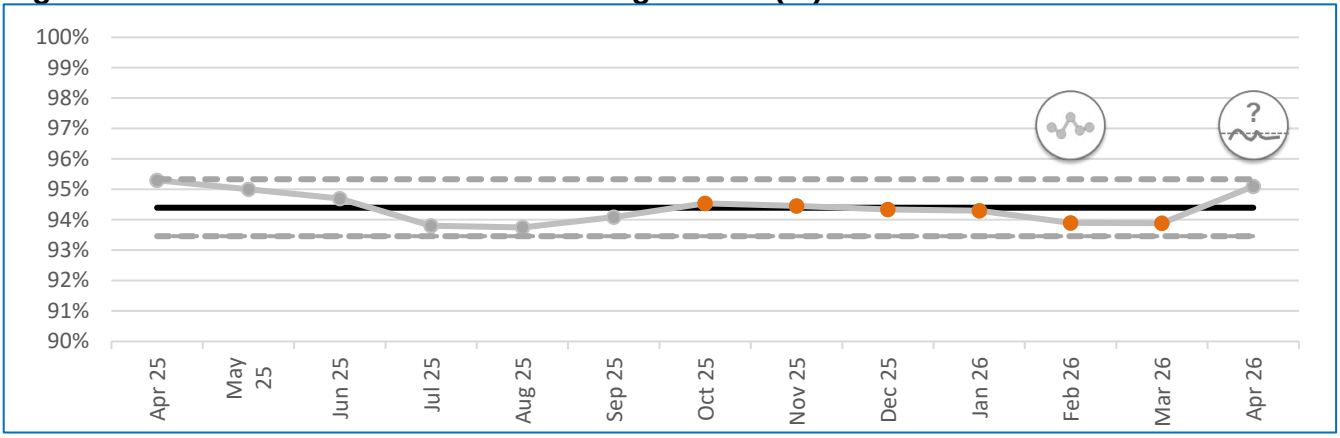
7. Fill rate

MFT is required to submit a monthly Safe Staffing Unify Report to NHSI detailing actual registered nurse staffing levels as a percentage against those that were planned. The fill rates are based on the budgeted bed base of each area and do not take account of any additional beds that are open and are inclusive of additional staff sourced through NHSP bank or additional substantive hours.

On average the MFT level fill rate has been maintained between 94% and 95% for the last 6 months (figure 9). 100% (114) of wards / departments reported fill rates above 85% in April 2026. This metric features in the workforce IPR.

Nursing staffing levels within the Clinical Groups are reviewed daily in real time and monitored through the safer 'staffing huddles' to ensure they meet the level of patient need and acuity on each ward and department. The daily staffing levels are viewed along with reported outcome measures to provide safe and effective patient care. Professional judgment is applied to respond to staffing gaps caused by unplanned absences or increased demand, with colleagues transferred between clinical areas to ensure the correct staffing levels and skill mix.

Figure 9: Planned vs Actual Nurse Staffing fill rate (%)



8. Care Hours Per Patient Bed Days (CHPPD)

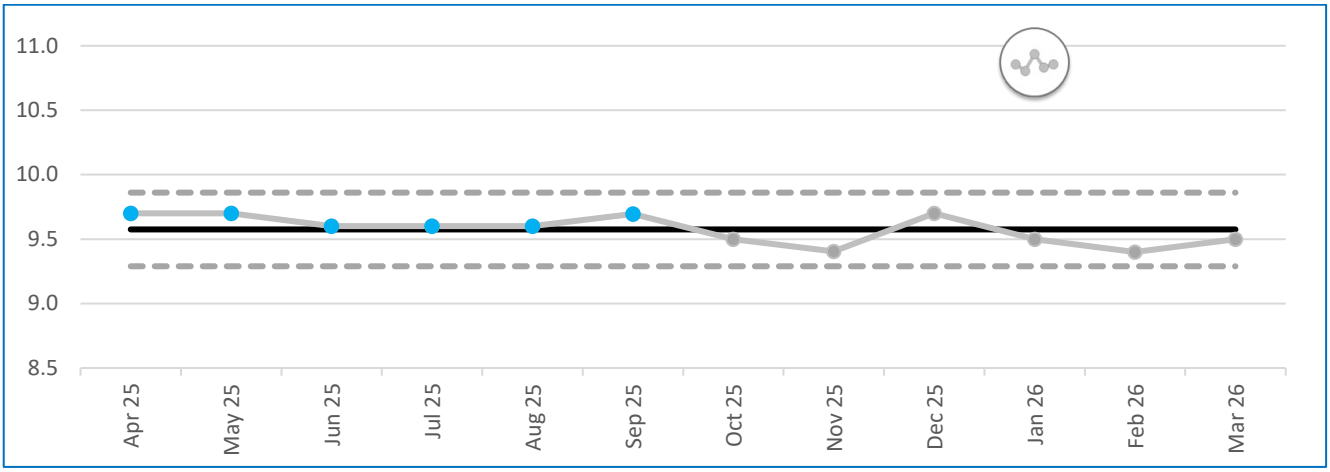
Care hours per patient day (CHPPD) is the principal measure of workforce deployment in ward-based settings since April 2016 and is calculated by taking all the shift hours worked over the 24 hours period by registered nurses and nursing assistants and dividing this by the number of patients occupying a bed at midnight.

CHPPD is not indicative of the total amount of care provided on a ward nor does it directly show whether care is safe, effective or responsive, therefore must be considered in conjunction with measures of safety and quality and using professional judgement.

There is no national target for CHPPD, however NHSE publish the data on the NHSE Model Hospital portal for Trusts to benchmark the data against other organisations. Figure 10 illustrates CHPPD data trend which has remained stable over the last 12 months demonstrating the workforce is being deployed to meet patient activity and patient needs.

The MFT wide average CHPPD in April 2026 was 9.6 against a Shelford Group rolling average of 9.8 hours.

Figure 10: Care Hours Per Patient Bed Days (CHPPD)



On further review of the latest available NHSE model hospital published data (December 2025), CHPPD at MFT is in the middle of the range when compared to the Shelford Group of NHS Trusts as shown in the table below.

Table 1: NHSE Model Hospital CHPPD Overview for Shelford Group Trusts

Trust name	Total Nursing and Midwifery CHPPD
University College London Hospitals NHS Foundation Trust	15.1
Guy's and St Thomas' NHS Foundation Trust	11.3
Imperial College Healthcare NHS Trust	10.7
King's College Hospital NHS Foundation Trust	10.4
Oxford University Hospitals NHS Foundation Trust	9.9
Manchester University NHS Foundation Trust	9.7
Newcastle Upon Tyne Hospitals NHS Foundation Trust	9.3
Cambridge University Hospitals NHS Foundation Trust	9.2
University Hospitals Birmingham NHS Foundation Trust	8.5
Sheffield Teaching Hospitals NHS Foundation Trust	8.1

9. Safe Staffing Incidents

During the period March and April 2026the majority of incidents were related to staffing were recorded as no harm (87.2%), and the appropriate actions were taken at the time following local investigation (Table 2).

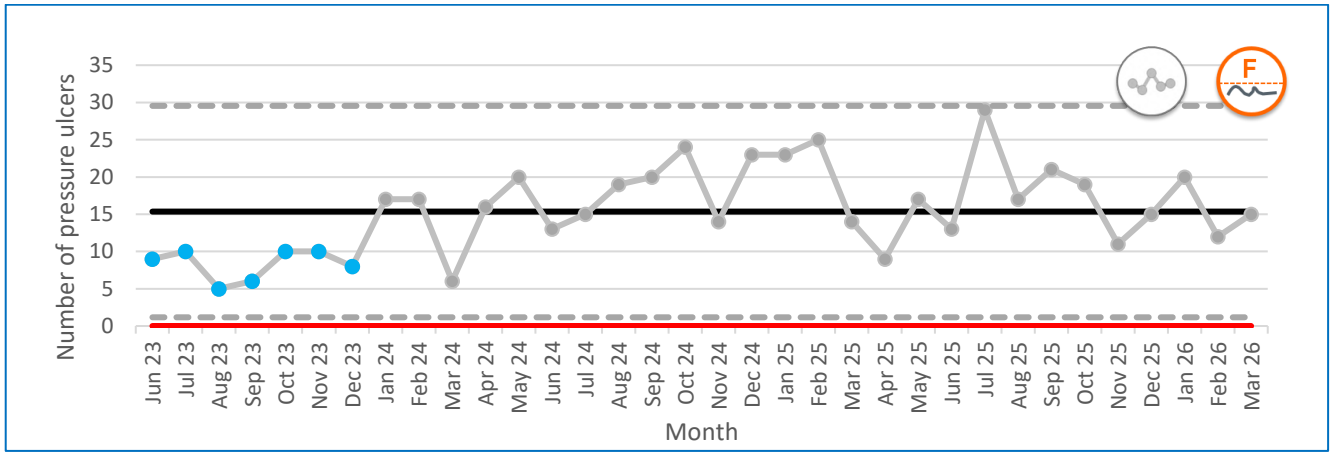
Table 2 – Safe Staffing Incidents

Incident Actual Impact	March 2026	April 2026
Level 1 – No harm	224	152
Level 2 – Low Harm	23	32
Level 3 – Moderate	0	0
Overall	247	184

Pressure Ulcers

There were 15 category 3 or 4 attributable pressure ulcers in March 2026. The majority were acquired in the community (13) with the remaining 2 reported at WTWA.

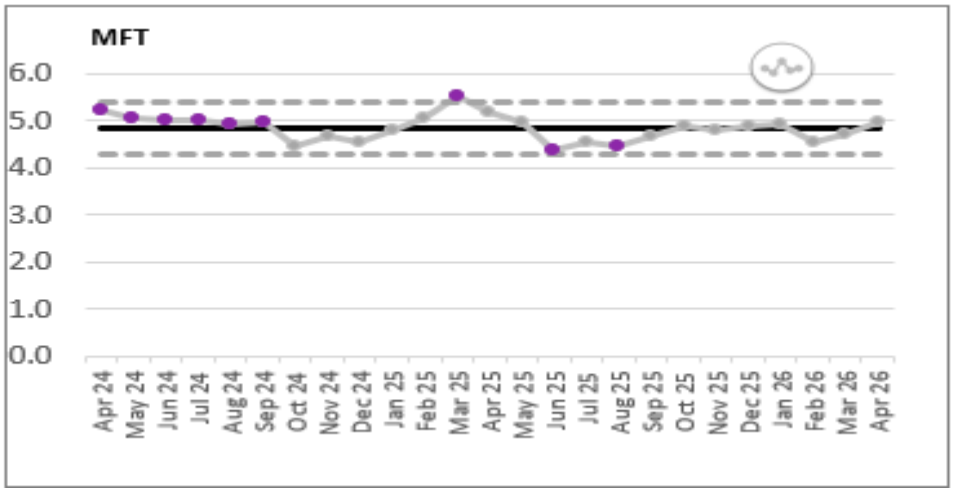
Figure 11: Attributable pressure ulcers (grade 3-4)



Falls

The overall falls data demonstrates a pattern of normal variation close to the mean average of 4.8 falls per 1000 beds days over the last 8 months with the rate of falls resulting in serious harm following a similar pattern with a mean average of 0.4. The falls strategy is currently being reviewed and will be aligned to Clinical Group falls prevention improvement work, which currently includes trials of a range of technological solutions such as falls sensors.

Figure 12: Falls per 1,000 bed days



10. Bi-annual Establishment Review

The Trust utilises the Safer Nursing Care Tools (SNCT - evidence-based tools developed by the Shelford Group and endorsed by the National Institute for Health and Care Excellence) to support nursing establishment and skill mix assessments. There are four tools currently available:

- Adult and Children and Young Persons Inpatient Ward Safer Nursing Care Tool (A&CYP IPW SNCT)
- Community Nursing Safer Staffing Tool (CNSST)
- Emergency Department Safer Nursing Care Tool (ED SNCT)*
- Mental Health Optimal Staffing Tool (MHOST)**

*Emergency Department Safer Nursing Care Tool (ED SNCT):

Additional work has recently been undertaken to incorporate a new algorithm for patients spending longer than 12 hours in the department and the revised tool has now been published for use across NHS Trusts. NHSE's safer Staffing Faculty provided training to 15 colleagues who have been nominated to cascade training to staff within each ED participating in the census. They all passed the inter-rater reliability assessment to provide assurance that they were at the required standard to appropriately assess the levels of care required by patients as defined by the tool. The first census using the revised tool is planned across the four ED's from 15 June for a 12-day period.

**Mental Health Optimal Staffing Tool (MHOST):

The MHOST tool, also developed by the Shelford Group in response to the Developing Workforce Safeguards (DWS) Guidance is a multi-disciplinary, evidence based all age acuity and dependency tool used for inpatient mental health settings to identify workforce requirements. MHOST was adopted for use in the Children and Young People Mental Health (CAMHS) inpatient unit (Galaxy House), in 2024, with the third census period completed in June 2025. Whilst results of the census have been provided, the accuracy of the feedback has been raised with the national safe staffing team in NHS England due to the inability to account for activity attributed to patients with high demand during the day, but on home leave overnight. It was also identified during the census completion and in networking with Alder Hey Children's Hospital, that an alternative approach to scoring was being used between the two hospitals and the validity of the data was therefore raised. The national team have acknowledged this inconsistency and asked RMCH/Galaxy House to contribute to a review and refresh project to look at the MHOST tool, particularly focusing on CYP in Mental Health settings which is taking place during June 2026 for 2 weeks.

SNCT has specific criteria that must be evidenced: a license, minimum data collection for 30 days including weekends, census collected by no more than 3 senior staff trained for each ward, established external validation of the data, interrater reliability assessment and data available showing the daily acuity and dependency levels for the previous 24 hours.

The tools are used alongside professional judgement and assessment of patient outcomes, patient experience and staff experience as part of a triangulated approach to ensure nursing establishments reflect patient needs related to acuity and dependency.

The Professional Judgement Framework (2023), based on the results of research funded by the National Institute for Health Research in England, and developed by several safe nurse staffing professional experts, is used to guide the review of the census results (appendix H). The framework provides a systematic approach to the staffing review and clear justification where judgement might be used to recommend a variation from the figures calculated by the tool.

SNCT guidance requires review of data from a minimum of two census periods before implementing changes to establishments/budgets as it is acknowledged that changing patient demographics, fluctuations in patient flow and seasonal variation are factors that influence the acuity and dependency scores. Significant structural changes between census periods, such as reduction/increase in beds and change in clinical speciality mean that it may not be possible to make direct comparisons with previous censuses.

This process allows for more targeted staffing adjustments, leading to improved operational efficiency and patient care outcomes. Aligning staffing levels more closely with demand, can achieve better cost efficiency without compromising care quality.

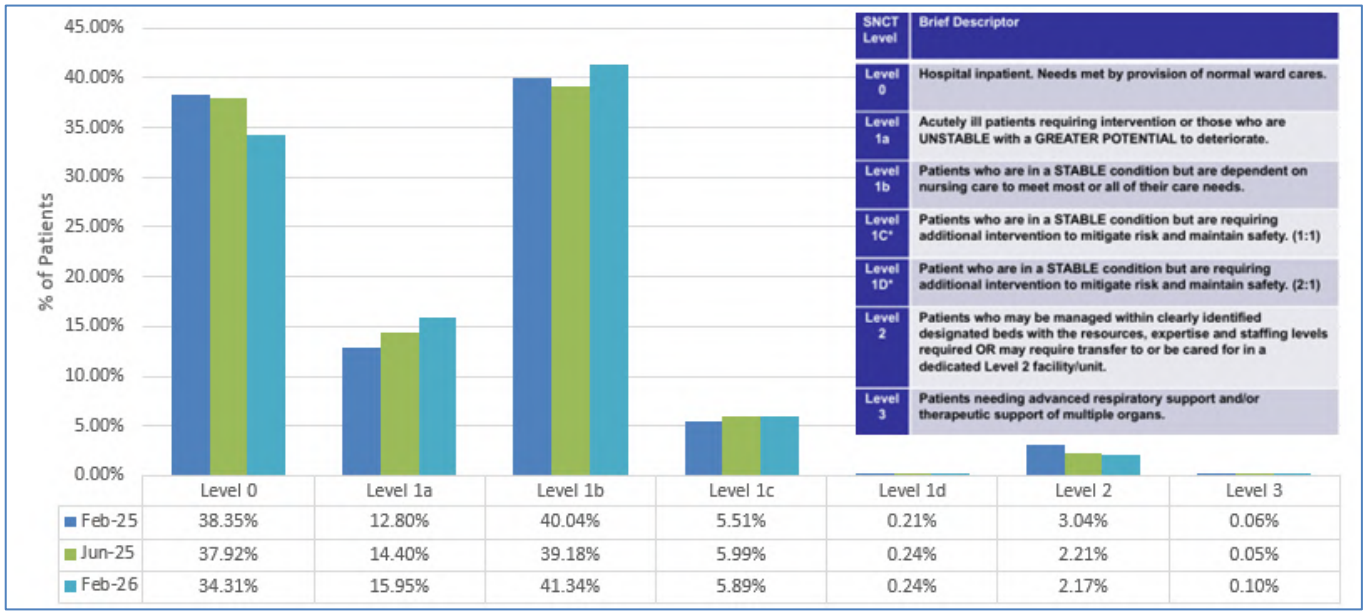
Adult and Children and Young Persons Inpatient Ward review

The inpatient census was undertaken for 30 consecutive days from 26th January 2026 to 24th February 2026 across all Clinical Groups within Adult and CYP areas. A total of 84 wards participated in the census. This represents the third consecutive SNCT data collection cycle, following previous censuses in February and July 2025. This continued programme of data collection has strengthened the reliability of the dataset and supports a more robust, longitudinal assessment of nursing establishments and skill mix across MFT.

Data from the last 3 census' over a 12 month period shows a reduction of 4.4% in the proportion of patients requiring hospitalisation whose needs can be fully met by normal ward care (Level 0). There was also a 3.15% increase in acutely ill patients (Level 1a) and a 1.3% increase in patients who are clinically stable but dependent on nurses for most or all of their daily living activities (Level 1b - eg. needing help with feeding, attending the toilet) (Figure 13).

This coincides with the implementation of the "care closer to home" programme, including the closure of beds at MRI, NMGH and WTWA hospital sites and utilisation of the hospital at home service. Direct correlation must be made with caution and further census periods alongside analysis of data from hospital at home activity is required.

Figure 13: Trust Adult and Children Inpatient SNCT Patient Acuity Score



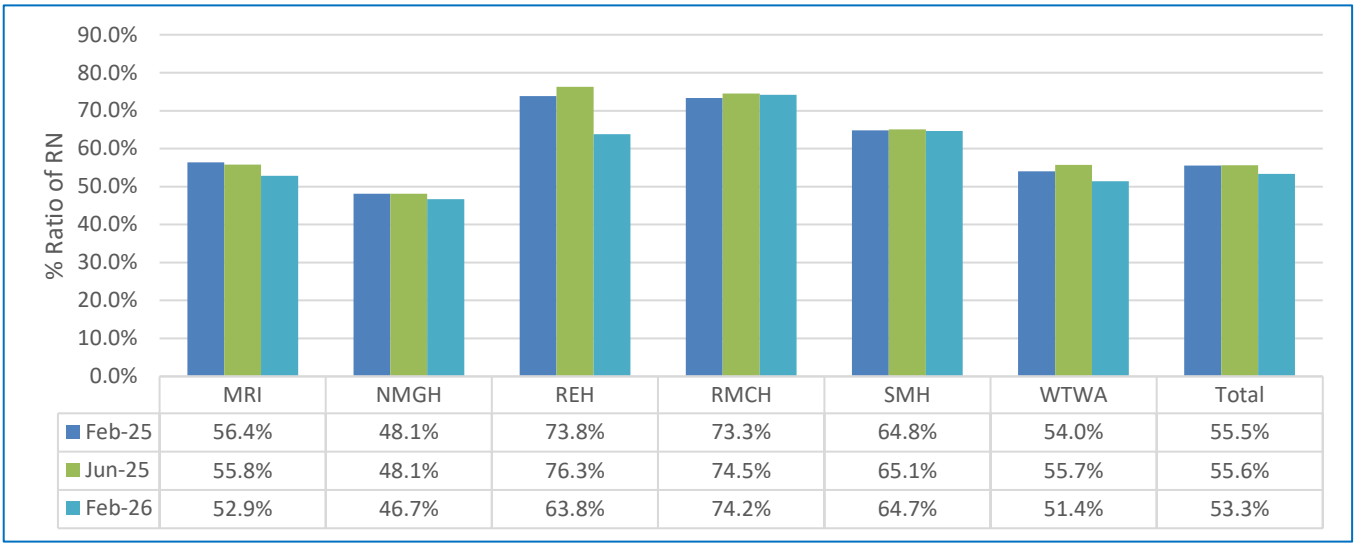
	Level 0	Level 1a	Level 1b	Level 1c	Level 1d	Level 2	Level 3
Feb-25	38.35%	12.80%	40.04%	5.51%	0.21%	3.04%	0.06%
Jun-25	37.92%	14.40%	39.18%	5.99%	0.24%	2.21%	0.05%
Feb-26	34.31%	15.95%	41.34%	5.89%	0.24%	2.17%	0.10%

Analysis of skill mix forms an important part of the establishment review process and Figure 14 provides a comparison by Clinical Group of the current establishment skill mix reflected in the ratio of registered nurses to nursing assistants.

NMGH has a higher proportion of nursing assistants on some in-patient wards, when compared to MRI and WTWA, with additional nursing assistants on duty at certain times to mitigate the risk related to fire evacuation. The higher ratio of registered nurses at the Royal Eye Hospital (REH) relates to one specialist Ophthalmic ward, and the 2 gynaecology wards at SMH have a higher ratio of registered nurses to account for day case surgical activity across both areas. Children's wards operate with a higher ratio of registered nurses compared to adult areas to account for

additional requirements related to clinical observation and complexity of medicines administration, as shown across RMCH areas.

Figure 14: % Ratio of Registered Nurses compared to Nursing Assistants (Skill Mix) - All Adult and Children Inpatient Ward Establishments



	MRI	NMGH	REH	RMCH	SMH	WTWA	Total
Feb-25	56.4%	48.1%	73.8%	73.3%	64.8%	54.0%	55.5%
Jun-25	55.8%	48.1%	76.3%	74.5%	65.1%	55.7%	55.6%
Feb-26	52.9%	46.7%	63.8%	74.2%	64.7%	51.4%	53.3%

A full establishment review triangulating the SNCT recommendations, patient outcomes and using the "Professional Judgement Framework", has been undertaken by the Clinical Groups.
Table 3 shows that from the 84 wards reviewed, there has been a recommendation to increase the funded establishment in 7 and the reduce the funded establishment in 8. A full breakdown of the results from SNCT census for Feb-25, Jun-25 and Feb-26 for each ward area with the recommendations following application of the professional judgement framework is provided in Appendix I.

NMGH and WTWA Clinical Groups have identified opportunities to transfer establishments between wards to achieve the recommended safer staffing establishments. SH Clinical Group have enacted a reduction in establishments across the two St Mary's wards and the SHCG Management Board has approved an increase in establishment for one ward at RMCH, with the transfer of funding to support an increase in establishment at the ward on the NMGH site. MRI Clinical Group concluded that the current funded establishments aligned with the recommendations from the comprehensive establishment review, with 6 wards requiring close monitoring and further review following the SNCT census during July 2026.

