

Board of Directors (Public)

Date: Wednesday 30th September, 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 (30 th July 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	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 (01/09/26) escalation and assurance report	Discussion	NED (MB)	
10.2	North Manchester Board Committee (18/08/26) 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 (25/08/26) escalation and assurance report	Discussion	NED (JH)	
11.2	Trust response to Maternity and Neonatal 10-point plan National Maternity Care Bundle Implementation Tool – links to point 5 of the 10 point plan	Approval	Deputy CEO / CNO JCMO	

11.3	Complaints Annual Report*	Discussion	Deputy CEO / CNO	
11.4	Patient Experience Annual Report*	Discussion	Deputy CEO / CNO	
11.5	Emergency Planning and Business Continuity including: • EPRR Core Standards Statement of Compliance* • EPRR policy* • Business Continuity Policy*	Approval	CDO	
11.6	Winter Plan - Board Assurance Statement*	Approval	CDO	
12	Strategic aim 3: Be the place where people enjoy working, learning and building a career			
12.1	People Board Committee (25/08/26) escalation and assurance report	Discussion	NED (AA)	
12.2	Safer Staffing Report (nursing and AHP) *	Discussion	Deputy CEO / CNO	
12.3	Medical Appraisal and Revalidation and Annual Statement of Compliance*	Discussion	JCMO	
12.4	Workforce Race Equality and Disability Equality Schemes' update and action plans*	Approval	CPO	
13	Strategic aim 4: Ensure value for our patients and communities by making best use of resources			
13.1	Finance Board Committee (26/08/26) escalation and assurance report	Discussion	NED (TR)	
13.2	Chief Finance Officer's report *	Discussion	CFO	
13.3	Audit and Risk Committee (09/09/26) escalation and assurance report	Discussion	NED (SL)	
13.4	Digital and Estates Board Committee (10/09/26) escalation and assurance report	Discussion	NED (SL)	
Good Governance				
14.	Risk Appetite Statement*	Approval	Deputy CEO / CNO	
15.	Any Other Business (verbal)	Discussion	Interim Trust Chair	
16.	Meeting Evaluation (verbal)	Meeting admin	Interim Trust Chair	
Date of next meeting: Wednesday 25 th November 2026 at 2:00pm				



Board of Directors (Public)		
Thursday 30th July 2026		
Present:	Angela Adimora (AA) Mark Cubbon (MC) Mark Gifford (MG) Jackie Hanson (JH) Sam Liscio (SL) Matt Makin (MM) Chris McLoughlin (CM) Meera Nair (MN) Tom Rafferty (TRa) Trevor Rees (TR) Kimberley Salmon-Jamieson (KSJ) Sohail Munshi (SM) David Walliker (DW) Claire Wilson (CW) Darren Banks (DB) Ashley Blom (AB)	Trust Non-Executive Director Trust Chief Executive 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 Deputy Chief Executive/ Chief Nursing Officer Joint Chief Medical officer Chief Digital and Information Officer Chief Finance Officer Interim Deputy Chief Executive Non-Executive Director
In attendance:	Nick Gomm (NGo) Lorraine Cliff (LC)	Director of Corporate Business / Trust Board Secretary Director of Elective Care & EPRR

Public questions

At the beginning of the meeting, TR explained that the following question had been asked by a member of staff:

Would it be possible to ask the Manchester University NHS Foundation Trust (MFT) to publish a clear, step-by-step mathematical formula detailing exactly how Agenda for Change (AfC) absence payments are calculated for both annual leave and sickness?

Across the 30,000-strong workforce, a significant number of dedicated staff regularly work unsocial hours and overtime, yet the precise calculations behind these payments remain opaque and difficult to verify.

By releasing an explicit and transparent formula, it will empower staff to independently audit their own payslips, and foster a workplace culture built on trust, transparency and fairness. ' A response will be provided directly to the colleague.

TR thanked the member of staff and explained that a response would be provided by email.

1.	Apologies for absence and confirmation of quoracy			
Apologies were received from Nic Gower and Vanessa Gardener				
2.	Declarations of Interest			
No interests were declared.				
3.	Patient Story			
KSJ introduced the story of baby Elliot's and his mum, Ojay's, experience of meeting George, the Pets as Therapy dog, whilst being cared for at MFT. The family's experience highlighted the value of holistic support alongside clinical treatment and the contribution of volunteers and therapy services to patient wellbeing.				
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 20 th May 2026			
The minutes of the Board of Directors' (Board) meeting held on the 20 th May were approved as a true record of the meeting with the following amendment: KSJ noted that there had been 13 cases of MRSA, not 30 as written in the minutes of the last meeting.				
5.	Action Log			
There are 2 actions on the action log, with 1 action in progress relating to the scheduling of a Board Seminar session on the analysis of the National Cost Collection return. CW confirmed that a full update, including productivity opportunities and NCC analysis will be presented to FBC in October 26 so the action can now be closed.				
6.	Matters arising			
There were no matters arising.				
7.	Trust Chair's Report			
TR provided a verbal report on matters of interest since the last Board meeting and drew attention to:				

- The success of the Ignite Festival and Conference held during July and highlighted the strong participation from staff across the organisation.
- The launch of the Trust's Anti-Discrimination Pledge and emphasised that this represented the beginning of a continued programme of work.
- The success of the MFT charity's donor appreciation campaign and the opportunity to personally thank major charity fundraisers.
- The successful opening of the MediCinema facility at the Oxford Road Campus.
- The recent long service awards volunteer recognition events which have taken place across the Trust. TR paid tribute the contribution made by staff and volunteers.
- The future of NHS Foundation Trust Governors following the Health Bill proposals. TR confirmed that work was underway to consider future public and community engagement arrangements.
- Formal thanks were recorded for outgoing governor Mike Cordingley.
- Best wishes were extended to long-serving governor Chris Templar.

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:

- Progress with the North Manchester General Hospital redevelopment programme. The Trust was entering a significant new phase of the programme, with work progressing on business case development and contractor arrangements. It was noted that this next stage would provide renewed opportunities for staff, partners and local communities to contribute to shaping future services
- The Manchester and Trafford Community Diagnostic Centre at Withington. The facility was expected to undertake approximately 130,000 diagnostic tests annually and represented a significant opportunity to improve access to diagnostics closer to patients' homes. It was further noted that the model would continue to evolve to provide a more integrated "one-stop" diagnostic and treatment experience where possible.
- Urgent and emergency care standards remained under pressure due to increased demand and periods of extreme weather. Whilst progress had been achieved, performance remained below desired levels and significant improvement work continued through a range of operational programmes.
- The Trust had achieved the national 18-week Referral to Treatment standard but was continuing to monitor increasing referral demand and changing referral patterns from across the health system. Further analysis was underway to understand these trends.
- Cancer performance remained strong against the Faster Diagnosis Standard; however, challenges remained in relation to the 62-day cancer standard. Focused improvement work was underway within relevant specialty areas and further improvement was anticipated during Quarter 2.
- The Ignite Festival and associated inclusion events. Particular recognition was given to the scale and success of the programme and the positive impact it had across the organisation.

- The Trust's improvement within the National Oversight Framework. It was reported that the Trust had moved from Segment 3 to Segment 1 and had improved significantly in the national rankings. Whilst recognising that further work remained, the improvement was described as an important milestone reflecting sustained organisational progress.
- The recent national maternity reviews and the Trust's response. Significant work was underway to review findings from national reports and to identify opportunities for learning, assurance and improvement across maternity services within MFT.

Board members:

- Congratulated colleagues on the success of the Ignite Festival and noted the strong representation of different communities across the organisation.
- Sought clarification regarding Trust implementation of the Cardiovascular Disease Modern Service Framework and the Online NHS model. MC explained that work had commenced with cardiology colleagues regarding the cardiovascular programme and that it would be aligned with the Trust's elective reform programme. He further advised that the Online NHS model remained at an early stage of development nationally and would require careful consideration to ensure complementarity with existing services.
- Welcomed the direction of travel set out in the report and reflected on the alignment between the Trust's strategy and recent national policy announcements. MC agreed that the Trust's strategic direction remained broadly aligned with emerging national policy and highlighted the importance of continued partnership working and integration.

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

8. Board Assurance Framework

DB introduced presented the Board Assurance Framework (BAF) for July 2026. He drew attention to:

- The new format of the BAF represented the next stage in a continuing programme of development and refinement of Board assurance arrangements.
- The revised format indicated the strong alignment between strategic objectives, risk management arrangements and Board assurance processes.
- The detailed content of the strategic risks was already subject to regular scrutiny through Board Committees and the Trust Risk Oversight Committee.

Board members:

- Welcomed the revised format and commented positively on the summary section, noting that it provided a useful overview of key developments and risk themes.
- Queried an apparent tension within Strategic Aim 2, whereby overall performance and national oversight ratings were improving whilst the risk relating to harm caused by waiting for treatment had increased. DB explained that significant work had been undertaken to review risk scoring methodology and ensure that risks accurately reflected the current operating environment, including continuing pressures associated with waiting times.
- Sought confirmation that cyber security and digital infrastructure risks continued to receive appropriate oversight through the Trust's governance arrangements.

Assurance was provided that these matters were monitored through the relevant committees and risk management structures.				
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 introduced the Quality and Safety section and drew attention to:				
- Significant work had been undertaken in response to the recent never events and analysis had identified that the common theme related to procedural safety checks rather than individual specialties. - Further work was underway to strengthen procedural safety checklists and ensure that safety-critical checks were undertaken consistently across the organisation. - MRSA bacteraemia incidents had not featured prominently within the reporting period covered by the IPR because there had been a period during April, May and June with no MRSA bacteraemia cases reported. However, three MRSA bacteraemia cases had occurred during July and would therefore feature within subsequent reporting periods. - A substantial programme of work continued in relation to infection prevention and control, including MRSA bacteraemia, pathway compliance, training associated with vascular access device care, catheter-associated urinary tract infections, and environmental cleanliness. Work was also being undertaken to explore potential links between environmental factors and infection trends, including pseudomonas and MRSA infections. - Demand within maternity triage services continued to increase and maintaining performance remained challenging due to operational pressures and staffing requirements. - Category 3 Caesarean section rates had increased. KSJ explained that these were planned Caesarean sections rather than emergency or urgent procedures and advised that similar trends were being observed nationally, reflecting changing patterns of maternity activity and demand rather than concerns regarding emergency care. The Trust continues to monitor the position closely and engage with women and families regarding decision-making and care choices. - Maternity triage performance remained strong against the Greater Manchester standard and work continued to ensure that performance was maintained despite increases in demand. No national standard currently existed, although recommendations emerging from national maternity reviews suggested a likely future expectation that all women should be seen within 15 minutes. - Significant work was taking place across the Trust's emergency departments to improve patient flow and reduce delays through strengthened operational oversight and nursing leadership. Nursing teams were undertaking real-time reviews of patient flow and movement through departments with the work focused on improving oversight of patients and ensuring timely care and movement through emergency care pathways.				

Board members:

- Reported that recent executive walk-rounds across all three maternity sites had demonstrated a strong focus on patient safety and vigilance and stated that there was no evidence of complacency within services.
- Reported positive observations from recent site visits and commented on the visible focus on infection prevention measures and patient safety practices.
- Sought clarification as to whether recent MRSA bacteraemia cases were linked. KSJ advised that the cases reflected different contributing factors and were subject to detailed investigation.
- Discussed the increase in Category 3 Caesarean sections and the continued requirement to monitor activity and maintain appropriate patient engagement.

LC introduced the operational performance section and drew attention to:

- Performance against the four-hour emergency care standard had been adversely affected by increased demand, industrial action and periods of extreme weather.
- Recovery actions continued through the Care Close to Home improvement programme, with a focus on patient flow, discharge arrangements and ambulance handover performance.
- Referral to Treatment performance continued to improve and was being supported through the Care on Time programme.
- Some areas were experiencing increasing referral demand and further analysis was underway to understand the causes of these increases.
- Strong performance continued against the Faster Diagnosis Standard.
- Challenges remained against the 62-day cancer standard, particularly within breast, gynaecology and lower gastrointestinal services, and targeted recovery plans were in place.
- Productivity improvement remained a key organisational priority and a summer improvement programme had been established to maintain momentum and support delivery of operational objectives.

Board members:

- Queried the gap between planned and actual performance in relation to Patient Initiated Follow Up arrangements and sought assurance that improvement actions would address the trend. LC advised that PIFU formed an important component of the Care on Time programme and that work was underway with clinical services to redesign pathways and increase appropriate adoption.
- Discussed the importance of ensuring that every appointment added value for patients and recognised the cultural and behavioural changes required to support pathway transformation.
- Welcomed the continuing progress in elective care recovery whilst acknowledging the operational pressures being experienced across the wider system.

MN introduced the People section and drew attention to:

- Progress across a range of workforce indicators.
- Ongoing work to improve workforce metrics and organisational culture measures.
- The continued importance of workforce wellbeing, inclusion and staff experience.
- The requirement to maintain progress against workforce objectives as part of wider organisational improvement.

CW explained that the finance metrics within the IPR would be covered in her report later on the agenda.

DW introduced the digital section and drew attention to:

- Digital performance indicators had been reviewed through the Digital and Estates Board Committee.
- There were no digital indicators requiring escalation to the Board.

- The current presentation of downtime metrics did not provide the most meaningful representation of service resilience. Future reporting would be amended to place greater emphasis on the duration of downtime incidents and the speed with which services were restored, rather than simply the number of incidents reported. The intention was to provide a more meaningful assessment of service performance and resilience.

Board members:

- Sought clarification regarding the proposed changes to downtime reporting and the rationale for moving away from reporting the number of incidents. DW explained that the revised approach would provide a better indication of the impact of outages on services by focusing on how quickly systems were restored and normal service resumed.
- Referred to performance relating to Subject Access Requests and Freedom of Information requests and questioned whether performance against these targets reflected increasing demand and complexity. DW advised that increasing demand was being experienced in these areas and confirmed that the relevant teams continued to monitor performance closely. He explained that targets in place remained appropriate as the reflected statutory requirements.

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

- The metrics presented related to nationally recognised specialised services and research performance measures.
- Performance against the reported measures continued to evolve as the reporting framework developed.
- The indicators were relatively new and would continue to be refined through the Trust's reporting arrangements.
- The 150-day target has been achieved for the last 4 months but is showing as only 38% because the metric measure compliance over the last 12 months.
- The metrics were being monitored through the Research, Innovation and Population Health Board Committee as part of the wider oversight framework.

Board members:

- Noted that the research and innovation metrics were relatively new and evolving as reporting arrangements matured.
- Acknowledged that that oversight of these measures sat within the Research, Innovation and Population Health Board Committee and noted that further development of the reporting framework would continue as additional data became available.

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

10.1	Research, Innovation and Population Health Board Committee (RIPHBC) (19/06/26) escalation and assurance report.
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MB introduced the escalation and assurance report from the RIPHBC held on the 19/06/26 and drew attention to:

- Positive progress continued to be made in relation to the development of population health metrics and reporting arrangements.

- The Committee had reviewed the Population Health Annual Report and noted strong alignment between the Trust's work and the wider Greater Manchester population health agenda.
- The Committee had discussed the importance of ensuring that population health reporting increasingly focused on demonstrating impact and outcomes rather than solely describing activity.
- The Sustainability Annual Report had been reviewed and demonstrated continuing progress against sustainability objectives.
- Discussion had taken place regarding the need to ensure environmental considerations were incorporated into future transformation and innovation activity.
- Work was ongoing to develop the strategic direction for research and innovation and strengthen arrangements for future research activity.
- The Committee had considered future research funding opportunities and the Trust's position in relation to research growth and research capability.

Board members:

- Noted that Trust performed strongly in relation to research infrastructure funding but identified opportunities to secure further growth funding and expand research capability. AB outlined national research funding opportunities and described the potential benefits that successful bids could bring to both the Trust and the wider health and care system.
- Welcomed the contribution being made by research and innovation activities to the Greater Manchester agenda and emphasised the importance of demonstrating impact through measurable outcomes and benefits for patients and communities.
- Welcomed DB's explanation of the research and innovation promotional work which the Trust had hosted during the NHS Confederation Expo.

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

10.2	North Manchester Board Committee (NMBC) (17/06/26) escalation and assurance report
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MG introduced the escalation and assurance report from the NMBC held on the 17/06/26 and drew attention to:

- Significant progress continued to be made across the North Manchester transformation programme.
- The Committee had reviewed progress against the initial design phase of the programme and received updates regarding governance and programme oversight arrangements.
- The Committee had considered programme milestones and dashboards which supported effective oversight and scrutiny of delivery.
- Assurance had been received regarding legal and financial due diligence arrangements associated with the programme.
- The Committee had considered whether the strategic direction of the programme remained appropriate and had received assurance that the programme continued to progress in the right direction.
- Future meetings would continue to focus on major transformation projects, future service requirements and programme delivery.

• Clear evidence of progress, effective leadership and strong programme management had been demonstrated across the programme. • The Committee also recognised the scale and complexity of the transformation programme and the need to ensure governance arrangements continued to evolve appropriately as work progressed.				
Decision		Action	Lead	Complete / date for completion
The Board of Directors noted the report.		None	n/a	n/a
10.3	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: • A range of strategic developments continued to take place at national, regional and local level which would influence the Trust's future operating environment. • Work continued in relation to provider collaboration arrangements and wider system developments across Greater Manchester. • Progress was continuing in relation to community-based services and neighbourhood delivery models as part of wider service transformation activity. Expansion the Hospital @ Home pathway is underway and the potential to include end of life care within it is being discussed. • Strategic programmes continued to support the delivery of the Trust's objectives through innovation, partnership working and service redesign. • The Trust remained engaged in future funding opportunities and strategic programmes which could support long-term service development. • The Advanced Foundation Trust programme and associated self-assessment requirements. • The Trust continued to monitor changes taking place nationally and regionally and assess their implications for future strategy and organisational development. Board members: • Reflected on a number of successful innovation initiatives that had been highlighted across recent Board discussions and suggested that consideration should be given to how these could be brought together more coherently to demonstrate the Trust's strategic position and areas of distinctiveness. TR agreed that there was merit in bringing together examples of innovation activity to demonstrate more clearly how they contributed to the Trust's wider strategic objectives and future direction. • Sought clarification regarding the timetable for achieving Advanced Foundation Trust status and asked specifically about the anticipated timing of assessment and progression through the process. TR advised that the national process was based on a two-quarter assessment period rather than a single-quarter assessment. He explained that progression remained dependent on future national assessments and associated requirements and outlined the forthcoming milestones currently anticipated. A future Board seminar discussion was proposed to discuss further.				
Decision		Action	Lead	Complete / date for completion
The Board of Directors noted the report.		Board seminar item on Advanced Foundations Trusts to be scheduled.	NGo	October 2026

11.1	Quality, Safety and Performance Committee (QSPBC) (30/06/26) escalation and assurance report			
JH introduced the report and drew attention to: • The Committee had considered the Trust's position in relation to National Oversight Framework and recognised the importance of maintaining improvements in quality and performance. • The Committee had approved changes to its Terms of Reference, including amendments relating to digital and information governance oversight. • Updates had been received in relation to genomics services and national reviews and enquiries. • Assurance had been received regarding NHS England requirements concerning governance and oversight arrangements following the Ockenden and Amos investigations. • The Committee had reviewed the positive feedback from the Human Tissue Authority following its recent visit. Work was underway to complete all required actions by September 2026. • The Committee had reviewed the refreshed quality and safety section of the Board Assurance Framework. • The Transfusion Service Annual Report had been reviewed, including discussion of governance arrangements, digital developments and traceability requirements. The Committee had requested further updates regarding actions to address traceability and information management issues identified within transfusion services. • The Committee had reviewed the Patient Safety Incident Response Framework assessment and received assurance regarding strengthened governance arrangements. • Strong participation in national clinical audit programmes was noted.				
Decision		Action	Lead	Complete / date for completion
The Board of Directors noted the report and approved the addition of DW to membership of Committee.		None	n/a	n/a
11.2	Spinal Surgery Independent Patient Safety Investigation			
SM presented the report which provided an overview of the findings from the independent Niche Review commissioned by NHS England. SM drew attention to: • The report set out the Trust's proposed response to the findings and recommendations of the independent review. • The recommendations from the investigation had been reviewed and assessed in detail by the Trust. • A single consolidated action plan was being developed to bring together all actions arising from the review and provide a clear mechanism for oversight and assurance. • A number of improvement actions were already underway and some changes had been implemented prior to publication of the final report.				

- The approach being taken focused not only on responding to individual recommendations but also on ensuring sustainable service improvement and strengthened governance arrangements.
- Progress against the recommendations would be monitored through established governance structures and reported through the Quality, Safety and Performance Board Committee.
- The review provided an opportunity to strengthen visibility, oversight and assurance in relation to spinal surgery services and patient safety.

Board members:

- Welcomed the clarity of the review findings and recommendations and observed that a number of the themes aligned with issues previously identified through wider quality improvement work. He noted that the recommendations provided a clear framework for future improvement activity.
- Commented positively on the visibility of the recommendations and the proposed arrangements to monitor implementation and delivery.
- Discussed the importance of ensuring that learning from the review translated into genuine improvements in services and patient outcomes and that implementation was maintained over time.
- Highlighted the importance of ensuring that actions resulting from the review continued to strengthen services rather than being treated solely as a compliance exercise.
- Sought assurance regarding patients affected by the issues identified during the review and queried whether all affected patients had been contacted and appropriately supported. SM confirmed that affected patients had been contacted and remained under review through appropriate pathways. It was noted that some patients had elected to defer treatment but remained within managed pathways and continued to receive support.
- Members welcomed the proposal for ongoing oversight through the Quality, Safety and Performance Board Committee and supported the development of a consolidated action plan.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report with ongoing assurance being sought through the QSPBC.	None	n/a	n/a

11.3 Annual Infection Prevention and Control Report*

KSJ presented the Annual Infection Prevention and Control report and drew attention to:

- The report provided the annual overview of Infection Prevention and Control activity across the Trust. Infection Prevention and Control remained a key organisational priority given its importance to patient safety, quality of care and regulatory compliance.
- Continued strengthening of governance arrangements in relation to infection prevention and control.
- Progress made during the reporting period and priorities identified for the forthcoming year.
- The report demonstrated the continuing development of assurance arrangements and oversight in relation to infection prevention and control activity across the Trust.

Ongoing work would continue to focus on strengthening governance, assurance and improvement activity during 2026/27. New thresholds have been developed nationally and would feature in future reporting.				
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) (30/06/26) escalation and assurance report			
AA introduced the report and drew attention to: - The Committee had reviewed a wide range of workforce, organisational development and culture-related matters and continued to maintain oversight of key workforce indicators and associated improvement plans. - Particular attention had been given to sickness absence rates, appraisal rates, workforce culture, staff wellbeing, inclusion and organisational development. - The Committee had reviewed progress against workforce priorities and considered actions designed to improve staff experience, retention and engagement. - Assurance had been received regarding delivery of workforce improvement programmes and the governance arrangements supporting those programmes. - Safe staffing standards were being met for nursing and midwifery. - A follow-up report to the GMC report from 2025 into Obstetrics and Gynaecology at North Manchester General Hospital is expected soon.				
Decision		Action	Lead	Complete / date for completion
The Board of Directors noted the report.		None	n/a	n/a
12.2	Freedom to Speak Up Annual Report*			
DB introduced the Freedom to Speak UP (FTSU) annual report which covered the period 1 April 2025 – 31 March 2026.				
DB drew attention to: - The report provided an overview of Freedom to Speak Up activity across the Trust during the reporting period and had been discussed in detail at the People Board Committee. - The volume of cases raised through the Freedom to Speak Up service was consistent with levels seen across comparable organisations nationally. - The report provided assurance that staff continued to utilise the service and felt able to raise concerns through established channels. - Increased utilisation of the service was viewed as a positive indicator that staff were willing to raise concerns and seek support when required. - The report highlighted the importance of maintaining a visible and accessible Freedom to Speak Up Guardian function and Champion network across the organisation.				

- Work continued to ensure appropriate representation of Freedom to Speak Up Champions across services and sites.
- The report demonstrated the Trust's continued commitment to developing an open and transparent culture in which staff felt able to speak up safely.

Board members:

- Noted that a meeting of the Freedom to Speak Up Champions network had taken place. MG described the discussion as constructive and valuable and advised that it had been encouraging to hear directly from Champions and that the network was providing important insight into issues emerging across the organisation. The Champions had recognised the positive impact of wider organisational initiatives designed to improve culture and staff experience and noted that discussions had focused not only on responding to issues but also on creating the conditions for MFT to be a positive place to work.
- Considered the link between the raising of issues within maternity services with the FTSU activity report. KSJ highlighted the changes that had taken place within maternity services and drew particular attention to strengthened supervision arrangements. She advised that some concerns which may previously have been raised through Freedom to Speak Up routes were now being addressed directly through supervisors and managers at an earlier stage. DB agreed that this reflected a positive cultural development and advised that the objective was not simply to increase Freedom to Speak Up referrals, but to create an environment where concerns could be raised safely and addressed through the most appropriate route.
- Thanked the FTSU team for their work over the year.

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 covered the period March to April 2026 and set out the Trust's position in relation to nurse staffing, workforce controls and compliance with national safer staffing requirements. It had been discussed in detail at the June PBC meeting.
- The report demonstrated strong overall compliance with national safer staffing guidance and requirements.
- Staffing establishments continued to be actively reviewed and managed through established workforce governance arrangements.
- Internal movement of staff and workforce controls had supported a slight increase in establishment levels without requiring significant additional investment.
- Vacancy levels remained significantly below the national average and reflected sustained progress in recruitment and retention activity.
- The reduction in vacancy levels represented a significant achievement for the organisation and reflected the work undertaken by nursing and workforce teams.
- Expenditure on temporary staffing continued to be managed through workforce controls and establishment management arrangements.
- Investment in Trafford's community nursing services continued and was supporting delivery of community-based care and wider service transformation objectives.
- The report provided assurance regarding the Trust's ability to maintain safe staffing levels across services whilst managing workforce pressures.

Board members:

- Commented positively on the continued reduction in vacancy levels and acknowledged the progress made in maintaining safer staffing levels across services. KSJ advised that workforce planning continued to reflect the changing requirements of services and described the ongoing work taking place in relation to specific staffing arrangements and workforce deployment.
- Welcomed the sustained reduction in vacancy levels and the positive assurance provided regarding safe staffing arrangements.

TR raised a question on behalf of Nic Gower regarding the Care Hours Per Patient Day data within the report. He noted that the average nursing hours appeared lower than some comparable organisations and sought assurance regarding whether this reflected a difference in workforce mix or presented any cause for concern. KSJ explained that variations in the metric largely reflected differences in service models and organisational case-mix and advised that the Trust routinely benchmarked its position against comparable organisations. KSJ added that the organisation continued to use recognised acuity and dependency tools to determine staffing requirements and monitor safety, and confirmed that she remained assured regarding the safety and appropriateness of staffing establishments.

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 covered the position within maternity and newborn services and provided assurance regarding compliance with national maternity staffing requirements and had been discussed in detail at the June PBC meeting.
- Strong levels of compliance with national safer staffing standards and requirements.
- Staffing levels continued to be monitored through established governance arrangements and benchmarked against relevant national standards.
- Workforce planning within maternity services continued to be informed by recognised staffing tools and national guidance.
- Continuing progress in relation to workforce controls and the management of staffing establishments.
- Investment and workforce actions undertaken across maternity services had supported the maintenance of safe staffing levels despite ongoing operational pressures.
- The report also outlined progress towards compliance with requirements arising from Maternity Incentive Scheme Year 8.
- Appropriate governance arrangements are in place to oversee maternity and newborn staffing and associated quality indicators. Ongoing work continues to address areas requiring further improvement, including sickness absence and workforce sustainability.

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 Committee had undertaken a detailed review of the Month 2 financial position and supporting financial reports and received a candid assessment of the Trust's financial position, including the financial challenges facing the organisation during 2026/27.
- Assurance had been received that the financial position was subject to strong executive oversight, strengthened forecasting arrangements and regular scrutiny through established governance routes.
- The Trust's challenging cash position with significant management attention continuing to be devoted to cash management and liquidity monitoring.
- The Committee had undertaken a detailed review of the Value for Patients programme to understand both programme delivery and the shift towards more recurrent savings schemes. Particular focus had been placed on ensuring that future schemes delivered recurrent and cash-releasing savings rather than reliance on non-recurrent benefits.
- The Committee had reviewed the Trust's capital resource position and noted that the associated risk score had increased from 12 to 20.
- Capital constraints continued to represent a significant challenge and were linked to wider discussions regarding estates, infrastructure and the PFI estate.
- The Committee had considered productivity opportunities and received updates regarding work to redesign clinical pathways and improve productivity without compromising patient safety or quality of care.

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 (Month 2 2026/27)

CW introduced the Chief Finance Officer's report for Month 2 of 2026/27 and drew attention to:

- The Trust continued to operate in a challenging financial environment and significant management attention remained focused on delivery of the financial plan. Performance against plan was improving. Whilst progress was encouraging, the year remained financially challenging and substantial work remained to be undertaken to deliver the full year financial plan
- The Value for Patients programme was delivering a larger programme of recurrent savings than had been achieved during the previous year. However, the organisation remained focused on reducing reliance on non-recurrent measures and strengthening delivery of recurrent improvements.
- The cash position remained challenging, continuing to require close day-to-day management, with mitigations being implemented to manage associated risks.

- Positive progress had been made through negotiations with commissioners and wider system partners which had assisted the Trust's financial position.
- Discussions were also progressing in relation to other financial matters that could support delivery of the financial plan.
- Whilst progress had been achieved, the organisation would need to maintain strong focus throughout the remainder of the year to deliver the required financial outcomes.

Board members:

- Emphasised the importance of ensuring that all financial improvement and Value for Patients schemes continued to be assessed through robust quality impact assessment processes and that delivery of financial benefits should never compromise patient safety or quality of care. DB commented that maintaining confidence in the quality impact assessment process supporting Value for Patients schemes remained essential given the scale of savings required.
- Discussed the continuing challenge of balancing financial recovery requirements with operational and quality priorities across the organisation.
- Welcomed the external support being received from commissioners and system partners and recognised its importance in supporting delivery of the financial plan.
- Noted the ongoing focus on cash management and the significant management attention being devoted to maintaining liquidity during the year.
- Welcomed the progress achieved through the Value for Patients programme whilst recognising that sustained delivery would be required throughout the remainder of the financial year. MC noted that 210 ideas had been shared by staff as part of the 'Share to Save' campaign.
- Discussed the potential for staff rewards for innovation. DB explained that recognition processes were in place but no financial award.

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

TR introduced the report in the absence of the Committee Chair, Nic Gower, and drew attention to:

- The Committee had exercised its delegated authority on behalf of the Board to approve the Trust's Annual Report and Annual Accounts for 2025/26. The approval process had supported completion of the external audit and annual reporting requirements for the financial year. External auditors had attended the previous day's Governors' meeting and had provided a positive assessment of both the Trust's Annual Accounts and Value for Money arrangements.
- The Committee had reviewed a number of internal audit reports completed during the reporting period. Two internal audit reviews had received Partial Assurance opinions. These related to Infrastructure Project Planning and Co-ordination and Medicines Management. The Committee had considered the recommendations arising from both reviews and had discussed the actions required to address the findings. Arrangements were in place to monitor implementation of the agreed actions and ensure that improvement activity was completed.

TR requested that the Board's appreciation be formally recorded and conveyed to those involved in preparing the Annual Accounts and supporting the audit process.

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

13.4 Digital and Estates Board Committee (DEBC) (02/06/26) escalation and assurance report

SL introduced the report and drew attention to:

- The Committee had considered a number of significant estate and digital risks and issues affecting the Trust. Primary areas of focus included challenges associated with the PFI estate, contractor performance and fire safety compliance.
- These risks continued to be actively managed through the Trust Risk Oversight Committee, Estates and Facilities governance arrangements and the Digital and Estates Committee.
- The Committee had reviewed an emerging strategic risk relating to pathway management and information management arrangements which highlighted the requirement for a single organisational framework to strengthen oversight and governance of records, pathways and associated information management processes. The availability of improved data was enabling the organisation to identify risks that had previously been less visible. The risk was being managed through established governance arrangements, including the Serious Issues Oversight Group and the Data Quality Sub-Group, both of which reported through the Trust's governance structure. Ownership of the risk sat within the Digital Management Committee, with onward escalation through the Trust Leadership Committee and Board governance arrangements.
- The Committee had also reviewed cyber security performance and received assurance that progress continued against national cyber security requirements.
- Updates had been received regarding digital transformation programmes including Ambient Voice Technology and continuing expansion of digital solutions across the Trust.
- Progress against the Strategic Estates Plan was reviewed.
- The Committee concluded that immediate risks were being managed appropriately but identified a continuing need for sustained oversight of estate risks, capital constraints, backlog maintenance and organisational resilience.

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

14. Any Other Business

There were no further items of business.

15.	Meeting Evaluation
TR sought views regarding the format, structure and contents of the meeting.	
Date and time of next meeting: 30 th September 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
30/07/2026	1	BOD-30072026-01	10.3 Strategic Developments	Board Seminar Item on Advanced Foundations Trust to be scheduled	Nick Gomm	Scheduled for Board Seminar on 28 October 2026.	28/10/2026	In Progress

Public Board of Directors

Wednesday, 30 September 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 <u>one</u> box only:	☐ For approval ☐ For support ☒ For discussion ☐ For noting	

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 the report what action has been taken to address this ☒ No
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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 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 <u>all</u> that apply	☒ Safe ☒ Caring ☒ Effective ☒ Well-Led ☒ Responsive
Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the 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

1. Work with partners to help people live longer, healthier lives 3
2. Provide high quality, safe care with excellent outcomes and experience..... 4
3. Be the place where people enjoy working, learning and building a career.... 7
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Full content of the report is included as Appendix A

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

Annual Planning Preparations

The Annual Planning process for 2027/28 has commenced, with foundational work having been completed over the summer. The MFT process will be undertaken over 2 phases, with Phase 1 focusing on activity, finance and workforce plans and agreeing a position with commissioners by December, and Phase 2 focussing on transformation and delivery planning and concluding early in the new calendar year. As was the case last year, a multi-year approach to planning is being taken, in line with national guidance.

The process is being overseen internally by the Annual Planning Oversight Group (APOG) which provides regular update reports to TLTC. The Board will continue to be involved at key points between now and the national submissions, the first of which is expected in December.

Digital First Approach to Translation

During 2025/26, the Trust's interpretation and translation service recorded over 165,000 interactions across 136 languages and dialects, reflecting the scale and diversity of communication support required. On-Demand Video Interpreting provides rapid access to qualified interpreters by video, improving access to a wider range of languages while maintaining visual communication, including urgent British Sign Language support for Deaf patients. CardMedic provides multilingual clinical resources, live translation, and integrated access to telephone interpreting across digital devices and clinical settings.

There is a significant opportunity to improve resource use through increased use of digital services, protect face-to-face provision for the greatest clinical need, and support sustainable, equitable access to care. Following an initial pilot across 15 clinical areas, On-Demand Video Interpreting continues to expand. CardMedic was soft-launched in August 2026 on Rover devices, Patient Experience iPads and Single-User Devices, with over 800 registered users to date. A Trust-wide launch is planned in October 2026, and updated guidance is supporting colleagues to adopt a Digital First approach where appropriate. Ongoing monitoring will track uptake, savings delivered and any impact on patient access and experience. Full financial analysis will be completed at the end of Q3 26/27.

Mortality Intelligence and Learning from Deaths

MFT's mortality position remains strong and continues to provide positive assurance. Trust-level Hospital Standardised Mortality Ratio (HSMR) is 79.9, significantly better than the national benchmark of 100, and Summary Hospital-level Mortality Indicator (SHMI) is 100.5, remaining within expected limits. MFT continues to report lower-than-expected mortality, with a crude mortality rate of 3.3% compared with an expected mortality rate of 4.1%. This favourable position has been maintained over the previous 12 months and compares positively with both national and Shelford peers.

Clinical Groups and Divisions will continue to take clear ownership of these signals, ensuring they are reviewed through Learning from Deaths processes, Structured

Judgement Reviews, specialty governance arrangements and targeted deep dives. The focus will be on translating mortality intelligence into timely clinical action and measurable improvement, with progress reported through established governance routes and strengthened by the continued development of the Mortality Portal and revised Learning from Deaths framework.

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

Operational Delivery

- **Urgent Care**

During August 74.4% of patients were seen and treated within 4 hours at our Emergency Departments, against a planned trajectory of 78.7%. Performance was impacted by sustained operational pressures, including the effects of the heat waves on demand and patient flow. Improvement plans are in place, and we are expected to return performance to plan in October.

Ambulance handovers within 15 minutes reached 58.3% in August, against the national standard of 65%, which the Trust is planning to achieve by March 2027. The average handover time for the month was 15.06 minutes, closely aligned to the Trust's plan of 15 minutes.

- **Elective Care**

The most recently available data for elective care relates to July, when 18-week referral to treatment (RTT) performance reported 63.88%, against a plan of 64.73%. The number of patients waiting over 52 weeks for elective treatment was 1,384, an improvement against our plan of 1,523. RTT recovery efforts are in place at specialty-level with a focus on increasing first appointments and treatments, reducing avoidable follow-up activity and Do Not Attends (DNAs), strengthening waiting list validation, and delivering productivity improvements through enhanced booking and scheduling, High Performing Lists and pathway redesign.

- **Cancer Care**

During July the cancer standards were met for both the faster diagnostic standards (80.1%) and 31-day standard (92.5%). 72.85% of cancer patients were treated within 62-days, against a plan of 76.82%. Targeted interventions are being implemented across tumour pathways, including increased diagnostic and treatment capacity, strengthened waiting list management, robust escalation processes and enhanced validation to ensure that the 62- day pathway is delivered in a sustainable way.

- **Diagnostics**

Performance across all DM01 modalities for July was 9.0%, against a plan of 8.43%. The key drivers for being slightly under plan are the increase in referrals for Sleep Services for which additional activity is in place, and ongoing work with NHS Greater Manchester to manage the demand for Cardiac MRI/CT due to downtime of the scanner at Wythenshawe. Mitigation is being put in place during September through the use of a mobile scanner. Actions to optimise capacity and productivity across these areas remain a key operational focus.

National Oversight Framework Update

Q1 2026/27 NHS Oversight Framework (NOF) scores and rankings were published on 11 September. MFT ranks 29th out of 134 Trusts nationally and has been placed in Segment 2, with an average metric score of 2.24; this is an expected change due to modifications to the 2026/27 scoring methodology. Continued delivery against the annual plan's objectives and targets will support MFT in maintaining its Segment 2 position through the remainder of the year.

National Maternity and Neonatal 10-point plan

In June, we received the publications from Donna Ockenden's independent review of maternity services at Nottingham University Hospitals NHS Trust and Baroness Amos' independent investigation into maternity and neonatal services in England. NHS England wrote to all provider Boards on 1 July setting out a 10-point plan for urgent action, focused on safer, more responsive and more compassionate services, stronger Board accountability and listening to women and families. On 12 August, NHS England issued the national assurance framework, requiring a Board-approved baseline assessment by 25 September and a progress update by 31 December.

We welcome the publication of the national Maternity and Neonatal 10-Point Plan, and we have reviewed the findings and completed our baseline assessment. A single local action plan is being overseen through established maternity and Trust governance arrangements. The Trust is well positioned to support delivery of the plan through its ongoing focus on safety, quality improvement, workforce development, service user engagement, and reducing inequalities. A number of key dependencies are of note, including national guidance, completion of maternity triage assurance and progression of the National 'Amos into Action' staff listening programmes, creating an NHS-wide conversation to translate the recommendations of the investigation into meaningful action and support culture change.

Quality Strategy

The national Quality Strategy provides a 10-year framework for strengthening the quality of NHS-funded care in England. The emphasis for all NHS organisations is shifting from demonstrating compliance with standards to demonstrating how we consistently deliver safe, effective and person-centred care, and how we translate learning, insight and

evidence into measurable improvement. The strategy strengthens the framework through which existing commitments are delivered, supporting improved outcomes, reducing inequalities and achieving greater public confidence in the delivery of care.

In response to the NHS Quality Strategy, MFT will continue the development of its Quality Management System (QMS) and commence implementation by the end of the financial year, bringing together, patient safety, clinical effectiveness, quality improvement, patient experience and assurance within a single framework.

Phased implementation during 2027/28 will establish a consistent and systematic approach to quality management across the Trust, with stronger alignment between improvement, assurance and accountability arrangements. This represents a significant organisational transformation and cultural shift, embedding quality management as a core component of how the Trust leads, delivers and continuously improves care. In doing so, it will provide the Board with enhanced visibility of quality performance, risks, outcomes and improvement priorities, enabling more effective oversight of the impact of improvement activity on patient safety, experience and clinical outcomes. Assurance reports with regard to this programme of work will be monitored through Quality and Safety Management Committee bi-monthly and reported to the Trust Leadership Team Committee as required.

National Inpatient Survey Results

The results of the 2025 Adult Inpatient Survey provide a positive and stable assurance position. The Trust achieved an overall patient experience score of 8.3/10, slightly above the national average of 8.2. All 12 patient experience sections were rated in line with other participating NHS trusts, with no Trust-wide questions rated worse than expected. One discharge-related question performed better than expected compared with national benchmarks, relating to whether staff discussed patients' needs for further health or social care support after leaving hospital.

Compared with the previous year, MFT showed statistically significant improvement in three areas: waiting time to reach a ward bed, cleanliness, and access to staff when patients needed attention. No questions demonstrated statistically significant deterioration. The survey also highlights opportunities for continued improvement in meeting individual patient needs, particularly in relation to mental health support, accessibility, language support and dietary requirements. These areas align with existing patient experience priorities and are being addressed through established improvement programmes and governance routes.

A full analysis report, including detailed action plans and site-level improvement priorities, will be presented through Trust Leadership Team Committee and Quality and Safety Patient Board Committee.

Hot Weather Events

During the summer period, the Trust experienced a number of periods of unusually hot weather, including periods of amber Heat Health Alerts across the North West. High temperatures and humidity resulted in overheating within a small number of clinical and operational environments. Reduced resilience of cooling and ventilation systems disrupted some planned patient activity.

The Trust responded through established command and control arrangements and implemented a range of mitigations including enhanced environmental monitoring, temperature and humidity management guidance, targeted estates interventions and daily system reporting. Whilst the impact on patient safety was successfully managed, the events highlighted the increasing risk posed by extreme weather to healthcare delivery and critical infrastructure. A comprehensive debrief has been completed, with learning informing strengthened preparedness arrangements, enhanced monitoring processes and longer-term work to improve organisational resilience to future extreme weather events. I would like to thank colleagues across the Trust for their continued efforts to support patients and maintain our services effectively during these difficult circumstances.

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

HUMAN Recognition Platform Roll-out

HUMAN by ShareGratitude continues to be implemented across MFT, providing patients, families, carers and colleagues with a simple mechanism to recognise and thank staff in real time. Full rollout to patients will be in place by the end of September 2026. Since the launch in February 2026, 2,256 compliments have been delivered, strengthening the visibility of positive patient feedback, supporting colleague wellbeing and engagement, and reinforcing the strong relationship between colleague experience and high-quality patient care.

Culture and Staff Experience Forum

I continue to lead discussions at our Culture & Staff Experience Forum with representation from across all our Clinical and Staff Groups. The first forum discussed violence and abuse and sexual safety, with the most recent providing a specific focus on support for staff with disabilities and long-term health conditions. Colleagues who have attended the forums have provided valuable insight, reflection and challenge. Both forums have informed a number of improvement actions, including enhanced reporting routes, violence and abuse roadshows and the development of an MFT Disability Passport. The CEF continues to demonstrate a clear "You Said, We Did" approach, ensuring colleague feedback is translated into tangible improvements across the Trust. The forum will continue to meet on a regular basis, and I will keep the Board update on its progress.

Inclusive Recruitment Programme

In support of MFT's commitment to equality, diversity and inclusion, the Inclusive Recruitment Panellist (IRP) Programme has been launched as part of a wider package of inclusive recruitment initiatives building on the momentum of the Ignite events. The programme will introduce trained colleagues with lived experience and diverse perspectives to support Band 8A recruitment processes, helping to strengthen fairness, transparency and inclusivity in recruitment decision-making whilst creating valuable development opportunities for participating staff. Expressions of Interest are currently being sought, with the aim of the first cohort undertaking training during September ahead of the programme launch in October.

Proud2b@MFT – One Year Celebrations

The Proud2b Network will mark its first anniversary with a two-part celebration. On 23 September 2026, the network looked back over its first year with highlights including celebrating Admin Professional's Day, delivering Digital Training and the Cancer Masterclass, and "Making the Difference Together" which brought together subject matter experts on Population Health, Equality Diversity & Inclusion, Patient Experience and delivery of two Improvement sessions on how we can work together to improve our administration services and patient experience. This will be followed on 8 October 2026 by a face-to-face recognition ceremony. The event will present the Proud2b Network Champions awards, recognising individuals and teams across all our Clinical Groups and Corporate Teams.

Together, both events offer a great opportunity to showcase the work delivered over the last year and to celebrate our administration and operational professional colleagues for the vital role they play in delivering our services to patients, while reinforcing how we continue to support colleagues around the network's key themes of Connect, Collaborate, Celebrate, Career Development and Continuous Support.

One Born Every Minute filming

I am pleased to report that filming of Channel 4's One Born Every Minute at Saint Mary's Hospital concluded successfully in August. Filming has been extensive, with involvement of a broad range of colleagues from our Specialist Hospitals and Clinical and Scientific Services Clinical Groups. It has provided an opportunity to show the day-to-day running of the busiest maternity service in the country, highlighting the diverse stories within our local community and the way midwifery and obstetrics services are transforming care and experience. The series will be broadcast later in the year.

Events and Celebrations

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

- **Veteran Aware Accreditation** – I am pleased to report that MFT has been recredited as a Veteran Aware organisation, recognising our continued commitment to identifying, understanding and supporting members of the Armed Forces community who access our services or work alongside us. The recreditation reflects the dedication of colleagues across the Trust, and our next phase of work will strengthen governance, staff training, the Armed Forces Network and the identification and support of veterans.
- **Visit from the Chief Scientific Adviser to the Department of Health and Social Care** – On 4 August, we welcomed Lucy Chappell, Chief Scientific Adviser to the Department of Health and Social Care, to Manchester. The visit demonstrated the scale, quality and impact of research and innovation across MFT and our partnerships, with discussions focused on our research strategy and future Biomedical Research Centre ambitions, followed by visits to our Clinical Research Facilities and Research Van, and discussions with wider GM Partners.
- **Visit from the National Chief Medical Officer** – On 7 September, we welcomed Frankie Swords, National Medical Director for NHS England, to see our digital dialysis service. The visit provided an opportunity to showcase how digital technology is supporting service transformation and enhancing patient care, while highlighting the wider work taking place across MFT and Greater Manchester to develop and adopt innovative digital solutions.
- **CRDC Celebration Event with Lord James O Shaugnessy** – On 17 September, colleagues and partners came together to celebrate the impact achieved during the first 18 months of the Greater Manchester Commercial Research Delivery Centre. The event highlighted partnership working across the region and the Centre's work to establish new commercial partnerships and encourage more researchers to deliver commercial studies, helping to expand opportunities for local people to participate in research.
- **Visit from National Director of Primary Care and Community Services** – On 18 September, we welcomed Dr Amanda Doyle, NHS England's National Director for Primary Care and Community Services, to Moss Side Millennium Powerhouse. Dr Doyle met colleagues from the integrated neighbourhood team and heard about the development of neighbourhood working across Manchester and Trafford, before joining Neighbourhood Health Champions in the community to see how trusted local relationships are supporting prevention, earlier intervention and access to health checks.
- **Visit from the NHS England Chair** – On 21 September, we welcomed Dr Penny Dash, Chair of NHS England, to the Trust. The visit provided an opportunity to highlight MFT's role as a major provider and system partner, and to demonstrate how our transformation work is supporting the NHS 10 Year Health Plan's three shifts through prevention, community-based care and digital innovation. The programme included discussions with senior leaders and visits to services showcasing Live Well Hubs, Care on Time, wearable technology and Ambient Voice Technology.

Consultant Appointments

Since our last Board meeting in July, 49 Consultants (31 substantive and 18 locum) have been appointed to roles within the following specialties: Acute Medicine, Anaesthetist with interest in Obstetrics, Burns & Plastic Surgery, Cardiac Surgeon, Cardiothoracic Anaesthesia, Colorectal Surgeon, Community Paediatrician, Dermatologist, Emergency Medicine, General in Head and Neck, Gastroenterologist, Histopathologist (Skin), Infection, Laryngology, Oncoplastic Breast Surgeon, Paediatric and Adolescent Rheumatology, Paediatric Nephrologist, Paediatric Oncology, Paediatric Respiratory Medicine, Paediatrician with an interest in Child Mental Health, Physician - Respiratory Medicine, Plastic Surgery in Skin Cancer and General Plastic Surgery, Plastic Surgery Skin Cancer and General Plastic Surgery, Radiologist with Thoracic and/or Cardiothoracic Interest, Respiratory Medicine, Rhinology.

MFT continues to draw in exceptionally qualified candidates for consultant positions who are not only attracted by our exceptional services, but our established development programme specifically for new consultants transitioning from their positions as Resident Doctors.

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

Financial Recovery

The Trust continues to manage a challenging financial and operational position for the remainder of 2026/27, with further action required to strengthen delivery and improve our year-end position. We have therefore begun an intensive phase of planning for the remainder of the financial year in order to secure the turnaround in financial performance required, concentrating on the actions that will have the greatest impact on elective performance and the financial gap in our current forecast.

We are reviewing projected demand and activity plans for the remainder of the year, with a clear focus on the year-end position and reducing the underlying expenditure run rate through recurrent efficiencies and service transformation. This is essential to avoid carrying a significant challenge through our underlying position into 2027/28.

Ambient Voice Technology (AVT)

MFT's Ambient Voice Technology programme has transitioned from pilot to delivery following 15 months of successful evaluation and refinement. The scale of deployment and consistently positive feedback have enabled the development of a Trust-wide investment case, now progressing through governance. Following the successful pilot and evaluation which concluded in June, rollout activity is now underway across 19 priority specialties, with the first services already reaching adoption milestones. By reducing the administrative effort associated with clinical documentation, AVT is creating capacity within outpatient

services, improving the patient and clinician experience, and supporting the Trust's wider ambitions around productivity, access and elective recovery. Over 11,500 outpatient encounters have now taken place with AVT support and over 400 colleagues are using the functionality every day.

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

MFT and MHRA launch Manchester Sandbox

On Wednesday 2 September colleagues from the Medicines and Healthcare products Regulatory Agency (MHRA), including their Chief Executive Lawrence Tallon, visited MFT to formalise the creation of the "Manchester Sandbox", which provides which aims to bring innovative new approaches safely to patients and communities, enabling earlier diagnosis, more personalised care and faster access to proven new technologies.

The MHRA team saw demonstrations of new innovations, including wearable patient monitoring devices and Ambient Voice Technology, ahead of formalising the sandbox agreement which will allow innovative technologies to be evaluated and tested in NHS settings, generating evidence on how they perform with patients and clinicians in day-to-day practice before wider deployment. The Sandbox initiative will be a key element of the developing Research and Innovation prospectus, aiming to attract industry partners and support our wider growth ambitions.

New Drug for common Heart-thickening Disease

A new drug is offering hope for people with hypertrophic cardiomyopathy, the world's most common inherited heart disease. The condition, which causes thickening and scarring of the heart muscle, is sometimes asymptomatic but some patients suffer from breathlessness, fatigue, chest pain and blackouts. A small minority of people have an increased risk of developing a dangerous heart rhythm.

The TEMPEST trial led by researchers at MFT, The University of Manchester and supported by the MFT-hosted NIHR Biomedical Research Centre: Manchester tested the drug in a year-long study and found it led to a reduction in heart muscle thickening.

6. Strategic Updates and Policy Developments

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

Framework for NHS boards: Monitoring Research Activity

On 26 August 2026, NHS England published a framework which defines what NHS boards need to do to monitor research and describes what a high-performing, research-active organisation looks like. There are 2 categories of high-level research activity metrics in the framework: those drawn from publicly available national data sources and those that

require data to be collected locally. Boards are required to track the trajectory of metrics and set ambitions for improvement. The new framework can be found [here](#).

Research activity at MFT is already monitored through the Integrated Performance Report (IPR) presented at the Research, Innovation and Population Health Board Committee and the Board of Directors. The content of the IPR will be reviewed to ensure that future reporting covers all the requirements from this national framework.

Health Bill: Providers Fact Sheet

On 9 September 2026, the Department of Health and Social Care published an update fact sheet regarding the Health Bill 2026. The fact sheet, which can be found [here](#), sets out the changes related to provider Trusts which form part of the Bill currently passing through Parliament. Within the fact sheet there is a particular focus on:

1. Removing the requirement for NHS Foundation Trusts to have a Council of Governors so they can choose a dynamic approach to local engagement tailored to the needs and structure of local communities as opposed to the 'one-size-fits-all' governor model.
2. Introducing a power for the Secretary of State to be able to de-authorise NHS Foundation Trusts in cases of serious failure, where it is in the public interest to do so.
3. Transferring NHS England's responsibility for provider oversight and regulation to the Secretary of State.

We have surveyed our current Council of Governors to seek their views on future public engagement opportunities if the Bill passes through Parliament unamended. These views will be taken into account when developing a future model which reflects the expectations of the Health Bill, supports meaningful public engagement, and meets the needs of the organisation and the communities we serve.

Your Voice: Shaping the Future of Maternity and Neonatal Care

An NHS-wide conversation opens on 21 September to give everyone working in maternity and neonatal care the opportunity to share views and help shape improvements to maternity and neonatal services. Feedback will inform the National Maternity and Neonatal Taskforce's action plan. The initiative aims to capture frontline perspectives on what changes are required at individual, organisational and national levels, ensuring future decisions reflect the experiences of staff working within services. The conversation runs for three weeks from 21 September. At the end of the three weeks, Trusts will receive tailored reports summarising the views of their workforce which are intended to help boards and leadership teams understand staff priorities, identify barriers to improvement and inform local quality improvement activity. The initiative sits within a broader national

commitment to improving safety, quality, culture and equity across maternity and neonatal services.

Social Care - The Big Conversation on Care

A public engagement exercise has been launched to seek views to inform the recommendations for the long-term reform of social care. Many of the factors that determine demand on our services are social in nature and social care is critically important to the NHS. The current system is not thought to be working as well as it should and the Prime Minister has asked Baroness Louise Casey to consider how adult social care should change to meet the needs of current and future generations, and to make recommendations for reform. The Big Conversation is part of the work being undertaken by the Independent Commission on Adult Social Care, also known as the Casey Commission. Between now and April The Big Conversation will give people the opportunity to share their views on what adult social care should look like in the future, including who should receive support, the role of families and communities, and how care should be funded. The public engagement phase concludes in April 27 and the single final report, covering both immediate priorities and long-term recommendations, will be published in Summer 27.

7. Leadership Updates

Deputy Chief Executive Appointment

I am pleased to confirm the appointment of Darren Banks, formerly Chief Strategy Officer, to the role of Deputy Chief Executive. Darren, who has been undertaking the role on an interim basis, will share the position with Kimberley-Salmon Jamieson. His appointment provides continuity and stability to the executive leadership team and wider organisation. A recruitment and selection process for the role of Chief Strategy Officer is currently underway.

8. Top concerns

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

Financial Position

The Trust has continued to report a position broadly in line with its financial plan at month 5. However, the underlying financial challenge remains significant, with savings delivery and the expenditure run rate continuing to require sustained attention. We are maintaining close executive oversight, focusing on accelerating delivery of the Value for Patients programme, strengthening our cash position and improving financial control across Clinical Groups. Our review of plans for the remainder of the year described above will intensify this work and support a more sustainable exit position from 2026/27.

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

Patient Administration

Work to strengthen patient administration processes and data quality remains a significant area of focus, given the potential impact on patient safety, experience and operational delivery if processes are not consistently managed. The programme is now operating through a formal assurance, improvement and governance framework, with a dedicated strategic risk, regular oversight through Digital Management Committee and Digital & Estates Board Committee, and additional assurance through the Quality, Safety and Performance Board Committee. This will support closer executive and Board oversight of progress, risks and delivery actions, while ensuring that current issues are addressed and the Trust is well positioned to realise the benefits of future clinical, operational and digital transformation safely and effectively.

The above concern is relevant to strategic objective 7 in the Board Assurance Framework.

Industrial Action in Greater Manchester

Northern Care Alliance (NCA) has continued to experience industrial action involving theatre colleagues in relation to enhanced pay rates for additional work. MFT has remained engaged through Greater Manchester system arrangements, supporting discussions where appropriate and monitoring any potential impact on elective services and patient pathways. The Trust continues to work collaboratively with partners to minimise disruption to patients, support earlier treatment options where possible and maintain system resilience.

The above concern is relevant to strategic objective 7 in the Board Assurance Framework

Public Board of Directors

Wednesday, 30 September 2026

Paper Title:	Integrated Performance Report (IPR)	Agenda Item 9.1
Presented by:	Chief Delivery Officer Chief Nursing Officer Joint Chief Medical Officers Chief Finance Officer Chief People Officer Chef 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 Consultant in Public Health	
Meetings where content has been discussed previously	Board Committees	
Purpose of the paper Please check <u>one</u> box only:	☐ For approval ☒ For discussion ☐ For support ☐ For noting	

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**
☒ **No**

Please set out in the report what action has been taken to address this

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

Main report
Main report in appendices.

MFT Integrated Performance Report

July 2026



Measuring our performance

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

Executive Summary



Executive Summary:

Strategic Domain	NOF Domain	Summary
Quality and Safety	Experience of Care	<i>Single sex accommodation breaches remain attributable to critical care patients awaiting step-down to an appropriate ward bed, with no breaches arising from non-critical care areas.</i>
	Patient Safety	<i>A Never Event was reported relating to a wrong intraocular lens (IOL) implant at Manchester Royal Eye Hospital- a total of 14 Never Events have been reported since April 2025 (12 in 2025/26, 2 in 2026/27 to date).</i> <i>Category 3 caesarean sections not performed within 24 hours is above target (29 against a plan of less than 10 per month), due to increasing demand. Mitigations are in place, with interim Oxford Road Campus (ORC) Sunday lists agreed, capacity and demand review complete and paper in development due for October 2026.</i>
Operational Performance	Access to services	<i>Summer heatwaves resulted in demand increases with more ED attendances and a small number of elective cancellations due to humidity: four-hour performance was 2.6 percentage points (pp) below plan and RTT although improving was 0.85 pp below plan. FDS and 31-day cancer standards were met, but 62-day performance was 4 pp below plan with reduced ability to staff additional activity due to specialist workforce availability and complexity of patients. Improvement plans are in place to return to plan by September for RTT and cancer and October for UEC.</i>
Workforce	People	<i>Sickness absence rose to 6.0% against 5.8%; AfC appraisals fell to 83.5% against 90%, while medical appraisals remained above target. Mandatory training exceeded 90% and turnover fell to 7.9%. Staffing was 62 WTE below plan, with substantive staffing above plan and lower bank and agency use.</i>
Finance	Finance, Productivity & Innovation	<i>Operating cash and Value for Patients remain under pressure, with VfP £22.5m below target and agency spend marginally above the external cap. Month 4 was delivered in line with plan after non-recurrent and technical adjustments, Tiered oversight and recovery support are being strengthened through August and September.</i>
Research & Innovation	Effectiveness of Care and Population Health	<i>Weighted recruitment has declined and commercial study set-up remains variable, although set-up times are improving. The Trust maintained 907 active studies; 93% of MFT-sponsored NIHR portfolio studies were on track, with the latest set-up and recruitment measures meeting standard.</i>
Digital	N/A	<i>FOI (92.31%) and SAR (98.07%) performance remained above 90%, with backlogs reducing. Unplanned clinical and operational downtime remained within the 15-hour standard.</i>

Q1 NOF segmentation

For quarter 1 MFT has been rated as **segment 2** from **segment 1** of the NHS oversight framework (NOF) based on the new methodology introduced in 26/27. Q4 ranking was 19/134 with an average metric score of 1.94. The average metric score for Q1 is 2.24, with a national ranking of 29/134.

Domain	Domain Score (June Q1)	Segment	Direction of Travel since last segmentation	Previous score (March Q4 Segmentation)
Access to services	2.43	2	↓	1.78/ Segment 1
Experience of care	2.16	2	↔	1.93 / Segment 2
Effectiveness of care & Population Health	1.31	1	↑	
Patient safety	1.92	2	↔	2.27 / Segment 2
Finance and Productivity and Innovation	2.72	3	↓	1.35 / Segment 1
People	2.37	2	↑	2.96 / Segment 3

Measures for Board attention



Never Events

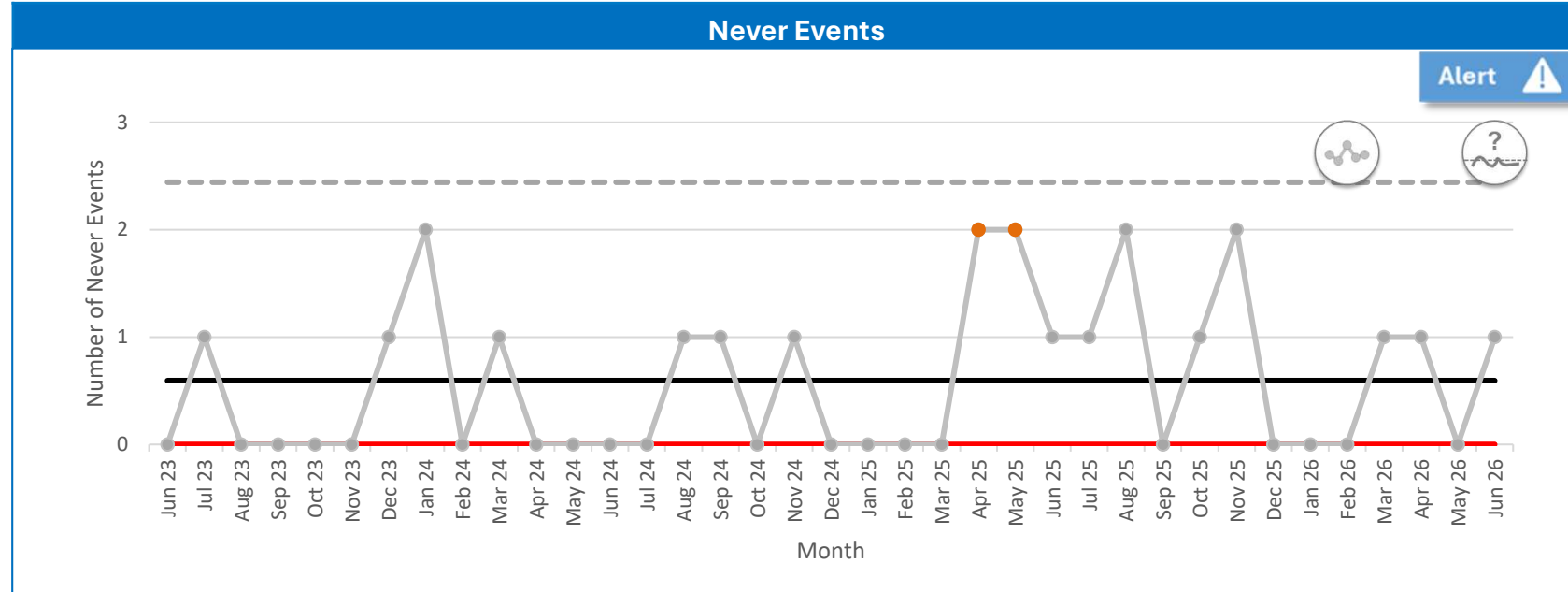
Accountable Executive: Kimberley Salmon-Jamieson | Accountable Group: Quality & Safety Performance Board Committee
NOF: N/A | NHS England Reportable

Actual	Standard / Plan	Variance
1	0	+1

Compliance	Variance	Assurance	Actions

Clinical Group breakdown (12 months)

Specialist	7
CSS	2
WTWA	
NMGH	
MRI	
LCO & Dental	



Understanding the performance

1 Never Event reported in June 2026 - Wrong Intraocular Lens (IOL) Implant at MREH (incorrect lens power implanted).

Risks and controls

- Patient safety incident oversight through SHG and Trust Patient Safety Oversight Groups.
- Interventional Procedures Safety Group leading human factors improvement.
- Strengthened implant and equipment storage arrangements.
- Audit programme review to strengthen assurance and identify improvement opportunities.

Actions and timescales

Patient Safety Network implementation by Q3.

Never Event improvement programmes on-going in Ophthalmology, Maternity, and Specialist Hospital theatres with actions complete across 2026/2027. Audit programme review November 2026

Category 3 Caesarean sections not performed within 24 hours

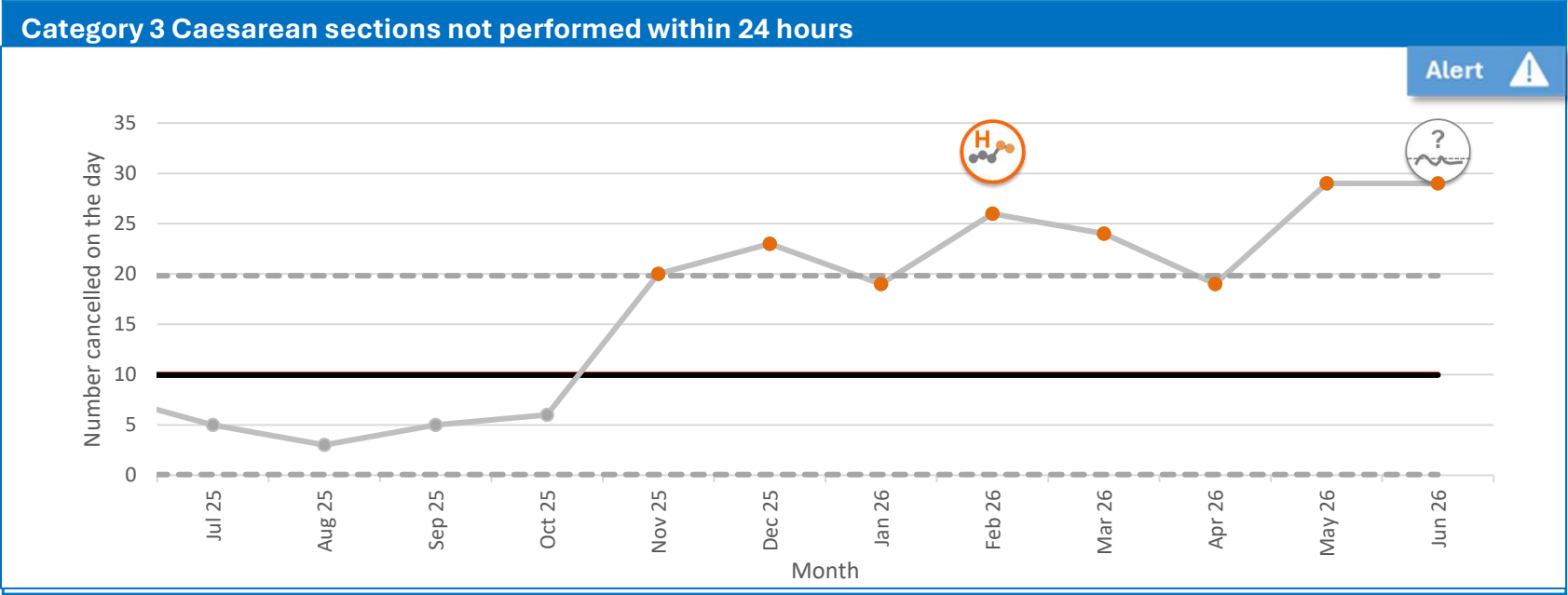
Accountable Executive: Kimberley Salmon-Jamieson| Accountable Group: Quality & Safety Management Committee

NOF: N/A | Internal Measure

Actual	Standard / Plan	Variance
29	<10	+19

Compliance	Variance	Assurance	Actions

Site breakdown	
Wyth	16
ORC	7
NM	6



Understanding the performance

Increased delays at Wythenshawe compared to the previous month (3) due to increased activity. Delays declined at ORC (16) and NMGH (10).

Risks and controls

Increasing demand for non-emergency caesarean sections. Awaiting development of a robust digital validation solution – interim manual data validation process in place. Activity continues to be monitored at the twice daily flow meetings and action taken to reduce delays. Twice weekly forward planning meeting in place.

Actions and timescales

Additional interim weekly ORC Sunday list agreed. Following feedback on the Capacity and Demand Review completed May 2026 a paper will be prepared by October 2026 to support commissioning discussions and annual planning and budget-setting processes.

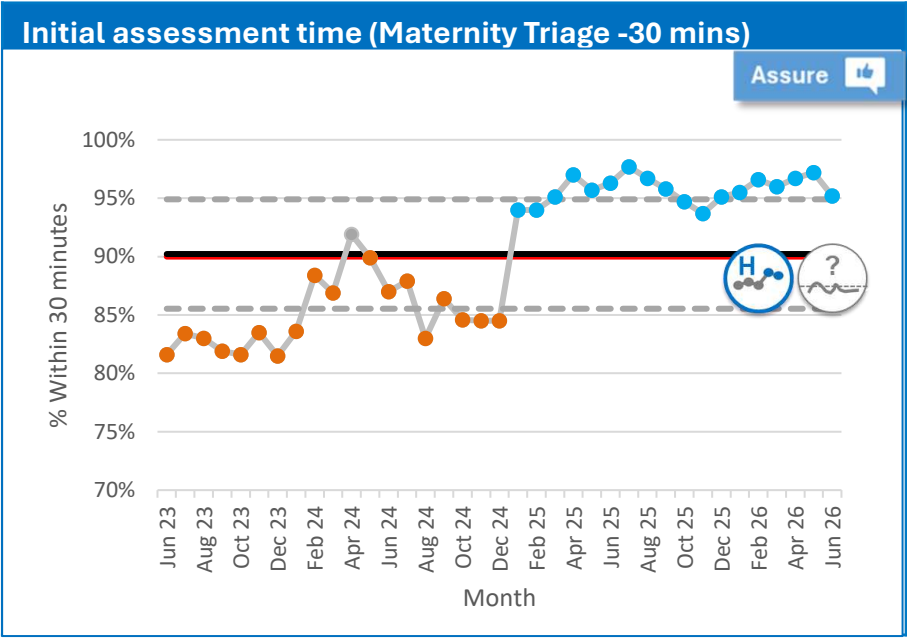
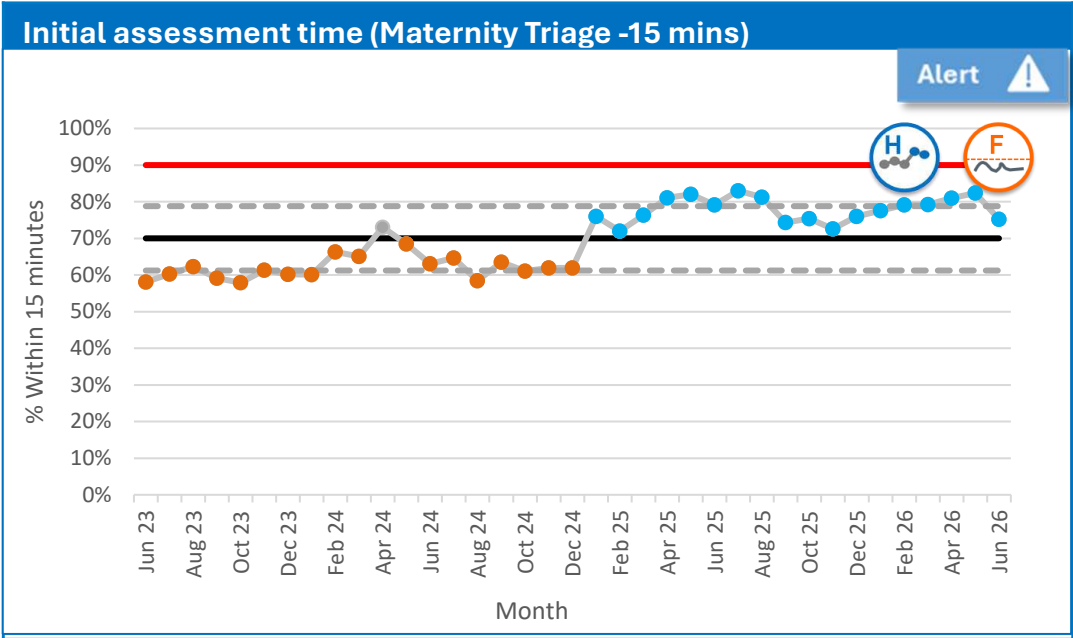
Initial assessment time (Maternity Triage)

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

Actual	Standard / Plan	Variance
75.2%	>90	-24.8%
95.2%		+0.2%

Compliance	Variance	Assurance	Actions

Site breakdown	
ORC	77.20%
NM	74.40%
Wyth	72.70%



Understanding the performance

Performance declined overall for assessment within 15 minutes compared to the previous month (82.4%) - correlates with increased attendance and activity. No poor outcomes identified in relation to initial assessment times.

Risks and controls

Increased activity continues (4543 attending in June 2026 compared to 4016 June 2024 – 13.1% increase).

Twice daily flow meetings in place. Triage workstream meetings in place.

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Actions and timescales

Following feedback on the Capacity and Demand Review completed May 2026 a paper incorporating proposed workforce uplift across the MCS and estate enhancements at Wythenshawe will be prepared by October 2026 to support commissioning discussions and annual planning and budget-setting processes.