Table 3 – Summary of Adult and Children Inpatient SNCT Recommendation

			Recommendation following analysis of SNCT data using Professional Judgement Framework		
Clinical Group		Number Wards	No change	Increase establishment	Decrease establishment
MRI		24	24	0	0
NMGH		20	16	2	2
SH	REH	1	1	0	0

	RMCH	8	6	2	0
	SMH	2	0	0	2
WTWA		29	23	3	3
TOTAL		84	59	7	8

Manchester and Trafford Local Care Organisation (LCO) and University Dental Hospital Manchester (UDHM) Clinical Group

The first census using the updated Community Nursing Safer Staffing Tool (CNSST) tool was completed in September 2025 at MFT for a period of 14 days by all District Nursing teams. As a minimum of 2 census is recommended before implementing any changes to the establishment a second census is now scheduled in June 2026.

The September 2025 census was recorded over 16,000 interactions over the two-week period. The acuity for each intervention was added to the Community Electronic Patient Record to enable data collection. However, issues identified in EMIS resulted in missing acuity for some contacts, resulting in additional manual submissions of data/acuity. Further work remains ongoing by EMIS to rectify the issues with a planned solution from EMIS team due in Quarter 1.

September 2025 audit results have been produced in SNCT data format in March 2026 (Table 4). There are 3 areas that indicate within 10% of the recommended establishment, 13 areas that indicate above 10% of the recommended establishment and 4 areas that indicate >10% below recommended establishment. Following initial validation of the data there is further work required to ensure reflective data collection. Adult Community and Neighbourhood Care Head of Nursing, Lead Nurse and NMAHP Workforce Programme Lead have created a planned approach for future data collection and are currently agreeing timescales for next the data collection for summer 2026. Following the next census the results will be triangulated with national benchmarking and Queen's Nursing Institute recommendations to inform further workforce modelling.

Table 4: September 2025 CNSST results

Neighbourhood	Sep 2025 - Rag Rating			
	within 10% of the recommended establishment	**>10% above recommended establishment**	**>10% below recommended establishment**	Total
South	0	5	0	5
Central	1	4	0	5
North	1	4	0	5
Trafford	1	0	4	5
Total	3	13	4	20

In February's Safer Staffing paper it was reported that Trafford's Adult Community Nursing services are under unprecedented pressure due to sustained referral growth, rising complexity of patient need, and insufficient workforce capacity. Current models are no longer sustainable, resulting in deferred visits, long waiting times, increased clinical risk and patient harm (reflected in MFT Risk Register with District Nursing scoring 16).

A business case was approved by the Local Care Organisation Clinical Group Senior Leadership Team and Greater Manchester Integrated Commissioning Board for a comprehensive redesign and targeted investment in Trafford's adult core and specialist community nursing services. This

includes £659,703 recurrent investment and delivers an additional 16.33 WTE into front line community nursing services, offset through repurposing of existing budgets.

Implementation of the workforce model is being delivered through a phased approach to ensure a sustainable and resilient District Nursing service aligned to neighbourhood team delivery.

Phase 1 – Workforce Alignment was completed during February 2026 and focused on establishing the required workforce skill mix within existing budgets and allocating additional Band 5 capacity across Trafford DN teams. This work has now been completed and aligns with the divisional model for District Nursing care. Recruitment to the additional posts has commenced.

A phased recruitment strategy has been implemented, with initial recruitment activity prioritised towards Bladder and Bowel Services and Treatment Rooms to support service resilience and reduce operational pressures. In total, 7.9 WTE posts were externally advertised, resulting in the successful appointment of 3 WTE to date. The remaining vacancies have subsequently been re-advertised and are currently progressing through active recruitment processes.

The Head of Nursing for Adult Community Services will prioritise deployment of the outstanding WTE resource to Bladder and Bowel Services to support waiting list reduction and enhance service sustainability and continuity of care.

Phase two recruitment, relating to the remaining 8.43 WTE, will commence following completion of the wider service reconfiguration programme.

Phase 2 – Service Redesign (March–June 2026) will support the disestablishment of the Clinical Prioritisation and Ear Care services. This will involve staff consultation and the reallocation of budgets and duties to support the future service model within Trafford DN service.

A Quality Impact Assessment has approved the cessation of the Ear Care service in line with national delivery models, with associated funding absorbed into the Trafford DN budget. The proposal has progressed through system governance including the Provider Collaborative, Scrutiny Committee, and Locality Board. Colleagues impacted by the change will be supported through redeployment via the organisation's management of change process. Progression of this workstream has been impacted by significant community engagement and response associated with the proposed closure of locally delivered ear syringing services across Trafford.

Staff consultation is currently underway within the Clinical Prioritisation service with redeployment opportunities being explored within either Trafford DN or the Single Point of Access (SPOA).

Within the Bladder and Bowel Service recruitment to the vacant 0.6 WTE Band 6 post was successfully completed in February 2026 and measures are in place to support the transition of activity between specialist and core DN teams.

At the University Dental Hospital of Manchester (UDHM), bespoke staffing guidance has been developed for clinics, with daily staffing reviews and ongoing optimisation of health roster systems. The senior dental nursing team is fully engaged in maximising roster functionality and improving workforce systems and reporting.

11. AHP Safe Staffing at MFT

9.1 Background

AHPs form a core part of the MFT workforce, delivering services across acute hospitals, community settings, and specialist hospitals. Within the acute hospitals, AHPs support emergency and inpatient care, play a key role in admission prevention, patient flow, rehabilitation, and discharge planning. In community services, they provide care closer to home, supporting long-term condition management, prevention, and rehabilitation, and work as part of integrated neighbourhood teams. Specialist hospitals, such as the Royal Manchester Children's Hospital (RMCH) and the Manchester Royal Eye Hospital (MREH) are supported by highly specialised AHP roles delivering complex tertiary care. This breadth of contribution illustrates the wide-ranging work of AHPs across MFT, underlining the importance of ensuring safe, effective, and patient-centred staffing**.**

The NQB Safer Staffing Guidance (2016) and NHSI Developing Workforce Safeguards (2018) apply to all professional groups, including AHPs. However, unlike nursing, there is currently no nationally validated tool to determine AHP staffing requirements. This has led to variation across services nationally and a reliance on local judgement, demand assessments, and professional expertise.

The Allied Health Professions Strategy for England 2022-2027 highlights the need to deploy 'the right AHPs, with the right skills, in the right place at the right time' (NHS England, 2022). Reflecting this, MFT is developing an approach to AHP safe staffing assurance that aligns with the established nursing reporting model, using available data, advisory standards and benchmarking to support Board oversight.

A Trust wide AHP Safer Staffing Survey was undertaken to understand the current approaches to establishing and monitoring safe staffing across all AHP professions. The findings indicate significant variation between services and highlight several gaps that need to be addressed to support future staffing assurance.

Key findings include:

- Variation in methods for determining safe staffing, with most services relying on professional judgement and historic establishments rather than prospective modelling.
- Limited measurement of complexity and acuity, particularly in outpatient and community pathways, restricting the ability to evidence staffing risk.
- Inconsistent escalation routes when AHP staffing becomes unsafe, and no red flag indicators comparable to nursing.
- Skill mix and specialisation reduce redeployment flexibility, meaning headcount alone does not represent service capability.
- Restricted temporary staffing option, limiting resilience during vacancy, sickness or maternity leave.

Overall, the survey demonstrates mixed confidence in AHP workforce planning capability, with strong local knowledge but limited Trust wide standardisation, visibility and consistent use of

data, These findings directly inform the Chief AHP's work to develop a triangulated AHP safer staffing model.

9.2.2 Proposed MFT Approach to Reporting AHP Safer Staffing

Bi-annual establishment and skill mix review

It is proposed that MFT introduces a formal process for the bi-annual assessment of AHP establishments and skill mix, aligned with the principles of the NQB Safer Staffing Guidance (2016) and NHSI Developing Workforce Safeguards (2018). This would triangulate workforce data with quality, safety, and patient outcome indicators.

Job planning and deployment

While job planning, templates, and e-rostering systems are already in place, these are not yet fully utilised to provide consistent data on delivery against planned capacity. Strengthening this capability is a key improvement priority and would enable clearer measurement of planned versus delivered AHP workforce capacity. This includes capturing the balance of DCC and SPA, alongside quality outputs, so assurance extends beyond workforce numbers to demonstrate impact on patient care, outcomes, and service sustainability.

Benchmarking against national guidance

To strengthen assurance, it is proposed that AHP staffing levels are RAG-rated against the NQB framework to identify areas of compliance, partial compliance, or risk. This approach would highlight where further action is required, ensure alignment with national principles, and provide the Board with a consistent method of benchmarking AHP staffing alongside nursing and midwifery. In the absence of profession or pathway specific standards for all AHPs, the methodology will draw on existing, established national guidance and datasets as reference points, to inform and support a consistent Trust wide AHP approach**.**

AHP workforce dashboard

Work has already been undertaken to cleanse ESR data and develop a dedicated AHP workforce dashboard. This tool now provides a baseline view of AHP staffing, highlighting areas of pressure, variation, and opportunity, and will be refined to support future reporting of agreed metrics. To ensure data quality, ESR data should be subject to an agreed review cycle for assurance. Responsibility for checking ESR data rests with local AHP leads, who should review their workforce information at divisional workforce and education committees and feed back discrepancies to the corporate workforce team to maintain accuracy.

Horizon scanning and external engagement

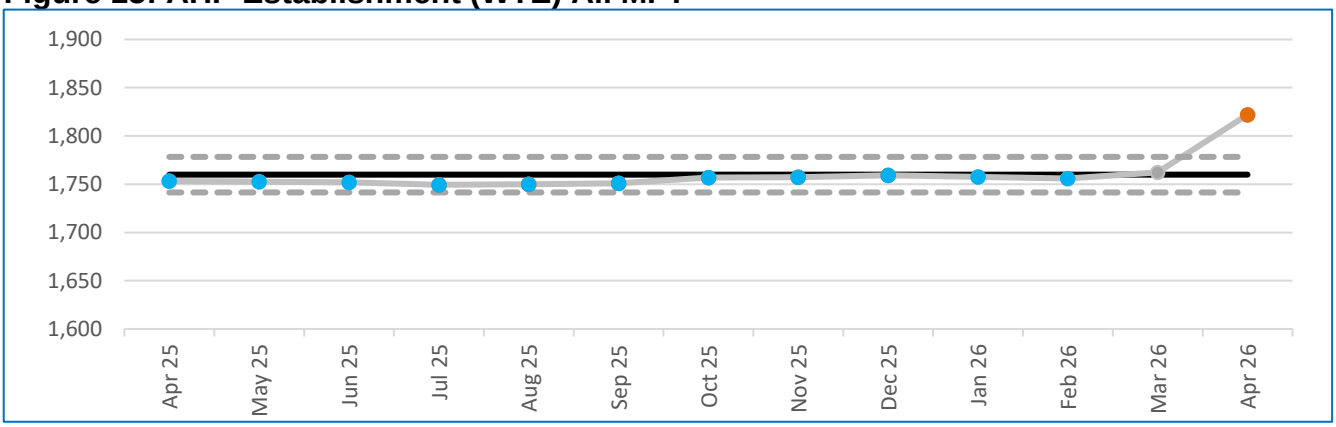
AHP leaders at MFT have engaged with peer NHS trusts, including Wirral University Teaching Hospitals NHS Trust and Northern Care Alliance NHS Foundation Trust, to scope existing methodologies and approaches for AHP safe staffing. Insights from this work will inform the development of local metrics and ensure MFT's approach is aligned with emerging best practice. To support this work, a core AHP safe staffing working Group has now been established to oversee development, testing, and refinement of the methodology, ensuring consistency and professional input. Progress of this work will be monitored by the AHP Forum (a subgroup of the NMAHP Advisory Group), chaired by the Trust Chief AHP.

9.3 Current MFT AHP Establishment

Registered AHP

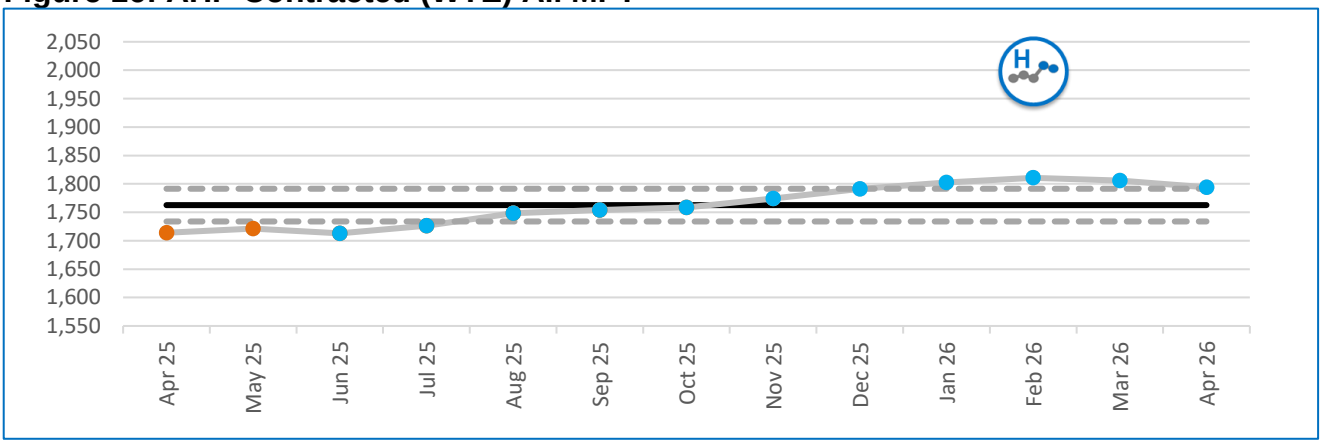
The current registered allied health professional establishment wte for roles band 5 and above in April 2026 was 1,822.0wte (figure 15). There has been an increase of 66.3wte into the new financial year, primarily driven by increases in CSS (AHP Therapy Division 17.2wte and Imaging Division 33.1wte).

Figure 15: AHP Establishment (WTE) All MFT



The current registered allied health professional contracted wte for roles band 5 and above in April 2026 was 1,794.2wte (figure 16). There has been a decrease of 16.4wte in the last two months.

Figure 16: AHP Contracted (WTE) All MFT



Increases in establishment wte for registered AHP role have seen an increase in overall vacancy position in April 2026. There are currently 27.8wte AHP vacancies at Trust level (figure 17). Within AHP services there are several professions with higher levels of vacancies most notably occupational therapy 19.8wte in April 2026 (Table 5). Further details and breakdown of registered AHP vacancies by clinical group can be found in Appendix G.

Figure 17: AHP vacancies (WTE) All MFT

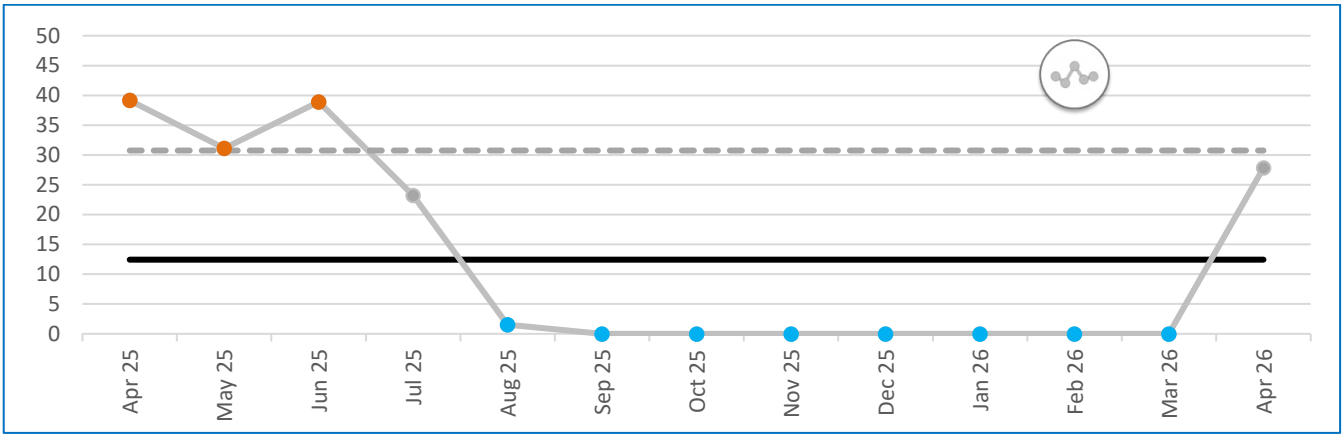


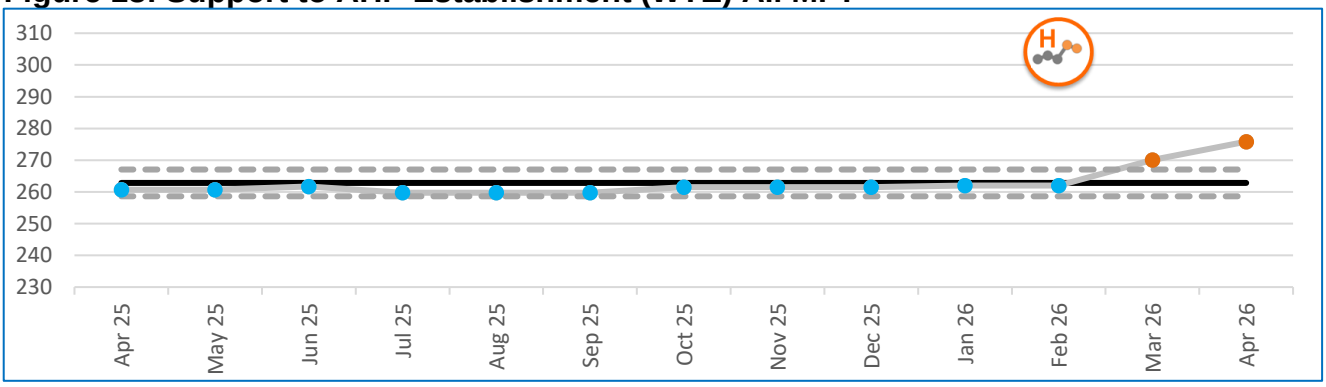
Table 5: AHP Vacancies by Profession – All MFT – April 2026

AHP Profession	Establishment WTE	Contracted WTE	Vacancies WTE
Chiropody / Podiatry	67.14	65.03	2.11
Dietetics	144.02	149.14	0.00
General AHP	7.73	0.00	7.73
Occupational Therapy	307.25	287.48	19.77
Orthoptics	30.36	29.73	0.63
Physiotherapy	620.79	631.03	0.00
Radiography	472.5	457.68	14.82
Speech Therapy	172.27	174.15	0.00

Support to AHP

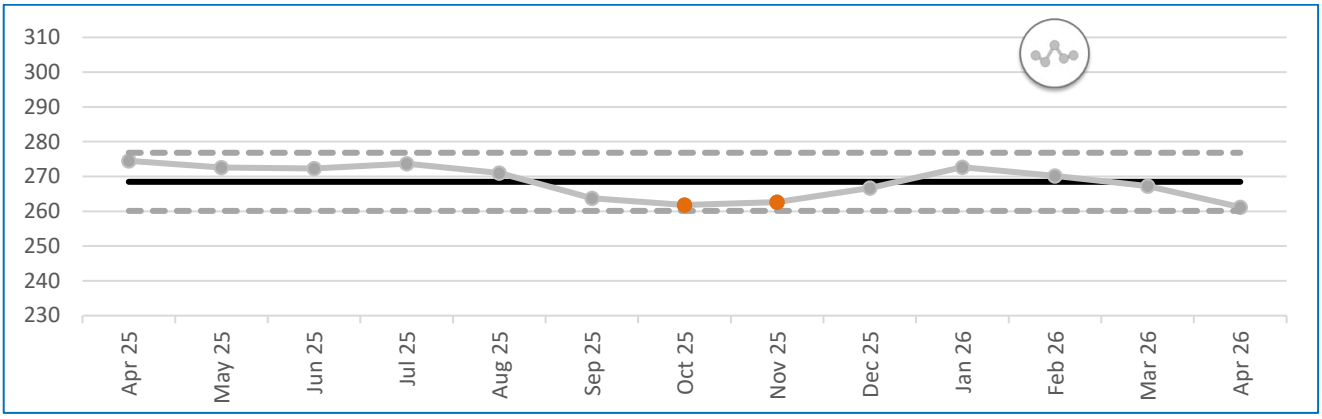
The current support to AHP establishment in April 2026 was 275.8wte (figure 18). There have been an increase of 5.8wte increase into the new financial year.

Figure 18: Support to AHP Establishment (WTE) All MFT



The current support to AHP contracted wte in April 2026 was 261.2wte (figure 19). There has been a decrease of 9.0wte in the last two months.

Figure 19: Support to AHP Contracted (WTE) All MFT



Increases in establishment and decreases in contracted wte for support to AHP in the last two months, have increased the vacancy position to 14.6wte (figure 20). A breakdown by AHP service is provided in table 6 and by clinical group can be found in Appendix G.

Figure 20: Support to AHP vacancies (WTE) All MFT

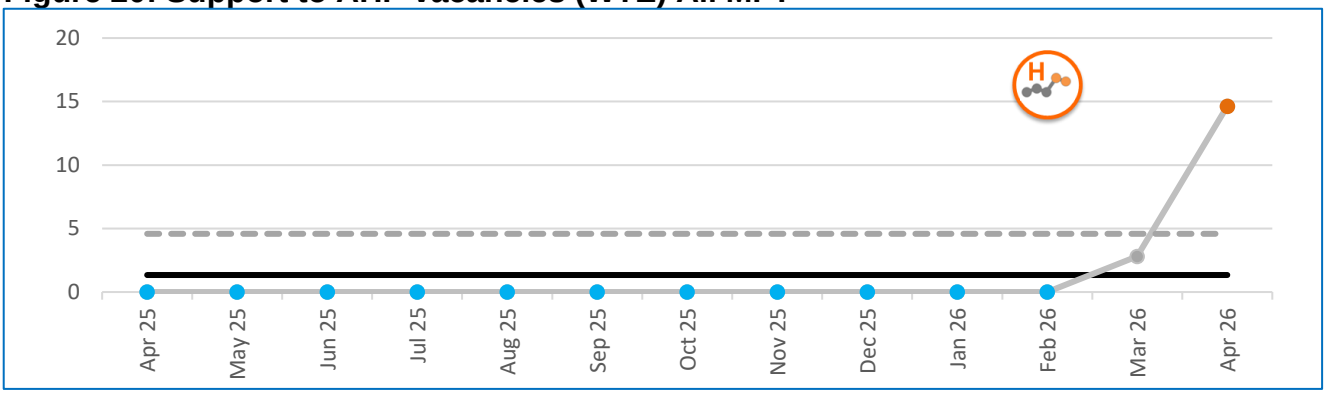


Table 6: Support to AHP Vacancies by Profession Type – All MFT – April 2026

AHP Profession	Establishment WTE	Contracted WTE	Vacancies WTE
Chiropody / Podiatry	5.17	2.37	2.8
Dietetics	17.99	18.52	0.0
Occupational Therapy	34.83	39.15	0.0
Orthoptics	1	1	0.0
Physiotherapy	101.52	93.3	8.22
Radiography	92.88	83.81	9.07
Speech Therapy	22.45	23.05	0.0

<u>AHP Staffing Escalation and Managing Shortfalls against Current Establishment</u>

AHP staffing levels are actively monitored across Clinical Groups, with risks identified in key services including adult and paediatric dietetics (particularly acute dietetics at WTWA), critical care (below GPICS standards), stroke services (below SSNAP recommendations), burns and paediatric burns therapy (below recommended levels), and the Manchester breast cancer service (no specialist breast therapist). These risks, and their mitigations, are recorded on divisional and AHP risk registers and reviewed through established workforce governance forums.

Daily shortfalls are discussed at therapy department lunchtime huddles to identify immediate mitigations and seek cross-team support. Weekly escalations are managed through workforce

and Clinical Group management boards, with issues added to risk registers as required. Longer term shortages are raised at divisional risk meetings and AHP vacancy control meetings with HR and Finance, with business cases developed where guidelines or standards cannot be met.

Managing shortfalls includes redeployment, use of cross-cover arrangements, and prioritisation of urgent services. Patient caseloads may be adjusted, clinics rescheduled, or waiting times extended where unavoidable. Risk registers are updated to capture ongoing issues, and bank and agency staff continue to be used where necessary, though reliance varies across professions. Retention and staff wellbeing remain a focus to reduce attrition and strengthen workforce resilience.

Workforce risks and responses are tracked through the AHP Workforce Efficiency Committees, divisional workforce efficiency meetings, and commissioned service reviews (e.g. weekend service models and safer staffing in medical wards). This escalation and review process provides assurance that AHP staffing risks are identified, tracked, and mitigated in real time, with governance aligned to the nursing escalation framework to ensure safe, effective, and sustainable care delivery.

9.4 AHP Workforce Productivity

The NMAHP Corporate Workforce team is working with Clinical Group AHP Workforce Leads and Directors of Finance to strengthen oversight of workforce expenditure, covering bank and agency use, vacancy management, recruitment, retention, and workforce redesign.
The recently established AHP Value for Patients Task and Finish Group is progressing a set of AHP workforce levers (safe staffing levels, shift patterns, cost per WTE, vacancy policies). Early work shows variation in vacancy management and temporary staffing, with standardised reporting being developed to provide trend data comparable with nursing.

9.4.1 High Priority Levers

While several workforce and financial pressures affect AHP services, the following highlight the current high-priority levers where targeted action is underway to provide assurance and drive improvement.

- Supporting CSS AHP review of demand / capacity 7 day modelling
- Reducing premium overtime spend for AHP roles, primarily in CSS imaging
- Promote NHSP campaign to increase AHP bank and migrate overtime to bank
- Removal of recruitment and retention payments for Sonography roles.
- Supporting GM review of imaging outsourcing arrangements including rate cards.

12. Recommendations

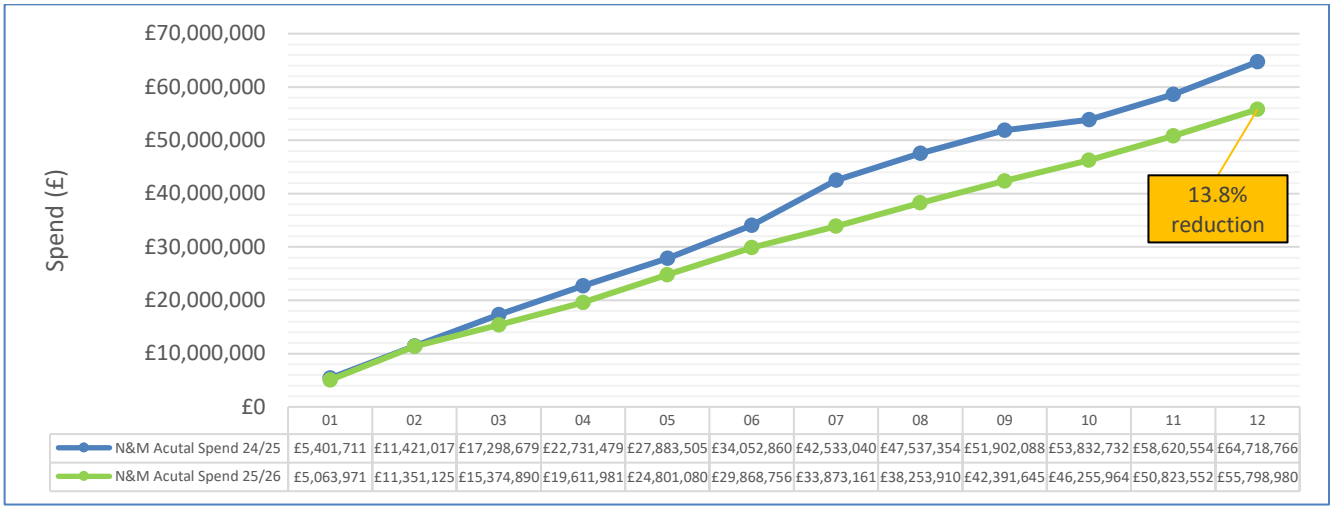
The Trust Board of Directors is asked to:

- Receive this report as assurance that MFT remains compliant with the national guidance (NQB 2026; DWS 2018) in relation to safer nurse staffing.

- Note the report was received and discussed at the People Board Committee on 30th June 2026.
- Receive assurance of safe nurse staffing as described in sections 5, 6, 7, 8 and 9.
- Receive the outcome of the annual safer staffing comprehensive establishment review which shows that safer staffing establishments have been maintained across all in-patient ward areas following realignment of funded establishments within respective Clinical Groups.
- Receive assurance of the revised workforce model in Trafford District Nursing service with service reconfiguration completed in February 2026 and commencement of a two phased recruitment to the additional 16.33 WTE.
- Note the risk of between c£9m and c£12.3m increase in the annual pay bill as a consequence of the review of band 5 job descriptions taking place during 2026/27.

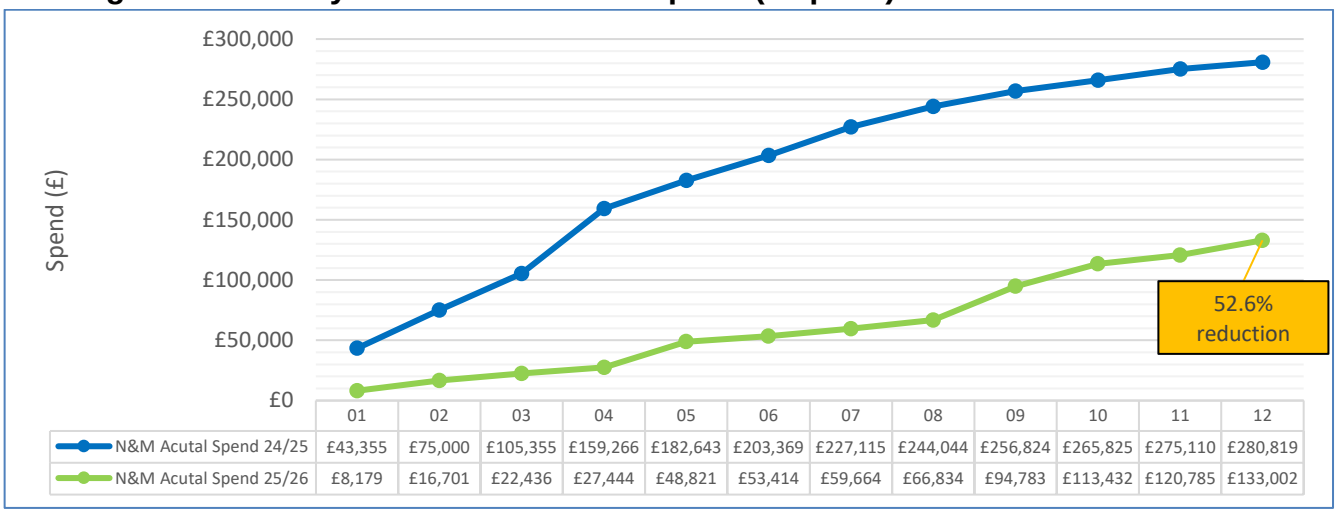
Appendix A

Nursing and Midwifery bank reduction 26/27 compared to 25/26 (£ spend)



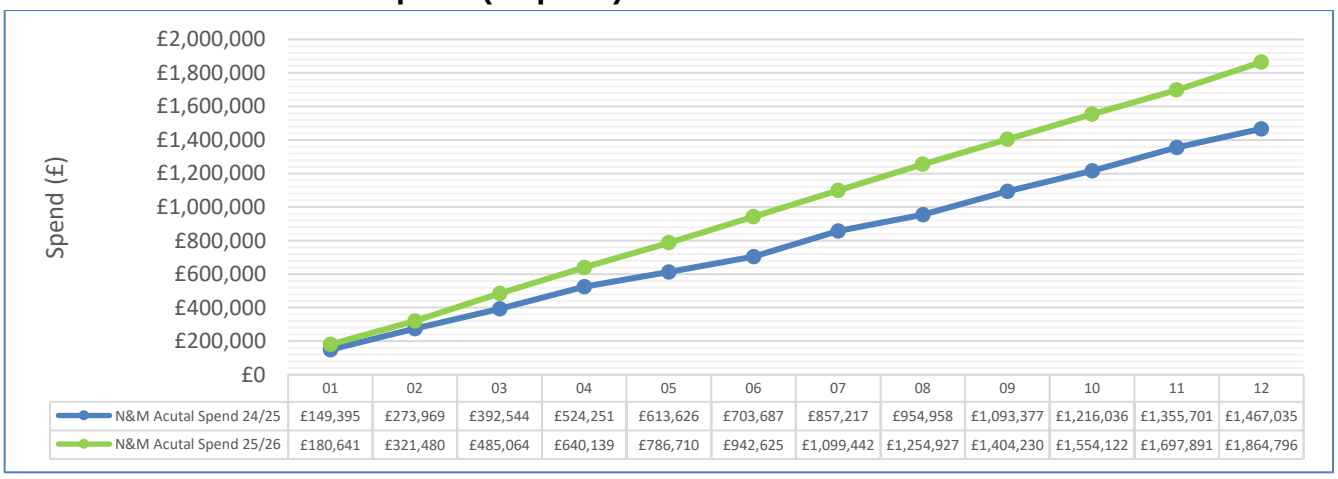
	01	02	03	04	05	06	07	08	09	10	11	12
N&M Acutal Spend 24/25	£5,401,711	£11,421,017	£17,298,679	£22,731,479	£27,883,505	£34,052,860	£42,533,040	£47,537,354	£51,902,088	£53,832,732	£58,620,554	£64,718,766
N&M Acutal Spend 25/26	£5,063,971	£11,351,125	£15,374,890	£19,611,981	£24,801,080	£29,868,756	£33,873,161	£38,253,910	£42,391,645	£46,255,964	£50,823,552	£55,798,980

Nursing and Midwifery Premium Overtime spend (£ spend) All MFT



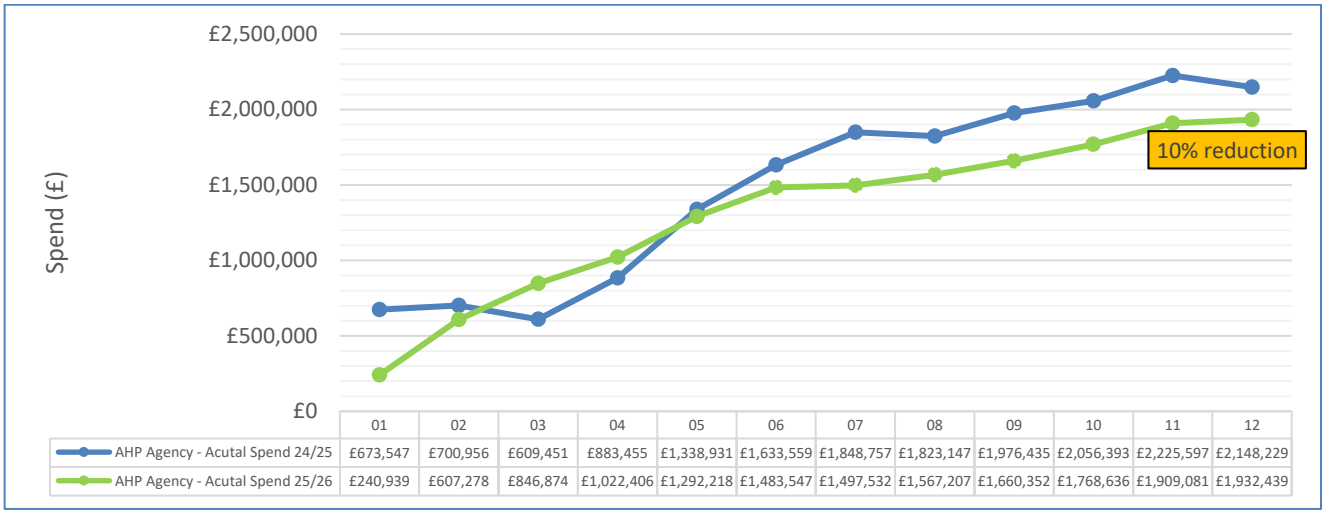
	01	02	03	04	05	06	07	08	09	10	11	12
N&M Acutal Spend 24/25	£43,355	£75,000	£105,355	£159,266	£182,643	£203,369	£227,115	£244,044	£256,824	£265,825	£275,110	£280,819
N&M Acutal Spend 25/26	£8,179	£16,701	£22,436	£27,444	£48,821	£53,414	£59,664	£66,834	£94,783	£113,432	£120,785	£133,002

AHP Premium Overtime Spend (£ spend) All MFT



	01	02	03	04	05	06	07	08	09	10	11	12
N&M Acutal Spend 24/25	£149,395	£273,969	£392,544	£524,251	£613,626	£703,687	£857,217	£954,958	£1,093,377	£1,216,036	£1,355,701	£1,467,035
N&M Acutal Spend 25/26	£180,641	£321,480	£485,064	£640,139	£786,710	£942,625	£1,099,442	£1,254,927	£1,404,230	£1,554,122	£1,697,891	£1,864,796

AHP Agency Spend reduction 26/27 compared to 25/26 (£ spend)



	01	02	03	04	05	06	07	08	09	10	11	12
AHP Agency - Acutal Spend 24/25	£673,547	£700,956	£609,451	£883,455	£1,338,931	£1,633,559	£1,848,757	£1,823,147	£1,976,435	£2,056,393	£2,225,597	£2,148,229
AHP Agency - Acutal Spend 25/26	£240,939	£607,278	£846,874	£1,022,406	£1,292,218	£1,483,547	£1,497,532	£1,567,207	£1,660,352	£1,768,636	£1,909,081	£1,932,439

Appendix B

The National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016), states 3 expectations of the Trust Board of Directors. These are endorsed by the NHS Improvement (NHSI) Developing Workforce Safeguards (DWS) Guidance (2018).

Expectation 1: Right staff
Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations.
Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (ie the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.

Expectation 2: Right skills
Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services.

Expectation 3: Right place and time
Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise.

Appendix C

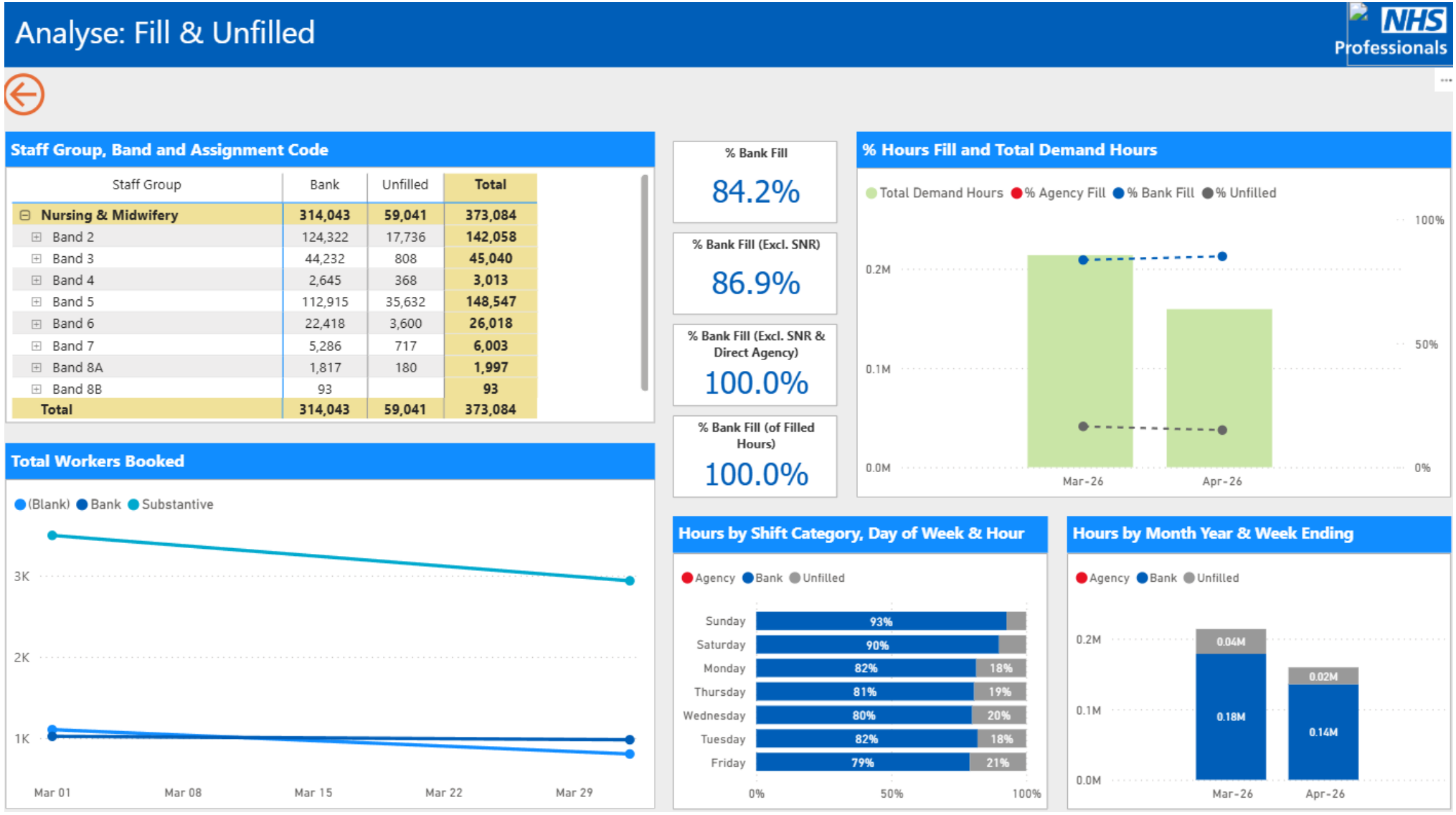
Registered Nursing - Workforce Metrics by Clinical Group (April 2026)

Clinical Group	Establishment (WTE)	Contracted (WTE)	Vacancies (WTE)	Vacancy Rate %	Turnover %	Maternity Leave %	Sickness %
CSS	1011.8	1007.2	4.5	0.4%	6.6%	5.0%	5.5%
LCOD	1156.6	1119.4	37.3	3.2%	8.1%	3.7%	6.6%
MRI	1752.6	1696.6	56.0	3.2%	4.8%	5.3%	6.3%
NMGH	870.1	860.7	9.4	1.1%	5.8%	5.6%	5.1%
SPEC	1989.5	1959.7	29.8	1.5%	7.0%	4.7%	5.7%
WTWA	1856.8	1896.0	0.0	0.0%	6.0%	4.6%	5.7%

Support to Nursing - Workforce Metrics by Clinical Group (April 2026)

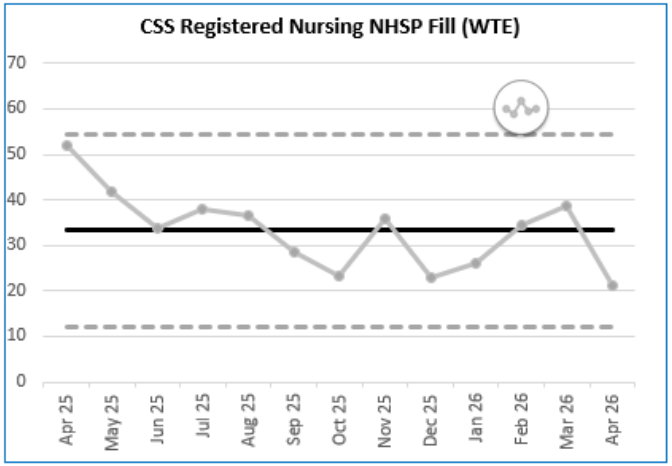
Clinical Group	Establishment (WTE)	Contracted (WTE)	Vacancies (WTE)	Vacancy Rate %	Turnover %	Maternity Leave %	Sickness %
CSS	91.3	82.9	8.3	9.1%			
LCOD	519.7	458.0	61.7	11.9%			
MRI	898.7	838.5	60.2	6.7%			
NMGH	605.7	565.0	40.6	6.7%			
SPE	575.5	506.5	69.0	12.0%			
WTWA	951.6	897.8	48.9	5.1%			

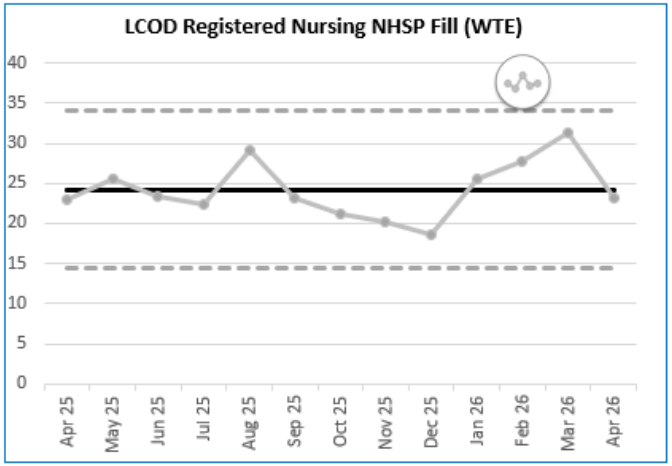
Appendix D - NHSP Fill Overview – Nursing

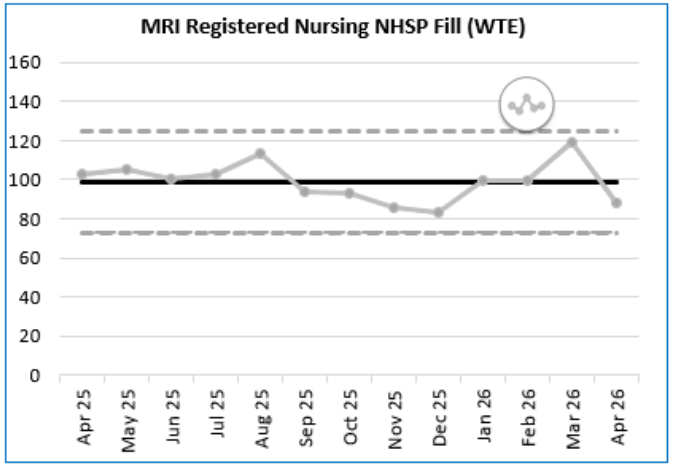


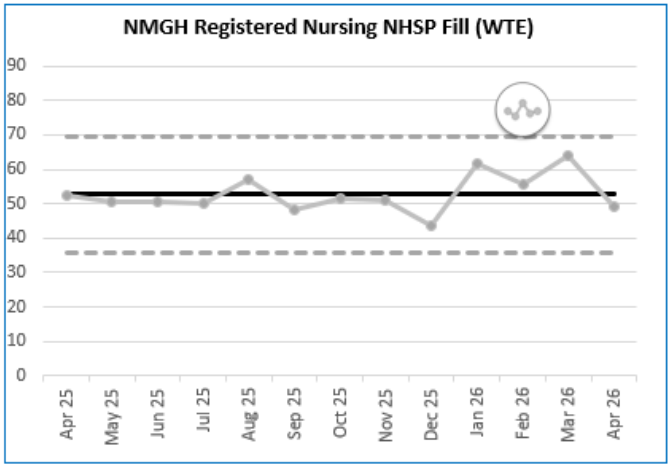
Appendix E

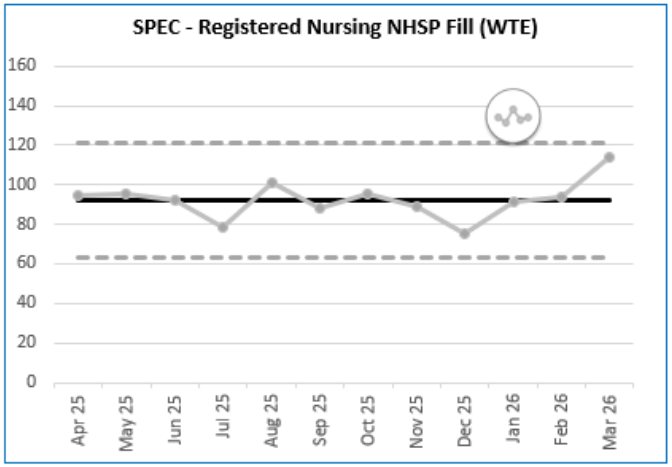
NHSP registered nursing fill rate by clinical group