Induction of Labour pathway - transfer to intrapartum area within 24 hours

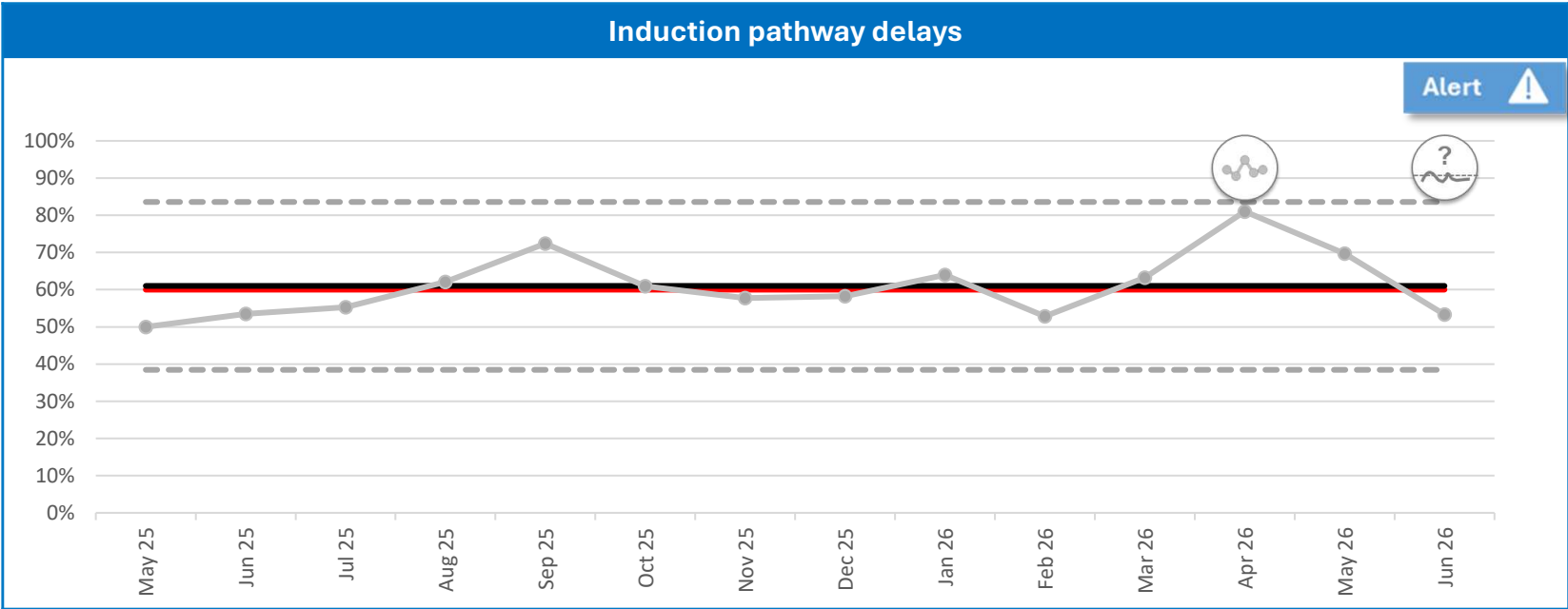
Accountable Executive: Kimberley Salmon-Jamieson| Accountable Group: Quality & Safety Management Committee
NOF: N/A | Internal Measure

Actual	Standard / Plan	Variance
53%	60%	-6.7

Compliance	Variance	Assurance	Actions

Site breakdown

NM		57.58%
Wyth		51.56%
ORC		51.55%



Understanding the performance

Performance declined overall compared to the previous month (69.7%) and at all sites.

No adverse outcomes identified as a result of delays in the IOL pathway.

Risks and controls

Increased acuity impacts on patient flow on all three sites. Women may decline transfer for care at an alternative site, or it may not be appropriate to offer transfer due to level of clinical care required. Validation of impact of changes induction agents due to medication shortage. Twice daily flow and twice weekly IOL capacity meetings.

Actions and timescales

Following feedback on the Capacity and Demand Review completed May 2026 a paper incorporating proposed workforce uplift across the MCS and estate enhancements at Wythenshawe will be prepared by October 2026 to support commissioning discussions and annual planning and budget-setting processes.

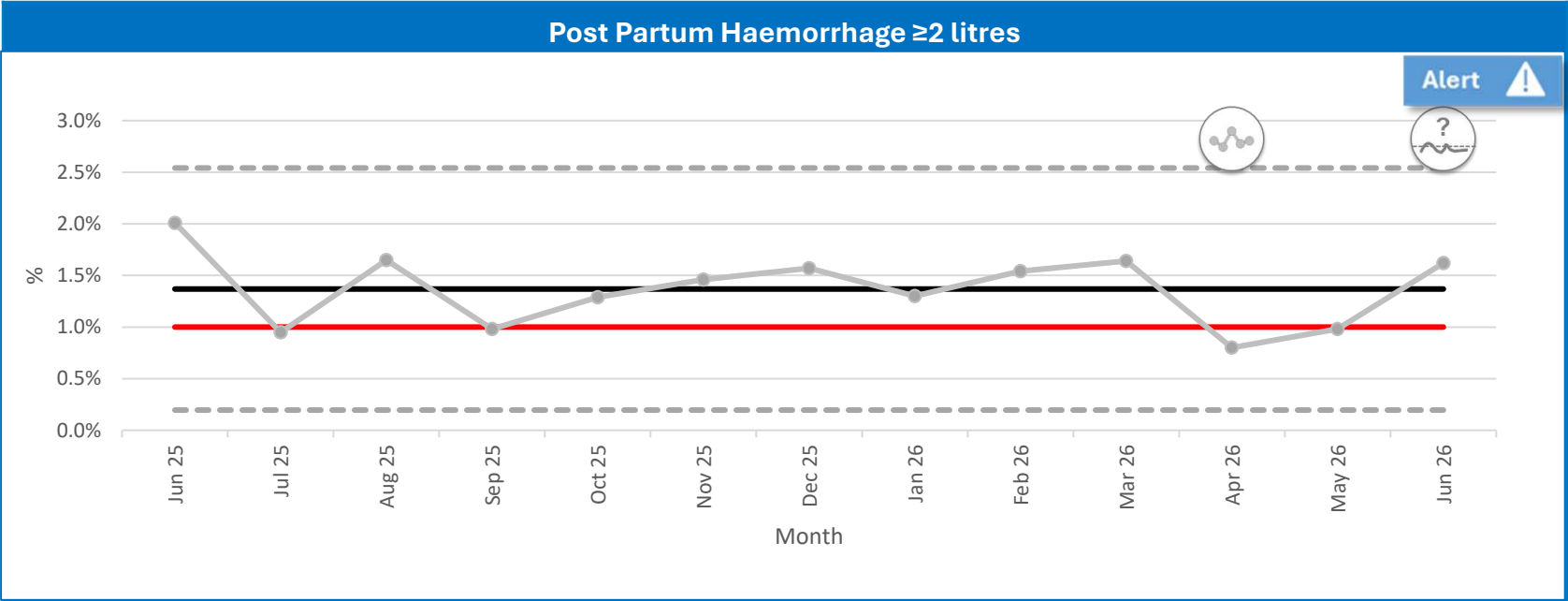
Post Partum Hemorrhage ≥2 litres

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

Actual	Standard / Plan	Variance
1.62%	<1%	+0.62%

Compliance	Variance	Assurance	Actions

Site breakdown	
ORC	2.48%
Wyth	1.23%
NM	0.58%



Understanding the performance

No care issues identified on review of cases.

Risks and controls

PPH Guidance in place aligned to best available evidence.

ORC provides complex caesarean section care, including women with placenta accreta syndrome - high risk cohort of women.

Actions and timescales

MDT review process will be aligned to the new Maternal Care Bundle being developed (September 2027).

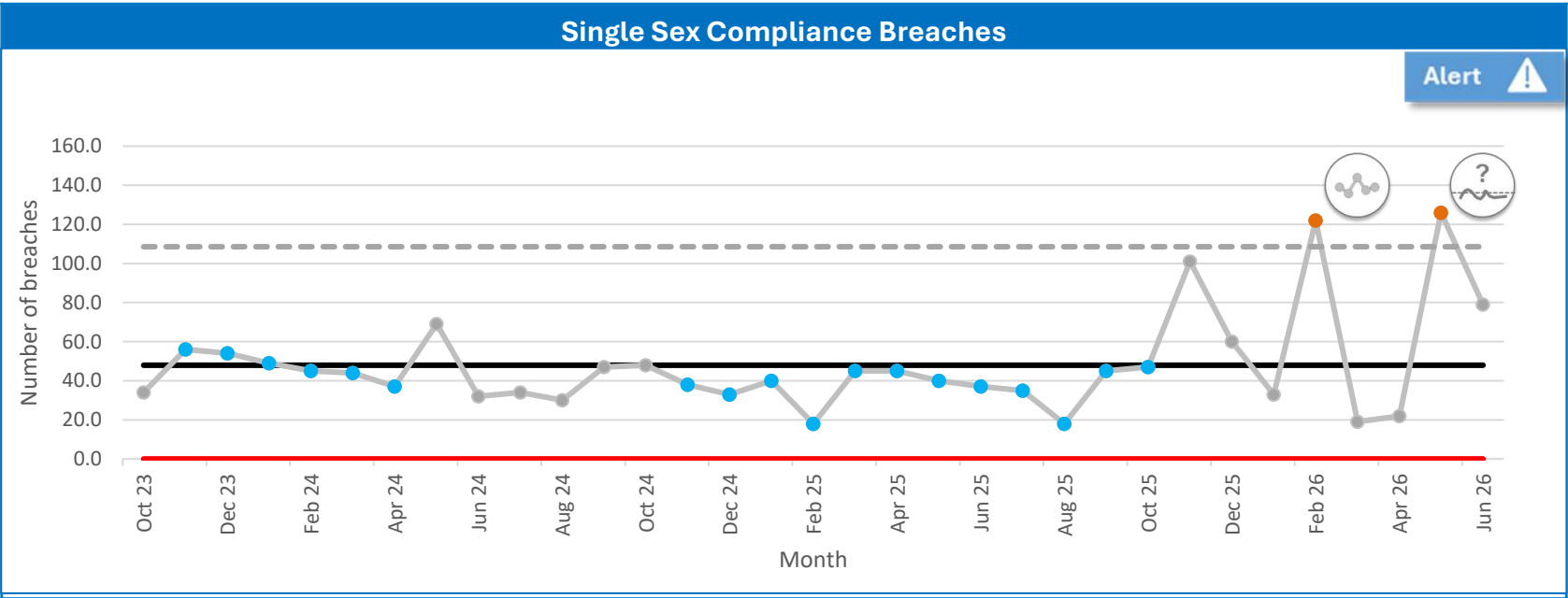
Single Sex Compliance Breaches

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

Actual	Standard / Plan	Variance
79	0	+79

Compliance	Variance	Assurance	Actions

Clinical Group breakdown	
MRI - ACC	47
NMGH - ICU	20
WTWA - AICU	5
MRI - CICU	4
MRI - EDHU	2
MRI - HDU	1



Understanding the performance

Decrease overall compared to the previous month (126) and for MRI ACC (85), WTWA AICU (10), MRI HDU (10) remained the same for MRI CICU, and increased for NMGH ICU (15) and the MRI EHDU (1).

Risks and controls

Continued focus on timely escalation, intervention, and transfer to ward. Clinical Groups continue to evaluate the efficiency of step-down processes.

Actions and timescales

Nil to report.

Complaints

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

Actual	Standard / Plan	Variance
173	N/A	N/A

Compliance	Variance	Assurance	Actions

Clinical Group breakdown	
SHCG	55
MRI	25
WTWA	46
NMGH	20
CSS	13
LCO & UDHM	5
Corporate	9

Understanding the performance

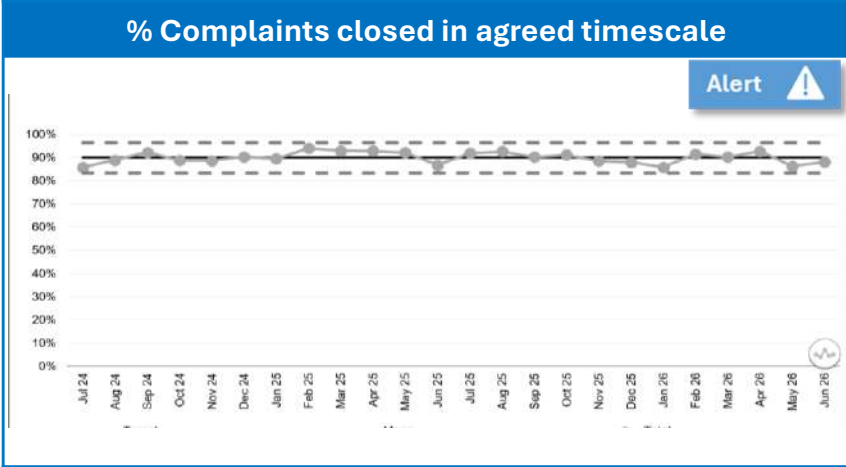
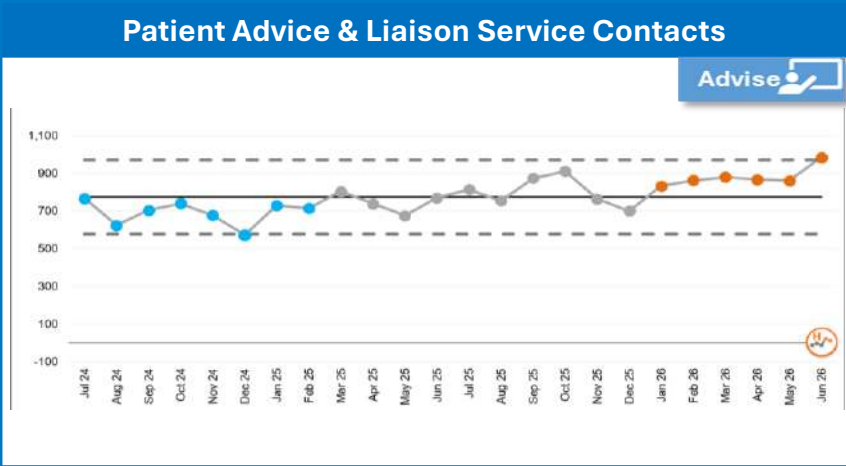
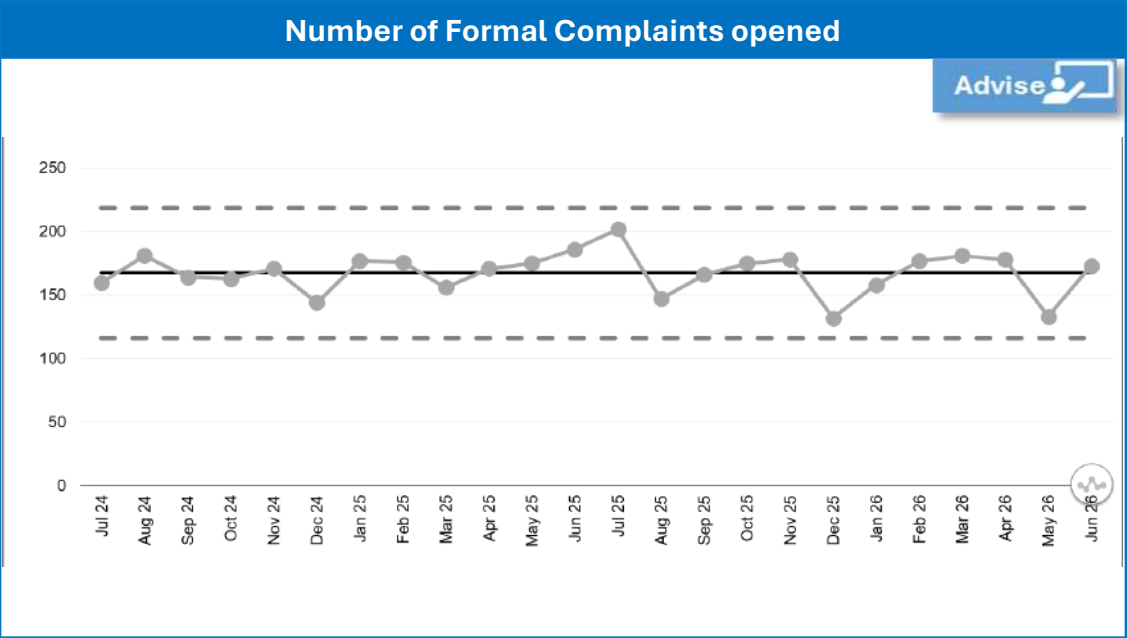
30% increase in Complaints and 14% increase in PALS compared to the previous month, reflective of national position – themes and trends are: Appointment waiting times, communication in WTWA UEC, Medicine, and Surgery, Paediatric Surgery and MREH. Complaints response performance improved from 86.3% to 88.1%, against a 90% target.

Risks and controls

- Risk to patient satisfaction. Focused work plans in place in T&O, SHCG and MRI.
- Escalation processes to support timely response.
- KPI meetings and to CG SLTs in monthly CEO 1:1s.

Actions and timescales

- PALS & Complaints dashboards and new monthly governance dashboard in place to support efficiency.
- Escalation process to be reviewed and concluded October 2026.
- Exploration of AI solution to support performance.



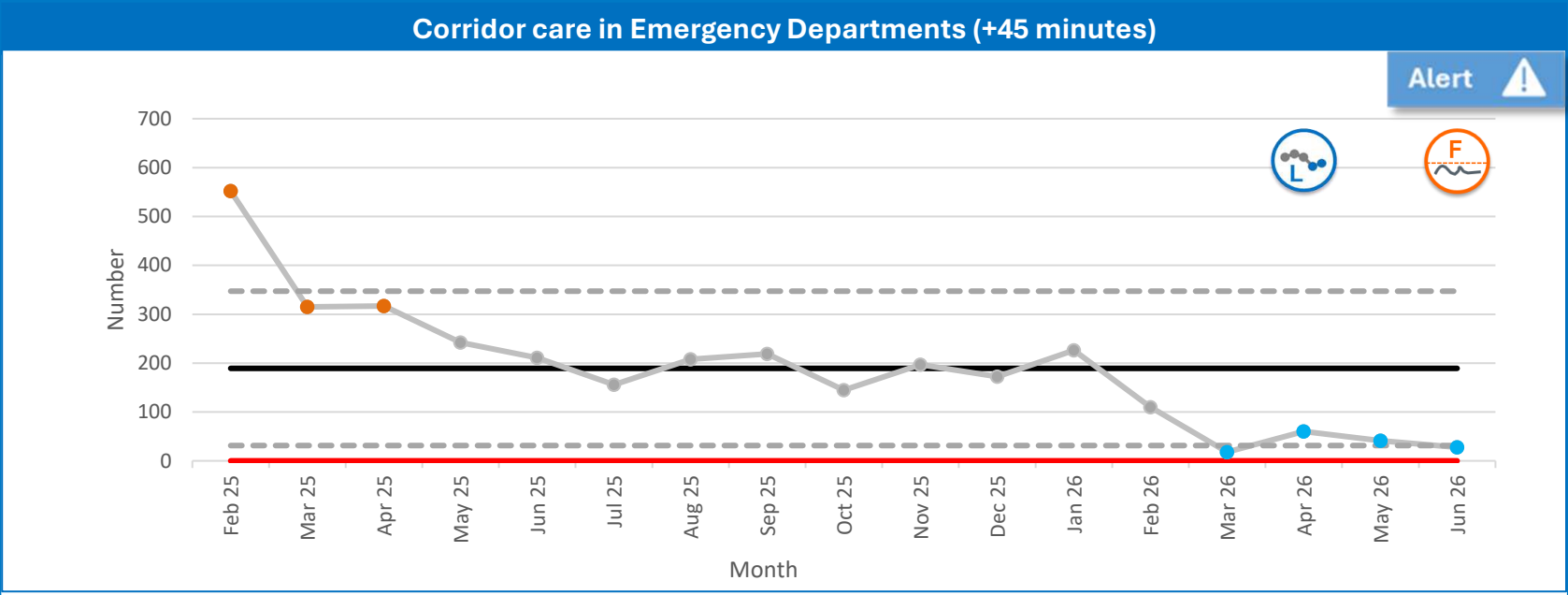
Corridor care in Emergency Departments

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

Actual	Standard / Plan	Variance
28	0	+28

Compliance	Variance	Assurance	Actions

Clinical Group breakdown	
MRI	22
WTWA	4
NMGH	2



Understanding the performance

Performance improved overall reporting 12 episodes less compared to the previous month (41) and at WTWA (37), remained the same for NMGH (2), and declined at MRI (2).

Risks and controls

Updated SOP in place including escalation in real time. Incident reporting and harm reviews ensure oversight of the safety of care delivered to patients placed in a temporary escalation space. All cases reviewed and validated by the Chief Nursing Officer, ensuring consistent decision-making, timely escalation, and strengthened executive oversight.

Actions and timescales

Visibility tracker for corridor care in Hive - August 2026.

Urgent & Emergency Care (UEC)

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

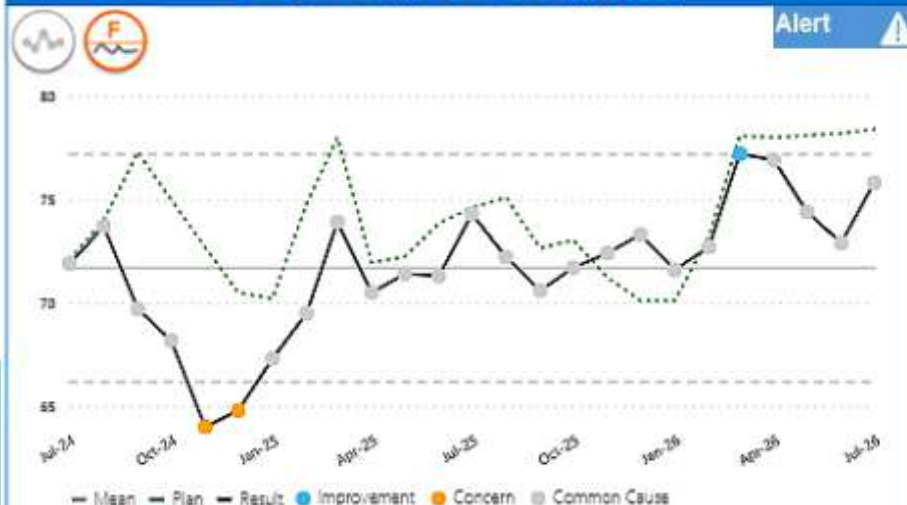
	Jul-26
Actual	75.8%
Plan	78.4%
Variance	-2.6%

Compliance	Variance	Assurance

Clinical Group Overview

LCO Dental	100.0%	96.7%
Specialist	90.6%	93.4%
North	72.8%	74.1%
WTWA	75.8%	78.8%
MRI	69.0%	72.1%

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



Understanding the performance

During July more patients attended ED than expected (47,654 patient attendances versus a plan of 46,746), following the national "summer surge" trend. Despite this 75.8% of patients attending our 4 EDs were seen within 4 hours (-2.6pp below plan). Challenges were noted in patient flow and the wait to be seen, which prevented higher performance.

The proportion of patients spending more than 12 hours in ED remained stable, and following improvements achieved in previous months, the number of patients with a Decision to Admit (DTA) waiting over 12 hours also remained broadly stable (86) ranking 59/148 nationally.

Risks and controls

Demand, wait to be seen and patient flow remain the greatest challenges.

Care Closer to Home work programme is in place with dedicated resource with progress reporting to the Delivery Oversight Management Committee.

The key risk is under delivery of these plans. Oversight through the UEC Programme Board, and through the established Delivery Oversight Framework.

Actions and timescales

Clinical Group action plans are in place with priority programmes focused on safety and experience through the Model Emergency Department, First 72 Hours in Hospital, and the expansion of Care Closer to Home across WTWA and NMGH. The Model ED work is expected to be completed October 26, with other actions timetabled into the new year.

Single Point of Access (SPOA) expanded in July over 7 days and the Model ED implementation remains on track for October 2026, supported by a dedicated summer sprint programme to monitor progress, manage risks and improve delivery ahead of winter.

A&E patient stays less than 4 hours - Paediatrics

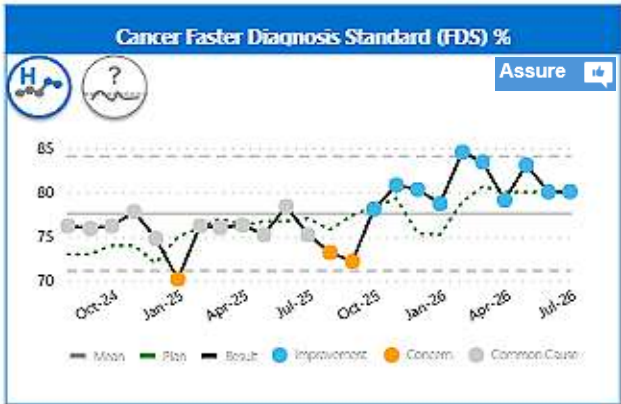
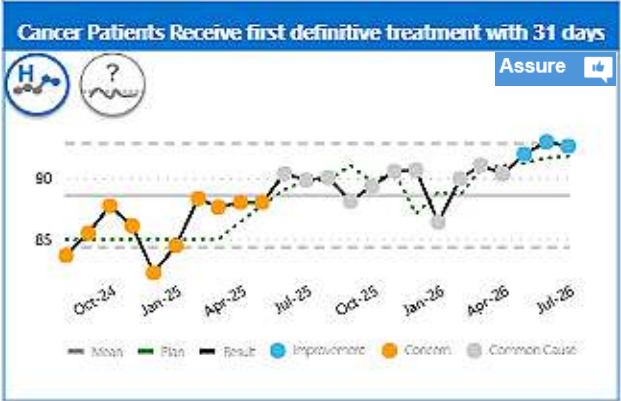
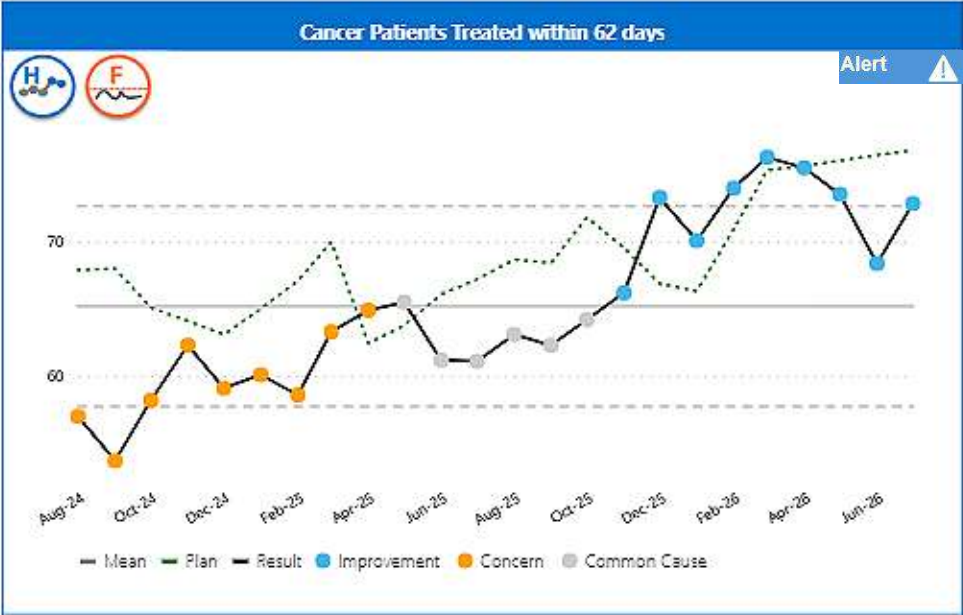


Cancer Standards

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'

Jul-26		
Actual	Plan	Variance
72.9%	76.8%	-4.0%
Compliance	Variance	Assurance

Clinical Group Overview		
MRI	67.4%	67.4%
WTWA	73.8%	76.7%
North	73.2%	77.5%
Specialist	86.1%	78.3%



Understanding the performance

In July we delivered to our plan for 28-day faster diagnosis standard and 31-day decision to treatment standard for patients on cancer pathways.

A combination of availability of specialist workforce and complex patient cohorts meant that the 62 day pathway was not delivered to plan. In July 72.9% of patients were treated within 62 days against the plan of 76.8% A total of 143.5 patients waited longer than 62 days.

Risks and controls

Key risks include patients waiting beyond optimum timescales for tests and appointments, availability of specialist workforce internally, and GM PET waits and HODs reporting which has been escalated for system action.

High volume of patients in the backlog

Daily management of pathway compliance

Lead indicators in place.

Weekly reporting in place.

Actions and timescales

Action plans in place to support key tumour sites returning to trajectory, which intend to see MFT return to trajectory in October.

Daily huddles in place with higher risk tumour groups

A Trust-wide improvement programme will commence October 26 to deliver significant pathway redesign leading to sustainable change and delivery of the longer term performance ambitions.

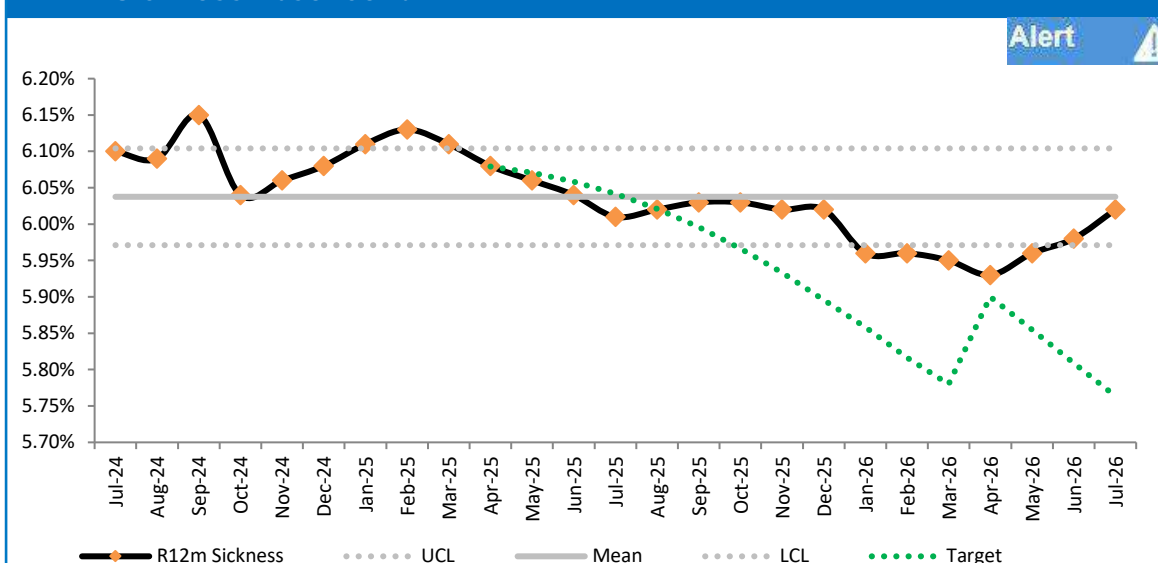
Rolling 12 month (R12m) Sickness Absence

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

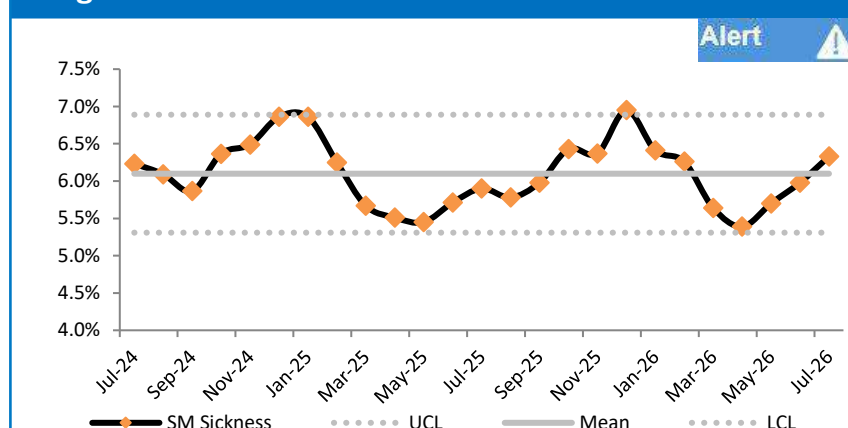
Jul-26	Target
SM 6.3%	5.0%
R12M 6.0%	5.8%

Compliance	Variance	Assurance	Actions

R12M Sickness Absence %



Single Month Sickness Absence %



Understanding the performance

MFT's rolling 12-month sickness absence rate was 6.0% in July 2026, above the Trust target of 5.8%. After a decline in absence over the previous 12 months, the rolling position has started to increase during the warmer weather with sickness absence in July 2026 (6.3%) above the equivalent position in both July 2025 (5.9%) and July 2024 (6.2%).

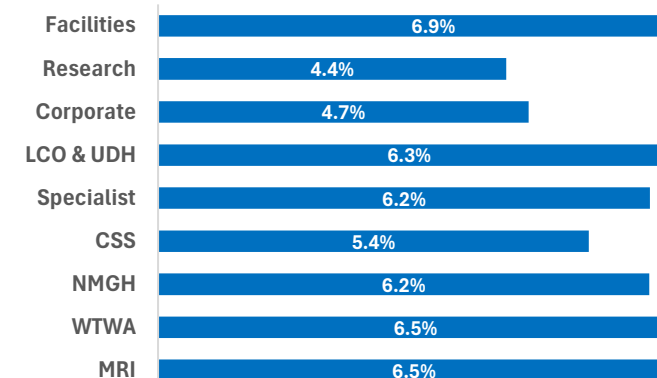
Risks and controls

Sickness Absence continues to be monitored rigorously in Clinical Groups. Improvements to system notifications and policy surveillance reporting have been implemented to provide managers with clearer tools and data to manage sickness absence more effectively. Improved oversight controls are being introduced. A programme to support leaders, alongside models to support promotion of good health is in development

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. Weekly reporting
5. Development of a programme to support leaders, build capacity and design a financially sustainable prevention model

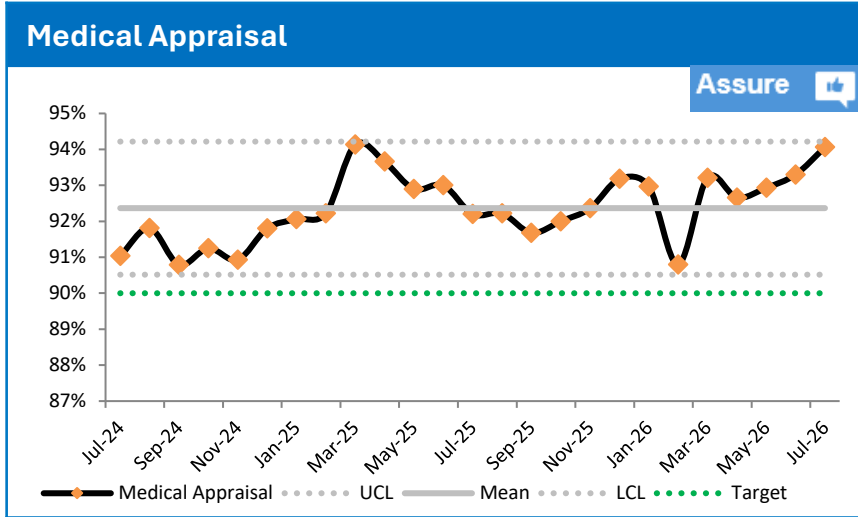
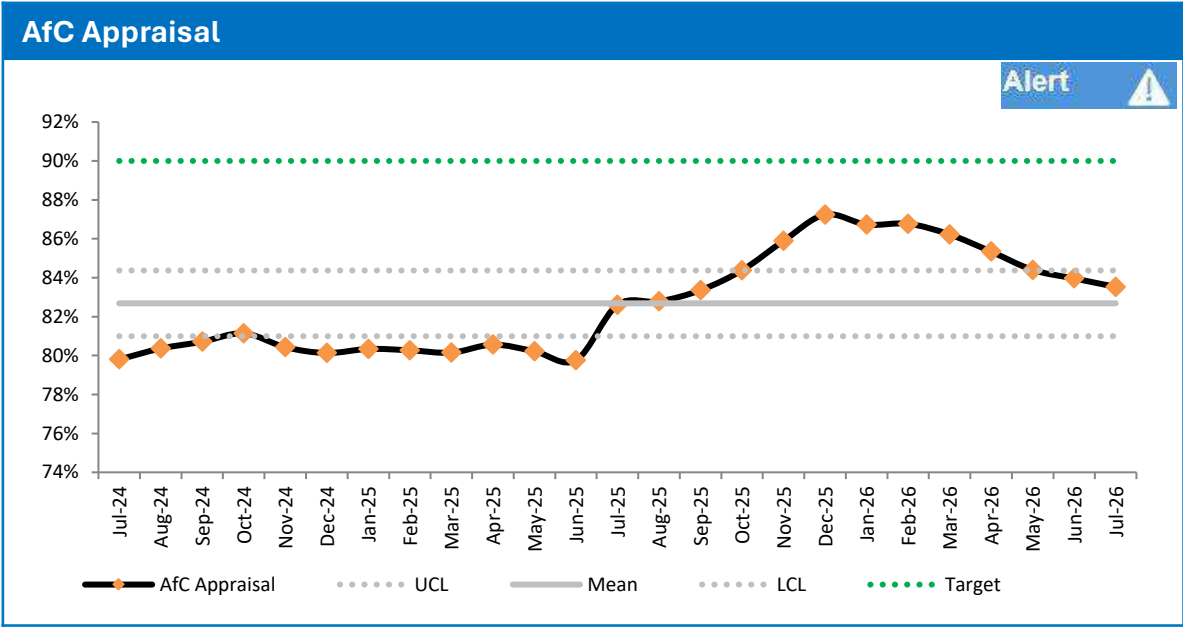
Clinical Group breakdown (R12m)



Appraisal: AfC and Medical

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

July-26		Target			
AfC 83.5%		90.0%			
Med 94.1%		90.0%			
AfC	Compliance	Variance	Assurance	Actions	
Med					



Understanding the performance

In July 2026, AfC appraisal compliance was 83.5%, against a Trust target of 90%, while Medical Appraisal compliance was 94.1%, exceeding the target. Although Medical Appraisal performance remains strong, AfC appraisal compliance has shown a downward trend over the previous seven months and continues to be closely monitored to support improvement across the Trust.

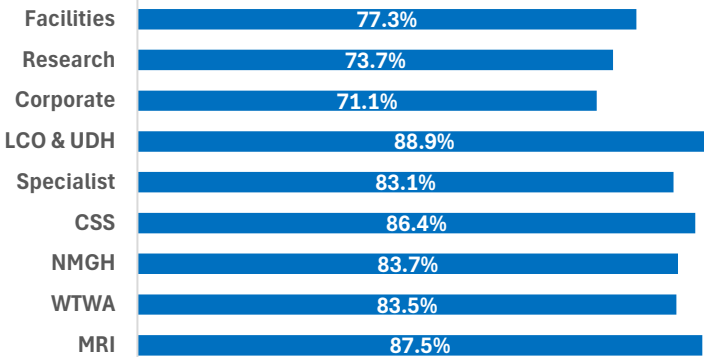
Risks and controls

Delays in appraisal completion, particularly in frontline services, are partially 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
3. Improved oversight to mirror outcomes on mandatory training

Clinical Group breakdown (AfC)

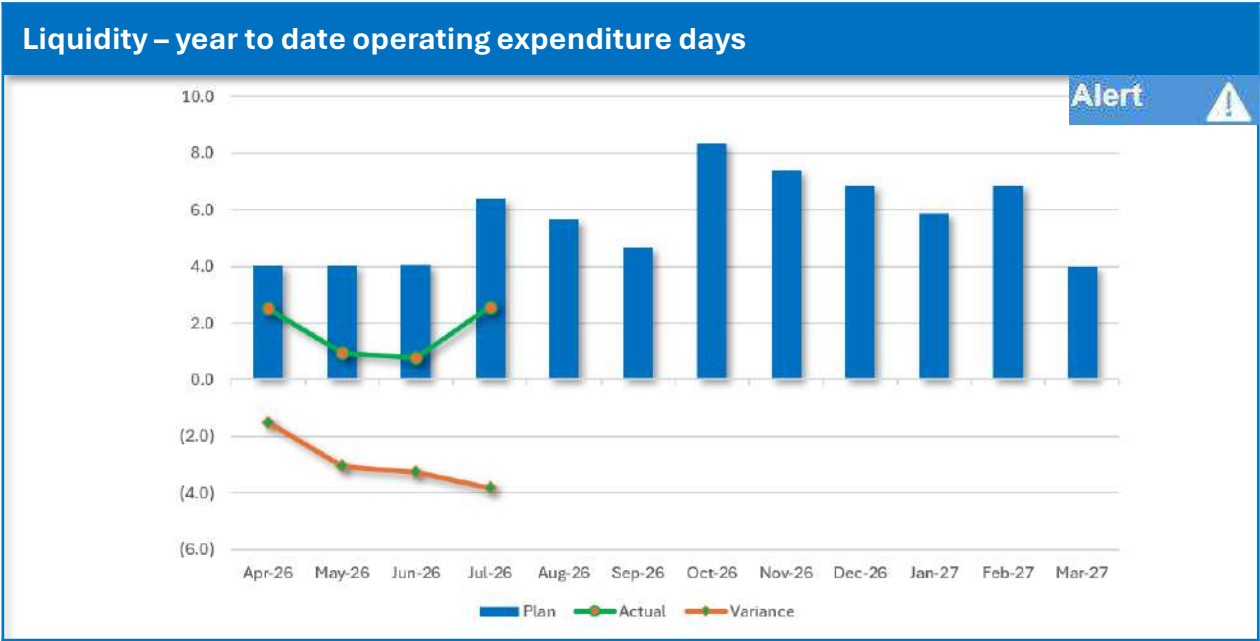


Liquidity – Operating Expenditure Days

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

Jul-26		
Actual	Plan	Variance
Days	Days	Days
2.6	6.4	(3.8)

Compliance	Variance	Assurance
		



Understanding the performance

The Trust cash balance at the end of July is £21m, the equivalent of 2.6 days of revenue operating cash, and an increase of £6.3m compared to the end of June. This balance is £30.3m below plan and £17.6m below forecast due to YTD I&E delivery being based on assumptions on PFI penalties and other non-cash items.

Risks and controls

Key risk is there will be insufficient cash flow to meet operational commitments. Continued liquidity pressure being managed in the short term with daily cash management, early commissioner payment support and Capital PDC drawdown.

Actions and timescales

Improvement in VfP programme delivery through cash reducing schemes is essential to holding sufficient cash to pay suppliers and payroll – August 26 – March 27.

Continue to manage the Trust's working capital through management of payments and maximising income – March 27

Agency expenditure as a proportion of total pay expenditure YTD (£m)

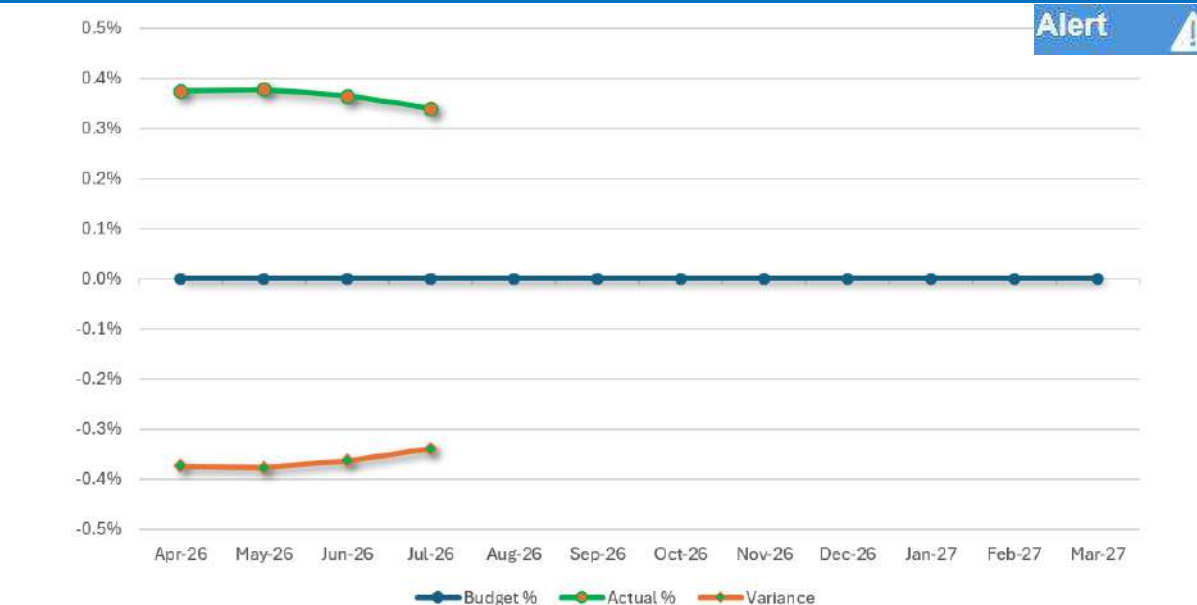
Accountable Executive: Meera Nair/Claire Wilson | Accountable Group: Finance Board Committee

Jul-26		
Actual	Target	Variance
%	%	%
0.3	0.0	(0.3)

Compliance	Variance	Assurance	Actions
			

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

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



Understanding the performance

YTD expenditure on agency staffing is £2.2m against an internally set target of £0. This equates to just 0.3% of total pay expenditure.

The externally set annual cap for MFT is £6.4m. Pro-rata to month 4 this would be £2.1m, so the Trust is adverse to this by less than £0.1m.

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. Exit plans are in place and tracked through workforce governance processes.

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. The internal target has been set at zero usage for 2026/27, linked to the Trust's VFP programme.

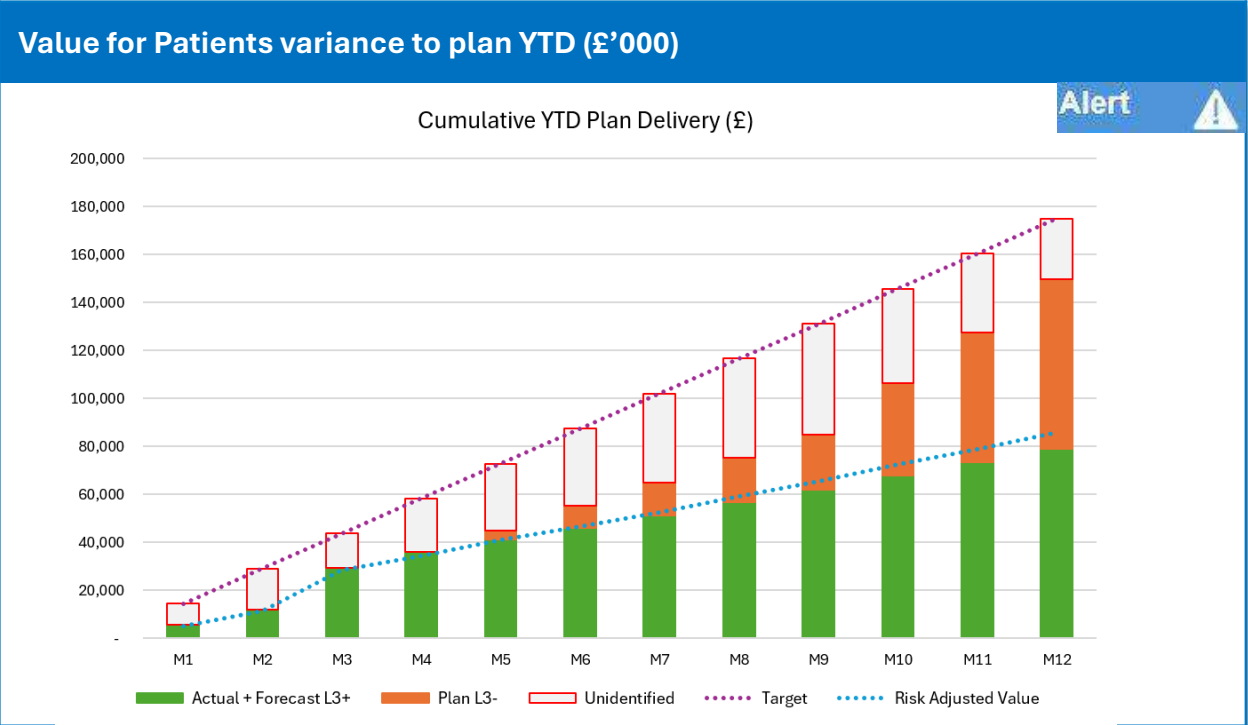
Target delivery date - March 2027.

Value for Patients variance to plan (£'000s)

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

Jul-26		
Actual	Plan	Variance
£m	£m	£m
35.9	58.4	(22.5)

Compliance	Variance	Assurance	Actions
			



Group breakdown	
Estates & Facilities	144%
NMGH	104%
CSS	31%
SHCG	49%
WTWA	36%
LCO & UDHM	23%
MRI	26%
Corporate	51%
Digital Services	81%

Understanding the performance
26/27 programme has identified £149.8m against a target of £175m (£85.8m risk adjusted). - Financial planning continues, although minimum £25.2m additional is required to reach the £175m target. - YTD actual delivery £35.9m against a target of £58.4m (variance to target £22.5m) (Note: the target phasing in Wave (YTD £58.4m) is different to the phasing as per the PFR (YTD £50.0m). Full year target reported is the same.)

Risks and controls
- Risks remain in the maturity and value of the current programme. - Controls include: - Month-end reconciliation between Wave and the Financial ledger - Workstreams report progress to the Value for Patients Team Management Group, which meets monthly. - Recovery governance in each CG. - Executive oversight via TLTC, DOF, fortnightly VFP SLT.

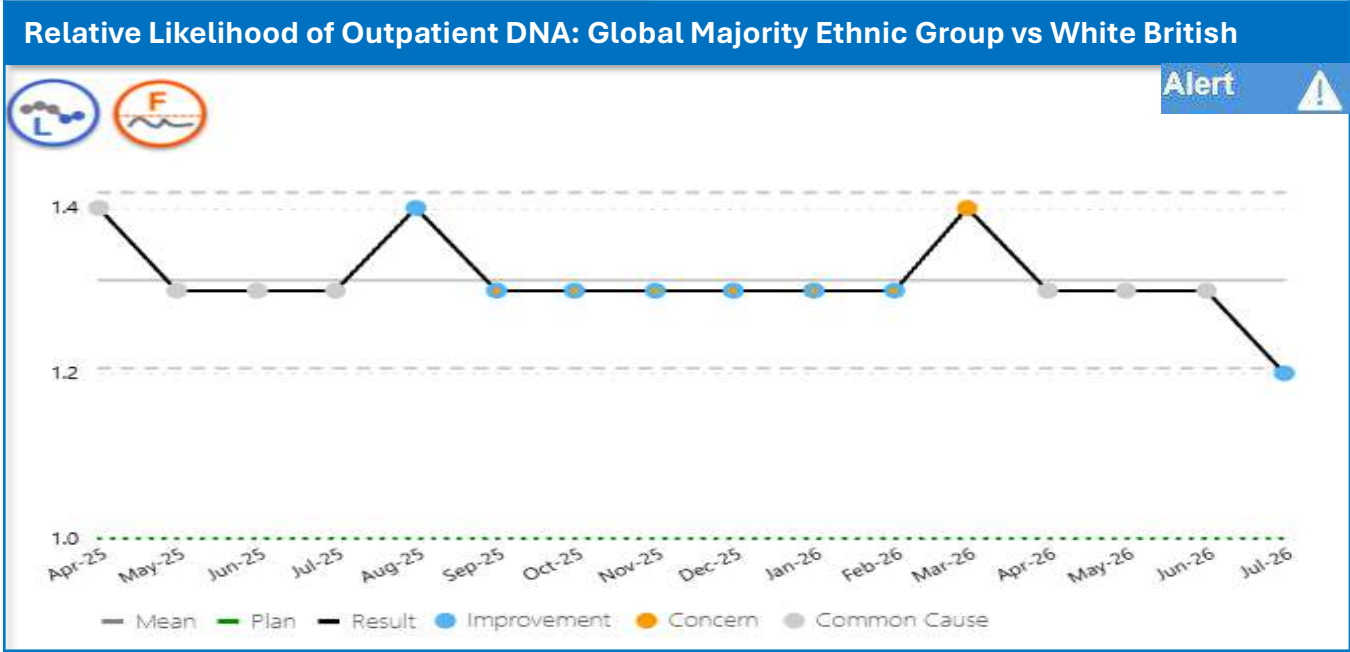
Actions and timescales
- Introduction of a more targeted assurance model through tiering of Clinical Groups and Corporate Services. - Strengthened support arrangements, gainshare incentives, increased focus on higher-value schemes, improved month-end controls. - Earlier integration of productivity and transformation requirements into 2027/28 planning

Relative Likelihood of Outpatient DNA: Global Majority Ethnic Group vs White British

Accountable Executive: Vanessa Gardener | Accountable Group: Population Health Committee

July 26		
Actual	Plan	Variance
1.2	1.0	0.2

Compliance	Variance	Assurance



Metric Definition

Outpatient DNA rate ratio shows the gap in missed appointments between global majority groups and White British groups: 1.0 = parity.

This has been included as we want to narrow the gap while reducing the overall DNA rate. If we don't track the gap, there is a risk that the overall rate decreases but the gap between certain demographic group widens.

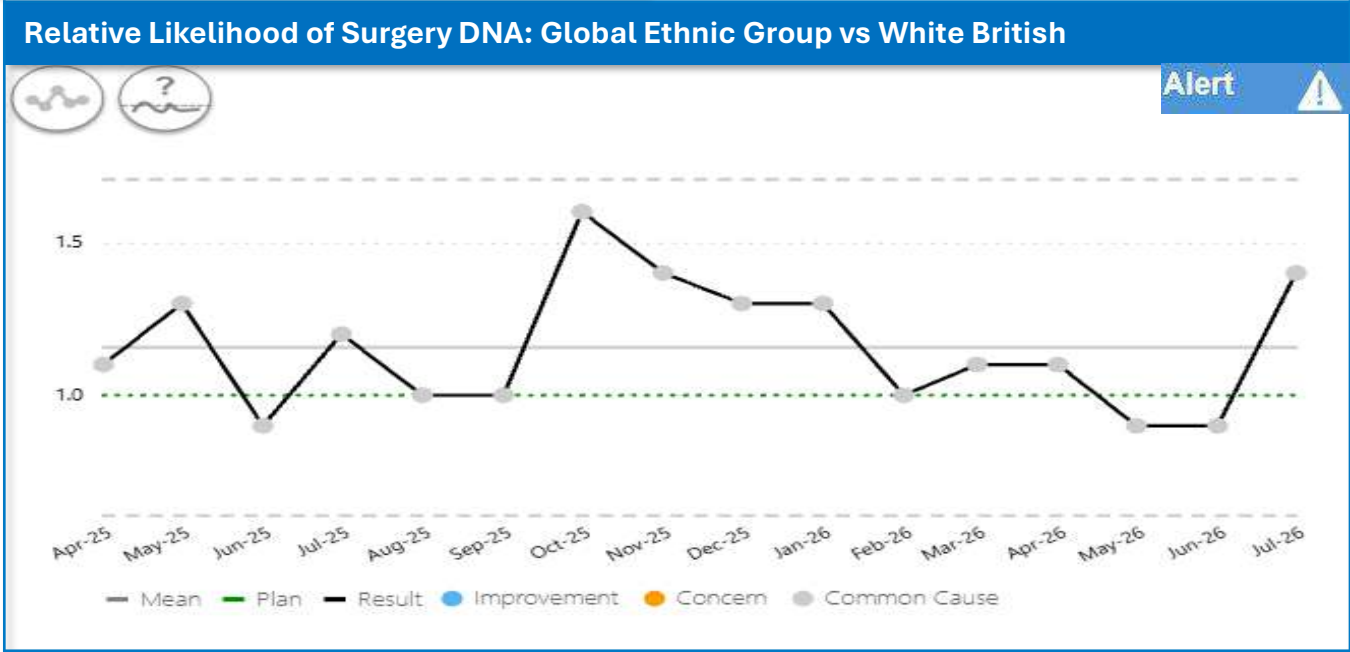
Understanding the performance	Risks and controls	Actions and timescales
First time presented. 12-month average 1.3; broadly unchanged.	Add data-quality measures. Continue to keep tracking the gap. Narrow the gap though DNA predict, communications work and other initiatives	Persistent ethnicity gap showing that those from global majority backgrounds are more likely to miss appointments; data-quality measures for ethnicity recording not yet in the dashboard.

Relative Likelihood of Surgery DNA: Global Majority Ethnic Group vs White British

Accountable Executive: Vanessa Gardener | Accountable Group: Population Health Committee

July 26		
Actual	Plan	Variance
1.4	1.0	0.4

Compliance	Variance	Assurance



Metric Definition

Surgery DNA rate ratio shows the gap in missed appointments between global majority groups and White British groups: 1.0 = parity.

This has been included as we want to narrow the gap while reducing the overall DNA rate. If we don't track the gap, there is a risk that the overall rate decreases but the gap between certain demographic group widens.

Understanding the performance

First time presented.
2-month average 1.2; last 5 months averaged 1.0.

Risks and controls

Monthly variation remains despite the recent average reaching parity.

Actions and timescales

Add data-quality measures.
Continue to keep tracking the gap.
Narrow the gap through targeted work to reduce surgical DNAs

Relative Likelihood of Outpatient DNA: Most vs Least Deprived Quintile

Accountable Executive: Vanessa Gardener | Accountable Group: Population Health Committee

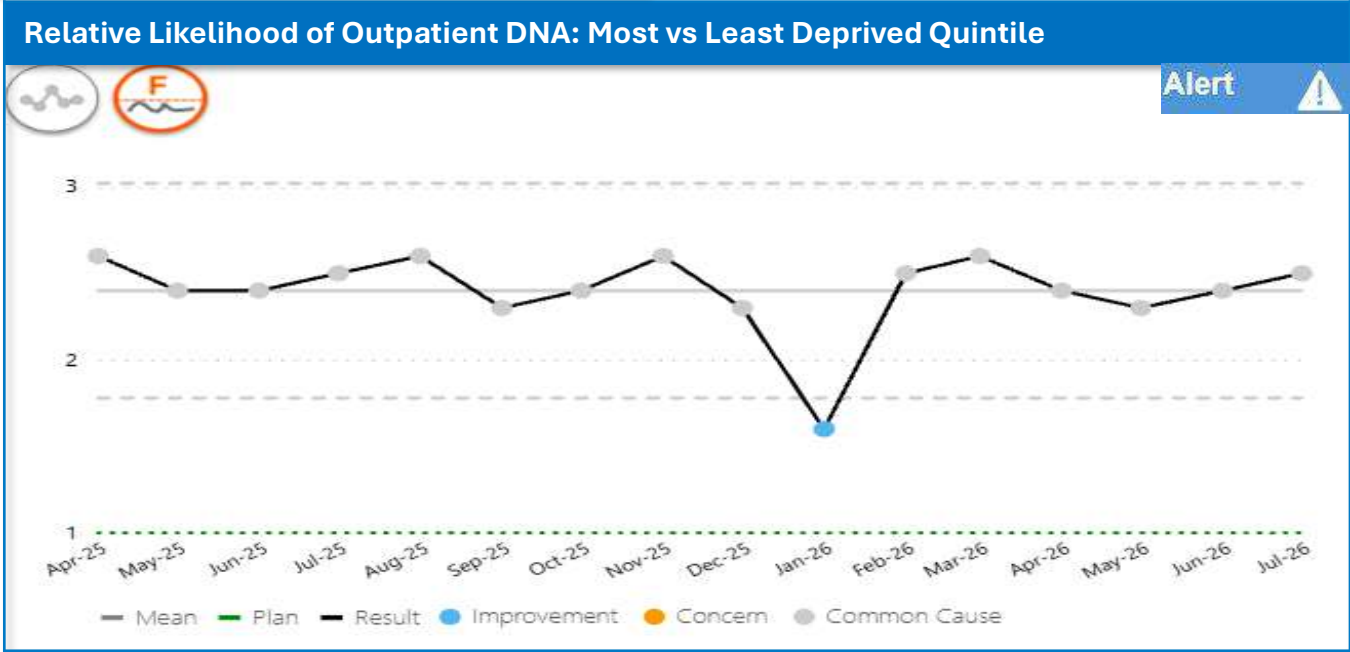
July 26		
Actual	Plan	Variance
2.5	1.0	1.5

Compliance	Variance	Assurance

Metric Definition

Outpatient DNA rate ratio shows the gap in missed appointments between the most deprived and least deprived patients linked to their postcode: 1.0 = parity.

This has been included as we want to narrow the gap while reducing the overall DNA rate. If we don't track the gap, there is a risk that the overall rate decreases but the gap between certain demographic group widens.



Understanding the performance

First time presented.
12-month average 2.4; broadly unchanged.

Risks and controls

Persistent 2.4× inequality despite a stable Trust DNA rate shows a stark gap between low and high income groups in terms of their ability to attend appointments.

Actions and timescales

Continue monthly monitoring.
Address and attempt to narrow the gap through DNA predict, communication improvement work and other targeted work such as planned free travel pilot with TFGM.

Relative Likelihood of Surgery DNA: Most vs Least Deprived Quintile

Accountable Executive: Vanessa Gardener | Accountable Group: Population Health Committee

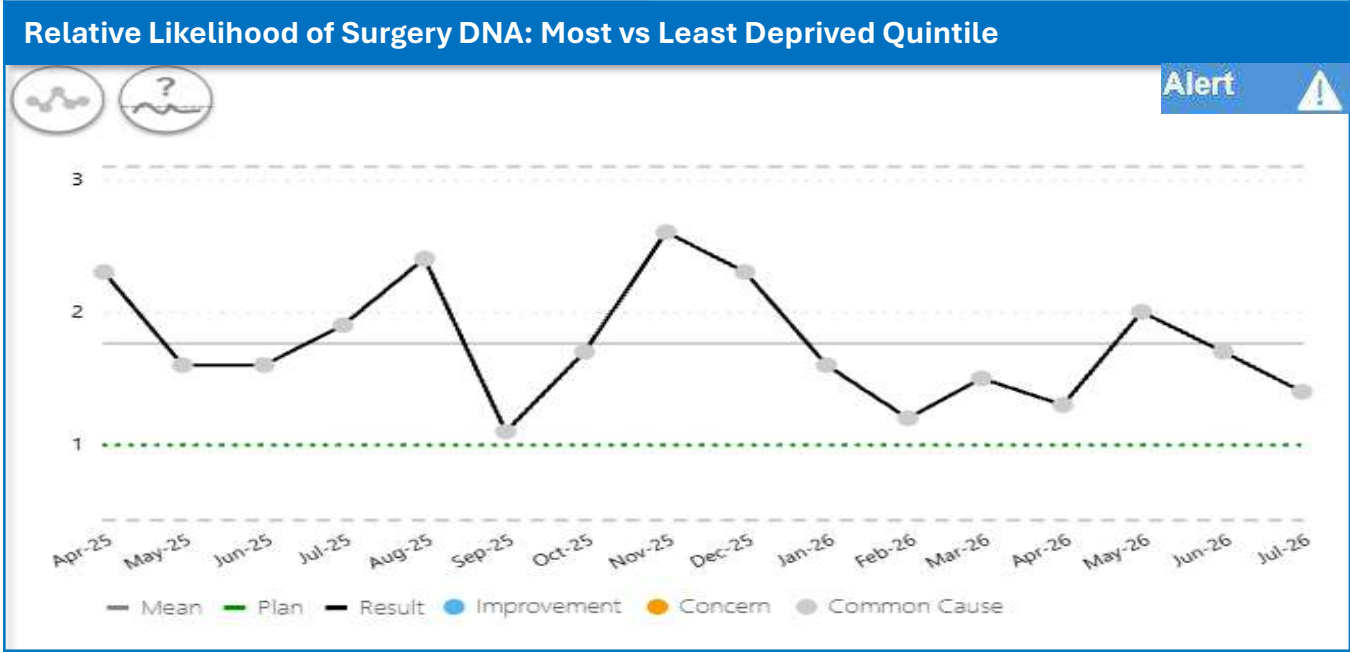
July 26		
Actual	Plan	Variance
1.4	1.0	0.4

Compliance	Variance	Assurance

Metric Definition

Surgery DNA rate ratio shows the gap in missed appointments between the most deprived and least deprived patients linked to their postcode: 1.0 = parity.

This has been included as we want to narrow the gap while reducing the overall DNA rate. If we don't track the gap, there is a risk that the overall rate decreases but the gap between certain demographic group widens.



Understanding the performance

First time presented.
12-month average 1.7; broadly unchanged.

Risks and controls

Persistent 1.7x inequality despite a stable Trust DNA rate shows a stark gap between low and high income groups in terms of their ability to attend appointments.

Actions and timescales

Continue monthly monitoring.
Address and attempt to narrow the gap through DNA predict, communication improvement work and other targeted work.

Measures to note



Measures to note – Quality

Accountable Executive: Kimberley Salmon-Jamieson | Accountable Group: Quality & Safety Performance Board Committee



Key Oversight Performance Metrics

Focus	Compliance	Variation	Assurance	Action status	Performance	Plan / standard	Indicator
Infection Prevention and Control					13	<12.58	Gram negative infections – <i>Klebsiella sp.</i>
Maternity					1	0	Maternity related concerns (MNSI/ NHR/ CQC/ PFD Reports)
Complaints			N/A		173	N/A	Number of formal complaints opened
			N/A		0	N/A	Number of PHSO complaints
Learning from Deaths			N/A		79.5	N/A	Hospital Standardised Mortality Ratio (HSMR)
			N/A		3.31%	N/A	Crude mortality (rolling 12 month)
			N/A		100	N/A	Summary Hospital-level Mortality Indicator (SHMI)

Measures to note

Infection Prevention and Control: 13 *Klebsiella sp.* cases reported in month, continued oversight in place.

Maternity: 1 CQC enquiry received relating to maternity services.

Complaints: 0 PHSO complaints received since previous month, with complaint numbers increasing compared to the previous month.

Mortality: Measures continue to be stable and in line with or better than Shelford peers.

Ambulance Handover

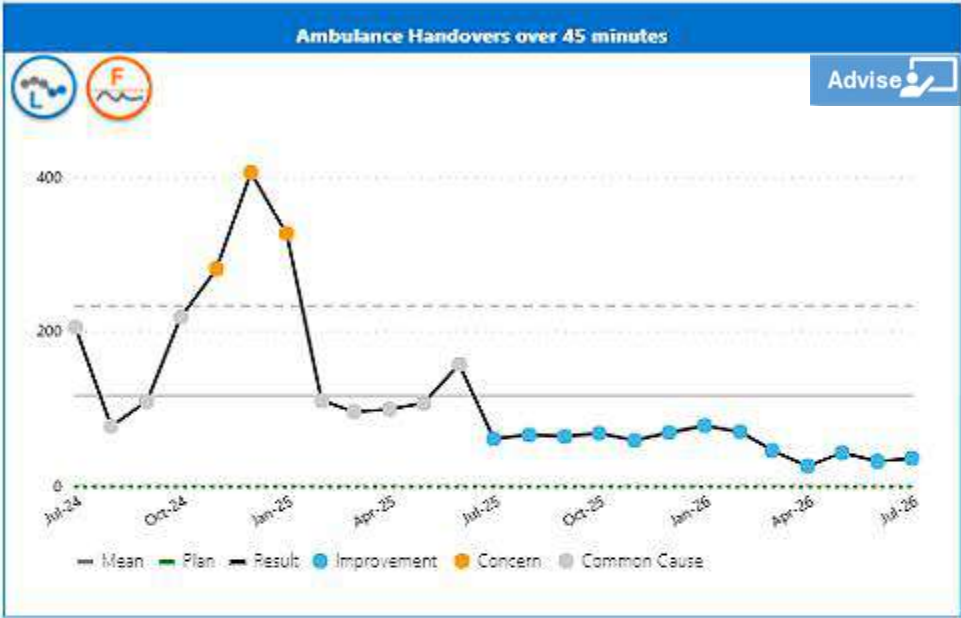
Accountable Executive: Vanessa Gardener | Accountable Group: Quality and Safety Board Committee

Jul-26		
Actual	Plan	Variance
37	0	37

Compliance	Variance	Assurance
		

Clinical Group Overview

NMGH	3
WTWA	10
MRI	24



Understanding the performance

In July 26, there were 37 patients handed over beyond 45 minutes. This compares to 33 in June 26. Performance against <15 min handovers remains below standard (65%) at 57.6%. In July this equated to 3,350 patients. Average turnaround times decreased to 24m 12s (24m 46s in June), and average handover time also decreased to 15m 17s from 15m 51s. Patient handovers over 45 min equates to 0.6% of ambulance attends during June.

Work continues in collaboration with the Northwest Ambulance Service (NWS) to ensure ambulance crews pin out accurately, particularly when taking patients to catheter labs. Pinning out remains the main reason for these breaches.

Risks and controls

The Trust remains committed to continuing to reduce turnaround times. Sustained operational pressures, particularly within catheter lab pathways remain the key challenge along with accurate data recording.

A programme of regular validation, assurance and shared learning with NWS is supporting improvements in data quality and operational processes. weekly performance oversight on all UEC quality metrics. Delivery Oversight Framework provides governance on improvement and to support the elimination of handover delays.

Actions and timescales

A coordinated programme of work with NWS and Clinical Groups remains in place to improve timely pin-outs, with a particular focus on PCI and ambulance handovers during August and September. Directors of Nursing have reviewed and refreshed the Trust's ambulance handover Standard Operating Procedure, strengthening expectations, accountability and site-level escalation processes. Revised monitoring arrangements have also been introduced, providing enhanced oversight of handover performance, SOP compliance and improvement actions at both site and Group level. Delivery is supported through routine performance oversight, assurance processes and site-based improvement activity to strengthen recording accuracy and operational reliability. Performance is improving against baseline measures, with continued focus on embedding standardised processes and delivering sustained improvement across all hospital sites.

Patient Flow

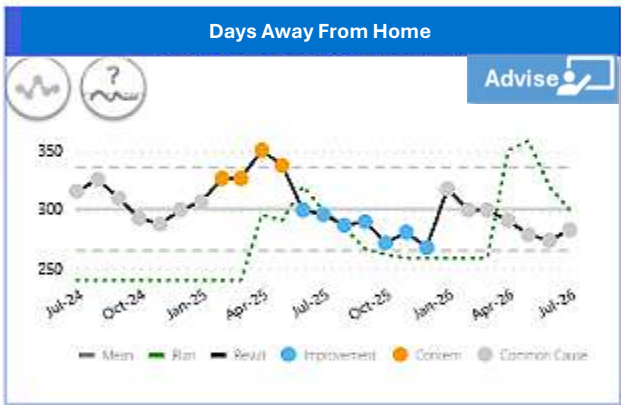
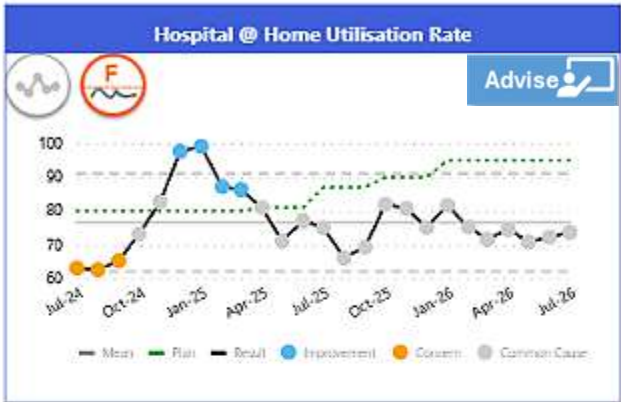
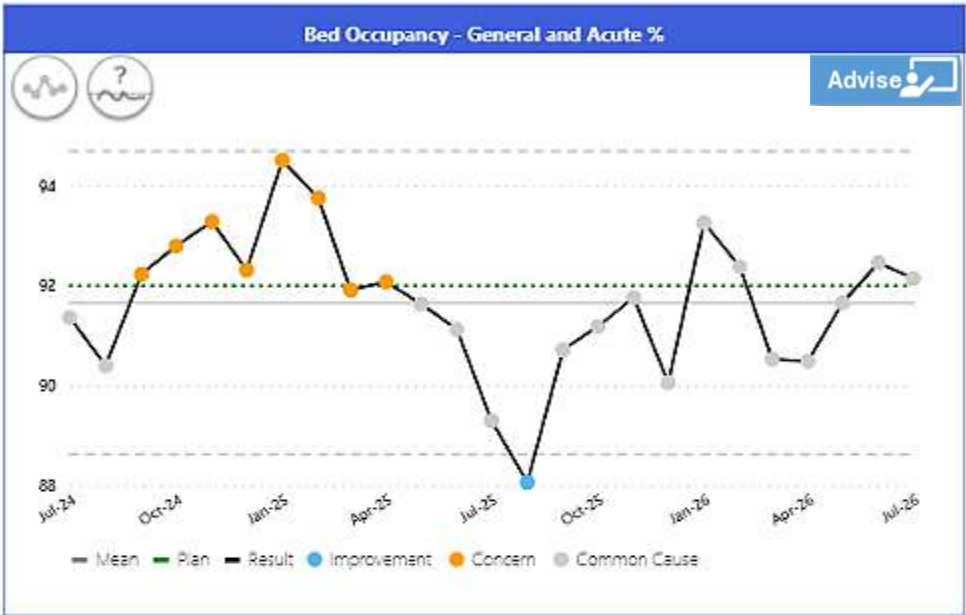
Accountable Executive: Vanessa Gardener | Accountable Group: Quality and Safety Board Committee

Jul-26		
Actual	Plan	Variance
92.1%	92.0%	0.1%

Compliance	Variance	Assurance

Clinical Group Overview

MRI	97.90%	96.6%
WTWA	88.50%	89.1%
North	92.50%	98.8%
Specialist	89.60%	81.6%



Understanding the performance

G&A occupancy reports marginally above plan across MFT in July, with site variation but overall common cause variation.

Days Away From Home averaged 283 NCTR patients per day in July, despite ongoing reablement and MDT improvements. Hospital @ Home performance was 72% providing more care for patients outside hospital for July.

Risks and controls

Higher than plan attendance, high ED acuity and flow remain challenges.

Hospital at Home under occupancy remains a key risk, focus work to increase referrals across adult 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. CCTH silver and gold cycles are now operational which will support collective review of data with acute, community and ASC SLT leads. Updated communications plan for both internal and external stakeholders is being finalised to support awareness and utilisation of Hospital at Home and SPOA. Acute telemedicine on track to co-locate with SPOA by end of September 2026.

Diagnostic Waiting Times

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

Jul-26		
Actual	Plan	Variance
9.03%	8.43%	0.60%

Compliance	Variance	Assurance

Clinical Group Overview		
MRI	3.0%	4.1%
WTWA	19.9	16.1%
CSS	3.8%	3.8%
North	0.0%	13.5%
Speci...	59.7%	51.1%
LCO...	0.0%	0.0%

Understanding the performance

In July, there were 1095 less patients on the diagnostic waiting list than plan at 32,823 patients (plan 33,918) with 9.0% (2,955) of patients waited over 6 weeks for their test(0.57pp more than plan).

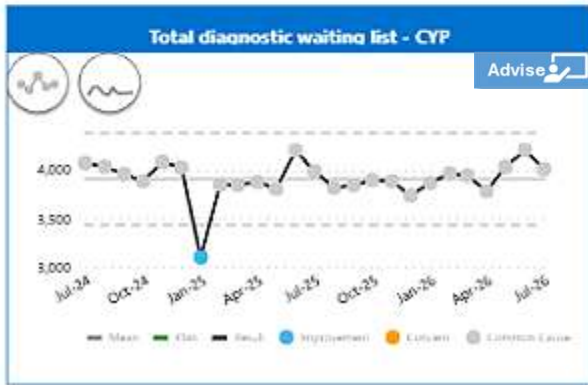
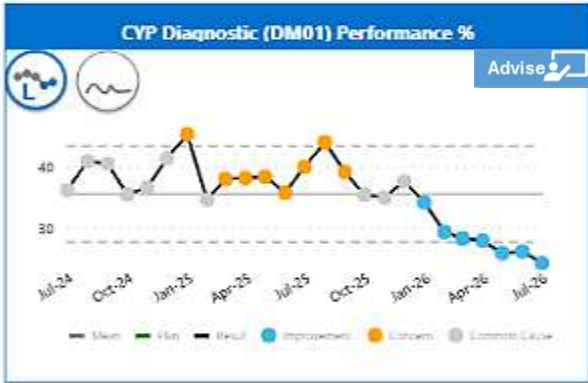
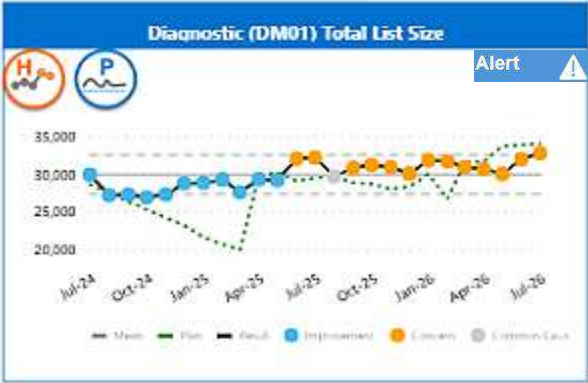
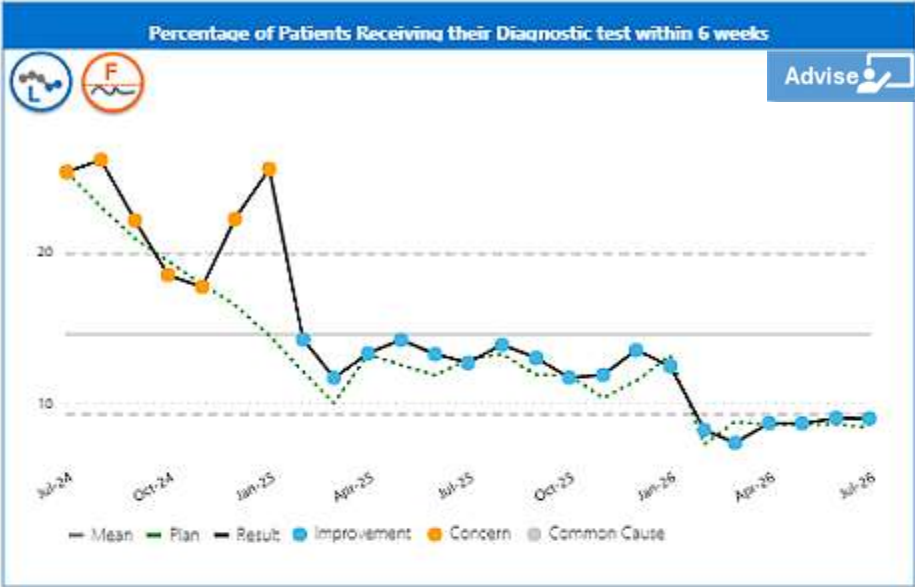
This was driven in in the main by adult Sleep Studies which have seen a 20% demand increase above plan, alongside Paediatric diagnostics being higher than plan linked to specialist equipment and workforce.

Risks and controls

The waiting list size, particularly in children and young people (CYP) is increasing and therefore additional diagnostic tests will be required to be undertaken. CYP capacity remains constrained for MR sedation lists and theatre access for sedated endoscopy, affecting gastroscopy performance and limited equipment impacting CYP respiratory physiology. Sleep demand increases since January remains and is under discussion with the ICB. Order wisely work programme and planned care transformation programmes in place.

Actions and timescales

For CYP an improvement plan is in place and we continue to maximise all available capacity to support the position and rising demand in addition to utilising an additional scanner and additional equipment to support backlog reduction. Weekend insourcing in place for Gastroscopy and additionality planned in August for Urodynamics. A business case for Sleep in development for end August and the forecast is to return to plan for October.



Elective Referral to Treatment (RTT) standards

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

Jul-26		
Actual	Plan	Variance
63.88%	64.73%	0.85%
Compliance	Variance	Assurance

Clinical Group Overview

MRI	31,753	32234
WTWA	38,765	36576
CSS	4,563	4028
North	27,199	26926
Specialist	52,325	50745
LCO Dental	11,491	11428
Unallocated	680	345

Understanding the performance

63.88% of patients were seen within 18 weeks in July, 0.85pp below plan.

Patients waiting over 52-weeks continue to reduce. For the first time, RTT performance has fallen below plan.

The overall waiting list size remains off plan in July, with an additional 4,494 patients.

Demand has increased and is being investigated with the ICB to understand key drivers in order to develop plans to address.

Risks and controls

Demand increases are creating a risk to delivery. This is being addressed with system colleagues.

Improvement at the required pace is also a key risk.

Weekly reporting is in place, with oversight through the established delivery Oversight Framework. Care on Time programme is in place to drive elective and outpatient transformation

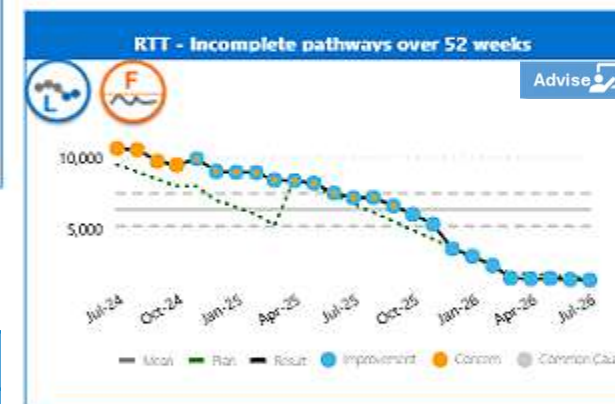
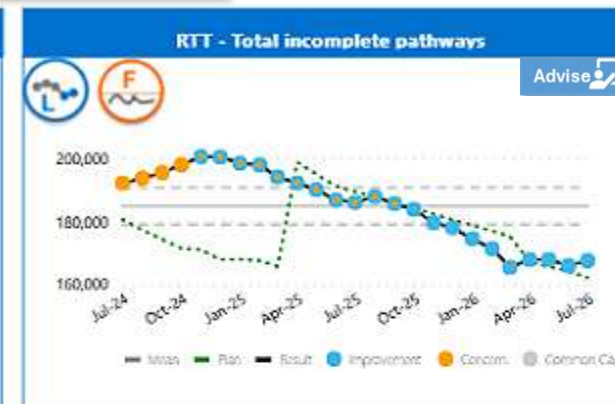
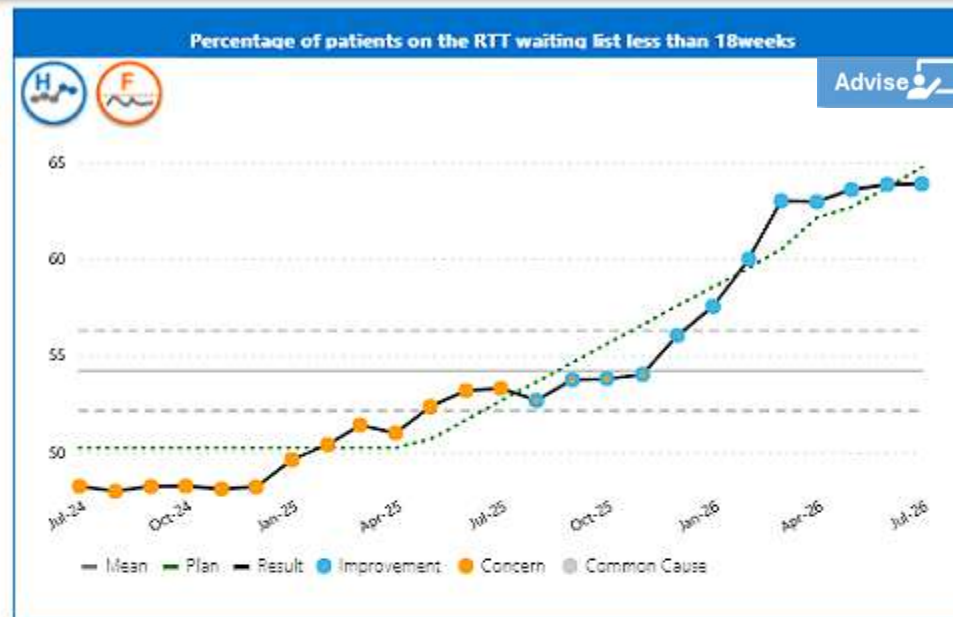
Actions and timescales

Clinical Groups have delivery plans in place which are due to be completed in September.

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

Milestones are in place from October onwards.

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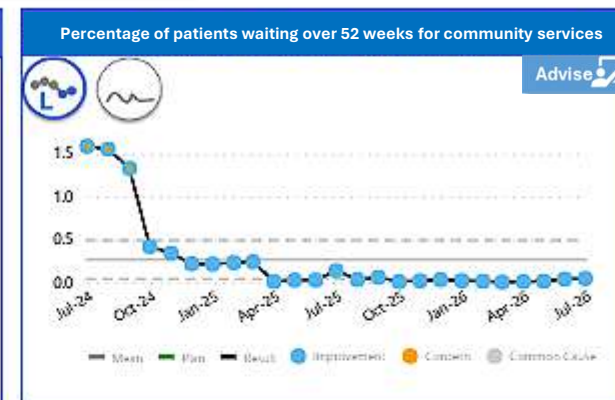
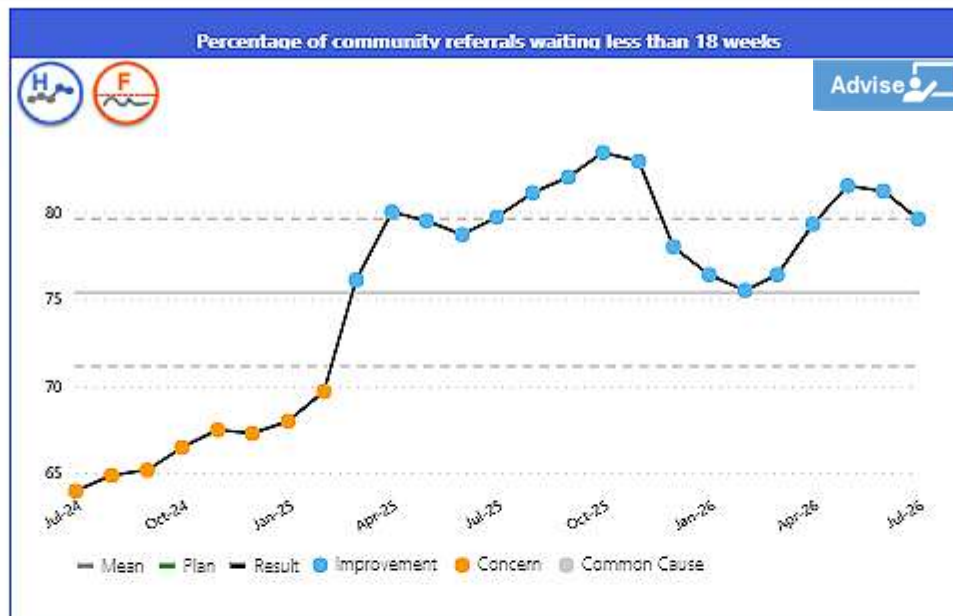


Elective Waiting Times in the Community

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'

Jul-26		
Actual	Plan	Variance
79.6%	82.8%	-3.2%

Compliance	Variance	Assurance



Understanding the performance

The Community 18-week performance is exceeding the national 26/27 ambition of 78%; however, July RTT delivery has fallen by 1.6% to 79.6% compared to the previous month. The total waiting list has decreased by 453 patients (2.3%) compared to the previous month. There were 8 (0.04%) patients who waited over 52-week in July with work underway to manage 52-week risk. Crisis performance continues to be above the national average.

Risks and controls

Neurodevelopmental patient pathways remain a key operational risk, with sustained growth in demand driving long waits and increasing ADHD waits.

Oversight is in place through the Delivery Oversight Framework.

Actions and timescales

Action plan in place to mitigate immediate capacity shortfalls.

Recovery plans and transformation initiatives are being progressed with GM ICB to improve capacity and support long-term sustainability. Service reviews to be completed in September for Podiatry and Bladder & Bowel to support development of recovery plans.

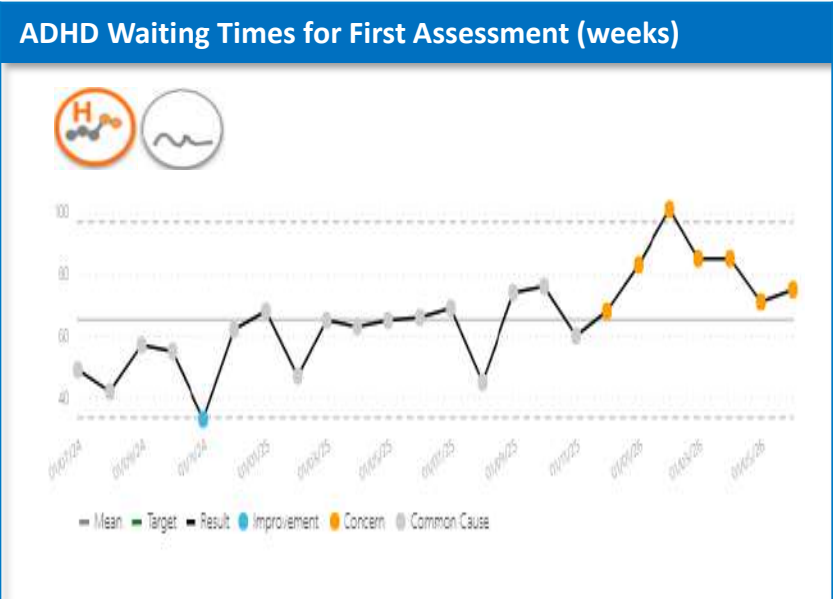
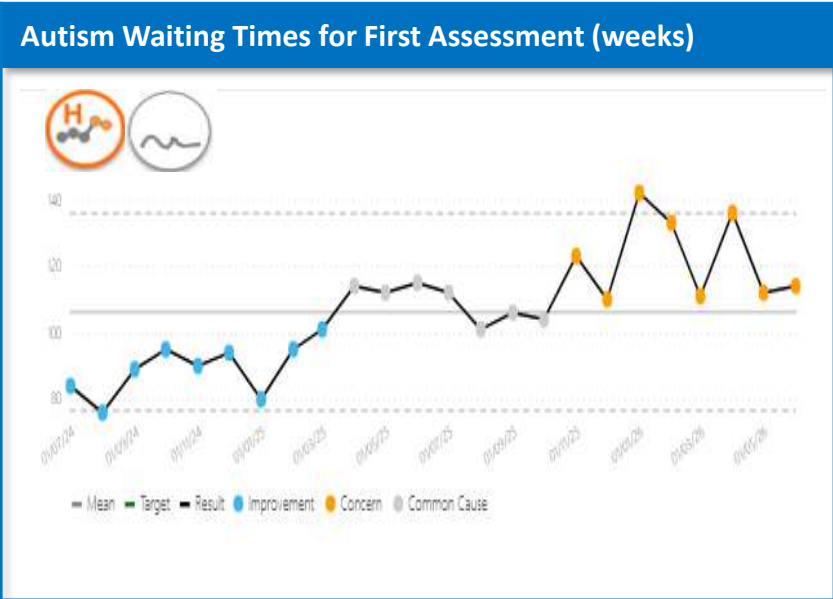


Neurodiversity waiting times (CAMHS)

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

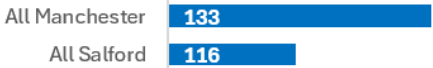
	July- 26	Plan
Autism	126	-
ADHD	91	-

	Compliance	Variance
Autism		
ADHD		

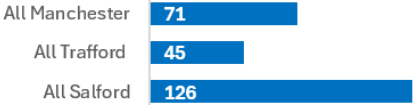


Overview – July 26

Autism average wait by Borough



ADHD average wait by Borough



Understanding the performance

Patients awaiting autism assessment, shows variation, with waits averaging 126 weeks for first assessment, in July, an increase from June (112). The longest waits were in Manchester (133 weeks).

ADHD assessment waits also show concerning variation, averaging 90 weeks for first appointment and increase from June (75), with the longest waits in Salford at 126 weeks.

Demand for neurodevelopmental assessments (Autism and ADHD) continues to exceed CAMHS capacity and funding. Shared approach to MDT triage as per newly commissioned specification being mobilising, including a needs led model. £525k funding to re-triage the MFT ND waiting list.

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 from April 2027.

Actions and timescales

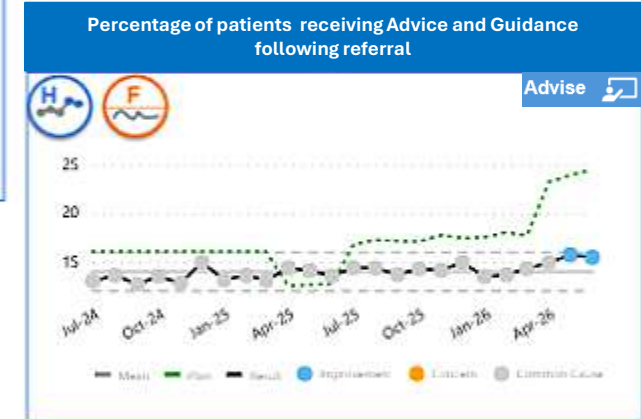
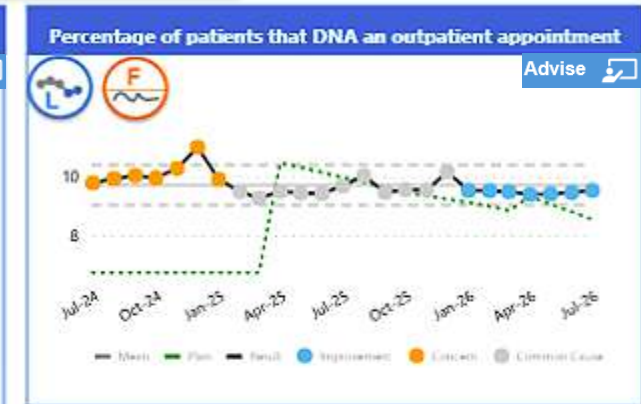
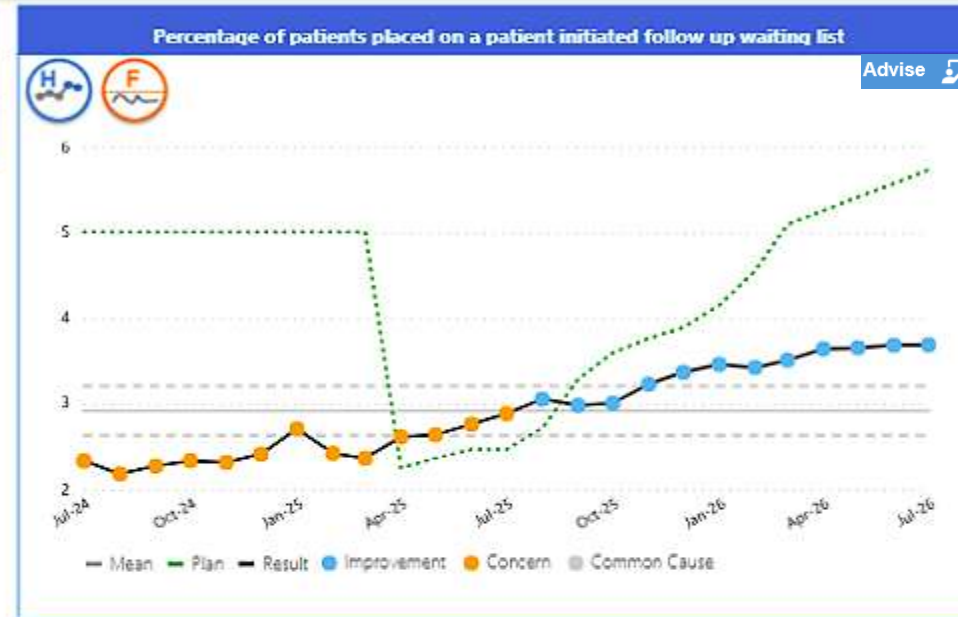
CYP ND – Autism and ADHD: A full business case is being finalised for submission to GM ICB in September 2026, outlining c.£3m recurrent investment requirements to support implementation of the new GM needs-led ND pathway across Manchester and Trafford. This includes investment to deliver the MDT needs-led triage (£1.1m) and additional capacity to address the gap between demand and commissioned activity for new referrals (£1.9m). In the interim, MFT has received £525k non-recurrent funding to support delivery of longest waits and priority cohorts, with mobilisation underway across LCO and CAMHS services. ND Needs Led Model being mobilised New triage model official launched 16th July at North Star (Manchester). Engagement events continue with young people and parent/ carers.

Outpatient Productivity

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

Jul-26		
Actual	Plan	Variance
3.7%	5.7%	-2.0%

Compliance	Variance	Assurance



Understanding the performance

PIFU performance continues to show improving variation although remains below plan at 3.7% in July against the 5.7% plan (-2pp).

Risks and controls

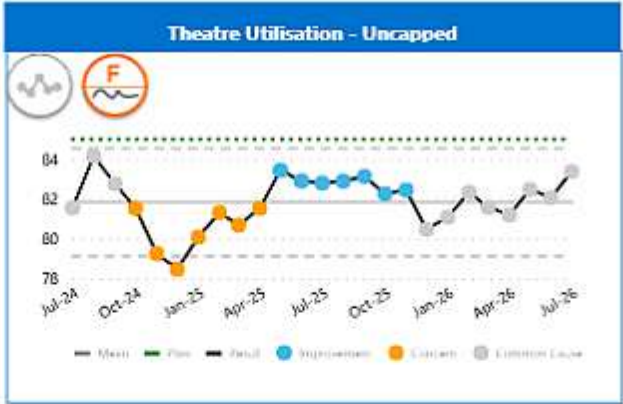
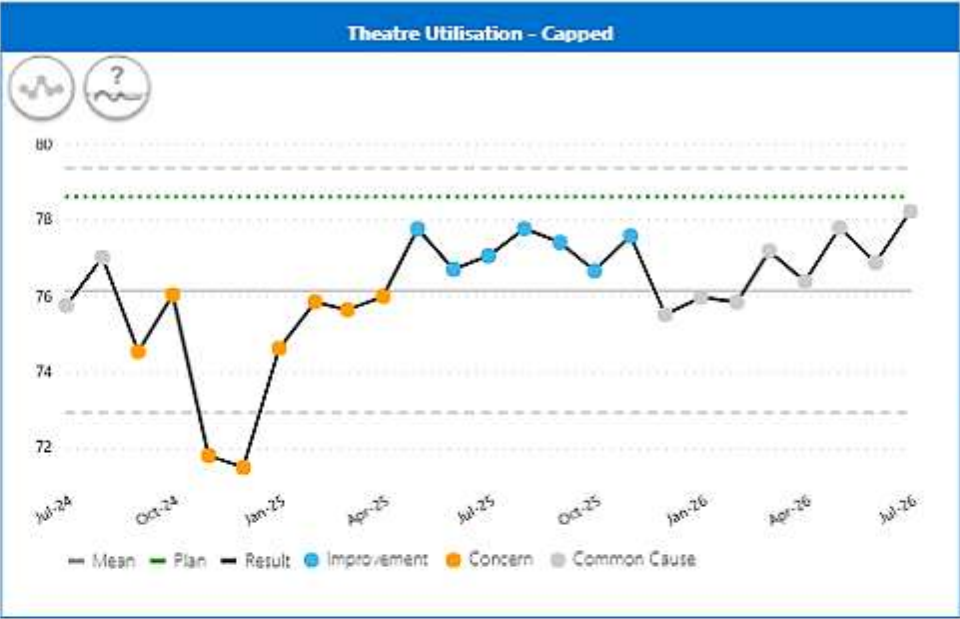
There remains a risk of under-delivery against planned activity levels, resulting in additional follow-up demand and reinforcing the need for service transformation. Clinical Groups have defined productivity targets within annual plans, supported by established monitoring arrangements and performance oversight to maintain visibility and drive delivery.

Actions and timescales

Work is ongoing to enable PIFU at scale through digital tools to enable proactive clinical identification to increase uptake, strengthened tracking/reporting of PIFU cohorts, and consistent pathway management to convert demand. GIRFT follow up pathway implementation as part of Care on Time programme.

Jul-26		
Actual	Plan	Variance
78.2%	78.6%	-0.4%

Compliance	Variance	Assurance



Understanding the performance

Theatre utilisation remains statistically stable, with July delivery at 78.2% against a 78.6% plan (-0.4pp). Performance is above the current mean (~76%) and consistent with recent months, but not yet reliably at plan.

Trafford Elective Hub achieved 85.8% utilisation in July, up 0.5 percentage points from 85.3% in June, including insourcing.

No other site met the 85% standard. Late starts at NMGH, Wythenshawe and MRI continue to reduce utilisation.

Risks and controls

Theatre flow is not optimised, resulting in delays, activity below plan, additional costs, and failure to meet RTT performance and productivity requirements.

Improving theatre productivity is a key focus of the Care on Time Programme’s Theatre Improvement workstream, with focus on best-practice scheduling and daily operational oversight, supported by strong governance and quarterly sprints to test and embed improvements.

Actions and timescales

Theatre Booking & Scheduling Gold Standards: SOP finalised and submitted to COT for approval. Clinical Groups are now implementing the agreed standards across elective theatre services.

On-the-Day Operational Processes: Standard processes and escalation arrangements have been agreed and are being implemented. Daily operational huddles resumed in July 2026. Progress varies across sites, with further work ongoing to address local challenges and improve consistency.

Elective Theatre Focus Weeks: Quarterly focus weeks continue in line with GIRFT Hub Optimisation Weeks to test, embed and spread theatre productivity improvements.

Financial performance against budget YTD (£m)

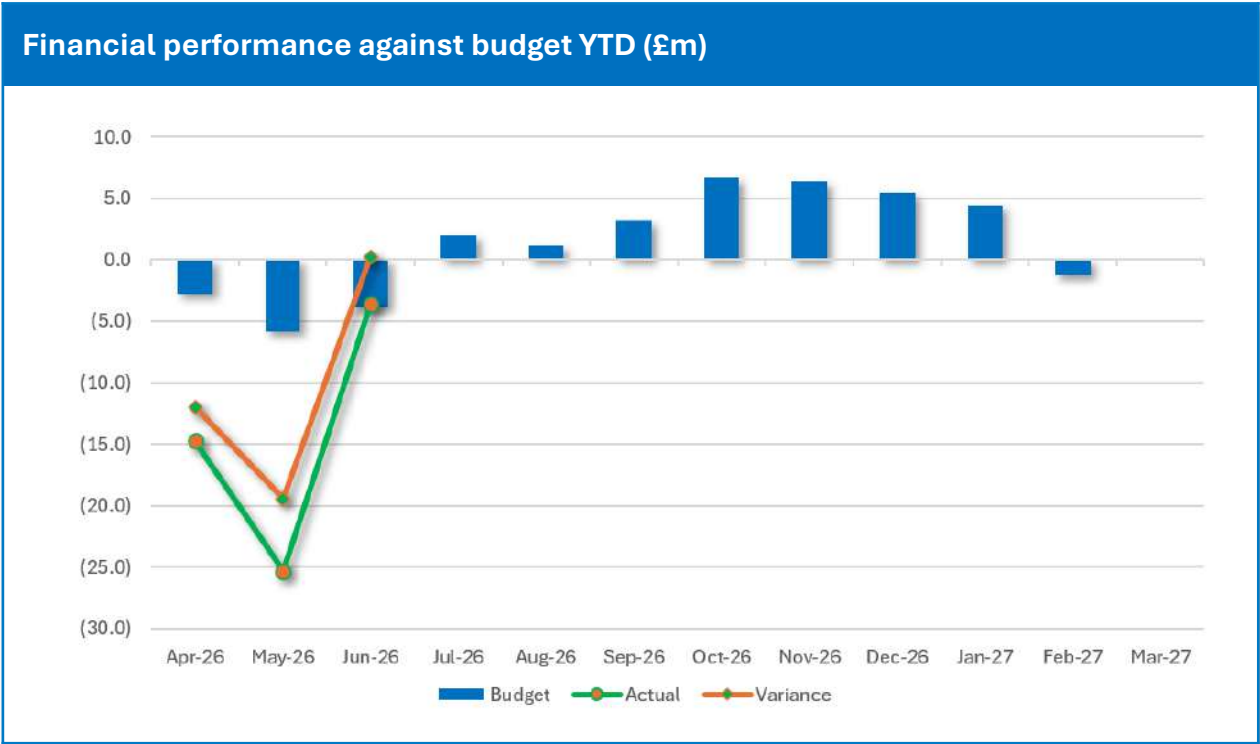
Accountable Executive: Claire Wilson | Accountable Group: Finance Board Committee

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

Advise 

Jul-26		
Actual	Plan	Variance
£m	£m	£m
2.0	2.0	0.0

Compliance	Variance	Assurance	Actions
			



Clinical Group breakdown		
Rank	Clinical Group	YTD Value £m
1	NMGH	(0.62)
2	LCO & Dental	(1.61)
3	WTWA	(6.93)
4	MRI	(7.75)
5	CSS	(10.18)
6	SHCG	(12.27)

Understanding the performance

Month 4 delivered in line with plan, although supported with material non-recurrent and technical items. These include PFI deductions for emergency lighting, VAT benefits following the 25/26 year end review, and recognition of partially completed spells income.

Risks and controls

VfP under-delivery and scheme maturity remain the main drivers of financial risk. Improved forecasting and reporting process in place from month 4 to support scenario planning and a deeper understanding of underlying run rates.

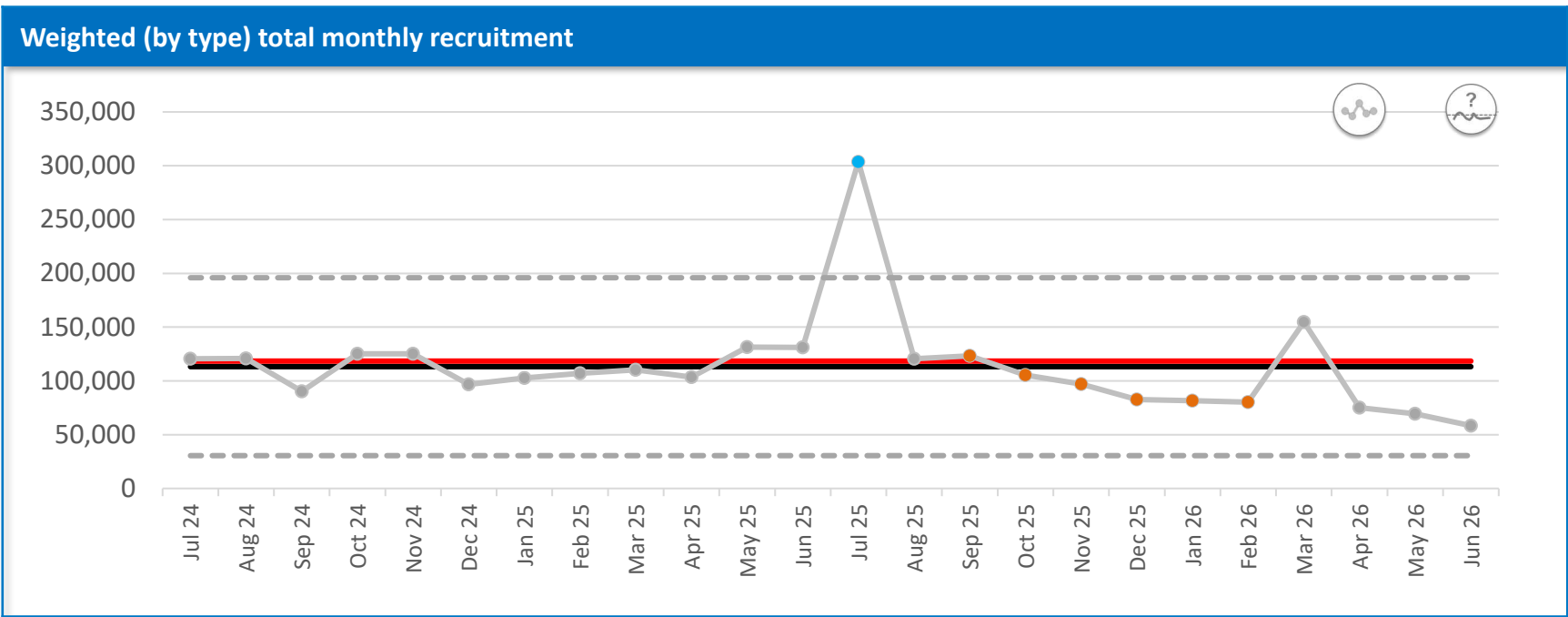
Actions and timescales

A tiered financial oversight and support framework is being implemented immediately to focus executive intervention on the areas with greatest delivery risk.

Jun-26	Target
58,349	118,375

Compliance	Variance	Assurance	Actions

Status
Advise



2025						2026					
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2634	1547	1676	1567	1412	1194	1105	1083	1992	1022	911	800

Non weighted recruitment

Updates since previous month

Lower recruitment in June compared to previous months. Changing status to Advise due to decreases in successive months.

Key dependencies

This metric is about recruitment of participants which is weighted based on the study type as defined by the Research Delivery Network (RDN). Weighted recruitment is one measure which impacts RDN funding.

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Current issues

Balancing capacity to recruit with follow-up of patients already on trials.

Future actions

Focus on recruiting participants into more highly weighted studies to increase our weighted recruitment to maximise patient benefit and sustainability of our workforce through RDN funding. Implementation of study scoring tool from 1st May 2026.

Commercial Study Initiation – Set-up

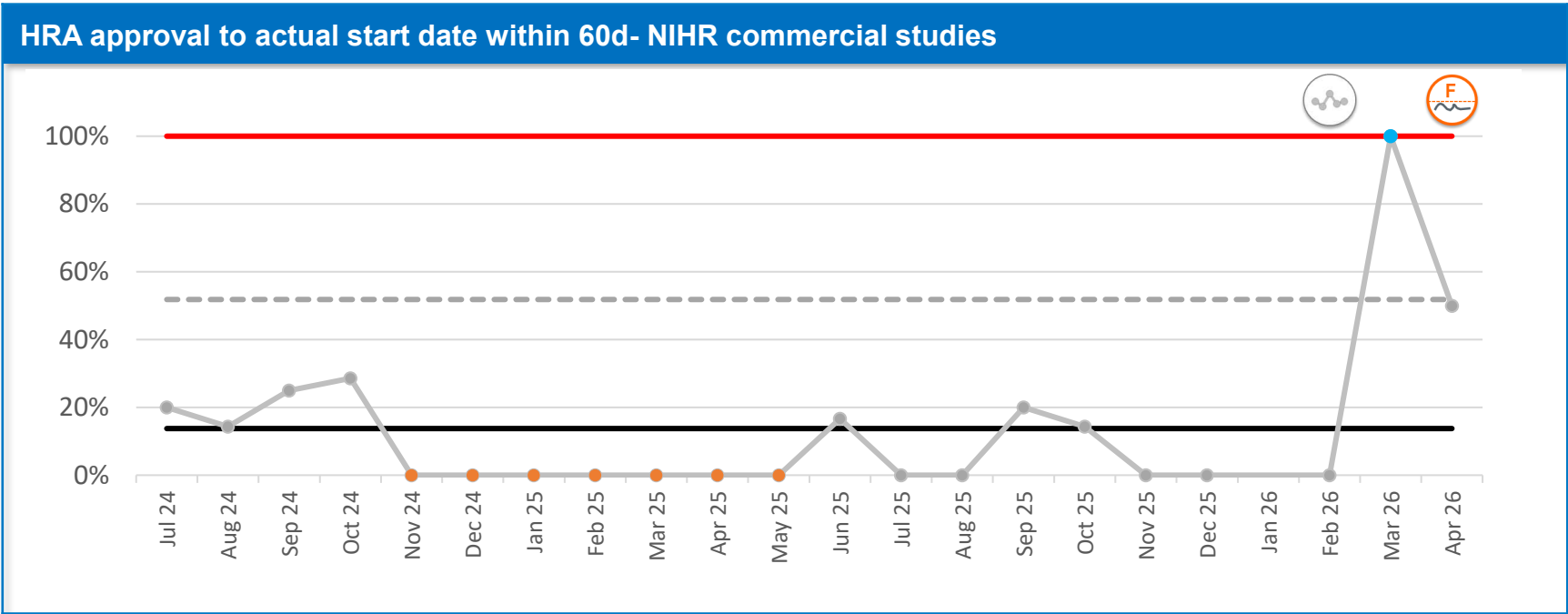
Accountable Executive: Matt Makin & Sohail Munshi | Accountable Group: Research and Innovation Board Committee

Apr-26	Target
50%	100%

Compliance	Variance	Assurance	Actions

Status
Advise

Month	Total studies	% HRA apr to start 60d
Feb-26	1	0%
Mar-26	1	100%
Apr-26	2	50%
May-26	0	N/A
Jun-26	0	N/A



Updates since previous month

Several studies have opened in the last 3 months, but they have HRA approval dates prior to April 2025 and so are not included in these metrics. Quarterly data is showing a positive decline in the number of days from site selected to confirmation of capacity and capability. Study approved in February took 61 days, so 1 day over target.

Key dependencies

This metric is about approval speed for commercially clinical trials approved at MFT each month. Metric only counts studies with a start date defined within time period of observation.

Current issues

This is one of the two UK Clinical Research Delivery metrics run nationally by NIHR which are publicly available for use by commercial sponsors and contract research organisations to see how sites perform.

Future actions

Maintain full staffing of research operational and research office staff to enable efficient set-up of studies. Weekly performance meeting in place.

Measures for assurance



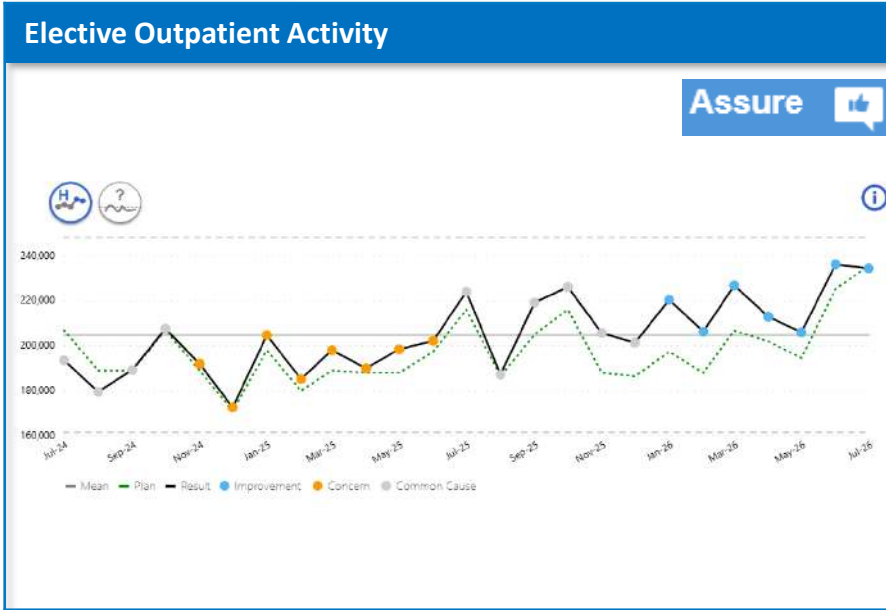
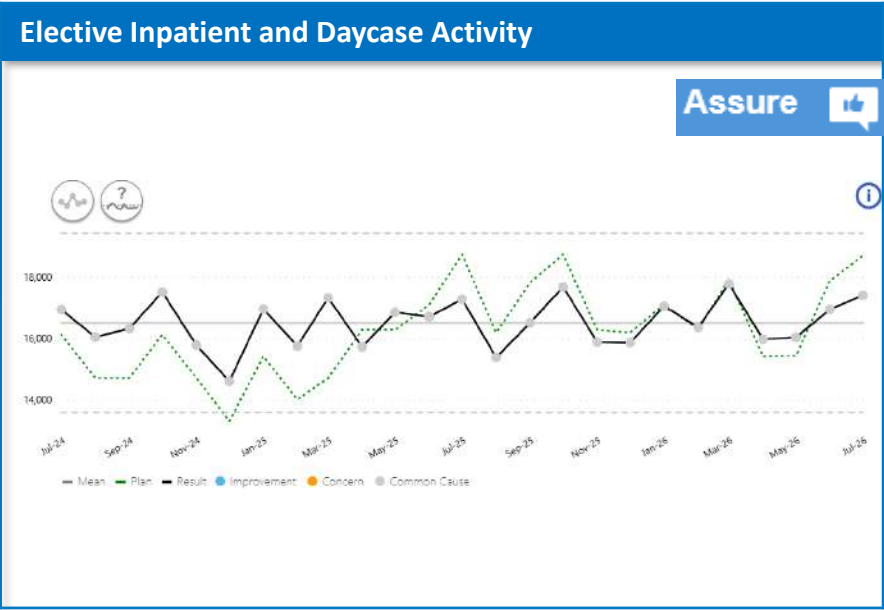
Measures for Assurance – Quality

Accountable Executive: Kimberley Salmon-Jamieson | Accountable Group: Quality & Safety Management Committee

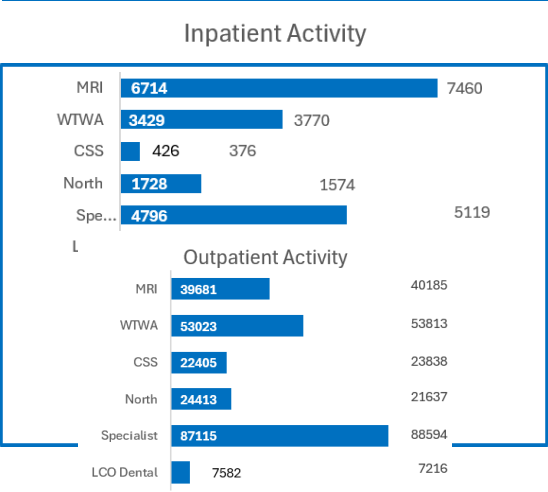
Key Oversight Performance Metrics							
Focus	Compliance	Variation	Assurance	Action status	Performance	Plan / standard	Indicator
Infection Prevention and Control					0	0	Trust attributable MRSA Bacteraemia
					11	<15.75	Trust attributable <i>Clostridioides difficile</i> infection
					23	<23.83	Gram negative infection – <i>E.Coli</i>
					0	<2.33	Gram negative infection – <i>Pseudomonas sp.</i>
Maternity					2.89	<4/1000	Neonatal deaths per 1000 live births
					4.34	<6/1000	Stillbirths per 1000 live births (excluding termination of pregnancy)
					0	N/A	Number of maternal deaths
					3	<4	Number of maternity incidents with moderate harm and above
					5.1%	<6	Term admissions to the Neonatal Unit
					95.2%	>90%	Initial assessment time in maternity triage – 30 minutes
					6.38%	<20%	Augmentation of labour pathway delays
					47	<4	Births outside of intrapartum birth setting
					0	<0.75	Number of babies with suspected hypoxic-ischemic encephalopathy grade 2/3
					N/A	0	Number of incidents accepted for MNSI investigation
Patient Experience					95.9%	95%	Patient Experience Survey (Overall Performance Score)
Learning from Deaths					0	0	Prevention of Future Deaths reports impacting the Trust

July- 26	Actual	Plan	Variance
Inpatient	17,401	18,687	-1,064
Outpatient	234,219	235,283	271

	Compliance	Variance	Assurance
IP			
OP			



Overview – July 26



Understanding the performance

Inpatient activity shows common cause variation for delivered activity in inpatients and daycase elective treatment. July Performance reported below plan -1,064.

Outpatient activity also shows common cause variation for delivered activity in outpatients. July Performance continues to deliver better than plan +271.

Risks and controls

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

CG activity plans in place and monitoring in place.

Actions and timescales

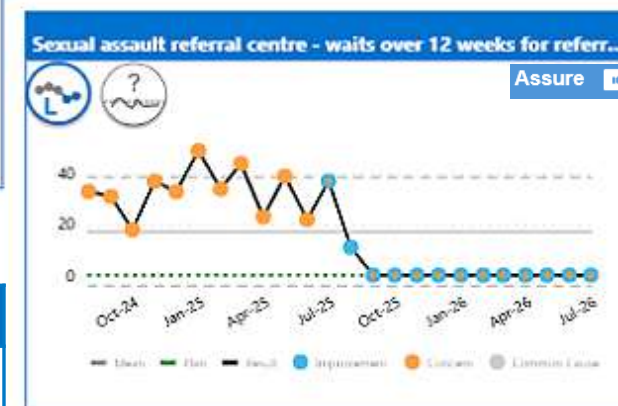
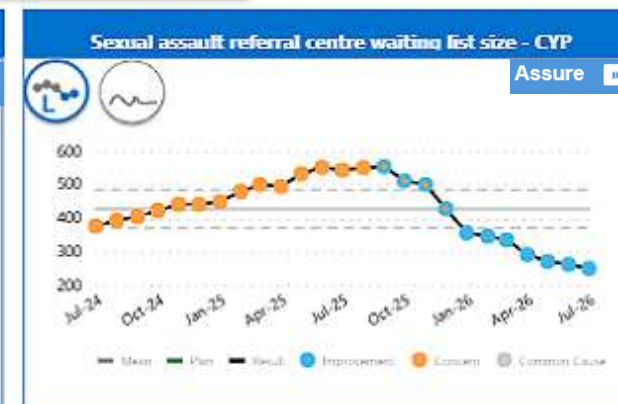
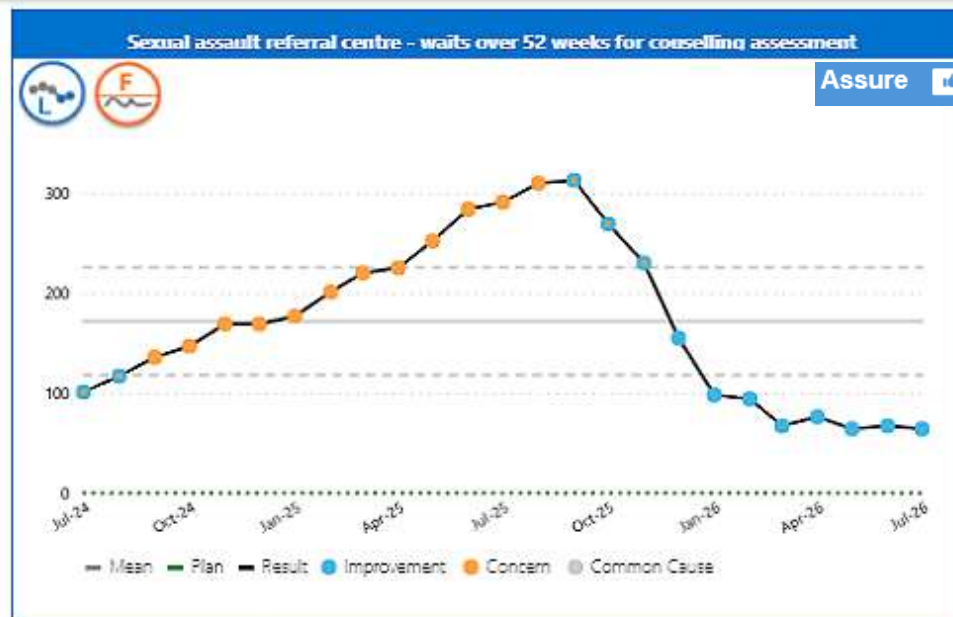
Ongoing demand and capacity planning, supported by strengthened activity monitoring, underpins delivery against agreed trajectories and provides in-year oversight with commissioners.

Sexual Assault Referral Centre waiting times

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

Jul-26		
Actual	Plan	Variance
64	0	64

Compliance	Variance	Assurance



Understanding the performance

Following a slight increase in June, when the longest wait reached 67 weeks, waiting times for Counselling have reduced by three weeks this month to 64 weeks in line with May levels.

The changes in referral criteria have continued to reduce the volume of referrals we have received.

Wait times for assessment remain within the 30-day KPI.

Risks and controls

The key risk remains workforce, with increased absence and vacancy.

Actions and timescales

Workflow review currently taking place.

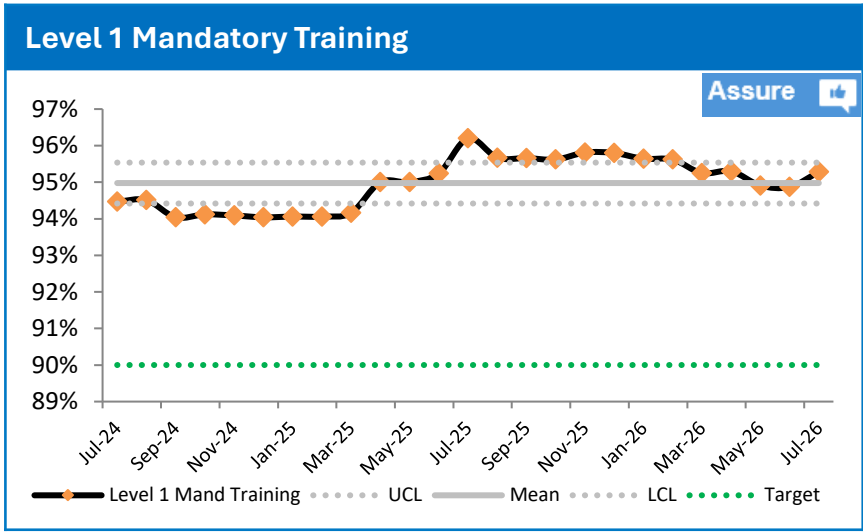
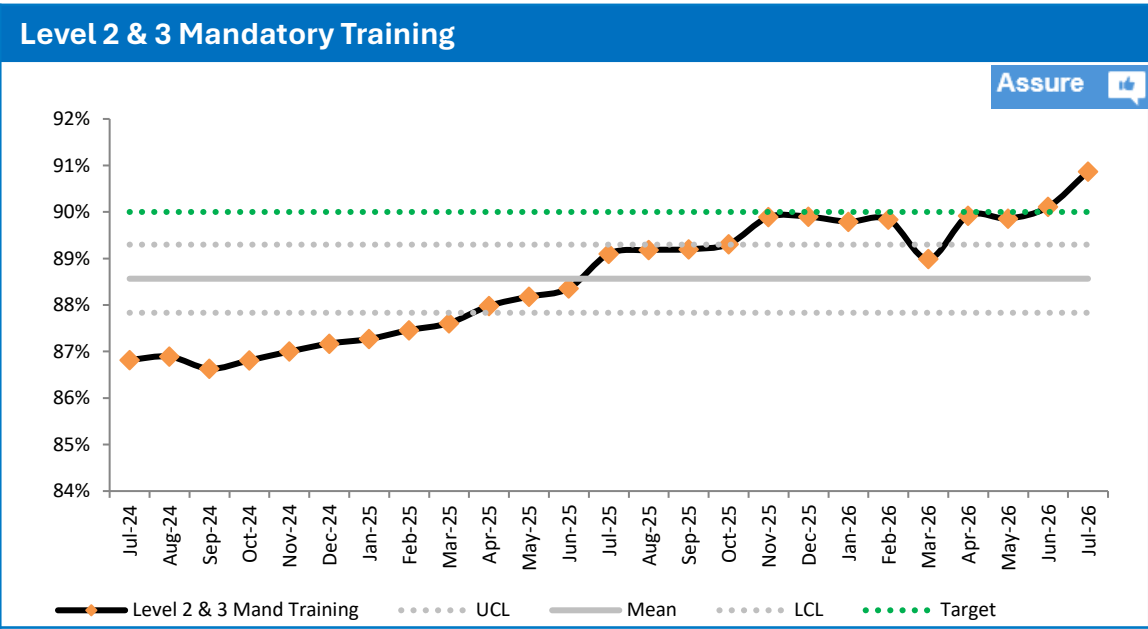
Current vacancies are within the recruitment process.

Mandatory Training: Level 1 and Level 2 & 3

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

July-26	Target
Lvl 1 95.3%	90.0%
Lvl2&3 90.9%	90.0%

	Compliance	Variance	Assurance	Actions
Lvl 1				
Lvl2&3				



Understanding the performance

In July 2026, MFT reported compliance of 95.3% for Level 1 mandatory training and 90.9% for Level 2 and 3 mandatory training, both exceeding the Trust target of 90%. Level 2 and 3 compliance has now remained above target for two consecutive months, reflecting the sustained focus on mandatory training across the organisation and continued improvement in compliance performance.

Risks and controls

Compliance remains below target in only a small selection of either Clinical groups or Staff groups for the Trust.

Operational pressures and competing priorities are likely contributing to lower completion rates in these parts of the organisation.

Actions and timescales

1. Targeted communications to reinforce the importance of mandatory training.
2. Detailed Mandatory Training compliance reports for the steering committee.

Clinical Group breakdown (Level 2 & 3)

Facilities	100.0%
Research	95.5%
Corporate	91.3%
LCO & UDH	94.9%
Specialist	90.3%
CSS	90.3%
NMGH	91.4%
WTWA	89.1%
MRI	90.4%

Staff WTE: Substantive, Bank and Agency

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

July-26	Target
29,822	29,884

Compliance

Variance

Assurance

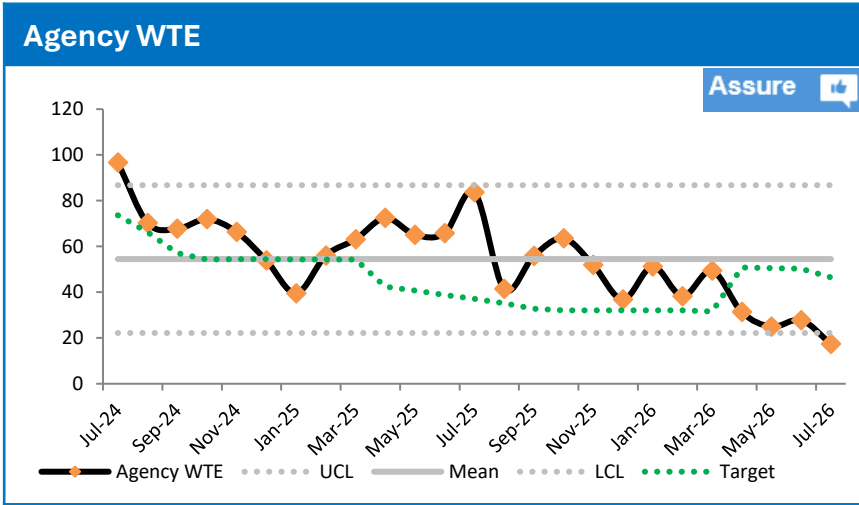
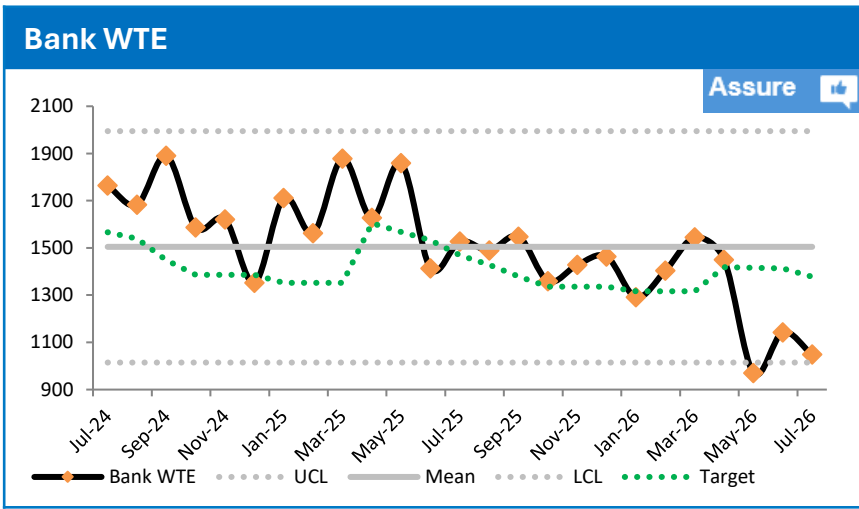
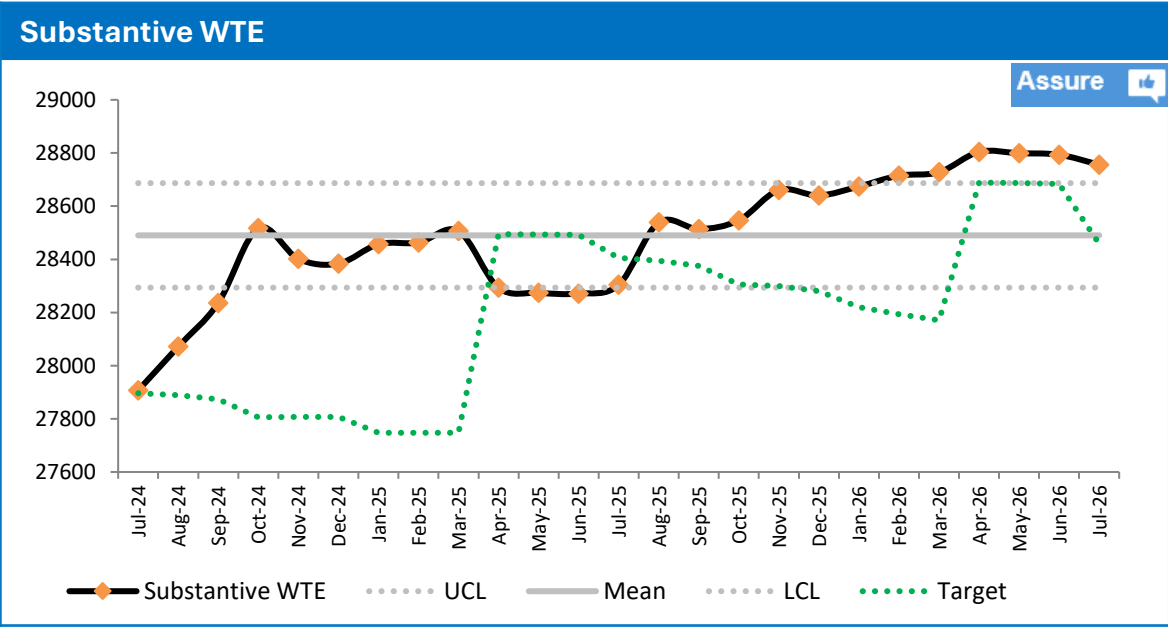
Actions

✓

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✓



Understanding the performance

Total staffing WTE is 62 below the Annual plan for July 2026. This variance is predominantly driven by temporary staffing with bank (-330 WTE) and agency (-29 WTE) usage exceeding expectations for this reporting month.

Substantive WTE remains above plan by +297 WTE, although this has reduced slightly by 37 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 7.9% impacts on organisational churn / reduction.

- #### Actions and timescales
- Enhanced scrutiny of agency bookings through workforce dashboards
 - Ongoing work continues with triangulation of income back changes and potential growth relative to 2026/27 annual planning.
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Turnover

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

July-26

Target

7.9%

11.0%

Compliance

Variance

Assurance

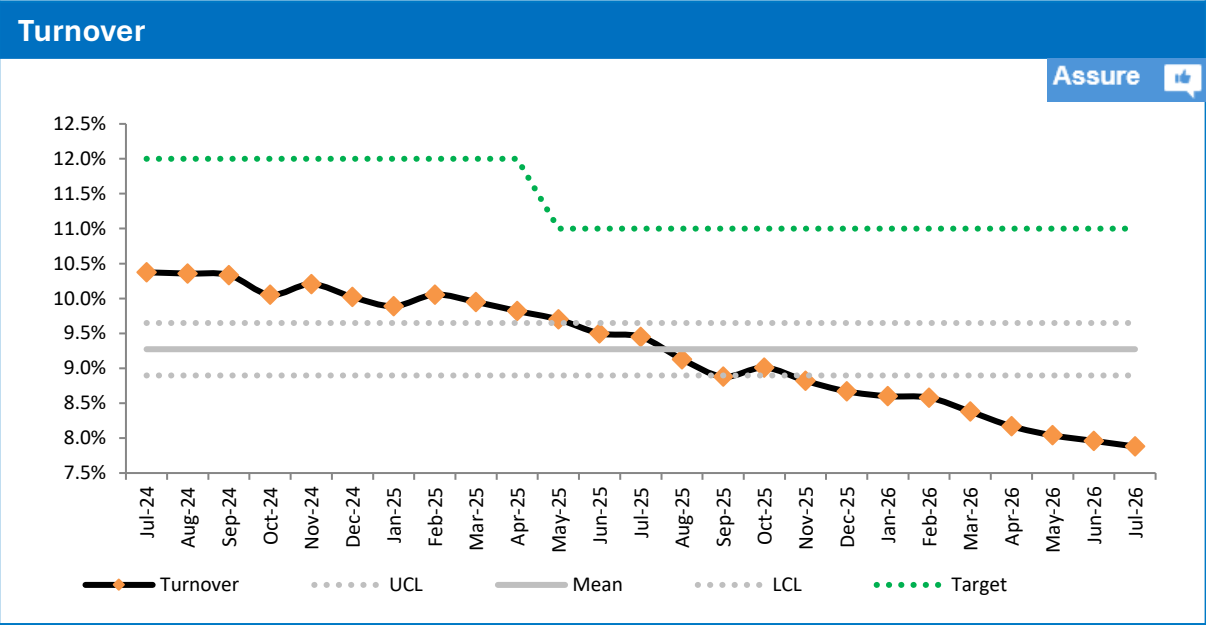
Actions







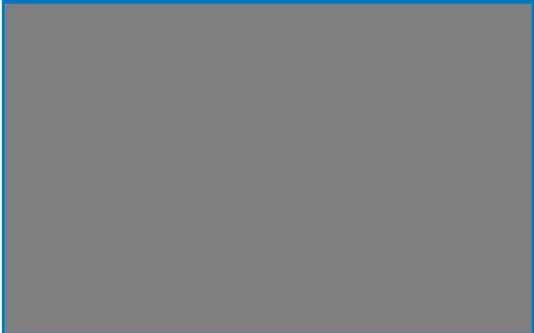




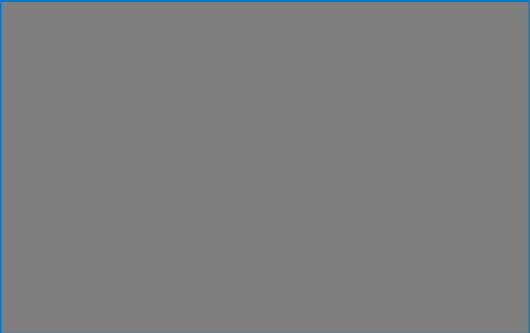
Understanding the performance

Turnover for July 2026 is 7.9%, continuing the sustained downward trend observed over the past two years and remaining well below the 11.0% threshold. Performance has steadily improved from 10.4% in July 2024 to the current level, with particularly consistent reductions throughout 2025 and into 2026.

Risks and controls



Actions and timescales



Measures for assurance – Finance

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

Key Oversight Performance Metrics							
Focus	Compliance	Variation	Assurance	Action Status	Performance	Plan	Indicator
Finance and Commercial					14.53	0.0	Income including Elective - variance to income in finance plan (£m)

Measures for assurance - Digital

Accountable Executive: David Walliker | Accountable Group: Digital

Key Oversight Performance Metrics: June 2026						
Compliance	Variation	Assurance	Action status	Performance	Plan	Indicator
				92.31%	90.00%	Freedom of Information Requests (FOIs)
				98.07%	90.00%	Subject Access Requests (SARs)
				9Hrs 30mins	<= 15Hrs	Clinical and Operational Unplanned Downtime

Commentary

FOI: The performance improvement delivered in recent months continues to satisfy ICO expectations with ongoing positive engagement. Remained above target (90%) for last two months, with backlog continuing to decrease.

SAR: Remained above target (90%) for last seven months, with backlog continuing to decrease.

Clinical and Operational Downtime: Performance represents an aggregate of all types of downtime at individual service level across the Trust. It equates to four incidents, two Laboratory system issues, one Service Desk system issue, and one Service Desk telephony outage.

Active studies

Accountable Executive: Matt Makin & Sohail Munshi | Accountable Group: Research and Innovation Board Committee

Jun-26

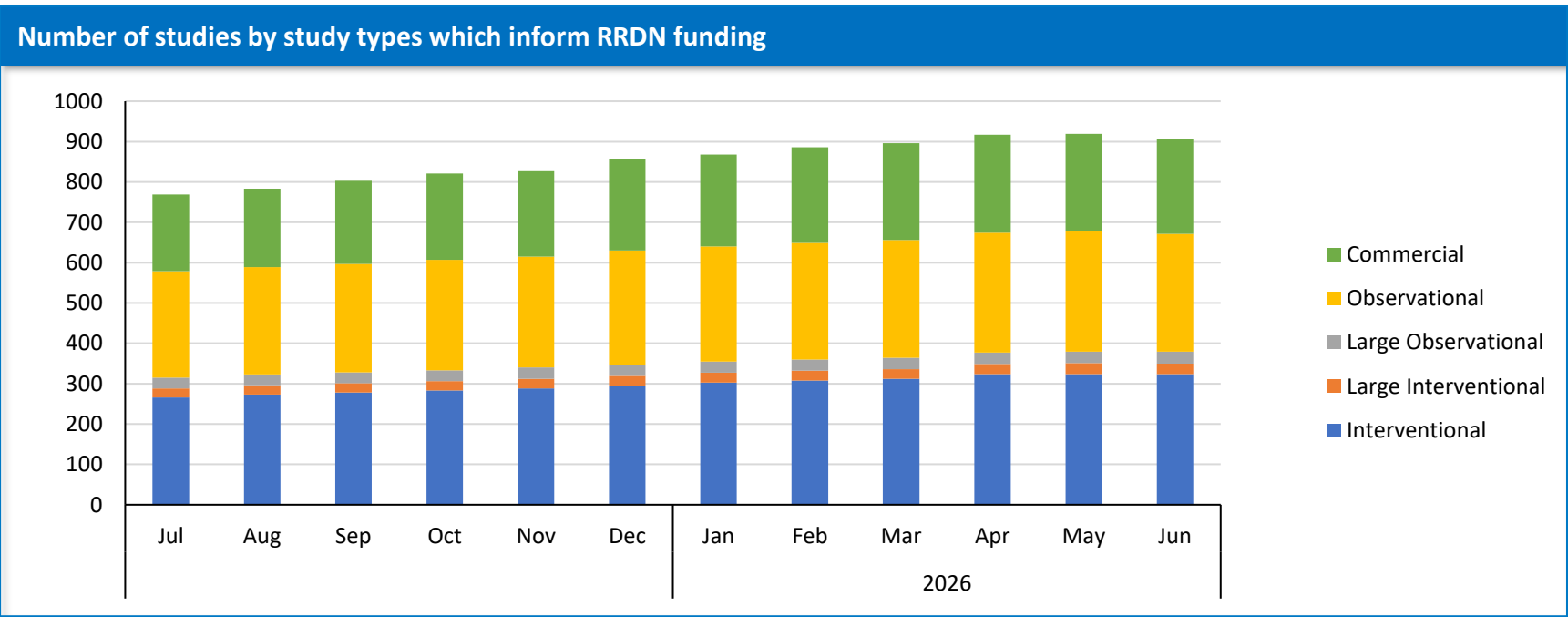
Target

907

Compliance	Variance	Assurance	Actions

Status

Assure



	2025						2026					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Comm	190	194	206	214	212	226	228	237	240	243	240	235
Interv	266	273	278	283	288	295	303	308	312	324	324	324
Large Int	22	23	23	23	24	24	24	24	24	25	27	26
Large Obs	27	27	28	28	28	28	28	28	28	29	29	30
Obs	264	266	269	274	275	283	285	289	292	297	300	292

Total number of studies (open and in follow up)

Updates since previous month

Decrease in active studies by 5 commercial, 1 large interventional, and 8 observational. Interventional studies remained the same and 1 additional large observational study was active in June compared to May.

Current issues

Staff turnover. Balancing capacity to open new studies alongside supporting studies open and in follow-up and closing out studies. First observed drop in total study numbers not cause for concern at this point.

Key dependencies

This metric is about number of studies open and in follow-up split by study type based on the Research Delivery Network weighting system.

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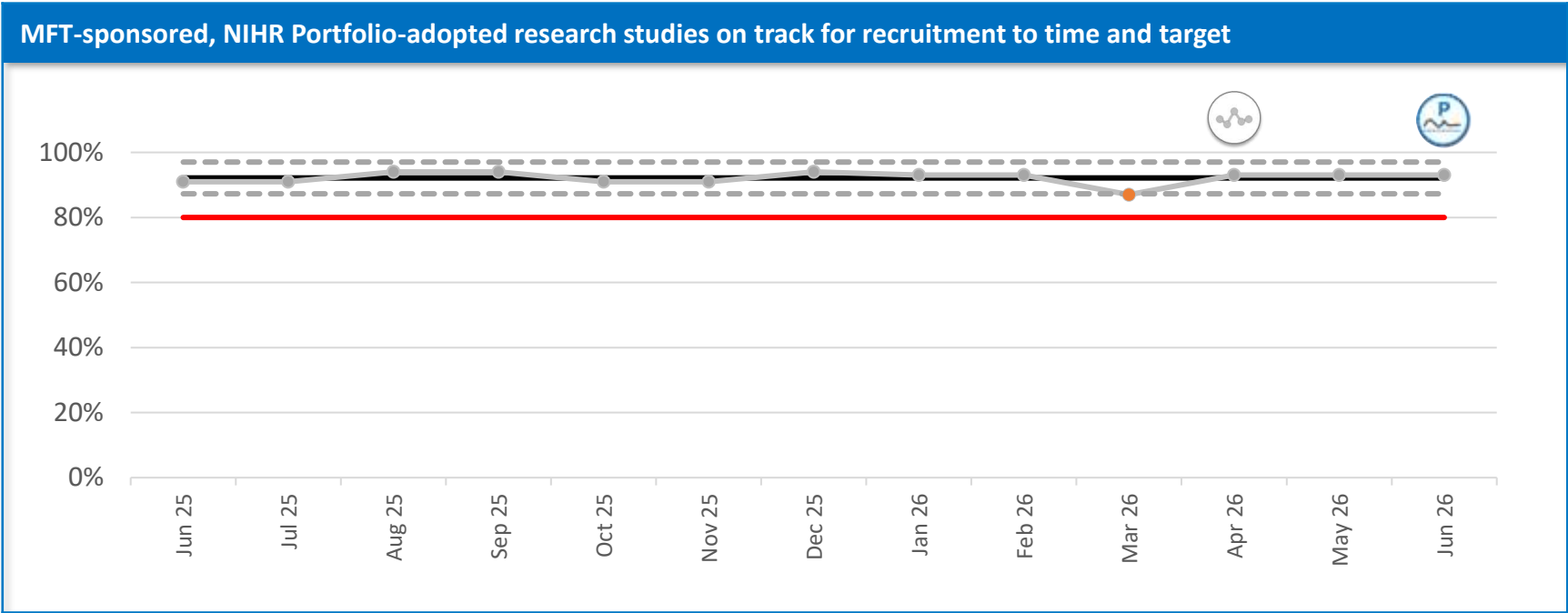
Future actions

Focus on opening highly weighted studies to support increasing our weighted recruitment to maximise patient benefit and sustainability of our workforce through RDN funding. Implementation of study scoring tool from 1st May 2026.

Jun-26	Target
93%	80%

Compliance	Variance	Assurance	Actions

Status
Assure



Updates since previous month
No change.

Current issues
No current issues.

Key dependencies
This is a nationally set target by the NIHR which MFT must meet to ensure infrastructure awards (e.g., BRC, CRF) are paid in full. Failing the 80% target will reduce such award income.

Future actions
Maintain focus on realistic research study methodologies, recruitment strategies and staff capacity to quickly identify and consent participants, and monitoring performance at senior levels in R&I.

All Clinical Trial Study Initiation – Set-up

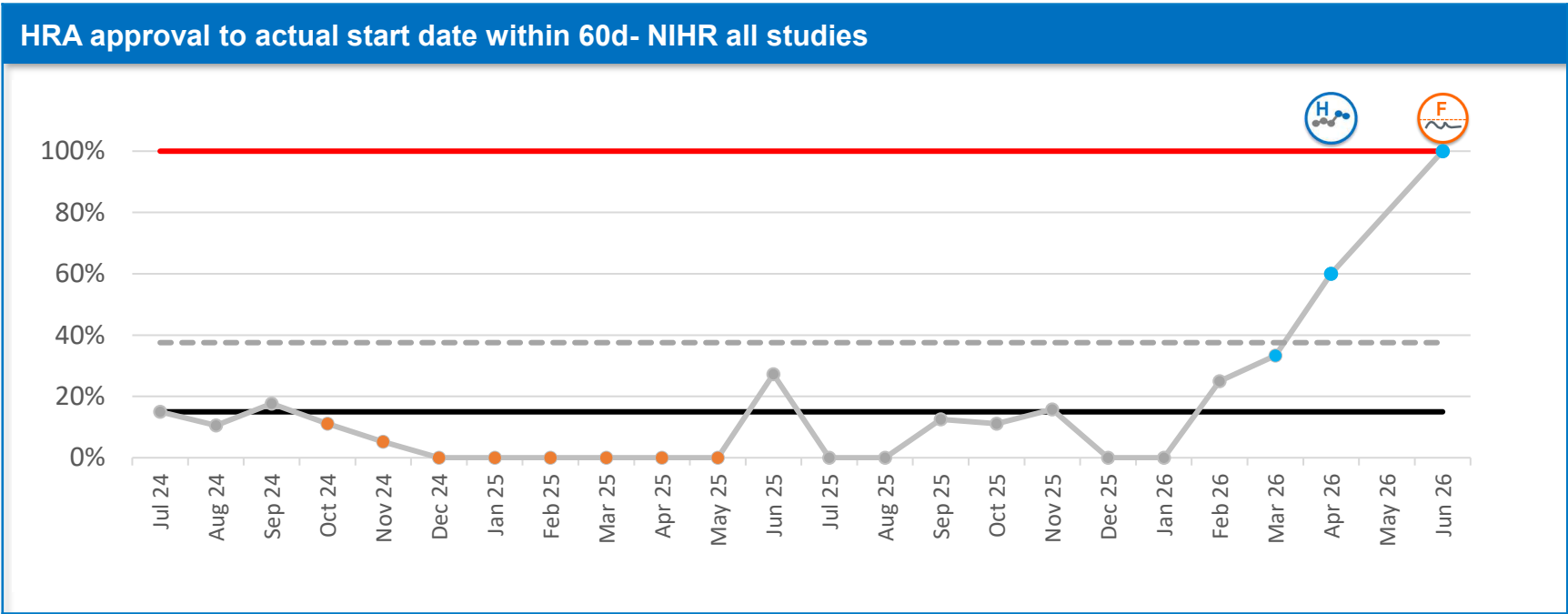
Accountable Executive: Matt Makin & Sohail Munshi | Accountable Group: Research and Innovation Board Committee

Jun-26	Target
100%	100%

Compliance	Variance	Assurance	Actions

Status
Assure

Month	Total studies	% HRA apr to start 60d
Feb-26	4	25%
Mar-26	3	33%
Apr-26	5	60%
May-26	0	N/A
Jun-26	1	100%



Updates since previous month

Most recent month with studies (February) was a successful month. Will need to see if this positive trend continues. Quarterly data is showing a decline in the number of days from site selected to confirmation of capacity and capability.