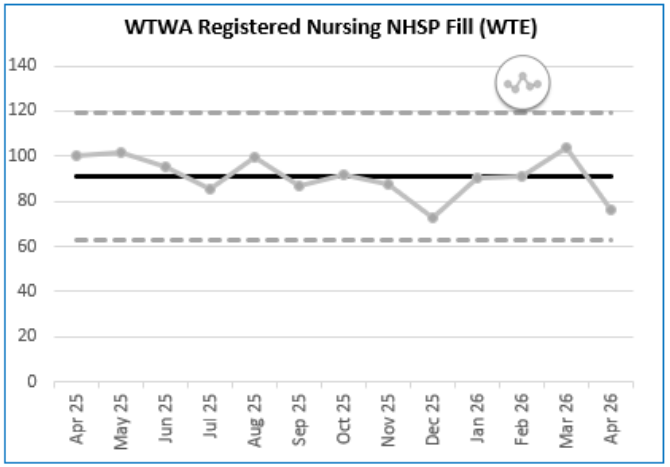






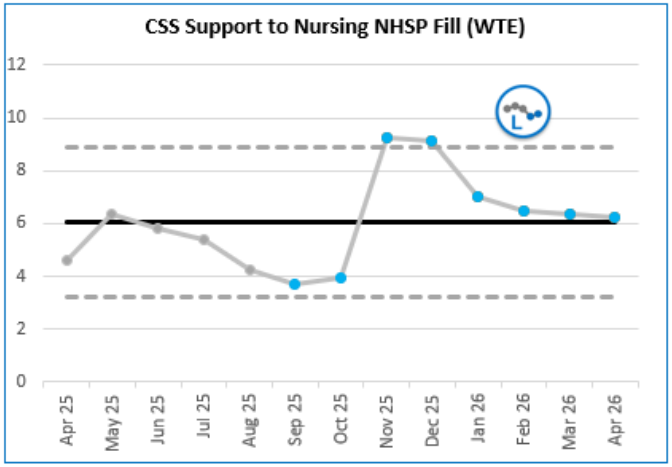


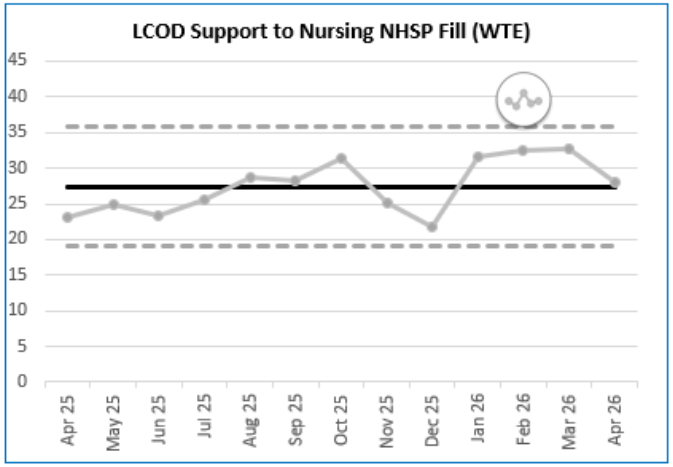


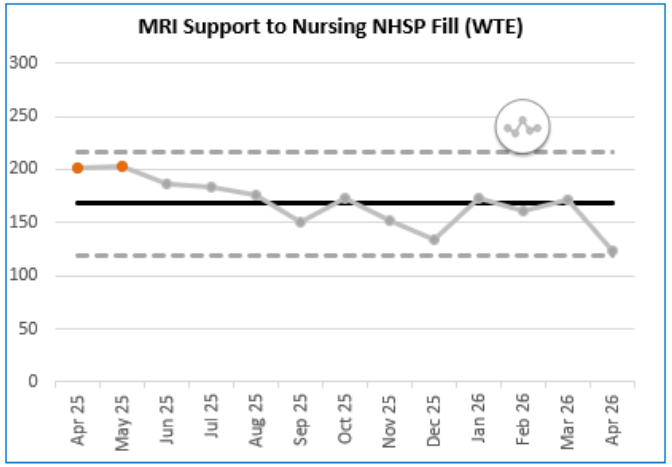


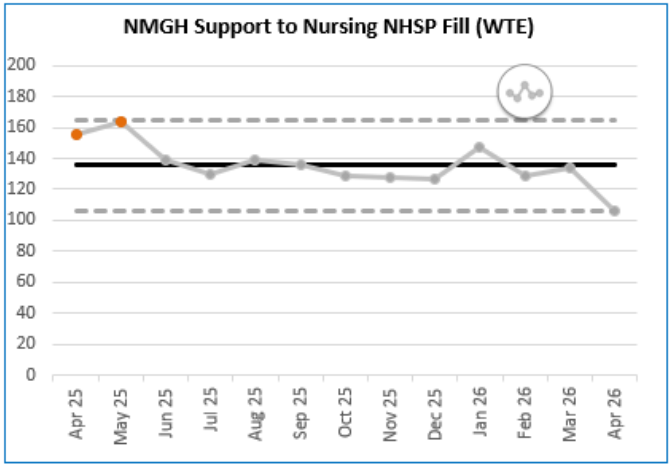
Appendix F

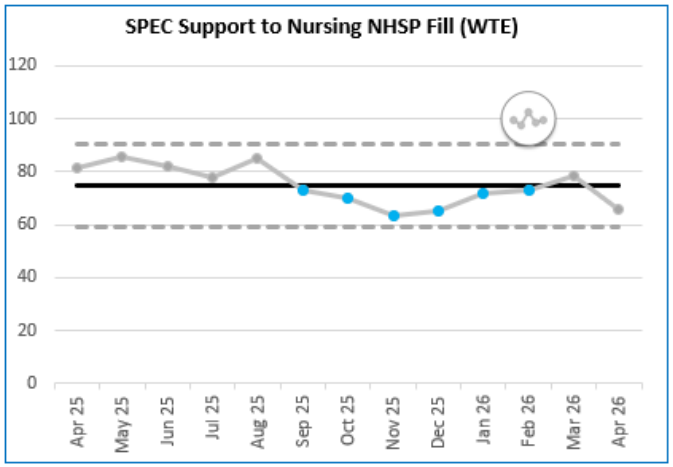
NHSP Support to Nursing fill rate by clinical group

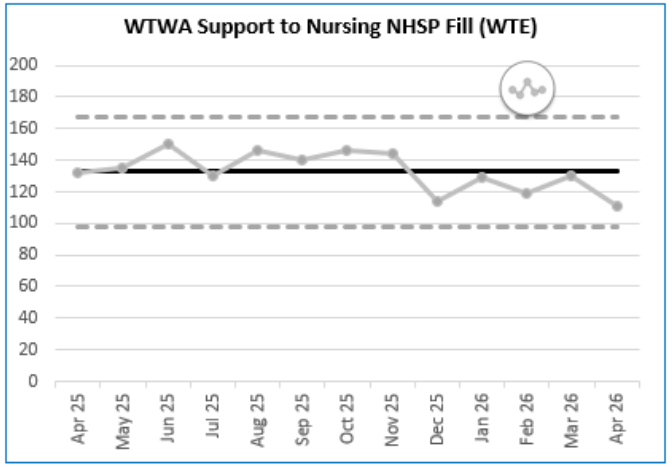












Appendix G

AHP Registered - Workforce Metrics by Clinical Group (April 2026)

Clinical Group	Establishment (WTE)	Contracted (WTE)	Vacancies (WTE)	Vacancy Rate %	Turnover %	Maternity Leave %	Sickness %
CSS	1135.7	1122.2	13.5	1.2%	8.1%	4.1%	3.4%
CSS AHP	662.5	668.1	0.0	0.0%	9.3%	4.3%	2.6%
CSS Imaging	467.0	453.5	13.5	2.9%	6.2%	4.0%	4.7%
LCOD	555.4	551.7	3.7	0.7%	6.0%	3.1%	5.4%
MRI	10.5	12.5	0.0	0.0%	8.0%	1.3%	6.2%
NMGH	5.0	3.6	1.4	27.3%	2.9%	0.0%	7.3%
SPEC	47.5	44.3	3.2	6.6%	6.2%	2.8%	4.4%
WTWA	55.8	55.5	0.3	0.5%	4.3%	4.8%	2.5%

Support to AHP - Workforce Metrics by Clinical Group (April 2026)

Clinical Group	Establishment (WTE)	Contracted (WTE)	Vacancies (WTE)	Vacancy Rate %	Turnover %	Maternity Leave %	Sickness %
CSS	185.2	173.8	11.4	6.2%			
CSS AHP	92.3	89.9	2.4	2.6%			
CSS Imaging	92.9	83.8	9.1	9.8%			
LCOD	81.2	72.0	9.3	11.4%			
MRI	0.0	0.0	0.0	0.0%			
NMGH	3.0	3.6	0.0	0.0%			
SPE	1.0	5.6	0.0	0.0%			
WTWA	5.4	6.3	0.0	0.0%			

Appendix H: Professional Judgement Framework V6.03 (Saville C, Griffiths P, Casey A, Chable R, Chapman H, Radford M, and Watts N (2023) Professional Judgement Framework, doi: 10.5258/SOTON/P1102 University of Southampton; https://doi.org/10.5258/SOTON/P1102)

- This framework is designed to guide the application of 'professional judgement' when considering the results of staffing reviews and the establishment recommendations using the acuity dependency measure of the Safer Nursing Care Tool.
- The guide is based on evidence relating to the use of the Safer Nursing Care Tool on acute general hospital wards and has been developed with those settings in mind, although the principles may apply in other settings.
- It is intended to provide a number of 'prompts' that might help sense check the results of staffing reviews and help to provide confidence in the results, or else flag circumstances where judgement might be used to recommend a variation from the calculated figures.
- It is aimed both at those with less experience looking for guidance, and those with more experience looking for help on how to articulate intuitive judgements using available evidence.
- Similar issues are likely to arise when considering the results of any tool.
- The framework is based on the results of research funded by the National Institute for Health Research in England, and has been developed working alongside a number of professional experts.
- It is acknowledged that staffing decisions will need to factor in the availability of staff such as where there are vacancy constraints. The use of ongoing risk assessment to maintain patient safety within and across wards and departments is therefore critical.

Initial sense check - things that might make you look particularly closely at the suggested staffing levels	
Can what's being suggested be right: does it seem to be in the right "ball-park"?	Measurements can help guide staffing decisions but cannot possibly take into account all the complex factors that determine staffing requirements. Also, just like all measurement, acuity and dependency measures can be imprecise or inaccurate because of variation in the sample, how measurements are taken and because not all patients in the same category need precisely the same amount of care. If the number seems wrong, it may well be!
Is a new recommended staffing level different from the current staffing establishment or the establishment of similar wards?	Obviously, if the measurement never resulted in a changed recommendation there would be no point in reviewing establishments. However, the current establishment level is a good starting point for considering any recommended changes. Is there a major difference? Is the current establishment based on acuity and dependency? Have there been service changes since last review? Are there problems with the existing staffing levels or the quality of care? What do staff on the ward say? Is there a high or increasing number of safety incidents / red flags?
Is the ward operating with a lot of vacancies, high staff turnover, sickness absence and/or using a high level of temporary staff	There appears to be a vicious cycle whereby wards that use a lot of temporary staff, for example due to vacancies, may not always have the capacity to meet patient need because of the relative inefficiency of using temporary staff.1 These wards may benefit from targeted support in the short to medium term in order to help stabilise. It may be that the high use of temporary staff /staff turnover is an indicator that the existing establishments were not properly reflecting requirements

Have there been changes in the ward since the last establishment review?	Changes such as the mix of patients or the physical layout of a ward can change the staffing requirements. This is not always reflected in the measurements and so especial care needs to be taken when reviewing staffing after any such changes, even if adjustments were made to accommodate them. The NHSI's "Developing workforce safeguards" report recommends reviewing establishments when changes happen rather than waiting for a scheduled review.
Is the current staff being rostered properly?	'Efficient' rostering of staff can be difficult and 'ideal' rosters are not always achievable. However, sometimes wards run into problem because more staff are routinely rostered on days of lower demand leaving insufficient staff for other days. Help with rostering is available in NHS England's Nursing and midwifery e-rostering guidance

Accuracy of the measurements	
Who assessed patients' acuity/dependency levels – have they received training and do they have experience?	There is evidence that the SNCT acuity and dependency measurement can be done reliably and can be valid, such that two experts will agree on how to categorise a patient. However, reliability and validity are properties of the measurements that are taken, not the measure itself. Staff assessing the SNCT should be properly trained and their competence assessedD. Ideally this needs to be retested from time to time. If not, it is possible that there is both imprecision (random error) and systematic mistakes (bias) in the measurement. Staff need training and support while becoming experienced in assessing acuity/dependency levels.
How many days of SNCT acuity/dependency ratings were you able to collect? Was it enough?	To get a reliable estimate of typical patient need and so estimate the establishment you need to observe 'enough' patients. This means measuring all the patients on the ward every day over a period of time. Guidance for the SNCT suggests a minimum number of days, but for some wards there is more variability from day to day, making it harder to get an accurate baseline. We've developed a tool to give you an idea of how precise your establishment might be (see benchmarks in accompanying document). Sometimes you might benefit from collecting a few days more data, other times you may simply have to be more cautious about using the recommended establishment.
Is the uplift (for annual leave, study leave etc.) appropriate for this ward?	The SNCT multipliers have an inbuilt 22% uplift but some wards might require a higher uplift if (for example) they have higher rates of absence than is typical. For example the age profile of staff affects annual leave entitlements and parental leave rates, while some wards have higher study leave requirements for specialty-mandated training

Particularities of Nursing work	
Does this ward have high patient turnover/throughput?	Although the SNCT includes an allowance for patient turnover (admissions / discharges), the level of activity can vary a lot between wards. Special multipliers have been developed for acute admissions units but other wards with unusually high turnover might also need more staff. In general, turnover is reflected by the unit's length of stay - units with shorter stay may need more staff for a given level of acuity / dependency.
Does the layout of this ward add to workload e.g. because of distance or difficulty observing patients?	There is some evidence that suggests that some ward layouts may impact on how care is delivered. For example, some ward layouts with a high proportion of single rooms can make it harder to monitor patients and also make it harder for staff to find colleagues. This is being studied for the next version of the SNCT.

Does the the number of beds on the ward increase the (relative) staffing requirement?	Small wards can be difficult to staff because there needs to be a minimum number of staff present at all times to ensure safety. This means that the daily staffing requirement may be higher than implied by the calculated establishment.
Does the amount of work on this ward vary between times of day and day of week?	Predictable variation by time of day and day of week might be adressed by careful rostering. Do the rosters match known variation? However, if demand is unpredictable it may be that more staff are needed to cope with fluctuations in demand. Are staff working flexibly between teams within and, where needed, across wards so that patient needs are met?
What is ‘usual’ care for this ward?	Depending on who is rating patients, keep in mind that some aspects of care that are 'normal' ward care for this unit might still reflect higher acuity and dependency for the patients. For example, on cancer wards it is usual to deliver a high number of infusions, but this is not 'normal' ward care.
Is there a lot of enhanced therapeutic observations and care?	Although this might be accounted for when it is covered by 'extra' staff outside the establishment, consider whether the establishment is sufficient to cover work associated with these patients, including covering for breaks taken by the staff providing specialling. The current version of the SNCT provides a new level of care for continuous care on a one to one basis - sometimes referred to as 'specialing'.
Any other factors that might make this ward unusual in some way?	The SNCT multipliers reflect average need across a wide group of patients and a wide range of settings. The recommended staffing levels provide a guide but this guide will not reflect every possible situation. While every ward is 'different' and this average works well for many wards there might be specific factors that mean that the measured demand doesn't work well in a particular setting. We have tried to highlight a few factors above.

Local staffing context and daily demand	
Are there particular skills required? Does the establishment allow for this?	The fewer staff that are available to undertake a specific role, the more challenging it will be to make sure staff with the appropriate skills are rostered. Have such factors been considered in the establishment? If at least one member of such staff is required on each shift, it is likely that at least 40% of staff in the establishment will need to be trained to ensure reliable coverage.
Does the skill mix meet the needs of the patient mix on this ward?	Skill mix should also be considered as part of establishment review. If some staff are unable to provide a full range of care (e.g. more junior RNs), overall staffing requirements for more experienced staff may be increased because the staff group as a whole are less flexible and there is more planning involved in allocating work.
What is the level of skill and experience for the team as a whole?	If a lot of staff in the establishment are new and / or junior, is there a plan to ensure that staff requiring support get the support they require?
What shift patterns are used?	It's important to balance the needs of patients and staff, whatever shift patterns you use. Where a mix of shift patterns is used in a single ward, overall staffing requirements may be increased because of the need for multiple handovers.

Appendix I: Adult and Children and Young Persons Inpatient Ward SNCT Census – February 2026

						Feb-25			Jun-25			Feb-26			
Clinical Group	Division/CSU	Ward/Department	Current Funded Establishment WTE	Skill Mix % Registered	Skill Mix % Unregistered	SNCT Recommended Establishment WTE Feb-25	Variance WTE Feb-25	Variance % Feb-25	SNCT Recommended Establishment WTE Jun-25	Variance WTE Jun-25	Variance % Jun-25	SNCT Recommended Establishment WTE Feb-26	Variance WTE Feb-26	Variance % Feb-26	Decision Outcome
MRI	Cardio-Vascular	ACC	44.17	72%	28%	28.36	14.68	34%	24.64	18.53	43%	30.47	13.70	31%	No Action
MRI	Cardio-Vascular	Manchester Vascular Centre	46.18	48%	52%	50.03	26.41	35%	51.08	-7.90	-18%	53.04	-6.86	-15%	No Action
MRI	Cardio-Vascular	EVC	33.52	51%	49%	38.57	37.87	50%	37.48	-3.96	-9%	42.31	-8.79	-26%	No Action
MRI	Cardio-Vascular	Ward 3	46.80	53%	47%	43.44	1.27	3%	38.23	7.57	17%	55.91	-9.11	-19%	No Action
MRI	Cardio-Vascular	Ward 4	40.52	53%	47%	37.41	-7.96	-27%	38.63	1.19	3%	45.89	-5.37	-13%	No Action
MRI	Emergency Assessment & Access	AM3	49.77	60%	40%	44.88	3.90	8%	35.97	13.20	27%	40.67	9.10	18%	No Action
MRI	Emergency Assessment & Access	AM4	46.80	49%	51%	41.01	7.02	15%	40.60	5.20	11%	41.29	5.52	12%	No Action
MRI	Emergency Assessment & Access	AMU - MRI (Ward 18 & 19)	85.55	59%	41%	91.88	-7.60	-9%	97.93	-14.38	-17%	93.19	-7.64	-9%	No Action
MRI	In Patient Medical Specialties	Ward 5				50.14	-11.54	-30%	56.24	-16.68	-42%	52.98			
MRI	In Patient Medical Specialties	Ward 10	34.52	57%	43%	30.22	1.77	6%	35.20	-1.68	-5%	39.30	-4.78	-14%	No Action
MRI	GI Medicine & Surgery	Ward 11	45.18	49%	51%	34.08	9.84	22%	49.18	-5.00	-11%	38.68	6.50	14%	No Action
MRI	GI Medicine & Surgery	Ward 12	43.44	49%	51%	40.52	-2.42	-6%	39.83	2.61	6%	44.48	-1.04	-2%	No Action
MRI	GI Medicine & Surgery	Ward 46 Gastro	45.06	47%	53%	38.88	4.83	11%	40.76	4.30	10%	37.20	7.86	17%	No Action
MRI	Theatres & Elective in Reach	ETC Sal & DC	29.24	48%	52%	33.50	-3.28	-11%	30.69	-3.13	-11%	30.69	-1.45	-5%	No Action
MRI	Head & Neck	ETC Surgery	52.16	51%	49%	30.69	16.67	35%	31.49	19.67	38%	37.31	14.85	28%	No Action
MRI	In Patient Medical Specialties	AM1	40.56	48%	52%	55.62	-14.71	-36%	51.12	-11.56	-29%	51.58	-11.02	-27%	No Action
MRI	In Patient Medical Specialties	AM2	40.56	48%	52%	48.00	-8.08	-20%	47.00	-7.44	-19%	51.78	-11.22	-28%	No Action
MRI	In Patient Medical Specialties	Ward 1				46.00	-4.44	-11%	47.51	-19.23	-68%	61.39			
MRI	In Patient Medical Specialties	Ward 2	40.56	48%	52%	55.76	-14.20	-34%	47.12	-7.56	-19%	55.30	-14.74	-36%	No Action
MRI	In Patient Medical Specialties	SAU	62.31	54%	46%	39.85	27.58	41%	37.76	23.55	38%	39.94	22.37	36%	
MRI	In Patient Medical Specialties	Ward 31	41.56	47%	53%	59.87	-20.77	-53%	63.57	-23.01	-57%	57.49	-15.93	-38%	No Action
MRI	In Patient Medical Specialties	Ward 32	36.94	43%	57%	46.24	-9.51	-26%	34.23	1.91	5%	35.44	1.50	4%	No Action
MRI	In Patient Medical Specialties	Ward 44	88.81	67%	33%	78.60	6.02	7%	77.32	9.49	11%	77.10	11.71	13%	No Action
MRI	In Patient Medical Specialties	Ward 45	44.43	58%	42%	35.71	2.38	6%	31.58	11.85	27%	35.51	8.92	20%	No Action
MRI	Urology, Renal & Transplant	Ward 36 Transplant	35.32	55%	45%	37.68	-7.51	-25%	36.71	-2.39	-7%	36.15	-0.83	-2%	No Action
MRI	Urology, Renal & Transplant	Ward 37	35.32	55%	45%	34.69	-4.34	-14%	35.05	-0.73	-2%	34.44	0.88	2%	No Action
NMGH	Division of Integrated Medicine	CCU	19.19	70%	30%	19.69	-0.50	-3%	17.52	1.67	9%	14.59	4.60	24%	Increase Establishment
NMGH	Division of Integrated Medicine	C3	36.02	37%	63%	57.29	-4.24	-8%	55.73	-2.68	-5%	24.86	11.16	31%	Decrease Establishment
NMGH	Division of Integrated Medicine	C4	36.02	37%	63%	47.51	5.54	10%	64.88	-11.83	-22%	22.14	13.88	39%	Decrease Establishment
NMGH	Division of Integrated Medicine	E1	53.64	34%	66%	23.61	17.52	43%	25.65	15.48	38%	48.78	4.86	9%	No Action
NMGH	Division of Integrated Medicine	E3	53.64	34%	66%	27.12	12.29	31%	23.95	15.46	39%	46.96	6.68	12%	No Action
NMGH	Division of Integrated Medicine	F1	41.82	36%	64%	33.67	3.46	9%	30.25	5.88	16%	26.34	15.48	37%	No Action
NMGH	Division of Integrated Medicine	F3	36.31	51%	49%	36.43	3.33	8%	41.09	-1.33	-3%	29.73	6.58	18%	No Action
NMGH	Division of Integrated Medicine	F4	40.12	33%	67%	51.64	4.90	9%	39.78	16.76	30%	40.05	0.07	0%	No Action
NMGH	Division of Integrated Medicine	I6	40.46	49%	51%	27.99	7.29	21%	27.83	7.45	21%	37.29	3.17	8%	No Action
NMGH	Division of Integrated Medicine	J3/J4	57.13	51%	49%	41.20	-5.92	-17%	31.83	3.45	10%	49.22	7.91	14%	No Action
NMGH	Division of Integrated Medicine	J6	32.92	51%	49%	107.18	-0.69	-1%	99.75	6.74	6%	62.60	-29.68	-90%	Increase Establishment
NMGH	Division of Surgery	C5	25.02	53%	47%	15.32	9.04	37%	13.01	11.35	47%	13.88	11.14	45%	No action
NMGH	Division of Surgery	C6	25.18	53%	47%	12.88	11.48	47%	11.88	12.48	51%	11.88	13.30	53%	No action
NMGH	Division of Surgery	D5	35.10	49%	51%	22.32	12.03	35%	17.32	17.03	50%	20.10	15.00	43%	No Action
NMGH	Division of Surgery	D6	35.51	50%	50%	22.96	11.80	34%	21.25	13.51	39%	23.82	11.69	33%	No Action
NMGH	Division of Surgery	E2	32.92	51%	49%	32.09	-0.75	-2%	30.64	1.70	5%	30.44	2.48	8%	No Action
NMGH	Division of Surgery	F2 STU	41.52	57%	43%	24.01	16.51	41%	17.93	22.59	56%	21.72	19.80	48%	No Action
NMGH	Division of Surgery	I5	49.97	48%	52%	21.17	14.41	40%	23.94	11.64	33%	51.65	-1.68	-3%	No Action
NMGH	Urgent Care & Patient Flow	Frailty Unit	36.85	40%	60%	29.22	5.07	15%	27.69	6.47	19%	30.60	6.26	17%	No Action
NMGH	Urgent Care & Patient Flow	H3/H4	107.66	51%	49%	48.25	-0.16	0%	54.11	-6.02	-13%	93.69	13.97	13%	No Action