Key dependencies

This metric is about approval speed for clinical trials approved at MFT each month. Metric only counts studies with a start date defined within time period of observation.

Current issues

This is one of the two UK Clinical Research Delivery metrics run nationally by NIHR which are publicly available for use by commercial sponsors and contract research organisations to see how sites perform.

Future actions

Maintain full staffing of research operational and research office staff to enable efficient set-up of studies.

Commercial Study Initiation - Recruitment

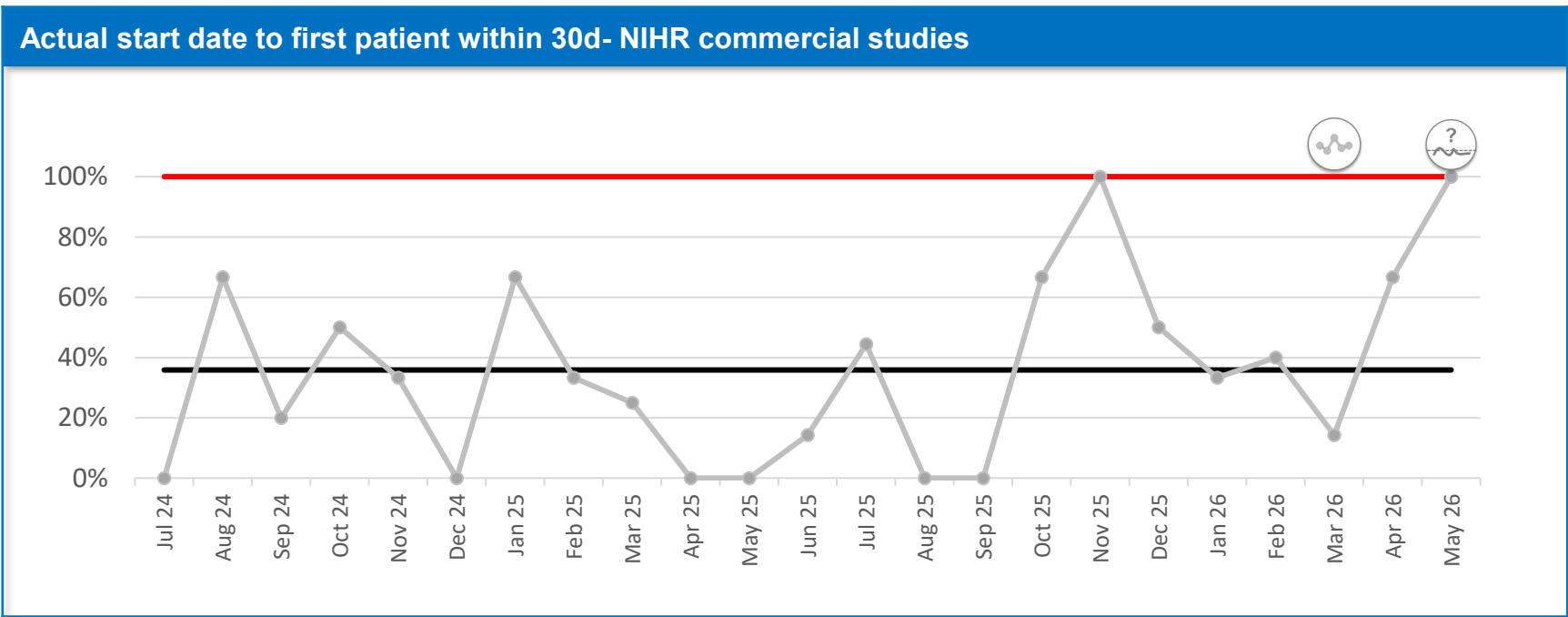
Accountable Executive: Matt Makin & Sohail Munshi | Accountable Group: Research and Innovation Board Committee

May-26	Target
100%	100%

Compliance	Variance	Assurance	Actions

Status
Assure

Month	Total studies	% Start to FP 30d
Feb-26	5	40%
Mar-26	7	14%
Apr-26	3	67%
May-26	3	100%
Jun-26	0	N/A



Updates since previous month

Most recent months have seen decline in recruitment times with more studies recruiting a first patient before 30 days of opening.

Key dependencies

This metric is about speed of recruitment of first participant to commercially clinical trials at MFT. Metric only counts studies with a start date defined within time period of observation.

Current issues

This is one of the two UK Clinical Research Delivery metrics run nationally by NIHR which are publicly available for use by commercial sponsors and contract research organisations to see how sites perform.

Future actions

Maintain focus on realistic research study methodologies, recruitment strategies and staff capacity. Weekly performance meeting in place.

All Clinical Trial Study Initiation – Recruitment

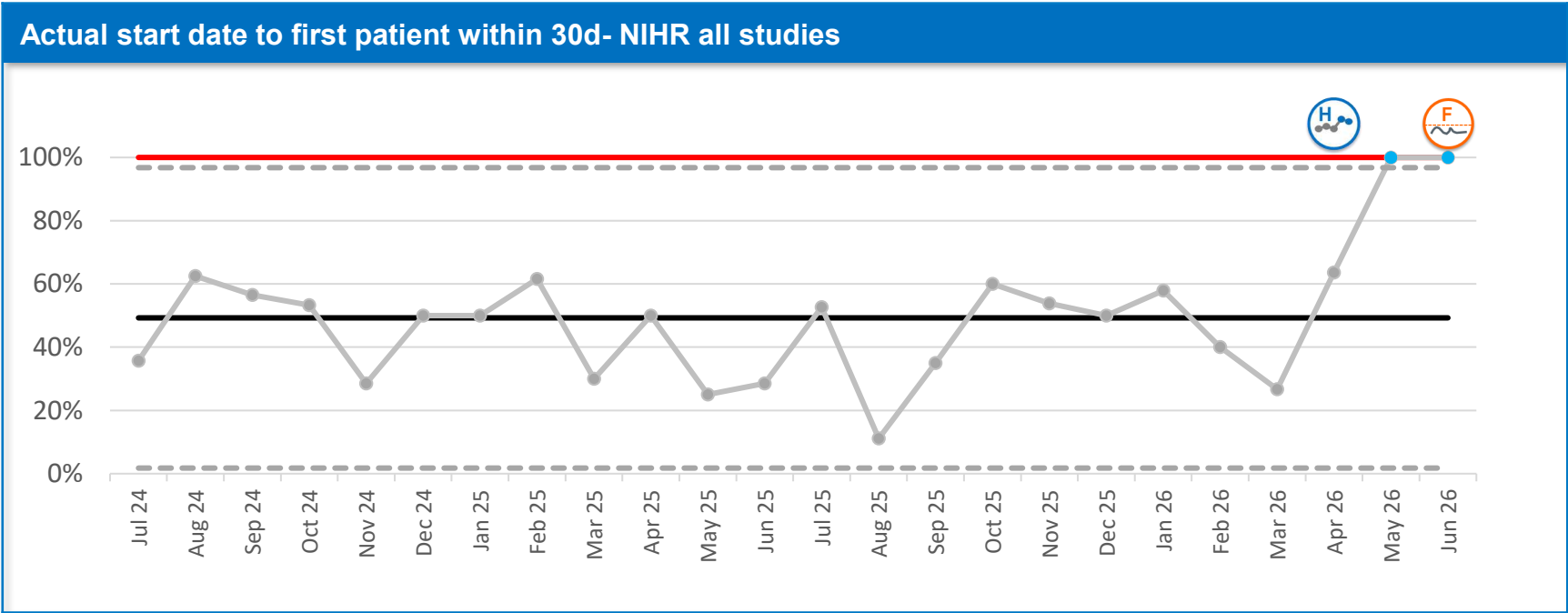
Accountable Executive: Matt Makin & Sohail Munshi | Accountable Group: Research and Innovation Board Committee

Jun-26	Target
100%	100%

Compliance	Variance	Assurance	Actions

Status
Assure

Month	Total studies	% Start to FP 30d
Feb-26	10	40%
Mar-26	15	27%
Apr-26	11	64%
May-26	7	100%
Jun-26	3	100%



Updates since previous month

Most recent months have seen improvement with more studies recruiting a first patient within 30 days of opening.

Current issues

This is one of the two UK Clinical Research Delivery metrics run nationally by NIHR which are publicly available for use by commercial sponsors and contract research organisations to see how sites perform.

Key dependencies

This metric is about speed of recruitment of first participant to clinical trials at MFT. Metric only counts studies with a start date defined within time period of observation.

Future actions

Maintain focus on realistic research study methodologies, recruitment strategies and staff capacity. Weekly performance meeting in place.

Escalation and Assurance Report

Research, Innovation and Population Health

Report to: Board of Directors

Report from: Ashley Blom, Non-Executive Director and Chair of RIPH Board Committee

Date of meeting(s): 1 September 2026

Key escalation and discussion points from the meeting

Alert

The Committee reviewed the three risk appetite domains outlined within the **Risk Appetite Statement** relating to partnerships and integrated care delivery, strategic transformation and major programmes, and wider system working, policy and external change. The Committee supported the proposed appetite positions for submission to the Board and requested that, following Board consideration, the partnership-related elements are shared with external partners to support alignment and understanding.

Advise

The **Population Health Integrated Performance Report** updated on the work underway to develop the IPR to include more of the socioeconomic agenda. The Committee was informed that, whilst overall performance indicators continue to improve, inequality gaps remain evident across a number of measures. Further analytical work is being progressed to strengthen understanding of the relationship between deprivation, ethnicity and access to services, enabling more targeted interventions and supporting the Trust's ambition to reduce health inequalities. The Committee welcomed the continued development of population health intelligence and associated research activity to support delivery of this agenda.

The Committee reviewed the **Research and Innovation Integrated Performance Report** which reported two advise metrics for noting by the Committee in respect to recruitment weighted by type and HRA approval to start date within 60 days for commercial studies. The overall reduction in recruitment to studies was noted as a national trend, although the data currently available was insufficient to determine whether further intervention was required. The position would continue to be monitored.

An overview of the work of the **Manchester Rare Conditions Centre (MRCC)**, which is a collaborative virtual centre that brings together research, clinical expertise and partner organisations from across Greater Manchester to support rare conditions research and innovation was provided. Members noted MRCC's strategic contribution to MFT's research portfolio, including its role in supporting nationally significant research programmes, strengthening links between clinical services, genomics and academic partners, and positioning Greater Manchester as a leading centre for rare conditions research. The Committee was advised that MFT is currently the highest recruiting site nationally to the Generation Study, a newborn genome screening programme of national importance, and received an update on work underway to secure future Biomedical Research Centre funding, including an expanded focus on genomics and rare conditions research. Discussion also highlighted the importance of ensuring sufficient protected time and organisational support for research activity and grant development, alongside timely recruitment processes for externally funded research posts, to maximise future research opportunities and funding success.

The Committee was updated on the latest Health **Inequalities Deep Dive** data which highlighted that both deprivation and ethnicity remain key drivers of unequal health outcomes for patients. Discussion focused on the impact of deprivation and ethnicity on access to services and health outcomes, with the Committee recognising the complex relationship between these factors and the importance of further analytical work to better understand their relative contribution. The Committee noted that whilst overall improvements were evident across a number of indicators, inequalities persist for some population groups and welcomed the continued development of data, research and targeted interventions to support reductions in unwarranted variation.

The **NIHR Patient and Public Involvement, Engagement and Participation (PPIEP) Strategy** was presented. This outlined a new approach for implementation across the NIHR infrastructure, including commitments to public partnerships. The opportunities to support clinicians new to research through the research infrastructure, particularly in respect to utilising prior patient engagement feedback or including funding requirements for PPIEP within research grant applications, were outlined. The Committee supported the Strategy, noting final stakeholder feedback was to be incorporated, and noted that it would be submitted as part of the NIHR infrastructure funding awards process.

The Committee received a verbal update regarding analysis of **Referral to Treatment (RTT) pathways and patient activity** across the wider health system. Based on the analysis undertaken to date, no significant correlation had been identified between Emergency Department attendances and time spent on an elective care waiting list. The analysis highlighted continuing interaction between patients awaiting elective care and other healthcare services, reinforcing the importance of effective pathways between primary and secondary care. The Committee noted the positive impact of arrangements including the Single Point of Access (SPOA) and advice and guidance processes in supporting patient management and access to specialist advice.

The Committee considered how the **impact of Research and Innovation studies on population health** was currently measured and the potential opportunities for further data collection, including utilisation of the social drivers of health tool within the electronic patient record. The value of qualitative case studies alongside quantitative data was noted.

The Committee received an update on developments across the **Greater Manchester Population Health** agenda. The continued population health challenges associated with deprivation and population growth across Greater Manchester, alongside encouraging improvements in a number of population health indicators, were noted. The Committee discussed emerging prevention initiatives and Greater Manchester's role as a test bed for new approaches to improving population health outcomes. An update was also provided on the reconfiguration of GMICB's population health functions and the opportunities this presents for strengthened collaboration, intelligence sharing and the use of population health data across the integrated care system. Members noted MFT's ongoing contribution to the prevention and population health agenda through its work with partners and the continued development of population health intelligence and interventions. An update on the Prevention Demonstrator was requested for a future meeting.

Assure

The **Research and Innovation Integrated Performance Report** identified five assure metrics in respect to active studies by study type that inform Regional Research Delivery Network (RRDN) funding; MFT-sponsored, NIHR portfolio-adopted research studies on track to recruit to time and target; HRA approval to actual start date within 60 days for all NIHR studies; actual start date to first patient within 30 days for all commercial studies; actual start date to first patient within 30 days - NIHR all studies.

The Committee received an update on progress of key programmes within the **Green Plan**, including confirmation that the recently published national figures confirmed a 7.1% reduction in MFT's carbon footprint. This reflected the largest reduction in the last 5 years and supported delivery of wider population health benefits. The work to embed and recognise sustainability as an organisational change vehicle through identified sustainability leads, develop a sustainability dashboard and progress partnership arrangements through the Green Heat Network were also described.

Risks discussed at the meeting

The Committee reviewed the **Strategic and Corporate Risks** within its remit and noted the change to the target risk date of the Inability to reduce health inequalities strategic risk. The Committee was also advised that the Green Plan risk had been re-assessed and reduced following receipt of additional external assurance, as reported in the Green Plan Update.

Report approved by: Ashley Blom, Non-Executive Director and Chair of RIPH Board Committee.

Agenda:



Research, Innovation and Population Health Board Committee

Date: Tuesday 1 September 2026

Time: 2:00pm – 4.00pm

Location: Main Boardroom, Cobbett House

Agenda

	Item	Purpose	Lead	Time
1.	Apologies for absence and confirmation of quoracy (verbal)	Meeting admin	Chair	2.00pm
2.	Declarations of interest (verbal)	Meeting admin	Chair	
3.	Minutes of the previous meeting (19 June 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	2:20pm
6.2	Risk Appetite Statement	Support	Deputy Director of	2.25pm

	Item	Purpose	Lead	Time
			Clinical Governance and Risk	
6.3	Integrated Performance Report			
	6.3.1 Population Health IPR	Discussion	JCMO	2.35pm
	6.3.2 Research and Innovation IPR	Discussion	Managing Director R&I	2.45pm
7.	Strategic aim 1: Work with partners to help people live longer, healthier lives			
7.1	Inequalities Deep Dive	Discussion	Public Health Consultant / JCMO	2.55pm
7.2	Report on RTT pathways and patient DNAs (verbal)	Discussion	JCMO	3.20pm
7.3	Greater Manchester Population Health Update	Discussion	Public Health Consultant / JCMO	3.25pm
7.4	Green Plan Update	Discussion	Director of Estates and Facilities	3.35pm
8.	Strategic aim 5: Deliver world class research and innovation that improves people’s lives			
8.1*	NIHR institutional strategy for Patient and Public Involvement, Engagement and Participation	Discussion	Deputy Director of Vocal, NIHR	3.05pm
8.2*	Manchester Rare Conditions Centre Update	Discussion	Clinical Director, MRCC	2.05pm
8.3	Impact of R&I Studies on Population Health	Discussion	Managing Director R&I	3.45pm
Committee business				
9.	Escalation report	Approval	Chair	3.55pm
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 8 December 2026, 10.00 am–12.00 pm				

	Item	Purpose	Lead	Time
Papers for Information • RIMC Escalation Report (June 2026) • PHMC Escalation Report (June 2026) • PHMC Escalation Report (August 2026)				



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 ODBC

Date of meeting: 18/08/26

Key escalation and discussion points from the meeting

Alert:

The Committee discussed the New Hospitals project's developing **Strategic Outline Case** and a current estimated funding gap which is recognised and well understood by the New Hospital Programme and national programme leadership. The identified cost pressures principally arise from application of Hospital 2.0 requirements, plant space requirements and site-specific abnormal costs rather than changes in Trust scope or service requirements. The Committee was reassured that national programme leads have acknowledged the affordability challenge as a shared programme issue and that a formal process is underway to agree the final funding position whilst allowing the scheme to continue progressing through the next development stage. Members emphasised the need to maintain Board oversight of financial risk and ensure appropriate governance as affordability discussions progress.

The Committee discussed the scale of the programme and commended the work of all involved in the programme for the significant progress made since the last meeting.

Advise:

The Committee received confirmation that negotiations with the **Main Works Contractor** had been concluded and that the phase zero contract had been executed under delegated authority on 31 July 2026. Members noted the agreed initial contract value and arrangements for future scope negotiations and were reassured that constructive working relationships have now been established and that contract governance arrangements remain robust.

The Committee received a detailed presentation outlining progress on the New Hospital Project and **preparation of the RIBA Stage 1 submission**. Members were advised that substantial work has been completed across strategic, economic, commercial, financial and management case development, together with extensive stakeholder engagement, independent design assurance and technical review. The Committee noted that the proposed hospital design remains aligned with previously approved principles and that engagement undertaken with clinical teams has been recognised by the New Hospital Programme as an example of good practice. Governance processes supporting progression to RIBA Stage 2 are established and operating effectively.

The Committee received an update on the wider **Masterplan workstream** and noted the successful approval of funding from the Greater Manchester Combined Authority Good Growth Fund to support development of the Healthy Neighbourhood proposals. Members were advised that work is progressing with housing providers and development partners and that further review work will be undertaken to assess interdependencies between the Healthy Neighbourhood programme, hospital construction activity and essential estate maintenance requirements. The Committee noted the importance of ensuring that masterplan decisions do not adversely impact delivery of the new hospital programme and that emerging external developments are incorporated into future planning assumptions.

The Committee received a detailed deep-dive presentation on the **Transformation workstream** which described work underway to develop target operating models, expand virtual care and outpatient transformation, reduce unnecessary hospital activity, support left-shift of care into community settings and optimise emergency and inpatient pathways. Members noted that whilst a dedicated New Hospital Programme team is established, the transformation workstream remains highly dependent upon operational leaders and clinical teams who are simultaneously managing day-to-day service delivery pressures. The Committee highlighted the risk that insufficient transformation capacity and dedicated resource could impact delivery of the required service redesign, demand management and operating model changes necessary to support occupation of the new facilities. Executive leads confirmed further work is underway to define resource requirements, associated funding and governance arrangements, with a clearer position expected later this year.

The Committee received positive feedback regarding **staff engagement activity** undertaken to date, including engagement events, design workshops and clinical user group involvement. Members noted that whilst participation has been encouraging, further engagement activity will be required to maintain momentum, strengthen staff ownership and support future change. The Committee also highlighted the importance of maintaining effective engagement with community partners, Local Care Organisations, commissioners and wider health system stakeholders to support delivery of left-shift and demand-management ambitions.

The Committee highlighted that **successful delivery of the new hospital** is increasingly dependent on the Transformation and Masterplan workstreams progressing at pace and in step with the build programme; given their growing interdependencies, capacity requirements and delivery risks, these areas will require increasing Executive and Board focus and assurance.

A high-level timeline was discussed at the meeting. Below is the version which has been included in recent stakeholder communications:



Assure	
The Committee reviewed the emerging programme dashboard and welcomed the development of a consolidated programme view bringing together hospital delivery, transformation and masterplan activities. Members noted that further refinement is required as programme plans mature, particularly regarding interdependencies, programme-level risks and milestone management. The Committee supported continued development of the dashboard as a key mechanism for future assurance reporting.	
Risks discussed at the meeting	
The Committee discussed the current programme risks. It was note that a strategic risk aligned to the programme has been approved and was reported to the Board in July as part of the Board Assurance Framework.	

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

Agenda:



North Manchester Board Committee

Date: Tuesday 18th August 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	2:00pm
3.	Minutes of the previous meeting (17 th June 2026)	Meeting admin	Chair	2:00pm
4.	Action Log	Discussion	Chair	2:05pm
5.	Matters Arising		Chair	2.10pm
6. Strategic Aim 4: Ensure value for our patients and communities by making best use of resources				
6.1	NMGH Programme Report: Bovis Contract & NHP Agreement Update	Discussion	CW	2:15pm
6.2	NMGH Programme Summary & Strategic Project Reports: 6.2a NMGH New Hospital Project Update 6.2b NMGH Transformation Project Update 6.2c NMGH Masterplan Project Update 6.2d NMGH Redevelopment Programme Dashboard	Discussion	CW VG TR CW	2.25pm

6.3	NMGH New Hospital Project: RIBA Stage 1 / SOC Project Report (Acute & OPD)	Assurance / Approval	CW	2.40pm
6.4	NMGH New Hospital Project: Programme Plan Update (Acute & OPD)	Discussion	CW	3.00pm
6.5	NMGH Transformation Project: Deep-Dive Briefing	Verbal	VG	3.10pm
Committee Business				
7.	Minutes of the Following Meetings (for information): 7.1 NMGH Strategic Programme Committee: 7.1a – 7 July 7.2 NMGH New Hospital Project Board 7.2a – 19 June 7.2b – 9 July 7.2c – 31 July	Information	Chair	3:25pm
8.	Escalation report	Discussion	Chair	3.30pm
9.	Workplan Review	Meeting admin	Chair	3:35pm
10.	Any Other Business (verbal)	Discussion	Chair	3.40pm
11.	Meeting Evaluation (verbal)	Meeting admin	Chair	3.45pm
Date of next meeting: Monday 12 th October at 2:00pm – 4:00pm, MS Teams				
Committee Supporting Information: A1: NMGH New Hospital Project Staff Newsletter June 2026 A2: NMGH New Hospital Project Staff Newsletter June 2026 B1: New Hospital Project – Trust letter to NHP (13 July 2026) C1: New Hospital Project – NHP letter to Trust (27 July 2026) D1: New Hospital Project – NMGH Brochure				

Public Board of Directors

Wednesday, 30 September 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 <u>one</u> box only:	☐ For approval ☒ For discussion	☐ For support ☐ For noting

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. Below is a summary of the key developments covered:

National Developments

- **Department of Health and Social Care (DHSC) Appointments:** there have been a number of new appointments to Minister and Under Secretary of State posts in the DHSC.

Regional and Local Developments

- **Manchester Brain Health Programme:** a 2-year pilot formally launched in September, in partnership with the Alzheimer's Society, Greater Manchester Mental Health and the University of Manchester, which will test a new model for the early diagnosis and treatment of dementia. In what is a UK-first, the pilot aims to generate evidence to support a new model of care.
- **Vascular and Cardiac Service Change Assurance Process:** the public consultation being undertaken as part of the assurance process will conclude in September. The output will inform the next steps and service proposals. MFT teams continue to work with partners to support the process and plan for potential implementation.
- **Major Trauma:** following the decision by NHS Greater Manchester that Major Trauma Centre services would continue at both MRI and Salford Royal, an implementation programme is now underway to move towards a single Greater Manchester Major Trauma Service operating across both sites. Cross-system work on designing the new model has commenced.

MFT Developments

- **OMFS** – the development of a single-service model for Oral and Maxillofacial Surgery (OMFS) at MFT continues alongside supporting OMFS and oral surgical services at other Trusts and exploring the development of a Lead Provider model for the whole of Greater Manchester.
- **Left Shift Programme Update** - the MFT Left Shift Programme is overseeing a range of projects designed to deliver care closer to people's homes and with a greater focus on early intervention. Current priorities include developing community based services for ENT, gynaecology, diabetes, general paediatrics, and all-age palliative and end of life care.
- **Mutli-year Planning 27/28 Update:** the foundational work for this year's planning round is largely complete. The next step is commencing the capacity and demand, financial and workforce planning. Regular updates will be brought to the Board as the process progresses.

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**
- ☐ **No**

Please set out in the report what action has been taken to address this

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 within this report links to the following strategic, corporate, or operational risks:

-

Care Quality Commission domains Please check <u>all</u> that apply	☐ Safe ☐ Caring ☐ Effective ☒ Well-Led ☐ Responsive
Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the 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 <i>2.1 Department of Health and Social Care (DHSC) Appointments</i> Following the appointment of Yvette Cooper as the Secretary of State for Health and Social Care, there have been further changes to ministerial appointments within the Department. The Rt Hon Dame Diana Johnson DBE MP for Kingston upon Hull North and Cottingham has been made Minister of State (Minister for Public Health and Patient Safety). She was previously Minister of State at the Department for Work and Pensions. Her responsibilities include health improvement, health inequalities and neighbourhood health. Alison McGovern has been made Minister for Social Care. She is a North West MP representing Birkenhead. She is responsible for adult social care, hospital discharge, frailty and dementia and end of life and palliative care. Chris McDonald MP for Stockton North has been made Minister for Science, Innovation and Investment working across the DHSC and the Department for Business and Trade. His responsibilities include research and development (R&D), UK science, research and innovation, life sciences and tech investment. Karin Smyth MP for Bristol South and a former NHS manager remains in post as Minister of State for Health (Secondary Care). James Frith is MP for Bury North, part of Greater Manchester. He has been appointed Parliamentary Under-Secretary of State (Minister for Health Innovation). His responsibilities include NHS data and technology, medtech, research and innovation, rare diseases and eyecare. Baroness Merron MP remains Parliamentary Under-Secretary of State (Minister for Women's Health and Maternity).

2. Regional and Local Developments

2.1. *Manchester Brain Health Programme*

In September, to mark World Alzheimer's Day, we launched with partners – including the Alzheimer's Society, Greater Manchester Mental Health and the University of Manchester – a 2-year brain health pilot service delivered at the MRI. Supported by funding from the Alzheimer's Society, the service aims to improve the early diagnosis and treatment of people with dementia, as well as providing personalised advice and support through dedicated Brain Health Advisors. The pilot – a UK first – will run for 2 years and help to generate evidence for a model of care that could be rolled-out routinely across the NHS.

2.2. *Vascular and Cardiac Service Change Assurance Process*

Work continues to support the assurance process for the proposed single arterial centre at MRI, as well as the cardiac service changes that were implemented across MFT around the time of the Covid pandemic. Public consultation will conclude in September with the output informing next steps and service proposals.

There are some key service dependencies including the Project RED estate works which are being actively managed. Business case development is ongoing, with particular consideration given to workforce planning and recruitment into specialist roles.

MFT teams are working closely with GM ICB and NHS England in this process, and particularly with colleagues at the Northern Care Alliance on the detail of potential service transfers from the Oldham site, as well as the services that would remain at Oldham following any change.

2.3 *Major Trauma*

In November 2025, following an independent review, NHS Greater Manchester confirmed that adult major trauma services will continue to operate through two Major Trauma Centres – MRI and Salford Royal – with greater collaboration between them. The longer-term ambition is to develop a single Greater Manchester Major Trauma Service operating across both sites, with shared accountability, common governance, workforce planning and learning.

An implementation programme is now underway, involving MFT, the Northern Care Alliance, NHS Greater Manchester and the North West Ambulance Service. A new operating model is being developed and is due to be finalised by March 2027. Clinical workshops to design the model commenced in August 2026.

3. MFT Strategic Developments

3.1 *Oral and Maxillofacial Surgery (OMFS)*

We continue to make progress on the development of a single-service model for Oral and Maxillofacial Surgery (OMFS), bringing together services from across the Trust under a single clinical leadership team as well as supporting the provision of OMFS and oral surgery at other Trusts in Greater Manchester. During the past year, we have successfully assumed responsibility for OMFS services previously delivered at Tameside Trust and completed the transfer of oral surgery activity from Stockport Trust. Work is now focused on strengthening

clinical pathways, enhancing clinical triage arrangements, improving access to specialist expertise and ensuring sufficient capacity to support future demand.

We are also in wider discussions with partners on the development of a potential lead provider model for other services across Greater Manchester. The aim of this would be to improve equity of access, reduce unwarranted variation and create a more sustainable service model across the region. Further work is underway to assess the operational, workforce and financial implications of any future service changes.

3.2 Left Shift Programme Update

The left shift programme encompasses a range of projects to move activity out of our acute hospitals into community settings and people's own homes. The Left Shift Programme Board has been established to oversee all of this work. It provides leadership, coordination, and assurance as well as overseeing the safe, clinically led transformation of pathways that move care closer to people's homes. The programme is currently focusing on the following pathways:

- **Tier 2 ENT service** – the community ENT service which employs GPs with enhanced roles and advanced nurse practitioners to provide care for people who would otherwise have been seen by hospital teams is operational. The service is currently hospital-based, but the use of Gorton CDC and other community facilities is being explored. The vision is to shift 25% of ENT workload to community settings by the end of the financial year.
- **Gynaecology** – a Single Point of access has been implemented which will facilitate consultant-led triage of all referrals. It will also provide insight into how the service is working to inform further improvements. The focus is now on the development of pathways for managing a range of gynaecological conditions in primary care and the provision of educational sessions to support implementation of the new pathways and upskill clinicians in the management of these conditions.
- **Diabetes** - Manchester and Trafford already benefit from highly effective Community Diabetes Specialist Nursing (DSN) services, however provision differs across localities. The development of a standardised Community Specialist Diabetes Nursing Model across Manchester and Trafford operating as a single service with locality-based teams has been identified as the most immediate and deliverable opportunity to strengthen neighbourhood diabetes care, reduce variation and establish the specialist community infrastructure required to support wider transformation. Alongside this work, engagement with General Practice and Primary Care Networks continues to identify opportunities for enhanced GP-led diabetes care and future pathway redesign.
- **General Paediatrics** - a Neighbourhood Multidisciplinary Team (MDT) model for General Paediatrics is to be piloted across three neighbourhoods in Manchester. The pilot will introduce weekly joint MDT triage of all general paediatric referrals to the Royal Manchester Children's Hospital. The outcome of this could be Advice and Guidance (A&G), attendance at joint local child health clinics delivered in a community setting, redirection to community or nurse-led pathways, or hospital referral where clinically required. The pilot will test whether the model delivers the expected benefits which include improved access, better experience for families, reduced hospital attendances, and real-time upskilling for primary care teams.
- **All Age Palliative and End of Life Care** – this workstream has focused initially on increasing the proportion of people able to receive care and die in their preferred place. A

key part of this has been supporting end of life care within care homes. The programme is also exploring the development of a dedicated palliative and end of life Hospital at Home pathway as part of the wider Hospital at Home expansion programme. Work is also progressing with hospice partners providing care for both adult and children, to identify opportunities for greater collaboration.

- **Frailty** – ongoing work with colleagues in primary care has identified a joint piece of work on a new model for proactive support for people living with frailty. A growing number of people are living with frailty and can experience high health and care needs. The aim is, through early and proactive support, working in partnership across primary, community and hospital teams, to improve people's health and avoid unnecessary hospital stays. The intention is to pilot a new model as a first step.

3.3 Multi-Year Planning 2027/28 Update

The planning process for the period starting 27/28 is underway. The intention is to build on the changes that we made last year and bring the planning process forward again so that we are ready to implement our plans from 1 April 2027.

A timeline incorporating financial planning, budget setting, capital planning, workforce planning, job planning, activity and performance planning has been developed. We are planning to undertake the work over 2 phases: Phase 1 will focus on the completion of activity, finance and workforce numerical plans and will run from September to December. Phase 2 will cover the development of delivery and action plans and run from December to March.

Foundational work carried out over the summer is largely complete, including reviewing service capacity, developing planning tools and guidance and setting up oversight arrangements: the Annual Planning Oversight Group has been stood up with a refreshed terms of reference for 27/28. Regular updates will be presented to the Board of Directors between now and submission to ensure that the Board is involved in the development of plans.

Demand modelling is due to complete at the end of September from which Clinical Groups can develop their activity plans and associated financial and workforce plans. Iterations of the plans will be shared internally at the start of November and again at the start of December, prior to approval by the Board. A first submission to NHS England is expected in mid-December.

4. 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.

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: 25 August 2026

Key escalation and discussion points from the meeting

Alert

The Committee received an update on the **HTA (Human Tissue Act) Evidential Compliance Assessment (ECA)** currently underway as part of the national regulatory requirement for all HTA post-mortem licence holders, to audit all incidents between 1 April 2015 – 30 June 2026. Confirmation was provided that MFT was on-track to complete the initial review, after which a detailed review of incidents potentially and definitely HTA-reportable would be undertaken. MFT will also meet the declaration submission deadlines in September 2026.

An update was provided on the **Regulation 28 Prevention of Future Deaths** notification, issued by the HM Coroner in July 2026. The Committee was updated on the immediate actions implemented and the on-going transfer of learning to prevent reoccurrence. It was confirmed that the response was being finalised for submission by 26 September 2026.

The refreshed **Risk Appetite Statement** was presented to the Committee. This included new and merged risk domains which reflected the discussion progressed at the Board Seminar session earlier in the year. The Committee considered the four risk domains within its remit and supported the direction of travel, though requested that risk appetite levels were reviewed and aligned across both the operational performance and access domain and the quality of care and patient safety domain. The role of risk appetite in decision-making, cross-committee connectivity and consideration of risk tolerance alongside risk appetite were also discussed, with the final report to be strengthened to reflect key points prior to submission to the Board of Directors.

The Committee received the **operational performance Integrated Performance Report**, with attention drawn to the summer surge in urgent and emergency care attendances and cancer performance, specifically patients waiting beyond 62 days and the review of actions to secure sustainable pathway improvement over the longer term are underway. The positive impact of the Care Closer to Home programme on UEC performance was outlined, however the increased UEC demand arising from recent hot weather had impacted on delivery. The Committee was informed that interventions are in place to return to trajectory by September for cancer 62-day standard and October 2026 for the UEC 4-hour standard.

The **quality and safety Integrated Performance Report** detailed 29 metrics requiring the Committee's attention including reported never events; incidents of moderate harm or above relating to delays on the waiting list and in follow-up; patients detained under the Mental Health Act missing from hospital, MHA section 136 detentions >12 hours; % of complaints closed in agreed timescale; and compliance with the sepsis 7 bundle metrics (excluding oxygen administration). The Committee was informed that whilst reported as alerts, improvement was noted in respect to reduced single sex accommodation breaches,

particularly in critical care areas, sepsis and mental health section 136 measures. Current performance against **Maternity IPR measures** was also discussed with the Committee's attention drawn to current performance relating to category 3 caesarean sections not performed within 24 hours; initial assessment time for maternity triage (within 15 minutes); induction pathway (transfer to intrapartum area within 24 hours); and post-partum haemorrhage $\geq$ 2 litres. Actions in-progress to support improvements were described.

An updated **Winter Plan** was presented, along with the **Board Assurance Statement**, with the Committee noting that learning from the previous year had been reflected and that further desktop exercises, both system level and local, were scheduled ahead of Board sign-off on 30 September. The Plan was structured around four key themes reflecting system and MFT coordination throughout winter; looking after our patients and staff; creating capacity to meet demand and communication and stakeholder engagement with delivery supported through existing Model ED, First 72 Hours, discharge improvement, No Criteria to Reside reduction, Care Closer to Home, Hospital at Home and strengthened system escalation arrangements. It was confirmed that scenario testing would incorporate patient surges arising from climatic and meteorological factors. The Committee recommended the statement to the Board for approval.

The annual **EPRR Annual Compliance Statement** was presented. The Committee noted an improved compliance position from 95% to 96%, supported by the updated evacuation and pandemic policy, and was advised that additional improvement would be delivered as the business continuity planning review programme progressed into its second and third year. The Committee recommended the statement to the Board for approval.

The Committee received an update on the **Patient Administration** programme, as part of the broader data quality governance agenda, which was moving from identification and monitoring into a structured assurance and delivery model. The programme's connectivity to patient safety, pathway visibility, RTT performance, operational management, digital optimisation and regulatory reporting was described. A new strategic risk had been introduced with oversight of both the risk and underpinning programme of work, provided via the Digital Management Committee and into Digital and Estates Board Committee. A briefing session with Non-Executive Directors would be scheduled ahead of reporting to the Digital and Estates Board Committee, and a further update into the Quality, Safety and Performance Board Committee was requested for October 2026.

The Committee noted the outcomes from the **Senior Leadership Visit** programme, which had relaunched in January 2026, aligned to the CQC Well-Led framework. To date, 17 visits had been undertaken with thematic analysis identifying compassionate care and team communication as highly rated.

The 2025/26 **Complaints Annual Report** was presented, with the Committee noting the increase in PALS contacts and complaints when compared to the previous year, which was consistent with wider system trends. The Committee supported onward submission to the Board of Directors. The planned launch of a new complaints framework in September and a programme of work, in partnership with Health Innovation Manchester (HinM), which would consider how learning could be translated into tangible improvement outcomes was also highlighted to the Committee.

The Patient Experience Annual Report was received and supported by the Committee for onward reporting to the Board of Directors. Overall patient experience survey responses reported strong performance in outpatients, community and antenatal services, with opportunities for improvement noted in respect to A&E and postnatal care. In terms of themes, patients' experience of waiting for care and treatment presented the least positive theme. Next steps were confirmed as integrating patient

experience as a core element of the leadership programme and finalisation of a new patient experience strategic development plan to bring learning together and enhance further improvement.

The Committee received an update on **MFT's self-assessed position against Baroness Amos' independent investigation into maternity and neonatal services in England**, as published on 30 June 2026, the NHS **England 10-point plan** shared by letter on the 1st July 2026 and the newly created standardised national reporting template to be submitted to the North West Regional team. Confirmation was provided that, in line with national guidance, attention had been focussed on the 10-point plan with only a high-level gap analysis of the Ockenden Report completed. Of the 79 individual recommendations within the 18 Immediate and Essential Actions, the self-assessed position concluded full compliance with 44 requirements, and partial compliance for 13 requirements. Additional national guidance was required to fully assess compliance with the remaining 22. The report outlined the dual board-level accountability between the Chief Nursing Officer and the Chief Medical Officer and the invited attendance of the Director of Nursing and Midwifery and Clinical Head of Division for maternity and neonatal services at meetings of the Board where maternity or neonatal matters were discussed. MFT's current position against the 10-point plan, including the amended accountability arrangements were recommended to the Board for approval.

Advise:

The **National Maternity Care Bundle Implementation Plan** was presented. This has been developed using the national tool and is focussed on five areas of clinical care: venous thromboembolism (VTE), pre-hospital and acute care, epilepsy in pregnancy, maternal mental health and obstetric haemorrhage. MFT's current baseline assessment reported 4 of the 5 elements as partially implemented, with the VTE requirement not yet implemented, although work to fully implement this element has commenced. Actions to support full implementation of all elements, and the additional functionality required within the electronic patient record, were outlined. Confirmation was provided that all elements were expected to be fully completed at the end of January 2027.

The Committee received an update on **Anti-Microbial Resistance (AMR)**, which reported a broadly positive position against the three national objectives. The Committee was informed of ongoing work on prescribing practice, bloodstream infections, duration of therapy, penicillin allergy de-labelling and high-use antibiotics, with learning expected to inform wider improvement through the improvement pioneers' programme.

An overview of the **Gynaecology Cancer Improvement** programme was provided, including detail of the recovery plans in place to support improvement of the 62-day and faster diagnostic standard (FDS) performance. The trajectory was expected to return to plan from September 2026, with the current position reported as ahead of the recovery plan, with the 62-day standard being met in July 2026 and indicatively good performance in August 2026. The Committee was also informed that backlog recovery and overall PTL has been reduced by approximately 50% from January 2026. Overall, it was reported that strong foundations had been established and will support longer-term sustainability of cancer pathway performance.

The Committee received an update on the **Urgent and Emergency Care (UEC) Quality and Safety** programme and noted key risks relating to ambulance delays, stays over 24 hours and corridor care. Assurance was provided on comparative performance, real-time Clinical Group escalation, daily review, thematic analysis and reporting through TLTC, with future reporting expected to strengthen the link between operational metrics and harm, mortality and morbidity. The partnership discussions with mental health providers to support patients on the mental health pathway and the use of the Single Point of Access, including advice and guidance, to support patients to access the most appropriate services and reduce UEC demand, were outlined.

The analysis of **Never Events**, covering the 12-month period from April 2025, was presented. The Committee noted that incident reviews had been completed and that no specialty-specific cause had

been identified. Recurring themes, human factors, digital safety controls, learning dissemination and cultural reporting were discussed, with emphasis placed on demonstrating that learning and checks are reducing risk.

The **quality and safety Integrated Performance Report** detailed 16 metrics that demonstrated improvement including the number of incidents accepted for MNSI investigation, maternity related concerns (MNSI/ NHSR/ CQC/ PFD Reports), % of critical medicine administrations omitted, and the Summary Hospital-level Mortality Indicator (SHMI).

The **operational performance Integrated Performance Report** detailed 8 measures to note, where performance was improving and associated risk being actively managed. These included ambulance handovers; patient flow; diagnostic waiting times; elective referral to treatment standards; elective waiting times in the community; neurodiversity waiting times (CAMHS); outpatient productivity and theatre productivity.

The Committee received the **Strategic Objectives** update which detailed progress against key programmes of work.

Assure

The **quality and safety Integrated Performance Report** detailed 19 measures that were in control and meeting the required standard set. Continuous improvement was noted in respect to duty of candour; trust attributable Clostridioides difficile infection; number of maternal deaths; number of maternity incidents with moderate harm and above; initial assessment time in maternity triage (30 minutes); number of incidents accepted for MNSI investigation; overall patient experience survey performance score and critical medication omissions due to medicines unavailable.

Two measures in respect of elective activity and Sexual Assault Referral Centre waiting times were confirmed as 'assure' metrics within the **operational performance Integrated Performance Report**. These measures are in control and on target.

Risks discussed at the meeting

The **strategic and corporate risk** position was presented with the Committee informed that risk appetite will be applied to future reporting once the revised statement is agreed. The Committee noted:

- the current assessed risk level in respect to harm whilst waiting for treatment was above the original risk score. Reassurance was provided on actions to manage and mitigate the risk to target level including strengthened oversight, harm review processes across Clinical Groups, prioritisation of waiting lists and exploration of a single point of access for referrals.
- a change to target date for mental health service capacity (MFT/009407) risk from March 27 to November 27 following management committee review
- a reduction in the current risk score relating to safe disaggregation of complex services (MFT/007342) from 12 to 6
- changes to controls, assurances and associated gaps in the failure to deliver improvement strategic delivery plan (MFT/008234) risk
- a revised risk description relating to Vascular service changes in Greater Manchester (MFT/008406)

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

Agenda



Manchester University
NHS Foundation Trust

Quality, Safety and Performance Board Committee

Date: 25th August 2026

Time: 10:00am to 1:00pm

Location: MS Teams

Agenda

	Item	Purpose	Lead	Time
1.	Apologies for absence & confirmation of quoracy (verbal)	Meeting admin	Chair	10.00
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 5.1 HTA Evidential Compliance Assessment (ECA) 5.2 Regulation 28 Prevention of Future Deaths Report	Discussion Discussion	DCEO / CNO DCEO / CNO WTWA DoN WTWA MD	10.05
6.	Assurance Reporting			
6.1	Strategic and Corporate Risks	Discussion	Trust Board Secretary	10.15
6.2	Risk Appetite Statement	Support	Deputy Director of Clinical Governance and Risk	10.20
6.3	Integrated Performance Report 6.3.1 Operational Performance 6.3.2 Quality and Safety	Discussion Discussion	CDO Executive Directors	10.30 10.40
7.	Strategic aim 2: Provide high quality, safe care with excellent outcomes and experience			
7.1	Maternity Assurance 7.1.1 National Maternity Care Bundle Implementation Plan 7.1.2 MFT Response to Independent Investigations into Maternity and Neonatal Services	Discussion Discussion	Director of Nursing and Midwifery	10.50
7.2	Antimicrobial Resistance Update (NHSE Framework)	Discussion	Chief Pharmacist Clinical Lead AMR	11.10
7.3	Gynaecology Cancer Improvement	Discussion	SHCG CEO	11.20

	Item	Purpose	Lead	Time
7.4	Urgent and Emergency Care Quality and Safety Report	Discussion	JCMO	11.30
7.5	Winter Plan – Board Assurance Statement	Support	CDO	11.35
	Break (5 mins)			11.45
7.6	Analysis of Never Events	Discussion	DCEO / CNO JCMO	11.50
7.7	Patient Administration Issues	Discussion	CDIO	12.00
7.8	Emergency Planning and Business Continuity including - EPRR Core Standards Statement of Compliance - EPRR Policy - Business Continuity Policy	Support	CDO	12.15
7.9	Senior Leadership Observational Visits	Discussion	DCEO/CNO	12.20
7.10	Service Developments (strategic objectives 4 and 5) Update	Discussion	Director of Strategy	12.25
7.11	Biannual Legal Services Activity Report	Discussion	Director of Clinical Governance	12.30
7.12	Complaints Annual Report	Support	Director of Clinical Governance	12.35
7.13	Patient Experience Annual Report	Support	DCEO/CNO	12.40
Committee business				
8.	Escalation report (verbal)	Approval	Chair	12.50
9.	Workplan Review	Meeting admin	Chair	
10.	Any Other Business (verbal)	Discussion	Chair	
11.	Meeting Evaluation (verbal)	Meeting admin	Chair	
Date of next meeting: 27 th October 2026				
Papers for Information: Quality and Safety Management Committee Escalation Reports: - May 2026 - June 2026 - July 2026 - August 2026				

Public Board of Directors Wednesday, 30 September 2026

Paper Title:	National Maternity and Neonatal 10 Point Plan Assurance Process, Baseline Assessment and Evidence Submission	Agenda Item 11.2
Presented by:	Kimberley Salmon-Jamieson, Deputy Trust Chief Executive & Chief Nursing Officer Sohail Munshi Joint Chief Medical Officer	
Prepared by:	Kathy Murphy, Director of Nursing and Midwifery, Specialist Hospitals Clinical Group (SHCG)	
Meetings where content has been discussed previously	Maternity Oversight Delivery Group (MODG) SHCG Senior Leadership Team Meeting (SHCG SLT) Trust Leadership Team Committee (TLTC) Quality, Safety and Performance Board Committee (QS&PBC) Maternity Safety Champions Meeting	
Purpose of the paper Please check <u>one</u> box only:	☒ For approval ☐ For support ☐ For discussion ☐ For noting	

Executive summary / key messages for the meeting to consider

Following the June 2026 independent maternity reviews and NHS England's subsequent 10-point plan, all provider Boards are required to assure delivery of urgent actions to improve the safety, responsiveness and compassion of maternity and neonatal services. This paper presents Manchester University NHS Foundation Trust's baseline assessment and supporting evidence for submission to NHS England Northwest by 25th September 2026, ahead of a progress update due on 31st December 2026. Both submissions **must** be signed off by the trust board

Baseline position.

Of the nine applicable points assessed, the Trust is

- fully compliant with two requirements: review of homebirth services and post-death care.
- Six requirements are assessed as partially compliant, covering Martha's Rule, real-time outcomes and experience reporting, dual Board-level accountability, inequalities, 24/7 safety and responsiveness, and compassionate, trauma-informed responses to incidents, complaints and concerns.
- Maternity triage is currently assessed as non-compliant due to the required Board-level audit which has not yet been fully completed.

Delivery and assurance. A single action plan is being monitored through the Maternity Operational Delivery Group and existing perinatal quality surveillance and Trust governance arrangements. Most locally controlled actions are expected to progress by the December submission; delivery remains dependent in part on completion of the maternity triage audit, confirmation of national reporting arrangements and further national guidance. There are no current alerts for escalation.

Governance and decision required. The baseline assessment has been considered through the established maternity and Trust governance routes, including the Quality, Safety and Performance Board Committee. As the national submission deadline precedes the scheduled Board meeting, Board members are asked to approve the baseline assessment by 24th September 2026, enabling submission by 25th September, with formal ratification at the Board meeting on 30th September 2026.

Recommendation(s)

The Board of Directors is asked to:

- To receive and approve the 10-point plan baseline assessment
- Support onward submission to NHSE Northwest Regional Maternity Team

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:
Nil

Main report

Following the publications in June 2026 of both Donna Ockenden's independent review of maternity services at Nottingham University Hospitals NHS Trust and Baroness Amos' independent investigation into maternity and neonatal services in England, NHS England wrote to all provider Boards on 1st July 2026 setting out a 10-point plan for urgent action, focused on safer, more responsive and more compassionate services, stronger Board accountability and listening to women and families.

Further correspondence was received from the Northwest Maternity team on 26th August which provided clarification regarding the submission of supporting evidence and the process for regional assurance review. All provider Trusts are required to submit the approved and compulsory standardised national template to their NHS England region at two points:

- **Baseline assessment:** 25th September 2026
- **Progress update:** 31st December 2026

Both submissions **must** be signed off by the trust board

In readiness for this first submission the completed baseline assessment for Manchester Foundation Trust (MFT) has been completed by the Specialist Hospital Clinical Group (SHCG). To ensure progress a single action plan is in place and monitored through the Maternity Operational Delivery Group (MODG) and in line with the perinatal quality surveillance model (PQOM) reported through existing Trust governance arrangements. Most locally controlled actions are expected to have progressed as planned by the December submission; some remain dependent on national guidance or action.

The full report against the baseline assessment was received and discussed in detail at Quality, Safety and Performance Board Committee on 25th August 2026 to support onward reporting to the Board of Directors in September 2026. (Appendix 1)

A summary of the baseline assessment position is outlined in Table 1

Listening to women and their families by rolling out Martha's Rule	All providers are required to roll out Martha's Rule in all inpatient maternity and neonatal areas, including Antenatal Assessment Units and Maternity Triage	Within the assurance template the baseline assessment is considered partially compliant . It is expected that this will be fully compliant for the December submission, supported by work from Health Innovation Manchester (HInM), who will support evidence against this element
Listen to women and their families using real-time and transparently reported outcomes and experience	It is required that all providers must ensure that maternity and neonatal services implement a monthly cycle of collecting	Within the assurance template the baseline assessment is considered partially compliant.

and clinical audit data that are acted upon at board level	and analysing real-time patient outcomes and experience data. This data must be received at provider public boards to ensure full transparency and enable Board scrutiny.	Progress will be evaluated for the December 2026 submission
Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	It is required for all providers to have clear joint accountability at Board level for maternity and neonatal services, with medical directors and chief nurses holding shared responsibility for oversight, performance and improvement. This must include consistent medical director engagement alongside the chief nurse. Directors of midwifery and clinical directors leading maternity and neonatal services should attend boards when maternity or neonatal matters are discussed.	Within the assurance template the baseline assessment is considered partially compliant . This is expected to be fully compliant for the December 2026 submission.
Addressing inequalities in maternity and neonatal outcomes	It is required for all providers to participate in the Perinatal Equity and Anti-Discrimination Programme (PEADP). In addition, provider Boards must also regularly review the inequalities dashboard and implement the maternity care bundle by March 2027.	Within the assurance template the baseline assessment is considered partially compliant . This is expected to be fully compliant for the December 2026 submission.
Ensuring 24/7 safety and responsiveness of maternity and neonatal services	It is required that provider Boards ensure safe, effective services, including 24/7 staffing and responsiveness across	Within the assurance template the baseline assessment is

	key workforce groups, including a review of resource deployment and appropriate skill mix.	considered partially compliant . Progress will be evaluated for the December 2026 submission.
Trusts to review their homebirth services	It is required that all providers should ensure a review of their home birth services has been undertaken and reported to the Board of Directors and that any safety concerns requiring urgent attention have been actioned.	Within the assurance template the baseline assessment is considered fully compliant
Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach	It is required for provider Boards to receive assurance that that intelligence from incidents, complaints, concerns are responded to in an honest and compassionate way to avoid additional trauma being experienced should care or outcomes are not as expected/desired.	Within the assurance template the baseline assessment is considered partially compliant . Progress will be evaluated for the December 2026 submission.
Deliver safe and effective triage in maternity services	It is required that all providers must deliver safe and effective maternity triage by completing a board-level audit within three months to ensure services are safe, responsive and appropriately resourced. Audit findings must be reported to NHS England and DHSC, with improvements implemented within 12 months to meet national guidance and ensure	Within the assurance template the baseline assessment is considered non-compliant . Progress will be evaluated for the December 2026 submission.

	consistent, high-quality triage care.	
Post-death care	There is a requirement for all providers to implement actions within the system letter ¹ in relation to the Fuller Report, including responding to the Board Assurance Statement by 31 st July and Human Tissue Authority (reviewing and assuring completeness of incident records over the last 10 years).	Within the assurance template the baseline assessment is considered fully compliant .

*Please note there was no requirement to submit against point 4 **Amos into action' staff listening exercise**

To support a consistent, efficient, and transparent approach to assurance, all completed assurance tools and associated evidence must be submitted via the NW Regional NHS Futures Platform no later than close of play on 25th September 2026. This approach has been designed to strengthen the assurance process by reducing duplicate information requests, establishing a consistent method for evidence submission, creating a single repository for assurance documentation, and enabling effective regional and national oversight

The type of evidence which will require to be submitted against the individual elements of the ten points includes: Integrated performance report; the CQC survey; maternity assurance papers as presented to QSPBC; patient Experience reports; thematic learning reports; board minutes and workforce reports.

As the MFT Board meeting takes place on the 30th September 2026, in order to comply with the national deadline, a virtual approach to approval has been agreed with the MFT Chairman as noted above the submission was received and discussed in detail by QSPBC on the 25th August 2026 and also the Maternity and Neonatal Safety Champions meeting, which is attended by the lead Non-Executive Director for Maternity and Board Safety Champions, on the 21st September 2026. It is now being shared with all Board members for virtual approval by the 24th September 2026 to support final submission as required. It will then be presented for ratification at the Board meeting on the 30 September 2026.

There are no current alerts for escalation. The principal dependencies are confirmation of national reporting arrangements, completion of the maternity triage audit tool and further national guidance.

¹ <https://www.england.nhs.uk/long-read/nottingham-maternity-review-findings-on-post-death-care-and-key-actions-required-following-the-fuller-inquiry/>

Appendix 1

Quality, Safety and Performance Board Committee Tuesday, 25 August 2026

Paper Title:	Maternity and Neonatal Care Division response to the publication of Baroness Amos’ independent investigation into maternity and neonatal services in England	Agenda Item 7.1.2
Presented by:	Kathy Murphy, Director of Nursing and Midwifery, SHCG	
Prepared by:	Kathy Murphy, Director of Nursing and Midwifery, SHCG Jen Sager, Interim Deputy Director of Nursing and Midwifery, SM MCS	
Meetings where content has been discussed previously		Divisional Leadership Team Maternity Oversight Delivery Group SHCG Senior Leadership Team Meeting SHCG Management Board Trust Leadership Team Committee Quality Compliance Oversight Group
Purpose of the paper Please check <u>one</u> box only:		☐ For approval ☐ For support ☒ For discussion ☐ For noting

Executive summary / key messages for the meeting to consider

The independent national investigation led by Baroness Amos was published on 30 June 2026, followed by an **NHS England 10-point plan** shared by letter on the 1st July 2026, requiring urgent action by all maternity and neonatal providers. The national priorities are stronger Board accountability; listening and responding to women and families; safe staffing and services 24/7; action on inequalities; effective maternity triage; safe homebirth services; compassionate, trauma-informed responses to incidents and complaints; and delivery of Martha's Rule.

On 12th August NHS England wrote to all providers to use a newly created standardised national reporting template and submit this to the North West Regional team at two fixed points in time; 25th September and 31st December 2026. The assurance process is intended to support and evidence progress, not create additional reporting burdens with accountability for delivery embedded within existing governance arrangements. The template, along with evidence, will be submitted to the regional team, who will independently review and confirm compliance against each element.

Saint Mary's Managed Clinical Service has reviewed all 10 requirements and have an established a single action plan, monitored through the Maternity Operational Delivery Group (MODG) and in line with the perinatal quality surveillance model (PQOM) reported through existing Trust governance arrangements. Most locally controlled actions are expected to be compliant by the December submission; some remain dependent on national guidance or action.

The new template (Appendix 1) has been completed based on progress provided within this report and will be shared via PQOM to Specialist Hospital Clinical Group Senior Leadership Team (SHCG SLT), this committee and onwards to Trust Board of Directors.

There are no current alerts for escalation. The principal dependencies are confirmation of national reporting arrangements, completion of the maternity triage audit tool and further national guidance.

Recommendation(s)

The Quality, Safety and Performance Board Committee is asked to:

- Acknowledge the system letter and new reporting requirements for the 10-point plan
- Receive assurance on progress against the 10-point action plan and reporting template
- Support continued oversight through established Trust governance
- Support onwards submission to Board of Directors to approve and sign the reporting assurance template

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 the 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 within this report links to the following strategic, corporate, or operational risks:

-

Care Quality Commission domains
Please check **all** that apply

- | | |
|-------------------------------------|-----------------------------------|
| ☐ Safe | ☐ Caring |
| ☐ Effective | ☐ Well-Led |
| ☐ Responsive | |

Compliance & Regulatory Implications

The following compliance and regulatory implications have been identified as a result of the work outlined in the report:

-

Main report

This briefing provides Quality, Safety and Performance Board Committee with a high-level summary of the response taken by SM MCS following publication of Baroness Amos' investigation and subsequent 10-point plan from Chief Executive Officer of NHS England for all providers to achieve at pace. An action plan has been created locally to monitor progress against all 10 points and on 12th August NHS England wrote to all providers to use a newly created standardised national reporting template (appendix 1) and submit this to the North West Regional team at two fixed points in time; 25th September and 31st December 2026.

Acknowledging Ockenden

The national team has been clear the focus must be on the 10-point plan, and in acknowledging this, only a gap analysis of the Ockenden Report has been completed at this time. There are 79 individual recommendations within the 18 Immediate and Essential Actions, of which SM MCS is considered compliant for 44, 13 for which further work is required to be considered fully compliant, and the remaining 22 require national action/guidance. SM MCS will now await the review from the National Maternity and Neonatal Taskforce, initially expected in September 2026, however currently expected in December 2026.

Updates on the 10-point plan

1. Listening to women and their families by rolling out Martha's Rule

All providers are required to roll out Martha's Rule in all inpatient maternity and neonatal areas, including Antenatal Assessment Units and Maternity Triage.

SM MCS Maternity and Neonatal Care Division commenced a pilot of Martha's Rule in early 2026, which focused on the postnatal wards (including neonatal care). This was in line with the wider roll out of Martha's Rule across Manchester University NHS Foundation Trust (MFT). In May 2026 as decision was made to widen the programme within the Care Division. Communications (Appendix 2), training and escalation pathways are all in final stages of development with Martha's Rule expected to be fully implemented in all inpatient areas of maternity and neonatal services during Q3 2026/27. This will be monitored with the Care Division and overseen at SHCG Quality, Safety and Performance Committee.

Within the assurance template the baseline assessment is considered partially compliant. It is expected that this will be **fully compliant** for the December submission, supported by work from Health Innovation Manchester (HInM), who will support evidence against this element.

2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level

It is required that all providers must ensure that maternity and neonatal services implement a monthly cycle of collecting and analysing real-time patient outcomes and experience data (including friends and family test FFT, insights from maternity and neonatal voices partnerships (MNVP's). Data should be collected both throughout the woman's pregnancy and post birth journey, focusing on those service users from global majority backgrounds. This data must be received at provider public boards to ensure full transparency and enable Board scrutiny.

To progress this action, work has commenced between SHCG, Deputy Chief Nurse and Interim Director of Patient Experience to support presentation of maternity data using the existing patient experience platform and Trust Integrated Performance Report (IPR).

The Care Division has reviewed learning from the Ockenden and Amos Reports and commenced additional local maternity triage audits. These include a telephone triage audit of cases where women do not attend the unit following advice, and a review of triage reattendances within 12 hours. Findings will be shared through MODG and escalated to the Maternity and Neonatal Safety Champions and captured in the quarterly Maternity Safety Assurance Report.

Within the assurance template the baseline assessment is considered partially compliant. **Progress** will be evaluated for the December 2026 submission.

3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care

It is required for all providers to have clear joint accountability at Board level for maternity and neonatal services, with medical directors and chief nurses holding shared responsibility for oversight, performance and improvement. This must include consistent medical director engagement alongside the chief nurse. Directors of midwifery and clinical directors leading maternity and neonatal services should attend boards when maternity or neonatal matters are discussed.

Within MFT, accountability currently sits with Deputy Chief Executive and Chief Nursing Officer. It is required for Trust Board to support a change to make this joint accountability for the Chief Medical Officer and Chief Nursing Officer.

Both the Director of Nursing and Midwifery and Clinical Head of Division for maternity and neonatal services were invited to the Board of Directors on 30th July 2026 and will be invited to every meeting when maternity or neonatal matters are discussed.

Within the assurance template the baseline assessment is considered partially compliant. This is expected to be **fully compliant** for the December 2026 submission.

4. **‘Amos into action’ staff listening exercise**

NHS England has committed to launching a full, open conversation with NHS staff and leaders to identify how the recommendations can be implemented across the system.

The engagement will explore and help address the role of culture, attitudes, approaches to practice and ways of working – bringing staff into the single largest national conversation about what providers and individual clinicians need to do differently to implement both the letter and spirit of the Amos recommendations. This engagement will be done in a way that aligns rather than duplicates the work of the taskforce and will report findings into it.

SM MCS are committed to ensuring representation once the listening event is announced, the timeframe for this has yet to be shared.

Although this is not featured within the reporting template, staff will be supported and enabled to engage with this work.

5. **Addressing inequalities in maternity and neonatal outcomes**

It is required for all providers to participate in the Perinatal Equity and Anti-Discrimination Programme (PEADP).

The programme has been developed to support maternity and neonatal teams to tackle racism and discrimination, improve the experiences and outcomes of ethnic minority groups and those from deprived communities, whilst also support colleagues to work in environments free from discrimination and racism. All Boards must ensure that provision is in place to enable enough colleagues to be released to complete the PEADP, with full participation expected across multi-disciplinary teams.

In addition, provider Boards must also regularly review the inequalities dashboard and implement the maternity care bundle by March 2027.

In response, the Care Division has received support from SHCG Senior Leadership Team to enable 70 members of the multidisciplinary team to attend the PEADP which will commence in November 2026. Whilst attendance at the programme is free of charge, the Care Division will incur costs of £80,000 to backfill clinical posts to ensure safe service provision, whilst clinical team members attend the sessions. Each of the 70 members of the team will need to complete both day 1 and day 2 of the programme, compliance will be monitored at MODG.

The implementation plan for the maternal care bundle² published in January 2026, which aims to reduce maternal mortality and morbidity and reduce inequalities in adverse outcomes, will be submitted in line with Perinatal Quality Oversight Model (PQOM), to this committee in August 2026. To ensure compliance with Maternity Incentive Scheme (MIS) Year 8 this will

² <https://www.england.nhs.uk/long-read/the-maternal-care-bundle/>

then be submitted to Board of Directors in September 2026 for final approval, which will demonstrate that the Care Division is on target to achieve all requirements by March 2027.

Work is underway within the Care Division to ensure that regular review of the national inequalities dashboard is included in the quarterly maternity assurance report which is next due to report to this committee in October 2026. The dashboard, launched in May 2026, focusses on the proportion of babies born preterm, and the proportion of women experience postpartum haemorrhage (PPH) of 1500ml or more. Locally, PPH is a PSIRP priority for MFT and preterm labour is reported to the Board via the quarterly assurance paper within the Saving Babies lives Care Bundle, as part of the Maternity Incentive Scheme Year 8. On review of the dashboard, latest data December 2025, there appears a higher number of women experiencing a PPH in women from Black or Black British ethnicities. A review has commenced to understand this data further.

Within the assurance template the baseline assessment is considered partially compliant. This is expected to be **fully compliant** for the December 2026 submission.

6. Ensuring 24/7 safety and responsiveness of maternity and neonatal services

It is required that provider Boards ensure safe, effective services, including 24/7 staffing and responsiveness across key workforce groups, including a review of resource deployment and appropriate skill mix.

Across all three maternity sites, an update on midwifery staffing is provided three times a day, via the Maternity Update Status (MUS) report. This is sent to Executive Board members, SHCG SLT and the Care Division leadership team. The report is completed by the site based maternity bleep holder who provides oversight of safe maternity services 24/7, which would highlight any staffing concerns across midwifery and medical staffing.

Should redeployment of midwives in non-clinical roles be required, these are undertaken following review by the maternity bleep holder and in line with the maternity escalation policy. The Care Division is undertaking a further review of the escalation policy to ensure the policy captures the appropriate skill mix and clinical competence required to support the clinical workforce in times of high acuity. Further actions will be to review the escalation policy for neonatal workforce and expected to complete during Q3 2026/27.

Following the publication of Maternity Incentive Scheme Year 8, a new workforce report will be submitted to the Board of Directors on a six-monthly basis, reporting across key disciplines including midwifery, neonatal medical and nursing staffing, obstetric staffing and anaesthetic staffing. Key maternity staffing metrics are also reported through Workforce IPR and onwards to bi-monthly Board of Directors meetings.

Within the assurance template the baseline assessment is considered partially compliant. **Progress** will be evaluated for the December 2026 submission.

7. Trusts to review their homebirth services

It is required that all providers should ensure a review of their home birth services has been undertaken and reported to the Board of Directors and that any safety concerns requiring urgent attention have been actioned.

This 'ask' was anticipated following HM Coroner issuing a national Prevention of Future Deaths report to several national bodies, including NHS England, the RCOG and the NMC as a conclusion to the inquest into the tragic deaths of Jen and Agnes Cahill.

As the Committee is aware, MFT has already completed a full review of the home birth service, following which a new dedicated home birth team was launched in April 2025. The home birth service and outcomes are monitored through MODG. The Care Division is awaiting the outcome of the national home birth review, expected in Q4 26/27. Following which, the Care Division will ensure compliance with recommendation generated. There are no safety concerns requiring escalation, however staffing the on-call rota remains the main challenge. As such, home birth remains on the risk register (MFT/008478 – level 9). Due to unprecedented sickness absence, the home birth service was temporarily suspended on two occasions during the week commencing 27 July 2026. All women were contacted, and none required home birth services during this period; therefore, there was no negative impact. The Deputy Chief Nursing Officer of the Integrated Care Board and the Regional Deputy Chief Midwife were both informed of the temporary suspension.

Within the assurance template the baseline assessment is considered **fully compliant**.

8. Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach

It is required for provider Boards to receive assurance that that intelligence from incidents, complaints, concerns are responded to in an honest and compassionate way to avoid additional trauma being experienced should care or outcomes are not as expected/desired.

The IPR has been shaped to include key maternity matrices with action already taken to share neonatal data in the same manner. Discussions are being held to determine how data presented to Board can be strengthened to provide assurance that incidents, complaints and concerns are responded to with compassion. Aligned to PSIRF, the Care Division has 100% compliance for completing Duty of Candour. Each maternity/neonatal review includes engagement with the family ensuring any concerns they have are considered as part of the review into the care provided to them and the learning response. A new quarterly learning report provides thematic analysis to the Board of incidents and complaints to support triangulation of learning. SHCG governance team have commenced work with the corporate governance team to ensure that engagement with families, either following an incident or complaint is undertaken in a trauma informed way.

Within the assurance template the baseline assessment is considered partially compliant. **Progress** will be evaluated for the December 2026 submission.

9. Deliver safe and effective triage in maternity services

It is required that all providers must deliver safe and effective maternity triage by completing a board-level audit within three months to ensure services are safe, responsive and appropriately resourced. Ensuring dedicated midwifery staff, with clear escalation and training processes. Boards are required to oversee triage performance through regular review of waiting times, assessment and review times, delays, and outcomes. Audit findings must be reported to NHS England and DHSC, with improvements implemented within 12 months to meet national guidance and ensure consistent, high-quality triage care.

Locally, since 2023 the Care Division has been continually improving both the triage pathway and environment of care. The Care Division has demonstrated sustained improvement in performance data which is regularly shared with the Board in line with PQOM.

There is a bespoke Triage tool Manchester Maternity Assessment Triage Tool (MMATT) in place to meet the requirements within the patient demographic of those accessing maternity care.

The National maternity triage specification³ was released on 7th July 2026, however the diagnostic triage tool required to undertake the audit was only published on 12th August 2026. The Care Division are working at pace to undertake the audit, and aims to submit this, in line with PQOM, to this committee in October 2026 and onwards to Board of Directors in November 2026.

There is an expectation to achieve all 10 recommendations within the Triage Specification. Whilst awaiting the audit tool completion, the Care Division have commenced a gap analysis which will be overseen monthly at MODG from August 2026. Currently, a number of key triage measures are reported as part of the IPR as received by this committee.

The new Triage Specification appears to suggest that all women must be seen within 15 minutes, this will be a significant challenge, particularly for larger maternity providers due to the unpredictable nature of attendances, and peaks in activity.

Within the new recommendations, there is an expectation for all maternity triage departments to be separate from any other inpatient/outpatient service. In addition, the telephone triage midwife must be in a separate room, without any distractions. Currently, the ORC site meets both requirements, however at North Manchester and Wythenshawe the environment of care encompasses Antenatal Assessment Unit, with no separate room for telephone triage.

Within the assurance template the baseline assessment is considered non-compliant. **Progress** will be evaluated for the December 2026 submission.

³ [NHS England » National maternity triage specification](#)

10. Post-death care

There is a requirement for all providers to implement actions within the system letter⁴ in relation to the Fuller Report, including responding to the Board Assurance Statement by 31st July and Human Tissue Authority (reviewing and assuring completeness of incident records over the last 10 years).

Clinical Scientific Services, alongside MFT colleagues, have reviewed all recommendations and requirements within the Fuller Report and submitted this to Board of Directors on 30th July and onward to NHS England Inquiry Team on 31st July 2026.

Within the assurance template the baseline assessment is considered **fully compliant**.

Conclusion

The Care Division has made progress with the 10-point plan, with engagement from across Clinical Groups, and Trust colleagues to ensure that the actions will be achieved at expected by the end of December 2026. There are no alerts to the committee at this time.

The template and supporting evidence will be submitted to the North West Regional Maternity Team for independent review of compliance against each element. This external assurance process will help ensure consistent evidence standards across all providers.

⁴ <https://www.england.nhs.uk/long-read/nottingham-maternity-review-findings-on-post-death-care-and-key-actions-required-following-the-fuller-inquiry/>

Appendix 1

Trust Board Assurance Template						
No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference <i>Please input reference number as listed in 3. Evidence Log tab</i>	Gaps in Assurance <i>Please provide detail of any gaps in assurance</i>	Improvement Actions (Including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Partially compliant	NA			Following on from successful pilot on postnatal wards, there are plans in place to launch Martha's Rule across all Maternity and Neonatal inpatient areas by 30th September 2026. Standard Operating Procedures in final stages of development, training in place, aligned to NHS requirements, and welcome webinar was attended on 12th August 2026 by senior clinical group members and leads within maternity and neonatal services, and working with HinM to ensure alignment with national roll out.
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.						
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT,	Partially compliant	IPR, CQC Survey, Assurance Paper, Cultural Work Paper presented to QSPBC, and captured in QSPBC report to Board		Implement Patient Experience Dashboard for all Maternity and neonatal areas	

	CQC survey findings when available, local intelligence from MNVPs and targeted outreach?					
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant	Patient Experience Report		Strengthen Maternity and Neonatal patient experience within the overall Board Report	
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant	Learning report, Board Minutes		Strengthen Dashboard and IPR to identify experience by ethnicity and deprivation	Learning report at Trust Board in July 2026. Minutes will be available at the end of September 2026

3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Partially compliant	NA			Chief Nursing Officer has this responsibility currently, paper will go to QSPBC in August 2026 to support submission to Trust Board on 30th September, where it will be formally requested for Joint Chief Medical Officer and Deputy Chief Executive & Chief Nursing Officer to have dual board level accountability for maternity and neonatal care. Minutes of which will be available at the end of November 2026
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant	NA			Director of Nursing and Midwifery and Medical Director attended Trust Board on 30th July 2026. Agenda and minutes will be available at end of September 2026
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Partially compliant	NA			Paper submitted to People Board (Sub Board of Trust Board) Will be received at Trust Board on 30th September 2026. Minutes of which will be available end of November 2026

5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant	NA				Inequalities dashboard within the quarterly Learning report which will next be submitted in October to QSPBC and onwards to BoD (Private)
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Partially compliant	NA				Paper and plan approved at QSPBC (sub Board of Trust Board) Will be received at Trust Board on 30th September 2026. Minutes of which will be available end of November 2026
6. Ensuring 24/7 safety and responsiveness of services							
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Partially compliant					In line with MIS Year 8, Trust is meeting the expected requirements with no concerns to raise. Will not be considered fully compliant until submission to Trust Board in November 2026 and subsequent declaration form signed by Trust CEO in January 2027 ahead of March 2027 MIS Year 8 submission.
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated	Partially compliant					In line with MIS Year 8, Trust is meeting the expected requirements with no concerns to raise. Will not be considered fully compliant until submission to Trust Board in November 2026 and subsequent declaration form signed by Trust CEO in January 2027 ahead of March 2027 MIS Year 8 submission.

	database of all short-term locums (≤ 2 weeks) working on tier 2/3 obstetric rotas? <i>(In line with MIS Year 8)</i>					
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? <i>(In line with MIS Year 8)</i>	Partially compliant				In line with MIS Year 8, Trust is meeting the expected requirements with no concerns to raise. Will not be considered fully compliant until submission to Trust Board in November 2026 and subsequent declaration form signed by Trust CEO in January 2027 ahead of March 2027 MIS Year 8 submission.
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and	Partially compliant	BR plus report			In line with MIS Year 8, Trust is increasing the funded establishment to meet the 2026 BR+ of 812.56 by the end of October 2026. Will not be considered fully compliant until MIS Year 8 submission to Trust Board in November 2026.

	Head of Midwifery? <i>(In line with MIS Year 8)</i>				
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? <i>(In line with MIS Year 8)</i>	Partially compliant			In line with MIS Year 8, Trust is meeting the expected requirements with no concerns to raise. Will not be considered fully compliant until submission to Trust Board in November 2026 and subsequent declaration form signed by Trust CEO in January 2027 ahead of March 2027 MIS Year 8 submission.
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed	Compliant	Assurance report, learning report, QS IPR, workforce IPR, PE IPR and daily MUS, bi-annual workforce report	Neonatal daily update needs strengthening to ensure all board level maternity and neonatal safety champions received daily sitrep.	Evidence attached for all except bi-annual workforce report which will be submitted to People Board in October 2026 and onwards to Board of Directors in November 2026. Minutes of which will be available at the end of January 2027.

	working, so that services can consistently and safely respond to the needs of women, babies and families?				
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of	Partially compliant		SM MCS has a robust escalation policy to support redeployment of staff in non-clinical roles however review has commenced to strengthen identification of those suitable for redeployment. A review of all specialist posts has commenced to ensure that champions are available on shift when specialists are not. A review of all specialist posts has commenced to ensure that champions are available on shift when	Once complete, the updated escalation policy will be ratified through existing governance process, expected by end of October 2026. Both redeployment into clinical areas and presence of specialist support will be captured within the quarterly maternity assurance paper submitted to QSPBC in October 2026, and within QSPBC escalation report to Trust Board in November 2026. Minutes of which will be available in January 2027

	redeployment across the service.				specialists are not.	
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Compliant	Assurance report and TLTC paper	NA	NA	Full review of HB service took place prior to the letter, and support provided by MFT in response to national PFD. No further response required.
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Not applicable	NA	NA	NA	NA
8. Responding to incidents, complaints and concerns with humanity and candour						

8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Partially compliant	MFT PSIRF (2022-2025) DoC Level 4 compliance, IPR, Quarterly Thematic Learning Report to Board		PSIRF requires updating and must be strengthened regarding maternity and neonatal incident responses.	
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Compliant	Learning report and Trust complaints report			

8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Partially compliant	Debrief service and poster, learning report, DoC compliance		Strengthen evidence around training for debrief and DoC	Debrief service in place for all women, all families involved in incidents have named contact and early DoC (professional or Statutory)
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Non-compliant		Until gap analysis and completion of tool takes place, it is not possible to determine whether the trust is on track to implement the improvements required.		Gap analysis undertaken. Tool published on 12th August. Division will complete the tool and submit to October QSPBC and onwards to Trust Board
9.2	Does the board have clear oversight of triage quality and performance,	Partially compliant	IPR	currently IPR does not focus on inequalities		

	supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?					
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Non-compliant		Until gap analysis and completion of tool takes place, it is not possible to determine whether the trust is on track to implement the improvements required.		Triage Specification highlights gaps in current MFT triage provision. Tool to be completed to demonstrate current issues, and action plan will be created to address gaps. All will be presented to QSPBC in October and onwards to Trust Board.
10. Post death care						
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	assurance statement			Submitted to england.nhsinquiryteam@nhs.net on 30th July 2026, following receipt at Trust Board in July 2026.
10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters	Compliant	Bi-annual QSPBC paper to Trust Board			update presented to QSPBC in April, included in report to Trust Board in May. Due again in October 2026.

	relating to mortuaries including review of incident records over the past 10 years?				
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Martha's Rule

**Your voice matters.
If you are worried,
please tell us.**

If you are worried that you, your baby, or someone you care for is getting worse and you feel your concerns are not being heard, please speak to a member of the maternity team.

Maternity Martha's Rule Escalation Number:

North Manchester – 0161 625 8173
St Mary's Oxford Road – 0161 701 2435
Wythenshawe – 0161 291 5526



Scan the QR code to find out more or ask a member of the ward team to help.



Public Board of Directors

Wednesday, 30 September 2026

Paper Title:	National Maternal Care Bundle Implementation Tool	Agenda Item 11.2a
Presented by:	Kimberley Salmon-Jamieson, Deputy Chief Executive and Chief Nursing Officer	
Prepared by:	Kathy Murphy, Director of Nursing and Midwifery, SHCG	
Meetings where content has been discussed previously	SM MCS Maternity Services Quality and Safety Committee August 2026 SM MCS Maternity and Newborn Services Divisional Management Board August 2026 SM MCS Quality, Safety and Performance Group August 2026 SHCG Quality, Safety and Performance Committee August 2026 Quality, Safety and Performance Board Committee August 2026	
Purpose of the paper Please check <u>one</u> box only:	☒ For approval ☐ For support ☐ For discussion ☐ For noting	

Executive summary / key messages for the meeting to consider

This report sets out the Saint Mary's Managed Clinical Services (SM MCS) plan for implementing the Maternal Care Bundle¹, published January 2026 and which establishes best practice standards across five areas of clinical care: venous thromboembolism, pre-hospital and acute care, epilepsy in pregnancy, maternal mental health and obstetric haemorrhage.

Implementation of the Maternal Care Bundle by March 2027 is a requirement of the Maternity Incentive Scheme (MIS) Year 82.

Following completion of the national implementation tool, the Maternity and Newborn Services Care Division baseline assessment reports four of the five elements (2-5), as partially implemented. Whilst Element 1 relating to venous thromboembolism requires a new clinical pathway to be developed to support care from the first point of contact. Preparatory work to support implementation is underway, including strengthening clinical pathways, updating relevant guidelines, developing audit and oversight mechanisms, and progressing required digital changes within Hive EPR. Specific timescales for completion are captured within Table 1, with final elements expected to complete at the end of January 2027.

¹ <https://www.england.nhs.uk/long-read/the-maternal-care-bundle/>

² https://resolution.nhs.uk/wp-content/uploads/2026/03/MIS-Year-8_Core-standards.pdf

There are several improvements required in relation to digital enablement within EPR, particularly for Elements 1 and 4, where additional documentation and workflow changes are required to support consistent clinical practice, data capture and audit. The Care Division is progressing these requirements and will continue to monitor delivery timescales every month, with all expected to complete during Q3 and Q4 26/27.

The report provides the Board of Directors assurance that a structured implementation programme has commenced, with monthly element-specific meetings, oversight through the Maternity Operational Delivery Group and onward reporting through the Perinatal Quality Oversight Model. This will enable monitoring and delivery against the required 31st March 2027 completion date, including escalating any risks or delays.

Recommendation(s)

The Board of Directors is asked to:

- Approve the Maternal Care Bundle implementation plan and trajectory of compliance by March 2027.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?

☐ **Yes**
☒ **No**

Please set out in the report what action has been taken to address this

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 within this report links to the following strategic, corporate, or operational risks:

- MFT/007609: Lack of point of care thrombotic testing (operational risk, score 12)
- MFT 8530: Cell salvage availability

	at North Manchester (operational risk, score 12) • MFT/005930: Meeting recommendations from national maternity reports (operational risk, score 8)
Care Quality Commission domains Please check <u>all</u> that apply	☒ Safe ☐ Caring ☐ Effective ☒ Well-Led ☒ Responsive
Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the report: • NHS Resolution Maternity Incentive Scheme (MIS) Year 8

Main report
Introduction The Maternal Care Bundle published in January 2026 represents a national best practice framework designed to reduce maternal mortality and morbidity, reduce unwarranted variation in care and address inequalities in maternal outcomes. As previously reported to this Committee in June 2026, publication of the national <i>maternal care bundle: a bundle for reducing maternal mortality and morbidity</i> implementation tool was delayed from March 2026 to 2nd June 2026. Whilst the Maternity and Newborn Services Care Division acknowledges that this delay has reduced the available implementation timeframe; the Care Division can confirm a structured programme of work commenced following publication of the care bundle to support full implementation of all five elements by 31st March 2027 Current Position The Care Division has completed the Maternal Care Bundle implementation tool and Table 1 below indicates the baseline self-assessment status for each of the five elements. This assessment confirms that four of the five elements are partially implemented. Implementation of Element 1 relating to venous thromboembolism requires a new clinical pathway to be developed to support care from the first point of contact; work has commenced to develop this new pathway. To support delivery, monthly divisional meetings have been established for each element. These meetings will oversee progress against the agreed action plan, identify risks or delays, confirm required mitigations and escalation through the Maternity Operational Delivery Group (MODG).

Progress will be reported to this Quality, Safety and Performance Board Committee (QSPBC), in line with the Perinatal Quality Oversight Model (PQOM), as a sub board committee providing a clear route for Board-level assurance.

The implementation of the Maternal Care Bundle by 31st March 2027 is included within NHS Resolution Maternity Incentive Scheme (MIS) Year 8 Safety Action E. To support Trust Board to sign the MIS Year 8 declaration form in January 2027, the Care Division must provide assurance that progress is **on target** to achieve full implementation by 31st March 2027. To achieve this Trust Board of Directors must:

- receive the current position and ongoing plan to achieve implementation in Q2
- via QSPBC, receive quarterly updates in Q3 & 4 demonstrating progress against each element, including any risks or delays and actions being taken.

The first quarterly update will be within the Maternity Assurance report provided to QSPBC in October 2026.

Table 1: Divisional self-assessment status and implementation plan

Element Self-assessment status	Rationale for self-assessment status and ongoing actions	Implementation Actions/updates and dates for completion
1: Venous thromboembolism (VTE) Not implemented	Work to fully implement Element 1 has commenced: • A care pathway in line with Element 1 is being developed, including: ◦ offering women the national self-assessment questionnaire for VTE	• Ensure Pregnancy VTE risk assessment questions included in the pregnancy care self-referral forms (October 2026) • Develop Process for identifying women at their first point of access (outside Maternity Services) to support self-referral (December 2026)
	◦ offering low molecular weight heparin (LMWH) to women identified as being high risk to receive this within 72 hours, and follow up within 4 weeks • Greater Manchester Integrated Care Board is supporting the review of the North West clinical guideline and engagement with primary care. • A task and finish group to oversee implementation wherever women first access care in pregnancy, including representation from Gynaecology and Emergency Departments is being established The required audits will be implemented following ratification of the guideline.	• Develop Process for offering and prescribing LMWH within 72 hours (January 2027) • North West Regional Guideline under review and expected to be ratified October 2026. • Develop Audit process (January 2027) • ICB supporting development of Primary Care processes (does not impact on MFT implementation but may impact women having timely first point of contact care)

2: Pre-hospital and acute care Partially implemented	Work to fully implement Element 2 has commenced: • Maternity Obstetric Early Warning Score (MEOWS) embedded into EPR supported by a clinical guideline. • A pre-alert system, with dedicated 'red' phone line, from NWAS is in place for each labour ward • A review of the signage from the road to each labour ward is being undertaken with NWAS • Acute care in pregnancy guideline being developed by the Maternal Medicine Network (MMN) • MMN care pathways in place (ORC hosts Maternal Medicine Centre) • The required audits will be implemented following ratification of the guideline.	• Signage from the road to each labour ward has been reviewed with NWAS and Estates and Facilities (November 2026) • Acute Care Guideline under review and will be ratified by MMN (November 2026) • Develop Audit process (January 2027)
3: Epilepsy in pregnancy Partially implemented	Work to fully implement Element 3 has commenced: • A clinical guideline is in place, which is being reviewed and updated by the MMN. • MMN processes in place, including management of women requiring complex epilepsy care (ORC hosts Maternal Medicine Centre) • The required audits will be implemented following ratification of the guideline.	• Epilepsy in pregnancy guideline under review and expected to be ratified by MNN October 2026 • Develop Audit process (January 2026)
4: Maternal mental health	Work to fully implement Element 4 has commenced: • A clinical guideline is in place, which is being reviewed and updated by the	• NW Regional Mental Health in Pregnancy guideline under review and expected to be
Partially implemented	North West Regional Guideline Group. • Process for implementing Whooley questions and Edinburgh Postnatal Depression Score (EPDS) into EPR requested • The required audits will be implemented following ratification of the guideline.	ratified by NW regional team October 2026 • Ensure Whooley questions and the EPDS embedded within EPR (January 2027) • Develop Audit process (January 2027)

5: Obstetric Haemorrhage Partially implemented	Work to fully implement Element 5 has commenced. • A clinical guideline is in place, which is being reviewed and updated by the North West Regional Guideline Group. • A review of clinical resources is in progress. • The required audits will be implemented following ratification of the guideline. • Multidisciplinary case review process in development. • Maternity dashboard to be updated to provide oversight in line with Element 5	• NW Regional Obstetric Haemorrhage guideline (October 2026) • Audit of appropriate clinical resources in progress (August 2026) • Multidisciplinary case review process (December 2026) • Audit process in place (January 2026) • Maternity dashboard providing oversight (January 2027)
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Digital Support

The key implementation dependency identified at this stage relates to digital support within EPR. Elements 1 and 4 require additional documentation and clinical workflow changes to support consistent assessment, referral, audit and reporting. Element 5 requires further development of the maternity dashboard to show obstetric haemorrhages 1-2 litres and those ≥ 2 litres.

A plan has been developed to identify all required digital changes with support from the Digital Midwives and the SM MCS Hospital Clinical Information Officer. Progress will be monitored within SM MCS digital committee, and escalated to MODG, SHCG SLT and the Maternity and Neonatal Safety Champions in line with the PQOM to ensure timely progress and achieve full implementation by 31st March 2027.

Oversight of progress and final sign off

The Care Division will provide scheduled progress updates in line with PQOM, which includes:

- Monthly progress updates to MODG
- Quarterly updates to Maternity and neonatal Safety Champions
- Quarterly updates to QPSBC in October 2026 and December 2026 within the Maternity Assurance report.

As with MIS submissions, the Care Division is expected to ensure all evidence of compliance is quality assured before confirming compliance with any specific element. A pathway is in place to review evidence once the Care Division considers an element of the implementation plan complete. This review will be undertaken by the SM MCS Hospital Leadership Team, who will confirm that appropriate evidence has been completed and provide assurance of compliance to MODG and the Maternity and Neonatal Safety Champions, supporting ongoing assurance to QSPBC.

A final report will be presented to QSPBC in February 2027, confirming the implementation position for all five elements of the Maternal Care Bundle. The Committee will be asked to review the final position and confirm that all five elements have been implemented.

Subject to Committee confirmation, the Care Division will request that the completed implementation plan is submitted to the Board of Directors' meeting in March 2027 for final sign-off ahead of the required completion date of 31st March 2027.

Summary

Overall, the Care Division can provide positive assurance that implementation has commenced across four of the five elements, with preparatory work underway for Element 1. A governance structure is in place to oversee delivery. Further assurance will be provided through quarterly progress reports, including updates on each element, delivery milestones and any areas requiring additional support.

Public Board of Directors
Wednesday, 30 September 2026

Paper Title:	MFT Annual Complaints Report 2025/26	Agenda Item 11.3
Presented by:	Kimberley Salmon-Jamieson, Deputy Trust Chief Executive and Chief Nursing Officer	
Prepared by:	Ailsa Gaskill-Jones, Associate Director Clinical Governance – Patient Safety & Complaints	
Meetings where content has been discussed previously		Quality, Safety and Performance Board Committee – 25 August 2026 Quality and Safety Management Committee - 7 July 2026
Purpose of the paper Please check <u>one</u> box only:		☒ For approval ☐ For support ☐ For discussion ☐ For noting

Executive summary / key messages for the meeting to consider

This report presents the Annual PALS and Complaints Report for 2025/26, providing an overview of activity, performance, learning and improvement across Manchester University NHS Foundation Trust from 1 April 2025 to 31 March 2026.

During 2025/26, MFT received 9,802 PALS contacts, an increase of 15.1% from the previous year, and 2,038 complaints, an increase of 3.2%. The growth in PALS activity was primarily associated with concerns regarding waiting times, access to services and communication, while complaint themes were most commonly related to communication, discharge and transfer, safeguarding, and documentation.

Complaints handling performance remained strong, with 100% of complaints acknowledged within the statutory three working day requirement and 90% responded to within agreed timescales, an improvement on the previous year. The proportion of re-opened complaints remained low at 7.2%, while over three-quarters of complaints were upheld or partially upheld, demonstrating continued openness to learning and service improvement.

Learning from PALS and complaints continues to inform organisational improvement. Access and waiting time concerns are being addressed through the Care on Time programme, while communication-related themes have driven a range of targeted initiatives, including compassionate communication training, relationship-centred care programmes and wider culture improvement work. Patient and family feedback remains a key source of intelligence for identifying opportunities to improve care and experience.

Governance and assurance arrangements have been strengthened during the year through enhanced reporting and oversight. Trust-wide Power BI dashboards provide real-time access to thematic and performance data, supported by regular reporting through Clinical Groups, Quality and Safety governance structures, the Integrated Performance Report and Board committees. Arrangements have also been introduced to strengthen oversight of Parliamentary and Health Service Ombudsman (PHSO) cases and complaints from Members of Parliament.

The PHSO opened 13 new investigations and completed reviews of 37 MFT complaints during the year. The majority of cases were either not investigated due to the quality of the Trust's local investigation or were not upheld, providing assurance regarding the robustness of complaints management processes.

The 2026 improvement programme is underway and includes implementation of a new Complaints Framework, enhanced internal audit arrangements and a continued focus on improving the timeliness of PALS resolution. Further work will strengthen triangulation of insights from complaints, PALS and patient experience data, supported by collaboration with Health Innovation Manchester to improve how learning is translated into sustainable organisational change.

Overall, the report demonstrates that MFT continues to maintain effective complaints management processes while using feedback and concerns as a key driver of quality improvement, patient experience and organisational learning.

Recommendation(s)

The Board of Directors is asked to:

- Approve the MFT Annual Complaints Report 2025/26.
- Receive and take assurance from the 2025/26 PALS and Complaints position, including compliance with NHS Complaints Regulations, sustained performance against response standards, and the key themes arising from patient and family feedback.
- Take assurance from the strengthened oversight, reporting and governance arrangements, and the improvement actions being delivered in response to learning from PALS, complaints and Parliamentary and Health Service Ombudsman (PHSO) outcomes.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?

☒ **Yes**
☐ **No**

Please set out in the report what action has been taken to address this

Relationship to the strategic objectives

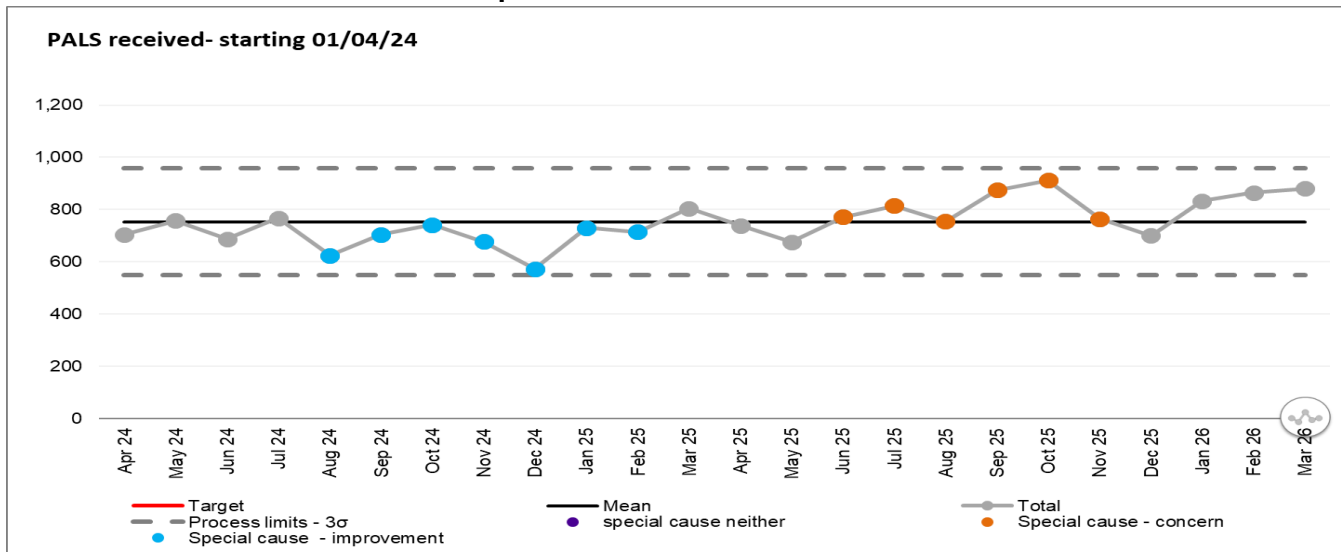
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)

☒ 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 within this report links to the following strategic, corporate, or operational risks:
Care Quality Commission domains Please check <u>all</u> that apply	☒ Safe ☒ Caring ☒ Effective ☒ Well-Led ☒ Responsive
Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the report: • CQC regulation 16: Receiving and acting on complaints

Main report
1. Introduction MFT's PALS and Complaints Teams ensure effective complaints handling and monitoring to meet national regulatory requirements. The teams support clinical and operational teams to ensure learning from complaints is used to triangulate with data from other sources to improve services for the people who use them and colleagues working in them. More broadly, the Central Complaints Team is working in partnership with Clinical Groups to strengthen PALS and complaints processes across the Trust. This work aims to standardise approaches, improve the timeliness and quality of responses, and support early local resolution, while ensuring compassionate engagement remains at the heart of how concerns are managed and addressed. To support this work, a PALS, and Complaints Team 2026 annual improvement workplan has been developed in collaboration with colleagues from both the central and Clinical Group PALS and Complaints Teams. As part of this wider work, a review of the reporting of quality and performance in relation to Complaints and PALS has been undertaken to ensure that all relevant committees are fully sighted and assured of the position and ongoing improvement work. 2. PALS performance and analysis 2.1 An overview and thematic analysis of PALS contacts During 2025/26, MFT received 9,802 PALS contacts, which is a 15.1% increase from the 8,517 contacts in 2024/25. The increase was mainly attributable to waiting times for appointments and procedures in both adult and paediatric surgery, trauma & orthopaedics, gynaecology and ophthalmology. There has been progress through the ongoing Care on Time initiatives across the organisation. However, it is acknowledged that some patients continue to experience lengthy waits for surgery, this is related particularly to Paediatric, Trauma & Orthopaedics, Oral and Maxillofacial and general surgery. This has contributed to an increase in contacts to PALS. The ongoing work of operational and clinical teams to improve access and deliver care on time will continue to be closely monitored, with support provided to patients while they await treatment.

Graph 1: PALS contacts 2024-2026



Communication remained a key driver of PALS contacts. In response a range of improvement initiatives have been implemented including, the implementation of organisational training programmes alongside targeted activity and initiatives within individual Clinical Groups:

- 4325 colleagues have attended Sage and Thyme training. This training is designed to support colleagues across the organisation in developing the skills to better support and respond to patients, clients, or carers, who are distressed or concerned.
- 300+ colleagues have attended Civility Saves Lives sessions and Civility Saves Lives 'Train the Trainer' is being rolled out across MFT, to exponentially increase the number of sessions delivered each year.
- Maguire Advanced Communication training for nursing, midwifery and AHP colleagues. This training is designed for healthcare colleagues to support them in handling complex, emotive, or challenging conversations.
- Ongoing monitoring of feedback from patients and families via the Patient Experience Surveys, to review areas of challenge and target focused improvement work
- MFT Workshop and focused training to support colleagues with compassionate engagement

In addition, the organisation wide Culture Programme is addressing communication, incivility and culture concerns via a number of workstreams, in particular:

- Psychological Safety Programme: Creating environments where colleagues feel safe to speak up, raise concerns, challenge decisions, ask for help, and discuss mistakes without fear of blame or negative consequences.
- Civility Programmes: Promoting respectful behaviours and reducing incivility through guides, masterclasses and practical support, recognising the impact of behaviour on communication, teamwork, colleagues' wellbeing and patient safety.
- Collective & Compassionate Leadership Development: Developing leaders who listen, engage, communicate effectively, and create cultures of trust, inclusion and accountability.
- Culture & Staff Experience Forum: Providing a structured mechanism for colleagues so they can share experiences, identify concerns and influence organisational priorities and improvements.

- Colleague Survey and 'You Said, We Did' Feedback Loops: Increasing transparency and trust by demonstrating how colleague feedback is informing decisions and resulting in tangible actions and improvements.
- Culture Experiments: Testing practical, local improvements through safe-to-learn approaches that help teams address cultural challenges and improve ways of working - mainly around psychological safety and leadership behaviours.
- Embedding Respect, Inclusion and Belonging - Discrimination pledge: Addressing themes of discrimination, exclusion and incivility by reinforcing expectations around behaviour, allyship, psychological safety and accountability.

The MFT Digital First Appointment Details for “All Project” is proving successful and correlated with a decrease in patients raising concerns with PALS in relation to the appointment information they received.

2025/26 data does show a reduction in PALS cases related to the attitude of colleagues and the PALS Team continues to work with senior leadership teams across Clinical Groups to embed early resolution of concerns. Through targeted training and support, clinical and operational teams are being equipped to address concerns promptly and compassionately at the point of care, reducing unnecessary escalation to PALS and improving the experience of patients, families and carers.

2.2 PALS responsiveness and key performance indicators (KPI)

The PALS Team continues to deliver a timely service to patients and their representatives, with >90% of cases closed within 10 working days during 2025/26.

As part of the annual improvement workplan the ambition is to increase the number of cases resolved within 5 days. This will be alongside the ongoing work to resolve PALS through local resolution via a face-to-face conversation where the concerns are being raised in relation to a current inpatient or through a telephone call with senior clinical, nursing or operational colleagues to patients/families where this is more appropriate, for example concerns raised regarding outpatient care or following discharge.

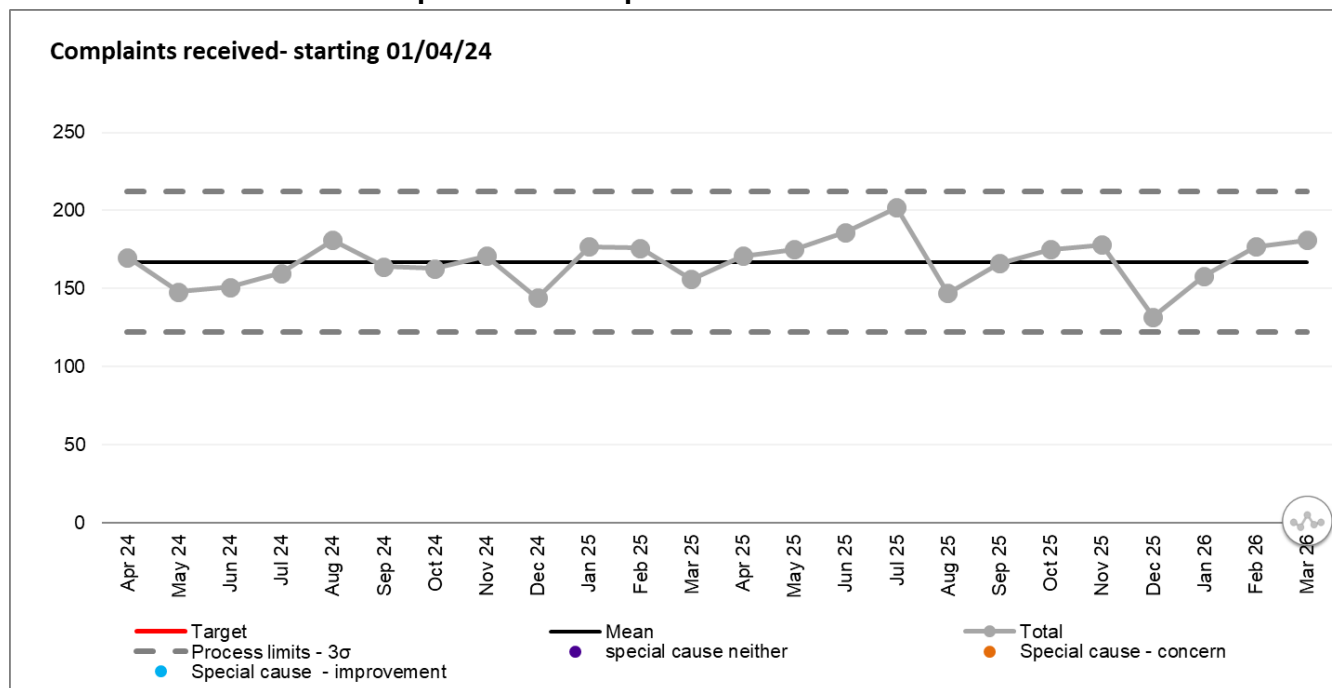
A total of 239 PALS cases were escalated to formal complaints in 2025/26, compared with 177 in 2024/25. This increase reflects the complexity of concerns being raised and highlights the continued importance of timely resolution, effective communication and proactive patient engagement. Targeted early resolution training is being delivered in Clinical Groups with higher levels of PALS contacts and complaint escalations. The programme focuses on improving the quality and timeliness of local responses and will be expanded throughout 2026/27 as part of the enhanced PALS support offer.

3. Overview of Complaints service performance and analysis

3.1 An overview and thematic analysis of Complaints

There was a 3.2% increase in complaints in 2025/26 from the previous year, with 2,038 new complaints received compared to the 1975 received in 2024/25 (Graph 2). The numbers of complaints remain consistent with numbers received at similarly sized organisations within The Shelford Group and across Greater Manchester.

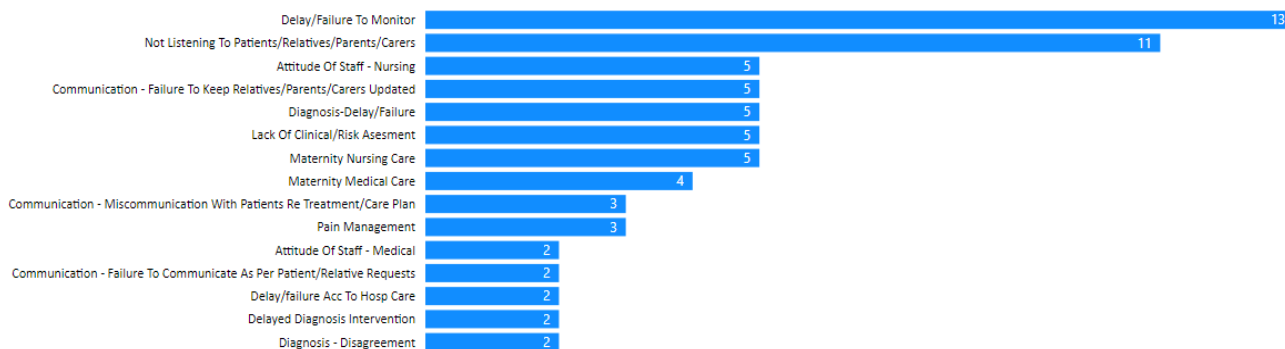
Graph 2: New complaints received 2024-2026



The rise in complaints is attributable to small increases across a number of themes, including communication, discharge and transfers, safeguarding, security, and documentation. An increase in complaints had previously been noted within Specialist Hospitals, particularly with regard to the maternity service.

Themes from maternity complaints are detailed below:

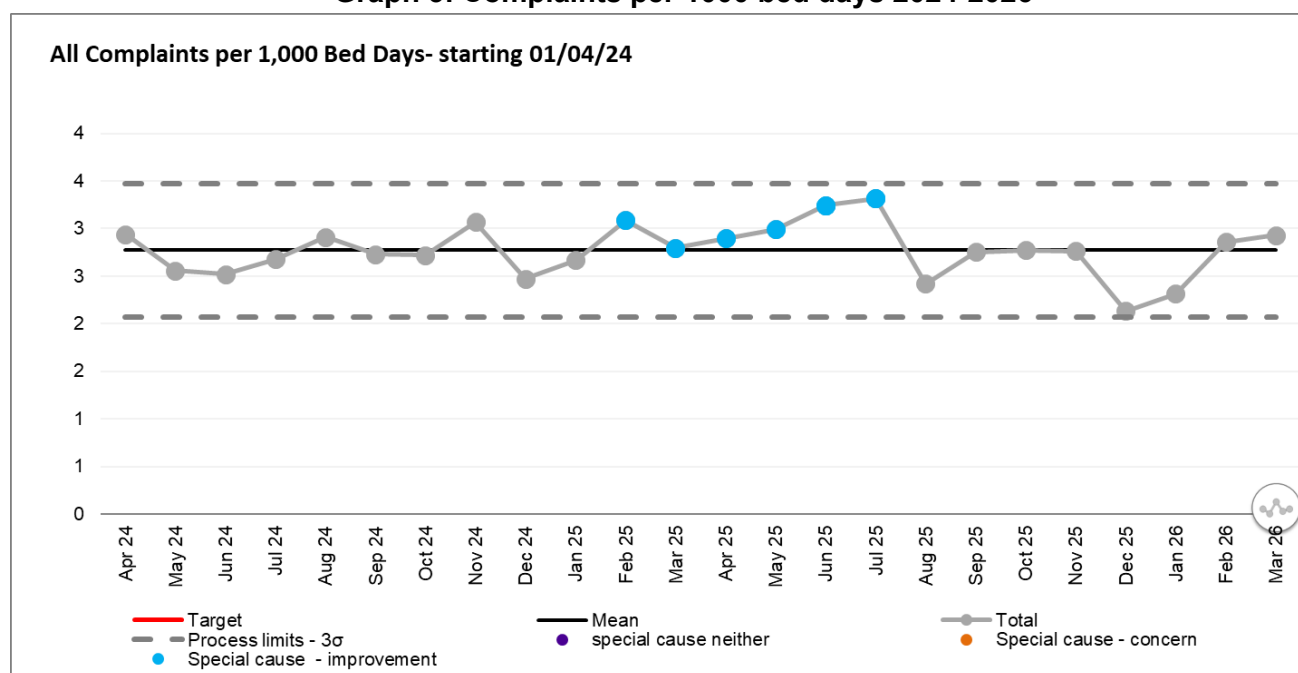
Formal Complaint Categories



To improve this position, the Complaints Team and Saint Mary's senior nursing leadership have implemented a revised approach to the management of maternity complaints. The new process places greater emphasis on compassionate engagement with patients and families and has led to increased use of debriefs and local resolution meetings, providing opportunities to discuss experiences in person, address concerns promptly and support earlier resolution where appropriate.

Graph 3 shows that, although the total number of complaints received across the organisation increased during 2025/26, the rate of complaints per 1,000 bed days demonstrated special cause variation of an improving nature, indicating a positive trend when activity levels are taken into account

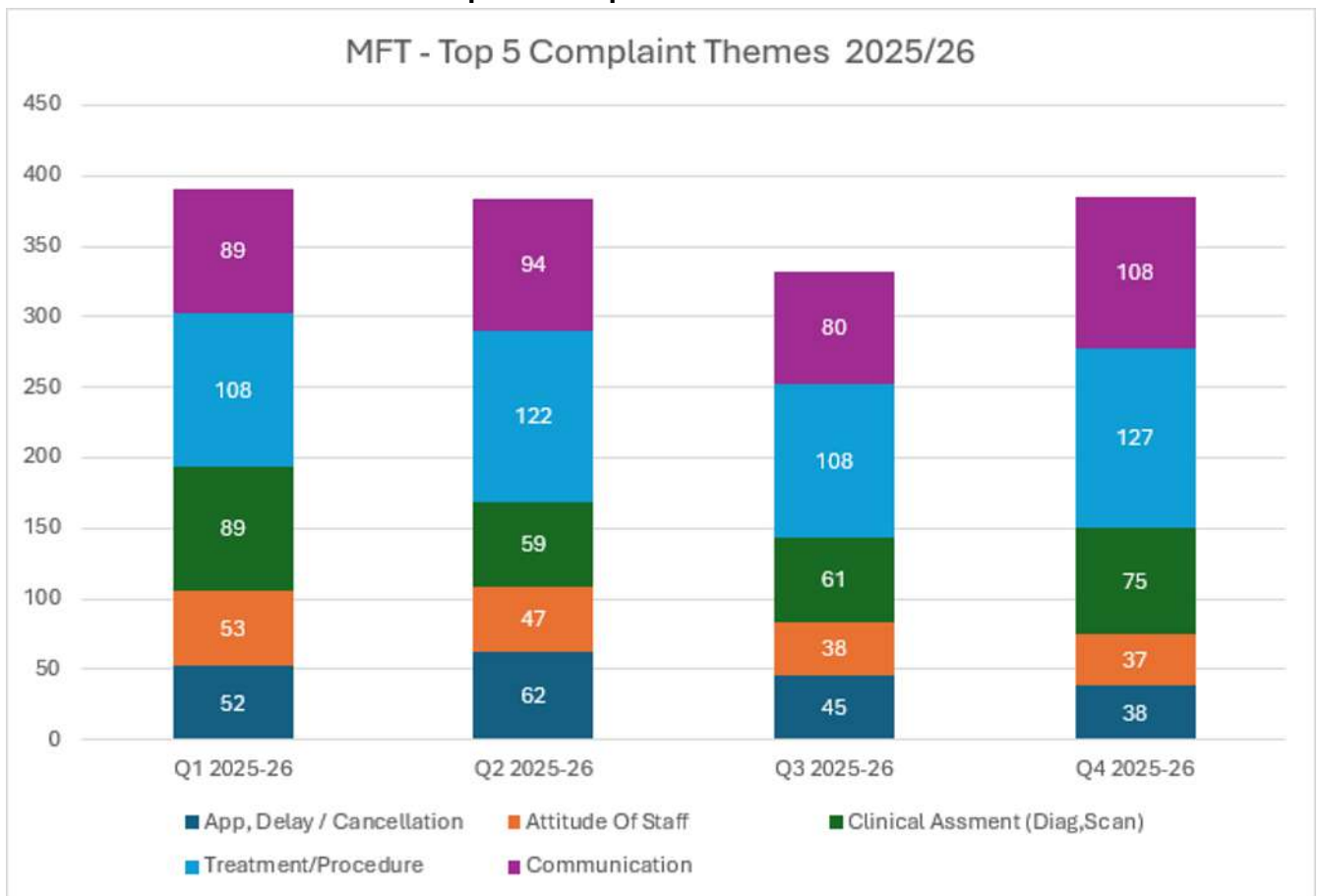
Graph 3: Complaints per 1000 bed days 2024-2026



The main themes of complaints across the organisation (Graph 4) have been in relation to Treatment/Procedure, Communication and Clinical Assessment. These themes are consistently amongst the top themes of complaints across the Shelford Group, Greater Manchester and other NHS Acute Trusts.

Improvement activity to address these themes is ongoing and evolving. Further information regarding work completed to date is included in sections 6 and 7.

Graph 4: Complaint themes 2025/26



3.2 Complaint responsiveness and key performance indicators (KPI)

The NHS Complaints Regulations (2009) require all new complaints to be acknowledged within three working days of receipt of the complaint; MFT is committed to achieving this in 100% of cases. This indicator was met during 2025/26, with 100% of complaints acknowledged on time.

Complaints often relate to more than one issue. In line with the expectations of the NHS complaints standards and based on the Parliamentary Health Service Ombudsman (PHSO) classification, if concerns are identified in all the issues raised and substantive evidence is identified to support the complaint then it is recorded as 'upheld'. If concerns are found in one or more of the issues, and not all, the complaint is recorded as 'partially upheld'. Where there is no evidence to support any aspects of the complaint made, it is recorded as 'not upheld'.

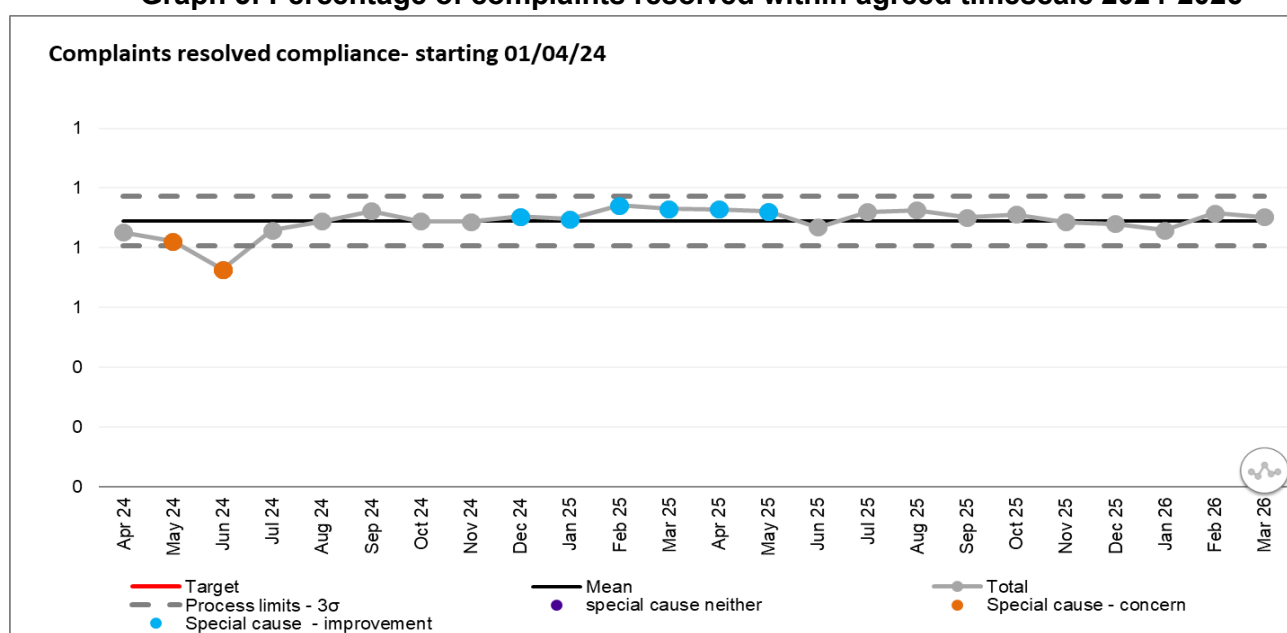
Using this approach, during 2025/26, 25% (499) of complaints were 'upheld', 53% (1028) were 'partially upheld' and 22% (427) were 'not upheld'. This terminology is consistent with that used by the PHSO. It should be noted however, in corresponding with patients and families, we do not use this terminology. Complainants will only be advised whether the complaint has been upheld or not in line with our compassionate engagement approach.

There has been a continued focus on achieving early resolution of concerns to improve the process and satisfaction outcomes for both patients and colleagues. During 2025/26, 256 complaints were resolved through the organisation's complaints early resolution process. Embedding this is an ongoing piece of work with the central Complaints Team taking a proactive role in supporting Clinical Groups to adopt a locally based, early resolution approach with increased use of telephone calls and face to face meetings to resolve concerns within five working days of the concern being raised.

MFT achieved closure of 90% of complaints within the agreed timescale during 2025/26. This is in line with the organisation's standard and was an improvement from the 89% achieved during 2024/25.

To improve the position against this metric, all overdue complaints, and causes, are escalated to CEOs and are included in monthly briefings. Complaints response compliance data is also presented to all Clinical Group senior leadership teams and governance colleagues, on a monthly basis.

Graph 5: Percentage of complaints resolved within agreed timescale 2024-2026



MRI responded to all complaints on time during 2025/26, with LCO&UDHM Clinical Group and Wythenshawe, Trafford, Withington & Altrincham Hospitals (WTWA) Clinical Group also achieving high rates of compliance with complaint response deadlines.

To seek assurance on improvements and adherence to policy and process a new monthly internal audit of MFT's complaints processes, which will be implemented by the end of Q1 2026/27.

4. MP Contacts

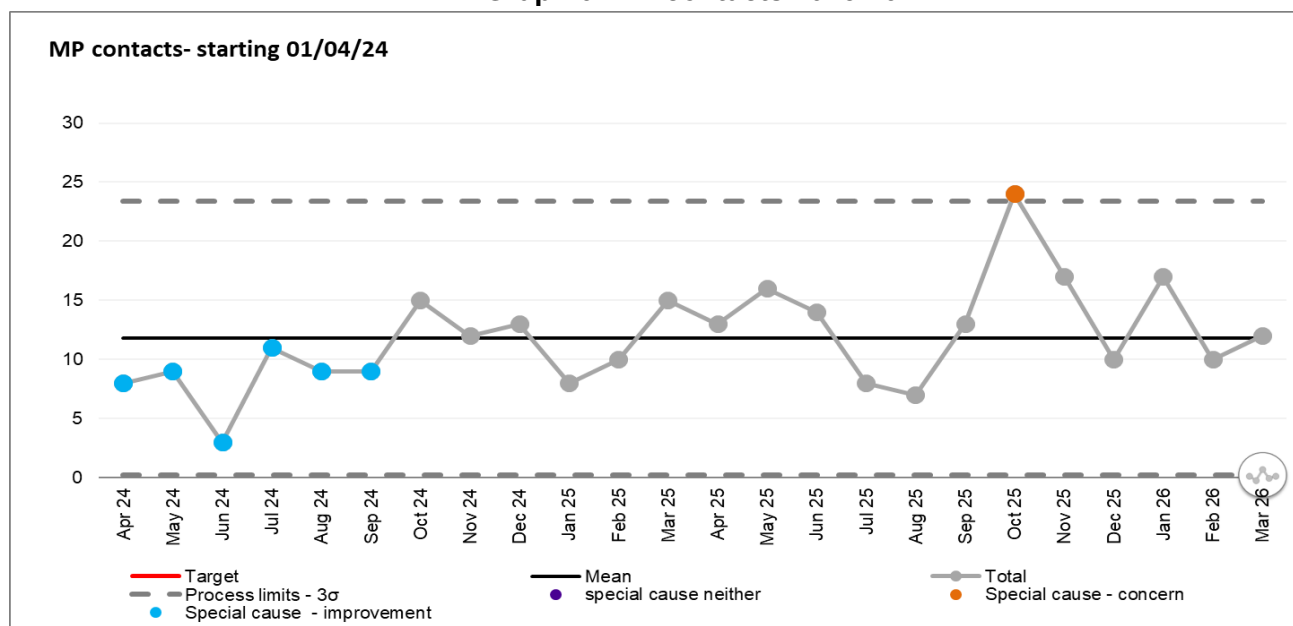
There was a 22% increase in contacts from MPs during 2025/26, in relation to patient care and experience, during 2025/26, with special cause variation seen in Q3.

MFT's position is reflective of a wider national picture, as has been confirmed through Complaints Managers meetings in Greater Manchester and with the Shelford Group. It was also noted, as is the case

at MFT, many of these MP contacts are being received even when patients/families have already contacted the respective PALS/Complaints Teams directly themselves.

The reasons for this is unclear albeit the availability of AI related tools is likely a factor as they will often direct patients and families to their elected representatives or to the MFT CEO as a route by which to most effectively raise concerns.

Graph 6: MP contacts 2025/26



A review of complaints received via MPs noted more than half (51%) of concerns were in relation to Waiting Times for appointments and procedures and Access to Services and a large proportion of concerns raised by MPs had already been sent to PALS direct from the patient/family.

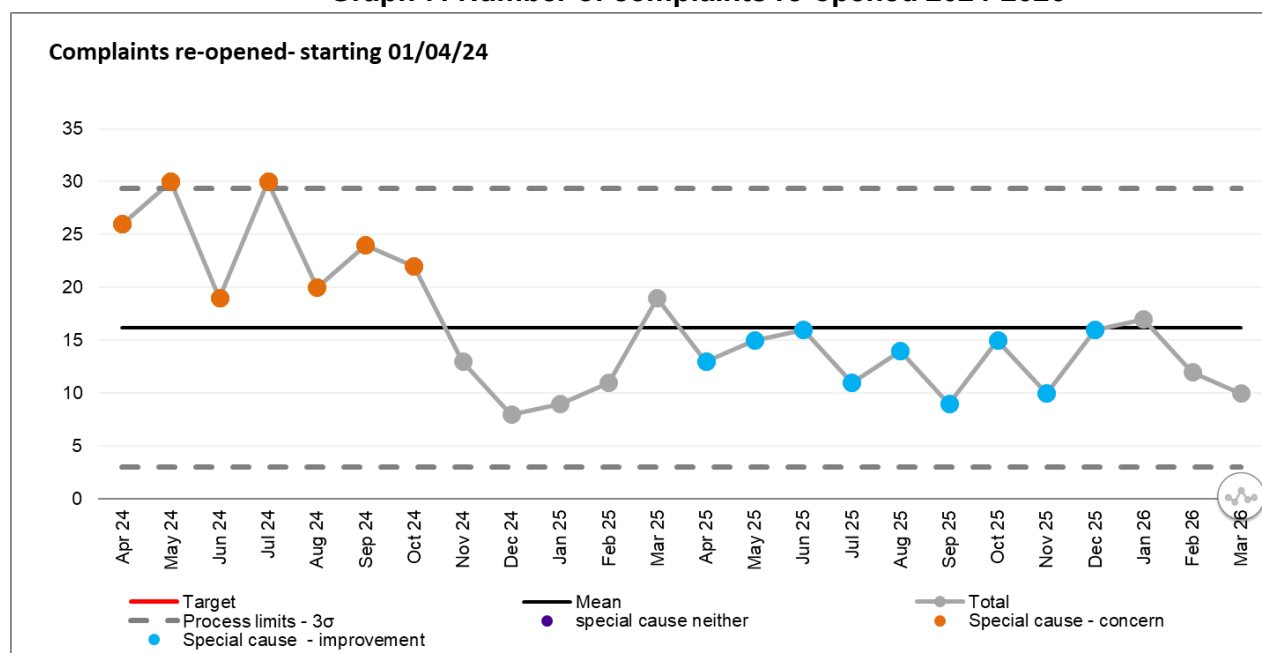
Although the MFT position appears to be reflective of a wider national picture, it is important measures are implemented to ensure cases are managed in such a way to avoid families and patients feeling their only recourse is to their elected representatives. Accordingly, a quarterly review of MP complaints will be undertaken to identify common and reoccurring themes and ensure there is improvement activity in place to respond to these challenges. MP complaints will also report on a quarterly basis to Quality and Safety Management Committee and the Patient Experience Oversight Group.

To continue to improve the MFT position the organisation's website will also be reviewed to ensure it is effectively signposting those who wish to raise concerns to the most appropriate pathways. In addition, to support the development of a more streamlined approach between MFT and elected representatives, MFT colleagues are developing plans to work collaboratively with MP caseworkers to ensure effective pathways between MPs and MFT to raise concerns are fully embedded thus ensuring a timely and efficient resolution to concerns.

5. Re-opened Complaints

Graph 7 shows the number of complaints which were re-opened across the organisation. The number of re-opened complaints is used as an indicator to measure the quality of the initial response. During 2025/26, 7.2% of complaints were re-opened (148 cases in total).

Graph 7: Number of complaints re-opened 2024-2026



The complaints team continue to deliver complaints investigation and response writing training sessions across MFT. These sessions equip colleagues who investigate complaints, with the skills and knowledge required to conduct thorough investigations and write clear and easy to understand complaint responses in a compassionate manner, to ensure complaints are resolved first time. A rolling programme of updated training for all clinical and operational colleagues across MFT, in relation to resolving and learning from PALS & Complaints and patient feedback, has been established to commence during Q1 2026/27.

6. Learning from PALS and Complaints

Patient concerns offer opportunities for learning which can be used to change practice and improve patient experience and outcomes.

Complaints and PHSO data, themes and learning is included in MFT's monthly Integrated Performance Report (IPR). MFT and Clinical Group data monitors the number of PALS and Complaints, themes, timeliness of responses, resolved outcomes and re-opened cases and PALS.

At an organisational level, learning from complaints is shared in the weekly MFT Risk and Safety Panels, and the monthly Patient Safety Group. Learning from complaints is shared at a local level via ward meetings and huddles, on ward notice boards, via ward manager and medical colleague meetings, via safety newsletters and Clinical Group Quality and Safety meetings. Each Clinical Group also holds regular forums where themes and trends relating to complaints are discussed with focused actions agreed for improvement.

Emerging learning from PALS and Complaints is reviewed on a weekly basis by the central PALS and Complaints Team. Where emerging trends or hot spots are identified the central team will reach out to the relevant service or division and work with them to implement improvement work.

One such example of this process relates to a trend identified by the PALS team in relation to telephone calls not being answered in certain services and clinics. The emerging themes have been reviewed by the relevant leadership teams, with improvement actions already underway, including targeted recruitment and strengthened call-handling processes. A detailed analysis is being undertaken to understand the impact on patient experience through both quantitative metrics and patient voice feedback, with the outcomes informing further improvement.

A further example follows increased patient feedback regarding car parking access at Wythenshawe Hospital; targeted improvement actions have been implemented in partnership with operational teams. These actions aim to improve patient access, optimise use of visitor parking, and reduce the impact of parking difficulties on attendance and patient experience. Further work with Transport for Greater Manchester will ensure the patient voice continues to inform transport and accessibility improvements across the Trust.

There is a learning focussed approach embedded in both the Patient Safety and Complaints/PALS workstreams. However, it is acknowledged further progress can be made to ensure learning effectively informs improvement across the organisation and that any improvement is sustained.

To support this, a project to explore the most effective approaches to ensure learning translates into sustained improvement will commence in September 2026 in collaboration with Health Innovation Manchester. Whilst this project is designed initially to explore this within the context of patient safety, the learning, actions and next steps from this group will also inform our approach to learning from Complaints and PALS.

7. Improvement as a result of learning for Complaints & PALS

Key actions have focused on improving patient communication through the standardisation of discharge and post-operative information, review of patient information materials and enhanced collaboration with external partners such as NHS 111. Clinical quality improvements have included strengthened pain management processes, implementation of structured ward round documentation, enhanced monitoring of Early Warning Scores and pain assessments and system-based learning from medication-related incident. This included the completion of a review of Total Intravenous anaesthesia (TIVA) related incidents and drug dose errors using SEIPS methodology to understand the system learning which resulted in the TIVA guidelines being updated.

Governance and assurance arrangements have been strengthened through complaint actions, audit outcomes and quality improvement initiatives via established divisional and Clinical Group governance forums. Workforce development has also been prioritised through targeted education and training programmes, including communication skills, mouth care and end-of-life care. In addition, a number of initiatives have focused on improving the care of patients approaching end of life and work to ensure

senior nursing oversight of, for example, use of discharge flowsheet within Hive and via discharge standards being monitored at monthly Divisional Quality and Patient Experience meetings. There have also been dedicated quality improvement projects implemented, including an IQP (improving quality programme) project in Gynaecology on post-operative pain management completed, which included prescribing of pain medication, timely administration and re-assessment of effectiveness. At WTWA focussed work has been undertaken to ensure oversight of waiting room safety and assurance that re-triage and welfare checks take place.

8. Complaints Scrutiny Review Group

The Complaints Review Scrutiny Group (CRSG), chaired by the Deputy Trust Chief Executive/Chief Nursing Officer and supported by a nominated Non-Executive Director and Governor, met on 10 occasions during 2025/26. The purpose of this group is to obtain assurance regarding clinical group compliance and performance in relation to Complaints and PALS in accordance with PHSO standards and MFT policy. This includes the appropriateness and effectiveness of actions implemented to address learning identified from Complaints and PALS.

CRSG includes representation from members of the Clinical Group Senior Leadership teams, to focus on the number of complaints and PALS their services have received, compliance with response times, reopened complaints, and PHSO escalations. CRSG also reviews the quality of the Clinical Groups' complaint responses with a focus on identifying organisational learning through the triangulation of complaints data and themes.

During 2025/26, the senior leadership teams from each Clinical Group attended CRSG with significant learning and improvement activity discussed across multiple services to strengthen patient safety, quality of care and patient experience.

9. Parliamentary Health Service Ombudsman (PHSO)

The Parliamentary Health Service Ombudsman (PHSO) is commissioned by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS. The PHSO considers and reviews complaints, when someone believes there has been injustice or hardship because an organisation has not acted properly or fairly or has given a poor service and not put things right.

In November 2025, the PHSO and PHSO Chief Executive visited MFT to meet with the Executive Team and senior Governance and Complaints colleagues. Following the visit, the PHSO has provided positive feedback in relation to MFT's detailed complaint responses, meetings held to resolve complaints and patient and public engagement. The PHSO also provided positive feedback to MFT, during the year, complimenting the level of detail provided in complaint responses and the empathy and compassion shown to grieving families throughout the complaints process.

The PHSO has raised a concern with the organisation regarding the use Manchester Early Warning Score 2 (EWS2), for recognising and responding to deteriorating patients, and that this differs from the nationally recommended NEWS2 system. The organisation has responded to the correspondence from the PHSO, providing an overview of the governance and assurance in place that the modified system is as safe and effective as NEWS2, and how any risks of operating a system that differs from that recommended nationally have been mitigated.

During 2025/26, the PHSO opened new investigations into 13 MFT complaints. The PHSO also completed its consideration of 23 MFT complaints for which it decided not to progress with an investigation, as it was assured by the quality of the investigation already undertaken.

During 2025/26, the PHSO informed MFT of 14 completed investigations into MFT complaints, of which 1 was 'upheld', 8 were 'partially upheld' and 5 were 'not upheld' according to the PHSO's classification of outcomes of complaint investigations (**appendix 1**).

10. Equality and Diversity Monitoring Information

MFT is committed to collecting data from complaints relating to Equality Diversity and Inclusion (EDI) to ensure all patients and representatives are supported and have equal access to providing feedback on services. Fundamental to this is the provision of an accessible PALS and Complaints service.

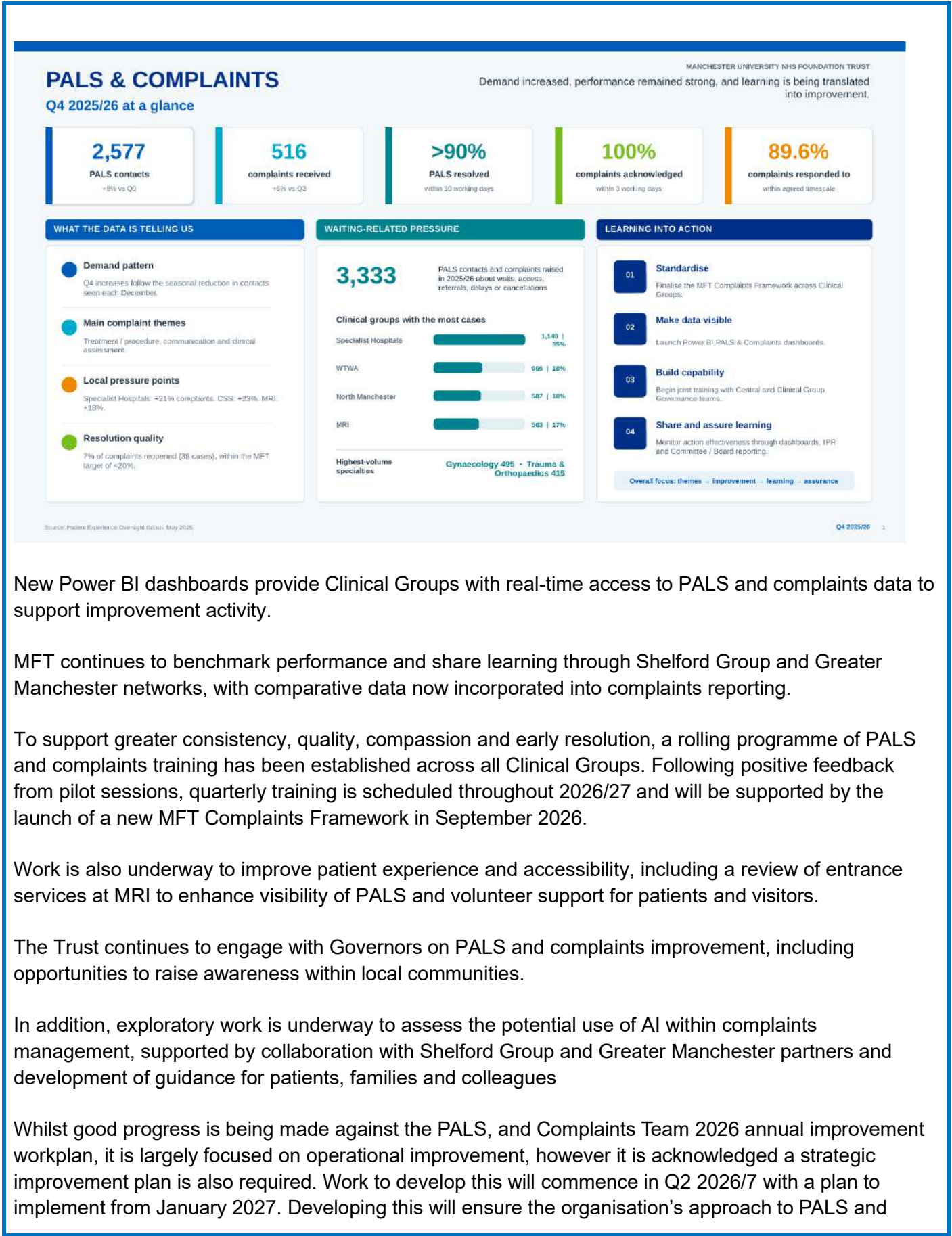
The PALS and Complaints leadership team are members of MFT EDI patient groups and use the opportunity of these groups to identify and address barriers patients and families experience when raising concerns and complaints.

During 2026/27, PALS will engage further with local community groups, to hold focus groups and awareness sessions on the support MFT offers patients and families from all demographics.

PALS and Complaints are collaborating with the Patient Safety and Risk Team, and MFT's Consultant in Public Health, to conduct a deep-dive review of EDI patient safety and complaints data and develop an EDI dashboard. This will be presented at MFT Patient Safety Group to enable the teams to identify further improvements that are required to address inequalities and improve accessibility across MFT.

11. PALS & Complaints improvement plan update

The PALS, and Complaints Team 2026 annual improvement workplan is ongoing. As part of this a review of PALS and complaints reporting has strengthened organisational oversight and assurance. Quarterly complaints reporting is now provided to this Committee, with emerging themes and learning reported through the Patient Experience Oversight Group (PEOG). This was most recently presented to PEOG in May 2026, this quarterly report is summarised below:



Complaints is fully aligned to the MFT Patient Experience Strategy and associated workstreams, the Strategic Delivery Plan alongside national strategic drivers and national complaints priorities and plans.

12. Recommendations

The Board of Directors is asked to:

- Acknowledge the 2025/26 PALS and complaints position, including compliance with the NHS Complaints Regulations, sustained response performance and the key themes arising from patient and family feedback
- Take assurance from the strengthened oversight arrangements, including routine reporting, dashboard development, thematic review and the improvement work underway in response to learning from PALS, complaints and PHSO outcomes
- Approve the MFT Annual Complaints Report 2025/26

Appendix 1

Parliamentary Health Service Ombudsman (PHSO)

The PSHO upheld a LCO complaint from 2013, in relation to the review and assessments of patient's mobility prior to discharge from a community hospital and joint handling of the complaint with Trafford Council. MFT paid the family £750, in recognition of the impact this had on them, and has developed a new Standard Operating Procedure (SOP) for the joint handling of complaints between MFT and Trafford Council.

The PHSO partially upheld an MRI complaint in relation to the delayed transfer of a patient between hospitals, and the availability of a High Dependency Unit (HDU) bed, in 2021. The PHSO was assured by the work MFT has since undertaken, with the implementation of an external referral and transfer policy and the dedicated 'Transfer Centre' within our electronic patient record (Hive).

The PHSO 'partially upheld' 2 other MRI complaints. One was in relation to the patient's reasonable adjustments not being met in 2021. The CEO has written to the patient to apologise for the impact of this, confirming this is now documented and of wider learning around raising awareness of, and meeting, reasonable adjustments across the organisation. The other MRI complaint was in relation to nutrition/hydration and enhanced observations for care provided to a patient in 2023, for which the PHSO was assured by the work undertaken across the MRI and organisation since then, to address the learning and make improvements in these areas.

The PHSO partially upheld another historic complaint from 2021, in relation to co-ordinated discharge planning between NMGH, MRI and external organisations for a vulnerable patient who lacked capacity. The PHSO recommended MFT write to the family to apologise and provide assurance of the improvements made since that time.

The PHSO partially upheld an MRI complaint in relation to nutrition/hydration and enhanced observations for care provided to a patient in 2023. The PHSO was assured by the work undertaken across the MRI and organisation since then, to address the learning and make improvements in these areas.

A WTWA complaint was partially upheld in relation to poor record keeping and documentation. The PHSO recommended MFT apologise to the family and develop an action plan of service improvements. WTWA Clinical Group is currently completing these actions, within the timescales requested by the PHSO.

A CSS complaint was partially upheld in relation to communication with patients regarding the accuracy of biopsies to diagnose breast cancer. The PHSO recommended MFT apologise to the patient, compensate £1200 and develop an action plan of service improvements. All actions were completed within the requested timescale and the PHSO was assured by action taken.

The PHSO also partially upheld a complaint in relation to the delayed reporting of a specialist paediatric MRI scan. The PHSO was assured by the actions already being implemented to improve timeliness of reporting and CSS paid the family £250 in recognition of the distress caused by the delay.

Public Board of Directors

Wednesday, 30 September 2026

Paper Title:	Patient Experience Annual Report 2025/26	Agenda Item 11.4
Presented by:	Kimberley Salmon-Jamieson, Deputy Trust Chief Executive & Chief Nursing Officer	
Prepared by:	Cheryl Casey Deputy Chief Nursing Officer Jemma Haines, Interim Director of Patient Experience	
Meetings where content has been discussed previously	Quality, Safety and Performance Board Committee – August 2026 Quality and Safety Management Committee- July 2026 Patient Experience Oversight Group- July 2026	
Purpose of the paper Please check <u>one</u> box only:	☐ For approval☐ For support ☒ For discussion☐ For noting	

Executive summary / key messages for the meeting to consider

The Quality & Patient Experience Annual Report 2025/26, provided as Appendix 1, sets out the Trust's position on patient experience and the progress made during the year to strengthen how patient feedback is captured and understood to support improvement. This paper provides a summary of the key areas of assurance, emerging themes and improvement priorities, with further detail and supporting evidence provided within the appended Annual Report.

During 2025/26, engagement increased across key feedback routes. Friends and Family Test responses rose by 5.4% to 245,107, local Patient Experience Survey responses increased by 7.7% to 105,216, and Care Opinion submissions increased by 30.6%. Overall experience ratings remained strong, with 94.3% of FFT respondents and 97.23% of local survey respondents rating their care as good. The report also highlights significant activity across interpretation and translation, volunteering, chaplaincy and spiritual care, patient story engagement, quality assurance and Clinical Group improvement.

Key achievements include expanded interpretation provision across 139 languages and dialects, increased volunteer numbers and hours, strengthened chaplaincy support, further development of the quality assurance accreditation programme and wider involvement of patients through the Bee Involved Network. Feedback has directly informed improvements in areas such as maternity pathways, children and young people's environments, privacy and dignity, food provision, accessibility and communication.

Priorities for 2026/27 focus on co-production, near real-time insight, reducing inequalities and embedding an "always listening" person-centred culture across MFT.

Recommendation(s)

The Board of Directors is asked to:

- Receive the Annual Quality & Patient Experience Report 2025/26 and note the assurance on patient, carer and family feedback across MFT.
- Acknowledge that feedback is supporting person-centred care by identifying what matters most to patients, carers and families.
- Recognise areas for continued scrutiny, including waiting, communication, involvement, accessibility, food and hydration, hygiene, pain, and survey response rates.
- Note the 2026/27 priorities to embed co-production, strengthen digital and real-time feedback, culture shift to person centred care “always listening” and partnership.

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 the 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 within this report links to the following strategic, corporate, or operational risks:

-

Care Quality Commission domains

Please check **all** that apply

- ☐ Safe ☒ Caring
- ☒ Effective ☒ Well-Led
- ☒ Responsive

Compliance & Regulatory Implications

The following compliance and regulatory implications have been identified as a result of the work outlined in the report:

- Care Quality Commission (CQC) Single Assessment Framework: supports Caring, Responsive, Effective and Well-Led through feedback, person-centred care, accessibility, quality assurance and governance.
- CQC Regulation 9: shows how feedback is used to improve care around individual needs, preferences, involvement, communication and accessibility.
- Equality Act 2010 and Accessible Information Standard: highlights actions for protected groups and people with communication or accessibility needs, including interpretation, British Sign Language, sensory spaces and equality segmentation.
- National Health Service (NHS) Constitution supports patients' rights to dignity, respect, involvement in decisions and accessible information.
- Health and Social Care Act 2008: supports fundamental standards for safe, effective, compassionate and person-centred care.

Main report

1. Background

Patient experience and feedback are key to support the Trust's Strategy to work together to improve the health and quality of our diverse communities. Listening to our patients, carers, families and communities is essential to support meaningful quality improvements that shape safer, compassionate patient centred care. The Annual Quality & Patient Experience Report for 2025/26 (*Appendix 1*) details how we have achieved this across the Trust during 2025/26. This paper provides a summary overview of the Annual Quality & Patient Experience Report for 2025/26 report and should be considered in conjunction with the attached appendix.

1.1 Data sources and report structure

The Annual Quality & Patient Experience Report for 2025/26 is informed by analysing data from a range of data sources including national survey results (2024 results, in line with national release of data), the Friends and Family Test (FFT), local Patient Experience Surveys, Quality Care Rounds and the Care Opinion platform. Report structure further synthesises key outputs and improvements from the Trust Patient Services team including patient story engagement,

volunteering, chaplaincy, interpretation and translation and quality assurance, as well as detailing Clinical Group annual activities.

2. Response rates and patient engagement activities

Compared with 2024/25, survey response rates and patient engagement activities increased across the board (see Table 1).

Table 1: Comparative response rates and patient engagement activities 2024/25 and 2025/26

Category	2024/25	2025/26	Variance
FFT responses	232,556	245,107	↑ 5.4%
Local Trust survey responses	97,666	105,216	↑ 7.7%
Care Opinion Platform submissions	49	64	↑ 30.6%
Interpretation interactions	144,244	165,195	↑ 14.5%
Interpretation languages/dialects available	133	139	↑ 4.5%
Number of active volunteers	416	513	↑ 23.3%
Number of volunteer hours given	33,488	34,069	↑ 1.7%
Quality assurance visits/accreditations completed	192	201	↑ 4.7%

3. Overview of 2025-26 patient feedback and learning response

- The percentage of respondents rating their overall experience as good through the Friends and Family Test (FFT) increased to **94.3%** in 2025/26, from **93%** in 2024/25. Whilst this represents an improvement year-on-year, the position remained 0.7% below the 95% ambition referenced within the MFT Annual Plan. The overall Trust position was primarily influenced by Accident and Emergency FFT (A&E)- **84.3%** and postnatal wards- **88.4%**.

In comparison, inpatient/day case (96.2%), outpatient (98.2%), community (98.5%) and antenatal ward care (98.5%) all reported more than 95% of respondents rating their experience as good.

- Targeted improvement arrangements are in place for the areas below standard.

To note, Maternity Services increased its FFT sample size for postnatal ward care from August 2025 through incorporation FFT into the new Patient Experience platform. A Postnatal Improvement Group is overseeing a trajectory to achieve 97% positive feedback by March 2027, with performance tracked bi-monthly. A&E FFT is noting an improving trajectory for positive feedback (85.1% currently) which is tracked through the Trust Urgent and Emergency Care meeting, supported by Clinical Group action plans. Analysis demonstrates a clear correlation between four-hour performance and A&E FFT, with patient experience improving as waiting times reduce.

- The most common theme within negative feedback across all patient feedback sources related to waiting. Whilst programmes of work, including Care on Time, have been implemented to

address delays in care and treatment, there is an opportunity to broaden the focus beyond clinical procedure waiting times. This will include the wider experience of waiting, such as delays when contacting services by telephone, the quality and frequency of updates provided to patients and families, and ensuring people understand what they are waiting for and what will happen next. This will support a more person-centred approach, recognising that communication and keeping people informed are important factors in how patients experience and perceive waits.

- Patient feedback has also directly informed improvement programmes in areas including pain management and food and drink, with dedicated workstreams established to address the themes identified and drive targeted improvement.

3.1 National Patient Experience Surveys

Response rates to the Young People's Patient Experience Survey, National Adult Inpatient Survey and Children and National Maternity Survey were 17%, 38% and 34% respectively. In all surveys, for the majority of questions, MFT performed about the same when compared with other Trusts. *[To note: national survey results report 2024 data in line with national reporting data release, except for National Maternity Survey reporting 2025 data].*

3.11 Children and Young People's Patient Experience Survey

Talking to hospital staff (being able to ask questions and receiving clear explanations about care and treatment) and being on a hospital ward with others their own age, were areas where children and young people reported their experience of care best. Areas where reported experience could be improved included the hospital ward sleeping environment, receiving enough privacy during care/treatment and unengaging waiting areas. Actions taken based on learning from feedback include:

- Introduction of bedtime standards and visiting policy review
- Review of waiting areas with introduction of notice boards, quiet rooms and play provision
- Improved privacy and dignity signage and better use of disposable curtains

3.12 National Adult Inpatient Survey

Strengths included virtual ward information, waiting list information, clear explanations from doctors and consistent messages from colleagues. Improvement areas included accessibility needs, access to food outside set mealtimes and support when patients needed attention.

Actions taken based on learning from feedback include:

- Through the Food and Drink Improvement group work with facilities colleagues to improve out-of-hours food provision to address individual patient needs
- Reviewed flow and discharge and impacts on meals
- Accessibility Information Standards incorporated into induction and ongoing education training programme in place

3.13 National Maternity Survey

The National Maternity Survey identified positive patient experience across several areas, including choice of place of birth, support for partners to remain with women during their inpatient stay, information about potential changes to mental health following birth, and advice

provided when contacting maternity triage services. Areas for improvement included the length of time waiting to be seen by a midwife in triage, access to feeding support during pregnancy, and women being left alone during labour or birth when they were worried or concerned.