						Feb-25			Jun-25			Feb-26			
Clinical Group	Division/CSU	Ward/Department	Current Funded Establishment WTE	Skill Mix % Registered	Skill Mix % Unregistered	SNCT Recommended Establishment WTE Feb-25	Variance WTE Feb-25	Variance % Feb-25	SNCT Recommended Establishment WTE Jun-25	Variance WTE Jun-25	Variance % Jun-25	SNCT Recommended Establishment WTE Feb-26	Variance WTE Feb-26	Variance % Feb-26	Decision Outcome
REH	Ward 55	Inpatient ward	22.12	64%	36%	20.74	-1.62	-8%	20.30	0.82	4%	20.12	2.00	9%	No Action
SMH	SMH Gynae	F16	27.96	65%	35%	14.87	13.09	47%	14.85	12.71	46%	14.85	13.11	47%	Decrease Establishment
SMH	SMH Gynae	Ward 62	46.97	64%	36%	34.49	8.28	19%	37.20	5.17	12%	37.45	9.52	20%	Decrease Establishment
WTWA	Medical Specialties and Outpat	ELM Unit	48.99	45%	55%	52.45	-3.46	-7%	46.92	2.07	4%	51.54	-2.55	-5%	No Action
WTWA	Medical Specialties and Outpat	Ward 11	55.61	53%	47%	48.61	5.00	9%	46.68	6.93	13%	48.59	7.02	13%	Decrease Establishment
WTWA	Medical Specialties and Outpat	Ward 2 OAK	68.08	44%	56%	74.00	-5.92	-9%	64.77	3.31	5%	66.36	1.72	3%	No Action
WTWA	Medical Specialties and Outpat	Ward 3	79.69	37%	63%	60.87	16.18	21%	55.55	24.14	30%	66.91	12.78	16%	No Action
WTWA	Respiratory	F3 Lung Surgery	42.75	69%	31%	39.80	1.94	5%	42.45	-0.70	-2%	46.87	-4.12	-10%	No Action
WTWA	Cardiac	F5	49.57	71%	29%	37.38	14.12	27%	37.97	13.53	26%	39.92	9.65	19%	Decrease Establishment
WTWA	Cardiac	F2N	73.93	68%	32%	18.89	9.22	33%	20.56	51.72	72%	20.44	53.49	72%	Decrease Establishment
WTWA	Cardiac	F6				38.56	7.62	16%	44.31	-44.31		41.04	-41.04		Decrease Establishment
WTWA	Cardiac	Jim Quick Ward	29.01	70%	30%	32.56	-11.01	-51%	29.56	-8.01	-37%	28.30	0.71	2%	No Action
WTWA	Respiratory	A1	55.38	57%	43%	47.29	7.09	13%	50.44	3.94	7%	51.58	3.80	7%	Decrease Establishment
WTWA	Respiratory	NWVU	36.98	62%	38%	30.66	5.32	15%	30.25	5.73	16%	38.02	-1.04	-3%	No Action
WTWA	Respiratory	Pearce (Side Rooms)	29.92	63%	37%	24.52	4.40	15%	23.52	5.40	19%	23.44	6.48	22%	No Action
WTWA	Respiratory	POU	24.31	54%	46%	23.13	0.19	1%	26.17	-2.86	-12%	24.39	-0.08	0%	No Action
WTWA	Trauma & Ortho B&P H&N	A3	43.93	45%	55%	43.96	-1.03	-2%	39.37	3.56	8%	40.40	3.53	8%	No Action
WTWA	Medical Specialties and Outpat	A7	37.87	47%	53%	47.65	-9.78	-26%	41.44	-3.57	-9%	40.64	-2.77	-7%	No Action
WTWA	Medical Specialties and Outpat	A9 (elderly care)/OAU	57.37	54%	46%	55.49	1.88	3%	51.93	5.44	9%	55.50	1.87	3%	No Action
WTWA	Emergency Care Village	AMU	92.61	55%	45%	104.33	-14.09	-16%	108.52	-15.91	-17%	114.16	-21.55	-23%	Increase Establishment
WTWA	Medical Specialties and Outpat	Doyle	33.07	42%	58%	37.11	-5.04	-16%	33.06	-0.99	-3%	37.53	-4.46	-13%	Increase Establishment
WTWA	Medical Specialties and Outpat	Wilson	31.40	49%	51%	37.99	-6.59	-21%	41.76	-10.36	-33%	38.40	-7.00	-22%	Increase Establishment
WTWA	Medical Specialties and Outpat	F12	39.54	44%	56%	46.34	-7.80	-20%	44.01	-5.47	-14%	48.21	-8.67	-22%	No Action
WTWA	Medical Specialties and Outpat	F14	39.65	43%	57%	47.50	-8.85	-23%	50.18	-11.53	-30%	43.43	-3.78	-10%	No Action
WTWA	Medical Specialties and Outpat	F15	39.25	52%	48%	35.39	3.86	10%	48.14	-8.89	-23%	44.97	-5.72	-15%	No Action
WTWA	Medical Specialties and Outpat	Opal House- Side Rooms	56.49	31%	69%	48.45	2.77	5%	53.07	3.42	6%	26.55	29.94	53%	No Action
WTWA	Medical Specialties and Outpat	A2	37.71	48%	52%	38.93	-2.22	-6%	42.25	-5.54	-15%	43.53	-5.82	-15%	No Action
WTWA	Surgery & Theatres	A4	41.20	47%	53%	38.74	-1.14	-3%	37.34	2.86	7%	39.24	1.96	5%	No Action
WTWA	Trauma & Ortho B&P H&N	A5	48.80	35%	65%	53.45	-8.36	-19%	65.27	-17.47	-37%	57.71	-8.91	-18%	No Action
WTWA	Surgery & Theatres	A6	47.00	48%	52%	45.46	-4.66	-11%	45.08	0.92	2%	46.91	0.09	0%	No Action
WTWA	Respiratory	F4	23.19	56%	44%	22.94	0.26	1%	23.66	-0.46	-2%	21.22	1.97	9%	No Action
WTWA	Surgery & Theatres	F7	51.88	54%	46%	37.39	11.12	23%	42.62	8.26	16%	38.97	12.91	25%	Decrease Establishment
WTWA	Trafford Hub	Ward 12a	54.45	49%	51%	41.69	-3.15	-8%	36.62	11.18	23%	18.89	35.56	65%	No Action
RMCH	Children's Surgery and Theatre	Ward 76	23.19	69%	31%	32.69	-9.50	-41%	33.45	-10.26	-44%	33.06	-9.87	-43%	Increase Establishment
RMCH	Children's Surgery and Theatre	Ward 77	63.29	73%	27%	65.86	-2.57	-4%	67.09	-3.80	-6%	68.81	-5.52	-9%	No Action
RMCH	Children's Surgery and Theatre	Ward 78	63.74	73%	27%	69.85	-6.11	-10%	72.51	-8.77	-14%	69.56	-5.82	-9%	No Action
RMCH	Children's Medicine Unit	Ward 84 Inpatients	59.75	65%	35%	61.57	-1.82	-3%	54.79	4.96	8%	59.79	-0.04	0%	No Action
RMCH	Children's Medicine Unit	Ward 85	54.72	79%	21%	60.29	-5.57	-10%	61.50	-6.78	-12%	56.70	-1.98	-4%	No Action
RMCH	Children's Medicine Unit	Ward 86	54.51	81%	19%	55.05	-0.54	-1%	55.89	-1.38	-3%	53.69	0.82	2%	No Action
RMCH	Childrens MCS	F8 Childrens ward	36.32	79%	21%	33.80	2.52	7%	32.69	3.63	10%	32.71	3.61	10%	No Action
RMCH	Paediatrics NMGH	NMGH inpatient ward	34.92	75%	25%	42.52	-7.60	-22%	41.75	-6.83	-20%	39.97	-5.05	-14%	Increase Establishment

Manchester University
NHS Foundation Trust

Public Board of Directors

Thursday 30th July 2026

Paper title:	Saint Mary's Managed Clinical Services (SM MCS) Midwifery and Newborn Services Care Division bi-monthly Safe Staffing Reporting period March and April 2026	**Agenda Item 12.4**
Presented by:	Kimberley Salmon- Jamieson, Deputy Trust Chief Executive & Chief Nursing Officer	
Prepared by:	Kathy Murphy, Director of Nursing and Midwifery, Specialist Hospitals Clinical Group (SHCG)	

Meetings where content has been discussed previously	SM MCS Quality, Safety and Performance June 2026 SHCG Quality, Safety and Performance June 2026 Maternity and Neonatal Safety Champions June 2026 People Board Committee June 2026
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion

Executive summary / key messages for the meeting to consider

The Maternity and Newborn Services Care Division submits a bi-monthly safe staffing report via the People Board Committee to provide assurance to the Board of Directors that the Trust remains compliant with national guidance on safer staffing and Maternity Incentive Scheme (MIS) requirements.

This update covers the reporting period March–April 2026.

- Neonatal Qualification in Specialty (QIS): the QIS position has improved at Wythenshawe and North Manchester, which are currently above the British Association of Perinatal Medicine (BAPM) standard (70%+).

  Although Oxford Road remains below 70%, and reflected on risk register (level 12), actions to address this include 18 nurses undertaking the course which is due to complete in September 2026.

- Midwifery workforce: Maternity Services has remained compliant with nationally recommended establishments in line with Birthrate Plus (BR+) calculations. An updated BR+ review concluded in March 2026; analysis is expected to be completed in May 2026 and presented to SHCG SLT in June 2026.

- Maternity Services achieved 100% compliance with a supernumerary coordinator on all labour wards at the start of every shift.

- During March 2026 Maternity Services provided one-to-one care in labour to 99.89% of women, and to 99.29% of women in April 2026. Oversight of occasions where 1:1 care in labour has not been achieved is in place, with actions monitored at divisional QSP and oversight at Maternity Operational Delivery Group each month.

- Midwife-to-birth ratios are monitored through the maternity dashboard, with no escalations required during this reporting period.

- Recruitment: Maternity recruitment remains strong, with an over-establishment of 21.81 WTE at the end of April 2026, inclusive of 10 NHS England funded posts.

- Newborn Services has 16.75 WTE vacancies across Bands 4–7, with 4 WTE (Bands 4/5) in the pipeline. All posts are at different stages of recruitment. Turnover has increased slightly since the last reporting period, from 2.0 WTE to 2.6 WTE per month.

- Sickness and absence: In April this was 6.2% across Maternity and Newborn Services. Sickness is closely monitored by the Heads of Nursing and Midwifery, with support from the HR Business Partner. To support compliance both services, have attendance improvement strategies and associated action plans, which are monitored through Bi-weekly divisional safer staffing meetings. Heads of Midwifery and the Head of Nursing, also strengthen oversight with scrutiny and assurance of absence reasons, actions taken, call-backs, and return-to-work interviews ensuring HR processes are followed.

Maternity Incentive Scheme (MIS) Year 8 was launched in April 2026 and alters the way in which provider Board of Directors should receive assurance on safer staffing. A new requirement is for a sub board committee to receive and scrutinise a 6 monthly integrated workforce report covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams.

It is expected that the first version of this new report will capture January – June 2026 data from across the relevant multi-disciplinary teams described above. The report will follow the established governance route as part of Perinatal Quality Oversight Model (PQOM) and be submitted to People Board Committee in August 2026 and onwards to Board of Directors in September 2026.

Recommendation(s)

The Board of Directors is asked to:

- **Receive** the SM MCS Maternity and Neonatal report in line with national guidance on safer staffing
- **Note** changes required in line with MIS Year 8
- **Recognise** progress towards QIS compliance, particularly on the ORC site
- **Note** the actions being taken to improve sickness and absence performance

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)			
LHL objective 1	☐	LHL objective 2	☐
HQSC objective 1	☐	HQSC objective 2	☐
HQSC objective 3	☐	PEW objective 1	☒
PEW objective 2	☒	VfP objective 1	☒
VfP objective 2	☐	R&I objective 1	☒
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: • MFT/005896: Midwifery staffing. Risk score 8 • MFT/008615: Community Midwifery Staffing. Risk score 12 • MFT/008478: Implementation of homebirth staffing model. Score 12 • MFT/004452: Insufficient neonatal nursing workforce qualified in specialty (QIS) to meet national service specification. Risk score 12	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Effective ☒ Responsive	☒ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • Maternity Incentive Scheme Year 8 • NHS England 3 Year Delivery Plan for Maternity and Neonatal services • CQC	

Main report

Background

The report outlines the current midwifery and neonatal nursing workforce position within the Division and provides assurance regarding safe staffing compliance and monitoring processes in relation to:

- Current Establishments
- Evidence of compliance against the required internal and national standards

- Health Roster benchmarking against KPI standards
- Evidence of midwifery workforce compliance with oversight of birth activity within the service and the escalation process
- Compliance with Qualification in Speciality (QIS) in line with the national British Association of Perinatal Medicine (BAPM)[1]

Safer Staffing Standards and calculation of Establishments using recognised staffing models

- The most recent BR+ review was completed in March 2026; recommendations are being analysed by Saint Mary's Managed Clinical Service (SM MCS) Divisional Leadership Team and are expected to be presented to the SHCG SLT in June 2026. Since April 2024 funded midwifery and neonatal nursing establishments of both clinical and non-clinical roles have been maintained at the recommended levels.

- Table 1 outlines the current funded midwifery establishment in month 01.

	ORC	Wythenshawe	North Manchester	Grand Total
Current Midwifery Establishment 2026/27	374.44	226.87	187.58	788.89

Table 1 Midwifery Establishment 2026/27 (WTE)

- BAPM recommended all intensive care and high dependency care should be provided by QIS staff, so where a unit has a high proportion of critical care activity, the percentage of QIS staff required needs to be above 70%. BAPM standards require all units to have a supernumerary shift coordinator to meet the care needs of the babies on the unit during each shift. All three sites within Newborn Services have the correct number of nurses in the budget and in post for the activity, therefore remain compliant with this cot side care measure. However, the Division remains non-compliant with the required QIS BAPM standard on the ORC site for the reporting period, with current compliance at 61%.

Site	Current Establishment (WTE)
Oxford Road	247.17
Wythenshawe	48.28
North Manchester	40.59
Total	336.04

Table 2 Current Funded Neonatal Nursing Establishment (WTE)

Recruitment and Retention March - April 2026

- Turnover rates continue to demonstrate a positive position for Maternity Services remaining around 2 WTE per month across the MCS. Newborn services had 0.6 WTE turnover per month across the MCS.

[1] https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/3581/BAPM_Service_Quality_Standards_FINAL.pdf

Maternity Services can report an over establishment of 21.81 WTE at the close of Month 01 (April 2026), and there is a vacancy within Neonatal Nursing of 16.75 predominately at ORC as demonstrated in Table 3.

Site	Midwifery Month 01 Vacancy (WTE) 2026/27	Nursing Month 01 Vacancy (WTE) 2026/27
Oxford Road	-0.8	12.36
Wythenshawe	-10.3	3.63
North Manchester	-10.71	0.76
TOTAL Vacancy	**-21.81**	**16.75**

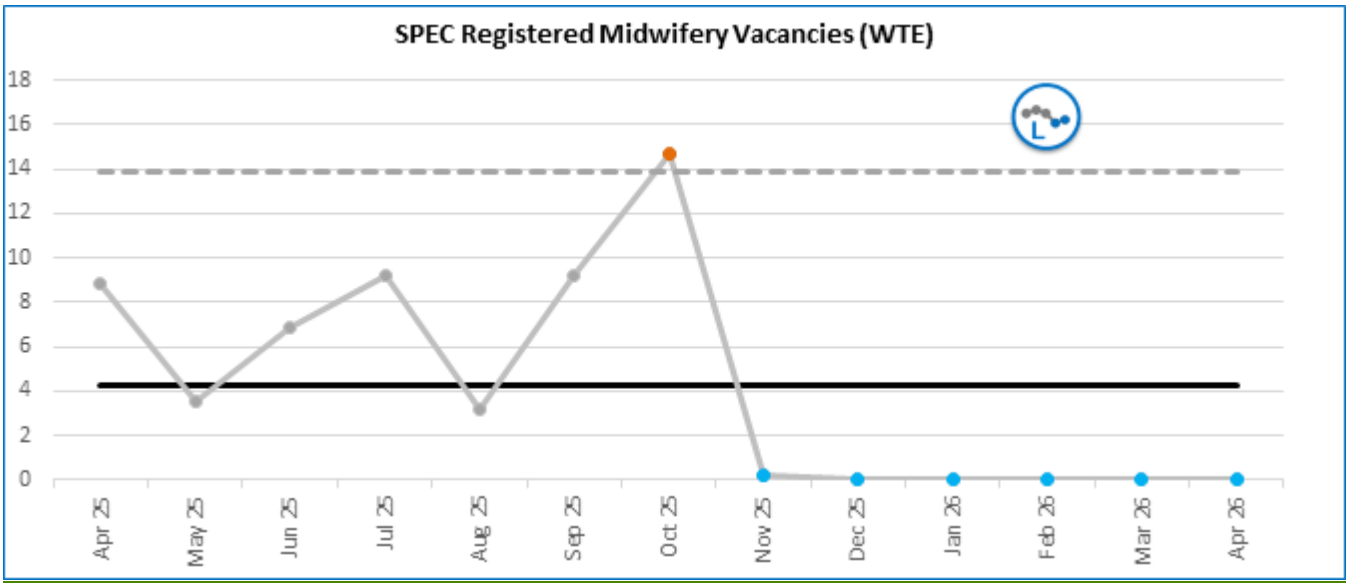
Table 3 Current midwifery and nursing vacancy

- Midwifery recruitment remains strong, with 6.03 WTE midwives in the pipeline at the end of April 2026. Maternity services are supporting 118 student midwives due to qualify between June 2026 and March 2027 and are reviewing the predicted vacancy and potential recruitment opportunities. A report to outline the potential recruitment opportunities is due to be submitted to SHCG SLT in June 2026 for consideration

- The current trend in midwifery vacancies is illustrated in the SPC chart shown in Graph 1.

- Maternity Services continues to see a positive impact of recruiting to turnover, demonstrated through:

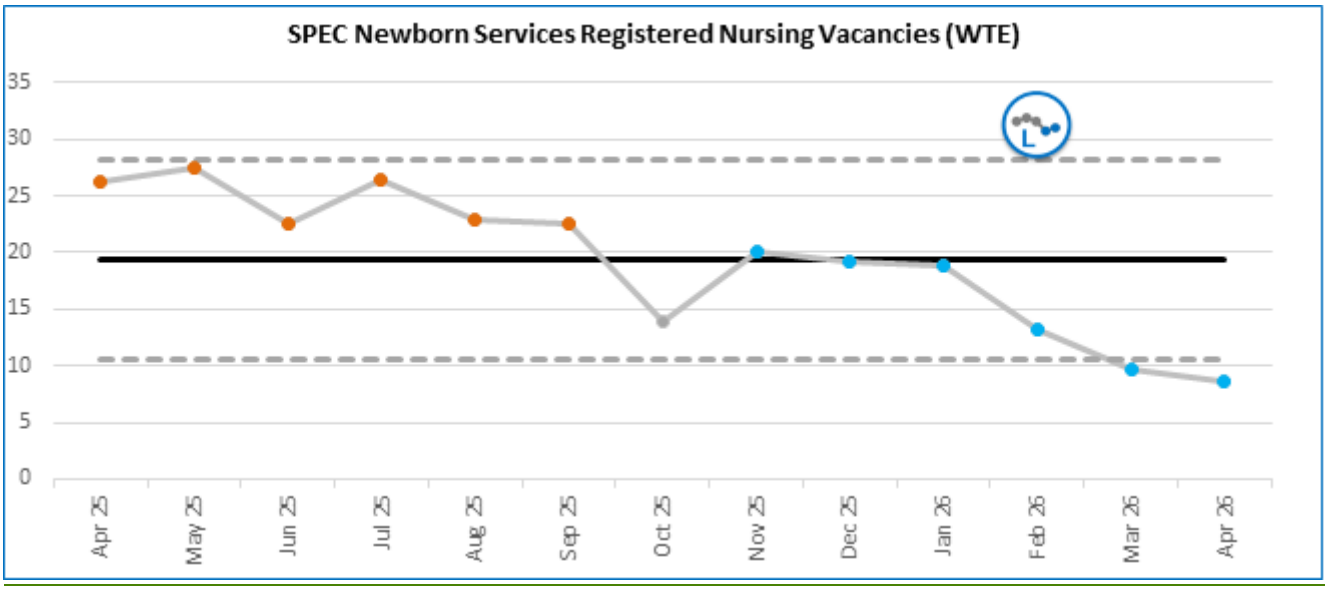
  - Improved flow within Maternity Triage and induction of labour (IOL) pathways:
  - 81.2% of women were assessed within 15 minutes of arrival on Maternity Triage in April 2026.
  - 96.7% were assessed within 30 minutes of arrival on Maternity Triage in April 2026.
  - 77.27% of women on the IOL pathway waited less than 24 hours for ARM in April 2026



Graph 1 Spec SMH Midwifery Registered Vacancies

- In Newborn Services' nursing workforce, there were 16.75 WTE vacancies at the end of April 2026 across Bands 4-7 with 4 WTE Band 4 and 5's commenced in May 2026. Graph 2 demonstrates the vacancy trend for neonatal nursing vacancies There has been a significant improvement in the WTE vacancy position in April 2026 compared to April 2025, reflecting strengthened workforce stability across the service.

- Newborn Services continues to support nursing colleagues to rotate from the NICU at ORC to Wythenshawe and North Manchester to support attrition.



Graph 2 Spec SMH Newborn Services Registered Vacancies

Nursing and Midwifery Workforce Productivity

- The Maternity and Newborn Services Care Division continues to support the Trust-wide Nursing, Midwifery and Allied Health Professionals (NMAHP) staffing finance accelerator schemes, aimed at improving efficiency and strengthening the financial impact of workforce initiatives. Key areas of focus have been reducing NHSP expenditure linked to paid break times (target compliance 95%). The service reports compliance with this measure.
- Compliance with 90% NHSP short shift / long day bookings has also been maintained across Maternity and Newborn Services maintaining over 97% compliance in this reporting period.

Areas of focus relate to:

- Part time staff who work additional hours rather than utilising NHSP continue to be reviewed weekly at SM MCS staffing meetings and are routinely monitored and scrutinised by the Heads of Midwifery alongside NHSP shift requests.

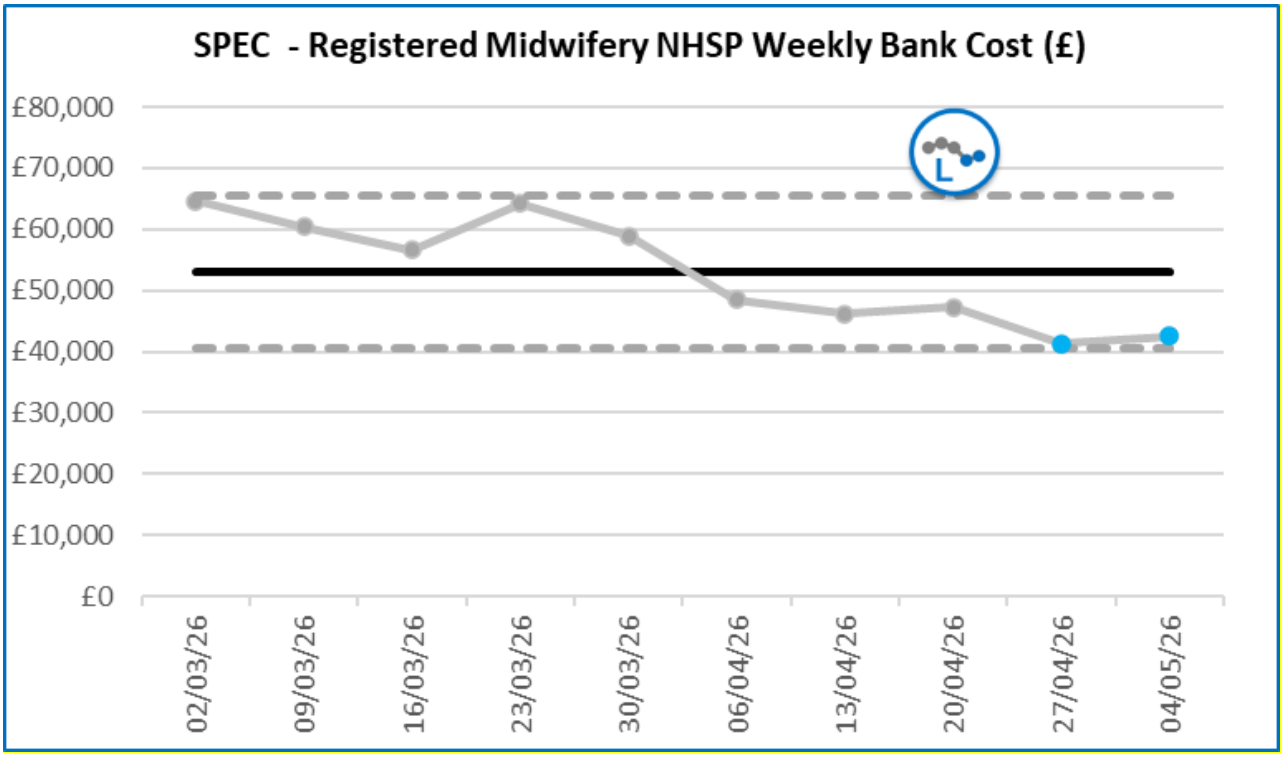
Hours owed, time owing, and annual leave allocation are reviewed weekly by the Matrons responsible for roster oversight across Maternity and Newborn Services, alongside the roster template. For staff who work less than full time, accruals are made until they reach over a full shift length and they are rostered appropriately. An exercise has been undertaken to cleanse the rosters, resulting in an understanding of those demonstrating in excess of 100 hour and actions have been taken to rectify this position and make corrections where necessary. NHSP temporary staffing continues to be utilised across the Trust, with Heads of Midwifery and Nursing meeting monthly with NHSP leads in dedicated temporary staffing huddles. These huddles

review NHSP fill rates, incidents and workforce applications, with appropriate actions agreed to ensure safe, efficient staffing.

- As a consequence of strong staff retention and tight control of temporary staffing, spend across maternity services has seen a downward trend which can been seen in Graph 3 below.

- NHSP fill rates are monitored weekly by the Heads of Midwifery and Head of Nursing using the Ward Establishment Review Model (WERM) tool. Both Maternity and Newborn Services continue to maintain compliance with zero premium-rate overtime spend (with the exception of Advanced Nurse Practitioners covering medical industrial action). Trends in NHSP fill rates are presented through SPC charts in Graphs 4 and 5, with further detail provided in Appendices 1 and 2.

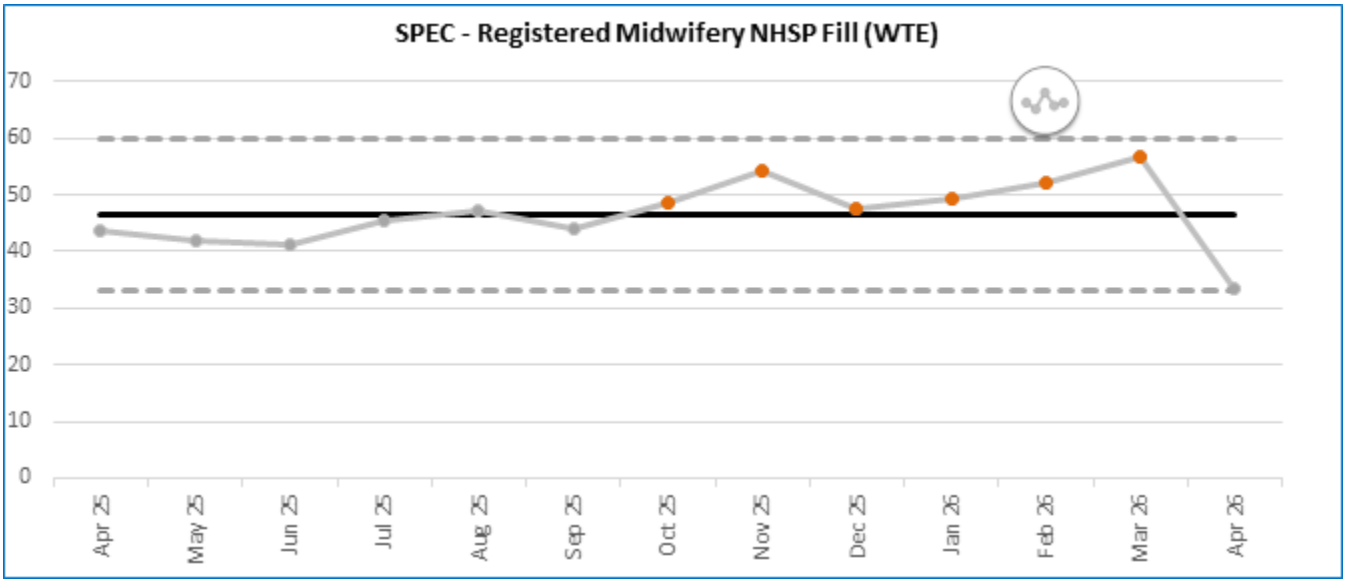
- Maternity Services continues to review NHSP expenditure prospectively on a weekly basis through manager-led staffing meetings, using a bespoke NHSP tool. This tool monitors spend in relation to vacancies, supernumerary staffing requirements, and uplift for sickness and training, and remains an effective resource for supporting managers to control budgets and reduce avoidable costs while maintaining safety.



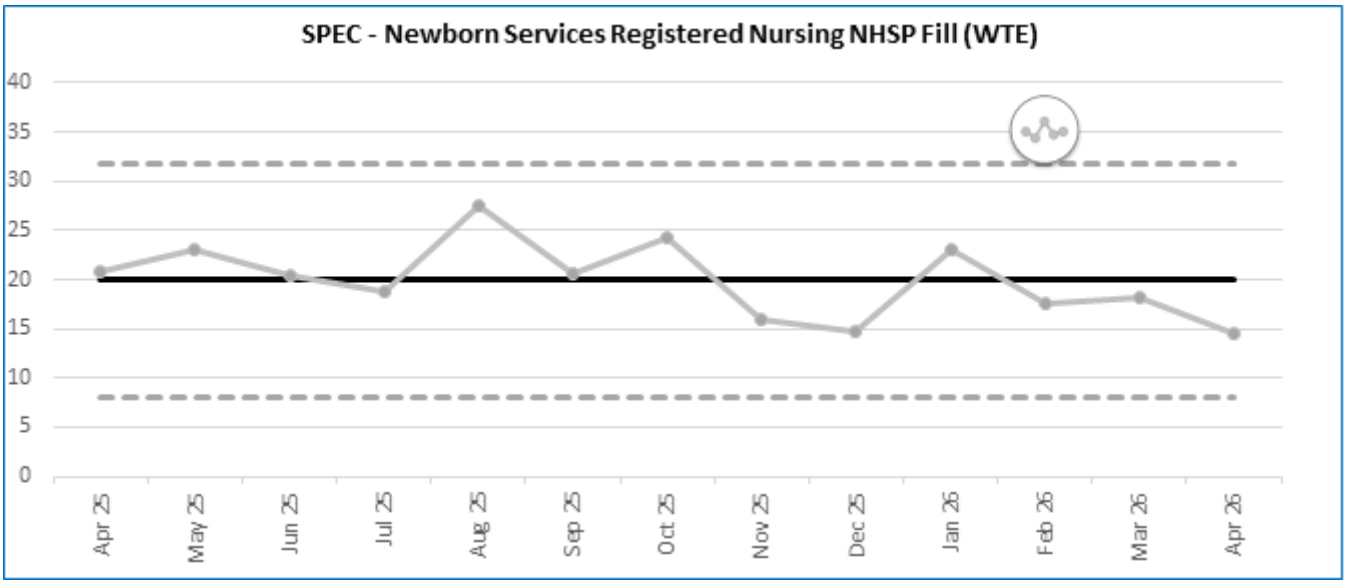
Graph 3 Midwifery NHSP Bank cost

- Newborn Services has required NHSP support to provide backfill for essential training, including the Neonatal Qualification in Speciality (QIS) and Foundation in Neonates (FiN), which commenced in April 2026. The cot side pressure is attributed to attendance on study days and the mandated supernumerary time required to complete the courses. NHSP usage is closely monitored through daily staffing meetings, with active consideration given to mutual aid arrangements and redeployment of staff from quality roles to minimise reliance on temporary staffing wherever possible. A Quality Impact Assessment (QIA) was completed in May 2026 to assess the potential impact of

temporary withdrawal of NHSP support within Newborn Services and to ensure patient safety and quality of care were maintained.



Graph 4 Spec SMH Midwifery Registered NHSP Fill Rates



Graph 5 Spec SMH Newborn Services Registered NHSP Fill Rates

Sickness Absence

There is a split of 56% short-term versus 44% long-term sickness during March–April 2026 across the Maternity and Newborn Services Care Division. Overall, the reduction in sickness has been sustained from February 2026 (7.02%) through to April 2026 (6.2%)

Table 4 below demonstrates the Divisional reasons for absence compared with Trust reasons for absence

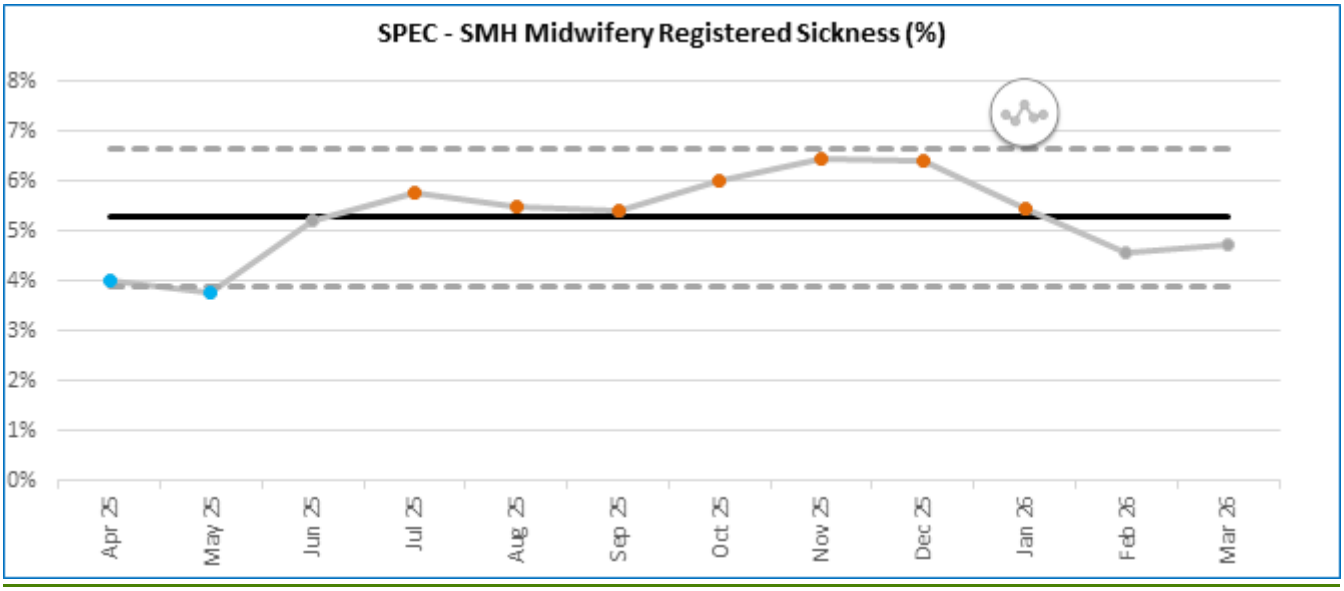
Month	Reason for Absence	Top 3 Divisional Rate %	Trust Rate %
March 2026	Anxiety/Stress/ Depression	16.8%	13.9%
	Cough/Cold/Flu	16%	15.6%

	Gastro/Intestinal issues	13.4%	14.6%
April 2026	Anxiety/Stress/ Depression	19.3%	13.4%
	Gastro/Intestinal issues	15.3%	12.9%
	Cough/Cold/Flu	38.8%	13.5%

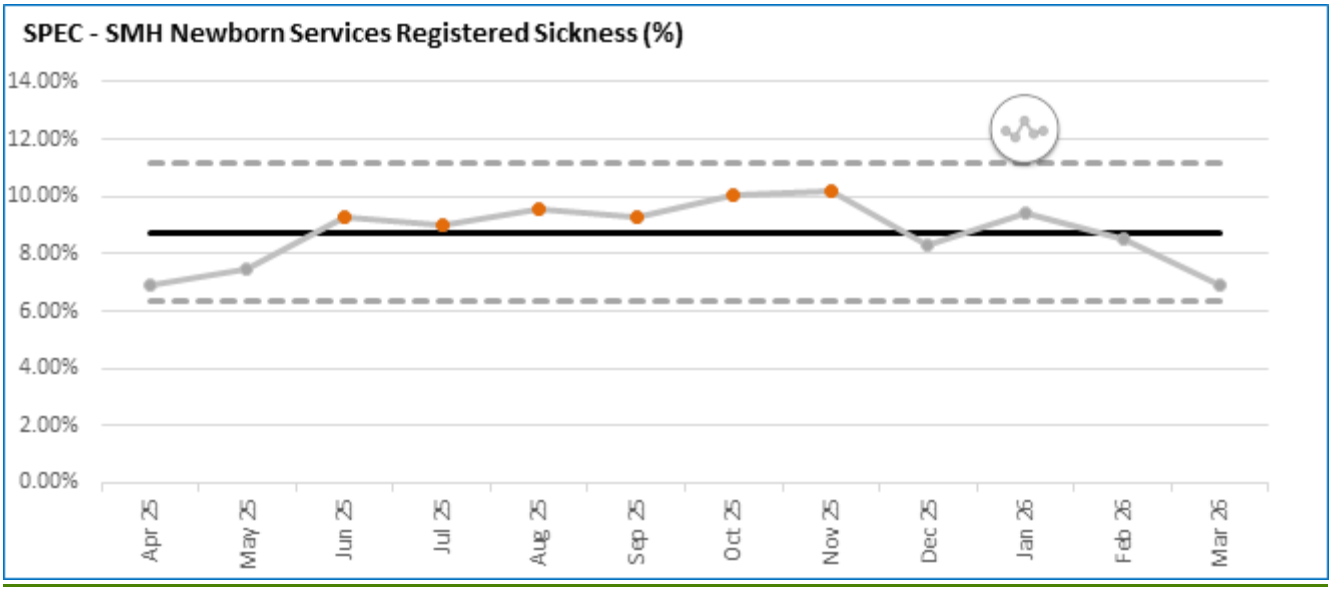
It is recognised that anxiety/stress/depression increased between March and April however it is important to note that this is a mixture of home and work-related stress. Work is ongoing to ensure stress/anxiety risk assessments are in place to support early intervention, identify appropriate support and adjustments, and facilitate an earlier return to work. Staff are signposted to support via the Employee Assistance Programme (EAP), online training and EHW. Managers, supported by HR, continue to review risk assessments at regular intervals following return to work to help prevent further absence episodes and to manage cases through the frequent absence process in a timely manner.

- Both services have attendance improvement strategies and associated action plans, which are monitored through divisional safer staffing meetings. During these meetings, sickness levels are reviewed by the Heads of Midwifery and the Head of Nursing, including analysis of absence reasons, actions taken, call-backs, and return-to-work interviews. In addition, workforce trends are presented to the SHCG Senior Leadership Team monthly at Divisional Delivery Oversight Framework meetings.

- To strengthen scrutiny and assurance within Maternity and Newborn Services, the attendance action plan is also reviewed through the Maternity and Newborn Services bi-weekly Safer Staffing Workstream which is supported by the Divisional Human Resources (HR) Business Partner (BP). The HR team further supports the management of sickness and absence through monthly attendance assurance meetings chaired by the HR BP. Trends in sickness and absence are illustrated through the SPC charts shown in Graphs 6 and 7.



Graph 6 Spec SMH Midwifery Registered Sickness

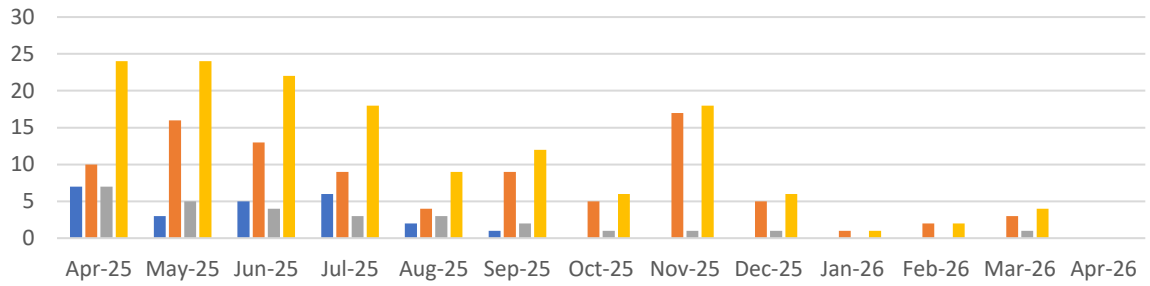


Graph 7 Spec SMH Newborn Services Registered Sickness

Maternity 'Red Flags Events', Escalation and monitoring of staffing MIS Year 7 Safety Action 5

- Red flag events are signs that incidents may relate to inadequate staffing.
- On analysis of Red Flag incidents reported in March and April 2026, there were four incidents reported across SM MCS, all four incidents which fitted the criteria as a red flag incident following review related to redeployment of staff from mandatory training. In all four cases, the correct escalation process was followed prior to staff being redeployed, and there was no impact on the training compliance trajectory. No incidents reported resulted in moderate harm or above following review.
- In Quarter 4, SM MCS had a reduction in Red Flag incidents.
- There is clear correlation of a reduction in Red Flag incidents and a reduction in the midwifery vacancy rate.
- Work supported by the Maternity Governance Team, has resulted in appropriate review and categorisation when delays occur that are not related to midwifery staffing.

Graph 8 Saint Mary's MCS Midwifery Red Flag (RF) Reportable Incidents



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
SM North	7	3	5	6	2	1	0	0	0	0	0	0	0
SM ORC	10	16	13	9	4	9	5	17	5	1	2	3	0
SM Wythenshawe	7	5	4	3	3	2	1	1	1	0	0	1	0
Total	24	24	22	18	9	12	6	18	6	1	2	4	0

Supernumerary status of labour ward coordinator

- Maternity Services has continued to report and monitor compliance with supernumerary labour ward coordinator status and the provision of one-to-one care in active labour. Maternity Services has continued to achieve **100% compliance with maintaining a supernumerary labour ward coordinator across the three maternity sites**.

Provision of 1:1 care in labour

- During March 2026 **Maternity Services provided one-to-one care in labour to 99.89% of women, and to 99.29% of women in April 2026**. As reported above, Maternity Services has a detailed action place for occasions where with provision of one-to-one care has not been achieved. The action plan is monitored through the Maternity Services' Site Obstetric Quality, Safety and Performance Committee and reported to the Maternity Operational Delivery Group chaired by the Director of Nursing and Midwifery.

Neonatal Qualification in Speciality

- Newborn Services remains non-compliant with the British Association of Perinatal Medicine (BAPM) Qualified in Specialty (QIS) standard, which requires a minimum of 70% of nursing staff to hold the qualification. As current compliance is below this threshold, a formal risk assessment has been completed and recorded on the Newborn Services risk register (MFT/004452) with a risk score of 12.

- To improve compliance and mitigate this risk, Newborn Services continues to support up to 40 nurses per annum to undertake the QIS programme. 18nurses commenced the course in April 2026 and are expected to complete in September 2026, which will further improve compliance across all sites.

- As previously reported, all new starters are enrolled onto the Northwest Neonatal Operational Delivery Network (NWNODN) Foundation in Neonates (FiN) programme. This six-month education programme represents the first stage of the QIS pathway and ensures staff develop core neonatal competencies at the earliest opportunity.

- Additional mitigation measures include the deployment of supernumerary QIS-qualified staff who provide enhanced clinical expertise and oversight within the care environment. This includes Band 6/7 Shift Coordinators, Specialist Nurses (e.g. Surgical Nurse Specialists), and site-based Matrons who provide visible clinical leadership. On the Newborn Intensive Care Unit (NICU), a dedicated Band 6/7 QIS-qualified Room Lead is also in place to provide expert support to staff working within the intensive care setting.