Actions taken based on learning from feedback include:

- Redesign of the maternity debrief service, led by Consultant Midwives and developed in collaboration with the Maternity and Neonatal Voices Partnership to incorporate the views and experiences of women and families
- In response to feedback on feeding support, a specialist tongue-tie clinic has commenced, alongside a review and standardisation of feeding advice to provide more consistent and effective support for women and families
- Visibility of pain scores has been strengthened, alongside delivery of the “Gone in One” campaign across maternity services to support timely assessment and effective management of pain

4. Overview of 2025-26 key achievements

Table 2 provides a high-level overview of patient experience key activity achievements during 2025-26. In addition, 34 members from our Bee Involved Network actively contributed to Trust programmes and initiatives to ensure they are shaped by patient experience and need (e.g. 12-month elective recovery co-design to improve access, inclusion and pathway redesign).

Table 2: Patient experience key activity achievements, 2025-26

Inclusion, accessibility and communication
• Interpretation and Translation Service delivered 165,195 interactions (14.5% increase), across 139 languages and dialects • Improved awareness of in-house British Sign Language support • Introduced a tool to identify patients admitted who use British Sign Language so can offer personalised support
Voluntary Services
• 531 volunteers contributed 34,069 hours • Hosted 21 volunteer recruitment events, with 890 applicants and 252 candidates progressing in on-boarding process • Introduced new volunteer roles aligned to Trust priorities (e.g. Active Hospital role)
Chaplaincy and spiritual care
• Supported 5,184 patient contacts with an average experience rating of 4.77/5; 85% of patients reported that they felt more spiritually or emotionally supported and 83% felt the interaction helped them feel calmer and more at peace

- Strengthened partnerships with 23 faith, community and organ donation organisations, supporting colleagues to deliver culturally competent end-of-life care and improving engagement with under-represented communities through collaborative outreach, education and patient and family support
- Delivered a programme of Trust-wide cultural awareness training, strengthening colleagues' knowledge and confidence to provide culturally competent and inclusive care

Quality assurance accreditation programme

- 201 clinical accreditations and quality assurance visits completed across 246 clinical areas, supported by 200 multi-disciplinary colleagues
- Development and introduction of Mortuary Accreditation Framework aligned to national learning and local priorities

5. Next steps

Key priorities for 26/27 are to build on the strong patient experience foundations achieved and strengthen patient, carer and community experience, with patient experience positioned as a core component of quality alongside safety and clinical effectiveness. To achieve this an overarching Trust Patient Experience Strategic Delivery plan is in development, aligned to national strategies (NHS England Quality strategy for NHS-funded care in England and the draft National Excellence Experience Framework). The plan includes priorities relating to:

- Partnership and co-production
- Digital and near real-time patient experience intelligence
- Creating an 'always listening' person focused culture
- Reducing inequalities through the use of experience insight and quality intelligence

6. Conclusion

The 2025/26 Annual Quality & Patient Experience Report provides positive assurance that MFT continues to strengthen how it listens to, learns from and responds to patients, carers, families and communities. The report demonstrates improved engagement, sustained positive experience ratings and tangible service improvements across accessibility, communication, volunteering, spiritual care and quality assurance. It also identifies areas requiring continued scrutiny, including waiting, communication, involvement in care, accessibility and variation in experience. The 2026/27 priorities provide a clear framework to further embed co-production, strengthen real-time insight and support a consistent, person-centred "always listening" culture across the Trust.

Appendix 1 attached - The Annual Quality & Patient Experience Report for 2025/26

Quality & Patient Experience Annual Report 2025/26

Listening, Learning and Improving

1. Foreword
2. Introduction
3. 2025/26 In Numbers and Themes
4. 2025/26 Overview
 - National Surveys
 - Patient Experience and Engagement
 - Volunteering
 - Chaplaincy and Spiritual Care
 - Interpretation and Translation Services
 - Quality Assurance
7. Clinical Group Activity
8. Looking Ahead: 2026/27



This Annual Quality & Patient Experience Report for 2025/26 sets out how listening to our patients, carers and families continues to shape safer, compassionate personalised care across our services.

Over the past year, we have strengthened how we capture, understand and act on feedback by simplifying patient experience surveys, improving engagement and generating more meaningful insights. Patient feedback—whether from real-time responses, surveys, national data or direct conversations—remains central to improvement, and this report shows how it has driven tangible change across wards, services and the Trust.

I would like to recognise the sustained commitment of colleagues, volunteers and partners in using feedback to drive learning and improvement. Throughout 2025/26, there has been a clear focus on both understanding patient feedback and strengthening our response, ensuring that actions are visible, meaningful and embedded, underpinned by investment in digital platforms, local improvement activity and governance arrangements.

We remain committed to addressing inequalities in experience, improving communication and involvement in care, and ensuring every patient feels listened to and respected. I would like to thank all those who have shared their experiences, as well as our patient and public involvement groups, volunteers and community partners, whose contributions are invaluable.

Looking ahead to 2026/27, improving patient experience will remain a key priority across MFT. This is not just about processes; it is about listening carefully to patients, families and carers, understanding what matters most to them, and using what we hear to make real improvements. By giving people more opportunities to share their experiences and making sure their feedback shapes decisions at every level, we will strengthen person-centred care, improve the quality and safety of our services, and deliver changes that reflect the needs of those who use them.



Kimberley Salmon-Jamieson
Deputy Trust Chief Executive Officer
and Chief Nursing Officer

At MFT, we are committed to delivering safe, effective and person-centred care, with patients, carers and families at the heart of everything we do. Feedback remains a key driver of high-quality care and continuous improvement.

We gather insight through a range of channels, including the Friends and Family Test (FFT), Patient Experience Surveys (PES), Quality Care Rounds (QCR), national surveys, Care Opinion, patient stories, complaints and direct engagement. By bringing these sources together, we are better able to understand experiences, identify themes and target improvement.

This report reflects the experiences of patients and service users across all MFT Clinical Groups, highlighting key themes, good practice, areas for improvement and the actions taken in response. It also provides an overview of patient experience activity across the Trust.

Looking ahead, we will continue to ensure that patient feedback directly informs service improvement through the implementation of Patient Experience Standards across services. This will support more consistent care and reduce differences in people's experiences. By creating real opportunities to listen to patients, families and carers, and acting on what they tell us, we will keep the patient voice at the centre of how we make decisions and develop services.

We will also continue to develop our teams as a King's Fund Listening Organisation, building a culture that actively listens to and values feedback from patients, families, colleagues and communities. We will use what we hear to make ongoing improvements, enhancing skills in listening, seeking meaningful engagement and delivering person-centred care.



2025/26 In Numbers and Themes

2025/26 PATIENT FEEDBACK METRICS & THEMES

Listening • Learning • Improving Together

FRIENDS & FAMILY TEST

245,107
RESPONSES

94.3%
OVERALL
GOOD

TOP POSITIVE THEMES

Emotional & Physical support	16,473
Compassion	16,203
Professional & Competent	16,002

TOP NEGATIVE THEMES

Waiting for care/treatment	9,407
Emotional & Physical Support	1,176
Pain	904

PATIENT EXPERIENCE SURVEY

105,216
SURVEYS
COMPLETED

97.23
%
OVERALL
GOOD

TOP POSITIVE THEMES

Compassion	3,707
Emotional & Physical support	3,593
Professional & Competent	3,043

TOP NEGATIVE THEMES

Waiting for care/treatment	2,228
Food & Beverages	1,333
Hygiene	974

CARE OPINION*

64
COMMENTS
RECEIVED



THEMES & FEEDBACK SUMMARY

Attitude of colleagues

38 COMPLIMENTS	5 NEGATIVE	3 MIXED
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Communication

3 COMPLIMENTS	3 NEGATIVE	0 MIXED
---------------	------------	---------

Treatment and procedure

3 COMPLIMENTS	0 NEGATIVE	0 MIXED
---------------	------------	---------



Thank you to all our patients and families for sharing your feedback. Your voice helps us deliver safe, compassionate, and outstanding care.



*Care Opinion UK is an independent platform that allows patients, service users, and carers to share their experiences with health & social care services including the NHS.

2025/26 In Numbers and Themes



MAKING A MEANINGFUL IMPACT

Our community. Our patients. Our commitment.



ANNUAL IMPACT METRICS



34

members involved
in transformational
work through
Bee Involved



531

volunteers
contributing
34,069
hours



5

patient
stories
shared at
Board



165,195

interpretation and
translation
interactions



54

written language
requests for
patient communication



5,184

Contacts



134

clinical
accreditations *



67

quality
assurance
visits *



OUR SERVICE THEMES



People First

Compassionate care, every person, every time.



Quality & Safety

Delivering high standards and continual improvement.



Partnership & Engagement

Working together for stronger communities.



Equity & Inclusion

Ensuring everyone feels seen, heard and valued.



Innovation & Transformation

Embracing change to build a healthier tomorrow.



PATIENT STORIES THAT INSPIRE CHANGE

We filmed **5** patient stories to highlight experiences and drive meaningful improvements.



CRITICAL CARE

A close look at the
impact of expert
care when it
matters most.



GYNAECOLOGY

Supporting women
through diagnosis,
treatment and
recovery.



VISITOR POLICY

Understanding
the policy changes
and what they
mean for families.



NEONATAL INTENSIVE CARE FUNDRAISING

How community
generosity supports
our tiniest patients.



MATERNITY

Celebrating the
journey of care
from bump to
baby and beyond.



SPINAL APPOINTMENT CANCELLATIONS

Exploring challenges
and how we're
working to improve
access and care.

*Clinical accreditations is a formal recognition process where healthcare services are assessed to ensure they meet recognised standards of safety, competence, and quality care.

*Quality assurance is a systematic, proactive process of evaluating and monitoring medical services to ensure they meet established standards of safety, effectiveness, and patient-centredness.

2025/26 Overview



Children and Young People's Patient Experience Survey 2024

MFT participated in the NHS Children and Young People's Patient Experience Survey 2024, which captures feedback from children and young people aged 0–15 years, as well as their parents and carers, following inpatient or day-case care. The 2024 survey introduced an improved methodology and mixed-mode approach; therefore, results are not directly comparable with the 2023 surveys.

Participation metrics



1250
invitation
sent out



212
completed



39%
inpatients



61%
day case



17%
response rate



20%
variance across
special groups

Comparison with other trusts

The number of questions at which MFT has performed better, worse, or about the same compared with all other trusts

↑	Better than expected	4
↗	Somewhat better than expected	3
=	About the same	71
↘	Somewhat worse than expected	2



Where Children and Young People reported their experience is BEST



Talking to hospital staff: Children and young people feeling able to ask staff questions.



Talking to hospital staff: Staff providing clear explanations about care and treatment.



Hospital ward: Children and young people being around others their own age on the ward.



Talking to hospital staff: Children and young people feeling able to ask staff questions.



Talking to hospital staff: Staff providing clear explanations about care and treatment.



Hospital ward: Children and young people being around others their own age on the ward



Where Children and Young People reported their experience could IMPROVE



Facilities: Children and young people finding the hospital Wi-Fi meets their needs.



Hospital ward: Children and young people not being stopped from sleeping by room temperature.



Being looked after in hospital: Children and young people being given enough privacy during care and treatment.



Hospital ward: Children and young people not being stopped from sleeping by noise from other patients.



The waiting area: Children and young people not feeling bothered by anything in waiting areas



Survey year:
2024



Age group:
0–15 years



Care types:
inpatient or day-case



Conducted by:
NHS

RMCH ACTIONS TAKEN

to Address Children and Young People
Inpatient Survey Results



Your feedback
helps us improve
the experience
for every child
and young person.



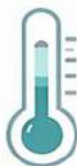
1 Quieter Nights



Through Bedtime
Standards and
Visiting Policy Review

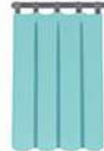
- ✓ Promoting rest, better sleep and a calmer night-time environment.

2 Room Temperature and Linen Improvements



- ✓ Keeping rooms comfortable and providing fresh, quality linen.

3 Privacy Through Disposable Curtains and Signage



- ✓ More privacy and dignity for children and young people.

4 Staff Introductions Relaunch



- ✓ Ensuring every child and young person knows who is looking after them.

5 Better Waiting Areas



Notice
Boards



Quiet
Rooms



Play
Provision

- ✓ More comfortable, informative and engaging spaces.

6 Food and Drink Access



- ✓ Drink stands on wards for easy access.

7 Snack Rounding



- ✓ Staff check in regularly to offer snacks and drinks.

8 Improved Handover Documentation



- ✓ Clearer, more consistent information for safer, seamless care.

9 Ongoing Wi-Fi Improvements



- ✓ We are continuing to improve Wi-Fi access and reliability.

10 Listening, Learning, Improving



- ✓ Your feedback drives meaningful change.

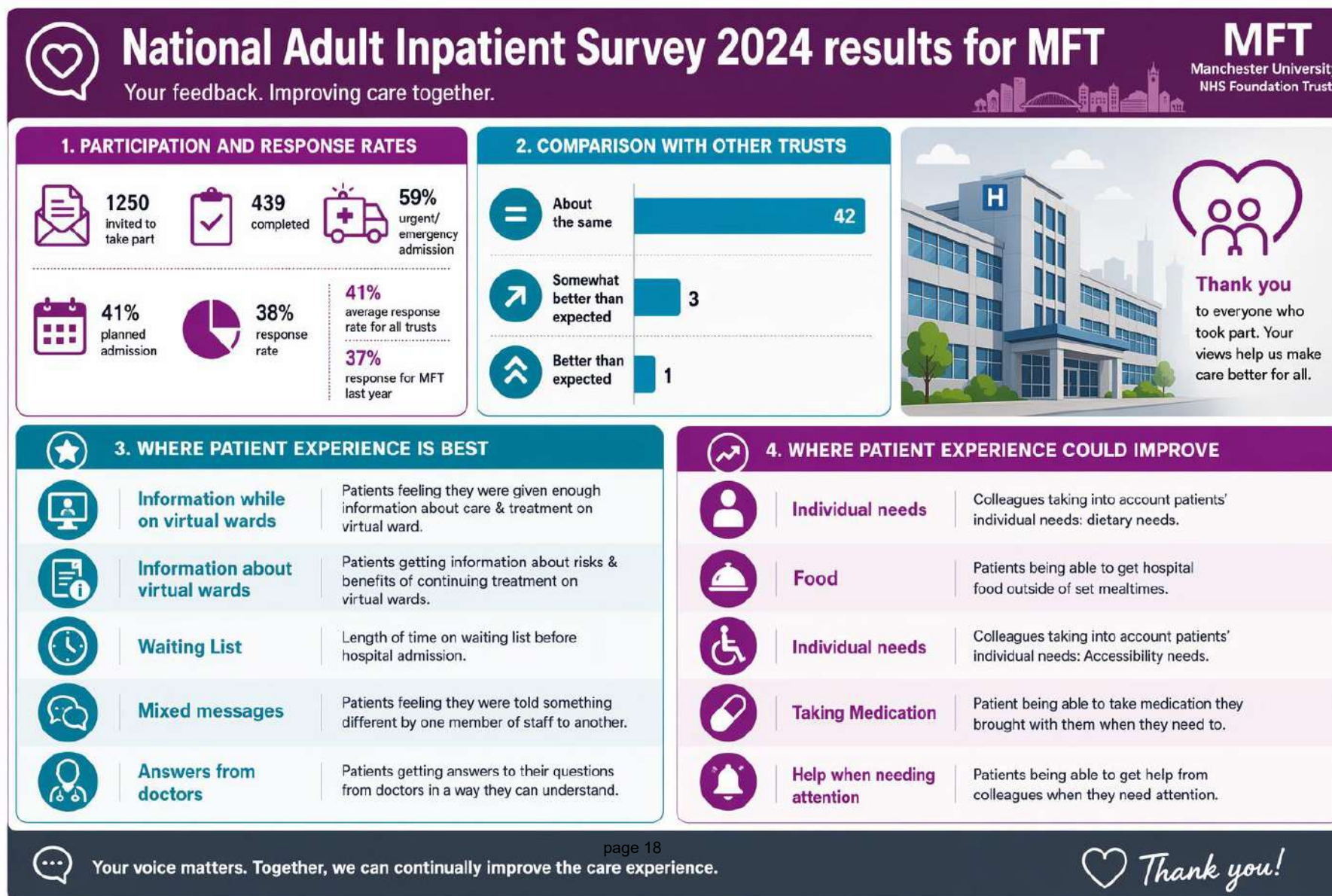


Thank you to all children, young people and families who shared their views.

Together, we're making RMCH an even better place to be.



MFT participated in the Care Quality Commission (CQC) National Adult Inpatient Survey (NIPS) 2024, which captures the experiences of patients aged 16 and over who had an inpatient stay during November 2024. The survey provides an important national benchmark and forms part of the CQC's ongoing assessment of NHS provider performance.





National Surveys



1 Improving Patient Comfort & Environment

- All sites** Noise reduction initiatives implemented (quiet hours / campaigns / ward-based actions)
- MRI / WTTA** Environmental improvements (equipment, bins, alarms) and staff-led campaigns
- NMGH** Standardised sleep aids (eye masks, earplugs) and reduction in night-time interruptions

2 Improving Flow, Delays & Ward Moves

- All sites** Strengthened operational processes to support flow and reduce delays
- NMGH** Daily board rounds and capacity meetings embedded; discharge lounge optimisation
- WTTA** Focus on reducing late moves, escalation processes and improved patient communication
- MRI** Linked to discharge and staffing improvements through governance forums

3 Communication & Coordination of Care

- All sites** Improved structured communication processes (handover, board rounds, training)
- MRI** Complex Patient Programme with named clinical leads and structured handovers
- WTTA** HIVE prompts and staff reinforcement on explaining ward moves
- NMGH** Clear escalation and communication processes, including ED senior nurse oversight

4 Nutrition, Hydration & Access to Food

- All sites** Actions to improve mealtime experience and access to food
- MRI / WTTA** Training programmes, standards embedding and audit/academy approaches
- NMGH** Focus on flow and discharge impacts on meals
- MRI / WTTA** Work with Sodexo to improve out-of-hours provision

5 Patient Involvement, Information & Inclusion

- All sites** Strengthened patient involvement in decision-making and access to information
- MRI / WTTA** Interpreter on Wheels rollout and digital care planning (HIVE, MyMFT)
- WTTA** Patient involvement embedded in QI and governance structures
- NMGH** Focus on improving communication at discharge and post-discharge support

6 Accessibility & Inclusive Care

- MRI / WTTA** Accessible Information Standards programmes and education delivered
- MRI** Hidden Disabilities Sunflower scheme embedded
- WTTA** AIS incorporated into induction and ongoing training
- NMGH** Less explicit AIS actions, but aligned through discharge communication improvements

7 Discharge Planning & Post-Discharge Support

- All sites** Strengthened discharge processes and earlier planning
- NMGH** Standardised discharge processes, referrals and patient contact information
- WTTA** Site-wide discharge communication campaign and MDT training
- MRI** Discharge checklist, MDT working and Citizens Advice support embedded

8 Workforce, Training & Continuous Improvement

- All sites** Increased focus on training, quality improvement and governance oversight
- MRI** Formal academies (PSIRF, Pain, IPC) and strong quality forum structure
- WTTA** Structured training programmes (nutrition, fundamentals of care) and improvement projects
- NMGH** IQPs established with progress monitored through governance frameworks





MFT participated in the National Maternity Survey 2025, delivered by the Picker Institute on behalf of the Care Quality Commission (CQC). The survey captures the experiences of women and birthing people across pregnancy, labour and birth, and postnatal care, and provides an important national benchmark for maternity services.



1159

invited to take part.



390

completed.



34%

response rate.



39%

average response rate for all trusts.



33%

response rate for MFT in 2024.



Where patient experience is best.



Antenatal care: Start of your pregnancy:
Being offered a choice about where to have their baby.



Care in the ward:
Partner or someone else close to them being able to stay as much as they wanted.



Postnatal care: Care at home after birth:
Being given information about possible changes to mental health.



Labour and Birth: Your labour and birth:
Feeling that they were given appropriate advice and support when they contacted a midwife or the hospital.



Triage: Assessment and Evaluation:
Being given the advice needed when they contacted the triage line.



Comparison with other trusts.

The number of questions at which MFT has performed better, worse, or about the same compared with all other trusts.



About the same

.....

56



Somewhat worse than expected

.....

1



Worse than expected

.....

1



Where patient experience could improve.



Triage: Assessment and Evaluation:
Feelings about the length of time they waited before being seen by a midwife.



Antenatal care: During your pregnancy:
Relevant information provided from midwives about feeding their baby.



Labour and Birth: Staff caring for you:
Left alone by midwives or doctors at a time when it worried them.



Postnatal Care: Care at home after birth:
Frequency of seeing or speaking to a midwife.



Labour and Birth: Staff caring for you:
Feeling that the midwives and/or doctors worked well together.



ACTIONS TAKEN

IN RESPONSE TO MATERNITY SURVEY RESULTS

Your feedback helps us deliver safer, kinder, person-centred care.

01



POSTNATAL CARE

Pain scores on PSAG boards,
Gone in One revisited,
Back to Basics
compassionate care.

02



COMMUNICATION

Daily patient experience
reviews and consistent
compassionate
communication.

03



DELAYS AND SYSTEM PRESSURES

IOL and Cat 3 delays reviewed
through divisional governance
and now business as usual.

04



FEEDING SUPPORT

Specialist tongue-tie clinic
closed delays and standardised
feeding advice review.

05



LABOUR AND BIRTH EXPERIENCE

Debrief service redesign led by
consultant midwives and MNVP.

06



CONTINUITY OF CARER

Specialist pathway workstream
monitored via monthly meetings
and closed into existing programme.

07



ENVIRONMENT

Cleanliness audits, checklists,
escalation and housekeeping
responsiveness with embedded
monitoring.



THANK YOU FOR
SHARING YOUR
EXPERIENCES



WE LISTEN
Your voice
drives change.



WE ACT
Making real
improvements.



WE ASSURE
Safe, high quality
care for all.



WE LEARN
Using feedback
to do better.



WE CARE
Kind, respectful
and inclusive.



TOGETHER, WE'RE BUILDING BETTER MATERNITY CARE

Strategic Approach to Improving National Survey Response Rates

Three coordinated levers make national surveys more visible, easier to discuss and actively supported.



Enhance colleagues' engagement

Embed survey prompts into walk rounds so colleagues can encourage participation.



Increase patient awareness

Use posters, discharge packs and direct conversations to keep surveys visible.



Mobilise volunteers

Place volunteers in high-traffic areas to guide patients, carers and families.

Intended impact: clearer promotion, stronger support and improved survey response rates

How patient voice shaped improvement in 2025/26

Patients, families, carers and the public contributed through Bee Involved, co-design, AI communication trials and patient stories.

34 members contributed to key initiatives through **Bee Involved**

Co-production helped ensure service changes were informed by experience and need.



Four routes for turning lived experience into action



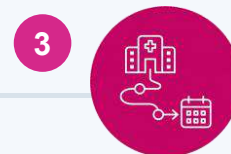
Bee Involved collaboration

Patients, families, carers and the public shaped outpatient improvement and wider co-production.



Clearer patient letters

Dragon Ambient Experience (DAX) Copilot explored AI-generated letters to improve timeliness, clarity and consistency while reducing admin.



Elective recovery co-design

A 12-month programme guided seven workstreams to improve access, inclusion and pathway redesign.



Patient stories

Stories informed Board discussions, governance, training and improvement in written, audio and video formats.

What this enables Lived experience is embedded across improvement priorities, governance, service redesign and inclusive care.



Improvement priorities



Governance & training



Service redesign



Inclusive formats

Patient insight is gathered through Bee Involved, engagement activity, referrals and stories — then shared back into decision-making forums.



VOLUNTARY SERVICES AT MFT | 2025/26



Volunteers are integral to improving patient, carer, and colleague experience, providing reassurance, companionship, and practical support that complements clinical care across the Trust.



VOLUNTEERS IN ACTION DURING 2025/26

During 2025/26 volunteers supported:



Interfaith Week



Annual Members Meeting



Pets As Therapy visits



Nurses Hand Massage Day



Memorial and dementia support events



RMCH Teddy Bears Picnic



PLACE activities



Children and young people's events



Professional conferences



National surveys



Rollout of MFT's digital Patient Experience Survey Platform



KEY ACHIEVEMENTS & FIGURES



531
volunteers
year to date
active and inactive



34,069
volunteer
hours



890
applications
awaiting
recruitment events



252
candidates
progressing

21 Volunteer Recruitment Events
between January 2025 and April 2026



960
applicants
invited



647
booked



335
attended



MANDATORY TRAINING SESSIONS



September 2025
Face-to-face at
Wythenshawe Hospital



January 2026
Online



April 2026
Face-to-face at
Wythenshawe Hospital



PLACEMENTS ACROSS SITES



MRI



ORC



RMCH



SMH



NMGH



Wythenshawe
Hospital



SUPPORT AREAS



A&E



Critical
Care



Cardiac
Services



Burns
Unit



AMU



Patient
Dining



PALS



Patient
Experience



SPECIALIST & COMMUNITY PROGRAMMES



Early
Pregnancy
Loss
Counsellors



Macmillan
Counsellors
and Information
Helpdesk
Support



Burns
Camp
support



Expert
Patient
Programme



Chaplaincy
Volunteers



Radio
Lollipop and
Radio Wishing
Well



Pets as
Therapy



Breast
Feeding
Volunteers



PREVENT
programme
support



SPOONS



Active
Hospital
Role



MFT Meet
and Greet
volunteers



Strengthened contribution to **patient experience, wellbeing, and engagement** across MFT.





CHAPLAINCY AND SPIRITUAL CARE

2025/26



Throughout 2025/26, the Spiritual Care and Chaplaincy Service (SCCS) has continued to deliver high-quality spiritual, religious and pastoral care across Manchester University NHS Foundation Trust, further strengthening its role as a key component of holistic, person-centred care. The service remains integral in supporting the emotional, spiritual, and cultural needs of patients, families and colleagues, particularly during times of vulnerability, uncertainty, and transition.



Key Achievements in 2025/26



Strengthened the visibility and integration of Chaplaincy services across MFT through implementation of a Trust-wide Site Lead structure, providing improved consistency of service delivery, clearer accountability arrangements, and enhanced 24/7 spiritual care access across all hospital sites.



Strengthened partnerships with 23 faith and community organisations and organ donation services, supporting culturally competent end-of-life care and improving engagement with under-represented groups through collaborative outreach, education, and patient/family support initiatives.



Supported the delivery of 14 Schwartz Rounds and reflective support sessions, alongside pastoral support during distressing incidents and operational pressures, supporting colleague wellbeing, resilience, and compassionate workforce culture across MFT.



Chaplaincy recorded 91 significant colleague pastoral support contacts across MFT.



Delivered 6 cultural awareness training sessions to colleagues and supported 10 multi-faith chaplaincy student placements, reinforcing MFT's role as a national training site and supporting development of a culturally competent workforce.



Distributed 99 Spiritual Care Boxes, alongside ongoing bedside and bereavement support, contributing to improved patient experience and compassionate end-of-life care.



Unique Patients Supported By Chaplaincy & Spiritual Care - 2025-26

	MRI	MREH	St Mary's	RMCH	Trafford	NMGH	Wyth	Unspecified	Annual Total
Christian Catholic	527	2	36	23	30	367	568	12	1565
Christian (Non RC)	333	1	42	45	21	276	370	6	1094
Total Christian	860	3	78	68	51	643	938	18	2659
Islam	304	0	100	169	8	466	189	6	1242
Total Muslim	304	0	100	169	8	466	189	6	1242
Jewish	48	2	11	60	1	582	167	4	875
Total Jewish	48	2	11	60	1	582	167	4	875
Hindu	2	0	0	0	1	1	6	0	10
Sikh	2	0	0	1	0	4	0	0	7
Jain	0	0	0	0	0	0	1	0	1
Buddhist	2	0	0	1	0	1	1	0	5
Total Dharmic	6	0	0	2	1	6	8	0	23
Unspecified or Other	132	1	25	17	5	84	120	1	385
Annual Total Patients By Site	1350	6	214	66	1781	1422	29		5184



Chaplaincy & Spiritual Care Delivery Plan 2025-2030

Patient feedback

Avg. experience rating: **4.77/5**

85% felt significantly more spiritually or emotionally supported.

83% said the interaction helped them feel calmer and more at peace.

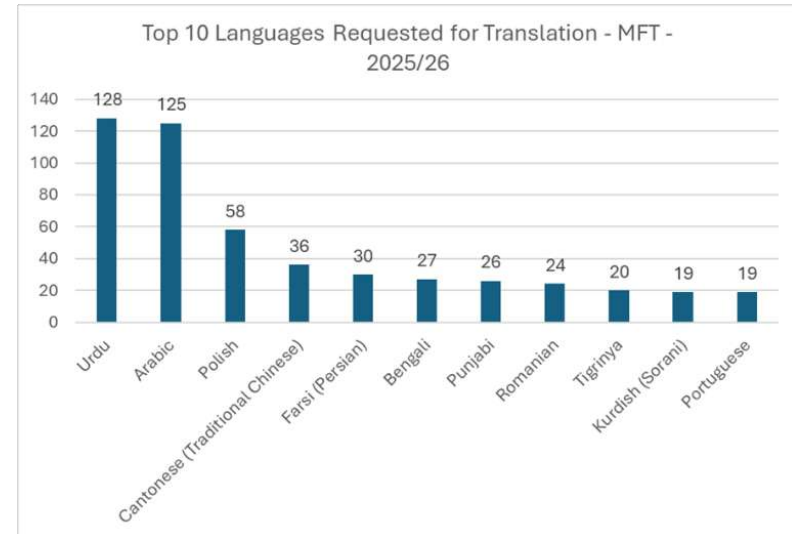
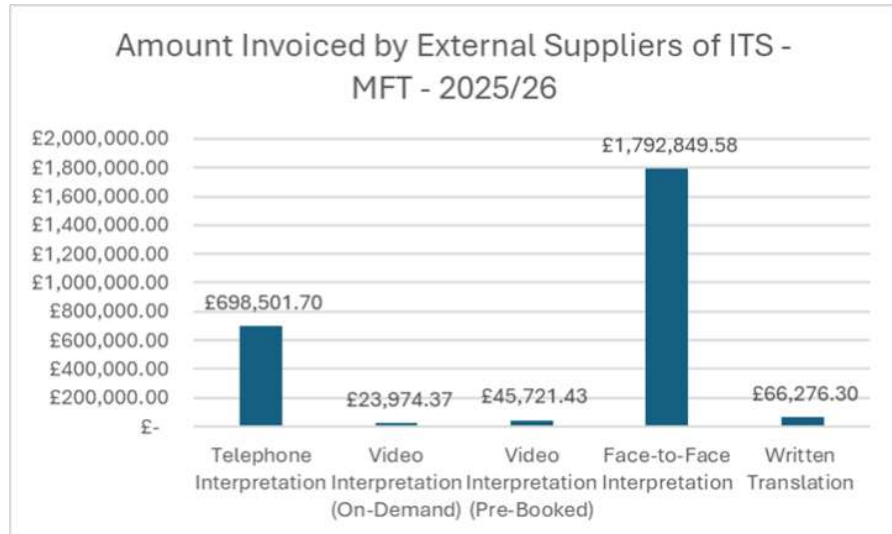
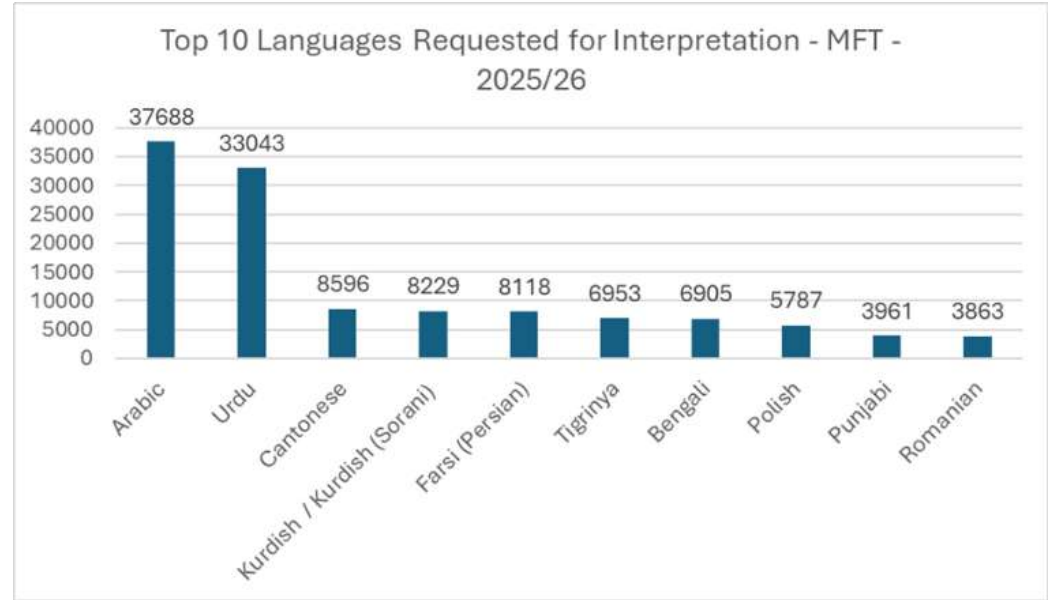
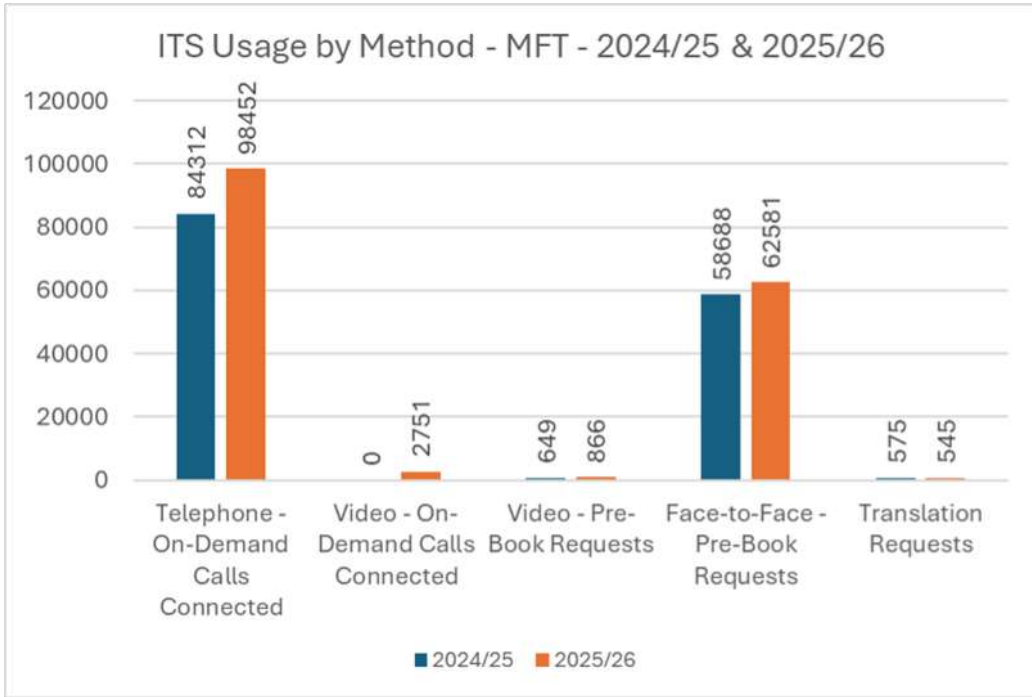
The Interpretation and Translation Service (ITS) plays a vital role in ensuring that all individuals receive compassionate, person-centred care that improves patient experience.

In 2025/26, ITS delivered 165,195 interactions, representing a 14.54% increase year-on-year, reflecting expanding utilisation and engagement across clinical areas. Communication support was provided across 139 spoken languages and dialects, ensuring equitable access to care for a diverse population. By removing language and communication barriers that can impact care quality, safety and outcomes, ITS enables patients, carers and families to fully understand diagnoses, treatment options and care plan supporting informed decision-making, reducing anxiety, and promoting dignity, trust and equity in care

Key Achievements in 2025/26

- Increased awareness of MFT's in-house British Sign Language (BSL) provision and improved consistency of experience for Deaf inpatients through the introduction of a new tool enabling the in-house interpreter and ITS team to view details of patients admitted who use BSL across MFT.
- Successfully trialed on-demand video interpreting access, leading to a Trust-wide rollout that improves interpreter availability and access to urgent communication support.
- Implementation of targeted IT automation within ITS triage booking processes to release administrative capacity and enable redeployment to priority service areas.





The Clinical Accreditation Programme remains a core component of MFT's quality assurance framework, providing Trust-wide oversight of standards and driving continuous improvement.

In 2025/26, 201 Clinical Accreditation and Quality Assurance visits were undertaken across 246 clinical areas, supported by over 200 colleagues, strengthening multidisciplinary learning and peer-led improvement. Overall accreditation outcomes improved compared to 2024/25, with more services achieving Gold ratings and fewer at Silver. This provides confidence that quality standards are continuing to improve across services, demonstrating a positive upward trajectory while highlighting areas for further improvement.

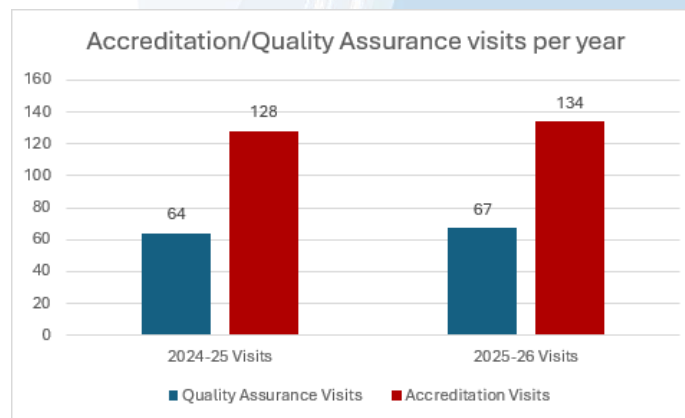
The most common safety action themes remained consistent across the Trust—Medication Management, Infection Prevention and Control, and Risk Management, which will form key improvement priorities for the 2026/27 programme.

Key Achievements in 2025/26

- The 2025/26 Clinical Accreditation and Quality Assurance Programme recognised achievement through Gold, Silver and Bronze ratings, reflecting how well services performed against standards in Clinical Effectiveness, Patient Safety and Patient Experience.
- Development and introduction of the new Mortuary Accreditation framework across MFT sites providing a constant and robust approach to assurance in response to national learning and local priorities.
- Improved quality of evidence and assurance, with a stronger focus on triangulating data from audit, patient feedback and observations.
- Strengthened multidisciplinary engagement, with over 200 colleagues from Nursing, Midwifery, Allied Health Professionals (AHPs) and area specialist staff participating in visits, enhancing peer review, shared learning and cross-site collaboration.

Award Level	2024-25	%	2025-26	%
Gold	5	4%	14	10%
Silver	106	83%	100	75%
Bronze	17	13%	19	14%
White	0	0%	1	1%
Total	128	100%	134	100%

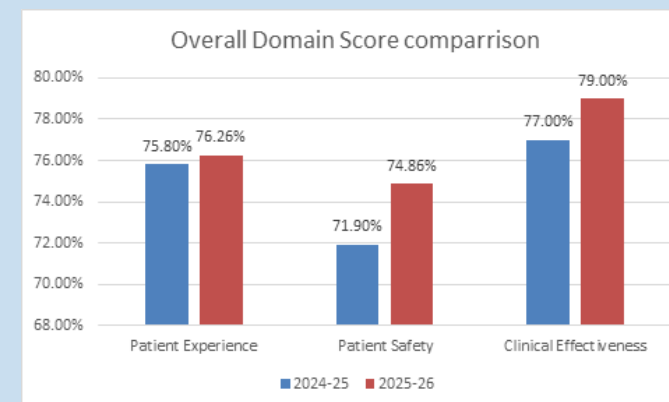
Clinical Accreditation award distribution comparison



Visit Comparisons

Award Level	2024-25	%	2025-26	%
Gold	31	48%	22	33%
Silver	26	41%	41	61%
Bronze	7	11%	4	6%
White	0	0%	0	0%
Total	64	100%	67	100%

Quality Assurance award distribution comparison



Overall, Domain Scores

Quarter 1 – Pain

Winner Wythenshawe AMU/SDEC

Used patient experience data to address pain management inconsistencies, delivering a multidisciplinary VLOG that improved staff practice and patient feedback.

Quarter 2 – Safeguarding

Winner RMCH Theatres

Identified areas for improvement in safeguarding and used PDSA methods to address them, introduced sustainable tools including clear reporting processes, early intervention resources, and a “pink dot” alert system. Strengthening protection for vulnerable patients.



Addressed mobility challenges through daily bed rounds and a ‘Ward Lap (500) challenge’, significantly improving patient activity, hygiene and overall wellbeing.

Quarter 3 – Active Hospitals

Winner Ward 77

Delivered an outstanding submission with 13 staff research pledges, clearly demonstrating how patients and colleagues can engage through tools such as MyMFT and highlighting the tangible impact of research on patient care.

Quarter 4 – Research

Winner HDU@ORC

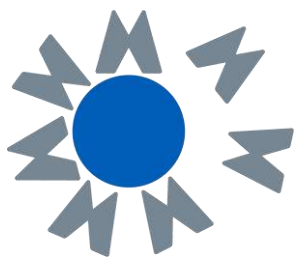


Bee Brilliant is a well-established, Trust-wide quality improvement initiative at Manchester University NHS Foundation Trust, designed to strengthen the fundamentals of care, inspire clinical excellence, and foster a culture of continuous improvement.

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Key Achievements in 2025/26

- Bee Brilliant sessions continued to attract significant participation, with 1392 attendees across the four quarters of 2025/26, demonstrating multidisciplinary engagement across nursing, midwifery, AHPs and support staff.
- The programme maintained its quarterly delivery model, providing consistent education, themed focus areas, and clear “Call to Action” initiatives aligned to clinical priorities such as pain, safeguarding, active hospitals and research.
- There have been 527 Bee Brilliant board submissions shared via the digital platform, evidencing widespread adoption of improvement activity across clinical areas and enabling Trust-wide learning and visibility.
- The programme has supported inclusive leadership, staff engagement, and capability building, reinforcing a culture of continuous improvement and aligning with the Trust’s strategic ambition for high-quality, compassionate care.
- Use of digital platforms has enabled scalable sharing of best practice, improving accessibility of learning across sites and supporting innovation at pace.



Clinical Scientific Services (CSS)



In response to NICE guideline NG193, the Community Pain Physiotherapy Team piloted a 4-week supervised pain and exercise programme at Altrincham General Hospital for patients lacking confidence to exercise with persistent pain. Eight patients completed the programme, showing improved physical function, pain self-management and confidence to return to exercise. Feedback was highly positive, and the service is exploring ongoing delivery to support self-management and reduce reliance on individual physiotherapy.

BBC and BBC Radio Manchester highlighted the introduction of Rocket Scanners, which use space-themed projections and interactive animations to help children prepare for MRI scans. The technology helps reduce anxiety, improve scan quality, minimise repeat appointments and reduce the need for sedation, supporting both patient safety and hospital efficiency. Families reported that the experience helped children feel calmer, more confident and better prepared, transforming MRI scans into a more positive experience.



The Pharmacy Team at Royal Manchester Children's Hospital delivers PILL School, an interactive programme helping children and young people take medicines safely and confidently through age-appropriate learning and hands-on practice. Feedback showed improved confidence, reduced anxiety and better medicine adherence. The Pharmacy Division also introduced British Sign Language (BSL) awareness training to improve communication and support more inclusive person-centred care for deaf and hard-of-hearing patients.



Manchester Royal Infirmary (MRI)



Care for Patients Living with Dementia

The Dementia Specialist Nurse at MRI has worked with site teams to reduce out-of-hours ward moves for patients living with dementia, helping to minimise distress and disorientation. She also collaborates across MFT to share best practice in dementia care. MRI continues to work closely with the Alzheimer's Society to enhance support for patients and families, with plans to introduce "Singing for the Brain" through a train-the-trainer programme.



Nutrition and Hydration Week

Nutrition and Hydration Week focused on strengthening oversight of meal services and reinforcing MFT mealtime standards, with Senior Leadership and corporate teams supporting service delivery and sharing good practice.

Patients were actively engaged in sharing feedback during mealtimes, while colleagues took part in daily nutrition and hydration quizzes and committed to personal pledges. Activities included a "Global Tea Party," Speech and Language Therapy education on IDDSI standards, and provision of additional fruit and pancakes for patients across clinical areas.





Manchester Royal Infirmary (MRI)



Therapeutic Activities

Therapeutic activities continue across the MRI site, with dedicated Therapeutic Activity Coordinators (TACs) supporting patients living with dementia and other patient groups through meaningful engagement activities.

Ward 31 delivered events celebrating Black History Month and Easter, including arts and crafts and themed group activities. MRI has also expanded the use of therapy pets, coordinated through voluntary services, which are highly valued by patients and contribute positively to wellbeing and patient experience.





Wythenshawe, Trafford, Withington and Altrincham (WTWA)



WTWA delivered a range of initiatives to improve care and understanding for patients living with dementia and their carers. Activities during Dementia Action Week 2025 included staff awareness and compassion training, alongside the first MFT Dementia Conference featuring lived-experience stories. Further work included launching a Delirium Flag for World Delirium Awareness Day 2026, creative staff wellbeing events, and the immersive “Me in Dementia” programme. Together, these initiatives demonstrate WTWA’s commitment to improving dementia care through education, collaboration, and engagement.





North Manchester General Hospital (NMGH)



Patient Engagement and Involvement

North Manchester continues to promote meaningful patient and carer involvement in service improvement through initiatives such as the Forget Me Not Bay on Ward E1. The bay was redesigned to provide a calmer, more therapeutic environment for patients requiring enhanced observations and falls prevention care, with activities and resources introduced to support wellbeing, reduce distress, and encourage interaction. Working closely with patients, carers, families, and volunteers, the initiative has contributed to a significant reduction in inpatient falls and positive patient feedback. It has also supported more person-centred observation practices, helping reduce restrictive interventions while maintaining patient safety, dignity, and comfort.

Person-Centred Care – Enhanced Observations and Innovative Practice

North Manchester is strengthening safe, high-quality care through innovative technology that supports patient safety, dignity, and wellbeing. A key focus has been improving observation practices to ensure care is delivered in the least restrictive and most therapeutic way possible.

The Ramble guard system has been introduced on Ward J6 to support proactive falls prevention, particularly inside rooms and isolation areas. It provides early alerts to patient movement, enabling quicker staff response while reducing the need for intrusive observations.

Early results from the pilot indicate a reduction in falls with harm and improved staff responsiveness.

Learning from Ward J6 will support consideration of wider rollout across similar settings to further enhance safe and dignified care.





North Manchester General Hospital (NMGH)



Supporting Compassionate and Holistic Care

North Manchester has strengthened its commitment to compassionate, person-centred care through the establishment of a Spiritual Care Working Group, developed with the Chaplaincy Team, Corporate Nursing, and clinical colleagues. The group supports recognition of patients' spiritual, religious, and cultural needs, while building staff confidence in having sensitive conversations around faith, beliefs, and values.

It provides practical guidance, shared learning, and a network of support to promote inclusive care across the organisation. This approach has already enhanced patient experience, enabling compassionate responses to individual wishes, including supporting a patient wedding on Ward C4. The initiative reflects a strong commitment to holistic care, ensuring patients feel respected, valued, and supported throughout their hospital journey.



Patient Engagement and Experience Improvement

SLT walk rounds and patient engagement events enabled real-time feedback on "How can we improve your care?", helping identify strengths and opportunities to enhance patient experience.

Clinical teams shared successful patient collaboration initiatives, highlighting the positive impact of involving patients in care decisions. Patient feedback identified food quality as a priority improvement area. In response, colleagues sampled meals from the new catering provider before launch to help shape the new service.





North Manchester General Hospital (NMGH)

Empowering the Patient Voice

Supporting Co-Production and Quality
in Patient Experience



Your North Manchester.



Patient Experience Week – Patient Engagement and Collaboration

Patient Experience Week at North Manchester focused on listening to patients, promoting collaboration, and improving person-centred care. Throughout the week, colleagues, patients, carers, and senior leaders came together through a range of engagement activities across the hospital.

Colleague Recognition – Human by Shared Gratitude App

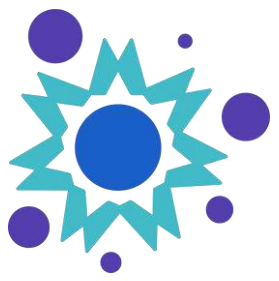
North Manchester introduced the Shared Gratitude App to give patients, families, and carers an easy way to share positive feedback and messages of appreciation with colleagues across the organisation. The app enables patients and visitors to recognise individuals and teams who have made a difference to their care experience, celebrating kindness, compassion, and outstanding care in real time. Feedback is shared directly with wards and teams, supporting colleague recognition, wellbeing, and morale.

Since its launch, the app has generated more than 500 interactions, with over 400 colleagues signed up across North Manchester. The initiative has strengthened patient engagement, reinforced a culture of appreciation, and highlighted the positive impact colleagues have on patients and families.



Over 400
colleagues
signed up

More than 500
interactions



Research and Innovation (R&I)

Patient Environment of Care – Improving Patient Experience at the RMCH Clinical Research Facility

The NIHR Clinical Research Facility at Royal Manchester Children's Hospital continued to enhance the experience of children and families through improvements informed by family feedback.

Updates included a new library and reading area within the playroom, providing a calm, child-friendly alternative to screen-based activities and supporting NHS England Play Well standards and NICE guidance. Refreshment options were also expanded to include decaffeinated and green teas, improving comfort and choice during longer visits. These changes demonstrate the facility's commitment to creating an inclusive, supportive, and compassionate research environment for children and families.

Maternal and Fetal Health Research Centre

Feedback from patients at the Maternal & Fetal Health Research Centre highlighted the professionalism, friendliness, and expertise of staff, with particular praise for the receptionist team's welcoming support. Areas for improvement included waiting times, communication accessibility, and wayfinding within Saint Mary's Hospital. In response, the service introduced additional clinical space to improve capacity and patient flow, alongside clearer appointment information to support access to 5th floor clinics.

Co-Designed Wall Art at the NIHR Clinical Research Facility

At the NIHR Clinical Research Facility at Wythenshawe Hospital, patients and colleagues helped co-design wall art and graphics to create a more welcoming and calming environment. Feedback highlighted the positive impact of involving service users and colleagues in shaping the space.

This collaborative approach ensured the designs reflected both lived experience and professional insight, supporting a more inclusive, compassionate, and person-centred environment for research participants and staff.



Specialist Hospitals: Royal Manchester Children's Hospital (RMCH)



Outpatients Youth Club

We held a Traitors-inspired experience in the Outpatient Youth Club, including a special message from Claudia Winkleman wishing the young people well. The session featured themed activities, round table discussions to identify Traitors and Faithfuls, and a final vote on whether to continue the game. Young people described it as “the funnest thing” and a “really nice way to bond.”

Scan the QR code to watch a video of the session.



Pediatric Service (PMS) – MPS Matter Engagement – June 2025

The PMS Matters Family Conference in June 2025 was attended by an RMCH Specialist Nurse and Specialist Physiotherapist. The community weekend provided valuable information, as well as an opportunity to meet families and other professionals, enabling the sharing of experiences, knowledge, and learning.



Specialist Hospitals: Royal Manchester Children's Hospital (RMCH)



Gaucher's Association – October 2025

Clinical Nurse Specialists Clare Hamilton-Kay and Janine Payne attended the Gaucher's Association Family Fun Day on Sunday 5th October 2025 at West Midlands Safari Park. The event provided an opportunity to support children and families living with Gaucher disease, while also enabling staff to engage with patients and families outside the hospital environment.

Christmas Celebrations

Hosted by nurses and dietitians from the service, this event provided an opportunity for engagement with families and patients outside the hospital environment. A buffet-style Christmas party, tailored to the dietary requirements of PKU patients, was provided. The event also enabled families to meet and connect with one another in a supportive setting.



Songbirds – Fledglings Wrap-Up

As our Fledgling musicians wrap up their residencies, the Fledgling Project 2025 is gently coming to an end. In a sentence: music met every child as they were – and quietly reshaped the musicians along the way.

This year, young musicians from the RNCM brought warmth, creativity, and open hearts into children's wards across MFT. With their musical partners, they gently tuned into the moods of each space, softening anxiety, lifting moods, and sparking joyful, playful moments.



Specialist Hospitals: Royal Manchester Children's Hospital (RMCH)



Health & Wellbeing Day – January 2026

The Youth Service ran another successful Health & Wellbeing Day for young people, starting with a healthy breakfast followed by an accessible yoga session led by returning volunteer Jessie. The session included breathing exercises and gentle stretches to promote relaxation and wellbeing.

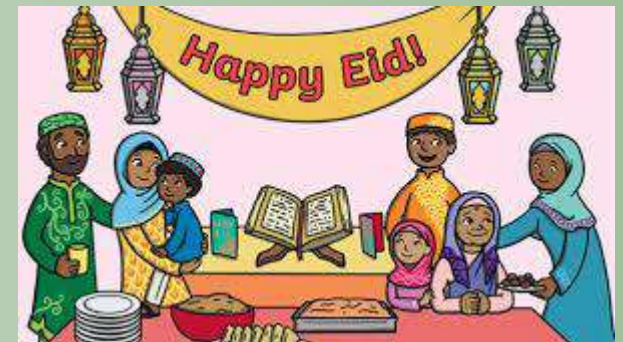
Artist volunteer Geraldine also attended, creating portraits of the young people and capturing the atmosphere and enjoyment of the day.



Eid Celebrations – March 2026

This month, we celebrated Eid by organising a party for young people and their families. It was a lovely event with music, food donated by Zouk's and fun games for everyone to enjoy. The young people were really happy and excited, It was so lovely to see so many smiles and to watch families spending time together. The response was very positive, and many families said they enjoyed the celebration.

The event was an great opportunity to support wellbeing and bring a sense of community within the hospital.





Specialist Hospitals: Royal Manchester Children's Hospital (RMCH)



Listening to Women: A Rainbow Haven Report

In February 2025, Saint Mary's Governance Team identified an emerging theme of Tigrinya-speaking women declining clinically indicated maternity care during labour, highlighting concerns around communication, cultural understanding, and inconsistent interpreter support.

Supported by the Maternity and Neonatal Voices Partnership, Saint Mary's Hospital held a listening event with 11 women from the Mama Group at Rainbow Haven to better understand their experiences of maternity care.

Key recommendations included tailored antenatal education, improved interpreter access, clearer birth planning, enhanced staff training on cultural safety and consent, and greater awareness of patient rights and complaints processes.

Conversations with Women

In April 2025, the "Conversations with Women Living and Birthing with HIV" event was a powerful and thought-provoking session led by experts by experience. Women generously shared their personal journeys of pregnancy, birth, and infant feeding while living with HIV.

Speaking directly to midwives, learners, and maternity professionals, their stories provided invaluable insight into how maternity care can be transformed through empathy, understanding, and a grounded knowledge of HIV.





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Specialist Hospitals: Royal Manchester Children's Hospital (RMCH)

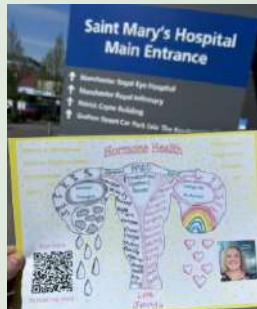


International Day For Zero Tolerance of Female Genital Cutting (FGM)

On 6 February 2026, Midwives Laura and Derin attended a “Conversations with...” session marking the UN International Day of Zero Tolerance for FGM, focused on women living and birthing with FGM.

The co-produced event, led by Mama Health and Poverty Partnership, centred lived experiences and insights from Black women and community advocates with direct experience of FGM in maternity care.

The session enhanced understanding of the impact of FGM on pregnancy and birth, challenged stigma, and reinforced the importance of culturally safe, compassionate care to improve maternity outcomes and reduce health inequalities



Hormone Health Month – March 2026

To raise awareness of Premenstrual Dysphoric Disorder (PMDD), Gynaecology Services shared a patient's lived experience, with Jenny hosting a stall in the Saint Mary's Atrium.

Her story supported increased awareness among staff and visitors, encouraged clinical reflection, and contributed to discussions on improving care pathways for patients with PMDD.





Specialist Hospitals: Manchester Royal Eye Hospital (MREH)



Patient Experience of Care Week – May 2025

The Macular Degeneration Clinic at Manchester Royal Eye Hospital received funding for an Eye Clinic Liaison Officer (ECLO) three days per week to enhance holistic care for patients with sight loss, alongside optimal clinical treatment.

The service has had a significant positive impact on patients and their daily lives, providing emotional support, practical advice, and guidance at a critical point in their care journey.

During Patient Experience of Care Week 2025, the Eye Clinic Liaison Officer team delivered daily clinic-based sessions to raise awareness and support patients living with sight loss. These sessions covered healthy eating, daily living skills, general wellbeing, and mental health support.

ACTIVITY TROLLEY FOR DEMENTIA PATIENTS



- We provide radios to play calming music for our patients living with dementia. This helps soothe distress, reduce agitation, and support relaxation when they are feeling unsettled or wandering.

Dementia Awareness

Ward 55 signed up to 'John's Campaign' and delivered focused education, training and awareness of Dementia and care pathways. They promoted a dementia friendly environment and provided care and reassurance to patients living with dementia and support for their relatives.



Carol Concerts





Specialist Hospitals: Manchester Royal Eye Hospital (MREH)



Nutrition and Hydration Week – March 2026

MREH introduced snack and drink rounds in outpatient and long-stay clinics in response to patient feedback about limited food options.

The menu was expanded beyond sandwiches, toast, and biscuits, and the new service was promoted to improve choice and patient experience during clinic visits.



Positive Impact

Patient and/or Staff Feedback:

"Such a fantastic addition to the eye hospital, we wish it had been here sooner"

"Beautiful sensory room, really helped to calm my child and help them regulate"

"A great initiative and use of space"

Details of reason for improvement:

To provide a dedicated sensory room to support our patients and families with LD & Autism. Maximising patient experience by providing a calm, safe space to wait and carry out eye assessments reducing sensory overload.



We Did



We invested in:

A mobile sensory unit with LED waterless tube, fibre optics lights and projector, comfortable bean bags, colour changing eggs, bubble mirror, storage tower with sensory fidgets.



Neurodiversity Awareness

Through Small Change Big Difference funding, the Eye Outpatient Clinic created a sensory space to support neurodiverse patients attending appointments.

The space has improved patient experience, helping younger patients remain calm during eye investigations and enabling more successful attendance at appointments, with positive feedback from parents. The MREH Learning Disability Nurse has played a key role in developing and promoting the space.



Improving experience for patients diagnosed with non-curative cancer within the community

Following a review of services and patient feedback, the palliative care team at Longsight Health Centre identified that patients with non-curative cancers often experienced anxiety and transport difficulties when attending hospital appointments, including MRI scans. In response, the team worked with Macmillan UK on a Small Change, Big Difference bid to transform an underused storeroom into a calm, welcoming clinic space. Established in July 2025, the room now hosts

Tuesday community-based clinics, bringing care closer to patients in a more supportive environment. The space is also used for sensitive conversations with patients and families, Macmillan Cancer Information & Support Centre services including bereavement counselling, and staff activities such as appraisals and one-to-one meetings. It additionally provides a quiet, restorative environment for staff wellbeing.



Supporting Children's therapy sessions in the community using Aquatic therapy

In 2025, Trafford Children's Therapy Services introduced community-based Physiotherapy Led Aquatic Therapy (PLAT) to improve access for children affected by post-COVID pool closures. An audit of the service identified significant inequality, with 16 eligible children in mainstream schools unable to access PLAT, while many children in special schools receiving it did not meet clinical criteria. In response, the pathway was updated to improve fairness and safety. One special school opened pool access to mainstream pupils, and physiotherapists provided training to school staff and parents to support safe delivery and reduce inappropriate referrals. So far, staff in two special schools and two parents have been trained. These changes have reduced inappropriate use of PLAT, freed physiotherapy capacity for children with greater clinical need, and increased provision of land-based therapy. Delivery has been consolidated to a single pool, improving safety and reducing training and evacuation risks. Early feedback from families and staff has been positive.



Local Care Organisation (LCO)



MLCO MSK Community Appointment Day (CAD)

In March 2025, the Central Manchester Adult Musculoskeletal (MSK) Physiotherapy Service piloted its first Community Appointment Day (CAD), offering a 'one-stop' community-based clinic for patients on the MSK waiting list. Designed to reduce delays and improve patient experience, the CAD brought together physiotherapists, administrative staff, voluntary sector partners, and wider community services at the Jain Community Centre in Longsight. Patients received assessment, advice, rehabilitation guidance, and onward referrals in a single visit, supported by face-to-face interpreters to meet local population needs. The pilot was delivered following patient feedback and successfully supported over 100 patients. It demonstrated that delivering integrated care within community settings, in partnership with VCFSE organisations, can improve access, efficiency, and patient outcomes.



From Ward to Home: Support Babies and Families Through Home Phototherapy

Neonatal jaundice affects around 60% of term and up to 80% of preterm babies, with about 1 in 20 requiring phototherapy. Traditionally, this has led to prolonged hospital stays, placing pressure on neonatal and pediatric wards and causing stress for families.

In response, Manchester (2022) and Trafford (2023) Children's Community Nursing teams developed a home-based phototherapy pathway through the Hospital at Home model. Eligible babies can now receive safe, effective treatment in their own homes, supported by community nursing teams. Audit data shows outcomes are comparable to hospital treatment, with reduced admissions and improved bed capacity. Between November 2025 and January 2026, 19 babies were treated at home, contributing to winter pressure management.

Families report reduced anxiety, improved bonding, and support for breastfeeding, with highly positive feedback on care quality and flexibility.



The pathway is supported by strong multi-agency collaboration and demonstrates safer, more patient-centred care closer to home.

Hospital at Home Celebration

The Paediatric Hospital at Home was established as a substantive service in Manchester in summer 2022, following a successful extended pilot, which began in November 2020. The service is provided by a team of nurses and is a partnership between the Manchester Local Care Organisation (MLCO), Trafford Local Care Organisation (TLCO) and the managed clinical service for paediatrics at the Royal Manchester Children's Hospital (RMCCH). In its first 2 years of operation, it is estimated that the service has saved 1000 bed days!



Trafford Hospital at Home Team



Manchester Hospital at Home Team

Testimony

'The virtual ward allowed us to care for our baby at home which made all of us feel very comfortable as babies and their parents can be at ease in their usual environment. The team checked on us regularly so her progress was monitored just like it would have been in hospital... We can't think of anything that the team could have done better. We received an excellent service.'

Trafford Parent (March 2023)

Feedback

91% of parents and carers rated hospital at home good or excellent and **93%** felt more confident to look after their child at home following contact with the hospital at home team!

Watch This Space...

The team continue to get feedback from families to explore what they can do better. Along with working with GPs to enable referrals directly into Hospital @ Home service and in developing a pathway for complex children with acute illness. If you would like to learn more about The Hospital at Home Service email: James.Ashton@mft.nhs.uk or Sarah.clayhill@mft.nhs.uk



Above: HSI Awards September 2023. The team were shortlisted in the 'Virtual or Remote Care Initiative of the Year' category!



University Dental Hospital of Manchester (UDHM)



Undergraduate patient coordinator role

The UDHM has introduced a new Undergraduate Patient Coordinator role to strengthen the link between NHS clinical services and the Undergraduate Dental Programme, ensuring a more coordinated and consistent patient experience.

The role acts as a central point of contact for patients treated by dental students, overseeing their progress, supporting communication between patients and students, and addressing queries or concerns during treatment. It also ensures safe and organised transfer of patients requiring ongoing care at the end of term, preventing loss to follow-up.

Overall, the post improves communication, reduces delays, and enhances patient support, while strengthening governance and ensuring safer transitions between student-led and NHS dental services.

Chaplaincy Support at the UDHM

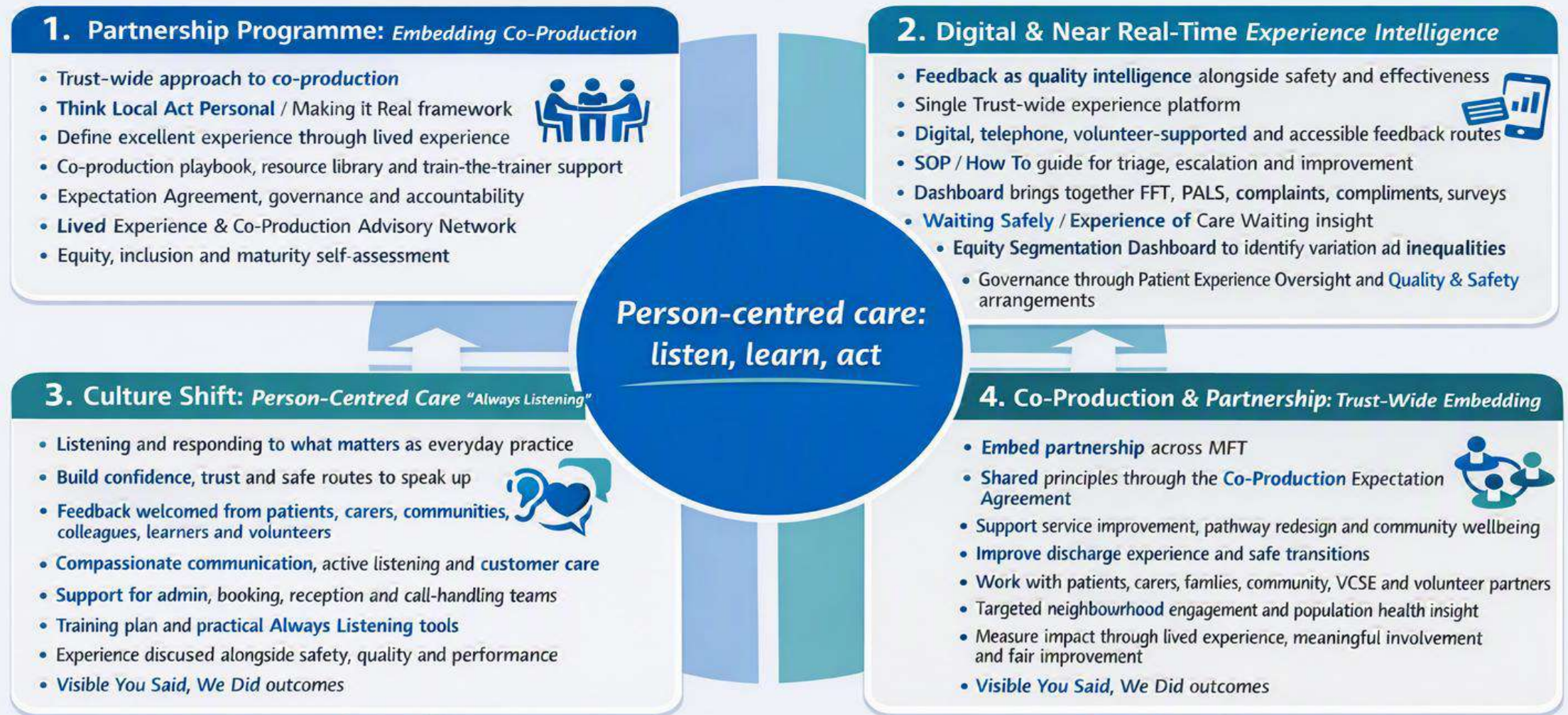
The UDHM has worked in partnership with the MFT Chaplaincy Service to introduce dedicated support sessions for both patients and staff. This initiative aims to strengthen emotional, spiritual, and pastoral support within the hospital environment, recognising the positive impact such services can have on wellbeing and overall patient experience. Introducing regular chaplaincy support enhances the hospital's holistic approach to care by addressing emotional and spiritual needs alongside clinical treatment. It also provides staff with an additional resource to help them support patients facing difficult diagnoses, stressful procedures, or personal challenges. Over time, the sessions are expected to contribute to improved wellbeing, stronger staff-patient communication, and a more compassionate care environment.'



Looking Ahead: 2026/27

2026/27 Patient Services Priorities

Embedding person-centred experience excellence across MFT



Outcome by 2027: consistent experience insight, reduced variation and inequalities, embedded co-production, and visible action from feedback.

Public Board of Directors

Wednesday, 30 September 2026

Paper Title:	MFT Core Standards Statement of Compliance	Agenda Item 11.5
Presented by:	Vanessa Gardener, Chief Delivery Officer	
Prepared by:	Nicky Shaw, EPRR Head of Service	
Meetings where content has been discussed previously	Trust Leadership Team Committee Quality, Safety and Performance Board Committee	
Purpose of the paper Please check <u>one</u> box only:	☒ For approval ☐ For support ☐ For discussion ☐ For noting	

Executive summary / key messages for the meeting to consider

This paper provides an update on MFT's preparations for the 2026/27 NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards submission.

The Trust achieved a Substantial Assurance rating in 2025, with 95% compliance against the applicable 62 standards. Work undertaken during 2026 has focused on maintaining that position while further strengthening business continuity, risk governance, live exercising and improving the Evacuation and Shelter Plan.

Based on current progress, the Trust remains on track to meet the submission deadline and is expected to maintain a Substantial Assurance rating.

The annual EPRR assurance process is a statutory requirement, requiring Board level sign off and must include:

- ✓ A formal Statement of Compliance
- ✓ An EPRR Action Plan
- ✓ The EPRR Core Standards Self-Assessment Spreadsheet RAG rated.

This year our submission is on track to remain substantially compliant with a 1% increase to 96%.

Recommendation(s)

The Board of Directors are asked to:

- Note the progress to date and the on-going work to ensure MFT achieve substantial compliance by September 2026.

- Sign off the contents of the EPRR Policy and the Business Continuity Policy.

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 the 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 within this report links to the following strategic, corporate, or operational risks:

- MFT/008229

Care Quality Commission domains

Please check **all** that apply

☒ Safe

☐ Caring

☒ Effective

☒ Well-Led

☒ Responsive

Compliance & Regulatory Implications

The following compliance and regulatory implications have been identified as a result of the work outlined in the report:

- Civil Contingencies Act 2004
- NHS Core Standards of EPRR
- MFT Incident Response Plan
- NHSE EPRR Framework 2022

Main report

The EPRR Team has continued to work with Clinical Groups and stakeholders to strengthen the Trust's preparedness arrangements and maintain compliance with national requirements.

Key areas of progress are:

- Updating and strengthening the EPRR Business Continuity policy framework.
- Supporting Clinical Group EPRR Forums to monitor risks, actions, training and preparedness.
- Launching Business Continuity Week to raise awareness across the organisation.
- Introducing the C2 Business Continuity Management System to support Business Impact Assessments, Business Continuity Plans and assurance reporting.
- Working with service leads to improve understanding of critical services and dependencies focusing on third party suppliers.
- Strengthening links with Digital Services, Cyber Security, Medical Devices, Procurement and Supplier Resilience teams.
- Leading on a number of exercises including 3 live exercises to test the CBRN decontamination facilities across three sites.
- Delivering training for commanders, loggists and Business Continuity leads.
- Supporting a comprehensive programme of exercises and incident preparedness activity.
- Undertaking a full trust exercise for a cyber-attack and regional participation by EPRR

Whilst the Trust continues to perform strongly overall, several areas remain a priority during the remainder of the assurance cycle. These include:

- Completion and approval of Business Impact Assessments.
- Continued review and sign-off of Business Continuity Plans.
- Further embedding of the C2 Business Continuity Management System.
- Closure of outstanding improvement actions arising from exercises and incidents.
- Continued focus on Core Standard 16 and Business Continuity Standards 46 and 47.
- The introduction of a new Major Incident Alerting system.

The table overleaf summarises progress made against the Core Standards. Two standards remain partially compliant, although significant progress has been made. These areas are now rated as 'amber – in progress' with detailed work plans in place:

- Business Continuity (Standards 46 and 47)

Domain Name	Acute Core Standards (62)	Fully Compliant
Governance	1, 2, 3, 4, 5, 6	6
Duty to Risk Assess	7, 8	2
Duty to Maintain Plans	9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19	10
Command and control	20, 21	2
Training and Exercise	22, 23, 24, 25	4
Response	26, 27, 28, 29, 30, 31, 32	7
Warning and informing	33, 34, 35, 36	4
Cooperation	37, 38, 39, 43	4

Business Continuity	44, 45, 46, 47, 48, 49, 50, 51, 52, 53	8
Hazmat/CBRN	55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66	12
The organisation is 89-99% compliant	MFT Compliance Total for 2025	60 (96%)

2026 EPRR Submission Update

There will be no Deep Dive component included in this year's EPRR assurance process. However, it is important to note that the absence of a Deep Dive does not contribute to the overall score and, therefore, will not impact the Trust's compliance level.

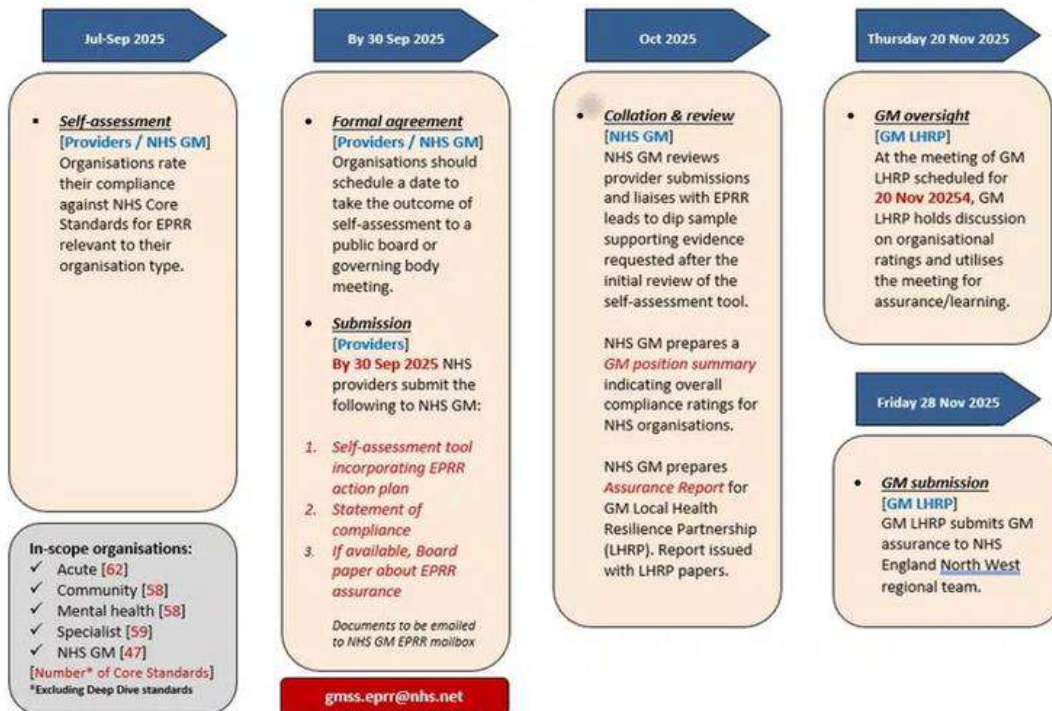
The assurance process will follow the same format as in 2025, including a meeting with the Trust to support inspection discussions and review the submitted evidence. Following the completion of all provider visits, the Integrated Care Board (ICB) will meet with Accountable Emergency Officers (AEOs) at the Local Health Resilience Partnership (LHRP) to finalise and sign off the regional submission to NHS England.

Next Steps

The Trust will follow the ICB process set out below:

Date	Activity
July - September 2026	Complete self-assessment and evidence review
30/09/2026	Final Executive and Board approval
30/09/2026	Submission of Statement of Compliance to NHS Greater Manchester
October 2026	Assurance review and requests for further evidence
12/11/2026	Greater Manchester LHRP assurance discussions
November - December 2026	Regional and national assurance process

2025-2029 NHS England Core Standards for EPRR | Summary of Greater Manchester Assurance Process



EPRR Core Standards - 2025-26 GM Assurance Process (v.01)

**Greater Manchester Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2026-2027**

STATEMENT OF COMPLIANCE

Manchester University Foundation Trust (MFT) has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, MFT will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer:

V. Gardner

Date signed: 30.09.2026

30/09/2026
Date of Board/governing body
meeting

30/09/2026
Date presented at Public Board

Date published in organisations
Annual Report



Business Continuity Policy

V2.4



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Document Title	Business Continuity Policy
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Authors	Stephen Maxwell
Owner/s	MFT EPRR
Accountable Emergency Officer (AEO)	Vanessa Gardener Chief Delivery Officer
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Collaborative Planning

NHSE EPRR Core Standard 9 (Domain 9, Business Continuity)

Version	Date	Contributor	Change/s
<i>New Template and previous version log starts from 2024 (contact EPRR for previous version)</i>			
2.2	15.07.2025	Dominic Sagar, EPRR Manager	Updated to align to NHSE Core Standards
2.2	01.10.2025	Vanessa Gardener, AEO	Policy Board sign off
2.2	15.07.2025	Nicky Shaw, Head of EPRR	Reviewed to align with NHSE EPRR Framework
2.3	01.10.2025	Vanessa Gardener, AEO	Policy Board sign off.
2.4	12.05.2026	Stephen Maxwell, EPRR Manager	Updated to incorporate the implementation of the C2 Business Continuity Management System.

Associated Internal Documents

Title	Owner	Location
Document Handling Procedure	EPRR Team	MFT hosted internet the Incident Management Toolkit, SharePoint provide access to all EPRR documents, plans, SOPs etc.

Please note: Responsibility for verifying the content and safety of all external links embedded in this document lies with the reader. MFT and the EPRR team do not assume any responsibility for external sources linked contained in this document.

Title: Business Continuity Policy	Version: 2.4	Page 3 of 19
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Document Approval

Document to be approved by the Accountable Emergency Officer, MFT Chief Executive Officer and Board of Directors Chair.

Signed by the organisation’s Chairman

Signed by the organisation’s Chief Executive

Signed by the organisation’s Accountable Emergency Officer

Date presented to Board/Governing Body meeting	Date presented at Public Board	Date published in organisation’s Annual Report

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MFT strategy

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The MFT strategy confirms our mission to work together to improve the health and quality of life of our diverse communities.

MFT values:

- We are compassionate
- We are collaborative
- We are open and honest
- We are inclusive
- We are curious

We have used these values to inform the aims, objectives and values that make up our strategy.

Document Purpose, Objectives and Scope

Policy Purpose

Manchester University NHS Foundation Trust (MFT) is committed to ensuring the continuity of its critical services in the face of disruptions. This policy sets out the framework through which the Trust meets its statutory and contractual obligations, aligning with the *Civil Contingencies Act 2004*, the *NHS Act 2006* (as amended by the *Health and Social Care Act 2012*), the *NHS Standard Contract*, and NHS England's *Emergency Preparedness, Resilience and Response (EPRR) Framework*.

Furthermore, the policy supports compliance with the NHS EPRR Core Standards and the international standard ISO 22301 for Business Continuity Management Systems (BCMS). Its purpose is to outline how MFT will discharge its responsibilities to ensure appropriate preparedness for, response to, and recovery from, emergency situations.

Policy Objectives

The objectives of the Business Continuity Policy at MFT are to implement a Business Continuity Management System (BCMS) aligned with ISO 22301 and to deliver a scalable, Trust-wide Business Continuity Plan.

The policy aims to ensure that all services are incorporated into service-level Business Continuity Plans and that effective response capabilities are in place, supported by increased organisational awareness.

Plans will be maintained and regularly reviewed in line with NHS EPRR guidance and standards. The Trust is committed to top-level management oversight, continual improvement of the BCMS, and fostering a culture where all staff embrace and embed business continuity into day-to-day operations.

Additionally, the policy supports the development and integration of the newly commissioned C2 software, which will serve as the Trust's central BCMS platform.

Policy Scope

This policy is a Trust-wide document and applies equally to all members of staff, either permanent or temporary and to those working within, or for, the trust under contracted services.

Statutory Requirements for EPRR

Applicable legislation and guidance

MFT is an acute provider of medical services and is designated as a Category 1 responder under the Civil Contingencies Act (2004). As such, it is subject to a range of statutory and strategic guidance including Civil Contingencies Act (2004); Emergency Preparedness and Emergency Response and Recovery guidance; NHS Act 2006; Health and Social Care Act 2012; NHS Constitution; NHS Core Standards for EPRR; ISO 22301:2019; and the NHS England EPRR Framework (2022).

NHS England EPRR Framework and Core Standards

The NHS England EPRR Framework outlines national principles and responsibilities for EPRR across NHS-funded organisations.

The NHS Core Standards for EPRR underpin the annual assurance process required of all providers and commissioners of NHS-funded services. Compliance is

assessed via self-assessment and validated by NHS England and Integrated Care Boards (ICBs).

Organisational Duties

MFT Duties

As a Category 1 responder, MFT must assess risks, develop emergency and business continuity plans, warn and inform the public, and collaborate with local responders. These duties align with the statutory requirements of the Civil Contingencies Act (2004).

EPRR Governance Process

EPRR Forums

- Manchester Royal Infirmary (MRI)
- Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA)
- North Manchester General Hospital (NMGH)
- Clinical and Scientific Services (CSS)
- Specialist Hospitals Clinical Group
- Local Care Organisation & University Dental Hospital (LCO/UDH)
- Digital Services (including Cyber Security and HIVE)
- Estates and Facilities (including Telephony and Security)
- Supplier Resilience (medical devices, Procurement, Risk Management)

The EPRR Team coordinates preparedness activity across the Trust through site-specific EPRR Forums, which meet every four to six weeks. Each Forum is chaired locally and ensures the effective coordination of emergency preparedness and the integration of risk management for Business Continuity Plans.

Every Forum operates under a standardised Terms of Reference that outlines its purpose, scope, and membership, and is supported by a designated EPRR Lead. These governance arrangements provide consistency across sites and enable alignment with Trust-wide assurance processes.

EPRR Work Plan

The Trust's EPRR Forums are responsible for ensuring that robust business continuity arrangements are in place, actively maintained, and implemented across all relevant services.

Each Forum is expected to oversee the maintenance of appropriate records by Clinical Groups and corporate stakeholders to support audit trails, regulatory assurance, and the annual NHS England Core Standards submission.

A key function of the Forums are to deliver and monitor an annual EPRR Work Plan that drives compliance, strengthens organisational resilience, and addresses areas of partial or non-compliance.

Assurance is provided through regular AAA reporting, including evidence of Business Continuity Plan (BCP) compliance. This includes ensuring that up-to-date BCPs are in place and that a trained and identified Business Continuity Service Lead (BCSL) is assigned to every service area, with oversight of planning and review schedules.

All business continuity plans must be signed off either at director level or through a governance structure agreed by the relevant Senior Leadership Team (SLT), providing clear accountability and assurance across One MFT.

Definitions

“A Business Continuity Incident is an event or occurrence that disrupts (or might disrupt) an organisation's normal service delivery to below acceptable predefined levels and would require special arrangements to be implemented until service delivery can return to an acceptable level.” [NHS England EPRR Framework, 2022](#)

Business Impact Analysis (BIA)

A Business Impact Analysis (BIA) is the process of analysing business functions and the effect that a business disruption might have upon them.

It involves identifying and evaluating the potential impacts of an interruption to critical business operations as a result of a disaster, accident, or emergency. This process identifies service criticality and categorises activities into four tiers: Essential, High Priority, Medium Priority, and Low Priority. This prioritisation informs the development and maintenance of effective continuity plans.

Business Continuity Plans (BCPs)

Business Continuity Plans (BCPs) are developed at both Trust-wide and service-specific levels to support a coordinated response to Business Continuity incidents, Critical Incidents, and Major Incidents. These plans are tailored to reflect local risks and operational priorities, addressing a range of potential disruptions including the loss or degradation of staffing, information and data, premises, digital and estates infrastructure, and critical suppliers or contractors.

Each BCP is subject to an annual review and testing process, with oversight from the EPRR Team to monitor compliance, quality, and alignment with current standards. This approach ensures that business continuity arrangements are fully embedded into day-to-day operations and remain responsive to the evolving risk landscape across One MFT.

Incident Threshold

An example of a Business Continuity Incident could be an Estates issue that causes a water leak, preventing staff and patients from accessing a facility. This could disrupt the delivery of care and would require activating alternative arrangements (such as moving temporarily to a new area, or rescheduling treatments) to maintain the continuity of the service.

Within MFT: Commanders may receive reports of incidents at any time. If you are unsure whether an incident meets the definition of Business Continuity Incident, consider:

- Do the impacts of the event occurring disrupt service delivery?
- Do they have the potential to disrupt service delivery?
- Do you have to put special or different arrangements in place to continue to deliver your service?

If the answer to any of these questions is “**yes**”, services should:

- Activate their Service-Level Business Continuity Plans, and
- Escalate to their Tactical Commander.

Commanders should oversee and support this process. Tactical Commanders should escalate to the Tactical Coordinator who will inform the Strategic Commander; together the Tactical Coordinator and Strategic Commander should

make an assessment of whether this is a Business Continuity Incident and the severity of the incident and take appropriate actions thereafter.

On declaring a Business Continuity Incident the Strategic Commander must alert the ICB using the agreed process.

Measures outlining the management of Business Continuity Incidents are contained within [the MFT Incident Response Plan](#).

NHSE EPRR Core Standards

Business Continuity related Core Standards

Domain 9 of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework outlines nine core standards relating to Business Continuity, with an additional business continuity core standard in Domain 6 (Response). The EPRR Team is responsible for ensuring that these standards are fully implemented, monitored, and evidenced across the Trust.

The primary aim of the Trust's Business Continuity Policy is to ensure the organisation can sustain the delivery of critical services and respond effectively during periods of disruption. It supports proactive preparedness, promotes regular testing and exercising of plans, and embeds a culture of resilience across clinical and corporate services.

The objectives of the policy are to ensure that business continuity is embedded as a golden thread throughout the organisation, with continuity, preparedness, and response fully integrated into routine operations. The Trust commits to maintaining and reviewing Business Continuity Plans (BCPs) in line with national standards, ensuring the BCMS is understood and used by staff at all levels, and integrating business continuity into wider governance and assurance frameworks.

The 10 NHS England EPRR Core Standards which relate to business continuity are:

Number	EPRR Core Standard
28	<i>Management of business continuity incidents</i> In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).
44	<i>Business Continuity Policy statement</i> The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.
45	<i>Business Continuity Management System (BCMS)/program</i> The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the program ensures a clear understanding of which areas of the organisation are in and out of scope of the BC program.
46	<i>Business Impact Assessment (BIA)</i> The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).
47	<i>Business Continuity Plans (BCPs)</i> The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure
48	<i>Testing and exercising</i> The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.

50	<i>BCMS monitoring and evaluation.</i> The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.
51	<i>Business Continuity Audit</i> The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.
52	<i>BCMS Continuous Improvement process.</i> There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.
53	<i>Assurance of commissioned providers and suppliers BCPs</i> The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.

Table 1: NHS England Core Standards relating to Business Continuity¹

Collectively, these standards provide a structured and consistent foundation for ensuring that business continuity arrangements are effective, auditable, and embedded across One MFT.

MFT Business Continuity Management System (BCMS)

C2 Implementation

To strengthen the Trust's business continuity arrangements and support full compliance with ISO 22301:2019 standard for Business Continuity Management Systems, NHS England's *EPRR Core Standards*, and the *Business Continuity*

¹

Institute Good Practice Guidelines (GPG), MFT has procured a three-year licence for a digital Business Continuity Management System (BCMS) provided by Continuity2 (C2). C2 is a secure, web-based platform that enables the Trust to manage all aspects of business continuity through a single, integrated tool

The implementation of C2 BCMS will be phased over three years and is essential to maintaining and improving Trust-wide compliance with statutory duties under the Civil Contingencies Act 2004, the NHS Standard Contract, and NHS England's EPRR Framework.

In addition to enabling more consistent and effective delivery of business continuity arrangements, the system supports continuous improvement of our resilience capabilities. It also provides a single source of truth for business continuity activity across One MFT, promoting standardisation, transparency, and reducing duplication of staff time.

Risk Management and Business Continuity

Risk Management is fundamental to the resilience of any organisation. As such, risk management has been integrated into MFT's BCMS to ensure that EPRR related risks are identified and then meaningful risk management is being employed through corrective actions, managed through C2.

Each week the EPRR Team reviews any new risks which have been entered into MFT's Ulysees risk reporting system. These new risks are assessed for EPRR relevance and corrective actions are then added to both Ulysees and C2, which in turn generate email notifications with instructions for the BCSL to review specific elements of their business continuity arrangements and ensure that they have captured the update in their BIA.

The identified risks are then monitored through the appropriate EPRR Forum, where the risk can be reviewed and reassessed following implementation of the corrective action.

Business Impact Analysis (BIAs)

Business Impact Analyses (BIAs) are embedded within the system, ensuring visibility of risk and prioritisation of essential, high-priority, and time-critical services.

The BIA will be conducted by an appropriately trained BCSL who will complete it on behalf of their service using the C2 system.

There are 5 main areas which the BIA covers:

1. Describe the activity
2. Understand the impact (if the activity is disrupted)
3. Define the Minimum Level of Operation
4. Identify critical dependencies
5. Complete disruption scenarios

Additionally, reviews of Service Level BIAs can be triggered by new risks added to Ulysees and learning from exercises, incidents and other sources. When this occurs, the BCSL will be sent a notification from C2 asking them to review a specific aspect of their Service's BIA.

In the event of disruption, C2 BCMS enables access to live plans and associated documents. This not only strengthens information governance and cyber resilience but also significantly reduces response time and eliminates reliance on paper-based documentation.

A fully integrated management information dashboard provides real-time oversight of the status and currency of BIAs, continuity plans, exercises, and governance documentation across all sites.

Business Continuity Plans (BCPs)

Trust and Service Level plans ensure effective response to Business Continuity, Critical incidents, Major Incidents and are reviewed annually. Service Level BCPs will be generated by the C2 system using the entered BIA data and address disruptions to People and Staffing, Information and Data, Premises, IT and Infrastructure, and Suppliers/Contractors.

Plans will then be sent for review and sign off by the Service Manager and an appropriate Director. The sign off process will be managed through the C2 system and will ensure an audit trail of reviews and approvals.

Business Continuity Training and Exercising

All EPRR training undertaken is recorded on the MFT Learning Hub. This information will be made available to EPRR Forum Chairs for oversight and to ensure compliance.

The BCSL will receive specific training for their role, which will include training on business continuity management, using the C2 system, and completing a BIA

A general business continuity management awareness training is also available on the MFT Learning Hub, which is open to all staff, to increase awareness of business continuity across the Trust.

Additional support will be available, through the EPRR Front Door – Business Continuity pages and through monthly support webinars.

MFT are required to exercise response plans as defined by the MFT EPRR Policy. This includes exercises to test the effectiveness of Business Continuity Plans, which will be done following sign off at a Service Level.

Business Continuity Audit

Internal audits of the BCMS are conducted annually, following a structured cycle of self-assessment using C2 to demonstrate levels of compliance. Quality assurance reviews, and evaluations of supplier resilience and external audits are undertaken every three years to provide independent assurance of BCMS effectiveness and compliance with ISO 22301.

Audit findings, along with recommended actions are reported through the EPRR Forums and Group, with escalation to the Trust Board as required.

To strengthen oversight, the Trust has a formal arrangement with KPMG to independently review the quality of emergency plans and the robustness of business continuity arrangements and records.

Lessons identified through audits, reviews, and exercises are shared across the organisation to inform continuous improvement and reinforce Trust-wide resilience.

Validation and monitoring (KPIs)

The effectiveness of the Business Continuity Policy is measured through a set of key performance indicators. These KPIs focus on the 3 year Business Continuity Improvement Programme, and include:

- a) Service Level BIA completion: Year 1 - 30%, Year 2 – 60%, Year 3+ - 100%
- b) Service Level BCP completion: Year 1 - 30%, Year 2 – 60%, Year 3+ - 100%
- c) Percentage of Service Level BCP's with Director Sign Off: Year 1 - 30%, Year 2 – 60%, Year 3+ - 100%
- d) Service Level BCPs which have been validated through an exercise: Year 1 - 30%, Year 2 – 60%, Year 3+ - 100%
- e) Maintaining accurate records of training and exercises on the MFT Learning Hub.

Performance against these KPIs is monitored by Site-level EPRR Forums. Any deviations, risks, or concerns are escalated to the EPRR Group for further review and action, ensuring timely intervention and continuous improvement.

Supplier Resilience

Supplier Resilience is of paramount importance to enabling the organizational resilience of MFT.

A number of recent business continuity incidents have been caused by supply chain, estates and facilities, and supplier issues, which has emphasized the importance of supplier resilience.

The Supplier Resilience Working Group has been set up to ensure an MFT wide approach to Supplier Resilience and will establish the scope, procedures and arrangements to ensure that the Trust meets the requirements of EPRR Core Standard 53 – Assurance of Third Party/Supplier BCPs.

Governance

Organisations must have an appointed accountable emergency officer (AEO) who is a board-level director and responsible for EPRR in their organisation.

The AEO must provide reports to the public board on EPRR activity no less frequently than annually and must publicly state readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements. Board reports will include:

- Training and exercising reports (including BC).
- Incidents experienced by the Trust.
- Lessons identified and lessons learned.
- Compliance with NHS England Core Standards.
- BC KPI summary.

Business Continuity Lexicon

This table provides commonly used BC abbreviations and their meanings according to ISO Standard 22301 and the BCI.

Abbreviation	Meaning
BAU	Business As Usual
BC	Business Continuity
BCI	Business Continuity Institute
BCM	Business Continuity Management
BCMS	Business Continuity Management System
BCMT	Business Continuity Management Team
BCP	Business Continuity Plan
BCPDR	Business Continuity Planning and Disaster Recovery
BCR	Business Continuity Requirements
BCRA	Business Continuity Risk Assessment
BCRP	Business Continuity Recovery Plan
BCRS	Business Continuity and Resilience Standards
BCS	Business Continuity Strategy
BIA	Business Impact Analysis
DRP	Disaster Recovery Plan
EPRR	Emergency Preparedness, Resilience, and Response
ISO	International Organisation Standardisation

Abbreviation	Meaning
BAU	Business As Usual
IT	Information Technology
KPI	Key Performance Indicator
MFT	Manchester University Foundation Trust
MTPD	Maximum Tolerable Period of Disruption
MTTR	Mean Time to Recover
NHS	National Health Service
NHSE	National Health Service England
OEM	Original Equipment Manufacturer
RPO	Recovery Point Objective
RTO	Recovery Time Objective
SLA	Service Level Agreement
SPOF	Single Point of Failure

Emergency Preparedness, Resilience and Response (EPRR) Policy

V4.3



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Authors	Nicky Shaw
Owner/s	MFT EPRR
Accountable Emergency Officer (AEO)	Vanessa Gardener Chief Delivery Officer
Applicable to	MFT
EqIA Registration Number	EPRR02
Location of Hard Copies	MFT Intranet and EPRR SharePoint

Collaborative Planning

NHSE EPRR Core Standard 9 (Domian 3, Duty to Maintain Plans)

Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.

Partner organisations collaborated with as part of the planning process are in planning arrangements. Consultation process in place for plans and arrangements, changes to arrangements as a result of consultation are recorded.

Version	Date	Contributor	Change/s
<i>New Template and previous version log starts from 2024 (contact EPRR for previous version)</i>			
4.0	01/06/2024	Nicky Shaw, Head of EPRR	Updated to align to NHSE Core Standards
4.0	08/07/2024	Vanessa Gardener AEO	Policy Board sign off
4.1	15/07/2025	Nicky Shaw, Head of EPRR	Reviewed to align with NHSE EPRR Framework
4.1	01/10/2025	Vanessa Gardener AEO	Policy Board sign off.
4.2	20/01/2026	Nicky Shaw, Head of EPRR	Reviewed to align with NHSE EPRR Framework
4.2	20/01/2026	Vanessa Gardener AEO	Policy Board sign off.
4.3	01/04/2026	Annual Review	Reviewed to align with NHSE EPRR Framework

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Signed by the organisation's Chairman

Signed by the organisation's Chief Executive

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Document Purpose, Objectives and Scope

Policy Purpose

The purpose of this document is to provide the framework for MFT to meet the statutory requirements of the Civil Contingencies Act (CCA) (2004), NHS Act 2006 (as amended by the Health and Social Care Act 2012), NHS Standard Contract and NHS England EPRR Framework. This document seeks to describe how the organisation will go about its duty to be appropriately prepared for dealing with emergencies.

Policy Objectives

The objectives of the Trust's EPRR Policy are:

To enable the organisation to prepare for the common consequences of emergencies rather than for every individual emergency scenario.

- To enable the organisation to have flexible arrangements for responding to emergencies, which can be scalable and adaptable to work in a wide range of specific scenarios.

- To supplement arrangements with specific planning and capability building for the most concerning risks in the Community Risk Register (CRR) and the National Risk Register (NRR).
- To ensure that plans are in place to recover from incidents and to provide appropriate support to those affected.
- To outline how MFT will demonstrate compliance with the Core Standards for EPRR as provided by NHS England.
- To provide a dedicated structure to maintain the delivery of EPRR functions regardless of organisational structure and staffing changes.
- To outline how the Trust will work with key suppliers and contractors with regard to EPRR functions.

Policy Scope

This policy is a Trust-wide document and applies equally to all members of staff, either permanent or temporary and to those working within, or for, the trust under contracted services.

Statutory Requirements for EPRR

Applicable legislation and guidance

MFT is an acute provider of medical services and is designated as a Category 1 responder under the Civil Contingencies Act (2004). As such, it is subject to a range of statutory and strategic guidance including Civil Contingencies Act (2004); Emergency Preparedness and Emergency Response and Recovery guidance; NHS Act 2006; Health and Social Care Act 2012; NHS Constitution; NHS Core Standards for EPRR; ISO 22301:2019; and the NHS England EPRR Framework (2022).

NHS England EPRR Framework and Core Standards

The NHS England EPRR Framework outlines national principles and responsibilities for EPRR across NHS-funded organisations. The NHS Core Standards for EPRR underpin the annual assurance process required of all providers and commissioners of NHS-funded services. Compliance is assessed via self-assessment and validated by NHS England and Integrated Care Boards (ICBs).

Organisational Duties

MFT Duties

As a Category 1 responder, MFT must assess risks, develop emergency and business continuity plans, warn and inform the public, and collaborate with local responders. These duties align with the statutory requirements of the Civil Contingencies Act (2004).

Greater Manchester Local Health Resilience Partnership (GM LHRP)

MFT participates in GM LHRP to coordinate regional planning and ensure NHS representation in Greater Manchester Resilience Forum (GMRF) structures. GM LHRP receives and confirms NHS organisational assurance against Core Standards.

The strategic nature of GM LHRP means it can provide a forum for consideration of system wide EPRR risks and arrangements that affect NHS organisations. GM LHRP may also serve as a link to regional governance structures for NHS EPRR.

The chair of GM LHRP will determine the need for any specific subgroups or projects groups to reflect locally identified risks and to ensure that effective tactical and operation planning/response arrangements are developed and maintained.

Greater Manchester Resilience Forum (GMRF).

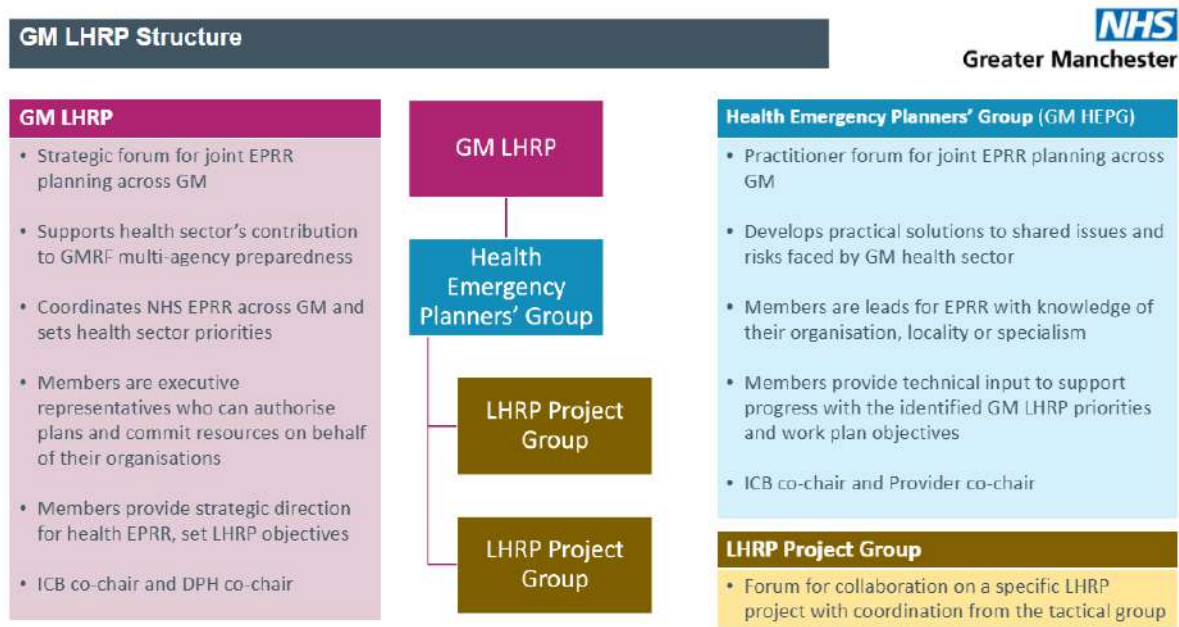
GM LHRP is a strategic forum with a focus on joint EPRR planning across the Greater Manchester integrated care system. GM LHRP also supports the health sector's contribution to multi-agency planning through Greater Manchester Resilience Forum (GMRF).

Compliance

The GM LHRP will annually confirm the assurance declared by NHS organisations against the NHS England EPRR Core Standards. This will include receiving a report on the overall level of GM compliance against the Core Standards and confirmation that any action plans arising from the assurance process are appropriate and achievable

Health Emergency Planning Group (HEPG)

The Health Emergency Planning Group (HEPG) is a tactical forum with representation from EPRR leads for GM NHS organisations will support GM LHRP to achieve this purpose. *Figure 1: GM LHRP Structure*



Accountable Emergency Officer (AEO)

Under the NHS Act 2006, there is a statutory requirement for relevant service providers (as defined in Section 8.2) to appoint an individual responsible for discharging duties under Section 252A(9). This individual is referred to as the Accountable Emergency Officer (AEO).

The AEO is a Board-level Executive accountable for ensuring that the organisation complies with all EPRR statutory duties. At MFT the role of AEO is held by the Chief Delivery Officer.

Key responsibilities of the AEO include:

Ensuring that effective EPRR arrangements and plans are in place, adequately resourced, and regularly tested.

Providing assurance to the Trust Board regarding EPRR compliance and organisational readiness.

Approving key strategic documents, including the Trust's Business Continuity and Incident Response Policies.

In the AEO's absence, their duties are assumed by the designated Executive On-Call to maintain continuity of oversight and compliance. In cases of prolonged absence, the Chief Executive may appoint a temporary AEO to fulfil these responsibilities.

For acute providers such as MFT, the AEO also holds responsibility for signing off the organisation's mass casualty distribution figures. At MFT, this duty is fulfilled in accordance with the Greater Manchester Mass Casualty Dispersal Framework, as referenced in the Trust's Incident Response Plan (IRP).

Non-Executive Directors (NEDs)

The independence that (NEDs) bring is essential to being able to hold the AEO to account, but responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met.

Therefore, EPRR should be included on appropriate Committee Groups forward plans and EPRR board reports, including EPRR annual assurance, should be taken to the board annually.

EPRR

The EPRR team is resourced via the Chief Deliver Officer Directorate (CDO). Strategic and functional officer roles are resourced centrally. Tactical, operational and loggist roles are resourced via clinical groups. Resources used to carry out preparatory and response EPRR functions are overseen by corporate, clinical group or stakeholder governance structures, with overall responsibility and oversight provided by the AEO.

Clinical Group

Chief Executives and senior leadership are responsible for embedding and approving an EPRR Work Plan through their clinical governance structures (e.g. Senior Leadership Team), ensuring compliant Business Continuity Plans (BCP) are in place and maintained, identifying and managing relevant risks, overseeing appropriate training and resourcing, and reporting into the EPRR Forum for escalation to the Trust-wide EPRR Group.

Assurance

The EPRR Team coordinates Trust-wide EPRR activity under the leadership of the Chief Delivery Officer. Site-specific EPRR Forums feed into the overarching Trust-wide EPRR Group, which provides assurance to the Board. This assurance is delivered through the implementation of the EPRR Policy, Business Continuity Policy, and EPRR work plan, designed to ensure an effective response in the event of an incident. The Board remains fully aware of its legal obligations to ensure organisational preparedness, safeguard public protection, and support a coordinated NHS response.

EPRR Governance Process

EPRR Forums

- Manchester Royal Infirmary (MRI)
- Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA)
- North Manchester General Hospital (NMGH)
- Clinical and Scientific Services (CSS)
- Specialist Hospitals Clinical Group
- Local Care Organisation & University Dental Hospital (LCO/UDH)
- Digital Services (including Cyber Security and HIVE)
- Estates and Facilities (including Telephony and Security)
- Supplier Resilience (medical devices, Procurement, Risk Management)

The EPRR Team coordinates preparedness activity across the Trust through Clinical Group EPRR Forums, which meet every five to six weeks. Each Forum is chaired locally and ensures the effective coordination of emergency preparedness and the integration of risk management for Business Continuity Plans.

Every Forum operates under a standardised Terms of Reference that outlines its purpose, scope, and membership, and is supported by a named EPRR officer. These governance arrangements provide consistency across sites and enable alignment with Trust-wide assurance processes.

EPRR Forum Work Plan

Clinical Group EPRR Forums are responsible for supporting the delivery of the Trust EPRR Plan at local level.

This should be achieved through local EPRR arrangements that support statutory and regulatory compliance, strengthen organisational resilience, and address any areas of partial or non-compliance identified through annual assurance, audits, incidents, exercises or other reviews.

Clinical Groups, through their EPRR Forums, must ensure that appropriate resources are in place to support preparedness, response and recovery activity. This includes maintaining a suitable Incident Command Centre (ICC) and ensuring there are enough trained staff available to undertake key EPRR roles. This includes On-Call Commanders and a sufficient number of trained Loggists to support incident coordination across each site.

A key responsibility of the EPRR Forum is to support and promote Business Continuity arrangements across the Clinical Group. Forums should ensure that Business Continuity is understood by the Senior Leadership Team (SLT) and embedded across all services.

Each Clinical Group should identify Business Continuity Service Leads (BCSLs). These leads will support the development, maintenance, testing and review of local Business Continuity Plans (BCPs). EPRR Forums monitor compliance and ensure

that BCPs are reviewed within agreed timescales. Plans require formal signed off either at Director level or through an agreed SLT governance process.

EPRR Forums are also responsible for overseeing the EPRR Training Needs Analysis (TNA) for their clinical group. This is to ensure staff receive training that is appropriate to their role and level of responsibility. Attendance should be monitored at training and exercises, ensure records are maintained, and identify any gaps in workforce capability or exercise participation.

Where Clinical Groups have responsibilities for CBRN arrangements, the EPRR Forum must identify a designated CBRNe Lead. This person should attend Trust CBRN Hub meetings and is responsible for PRPS suit availability, ensuring suits are serviced and in date, decontamination capability, equipment checks, training compliance, exercises and testing arrangements.

EPRR Forums must actively monitor EPRR-related risks held on the Trust risk register. This includes risks relating to operational resilience, business continuity and preparedness activity. EPRR Forums should ensure that corrective actions are progressed by risk owners, mitigation plans are monitored, and risks scored above 15 are escalated in line with Trust risk management arrangements.

Updates, concerns and areas requiring escalation are reported through the Clinical Group governance structure, the relevant Risk Subgroup and the Trust EPRR Group using AAA reports.

Following an incident, exercise or disruption, EPRR Forums should support the EPRR Team to complete a structured debrief. This should identify lessons identified and lessons learned. Directors of Performance and Operations are responsible for ensuring that actions arising from debriefs are tracked, implemented and formally closed. This supports continuous improvement and organisational learning.

EPRR Forums must maintain consistent senior leadership representation and demonstrate active engagement in preparedness activity, governance meetings, exercises and resilience workstreams.

Assurance should be provided through AAA reports. These reports should include updates and escalation relating to the EPRR work plan and risk monitoring:

Risk and Business Continuity Forums

For Estates and Facilities, Digital including Cyber, and Third-Party Supplier Resilience, dedicated Business Continuity and Risk Forums are in place quarterly. These forums are chaired by the relevant service area and include representation from EPRR, Risk, Procurement and other key stakeholders as required. Their purpose is to review risks, business continuity arrangements, interdependencies, exercising requirements and assurance activity.

Supplier resilience is a key component of organisational resilience. Recent business continuity incidents have highlighted the impact that supply chain and third-party equipment issues can have on the Trust's ability to maintain critical services.

To strengthen this area, the Supplier Resilience Working Group has been established to support a consistent Trust-wide approach to supplier resilience. The group will define the scope, processes and assurance arrangements required to support compliance with NHS EPRR Core Standard 53, Assurance of Third-Party and Supplier Business Continuity Plans.

Internal Governance Structure:

- EPRR Group
- Delivery Oversight Management Committee
- Trust Leadership Team Committee (TLTC)
- Quality, Safety and Performance Board Committee (QSPBC)
- Board of Directors

External Strategic and Operational Partnerships:

- Manchester Health Protection Board (HPB)
- Local Health Resilience Partnership (LHRP)
- Health Emergency Planning Group (HEPG)
- Shelford Group
- Security Advisory Groups (SAGs)
- Integrated Care Board (ICB) and NHS England (NHSE) – Regional and National Exercises.

NHS England Core Standards for EPRR Compliance

There are 62 Core Standards divided across 10 domains. MFT measures compliance using thresholds ranging from 'fully compliant' to 'non-compliant'. Evidence is captured via reports submitted to the EPRR Group and Trust Board.

- Fully compliant: 100% of relevant standards met
- Substantially compliant: 89-99% of relevant standards met
- Partially compliant: 77-88% of relevant standards met
- Non-compliant: up to 76% of relevant standards met

SOPs, guidance and supporting documentation across the Trust.

EPRR Front Door (SharePoint site)

The full suite of EPRR resources, tools, assurance information and supporting documentation is hosted through the EPRR Front Door. This is a SharePoint site available to all staff across the Trust, providing a central access point for EPRR information across MFT.

The site includes a dedicated page for Commanders on Call, which acts as a virtual Incident Coordination Centre (ICC). It also includes pages covering key EPRR domains and workstreams, including:

- Virtual ICC (Incident Management Toolkit)
- CBRN Hub
- Training Academy
- Business Continuity and Risk Portal
- Central Governance page (reports, meetings etc)
- Core Standards

The EPRR Front Door is constantly updated and will continue to develop as a coordinated one-stop to support the management of EPRR across MFT.

EPRR Front Door [SharePoint](#) site

MFT Incident Management Toolkit

(Virtual Incident Coordination Centre ICC)

The MFT Incident Management Toolkit is a central online hub to support incident response across Manchester University NHS Foundation Trust.

It should be used as the first point of reference during any incident or disruption and is designed to support Strategic Commanders, Tactical Commanders, Tactical Coordinators and Functional Officers in managing incidents confidently, safely and consistently.

The Toolkit brings key information, templates, guidance and links together in one place. It is accessible wherever you are, including on mobile devices, helping those on call to quickly find the information they need when responding to an incident.

Through the Toolkit, you can access:

- Notification and escalation timescales, including reporting to the Integrated Care Board (ICB) SITREP and SBAR templates and forms.
- Key plans and guidance, including the MFT Incident Response Plan
- On-call structures and support information
- Useful links and resources to support incident management

By keeping these resources in one central location, the Toolkit helps support a coordinated, consistent and resilient response to incidents across the Trust.

Use this link [MFT Incident Management](#)

Domain 1 – Governance

Organisations must have an appointed accountable emergency officer (AEO) who is a board-level director and responsible for EPRR in their organisation.

The AEO must provide reports to the public board on EPRR activity no less frequently than annually and must publicly state readiness and preparedness

activities in annual reports within the organisation's own regulatory reporting requirements.

Board reports will include:

- Training and exercising compliance
- Declared incidents by the Trust
- Lessons identified
- Compliance with NHS England Core Standards Domain 2 – Duty to risk assess

Domain 2 – Duty to Access Risk

Risk management is essential to organisational resilience. MFT will regularly identify, assess and manage EPRR-related risks that may affect the Trust's ability to prepare for, respond to, and recover from incidents or disruption.

EPRR risks will be informed by:

- The National Risk Register
- The Greater Manchester Community Risk Register
- The MFT Risk Register (Ulysess)
- Identified by GM Integrated Care Board and NHS England North West
- Identified by MFT - incidents, exercises, audits and assurance reviews

The Trust has a Risk Management Strategy and Framework. EPRR works within this structure to identify risks that may affect compliance with the NHS EPRR Core Standards or impact organisational resilience.

The EPRR Team will review new risks entered onto Ulysses each week. Where a risk is relevant to EPRR, business continuity, operational resilience or preparedness, a corrective action will be added to Ulysses and C2. The risk owner will be notified along with the relevant Business Continuity Service Lead and asked to review their Business Impact Analysis and Business Continuity Plan immediately for compliance.

EPRR-related risks will be monitored through the Clinical Group EPRR Forum who will monitor mitigation actions and escalate concerns through the agreed governance route.

For Estates and Facilities, Digital including Cyber, and Third-Party Supplier Resilience, dedicated Business Continuity and Risk Forums will review relevant risks, plans, interdependencies, exercising arrangements and assurance activity.

standing Agenda Items:

- Risks
- Lessons Identified Lessons Learnt (LILL)
- Corrective Actions
- Planned/Unplanned Downtime
- Business Impact Assessment (BIA) and Business Continuity Plans (BCP)
- Escalation - AAA Report
- Testing and Exercising Activity
- EPRR work plans updates

Lessons Identified Lessons Learned (LILL)

Lessons must be identified, recorded and acted on through a clear and consistent process. Learning may come from:

- Incidents
- Exercises
- Debriefs
- Audits
- Reviews
- Business continuity disruptions

All lessons are recorded centrally, with clear actions, named owners and agreed timescales. Progress must be monitored until actions are completed and formally closed.

Actions should be reviewed to ensure they have led to improvement. This helps demonstrate that learning has strengthened patient safety, staff safety, service quality and response arrangements.

The EPRR Team will maintain a tracker of lessons, this supports organisational learning and provides evidence for assurance, regulation and external scrutiny.

Domain 3 – Duty to maintain plans

No.	Plans
1	Incident Response
2	Adverse Weather
3	Infectious disease
4	New and emerging pandemics
5	Countermeasures
6	Mass Casualty
7	Evacuation and shelter
8	Lockdown (Owned by Security)
9	Protected individuals
10	Excess fatalities

EPRR Plans and Policies

The Trust must have plans in place that set out how it will prepare for, respond to and recover from:

- Major incidents
- Critical incidents
- Business continuity incidents
- Other significant disruption

Not all EPRR-related plans are owned by the EPRR Team or held at Trust level. Plans should be developed with the relevant stakeholders to ensure arrangements are practical, joined up and consider the whole patient pathway. All EPRR plans should follow a cycle of preparedness.

All plans and policies are reviewed, depending on the size and area of the plan a period of consultation may be carried out. EPRR policies follow the Trust policy approval process and be ratified by the MFT Trust Board.

Plans

All plans must clearly record any changes made, with accurate dates, version control, and supporting information to ensure alignment with due governance processes. A document control checklist has been developed to ensure all plans are complete, accurate, and compliant at the point of release.

Document Check List Template:

Confirm	Yes/No/Comment
All dates are correct throughout the document	
Headers and Footer are in date and correct.	
Contents page is correct	
Hyperlinks work and are in date and correct	
Page numbers are correct and match the contents page	
All formatting is correct, and font is Arial 12	
Consultation and contributors have been recorded (front page)	
EqIA Registration Number	

Coordination of Plan Reviews

The EPRR Team will coordinate the review of EPRR plans and policies to ensure a consistent approach across the Trust. Reviews will be aligned to NHS EPRR Core Standards, relevant guidance and recognised EPRR good practice.

The EPRR Team:

- Track and monitor plan reviews using internal trackers
- Coordinate consultation with internal and external stakeholders, where required
- Support the testing and exercising of plans
- Record progress, changes and key updates
- Share updates with relevant EPRR Forums and the EPRR Group, whole Trust

Sign off and distribution

Only full rewrites require sign-off through the Delivery Oversight Management Committee. Site-level plans and reviews do not require DOMC sign-off unless there is a significant change or specific escalation required.

EPRR policies must follow the Trust policy approval process and be ratified by the MFT Trust Board where required.

All plans will be stored in the first instance in the following places:

- MFT intranet – links to EPRR Front Door and Incident Response Plan
- SharePoint - MFT Incident Management Toolkit

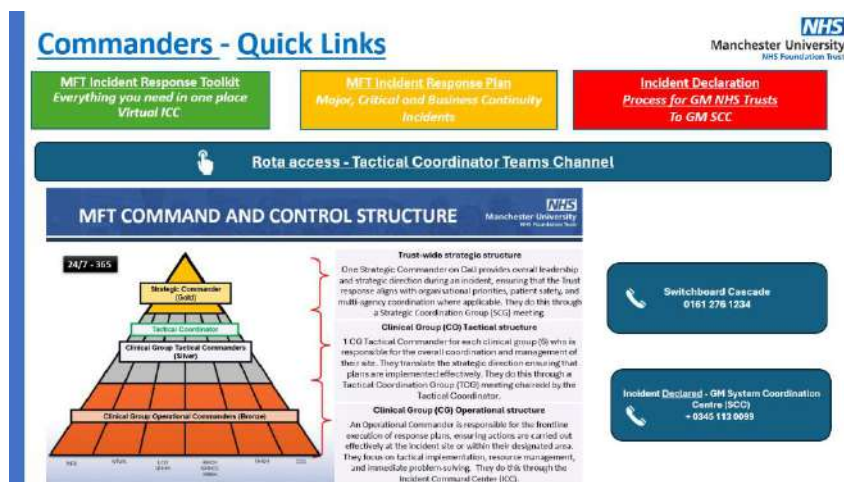
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- Clinical Group - Incident Coordination Centre (ICC) (plan hard copies)

Domain 4 - Command and control

A robust and dedicated Incident alert mechanism must be in place to receive and communicate incident alerts. Activation must be available 24 hours a day, seven days a week, and provide the ability to acknowledge, respond and escalate notifications to key staff identified on an incident distribution list. On call commanders must assure the board, they are trained and confident in their role as decision makers.

Staff performing the on-call function should also be trained in all aspects of incident response. The diagram below outlines the overall arrangements for incident notification and escalation within MFT, and the Command and Control.



Alert Cascade – AtHoc BlackBerry

The Trust will introduce a digital incident alert system in July 2026. This will replace the current manual telephone call cascade operated by Switchboard.

The new BlackBerry AtHoc alerting system will be used to send incident notifications quickly and consistently to identified on-call commanders and rota staff who hold a licence.

Training will be provided to relevant staff. This will include how to access the system, how to use the mobile app, and how alerts will be received and managed.

Clinical Groups are responsible for maintaining accurate rota information, distribution lists, names and contact details within the AtHoc system. Each Clinical Group must also appoint a dedicated administrator to keep this information up to date.

This will ensure that incident alerts are sent to the right people, through the right channels, at the right time.

Major Incident

A Major Incident is an event or situation that may cause serious consequences and requires special arrangements by one or more responder agencies. Usually received via METHANE Message.

In an NHS context, this may include:

- a serious threat to the health of the community
- casualty numbers or types requiring special arrangements
- terrorism or serious crime
- CBRNe or HAZMAT incidents
- major disruption affecting hospital sites
- significant mutual aid requirements

Critical Incident

A Critical Incident is usually more localised but serious. It may involve:

- loss of ability to deliver critical services
- risk of harm to patients, staff or visitors
- an unsafe environment
- a need for special measures
- support from other agencies

Business Continuity Incident

A Business Continuity Incident is an event or disruption that:

- affects normal service delivery
- requires special arrangements
- may last for a period of time
- may affect multiple services or stakeholders
- needs coordination to maintain or restore services

Business Continuity Disruption

A Business Continuity Disruption is usually lower level and may be manageable through local arrangements. However, it should still be monitored and recorded if there is a risk of escalation.

Use the incident criteria framework

The incident criteria framework should be used to support, not replace, professional judgement.

Make a clear and defensible decision

A good decision does not need to be perfect. It needs to be reasonable, timely and based on the information available at the time. Commanders should record:

- the time of the decision
- who made the decision
- what information was available
- what options were considered
- what decision was made
- why that decision was made
- who was informed
- when the decision will be reviewed

On Call commanders should make a note of their decisions, recording the rationale behind decisions, and understanding what may be reviewed after an incident, complaint, inquest or inquiry.

Simple decision log format

Time	Decision	Rationale	Action owner	Review time
10:15	TCG to be convened	Incident impact unclear and potential risk to service delivery	Tactical Coordinator	10:45
10:30	Clinical Groups to provide SBAR updates	Need consistent Trust-wide situational awareness	Clinical Group Tactical Commanders	11:00

Convene and use the Tactical Coordinating Group

The Tactical Coordinating Group is the main mechanism for coordinating incident notifications, decisions and actions.

A TCG should be used when:

- an incident meets criteria
- the incident level is unclear
- multiple Clinical Groups or services are affected
- there is a need for consistent messaging
- there is a need for collective decision-making
- there is a risk of escalation
- Trust-wide coordination is required

The Tactical Coordinator is responsible for establishing and chairing the TCG, ensuring appropriate representation, supporting collective decision-making and linking between the Strategic Commander and Clinical Groups.

Suggested TCG structure

Agenda item	Purpose
Situation update	What has happened and what is the current position?
Impacts	What services, patients, staff or sites are affected?
Risks	What are the current and emerging risks?
Decisions required	What needs to be decided now?
Actions	Who is doing what and by when?
Communications	What needs to be communicated, by whom and to whom?
Recovery	What is needed to return to normal or acceptable service levels?
Next meeting	When will the group reconvene?

Simple decision table

Decision	What this means	What to do
Meets criteria	The incident meets the threshold for formal response arrangements	Declare or activate the appropriate response arrangements, inform the Strategic Commander, convene a TCG and notify relevant partners
Does not meet criteria	The incident does not currently meet the threshold	Record the rationale, inform relevant Commanders, continue to monitor
Not currently clear	There is not enough information to decide safely	Convene a TCG or urgent discussion to support collective assessment

For incidents that meet criteria or are not currently clear, the framework advises that the Tactical Coordinator should convene a Tactical Coordinating Group as soon as possible. For declared incidents, this should ideally be within 15 minutes.

Use JESIP to support decision-making

JESIP provides a clear structure for making decisions during incidents.

Use the Joint Decision Model to help:

- gather information
- assess risk
- understand powers, policies and procedures
- identify options
- make decisions
- take action
- review what has changed

JESIP Joint Decision Model prompts

Stage	Commander prompt
Gather information and intelligence	What do we know, what do we not know, and what is changing?
Assess threat and risk	What is the risk to patients, staff, visitors, services and the organisation?
Consider powers, policies and procedures	What plans, policies, legal duties or action cards apply?
Identify options and contingencies	What can we do, what are the risks, and what might we need next?
Take action and review	What decision has been made, who is doing what, and when will we review it?

MFT Incident Management Toolkit (virtual ICC)

Commanders are encouraged to use the resources in the virtual ICC as first point of reference during any incident. This site supports Strategic Commanders, Tactical Commanders, Tactical Coordinators, and Functional Officers in managing incidents effectively across MFT through the [EPRR Front Door](#)

Domain 5 – Training and Exercising

MFT has a range of roles and training that fall within the scope of *Emergency Preparedness, Resilience and Response (EPRR)*. While EPRR operates as an

overarching framework, a number of specific roles are assigned to staff who are placed on an on-call rota to undertake Operational, Tactical, and Strategic leadership functions during incidents and emergencies.

These command and specialist roles carry **statutory responsibilities** and therefore require individuals to complete role-specific, mandatory, training and exercising.

Training - [EPRR Training Academy](#) (SharePoint site resources)

Delivery of EPRR training and exercising is coordinated by the EPRR Team and outlined in the annual:

Training Needs Analysis (TNA), coordinated by the EPRR Team. Training is delivered either via the Kallidus platform or directly facilitated by the EPRR Team. This approach supports the effective capture, tracking, and assessment of trained personnel across the Trust.

Training and Exercising Schedule - outlines the required frequency and compliance expectations to ensure the Trust maintains its capability to respond confidently and effectively to incidents. The schedule is reviewed and formally signed off each year. Access through the [EPRR Training Academy](#)

On Boarding SOP - is maintained, alongside a Commander On-Boarding SOP, which together provide a clear and auditable framework for the identification of training requirements, delivery of role-specific training, and planning and evaluation of EPRR exercises. These arrangements provide evidence of compliance with the NHSE EPRR Core Standards. To support oversight and ensure compliance, EPRR Forum Chairs will be provided with access to relevant training records.

Training reports are generated by L&D and shared with EPRR Group as part of formal governance. Training opportunities are also promoted through EPRR Forums and other internal communication channels.

eLearning Modules available:

Minimum Occupational Standards for EPRR

The Minimum Occupational Standards for EPRR sets out the minimum national occupational standards that health commanders, managers and staff responding to incidents as part of an incident management team and other staff involved in EPRR must achieve in order to be competent and effectively undertake their roles. The EPRR Team is responsible for establishing the structures and providing guidance required by staff to allow submission of evidence, which can be used for Personal Development Portfolios (PDP).



Exercising

In accordance with the MFT EPRR Policy, the Trust is required to exercise its emergency response, and business continuity plans regularly to test their effectiveness. The EPRR Team manages these exercises as part of the wider training programme, ensuring that all learning contributes to assurance reporting and continuous improvement.

MFT are required to exercise response plans in-line with minimum national requirements, as detailed below:

Live Exercise	Every 3 years
Tabletop Exercise	Every 12 months
Communications Exercise	Every 6 months
Command Post Exercise	Every 3 years
ICC equipment test	Quarterly

Roles within plans, not individuals, will be exercised to ensure they are fit for purpose and encapsulate all necessary functions and actions to be carried out in an incident.

MFT will consider exercising with partner agencies and contracted services where the identified risks and the involvement of partner organisations is appropriate. The EPRR Team will provide guidance and support to colleagues across the Trust in planning, undertaking and learning from exercises, in line with best practice and statutory requirements as outlined below.

All staff undertaking command roles are required to maintain continuous professional development and hold an up-to-date Personal Development Portfolio (PDP). PDPs must evidence training, exercising, operational experience, and reflective learning in line with NHS EPRR Core Standards. The Trust's EPRR Team and line managers will support staff in maintaining PDPs and can provide examples of good practice to support local assurance.

Personal Development Portfolio (PDP) evidence of:

- Training completed
- Exercises participated in
- Incident experience
- Reflective learning and lessons identified

PDPs form part of formal **EPRR assurance** and may be requested during internal audits or external reviews.

In summary

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No individual may be rostered as a Strategic, Tactical, or Operational Commander, or Loggist, unless they can evidence current competence for that role. An NHS Incident Commander **must** be trained, exercised, and competent for their specific role, maintain evidence of this through a PDP, and refresh their skills regularly. Command authority is dependent on demonstrated competence, not job title alone.

Domain 6 – Response

The EPRR Team will produce and support the production of plans, policies and procedures required to ensure that MFT can undertake its duties as outlined in the Civil Contingencies Act (2004) and associated guidance.

Operational detail for these arrangements is contained in the MFT Incident Response Plan (IRP) and all other Trust-wide and Site-specific incident response plans, a full list of plans maintained or supported by the EPRR Team is available.

Domain 7 – Warning and informing

As outlined in the Civil Contingencies Act (2004) and associated guidance, all Category 1 responders have a duty to warn and inform. MFT incident response plans contain operational detail on how to carry out effective warning and informing, and the MFT Communications plan provides further detail.

The EPRR Team will support the production and validation of appropriate plans, with submission to the EPRR Group for ratification. The EPRR Team will also support the coordination of communications exercises as mandated nationally via the NHS EPRR Framework.

Domain 8 – Cooperation

As outlined in the Civil Contingencies Act (2004) and associated guidance, all Category 1 responders have a duty to cooperate.

MFT primarily fulfils this requirement via attendance at and participation in the GM HEPG and LHRP.

Where relevant and in-line with plan review processes, the EPRR Team will identify and engage with external and internal stakeholders to participate in training, exercising and plan reviews.

Additionally, in order to support the continuous improvement of the organisation, the EPRR Team will support cooperative working with internal and external stakeholders to identify, share and embed lessons. Activity for this will be recorded and reported through the EPRR Forums and Groups escalation reports.

Domain 9 – Business Continuity

Business Continuity Policy

“A Business Continuity Incident is an event or occurrence that disrupts (or might disrupt) an organisation's normal service delivery to below acceptable predefined levels and would require special arrangements to be implemented until service delivery can return to an acceptable level.” [NHS England EPRR Framework, 2022](#)

The EPRR Team is responsible for the development and maintenance of the Trust's Business Continuity Policy, which is submitted to the EPRR Group and subsequently to the MFT Trust Board for review, approval, and ratification.

This policy sets out the framework for implementing an effective Business Continuity Management System (BCMS), aligned with ISO 22301:2019, the internationally recognised standard for business continuity. It also ensures compliance with NHS England's Emergency Preparedness, Resilience and Response (EPRR) Core Standards and the requirements of the Civil Contingencies Act 2004.

The primary aim of the policy is to ensure that MFT can maintain critical service provision and deliver a coordinated response in the event of disruption. It promotes a proactive approach to risk management, encourages adaptability and flexibility in planning, and supports the embedding of resilience as a cultural norm across the organisation. The policy further aims to raise awareness of continuity responsibilities at all levels, ensuring that plans and supporting structures are understood and accessible.

The objectives of the policy are to ensure that resilience is embedded as a golden thread throughout all clinical and corporate services, with continuity planning, preparedness, and response fully integrated into daily operations.

The policy commits the Trust to maintaining up-to-date Business Continuity Plans (BCPs), delivering annual Business Impact Analyses (BIAs), and ensuring a

sufficient level of staff training, exercising, and assurance activity to meet statutory and regulatory obligations.

Business Continuity Management System (BCMS)

The Business Continuity Management System (BCMS) at MFT is a Trust-wide framework designed to ensure organisational resilience and the continuation of critical services during periods of disruption.

Business Continuity Plans (BCPs) outline strategies and actions to address potential disruptions to people and staffing, premises, digital systems and infrastructure, estates, information and data, and external suppliers. Plans are reviewed annually and are subject to director-level approval or sign-off via an agreed governance structure.

To support delivery, the Trust has procured a secure, digital continuity platform – C2 BCMS – which enables the development, management, and testing of plans in a consistent and centralised manner.

The C2 system also supports the creation of audit-ready reports and dashboards, providing performance oversight and assurance to internal governance groups and external regulators.

Validation and monitoring

The effectiveness of the Business Continuity Policy is measured through a set of key performance indicators. These KPIs focus on the 3 year Business Continuity Improvement, Programme started on the 22nd May 2026, and include:

- a) Service Level BIA completion: Year 1 - 30%, Year 2 – 60%, Year 3+ - 100%
- b) Service Level BCP completion: Year 1 - 30%, Year 2 – 60%, Year 3+ - 100%
- c) Percentage of Service Level BCP's with Director Sign Off: Year 1 - 30%, Year 2 – 60%, Year 3+ - 100%
- d) Service Level BCPs which have been validated through an exercise: Year 1 - 30%, Year 2 – 60%, Year 3+ - 100%
- e) Maintaining accurate records of training and exercises on the MFT Learning Hub.

Performance against these KPIs is monitored by Site-level EPRR Forums. Any deviations, risks, or concerns are escalated to the EPRR Group for further review and action, ensuring timely intervention and continuous improvement.

Business Continuity Audit

Internal audits of the BCMS are conducted annually, following a structured cycle of self-assessment, quality assurance reviews, and evaluations of supplier resilience. External audits are undertaken every three years to provide independent assurance of BCMS effectiveness and compliance with ISO 22301.

Audit findings—along with recommended actions—are reported through the EPRR Forums and EPRR Group, with escalation to the Trust Board as required. To strengthen oversight, the Trust has a formal arrangement with KPMG to independently review the quality of emergency plans and the robustness of business continuity arrangements and records.

Lessons identified through audits, reviews, and exercises are shared across the organisation to inform continuous improvement and reinforce Trust-wide resilience.

Domain 10 – Chemical, biological, radiological and nuclear (CBRN) and hazardous materials (HAZMAT)

CBRN–HAZMAT Preparedness

MFT maintains a comprehensive CBRN–HAZMAT Plan and an associated Standard Operating Procedure (SOP), which set out the Trust's responsibilities, training requirements, and arrangements for the maintenance of specialist response equipment.

These documents provide guidance to Trust personnel on the management of CBRN- HAZMAT incidents, with a particular focus on the acute setting. They include background information based on incident types and offer detailed planning and preparedness guidance.

Supported by the EPRR team, clinical groups are responsible for ensuring the Trust's compliance with CBRN-HAZMAT requirements, supporting operational

readiness through internal exercises and external audit, including assurance activities led by North West Ambulance Service (NWAS).

CBRN–HAZMAT Training and Equipment Maintenance SOP

The CBRN–HAZMAT Training and Equipment Maintenance SOP outlines a structured process for the routine inspection, testing, and upkeep of CBRN/HAZMAT response equipment. It also defines the requirements for training staff in the correct use and handling of this equipment, ensuring that training records are accurately maintained and easily auditable. This SOP underpins the Trust's ongoing assurance that both equipment and personnel are prepared to respond effectively to a CBRN–HAZMAT incident.

Mutual Aid and Record Keeping

Mutual aid agreements are embedded into incident response plans. All incidents require trained loggists to maintain auditable records. The EPRR Team supports training and document retention via the Trust's policies.

MFT Intranet and EPRR Toolkit

MFT hosted internet the Incident Management Toolkit SharePoint provide access to EPRR plans, SOPs, guidance and support

Public Board of Directors

Wednesday, 30 September 2026

Paper Title:	MFT Winter Plan 2026/27	Agenda Item 11.6
Presented by:	Vanessa Gardener, Chief Delivery Officer	
Prepared by:	Dan Lythgoe, Director of Urgent and Emergency Care	
Meetings where content has been discussed previously	UEC Leadership Community, Clinical Group Winter Planning Workshops, Delivery Oversight Management Committee, Trust Leadership and Transformation Committee	
Purpose of the paper Please check one box only:	☒ For approval ☐ For support ☐ For discussion ☐ For noting	

Executive summary / key messages for the meeting to consider

Summary:

This paper presents Manchester University NHS Foundation Trust's Winter Plan 2026/27 for approval. The plan recognises winter as a predictable period of heightened pressure and sets out how the Trust will maintain safe, timely and effective care while protecting staff wellbeing and planned services.

Learning from Winter 2025/26 shows that, despite higher emergency department activity, access and flow improved. Across October 2025 to March 2026, 73.2% of patients were seen within four hours compared with 67.9% in the previous winter, equivalent to 11,621 more patients receiving care within four hours. The number of patients spending more than 12 hours in A&E reduced by 4,862 despite over 8,000 additional attendances.

The central learning is that winter pressure is driven not only by demand, but by predictable reductions in discharge flow, particularly around Christmas and early February. The 2026/27 plan therefore prioritises early clinical decision-making, stronger inpatient flow, timely discharge and care closer to home.

The plan is organised around four themes:

- System and MFT co-ordination throughout winter.
- Looking after patients and staff.
- Creating capacity to meet demand.
- Communication and stakeholder engagement.

Delivery will be supported by Model Emergency Department standards, the First 72 Hours programme, discharge and No Criteria to Reside improvement, Hospital at Home, respiratory and paediatric preparedness, improved mental health pathways and strengthened escalation

arrangements. The intended outcomes are reduced corridor care and ambulance handover delays, improved four-hour performance, shorter waits and length of stay, and a better patient experience.

The main risks are sustained high demand and acuity, reduced discharge capacity, respiratory infection, workforce pressures, mental health bed availability and the potential impact on elective care. These risks will be managed through clinical and operational escalation, demand forecasting, daily oversight, system partnership working and formal assurance to the Board.

Recommendation(s)

The Board of Directors are asked to:

- Approve the MFT Winter Plan 2026/27 and sign off the Board Assurance Statement.
- Note the learning from Winter 2025/26 and the priority actions to improve patient flow, discharge and alternatives to hospital admission.
- Note the principal delivery risks and the governance and assurance arrangements that will monitor readiness and performance through winter.

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 the 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 within this report links to the following strategic, corporate, or operational risks:

	MFT/006469: risk that the Trust is unable to meet urgent and emergency care demand and national standards, with potential impacts on patient safety, staff wellbeing, reputation and finance.
Care Quality Commission domains Please check <u>all</u> that apply	☒ Safe ☒ Caring ☒ Effective ☒ Well-Led ☒ Responsive
Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the report: The plan supports delivery of national urgent and emergency care priorities, integrated operational pressure escalation arrangements, winter assurance requirements and the Trust's duties for quality, safety and equality. Performance and risk will be monitored through established Trust and system governance.

Main report

1. Purpose and context

The purpose of this paper is to seek Board approval of the MFT Winter Plan 2026/27. The plan forms the Trust contribution to the wider Manchester and Trafford locality response and describes the arrangements for managing predictable seasonal pressure while maintaining safe care, supporting staff and protecting planned services wherever possible.

The plan treats winter as a period of heightened pressure that requires year-round improvement, clear escalation and coordinated action, rather than as an exceptional event. It has been informed by review of Winter 2025/26, Clinical Group planning and engagement with system partners.

2. Learning from Winter 2025/26

The Trust saw higher emergency department activity during Winter 2025/26 alongside improvements in several key measures:

- Four-hour performance across October 2025 to March 2026 improved to 73.2%, compared with 67.9% in the previous winter. This represents 11,621 additional patients seen within four hours.
- Performance for patients who were not admitted or referred improved by 4.5 percentage points, benefiting 7,877 patients.

- Despite more than 8,000 additional A&E attendances, 4,862 fewer patients spent more than 12 hours in A&E.
- Compared with the previous winter, admitted patients spent 100 minutes less in A&E and non-admitted patients spent 25 minutes less.
- Between January and March 2026, the number of out-of-area patients waiting more than 21 days for discharge reduced from 146 to 21; all 50 patients who had waited more than 100 days were discharged.

Review of activity and discharge patterns found that the system generally managed peak demand, but pressure increased when discharge activity fell. Discharges reduced by up to 40% after Christmas and in early February. Maintaining discharge flow through these predictable periods is therefore a central focus for 2026/27.

3. Winter Plan 2026/27

The plan is structured around four connected themes:

3.1 System and MFT co-ordination throughout winter

The MFT UEC Co-ordination Centre will provide a single Trust-wide view of operational pressure, supported by demand forecasting, dashboards and Operational Pressures Escalation Levels (OPEL) action cards. Trigger points covering demand, occupancy, patient flow, ambulance handovers, mental health waits and discharge performance will support earlier intervention. During peak surge periods, Trust-wide leadership meetings will operate twice weekly and sites will use Gold, Silver and Bronze arrangements.

MFT will work with Manchester and Trafford partners, NHS Greater Manchester and the Greater Manchester System Co-ordination Centre. A system patient tracking list will support oversight and escalation of delayed transfers of care, including people who live outside Manchester and Trafford.

3.2 Looking after patients and staff

Patient safety actions include improved clinical escalation, stronger oversight of corridor care, better discharge transport and processes, clearer flow responsibilities and real-time visibility of operational risk. The plan aims to eradicate corridor care as a routine model of care and reduce ambulance handovers over 45 minutes through Model ED, the “Think 15” approach, the First 72 Hours programme, stronger discharge processes and safe escalation arrangements.

Workforce arrangements include local escalation plans, monitoring of absence and safe staffing, vaccination, infection prevention, violence prevention, psychological wellbeing and occupational health support. The Trust’s frontline staff influenza vaccination ambition is to move from 47.8% uptake in 2025/26 towards the NHS England ambition of 60% in 2026/27. Vaccination is strongly recommended but is not mandatory.

A joint MFT and Greater Manchester Mental Health NHS Foundation Trust improvement plan will focus on earlier escalation, fewer prolonged waits, alternatives to emergency department admission, improved discharge for complex patients, workforce support and shared data.

3.3 Creating capacity to meet demand

The main approach is to create sustainable capacity by reducing avoidable admission, improving early care and decision-making, reducing length of stay and strengthening discharge.

The principal workstreams are:

- Model ED and First 72 Hours: common standards for streaming, senior decision-making, same day emergency care, specialty response and early inpatient care.
- Flow and length of stay: Clinical Group improvement plans, long-stay review and reduced unwarranted variation.
- Discharge and No Criteria to Reside: discharge planning from admission, seven-day processes and system escalation for complex discharge.
- Hospital at Home and community alternatives: expansion of Hospital at Home, Urgent Community Response and Single Point of Access pathways.
- Paediatric and respiratory preparedness: surveillance, vaccination, rapid testing, pathway optimisation and trigger-based surge arrangements.
- Elective resilience: protecting planned care through clear escalation, seasonal planning and use of the Trafford Elective Surgical Hub.

The system ambition is to have no more than 259 patients with No Criteria to Reside by November 2026. Hospital at Home plans describe expansion from a current 200 beds to 220 beds between September and December 2026, with 90% utilisation, subject to workforce and delivery arrangements.

The capacity transformation programme includes 138 planned bed releases and a £22.6 million 2026/27 value-for-money plan. Bed reductions will only proceed where compensating improvements in flow, discharge and care closer to home are in place. Each change will require validation, appropriate quality impact assessment, financial reconciliation and monitoring of occupancy, emergency department flow, length of stay, No Criteria to Reside and patient safety indicators.

3.4 Communication and stakeholder engagement

A detailed communication plan will provide clear information for staff, patients, the public and stakeholders. Internal communication will cover winter priorities, operational pressures, vaccination and wellbeing. External communication will be coordinated with NHS Greater Manchester and NHS England and will support appropriate service use, visiting advice and clear public information during periods of escalation. Reactive media and stakeholder briefing arrangements will be maintained for common winter scenarios.

6. Governance and assurance

Clinical Groups are accountable for local delivery. Trust-wide oversight will be provided through the UEC Improvement Group and Delivery Oversight Management Committee, with formal assurance to the Board. Readiness reviews and scenario-based exercises will test escalation and operational resilience before winter implementation.

A structured assurance framework will monitor key performance indicators which will include: emergency department flow, four-hour performance, ambulance handovers, corridor care, discharge and No Criteria to Reside. Variance or emerging safety risk will be escalated through established executive and system arrangements.

7. Conclusion

The Winter Plan 2026/27 provides a coordinated programme to improve resilience across MFT. It builds on measurable improvement in Winter 2025/26 and responds directly to the strongest identified source of pressure: reduced discharge flow during predictable periods. The plan combines front-door improvement, earlier inpatient decision-making, discharge, community alternatives, workforce support, infection preparedness and system escalation.

The Board is asked to approve the plan and sign off the Board Assurance Statement.

Winter Planning 26/27

Board Assurance Statement (BAS)



1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please include the Trust / Provider name at the top of the tab.

This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



Assurance statement			Confirm (Y/N)	Additional comment or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/2027.	Yes	Board approval on 30 September 2026	
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	QEIA approved	
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	System Planning events: 1. NHS North West event - September 2026 2. Greater Manchester event - September 2026 3. Operation Tempest Manchester & Trafford -September 2026 in addition UEC System Collaboration events through 2026	
	1.4	The Board has tested the plan during a regionally-led winter exercised, reviewed the outcome, and incorporated lessons learned.	Yes	North West Event attended by MFT and Manchester and Trafford System partners 18 September 2026 to stress test the plan, alongside a Manchester and Trafford event on 22 September.	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	Vanessa Gardener, Chief Delivery Officer	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes	Detailed in MFT winter plan and site level detail in individual Clinical Group winter plans.	

Winter Planning 26/27

Section B: 26/27 Winter Plan Checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.

Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Section B: 26/27 Winter Plan Checklist			Confirm (Y/N)	Additional comment or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	FHCW flu vaccination programme in place with Director of People leading the weekly Delivery Group and escalation reporting into Clinical Groups via an Oversight group chaired by the Deputy Chief People Officer PMO resource secured to develop weekly reporting of vaccinations, future delivery plans and escalation of any risks to Executive Directors and Clinical Groups. Communication Strategy and Plan for the whole campaign, delivered by Corporate Communications. The offer will be accessible between October and March through a bookable and walk in offer via peer to peer vaccinations across all sites. RAVS will be updated in line with national requirements FHCW flags have been reviewed and applied to all applicable occupational codes.	
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	Director of People oversight through operational delivery group. Weekly reporting of vaccinations and future delivery plans to Executive Directors.	
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	Patient vaccination programme coordinated by Director of Nursing - Workforce and Education with delivery by Clinical Groups and oversight through flu and covid vaccination operational delivery group.	
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	Population health intelligence, demand modelling and attendance forecasting are used throughout the winter planning process to identify periods of greatest risk and support targeted operational responses. MFT is working with system partners to identify and support high risk cohorts this winter.	
Occupancy and discharge					
	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	MFT has undertaken a detailed review of winter demand, discharge performance and occupancy with system partners. Analysis identified discharge reductions during key winter periods as a significant driver of operational pressure. Clinical Groups, the Local Care Organisation (LCO) and system partners have developed actions focused on reducing No Criteria to Reside, improving discharge flow and maintaining hospital occupancy within agreed trajectories. No Criteria to Reside standards have been agreed with LCO and Partner Organisations	

2	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: •coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes	Seven-day discharge arrangements, discharge planning from admission, Home First principles, No Criteria to Reside oversight, complex discharge escalation processes and integrated work with community and social care partners form a core component of the Winter Plan. Performance will be monitored through daily NCTR PTLs, discharge time of day monitoring, occupancy dashboards, long length of stay, Transfer of Care arrangements, and system-wide escalation processes. Annual Planning process accounted for Winter surge. Revised home first policy with key helpful guidance and tips/links for staff, particularly with reference to voluntary sector and neighbourhood teams. Daily PTLs will also ensure correct allocation of complex pathways, with ideal outcome MDTs in place to challenge all bedded care decisions. Clinical Group Level: Delivery is tailored to each hospital site. MRI uses receiving-unit review, escalation capacity and respiratory pathways; NMGH has daily receiving-unit length-of-stay review, afternoon MDT decision-making and Care Closer to Home actions; WTWA delivers through its Flow Improvement Group and Care Closer to Home workstreams; and RMCH uses SAFER, weekly review of patients with prolonged length of stay, community in-reach and paediatric Hospital at Home pathways. Site-specific performance and constraints are escalated through Clinical Group governance and the Trust UEC Co-ordination Centre.	
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	The Winter Plan includes targeted actions to reduce bed occupancy ahead of winter, including delivery of No Criteria to Reside trajectories, long length of stay reduction programmes, First 72 Hours initiatives, Hospital at Home expansion, and discharge optimisation. The Countdown to Christmas programme will begin planning in September, with weekly implementation meetings commencing in November to support occupancy reduction ahead of the holiday period. UPDATED: Site surge arrangements reflect different physical constraints. MRI has a defined hierarchy of escalation spaces and associated staffing and approval requirements. NMGH is prioritising EEMAC, SDEC and frailty capacity to reduce reliance on ED escalation space. RMCH has limited estate for a standalone winter ward and has identified conditional paediatric surge-bed options, with explicit recognition of the impact that use of day-case or SDEC capacity would have on elective care and front-door flow. Activation will therefore be risk assessed locally and overseen through Trust command and control arrangements.	
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	Same Day Emergency Care, EEMAC, Hospital at Home, SPOA and community alternatives to admission are key elements of the Winter Plan. Clinical Groups are expanding ambulatory pathways, refining referral routes and strengthening demand deflection arrangements to reduce avoidable admissions and improve patient flow	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	Frailty pathways form part of the Manchester and Trafford winter planning priorities. Clinical Groups continue to strengthen front-door streaming, community alternatives and admission avoidance pathways to ensure older people are managed in the most appropriate setting and unnecessary admissions are avoided	
Capacity					

3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	Workforce resilience plans are in place across Clinical Groups and include escalation arrangements linked to operational pressure, staff wellbeing support, vaccination programmes, workforce monitoring and redeployment approaches. Staff health, wellbeing and workforce resilience are monitored throughout winter through established governance processes. Clinical Group Level: Workforce risks vary by site and service. NMGH is mitigating senior decision-making risk through expanded ED consultant capacity and extended on-site presence. RMCH has identified additional paediatric medical staffing and consultant models linked to seasonal demand. MRI will use daily workforce monitoring, wellbeing support, local absence management and targeted vaccination delivery. CSS has identified service-specific resilience actions, including microbiology shift working, AHP deployment and critical care escalation support. Any residual gaps affecting safe activation of site escalation capacity will be reported through Clinical Group and Trust winter governance.	
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	Model ED implementation, strengthened specialty response arrangements, expanded consultant presence, early senior clinical review and enhanced clinical decision-making are core winter priorities. Clinical Groups are reviewing rotas and response arrangements to ensure appropriate senior oversight throughout periods of peak demand. Clinical Group level: The local delivery model reflects the different front-door configurations. NMGH plans expanded ED consultant presence to midnight and senior presence across the department. MRI will use respiratory consultant in-reach, acute and respiratory SDEC and early post-take review. RMCH will step up consultant cover at RMCH and NMGH in response to paediatric seasonality. WTWA will manage clinical decision-making improvements through its Urgent Care Improvement Group, including SDEC and clinical pathway redesign.	
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Activity has been front-loaded into Quarters 1 and 2 to create headroom for winter pressures. Elective recovery, theatre productivity, outpatient transformation and cancer improvement programmes are being delivered through the Care on Time programme to maintain planned care performance throughout winter	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	Winter delivery trajectories are aligned to Trust performance plans and include improvement trajectories for 4-hour performance and No Criteria to Reside. Delivery will be monitored through the UEC Improvement Programme, Clinical Group governance and the Co-ordination Centre	
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	IMC capacity is monitored twice daily, with a review of any community delays, ensuring adequate step up capacity. Crisis and Hospital @ Home capacity will be used flexibly across the city, ensuring capacity and expertise of staff available to keep community patients at home. Additional capacity will be on line for October 026 with an extra 20 beds across Hospital @ Home and an expansion into Trafford.	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	Eliminating corridor care is a key patient safety priority for Winter 2026/27. MFT is implementing Model ED, First 72 Hours, discharge improvement and No Criteria to Reside programmes, supported by a Trust Corridor Care SOP, escalation arrangements, governance oversight and daily monitoring of operational pressures. The Trust Executive team are taking a zero tolerance to corridor care use, any use being reviewed and signed off by the Chief Nursing Officer.	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	MFT has implemented the Think 15 ambulance handover process, HO45 escalation arrangements and Model ED standards to improve front-door flow, reduce ambulance handover delays and support timely access to care. Ambulance handover performance is monitored through established winter governance arrangements. The Trust performs well for ambulance handover.	