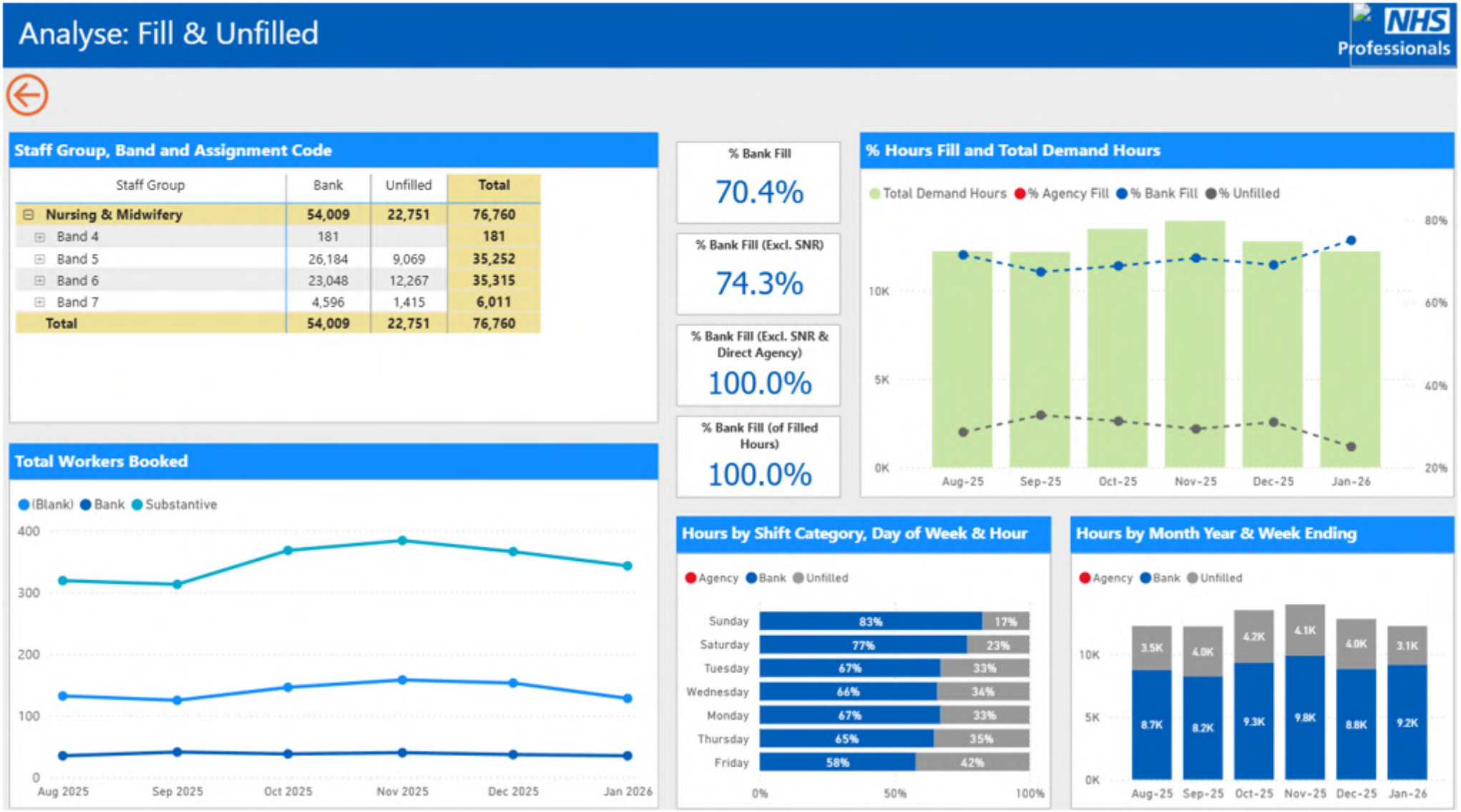
- Current compliance against national standards across all units is summarised in Table 6. Compliance on the Oxford Road NICU has slightly decreased to 61%, while Wythenshawe has increased to 71% and North Manchester to 70% since the previous reporting period; both sites are therefore currently compliant with the national standard.

- There is likely to be a future change in the QIS standard which describes needing more than 70% QIS trained where intensive care activity is high. Newborn Services will need to consider this potential change in future workforce plans.

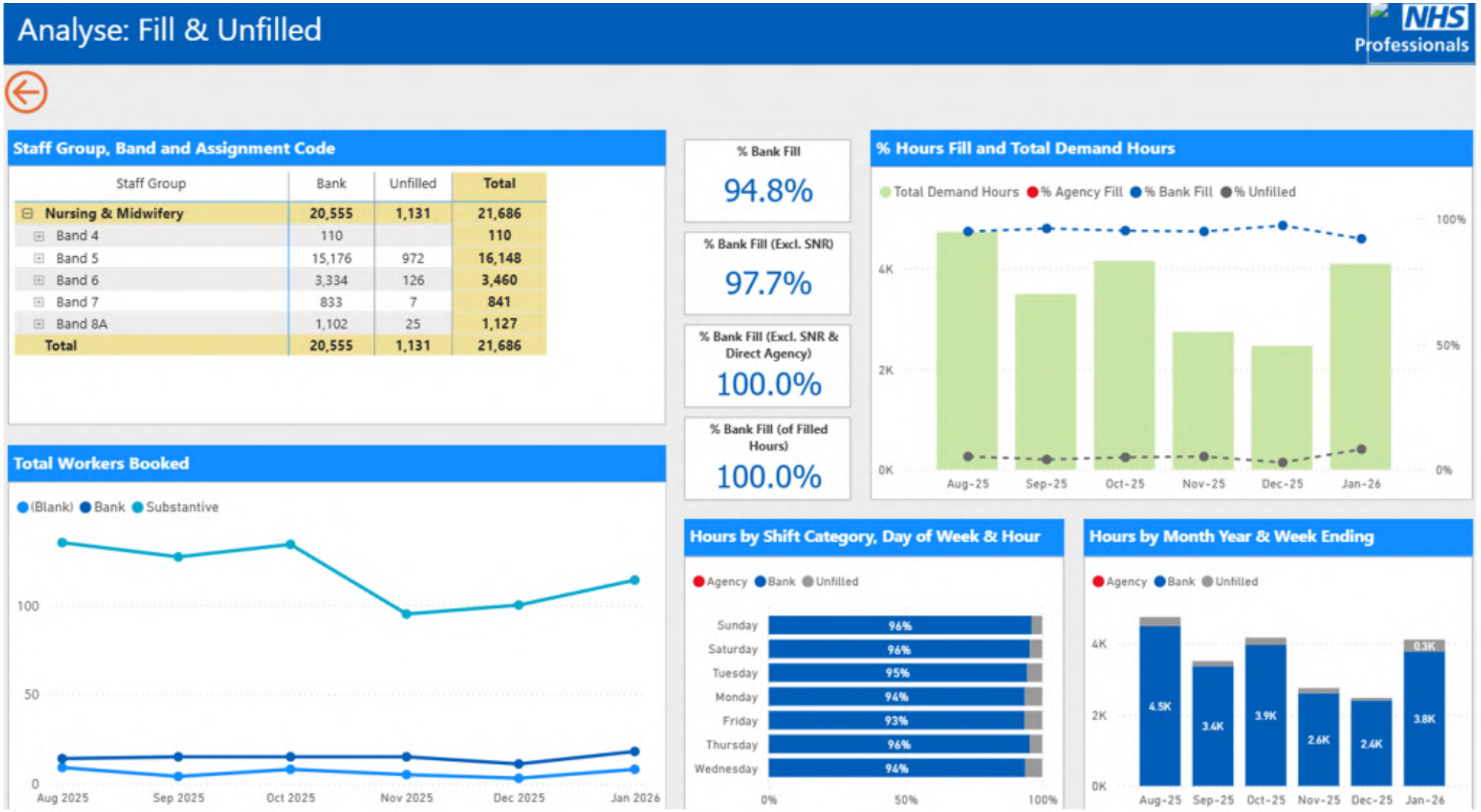
Site	Oxford Road		North Manchester		Wythenshawe	
	Feb 26	**April 26**	**Feb 26**	**April 26**	**Feb 26**	**April 26**
All bands	62%	61% ⇩	63%	70% ⇧	65%	71% ⇧

Table 6 – Qualification in Speciality Percentage Compliance (April 2026)

Appendix 1 NHSP Fill – SMH Maternity Services



Appendix 2 – NHSP Fill – SMH Newborn Services



Manchester University NHS Foundation Trust

Escalation and Assurance Report

Finance Board Committee

Report to: Board of Directors
Report from: Mr Trevor Rees, Interim Trust Chair and Chair of the Finance Board Committee
Date of meeting(s): 1 July 2026

Key escalation and discussion points from the meeting

Alert:

The Committee received the **Chief Finance Officer's Month 2 Report**, which provided a detailed and candid assessment of the Trust's financial position, including the emerging Quarter 1 impact, cash pressures and the scale of further VfP delivery required. The Committee was assured that these issues are subject to active Executive oversight, strengthened forecasting arrangements and continued scrutiny through governance routes. Specifically, the report detailed a current deficit of £10.6m against a planned deficit of £3.1m. The challenged **cash position**, of £8.0m against a planned £32.3m, and associated liquidity risks was also discussed in context of these reported positions. An early indication of the end of Q1 position was also outlined, with discussion on the potential risks to and impact on MFT's NHS Oversight Framework segmentation and Advanced Foundation Trust ambitions, in the event that the Q1 position was not achieved. The additional mitigations and controls to support delivery were described to the Committee. The Committee recognised the distinction between managing immediate liquidity pressures and addressing the Trust's longer-term strategic financial sustainability risk. Further reporting was requested to strengthen Board oversight of cash management activity and emerging risks.

The four finance performance metrics included within in the finance chapter of the **Integrated Performance Report** are alerted to the Board.

A detailed deep dive into the **Value for Patients (VfP) programme** was presented to the Committee. The continued development of the VfP pipeline was noted. The current underperformance against plan, and the impact of the programme delivery on cash management was discussed, with the importance of recovering the Quarter 1 position, accelerating transformational schemes during Quarter 2 and beyond, and maintaining an appropriate balance between delivery of financial improvement and the continued provision of safe and effective patient care emphasised. The Committee also discussed risks associated with delivery of high-impact schemes, due to delays in nationally agreed arrangements.

The Committee noted that following consideration by the Trust Risk Oversight Committee (TROC), the **Capital Resource** risk score was increased from 12 to 20 as whilst the Trust's capital allocation has increased compared with previous years, it remains insufficient to meet the scale of MFT's capital requirements. The impact of current cash constraints on capital expenditure was also recognised.

A detailed review of **productivity opportunities** across clinical and corporate services was presented to the Committee. This identified, further to a detailed analysis exercise of national benchmarking data, potential productivity opportunities of up to £290m over a three-year period. The Committee noted that realisation of benefits was dependant on translating benchmarking insight into corporate, operational and clinical change, and required focus to be directed from transactional to large scale transformational schemes, supported through existing governance arrangements, annual planning processes and the VfP programme.

The Committee reviewed a **contract award** recommendation report and a **business case** report and recommended these to the Board of Directors, in line with the Scheme of Reservation and Delegation.

Advise:

The Committee reviewed the **Integrated Performance Report** and welcomed the revised format, however requested that future iterations included timescales for delivery of actions to strengthen accountability and support tracking of progress.

The Committee received an update on the ongoing development of the **Greater Manchester Procurement Hub** proposal and associated assurance work relating to governance, risk, financial implications and benefits. The current target implementation date remains 1 April 2027, although this could be impacted by wider system factors. The Committee noted progress to date and the continued engagement with system partners.

A report on the adoption of the **Trust's reversionary interest under UK GAAP** was included as an appendix to the Chief Finance Officer Report for information. This described the change to accounting treatment, as applied and reported to the Audit and Risk Committee, in respect to the Trust's control total performance (as introduced by NHSE in 2024/25) and the CDEL (Capital Department Expenditure Limits) values that are reported in the Provider Finance Return (PFR) and Trust Accounts Consolidation (TAC) forms.

Assure:

No matters to assure.

Key Risks Discussed:

The Committee reviewed the **Strategic and Operational Risks** assigned to the Committee and noted:

- the Financial Sustainability Risk remained assessed at 20, reflecting the continued challenges associated with financial performance, delivery of the VfP programme and the Trust's cash position.
- the Capital Resource Risk increased from 12 to 20 following review by the Trust Risk Oversight Committee, reflecting the scale of capital need across the organisation and the additional constraints presented by the current cash position.
- no change to the assessed level of the corporate cash resources risk, which remained at 16.
- no change to the corporate commissioner affordability constraints risks, which remained at 20 against a target of 20.

Report approved by: Mr Trevor Rees, Interim Trust Chair and Chair of the Finance Board Committee

Agenda:

Finance Board Committee

Manchester University NHS Foundation Trust

Date: Wednesday 1st July 2026
Time: 2:00pm – 4:00pm
Location: MS Teams

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	2:00pm
2.	**Declaration of interest** (verbal)	Meeting admin	Chair	
3.	**Minutes of the previous meeting** 22nd April 2026	Meeting admin	Chair	
4.	**Action Log**	Discussion	Chair	
5.	**Matters Arising / Hot Topics**	Discussion	Chair	2.05pm
6.	**Assurance Reporting**			
6.1	Strategic and Corporate risks	Discussion	CFO	2.10pm
6.2	Integrated Performance Report	Discussion	DCFO	2.15pm
7.	**Strategic aim 4: Ensure value for our patients and communities by making best use of resources**			
7.1	Chief Finance Officer's Report (Month 2) including briefing on accounting treatment of the Trust's reversionary interest under UK GAAP.	Discussion	CFO	2.25pm
7.2	Value for Patients Programme Deep Dive	Discussion	Interim DCO	2.35pm
7.3	Productivity Deep Dive	Discussion	CFO	3.00pm
7.4	GM Procurement Service Proposal Update	Discussion	CFO	3:25pm
7.5	Contract Award Recommendation Reports: 7.5.1 Security Services (Trust Wide)	Support	Director of Procurement	3.35pm
7.6	Business Cases: 7.6.1 HIVE Cloud Business Case	Support	CDIO	3.45pm
Committee business				
8.	**Escalation report**	Approval	Chair	3.55pm
9.	**Workplan Review**	Meeting admin	Chair	
10.	**Any Other Business** (verbal)	Discussion	Chair	

	Item	Purpose	Lead	Time
11.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	
Date of next meeting: Wednesday 26th August 2026				
Papers for Information • Finance and Commercial Management Committee Escalation Report				

Manchester University
NHS Foundation Trust

Public Board of Directors
Thursday 30th July 2026

Paper title:	Chief Finance Officer's report - M2 Financial Position	**Agenda Item 13.2**
Presented by:	Claire Wilson, Chief Finance Officer	
Prepared by:	Izaaz Mohammed, Deputy Chief Finance Officer Paul Fantini, Deputy Director of Planning and Reporting	
Meetings where content has been discussed previously	Finance Board Committee, 1st July 2026	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

- In month 2, the Trust delivered a **£10.6m deficit** against a **£3.1m surplus plan** – a **£7.5m adverse** position. The year to date position is **£19.5m adverse variance to the plan.**
- VFP delivery is being strengthened to ensure that recurrent cash releasing efficiencies are maximised in 2026/27.
- Cash remains a key risk for the trust and is the subject of daily management and mitigation measures to provide the levels of liquidity we need to support day to day activities. However, reducing the trusts run rate through strong recurrent VFP delivery will be needed to ensure cash levels are adequate in the medium and long term.

Recommendation(s)

The Board of Directors is asked to:

- Note the contents of the report

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)			
LHL objective 1	☐	LHL objective 2	☐
HQSC objective 1	☐	HQSC objective 2	☐
HQSC objective 3	☒	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☒
VfP objective 2	☒	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: • MFT/001760- Implications of national restrictions on capital resource • MFT/005092 -Delivering Financial Sustainability in the medium term • MFT/008655 - Risk of insufficient cash resources to fund Trust operational and strategic requirements in 2025/26 and beyond.	
Care Quality Commission domains Please check **all** that apply	☐ Safe ☒ Effective ☐ Responsive	☐ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • n/a	

Main report
See report.

Manchester University
NHS Foundation Trust

CFO Report Month 2 2026/27

Where
Excellence
Meets
Compassion

Manchester University NHS Foundation Trust

June 2026

Summary – M2 Position – May 2026

Manchester University NHS Foundation Trust

I&E Category	2026/27 Original Plan £000s	Current Month - M2 Original Plan £000s	Current Month - M2 Actual £000s	Current Month - M2 Variance £000s	YTD Original Plan £000s	YTD Actual £000s	YTD Variance £000s
Total Clinical Income	*2,789,783*	*229,416*	*231,657*	*2,241*	*459,287*	*463,980*	*4,693*
Total Other Income	*329,904*	*27,492*	*28,138*	*646*	*54,984*	*55,105*	*121*
Total Income	**3,119,687**	**256,908**	**259,795**	**2,887**	**514,271**	**519,085**	**4,814**
Total Substantive Pay	*(1,738,687)*	*(144,891)*	*(156,731)*	*(11,840)*	*(289,782)*	*(315,198)*	*(25,416)*
Total Bank Pay	*(90,138)*	*(7,511)*	*(5,627)*	*1,884*	*(15,022)*	*(14,384)*	*638*
Total Agency Pay	*(6,504)*	*(541)*	*(621)*	*(80)*	*(1,082)*	*(1,254)*	*(172)*
Apprenticeship Levy	(6,535)	(545)	(582)	(37)	(1,090)	(1,153)	(63)
Total Pay Costs	**(1,841,864)**	**(153,488)**	**(163,561)**	**(10,073)**	**(306,976)**	**(331,988)**	**(25,012)**
Total Non Pay Costs	**(1,221,003)**	**(101,701)**	**(102,133)**	**(432)**	**(203,494)**	**(203,073)**	**421**
Total Financing Costs	**(58,082)**	**(3,072)**	**(3,013)**	**59**	**(27,879)**	**(25,563)**	**2,316**
Surplus / (Deficit) before adjustments	**(1,262)**	**(1,353)**	**(8,912)**	**(7,559)**	**(24,078)**	**(41,540)**	**(17,462)**
Adjust PFI revenue costs to UK GAAP basis	*1,262*	*(1,755)*	*(1,683)*	*72*	*18,199*	*16,204*	(1,995)
Surplus / (Deficit) for CT purposes	**0**	**(3,108)**	**(10,595)**	**(7,487)**	**(5,879)**	**(25,336)**	**(19,457)**
Total I&E Excluded from CT	**(82,361)**	**442**	**(53)**	**(495)**	**881**	**(24)**	**(905)**
Surplus / (Deficit) after CT excluded items	**(82,361)**	**(2,666)**	**(10,648)**	**(7,982)**	**(4,998)**	**(25,360)**	**(20,362)**

Summary

In month 2 2026/27 for NHSE reporting purposes, the Trust delivered a **£10.6m deficit** against a **£3.1m deficit plan** - £7.5m adverse. YTD the adverse variance stands at **£19.5m**.

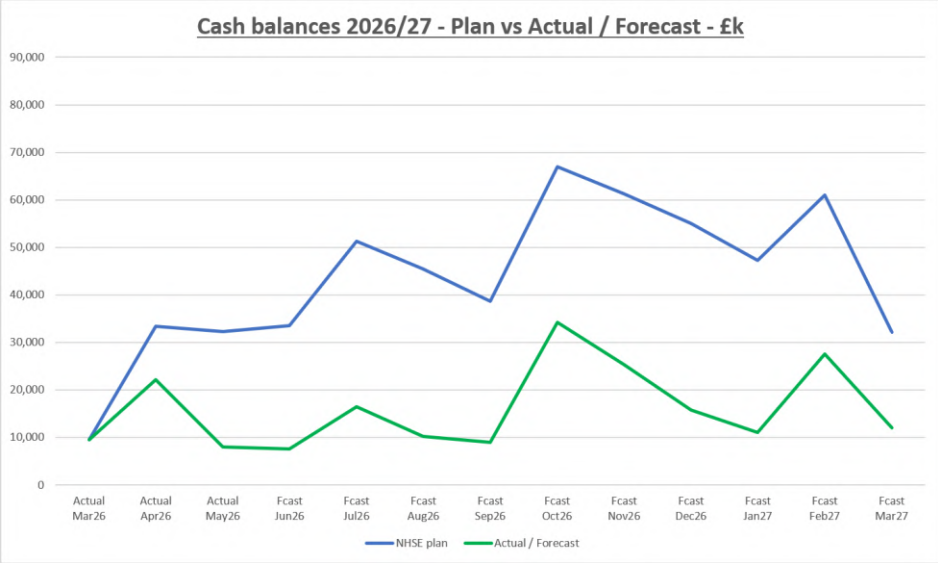
The drivers of this YTD deficit were:

- April Resident Doctors Industrial Action costs of -£2.7m (no National funding to support).
- Underperformance against the VfP programme plan by -£17.2m, the plan has been profiled in equal 12ths with higher actual delivery expected in later months.
- Offsetting adverse and favourable variances netting to +£0.4m

NHSE have indicated that the industrial action costs will not be funded and need to be mitigated in year by each organization.

The impact of the uplift in pay award for AfC staff from the original planned 2.1% to the agreed 3.3% is net neutral with a favourable variance in income YTD of £2.8m offset by an adverse variance in pay at the same value.

Cash and Liquidity



Cash Plan vs Actuals - M2	£m
Plan Cash Balance	32.3
Actual Cash Balance	8
Variance - Higher/(Lower) than plan	**-24.3**
Revenue Operating Cash Days	**0.9**
Monthly Low	7.8
Monthly High	193

Cash

The Trust has 0.9 days of revenue operating cash days at the end of May, which was in line with forecast and equates to £8.0m.

Adverse variances against plan include:

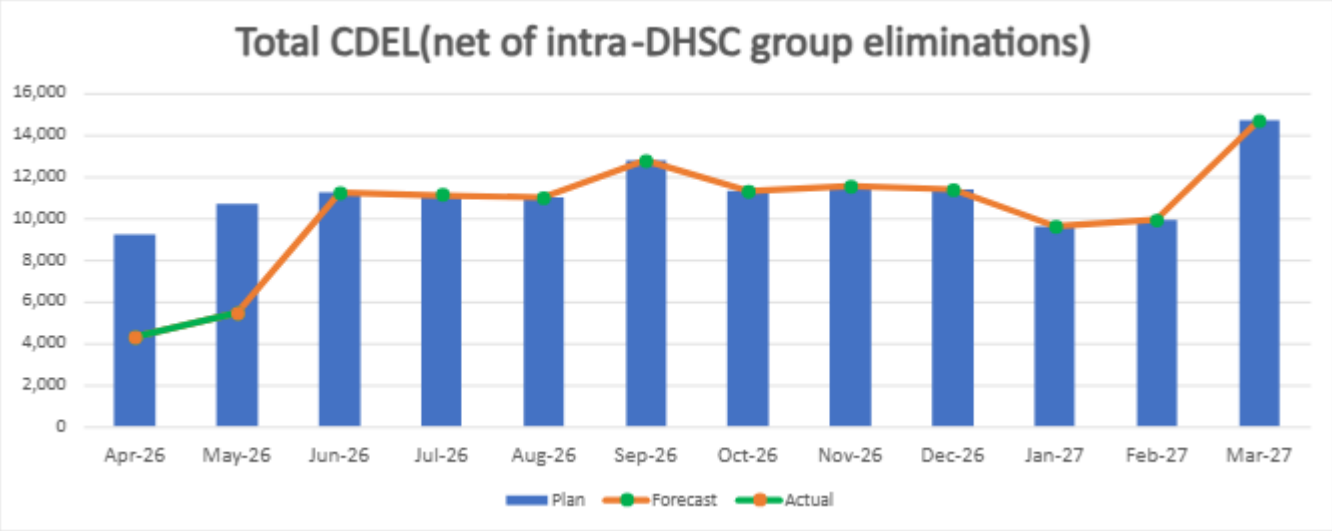
- c.£20m deficit against YTD plan.
- Planned £36m revenue support cash was not drawn down.

Favourable variances include:

- Active management of working capital, giving c.£30m benefit. This includes the receipt of a £10m payment on account from GM ICB.

Significant focus continues to be given to maximising the Trust's cash position. Delivery of the financial plan in line with the planned profile and delivery of VfP on a cash releasing basis is key to management of the monthly cash position. The forecast scenario shown above assumes that a payment on account will be received from Manchester City Council in July 2026.

Capital



• MFT's 2026/27 capital plan is a total of **£147.3m** including capital spend on IFRS 16 leases, PDC funded schemes, grant and charity schemes and the capital expenditure associated with the Trust's PFIs.

• **GM Envelope (inc IFRS 16)** - Allocation for 2026/27 is £46.5m.

•**Other capital (PDC, grant, charity and PFI)** – £100.8m.

•**Year to date spend -** £1.2m 2026/27 PDC funding received as of M2 - Several of the PDC schemes included in the 2026/27 capital plan are still pending receipt of MOUs. Related expenditure for these schemes is dependent upon receipt of MOUs and cash receipts. YTD expenditure relates to spend on essential capital including Health and Safety related spend and schemes already in train from 2025/26.

•**Total Capital** - Forecast total capital outturn is in line with the overall trust plan of £147.3m.

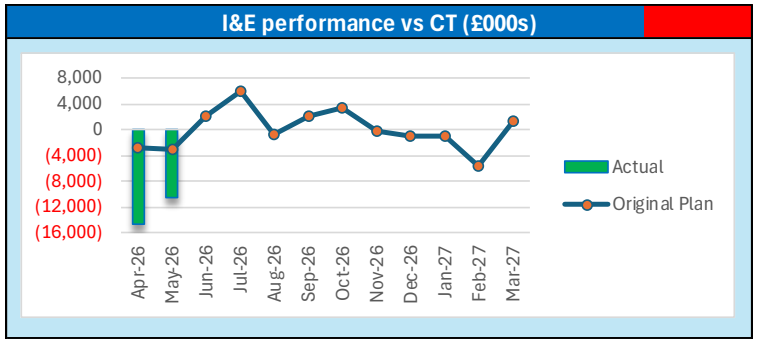
	Current Month - M2			YTD			Forecast		
	Original Plan £'000	Actual £'000	Variance £'000	Original Plan £'000	Actual £'000	Variance £'000	Original Plan £'000	FOT @ M2 £'000	Variance £'000
GM Envelope (including IFRS 16 Leases)	3,280	1,518	(1,762)	6,751	2,266	(4,485)	46,490	46,490	0
Other Capital (PDC, grant and charity, PFI)	8,529	0	(3,469)	14,525	9,122	(5,650)	100,803	100,803	0
Total Capital	**11,809**	**1,518**	**(5,231)**	**21,276**	**11,388**	**(10,135)**	**147,293**	**147,293**	**0**
CDEL (net of intra-DHSC group eliminations) included in Total Capital above	**10,681**	**5,450**	**5,231**	**19,929**	**9,794**	**10,135**	**134,577**	**134,577**	**0**

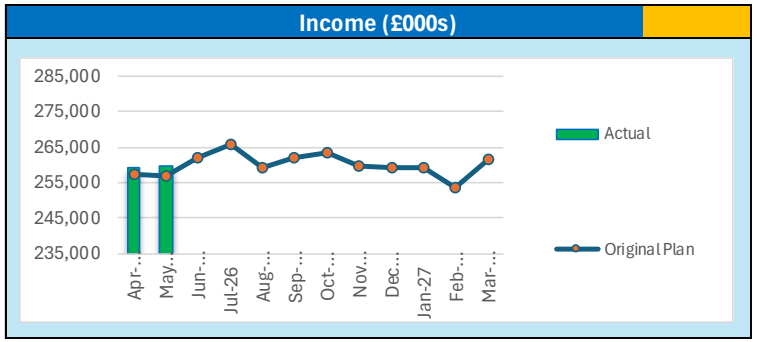
I&E Run Rates vs CT – May 2026

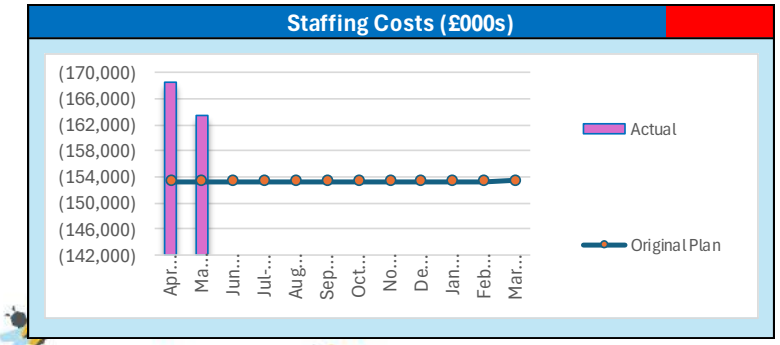
Manchester University NHS Foundation Trust

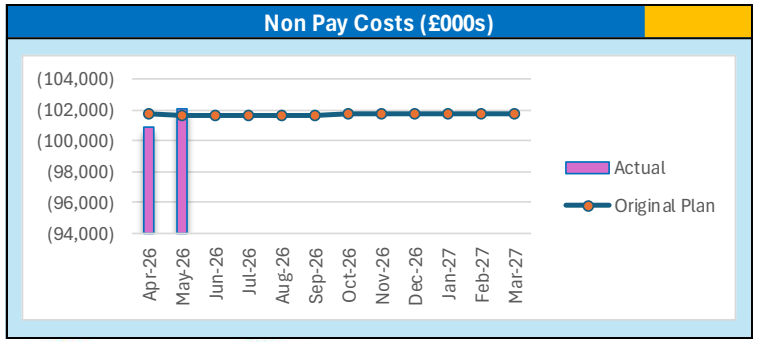
Actual

I&E category	Apr-26 £'000	May-26 £'000
Income	259,290	259,795
Staffing Costs	(168,428)	(163,561)
Non Pay	(100,940)	(102,133)
Financing Costs	(22,550)	(3,013)
PFI revenue costs on a UK GAAP basis	17,887	(1,683)
I&E Performance vs CT	**(14,741)**	**(10,595)**







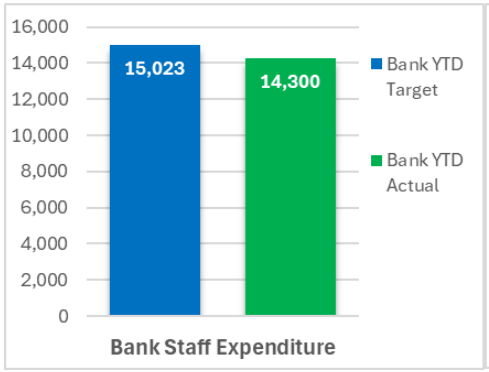


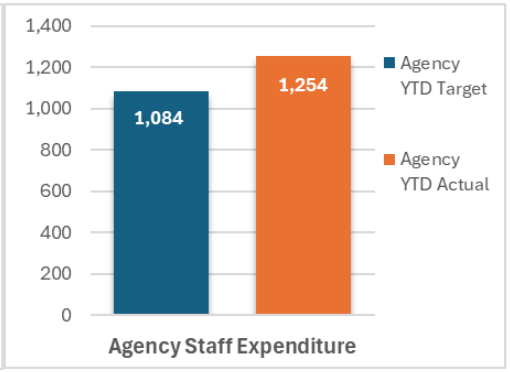
- The charts show the monthly run rate vs the plan.
- The expenditure run rate needs to significantly reduce over the rest of the financial year, driven by the delivery of VfP.
- Both income and expenditure include £2.8m YTD for the uplift to 3.3% for the AfC staff pay award that is in the plan at 2.1%.
- The impact of Resident Doctors industrial action in April was included in staffing costs at an estimated £2.8m, with a £0.3m favourable adjustment to the estimate in May. There is no national funding to support these costs.

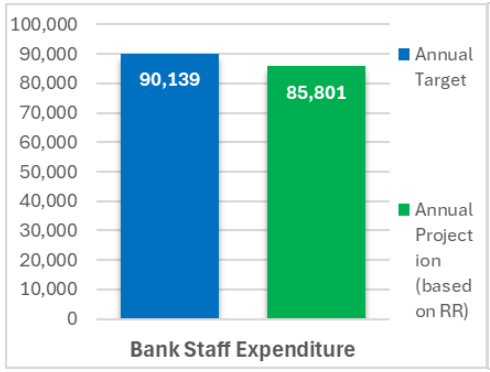
Bank & Agency Expenditure vs National Cap

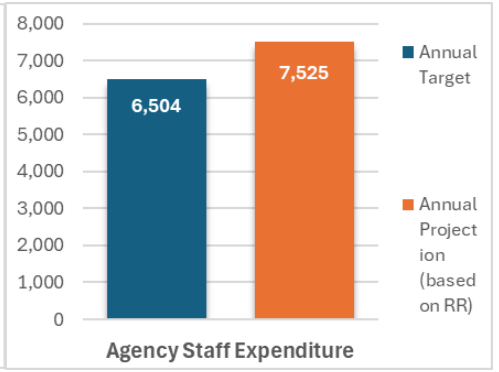
Manchester University NHS Foundation Trust

Clinical Group	Bank				Agency				Bank	Agency	Bank	Agency
	YTD Target £'000	YTD Actual £'000	YTD Variance £'000	YTD Variance %	YTD Target £'000	YTD Actual £'000	YTD Variance £'000	YTD Variance %	Annual Target £'000	Annual Target £'000	Projection (unmitigated) £'000	Projection (unmitigated) £'000
Clinical & Scientific Services	1,240	1,075	**164**	**13.3%**	243	383	**(141)**	**(58.0%)**	7,438	1,455	6,452	2,298
Corporate	378	417	**(39)**	**(10.2%)**	22	55	**(33)**	**(154.7%)**	2,268	129	2,500	329
Facilities	332	420	**(89)**	**(26.7%)**	18	0	**18**	**100.0%**	1,991	108	2,522	0
Exchequer	0	8	**(8)**	**0.0%**	0	0	**0**	**0.0%**	0	0	50	0
LCO & Dental	638	676	**(38)**	**(5.9%)**	7	29	**(22)**	**(320.2%)**	3,826	41	4,053	172
Manchester Royal Infirmary	2,938	2,732	**206**	**7.0%**	222	249	**(28)**	**(12.5%)**	17,628	1,329	16,390	1,496
North Manchester General Hosp	2,980	2,781	**199**	**6.7%**	313	199	**114**	**36.3%**	17,881	1,876	16,684	1,195
Research & Innovation	22	18	**4**	**17.5%**	0	0	**0**	**0.0%**	131	0	108	0
Specialist Hospitals	3,634	3,378	**256**	**7.0%**	108	170	**(62)**	**(57.6%)**	21,806	649	20,271	1,023
WTWA	2,862	2,795	**66**	**2.3%**	153	169	**(16)**	**(10.4%)**	17,170	917	16,772	1,012
Total	**15,023**	**14,300**	**723**	**4.8%**	**1,084**	**1,254**	**(170)**	**(15.7%)**	**90,139**	**6,504**	**85,801**	**7,525**









- Caps for B&A reduction are based on the FOT expenditure at M6 25/26 with a c30% reduction in agency expenditure and a c10% reduction in bank expenditure required in 26/27.
- At M2 the Trust is underspent against the bank cap and overspent against the agency cap when apportioned into equal 12ths. There is an expectation that VfP measures will reduce expenditure on bank and agency over the coming months.

Manchester University
NHS Foundation Trust

Escalation and Assurance Report
Audit and Risk Committee

Report to: Board of Directors
Report from: Mr Nic Gower, Non-Executive Director and Chair of Audit and Risk Committee.
Date of meeting(s): 23 June 2026

Key escalation and discussion points from the meeting
Alert
The Committee approved, under delegated authority from the Board of Directors, the Trust's **2025/26 Annual Report, 2025/26 Annual Accounts** and the **Letter of Representation** supporting the external audit process. The Committee noted the proposed unqualified (clean) audit opinion.
Advise:
The **Local Counter Fraud Progress Report** reported continued delivery against the 2026/27 work programme, increasing referral activity and ongoing awareness work. Members highlighted the importance of ensuring visibility of any outcomes arising from fraud investigations and requested additional assurance regarding controls associated with the MARS and Nursing Apprenticeship fraud prevention notices. The Committee received the annual self-assessed **Review of Compliance with the NHS Provider Licence** and discussed the alignment of this and other required self-assessment frameworks, all drawing upon similar evidence sources. The work underway to develop an overarching and structured evidence framework was outlined. The Internal Audit Progress Report outlined two partial assurance audits and completion of an advisory report. An update on the actions underway to respond to the **Infrastructure Project Planning and Coordination** recommendations, in line with the agreed timeframes, was provided to the Committee. The findings arising from the **Medicines Management** Internal Audit Review, which received a partial assurance opinion with improvements required, were discussed. The Committee noted the need to ensure that emerging themes and associated risks continue to be visible through established governance and assurance processes. A detailed Executive Director-led update has been requested for the next meeting. The advisory report relating to the **Value for Patients Programme Management** recognised the improved maturity and engagement in place and offered suggestions on further improvements in respect to lead indicator oversight and transformational delivery. The **Counter Fraud Annual Report** was received and approved by the Committee. This noted that MFT achieved full compliance against all NHS Counter Fraud Authority functional standards, reflecting improvement from the previous year. Items for noting included reports on **tenders waived** and **losses and special payments**. The analysis of tenders waived between 2023 and 2026 demonstrated a reduction in waivers and improved organisational focus on procurement compliance. The Committee also discussed the procurement process and its ability

to support social value and innovation and noted the ongoing work to strengthen controls and recovery arrangements in respect to aged debt.

The Committee noted the **escalation and assurance reports from Board Committees and Trust Risk Oversight Committee** provided to the Board of Directors.

Assure:

The Committee received the **Internal Audit Annual Report and Conclusion** for 2025/26. Internal Audit concluded Amber-Green ratings across governance, risk management, financial reporting and management, and data quality. recommendations. Internal Audit reported that MFT's governance framework remained fundamentally effective, that a positive cultural shift had been demonstrated and there was clear evidence of management's ability to deliver improvements in the control environment with positive progress in addressing high-priority recommendations.

The **External Audit Findings Report** and **Auditor's Annual Report** were received by the Committee. Grant Thornton confirmed completion of audit work and confirmed that an unqualified (clean) audit opinion would be issued and that no significant weaknesses had been identified in the Trust's governance arrangements. No significant issues were identified regarding management override of controls, revenue recognition or operating expenditure. The Committee noted commentary regarding financial sustainability, including the Trust's low cash position and the continued importance of recurrent savings delivery and cash management arrangements.

The **Internal Audit Progress Report** highlighted significant assurance opinions for reviews of Fit and Proper Persons and Code of Conduct arrangements, compliance with PSIRF (patient safety and incident response framework) standards, and Medical Examiners and Death Certification processes.

The Committee received a **Counter Fraud Recruitment Review**, commissioned in response to emerging risks including AI-assisted recruitment activity and qualification fraud. The review reported positive outcomes and confirmed that MFT compares favourably with peer organisations in several areas of recruitment control.

Report approved by: Mr Nic Gower, Non-Executive Director and Chair of Audit and Risk Committee.

Agenda:

Audit and Risk Committee

Manchester University NHS Foundation Trust

Date: Tuesday 23rd June 2026
Time: 10:00am – 12:00 noon
Location: Main Boardroom, Cobbett House, Oxford Road Campus

Agenda

	Item	Purpose	Lead	Time
1.	Apologies for absence & confirmation of quoracy (verbal)	Meeting admin	Chair	10am
2.	Declaration of interest (verbal)	Meeting admin	Chair	
3.	Minutes of the previous meeting (7th April 2026)	Meeting admin	Chair	
4.	Action Log	Discussion	Chair	
5.	Matters Arising / Hot Topics	Discussion	Chair	
	2025/26 Year End Matters			
6.	Internal Audit Annual Report and Conclusion	Discussion	Internal Audit (KPMG)	10:05am
7.	External Auditor Reports	Discussion	External Audit (GT)	10:20am
8.	**Review and Approve**			
8.1	2025/26 Annual Report (for the period 1 April 2025 to 31 March 2026)	Approve	Trust Board Secretary	10:35am
8.2	2025/26 Annual Accounts (for the period 1 April 2025 to 31 March 2026)	Approve	Chief Finance Officer	10.45am
9.	**Internal Audit**			
9.1	Internal Audit Progress Report	Discussion	Internal Audit (KPMG)	10.55am
10.	**Local Counter Fraud**			
10.1	Local Counter Fraud Progress Report	Discussion	Local Counter Fraud (KPMG)	11.05am
10.2	Recruitment Review	Discussion	Local Counter Fraud (KPMG)	11:10am

	Item	Purpose	Lead	Time
10.3	Counter Fraud Annual Report (including standard functional return)	Approve	Local Counter Fraud (KPMG)	11.15am
11.	**Items for Noting and / or Information**			
11.1	Analysis of Tenders Waived 2023-2026 (by volume and value)	Noting	Procurement Director	11.25am
11.2	Tenders Waived for the period 1st March to 31st May 2026 above £50,000	Noting	Procurement Director	11.30am
11.3	Losses and Special Payments for the period 1st April 2025 to 31st March 2026.	Noting	Deputy Chief Finance Officer	11:35am
Good governance				
12.	Review of Compliance with NHS Provider Licence	Noting	Trust Board Secretary	11.40am
13.	Escalation reports from Board committees and Trust Risk Oversight Committee	Noting	Trust Board Secretary	11.50am
Committee business				
14.	**Escalation report**	Discussion	Chair	11.55am
15.	**Workplan Review**	Meeting admin	Chair	
16.	**Any Other Business** (verbal)	Discussion	Committee Members	
17.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	
Date of next meeting: Tuesday 8th September 2026 at 10:00am – 12:00pm, Main Boardroom, Cobbett House, ORC				

18.	Private Meeting with External Auditor (committee members only)		Chair	12.05pm

Manchester University NHS Foundation Trust

Escalation and Assurance Report

Digital and Estates Board Committee (DEBC)

Report to: Board of Directors
Report from: Sam Liscio, Non-Executive Director and Chair of DEBC
Date of meeting: 02/06/26

Key escalation and discussion points from the meeting
Alert
The Committee discussed significant risks associated with the **Director of Estates and Facilities' report** including ongoing challenges within the Oxford Road Campus PFI arrangements, lifecycle delivery, variation management and fire safety compliance. Members noted that a contractor has ceased all estate variations with minimal notice, requiring intensified oversight. The Fire Enforcement Notice issued by Greater Manchester Fire and Rescue Service remains a key area of focus, with assurance provided that detailed surveys, improvement plans and escalation routes are in place. Regular monitoring continues through TLTC and executive forums. Data quality of pathway management within Hive was outlined through the **Chief Digital and Information Officer's report** with the Committee discussing and acknowledging this emerging strategic risk. This issue is being escalated through the Serious Issues Oversight Group alongside being reported to TROC. The purpose of this strategic risk is to provide a single organisational framework through which the Trust can strengthen oversight, governance, assurance and continuous improvement of patient record management across both digital and non-digital processes.
Advise:
The Committee received the **Integrated Performance Report,** noting strong overall performance across digital key metrics and continued improvement in information governance. FOI performance has stabilised above the 90% target, reflecting sustained backlog reduction and improved responsiveness. Members discussed the importance of articulating clinical consequences of digital risks, including cyber resilience, interoperability and downtime, and supported further refinement of KPI reporting to strengthen clinical assurance. The Committee noted that cyber risks remain stable, with recruitment challenges being addressed alongside continued capital prioritisation being required. A new target operating model for cyber security is being developed, supported by multi-year capital allocations and national funding streams. The Committee received a **Capital Planning Additional Funds** update**,** which included confirmation of an additional £10m allocation from the Estates Safety Fund, bringing the total to just under £19m for 2026/27. While this provides support for backlog mitigation, members recognised that cash constraints continue to limit the pace of delivery. Work is underway to determine how the additional resource will be deployed across priority schemes, statutory compliance and lifecycle requirements. The Committee was updated on the **Strategic Estates Plan,** including progress on the 10–15-year Strategic Estates Plan, Wythenshawe Masterplan feasibility work and the Healthy Neighbourhoods programme at North Manchester. Members noted dependencies on external funding streams, including GMCA, national programmes and One Public Estate, and supported continued engagement to mitigate delivery risks. The Committee welcomed the direction of travel while recognising the complexity and long-term nature of estate transformation.

The Committee received the **Chief Digital and Information Officer's report,** noting progress on key digital programmes including Ambient Voice Technology, Hive LCO expansion, clinic optimisation and productivity initiatives. Members acknowledged the scale and complexity of AVT implementation, including significant training requirements and dependencies on fast-pass scheduling and outpatient optimisation. The Committee recognised emerging productivity benefits and improved operational insight, while noting challenges in translating capacity gains into cash-releasing savings. Estates KPIs are being finalised and will be incorporated into the Trust IPR from Q2 onwards.

Assure:

The Committee was assured that subject access request performance, highlighted within the **Integrated Performance Report**, remains exceptionally strong, with compliance at 99.7% and confirmation that the Trust is now one of the highest-performing public bodies nationally. The ICO has removed its performance notification, reflecting sustained improvement in process, staffing and use of AI.

The Committee also received assurance through the **Strategic and Corporate Risks** discussion that immediate patient safety risks relating to estates and digital infrastructure continue to be mitigated through established controls, prioritisation and executive oversight. Cyber security remains stable, with no material issues requiring escalation and continued progress against national standards.

Risks discussed at the meeting

The Committee reviewed risks associated with digital infrastructure, cyber security, estates condition and PFI-managed assets through the Strategic and Corporate Risks item.

Members discussed the medium-term strategic risk arising from constrained capital availability and the scale of backlog maintenance, particularly in relation to ageing infrastructure, lifecycle delivery and fire safety compliance. The Committee noted that while immediate risks are mitigated through prioritisation and enhanced oversight, long-term operational resilience and service sustainability remain dependent on sustained capital investment.

The emerging data quality of pathway management within Hive, raised under the Chief Digital and Information Officer's report, was highlighted as a new strategic risk requiring further escalation and monitoring.

These risks are captured on the corporate risk register and will continue to be reviewed through TROC and Board committees.

Report approved by: Sam Liscio, Non-Executive Director and Chair of the Digital and Estates Board Committee

Manchester University
NHS Foundation Trust

Digital and Estates Board Committee

Date: Tuesday 2nd June 2026
Time: 10:00am – 12:00pm
Location: Virtual (MS Teams)

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	10:00am
2.	**Declaration of interest** (verbal)	Meeting admin	Chair	
3.	**Minutes of the Previous Meeting** (3rd March 2026)	Meeting admin	Chair	
4.	**Action Log**	Discussion	Chair	
5.	**Matters Arising:** • Confirmation of offline approval of the IPR/Digital KPIs proposal papers by DEBC core members (April 2026)	Discussion	Chair	
6.	**Assurance Reporting**			
6.1	Strategic and Corporate Risks	Discussion	NGm	10:15am
6.2	Integrated Performance Report	Discussion	DW	10:25am
Strategic aim 4: Ensure value for our patients and communities by making best use of resources				
7.1	Capital Planning additional funds update including: • Public Dividend Capital. • Charitable and national funding sources received by MFT to allow oversight and cashflow.	For noting	TRa	10:35am
7.2	Update on Strategic Estate including: • Strategic Estates Plan. • North Manchester Healthy Neighbourhoods. • Planning work including Wythenshawe Masterplan.	Discussion	TRa	10:45am

7.3	Chief Digital and Information Officer's report including: • Operational and BI Performance. • Vertical KPIs. • Update on Hive Programme.	Discussion	DW	10:55am
7.4	Director of Estates and Facilities' report including: • Review of the Annual Plan and timelines for strategic delivery plan. • Priorities 2026/27.	Discussion	CH	11:05am
Committee business				
8.	**Escalation report**	Approval	Chair	11:15am
9.	**Workplan Review**	Meeting admin	Chair	11:20am
10.	**Any Other Business** (verbal)	Discussion		11:25am
11.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	11:30am
Date of next meeting: Thursday 10th September 2026 at 2:00pm via MS Teams (virtual meeting)				