	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	MFT will coordinate winter pressures through the UEC Co-ordination Centre, Manchester and Trafford partners and the Greater Manchester System Co-ordination Centre. Escalation arrangements include defined OPEL triggers, daily operational reviews, system huddles, transfer of care escalation and mutual aid arrangements where required.	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	Model ED and First 72 Hours form the operational foundation of Winter 2026/27. Clinical Groups are implementing common standards for streaming, early senior decision-making, EEMAC, SDEC, specialty response, discharge processes and post-decision flow, supported by Trust-wide assurance and governance arrangements.	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	MFT's Winter Plan includes infection prevention measures, respiratory illness preparedness, ARI pathway planning and escalation arrangements to support safe use of physical space and clinical capacity during periods of increased demand or infectious disease transmission. Site and Clinical Group plans will support safe cohorting, escalation and operational decision-making, with IPC input incorporated through winter governance and readiness processes Clinical Group Level: Isolation and cohorting capacity differs across MFT sites and is therefore managed through site-specific IPC and respiratory escalation plans. MRI has a tiered viral escalation model using side rooms and designated cohort wards, with escalation triggered by occupancy, rising prevalence and forecast demand. It also has a front-door respiratory pathway using rapid testing, defined patient cohorts and Hospital at Home. Other Clinical Groups will activate locally agreed cohorting and escalation arrangements according to their estate, patient populations and available isolation capacity, supported by Trust IPC, virology and operational teams. RMCH will manage respiratory demand through paediatric pathways, surge capacity, critical equipment resilience and regional paediatric escalation where required. CSS will support all sites through diagnostics, point-of-care testing, IPC forecasting, outbreak advice and microbiology capacity.	
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	IPC, virology and operational teams are engaged in winter planning through the ARI planning process and Clinical Group readiness work. The plan includes an ARI meeting ahead of stress testing and incorporates infection prevention measures, respiratory illness preparedness and winter escalation arrangements.	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	Fit testing, PPE supply and respiratory infection preparedness will be managed through established IPC, procurement and operational escalation processes. The Winter Plan includes respiratory illness preparedness and ARI pathway planning, with arrangements to be tested and reviewed ahead of winter implementation. Fit testing information is recorded via Kallidus and then transcribed/uploaded to ESR for staff training compliance recording.	
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	Patient cohorting and risk-based escalation are included within MFT's winter preparedness approach, supported by IPC governance, ARI planning, Clinical Group winter plans and the Trust's operational escalation arrangements. Site management teams will use established escalation processes to activate cohorting arrangements during periods of infectious disease transmission or increased demand	
Leadership and operational grip					
	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	On-call and escalation arrangements are in place through MFT's established command and control structure, with access to operational, medical and nursing leadership. The Winter Plan will be supported by stress testing and readiness review to ensure arrangements are understood and capable of activation during standard, severe and extreme pressure scenarios	

6	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	MFT will monitor real-time pressure through the UEC Co-ordination Centre, site coordination arrangements, winter dashboards and OPEL escalation processes. The Co-ordination Centre provides a single Trust-wide view of operational performance, patient flow and system pressures, supporting escalation, decision-making and early intervention	
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	Mutual aid and escalation with system partners will be managed through Manchester and Trafford partners, the Greater Manchester System Co-ordination Centre and established winter governance routes. National guidance also requires tested escalation, surge and mutual aid arrangements agreed by partners	
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	Business continuity arrangements are supported through MFT's incident response and EPRR arrangements. The current weekend risk pack defines business continuity incidents and describes activation through Tactical Coordinator and Strategic Commander assessment, including use of the MFT Incident Response Plan where required.	
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	Severe weather and infrastructure disruption contingencies should be managed through existing EPRR, incident response and operational escalation arrangements, with winter operational oversight through the UEC Co-ordination Centre and site coordination structures.	
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes	Industrial action planning is supported through existing Trust planning routes, including industrial action TCG planning meetings and operational escalation arrangements. These contingencies should be kept aligned with winter pressures planning so that staffing, flow, patient safety and escalation risks are considered together.	
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	The Winter Plan includes workforce resilience, occupational health and wellbeing support, vaccination programmes, infection prevention measures and preparedness for respiratory illness. Staff welfare is also supported through MFT's existing Employee Health and Wellbeing offer, including psychological wellbeing, critical incident and trauma support, peer support, staff networks, wellbeing champions, physiotherapy, training and national support routes.	
Specification actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.			
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.			
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.			

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name: Manchester University NHS Foundation Trust

Provider CEO name: Mark Cubbon

Date reviewed: 30/09/2026

Provider Chair name: Trevor Rees

Date reviewed: 30/09/2026

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Vanessa Gardener, Chief Delivery Officer, 0161 276 6328

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Reviewed and presentation to Delivery Mananagement Oversight Committee on 28 July 2026, Trust Leadership Team Committee on 19 August 2026, Quality, Safety, Performance Board Committee on 25 August 2026, Trust Board on 30 September 2026.

Please confirm date reviewed

30/09/2026

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance



		Rating
Section B	Prevention	5 - Full assurance
	Flow, occupancy and discharge	5 - Full assurance
	Capacity and community	5 - Full assurance
	UEC Flow	5 - Full assurance
	Infection Prevention and Control (IPC)	5 - Full assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	5 - Full assurance
		Awaiting assessment



Manchester University NHS Foundation Trust Winter Plan 2026/27



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Winter Plan Overview



The Winter Plan outlines Manchester Foundation Trust's (MFT) preparations and operational approach for the winter period. It forms a key component of the broader Manchester & Trafford Locality Plan and is built upon learning from previous winters.

The plan is built on the recognition that:

- ❁ Winter presents significant challenges for health and social care services.
- ❁ It is not considered an emergency or an exceptional event. Winter is to be seen as a time of heightened pressure / surge due to clinical acuity and greater demand on resources.
- ❁ The season often brings a rise in infectious diseases such as Norovirus, Influenza, and Respiratory Syncytial Virus (RSV), along with the potential emergence of more severe threats like pandemic flu or COVID-19.

Key Success Factors for Winter Readiness

A successful winter response will depend on:

- ❁ Robust operational planning to ensure delivery of both elective and non-elective care.
- ❁ Strong performance management, with rapid identification of variances and effective corrective actions.
- ❁ Collaborative system-wide working, engaging with partners to coordinate winter preparedness and develop contingency responses.
- ❁ Achievement of the Trust's stretch targets as outlined in the annual plan.

Winter planning against the national context

The MFT plan will be under pinned by the unification of patient pathways across the system

Escalation will be clinically led

Hospital occupancy will reduce

Build and use capacity in alternative to ED services

Strong emphasis on Infection Prevention and Control

Response focus

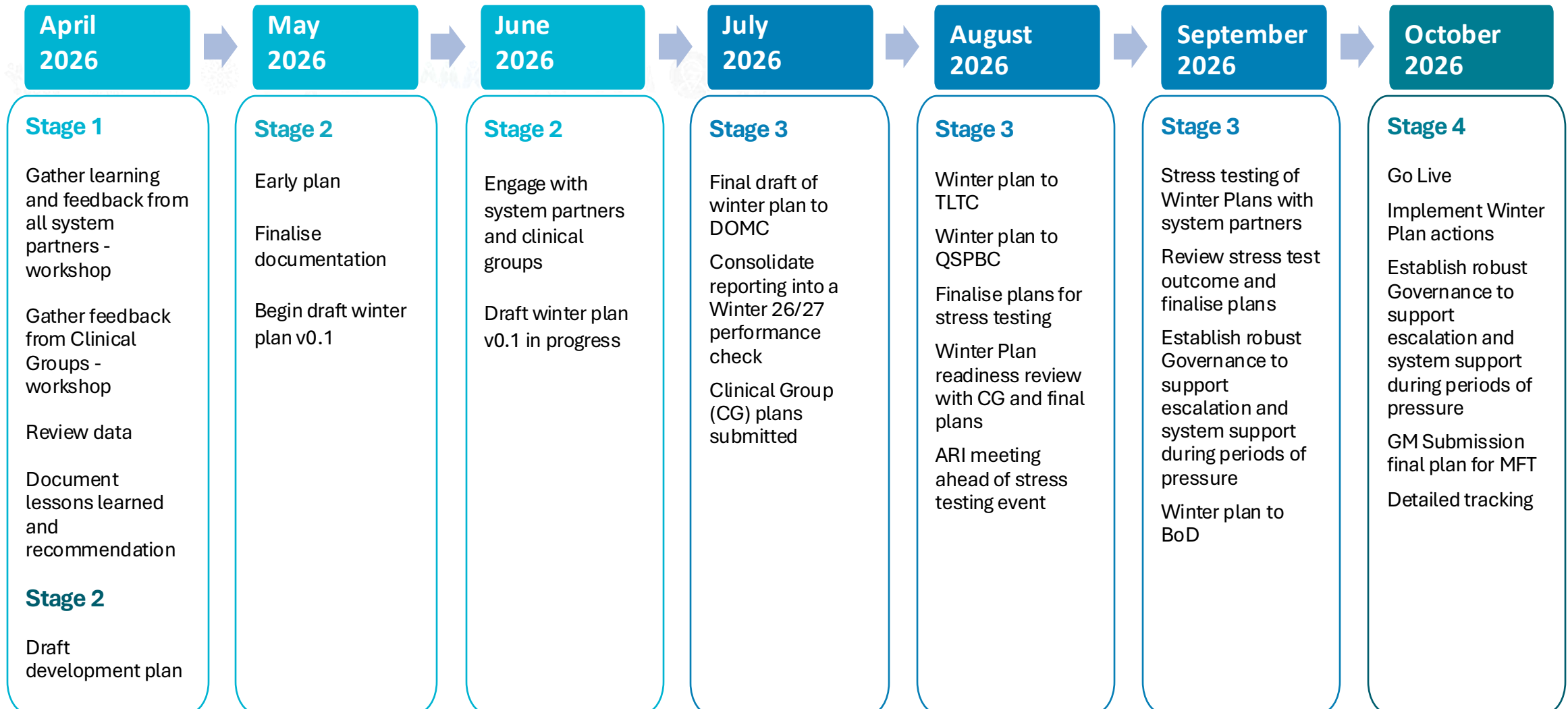
MFT has developed a winter assurance framework based upon forecast demand, defined escalation thresholds and pre-agreed actions for standard, severe and extreme winter pressures.

Assurance is provided through demand modelling, attendance and flow forecasting, Clinical Group winter plans, system-wide escalation processes, stress testing exercises and formal Board oversight.

The Trust will undertake scenario testing within MFT and Greater Manchester partners prior to winter implementation to ensure operational readiness at all levels of pressure.

The Trust will actively engage in ICS, Regional and England stress testing as required

Planning for Winter 2026/27





Review of Winter 2025/26



25/26 Winter Plan Evaluation Headlines

- ☀ MFT performance, recognised 4 hour Standard as a key marker of patient safety. Last year MFT improved to 77.2% in March 2026, compared to 73.9% in March 2025, 3.2 percentage point increase. Across the winter plan period (October 2025 to March 2026), delivery against the 4 hour standard improved by 5.3 percentage points compared to the previous winter (73.2% vs 67.9%). This equates to 11,621 additional patients being seen within 4 hours, representing a significant improvement in timely access to care at the front door.
- ☀ MFT achieved a 4.5 percentage point improvement over the winter plan period for patients who were not admitted or referred. This reflects a more efficient patient pathway and an improved experience for 7,877 patients.
- ☀ November to mid December is consistently the highest attends through Winter with c10,500 attends per month
- ☀ Despite an increase in A&E attendances (over 8,000) compared to winter plan period 2024/25, the number of patients spending more than 12 hours in A&E decreased by 4,862, indicating improved flow under increased demand.
- ☀ The amount of time that patients spent in A&E was reduced. Admitted patients spent 100 minutes less, and Non-admitted patients spent 25 less minutes, compared to the previous winter plan period.
- ☀ 12-hour trolley waits for patients decreased by 11%, with 153 fewer patients waiting over 12 hours in March 26 compared with March 25.
- ☀ Between January and March 2026, the position improved regarding the number of patients who were out of area and awaiting discharge. The number of patients who had been waiting over 21 days for a discharge reduced from 146 to 21, successful discharges for all 50 patients that had waited over 100 days, with a total of 698 out of area patients discharged overall.

Response to NHSE 25/26 UEC plan

Responsibility	Response to NHSE 25/26 UEC plan
Vaccination uptake	MFT delivered a staff vaccination campaign across all hospital sites. Uptake improved compared to previous years to 35%, although variation remained between clinical areas. Targeted approaches for lower-performing teams have been incorporated into 2026/27 plans.
Mental Health waits	A joint MFT–GMMH improvement plan was established, supported by weekly PTL reviews, executive oversight and strengthened escalation processes. While some patients continued to experience prolonged waits during periods of severe pressure, significant focus was maintained on reducing waits over 24 and 48 hours and improving patient experience.
System escalation and operational co-ordination	The Trust maintained enhanced operational oversight throughout winter through the System Co-ordination Centre, daily system calls and strengthened escalation processes. This supported timely decision-making, risk management and deployment of additional mitigations during periods of severe pressure.
Demand and capacity planning	Daily demand, capacity and flow reviews were undertaken throughout winter, supported by operational dashboards and enhanced reporting. These arrangements enabled early identification of pressure and informed escalation actions across sites.
Discharge improvement	Discharge performance remained a key focus throughout winter, with continued use of NCTR processes, daily review mechanisms and system partner collaboration to maximise patient flow and reduce avoidable length of stay.
Ambulance handovers and ED flow	Site teams implemented targeted actions to improve patient flow, reduce ambulance handover delays and manage periods of exceptional demand. Despite sustained operational pressures, ambulance handover performance and emergency department flow remained a priority throughout winter.
Paediatric and respiratory surge planning	Additional planning arrangements were implemented to manage respiratory illness and seasonal demand, including enhanced monitoring, escalation plans and capacity reviews across adult and paediatric services.
Workforce resilience	Clinical Groups maintained winter workforce plans supported by recruitment, temporary staffing arrangements and wellbeing initiatives to support service resilience during sustained periods of operational pressure.
Reporting and governance	Winter performance was monitored through established governance arrangements, including executive oversight, Clinical Group reporting and system escalation routes. Key lessons learned have informed planning for winter 2026/27.

Summary of Reflections 2025/26 & Actions for 2026/27

The Winter Plan 2025/26 defined the following actions to be undertaken

Action		2025/26	2026/27
VACCINATION	Consider the communication plan for delivering improvement to staff vaccination programme	Staff vaccination campaigns were delivered across winter alongside wider respiratory planning and IPC arrangements	Deliver a targeted vaccination improvement programme focused on frontline services with low uptake, supported by peer vaccinators, local champions and real-time reporting.
	Review processes for ensuring those that can be vaccinated are.	Vaccination formed part of the Trust's preparedness approach for influenza, RSV and COVID-19. Vaccination uptake and respiratory surveillance were routinely reviewed through winter governance structures.	Establish escalation arrangements where staff vaccination uptake falls below agreed trajectories, with monitoring through winter readiness governance.
MENTAL HEALTH	Co-ordination centre to continue to support clinical groups in the escalation and management of Mental Health DTA wait reduction	The coordination centre created and maintained a PTL for all patients awaiting a mental health bed. A risk score matrix was created to enable prioritisation according to risk across MFT for all patients on this list.	Implement the joint MFT-GMMH mental health improvement plan with a clear focus on reducing waits over 24 hours and eliminating waits over 48 hours.
	MFT Co-ordination centre to establish a weekly PTL review with GMMH and ad hoc escalation review at peak periods of pressure	The Co-ordination Centre attended daily meetings with GM and GMMH to review and escalate all patients with a DTA.	Continue weekly mental health PTL reviews, strengthened operational escalation routes and daily oversight during periods of severe pressure.
	Escalation through to GM SCC of MH (or Acute) patients waiting over 48 hours for admission	Escalation routes through GM SCC were utilised for patients experiencing significant delays.	Develop shared MFT/GMMH escalation triggers linked to OPEL and system escalation arrangements to support earlier intervention.

Summary of Reflections 2025/26 & Actions for 2026/27

The Winter Plan 2025/26 defined the following actions to be undertaken

Action		2025/26	2026/27
REPORTING PROCESSES	12-hour reporting to be added to the overview with associated escalation	12-hour waits became a core operational metric within winter reporting.	Incorporate a standardised winter dashboard including corridor care, arrival-to-triage, 45-minute handovers, 12-hour waits, MH waits and discharge performance.
	12-hour performance to be reviewed within clinical groups and added to reporting processes	Escalation triggers associated with prolonged waits were incorporated into oversight arrangements.	Introduce forecast-based reporting and escalation triggers using attendance, discharge and occupancy modelling to support earlier intervention.
FUTURE INVESTIGATIONS	Deep dive into reduction in the sickness rate	Review of workforce resilience and attendance performance undertaken through winter evaluation processes.	Complete detailed reviews of workforce absence, staff wellbeing and operational resilience and translate findings into Clinical Group winter actions.
	Deep dive into the spike of complaints received in January 25 to take actions into Clinical Group improvement plans.	Winter evaluation reviewed patient experience, flow pressures and operational performance. Learning was incorporated into improvement planning for Clinical Groups.	Undertake structured review of patient feedback, complaints and experience data following periods of severe pressure to identify improvements.
	Investigate opportunities to reduce Disruptive, Aggressive Behaviour Infection/Sepsis management and Safeguarding	Trust winter plans incorporated IPC escalation arrangements and clinical governance processes. Sepsis, infection control and safety considerations were reflected within site escalation plans and operational oversight.	Expand attendance forecasting and demand management plans, including surge actions for known high-risk weeks (e.g. late November, week 49).
	Winter plan to include a review of attendances and have associated plans to manage periods of surge	Detailed analysis of attendance growth and seasonal demand patterns. Development of attendance forecasting and surge management approaches. Expansion and optimisation of alternatives to admission including UTC, SDEC, Hospital at Home and community pathways.	Embed Model ED, First 72 Hours, discharge improvement and corridor care reduction programmes as core components of winter preparedness.
	UEC Improvement board to lead response to respiratory presentations in paediatrics	Paediatric services were included within winter planning and improvement programmes. Focus on improving timely assessment and treatment of children. Respiratory demand management incorporated into paediatric operational planning.	Strengthen paediatric and respiratory surge planning, linking RMCH actions directly to system-wide winter escalation arrangements.



Winter Plan 2026/27



The MFT Winter Plan is presented in the four areas identified below and will form part of the Manchester and Trafford System Plan:

System and MFT Co-ordination throughout winter

- Working together across the locality and GM with the Transfer of Care Hubs for Manchester & Trafford and ICS System coordination Centre
- Deliver on 6 System Priorities – High intensity users, frailty, paediatrics, CVD, respiratory and MH
- Establish Platinum UEC meetings from October 26
- Start further reporting and escalation of pressures
- Establish Manchester / Trafford UEC huddle
- Forsee period of increased demand and ensure clear visualisation of plans
- Support the escalation and management of Mental Health in UEC and Ambulance handovers

Looking after our patients & our staff

- Support the health and wellbeing for our people with MFT having a range of programmes in place to support staff.
- The MFT vaccination programme to be developed and implemented in September 2025
- Ensure the eradication of corridor care
- Ensure timely handover with eradication of >45 min handover
- Robust workforce plans in place to deal with surges in demand and management of leave over peak holiday times.

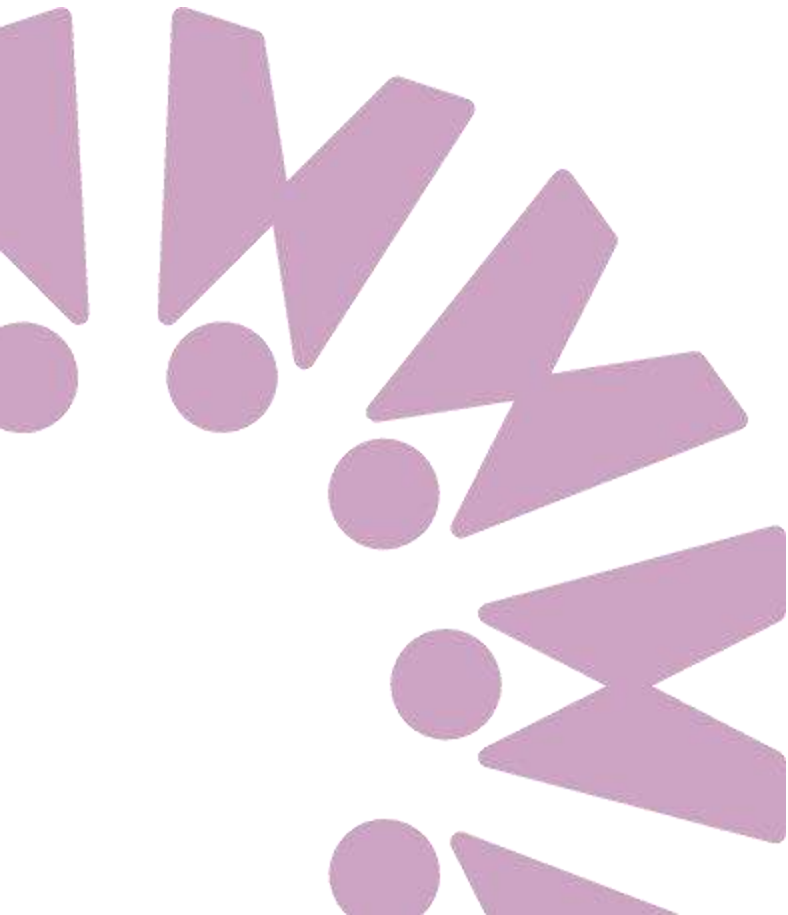
Creating the capacity to meet the demand

- Extend hospital front-door that sees ambulatory pathways materially reduce admission rates SDEC and Hospital at Home including Virtual Ward and Urgent Crisis Response.
- Making sure that people are only in hospital when they need to be and ensuring discharges are planned well with our partners
- Maintaining emergency surgery and ensuring as little disruption as possible to routine operations through protecting our elective capacity and optimising the elective programme
- Making sure that people who come to the ED are seen quickly and by a specialist in a timely way
- Work with partners across the system to keep patients well at home and avoid attendance to Emergency Departments driven through the Hospital at Home programme.

Communication Plan

- Preparing our people and communities ensuring communication is succinct and wide reaching
- Supporting our patients to understand when and what services to access and when to self-care

System and MFT Co-ordination Throughout Winter

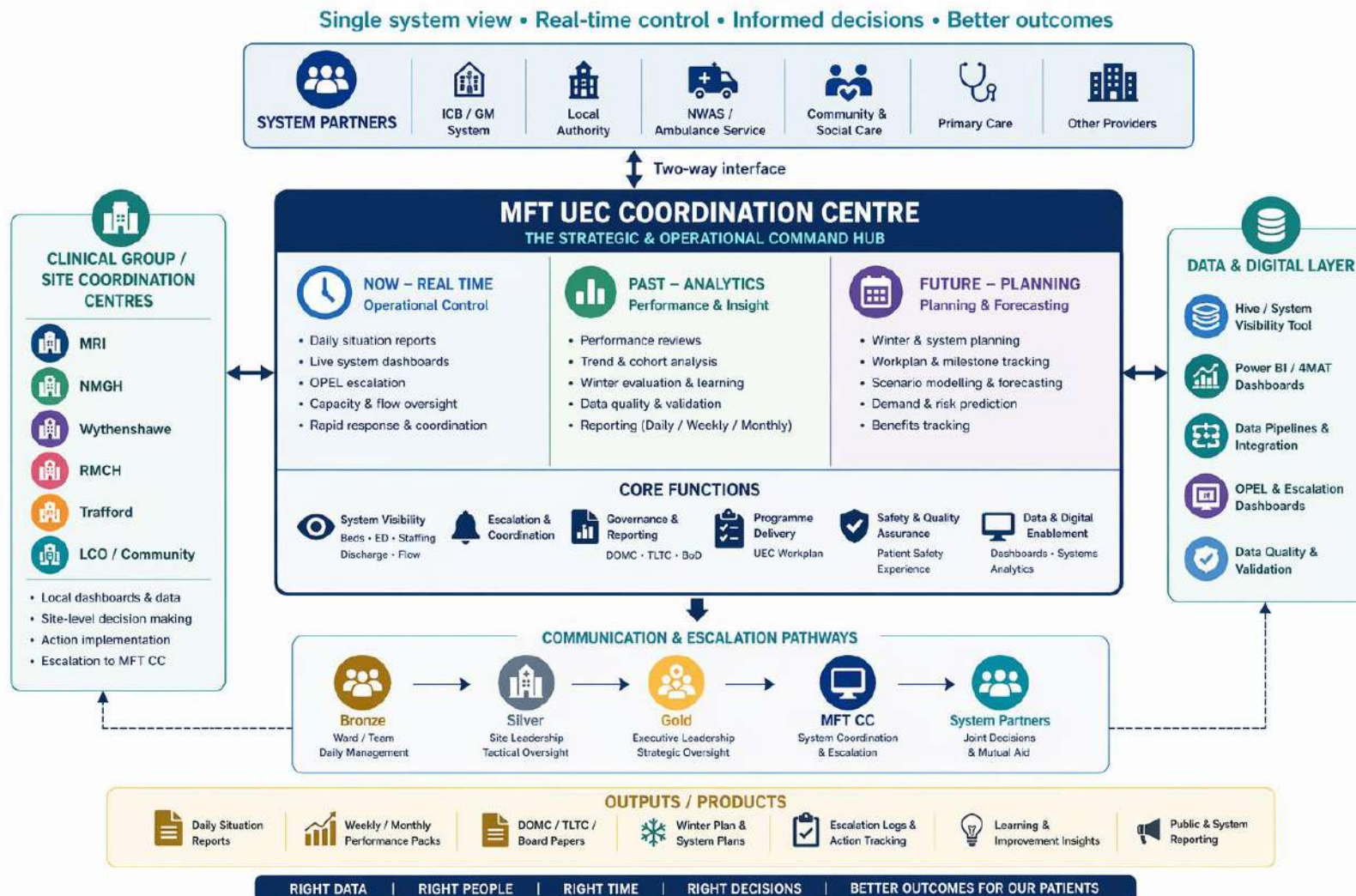


System and MFT Co-ordination Throughout Winter



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MFT UEC Coordination Centre



The MFT UEC Coordination Centre provides a single trust-wide view and uses data system visibility data to respond to surges alongside OPEL action cards

A System leadership meeting will be in place twice weekly during the peak surge period and all sites will run gold, silver and bronze meetings to ensure robust operational management of patient safety and flow

26/27 Delivery Trajectories

A&E 4hr

Clinical Group	Focus	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
MRI	4hr Performance	71.80%	71.91%	71.95%	72.10%	72.81%	71.71%	71.02%	69.23%	69.83%	69.04%	72.23%	77.03%
NMGH	4hr Performance	74.79%	74.62%	73.80%	74.09%	74.48%	73.52%	72.79%	70.52%	69.86%	68.92%	72.47%	77.21%
Wythenshawe	4hr Performance	71.44%	71.60%	71.81%	71.98%	72.37%	71.65%	70.95%	69.04%	69.75%	68.73%	72.14%	77.12%
Trafford	4hr Performance	96.61%	96.64%	97.06%	97.43%	97.46%	97.71%	97.09%	96.48%	96.44%	96.48%	96.99%	97.70%
MREH	4hr Performance	96.96%	96.94%	96.98%	96.92%	96.88%	96.85%	96.44%	96.00%	95.44%	96.04%	96.95%	97.03%
RMCH	4hr Performance	88.16%	88.57%	89.32%	90.67%	91.89%	93.87%	94.18%	94.18%	93.86%	93.68%	93.60%	93.75%
SMH	4hr Performance	95.44%	95.31%	94.86%	95.37%	95.18%	95.02%	94.44%	94.22%	93.62%	94.03%	94.50%	95.42%
LCO & UDH	4hr Performance	97.59%	96.67%	97.50%	96.70%	97.14%	97.47%	96.88%	96.15%	95.51%	95.56%	96.67%	97.50%
MFT Total	4hr Performance	78.00%	78.10%	78.20%	78.40%	78.70%	78.30%	77.80%	76.30%	76.30%	75.62%	78.20%	82.00%

No Reason to Reside

Unvalidated PBI reported vs Plan - RDP NHSE Discharge Sitrep figures			Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Site	North Manchester General Hospital	Plan	102	104	93	87	83	77	76	75	75	75	75	75
		Actual	97	95	87	95								
		Variance	-5	-9	-6	8								
	Manchester Royal Infirmary Hospital	Plan	102	104	93	87	83	77	76	75	75	75	75	75
		Actual	99	90	88	89								
		Variance	-3	-14	-5	2								
	Wythenshawe, Trafford, Withington & Altricham Hospitals	Plan	147	150	134	126	120	112	110	109	109	109	109	109
		Actual	115	119	132	114								
		Variance	-32	-31	-2	-12								
MFT Total	(Actuals are unvalidated system outputs)	Plan	351	359	320	300	286	266	262	259	259	259	259	259
		Actual	311	304	307	298								
		Variance	-40	-55	-13	-2								
MFT Total	(Actual NHSE system outputs)	Actual	291	279	274									
		Variance	-60	-80	-46									

Delivery of the interventions will be measured through the 4-hour A&E performance and No Reason to Reside numbers. Trajectories have been developed underpinned by Clinical Group plans. The UEC Improvement Workstream will be responsible for overseeing delivery of the plans. The plans aim to exceed the 82% by March 26. The NR2R plan will support a reduction in occupancy levels through Winter.

Trajectory to demonstrate ambition to reduce NC2R to 259 by November 2026 by Clinical Group

MFT Co-ordination Centre

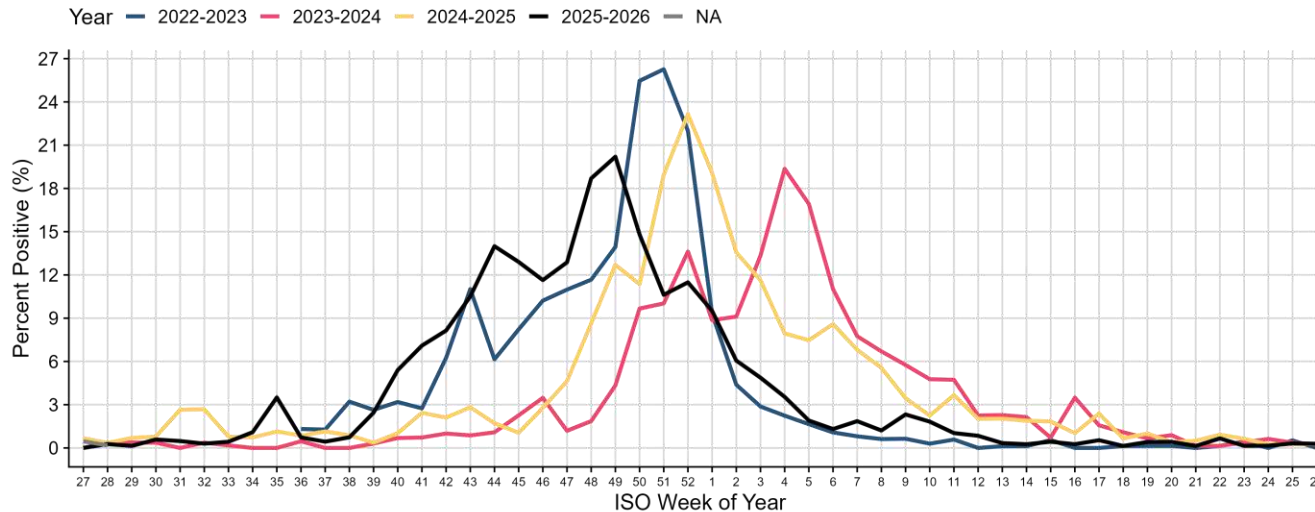
- ❁ MFT MFT will manage winter pressures through a structured escalation Opel process that combines operational intelligence, demand forecasting and system-wide coordination.
- ❁ Trigger points linked to demand, occupancy, patient flow, ambulance handovers, mental health waits and discharge performance will inform a proportionate response, ensuring early intervention before pressures become critical.
- ❁ The response will be led through the Co-ordination Centre, Clinical Groups and executive leadership teams, supported by the Greater Manchester System Co-ordination Centre when required.
- ❁ As pressure levels increase, additional actions will focus on accelerating discharge, expanding alternatives to admission, strengthening patient flow and deploying system support to reduce the risk of corridor care, prolonged waits and ambulance delays.

System Co-ordination

- ❁ MFT has worked collaboratively on refining our approach to discharge delays. Processes for routine and escalated response have been consistently adopted across all partners; working through system response to increasing pressures on sites.
- ❁ The approach is underpinned by a robust 'system Patient Tracking List (PTL)'. This method enables day by day tracking of all citizens according to the responsible body/bodies required to act to enable the next step in the discharge pathway. This therefore enables significant grip of the known reason for delay in transfer of care.
- ❁ Given the location of our acute sites, the nature of our population and the speciality services we provide, a significant number of citizens will be from other GM and non-GM localities. To ensure safe and timely discharges for these people, a system wide response to out of area delays has been formalised with escalation points, routes and named contacts.
- ❁ When hospitals are under sustained pressures this approach supports the recognition of the total volume of patients delayed, set against the use of GM agreed OPEL levels of escalation.

Presence of Influenza, RSV and Covid on MFT wards – Prediction for Winter 2026-27

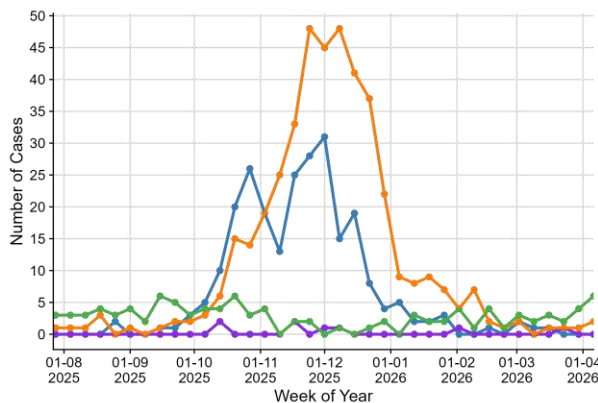
Percentage of Tests Positive for Influenza A Virus in Adults by Year



Weekly Child Admissions with a Positive Test for Influenza, RSV, and SARS-CoV-2

From week commencing 2025-08-01 to week commencing 2026-04-01

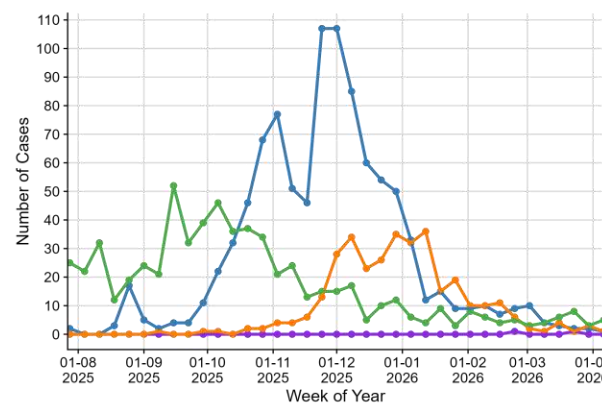
Virus — Influenza A Virus — Influenza B Virus — RSV — SARS-CoV-2



Weekly Adult Admissions with a Positive Test for Influenza A, RSV, and SARS-CoV-2

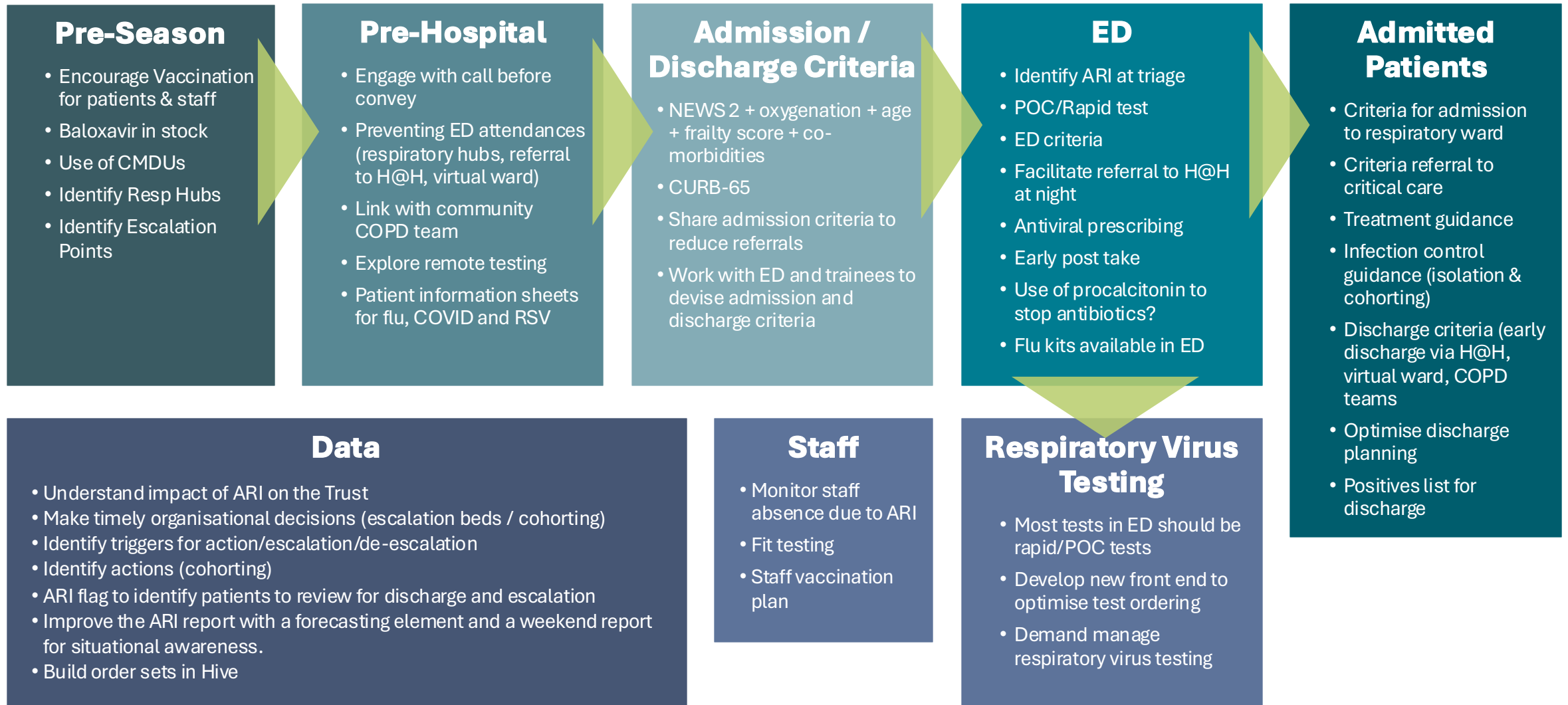
From week commencing 2025-08-01 to week commencing 2026-04-01

Virus — Influenza A Virus — Influenza B Virus — RSV — SARS-CoV-2



- For Adults, Influenza peaked in early December 25 and for Children RSV peaked around the same time.
- We've seen very few COVID admissions since November 2025.
- Comprehensive data from the Southern Hemisphere will be available by the end of August beginning of September which can aid in prediction for Northern Hemisphere data.
- It is too soon to predict what winter 26/27 might bring but we have resources that the IPC team are using in informing expectations :
 - FluNet (WHO) <https://www.who.int/tools/flunet>
 - Australian Respiratory Surveillance Reports (Australian CDC) <https://www.health.gov.au/resources/collections/arsr?language=en#reports>
 - National flu and covid reports (UKHSA) <https://www.gov.uk/government/statistics/national-flu-and-covid-19-surveillance-reports-2024-to-2025-season>
 - Northwest Winter Situational Awareness report - (UKHSA NW Field Service, emailed out)
 - Direct contact with UKHSA lead epidemiologists for Influenza, SARS-CoV-2 and RSV
 - All Hazards Winter Planning report

Acute Respiratory Infection (ARI) Pathway Planning and Optimisation



A series of small, light blue snowflake icons arranged in a horizontal line to the left of the title.

Looking After Our Patients and Staff



Looking After our Patients & Staff



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Following the Trust-wide UEC workshop in July 2026, MFT agreed a programme of clinically-led improvement actions to strengthen winter resilience.

Collectively, these actions support safer patient flow, reduced occupancy pressures and improved operational resilience ahead of Winter 2026/27.



Improved clinical escalation and decision-making for complex and critically ill patients in ED



Reducing delays caused by discharge transport and discharge processes including Criteria Led Discharge



Improving patient flow through clearer operational roles, responsibilities and escalation arrangements



Strengthening corridor care oversight through real-time visibility and escalation mechanisms within Hive



Improving operational communication through adoption of approaches such as NMGH's "Power Hour"



Ensuring sufficient equipment and infrastructure capacity through Trust-wide trolley and mattress reviews.

Having robust workforce plans in place to support the health and wellbeing of our staff

All Hospitals have Workforce escalation plans in place for tracking absence levels and triangulating with OPEL status to maintain safe staffing levels. Our staff matter to us and our people plan provides regular communication to support us all to look after each other. It is important to us that our staff have access to the right support and are vaccinated to protect both themselves and the population we serve. Below outlines what is on offer for staff.

Programme	Plan	Programme	Plan
System	System Co-ordination Centre – On behalf of Wider GM System to oversee pressure points and support all systems with a co-ordinated response to escalation pressures	Vaccinations – Flu	- The programme is expected to began in September 2026. (JCVI guidance is expected during Summer 2026) - Details of the plan can be found on the next slide
Violence Prevention	- Violence Prevention policy - Violence Prevention Charter – commitments to support staff - Violence Prevention training – de-escalation, release - Body Worn Camera pilot in Emergency Departments - Security Team support	Psychological Wellbeing and Mental Health Service	The Psychological Wellbeing Service provides a range of psychological wellbeing support to all MFT employees. This includes Critical Incident and Trauma Support Pathway.
Peer support	- Staff Networks to support colleagues with protected characteristics. - Wellbeing Champion initiative - Mental Health First Aiders	Physiotherapy Treatment Service	The Physiotherapy Team are highly skilled individuals that aim to support employees to access assessment, treatment and advice to help back to better physical health.
Staff Screening	Pledged to the Answer Cancer ‘Bee Seen, Get Screened’ initiative	Health & Well Being	- The Health and Wellbeing Programmes Team provides a range of data driven initiatives designed to enhance staff health and wellbeing. Their work focuses on encouraging healthy lifestyle choices, expanding access to support services at local, regional, and national levels, and fostering a positive organisational culture - Please click here to see all our education and training courses
National Support programmes	- Launch of the four MFT Live Well Hubs delivered in partnership with key internal and external partners supporting colleagues seeking support with financial, housing or energy advice concerns. - All staff access to ‘Supporting Our NHS People’ platform which includes a range of free to access Wellbeing apps - Text Support Service SHOUT to 85258 – free 24/7 confidential mental health support service	Employee Assistance	- Free and confidential legal, financial and psychological support available 24-hours a day for all MFT staff delivered by Health Assured via 0800 028 2047 or live chat and video call through the ‘Wisdom’ digital wellbeing platform (organisation code MFT123). - Wisdom provides access to an array of health and wellbeing resources including fitness and meditation videos, recipes, trackers and 4-week plans

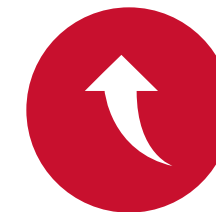
Influenza vaccination campaign

Programme Aim	The aim of the seasonal influenza vaccination programme is to reduce infection risks to patients, protect staff from influenza-related illness and maintain workforce resilience throughout winter.
National Ambition	NHS England has set a three-year ambition for frontline healthcare worker flu vaccination uptake of 60% (2026/27), 65% (2027/28) and 70% (2028/29).
Staff Vaccination Policy	Whilst flu vaccination is strongly recommended for all eligible frontline staff, there remains no mandatory requirement for staff to receive the influenza vaccine.
Employer Responsibilities	As an acute Trust, MFT is expected to make flu vaccination accessible, actively encourage uptake, monitor coverage and ensure all frontline staff are offered vaccination by the end of November.
Recent Performance	Following a post-pandemic decline in uptake, MFT achieved 47.8% frontline staff uptake in 2025/26, an increase of 6.7% on the previous year.
Delivery Model	The peer-to-peer vaccination model will continue in 2026/27, supported by Flu Leads, trained vaccinators, EHW, Pharmacy, Digital Services, Communications and local leadership teams.
2026/27 Key Priorities	The programme will focus on early mobilisation, strong governance, improved workstream ownership, enhanced reporting, targeted communications and reducing barriers to access for underrepresented groups.
MFT Ambition	To deliver a safe, accessible and equitable flu vaccination programme and increase frontline staff uptake from 47.8% towards the NHS England ambition of 60% in 2026/27.



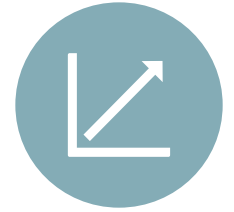
**2025/26
Result**

47.8 %



**Required
Improvement**

+12.2%



**2026/27 NHS
England
Ambition**

60%

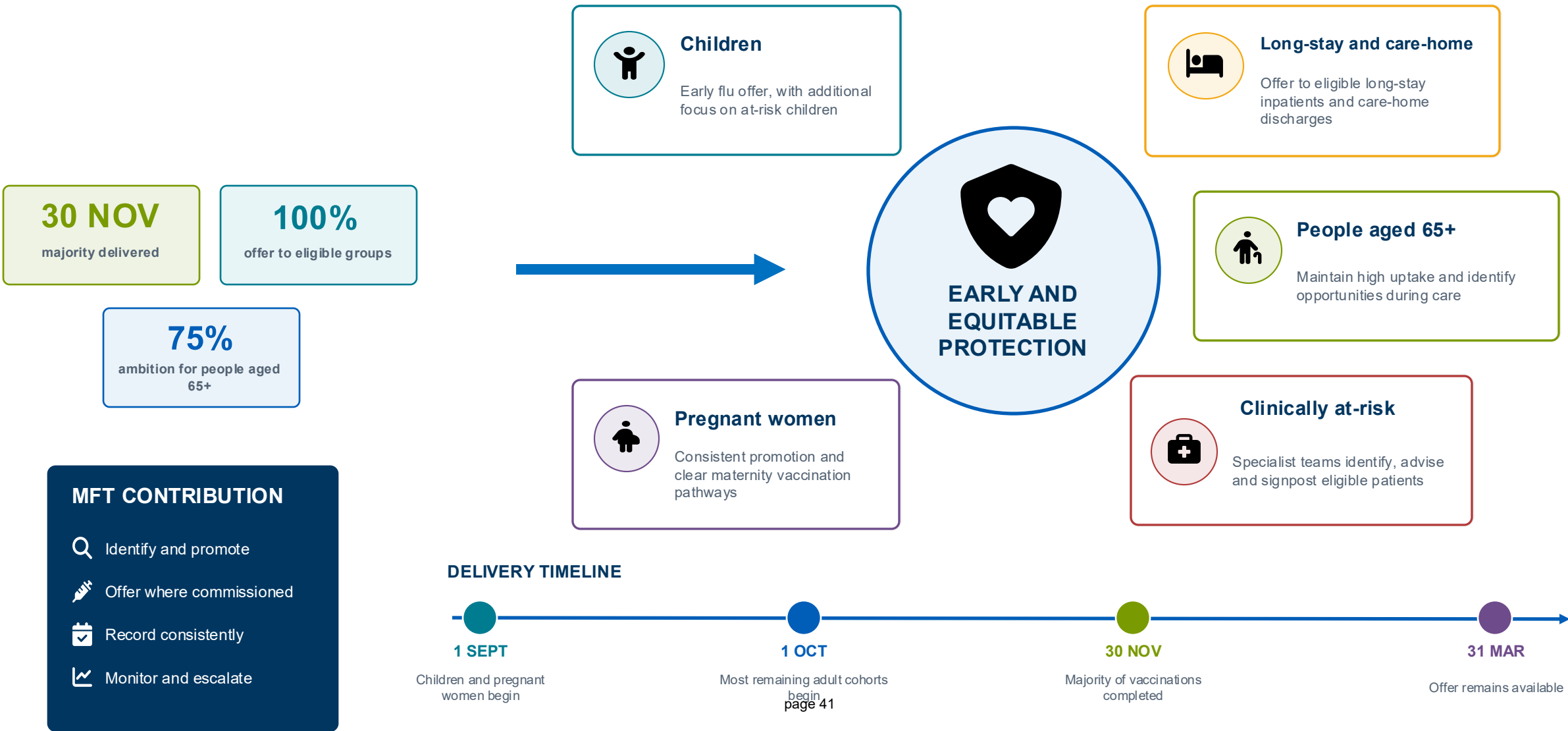


Key focus

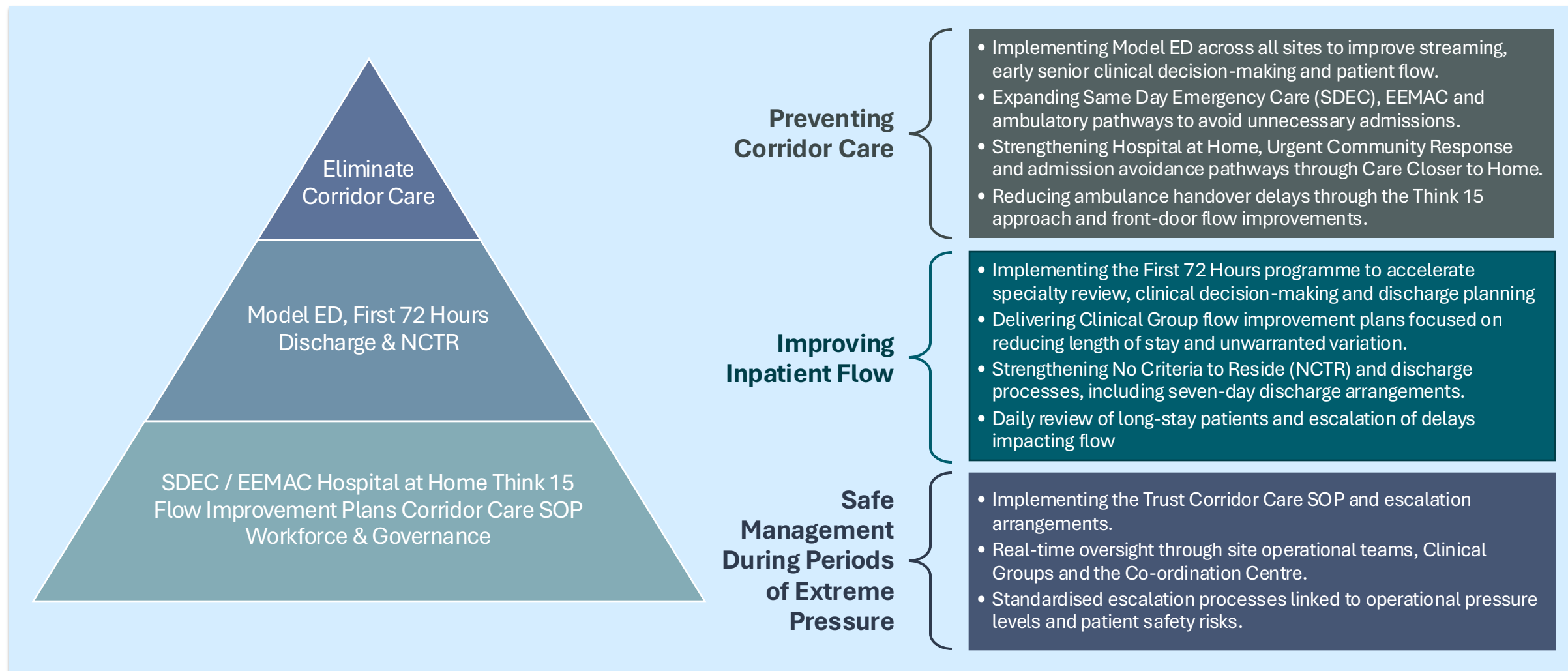
**Leadership, access,
communications, Flu
Lead accountability**

**and reducing
inequalities**

MFT will support early, equitable vaccination of eligible patients, focused on the cohorts at greatest risk of serious illness and winter admission.



To eradicate corridor care as a routine operating model by improving front-door flow, accelerating inpatient progression, reducing delays to discharge and strengthening whole-hospital ownership of patient flow.





Reducing ambulance handover time to improve patient care

Full implementation of the MFT "Think 15" ambulance handover process and HO45 escalation protocol.

Embedding Model ED standards to improve front-door flow and ensure patients are streamed, assessed and treated in the most appropriate setting.

Delivery of the First 72 Hours programme to improve early inpatient flow, reduce boarding and create capacity.

Increased use of Temporary Escalation Spaces (TES) only as an interim safety measure, supported by escalation SOPs.

Strengthened discharge, NCTR and length-of-stay programmes to reduce occupancy and avoid corridor care.

Daily review of corridor care utilisation through established governance and validation processes.

A joint MFT–GMMH improvement plan focused on reducing extended mental health waits, strengthening escalation and creating alternatives to ED admission.

1. Escalation & operational grip

- Test clear escalation triggers, route, daily review cadence and named decision owners
- Confirm GMMH OPEL 4 response: beds, AMHP actions, crisis/community capacity, OOA repatriation and CRFD escalation
- Clarify panel purpose, membership, referral criteria, decision rights and performance indicators

2. Alternatives to ED/admission

- Scope a Mental Health SDEC model with referral criteria, staffing, hours and links to ED/MHLT
- Design a streaming pathway for Mental Health Support Units in A&E
- Connect ED pathways with the 24/7 Neighbourhood model and admission-avoidance response

3. Flow, discharge & complex cohorts

- Clarify Later Life offer for Laurette House and support for complex older adults
- Strengthen local authority support for GMMH CRFD patients, including housing, care packages and escalation
- Identify high-frequency users and transition-age cohorts for proactive multi-agency review

4. Workforce, support & safety

- Identify AMHP workforce constraints and improvement actions
- Develop MH Support Worker training proposal to support lower-risk presentations and reduce reliance on security
- Review MHLT commissioning against demand, hours, response times and outcomes

Enablers to be in place before winter

Shared data set with definitions, frequency, ownership and information governance

Agreed process for multi-agency input, response times and recorded decisions

Agreed process for multi-agency input, response times and recorded decisions

Winter outcomes

Earlier escalation • Fewer prolonged waits • Improved patient experience and safety • Better use of community/crisis alternatives • Stronger discharge and CRFD flow

Expected Winter Outcomes for our patients



**Reduction in 45-minute
ambulance handovers**



Reduction in corridor care



**Improved 4-hour
standard for patients**



**Reduced time patients
are waiting for
assessment and
treatment**



**Reduced Length of Stay
for patients across our ED
department and Wards**



**Improved patient
experience and
satisfaction**

Creating the Capacity to Meet the Demand



Section Contents	
MFT UEC workplan 26/27 to deliver improved performance for patients during Winter	32
Managing Bed Numbers: Capacity Transformation	33
Managing Elective Care during Winter 25/26	34

MFT UEC workplan 26/27 to deliver improved performance for patients during Winter

To support patients being seen, treated, admitted and discharged timely for Urgent Care services the Trust is implementing a clear plan of improvement (see appendix for trajectories)

Workstream	Key Activities 2026/27	Winter Outcome
Model ED & First 72 Hours	Implement Model ED standards, improve front door streaming, optimise SDEC utilisation and strengthen the first 72-hour inpatient pathway.	Reduced ED congestion, improved 4-hour performance and earlier specialty intervention.
Flow & Length of Stay	Deliver Clinical Group flow improvement plans, daily review of long-stay patients, reduce unwarranted variation and improve ward-to-ward flow.	Lower occupancy and improved bed availability during periods of surge demand.
Discharge & No Criteria to Reside	Deliver NR2R trajectory, strengthen discharge planning from admission, expand seven-day discharge processes and improve system escalation for complex discharges.	Increased daily discharges and reduced delayed discharge pressure.
Hospital at Home & Community Alternatives	Expand Hospital at Home, UCR and call-before-convey pathways, improve utilisation through SPOA and increase admission avoidance.	More patients cared for closer to home and reduced emergency admissions.
Mental Health Flow	Joint work with GMMH to reduce waits for assessment and admission, strengthen escalation processes and improve management of patients awaiting mental health beds.	Reduced extended waits and improved patient experience.
Paediatric & Respiratory Preparedness	Implement paediatric winter actions, optimise respiratory pathways and strengthen ARI planning, surveillance and escalation arrangements.	Increased resilience during seasonal respiratory and paediatric demand.
Ambulance & Front Door Performance	Reduce arrival-to-triage delays, improve ambulance handovers and implement targeted recovery plans for periods of escalation.	Improved patient access and reduced ambulance delays.
Demand Forecasting & Operational Grip	Use predictive modelling, winter dashboards, scenario planning and OPEL action cards to identify and respond to emerging pressures.	Earlier intervention and more proactive management of winter pressures.

Bed reductions will only be enacted where compensating flow, discharge and care-closer-to-home improvements are in place.

138

planned bed releases

Programme total in the DOMC paper; site-level phasing tracked through UEC governance

£22.6m

2026/27 VfP plan

107 schemes across insourcing, outpatients, service redesign, theatres and outsourcing

£12.5m

service redesign value

Bed closure and length of stay schemes identified in WAVE

DOMC

executive oversight

Clinical Group accountability with Finance, VfP and Co-ordination Centre support

Delivery model: from scheme approval to safe capacity release

1



Validate the change

Clinical Groups confirm scheme, QIA requirement, support service impact and financial assumptions.

2



Record and reconcile

Capacity changes are captured in HIVE and reconciled with WAVE and VfP reporting.

3



Monitor safety and flow

Impact reviewed against occupancy, ED flow, LoS, NCTR and patient safety indicators.

4



Escalate variance

Sustained delivery variance or adverse flow/safety impact escalated through DOMC.

Winter guardrails

Bed reductions must not compromise safe delivery or the winter operating model.

● **Occupancy and bed availability**

● **ED flow and corridor care**

● **Ambulance handover risk**

Key message for Winter 2026/27

MFT will create capacity by reducing avoidable bed demand, improving inpatient flow and strengthening discharge, with each capacity change validated, recorded and monitored through a single governance process.

Operational plans are in place to maintain elective activity during periods of high pressure, supported through our Elective Recovery Programme ‘Care on Time’.

Activity plans have been modelled using seasonal capacity assumptions to forecast demand surges and enable responsive adjustments to elective delivery

Elective activity is front-loaded into Q1 and Q2 to create headroom for anticipated winter pressures

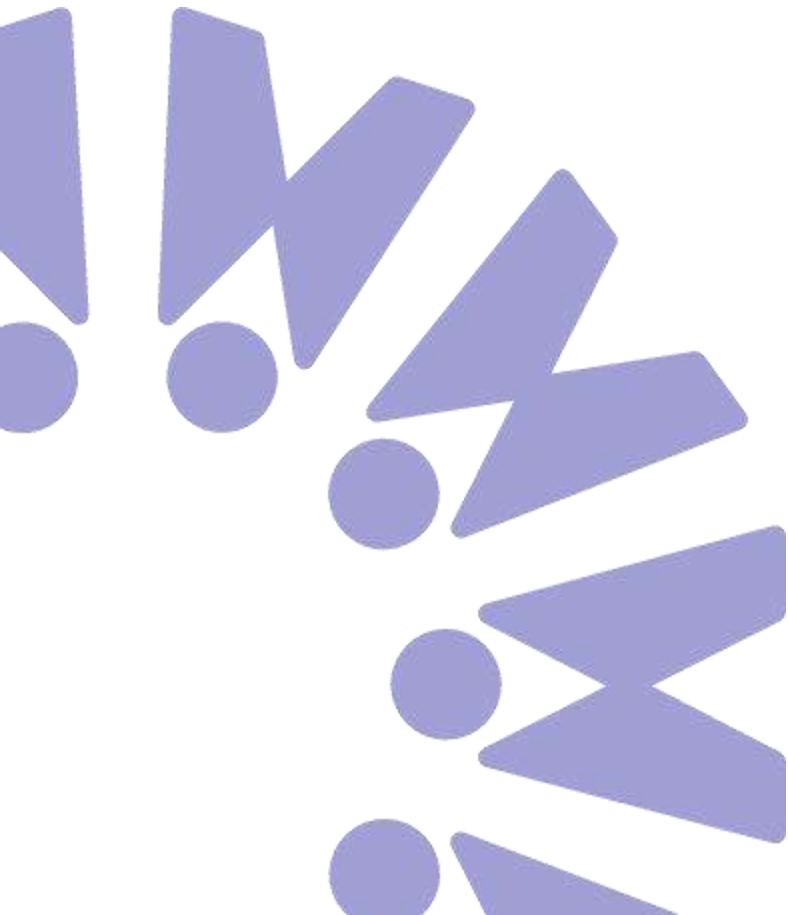
We are maximising utilisation of the Trafford Surgical Hub, prioritising high-volume, low-complexity (HVLC) procedures to maintain throughput during peak demand

An elective scheduling huddle established to enable dynamic reallocation and prioritisation of patients in response to operational pressures

- ☼ Protect elective activity with a clear escalation framework that prioritises maintaining planned care capacity and minimise cancellations
- ☼ Use Care on Time as vehicle for winter resilience, bringing together elective recovery, outpatient transformation, theatre and cancer improvement into a single programme
- ☼ Implement Single Point of Access across 10 specialties by October to reduce demand and ensure patients get to the right place, first time
- ☼ Accelerate pathway redesign focusing on 15 specialties that account for 80% of the waiting list by increasing one-stop, straight to test models and GIRFT further faster pathways
- ☼ Maximise theatre productivity, protect elective theatre sessions and optimise Trafford Elective Surgical Hub.



Communications Plan



- ✿ A detailed communications plan will set out internal and external communications activities which MFT will deliver in co-ordination with partners to convey key messages to staff, patients and stakeholders.
- ✿ Internally, the Winter Watch dashboard developed for 25/26 will be used again in 26/27, based on the positive feedback which it received last year.
- ✿ As in previous years, the external communications activity will support deliver of the NHS England and NHS GM communications plans and the activities of the System Coordination Centres – NHS GM has confirmed that it will not be producing any new campaign material for Winter 26/27 .

- ✿ Discussions are taking place on whether a targeted communications plan could be developed for a specific cohort of ED patients who could access care from other NHS teams – based on outcomes, this could act as proof-of-concept for future similar micro-campaigns within the wider winter plan.
- ✿ A reactive media plan will be in place for common winter scenarios, including template media responses and stakeholder briefing plans.
- ✿ The communications team will support all SCG/TCG activities, including use of the EPRR Whatsapp Group.

MFT will deliver its communication plan by working with locality partners and through the System Coordination Centres to ensure that messages reach staff, patients, the public and stakeholders.

Trigger	Internal messaging – all channels	External messaging/actions – all channels
OPEL 4	- Pressures awareness. - Actions to take /actions taken. - Wellbeing /support.	- Patients with minor ailments who attend EDs may be waiting for much longer than normal. - Highlighting NHS GM Get to Know where to Go campaign messaging. - Active media and stakeholder management as required. - Communications activity managed in conjunction with NHS GM and NHSE NW communications teams and led via SCC who will co-ordinate/share messaging with system partners.
OPEL 3	- Pressures awareness. - Actions to take /actions taken. - Wellbeing /support.	- Patients with minor ailments who attend EDs may be waiting for much longer than normal. - Highlighting NHS GM Get to Know where to Go campaign messaging. - Active media and stakeholder management as required. - Communications activity managed in conjunction with NHS GM and NHSE NW communications teams.
IPC alerts, e.g., Covid / Norovirus	- Importance of the basics. - Contextual messaging.	- Visiting guidance/restrictions. - Operational advice i.e. attend your appointment unless told otherwise. - Liaison with NHS GM and NHSE NW comms teams.
Cold weather alerts	Staff actions/advice in line with SCG/TCG activity.	- Keep warm in winter advice. - Operational advice i.e. attend your appointment unless told otherwise. - Communications activity managed in conjunction with NHS GM and NHSE NW communications teams and led via SCC who will co-ordinate/share messaging with system partners.
Autumn /winter BAU	- Channels to include Mark's Weekly Message, MFT Time, intranet stories, MFTV and Clinical Group briefings. - Support delivery of the staff vaccinations campaign. - Winter Watch weekly update. - Trustwide operational information - Info for staff at Clinical Group level. - Provision of wellbeing / support information.	Support delivery of the NHS England and NHS Greater Manchester Winter communications and engagement plans, with social media, digital and media activity.
Informed by NHS Winter Plan and NHS GM Winter Plan	Channels to include Mark's Weekly Message, MFT Time, intranet stories, MFTV and Clinical Group briefings as appropriate for communications to support delivery of the regional and national plans.	- Social media and digital stories on website - Media releases/case studies to demonstrate resilience ahead of winter. - MFTV content. - Stakeholder bulletin to provide assurance on MFT response to winter.



Risks and Issues



Risks, Issues and Dependencies

Risks	Impact	Mitigations
Sustained high attendances and high acuity to ED over predicted demand	Overcrowded A&E departments leading to potential safety risk, poor patient experience, negative media coverage and stakeholder involvement.	- Escalation Plans, Site winter plans - Virtual ward capacity to avoid admissions - Reduction in no reason to reside to ensure flow in maintained to 259 - Media and stakeholder management in line with an expected NHS GM Winter Communications and Engagement Plan
Mental Health demand, and mental health bed availability	- Loss of A&E cubicle capacity - Poor patient experience - Safety risk - Negative media coverage - Stakeholder interest	- Collaborative working with MH Teams, proactive management @Transfer of Care hubs / System Coordination Centre (SCC) - Managing MH in ED action cards - GMMH Winter plan escalation and media / stakeholder management plan - GM System Control Centre support
Infection, flu and Covid-19 outbreaks in the community. Risk of cross infection of Covid, flu, pneumonia, RSV following admission to hospital	- Increased staff absence - Risk of safe staffing levels - Loss of flow within acute bed base leading to longer length of stay and discharge delays	- IPC team working with Manchester University to develop a prediction tool that will be this winter to predict the expected demand over the coming weeks, providing greater opportunity for capacity planning - Vaccination programme, opportunistic vaccination programme - Surge plans enacted - COVID/IPC plans - MFT People Plan, HR, Workforce plans, Health & Wellbeing support teams
Patient transfer of care delays due to capacity pressures across system and 154 planned bed closures during 25-26.	- Longer length of stay and delays to discharge leading to increased no reason to reside numbers - Risk to elective recovery programme - Tertiary referrals delayed	- Transfer of Care Hub - Use of SCC to support escalation and adherence to GM Policies - Protected Capacity at Trafford - Use of the Independent Sector - Mutual aid - VfP schemes with associated Clinical Group level mitigation plans - Care Closer to Home programme for MRI with learning for other Clinical Groups
Industrial action	- Reduced non-elective staffing risking patient safety - Cumulative fatigue and stress in medical staff leading to increased sickness - Further elective cancellations	- Well being initiatives - Enhanced payments to boost rotas in line with GM pay rates - WLI
Staff being transferred to support other areas within group	- Low morale leading to increased sickness - Safe staffing levels	- Workforce plan 'Buddy system' in place - Well being initiatives - Ward handover booklets
Theatre recovery being converted into a critical care area	- Risk to elective recovery programme - Increased elective cancellations	- CC Surge plan enacted - Protected Capacity at Trafford
Timely access to diagnostics due to winter pressures on diagnostics teams alongside recovery	- Risk to elective recovery programme - Staff fatigue leading to increased absence levels - Longer length of stay	- Diagnostic Recovery plans - Additional radiology staffing - Use of Community Diagnostic Centres
If the Trust is unable to maintain complex discharge flow and therefore have increased numbers of patients with No Criteria to Reside then clinical groups will have increased occupancy which impacts on ED flow.	- Risk to patient to safety - ED performance - Site occupancy - Wider system pressures	- LCO winter plan - Increase in admission avoidance - Care Closer to Home programme - Oversight of No Criteria to Reside through daily PTL - Integrated Discharge Team – a consistent offer across MFT

Children and Young People Winter Preparedness



Primary winter risk

Respiratory demand creating pressure on PED, beds and PICU



A coordinated paediatric response across RMCH, NMGH, WTWA and community services to manage respiratory demand, maintain safe flow and protect elective care.



01

PREVENT

- ✓ Vaccination and vulnerable CYP prevention
- ✓ Parental advice and urgent primary care access



02

ASSESS

- ✓ Respiratory surveillance and escalation triggers
- ✓ Senior review and standardised streaming



03

TREAT WITHOUT ADMISSION

- ✓ Paediatric SDEC and community ACT
- ✓ OPAT, respiratory hub and Hospital at Home



04

MANAGE SURGE

- ✓ G&A and PICU escalation arrangements
- ✓ Equipment readiness and GM Paediatric Cell



05

DISCHARGE & RECOVER

- ✓ SAFER, EDD and discharge before midday
- ✓ Complex discharge and long-stay review

Surge capacity is activated in response to defined triggers. Using day-case or SDEC areas for overnight beds is reserved for exceptional circumstances.

Earlier assessment

Fewer avoidable admissions

Safer surge

page 56
Reduced long waits

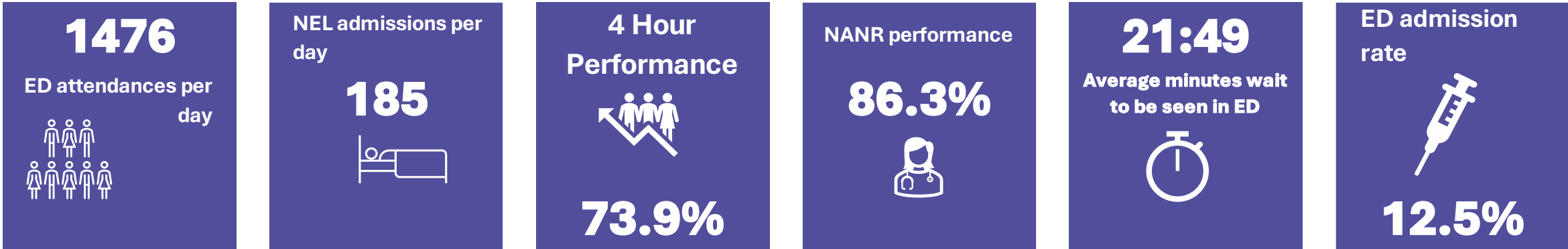
Fewer out-of-region
transfers

Protected elective capacity

Appendix 1 – Winter 25/26 evaluation data

MFT Winter 2025/26 at a glance

Urgent and Emergency Care Jan - Mar 2026



Beds - Jan - Mar 2026

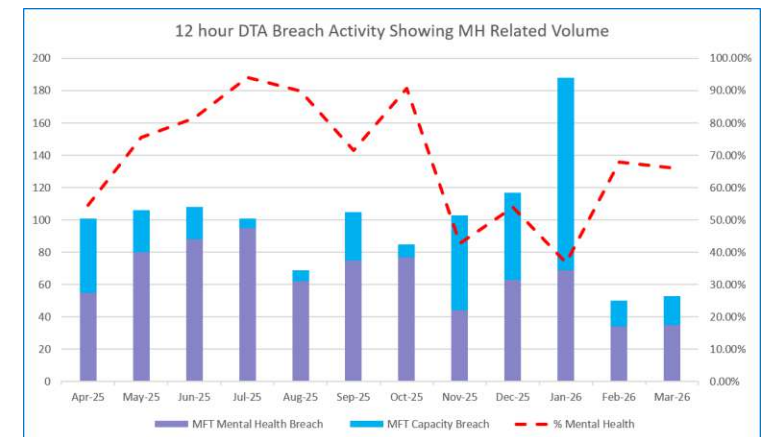
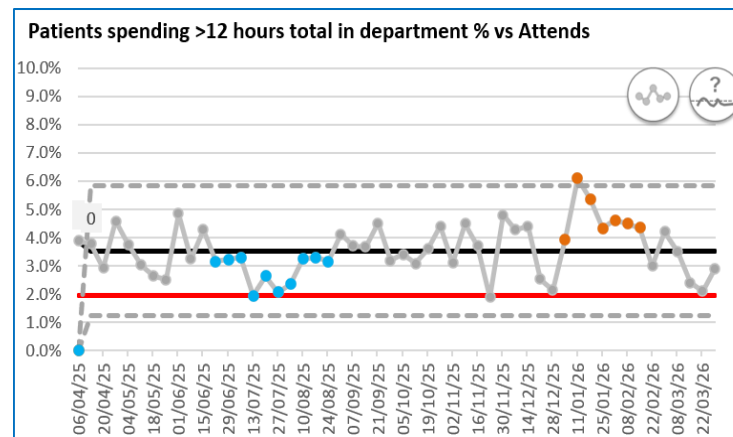
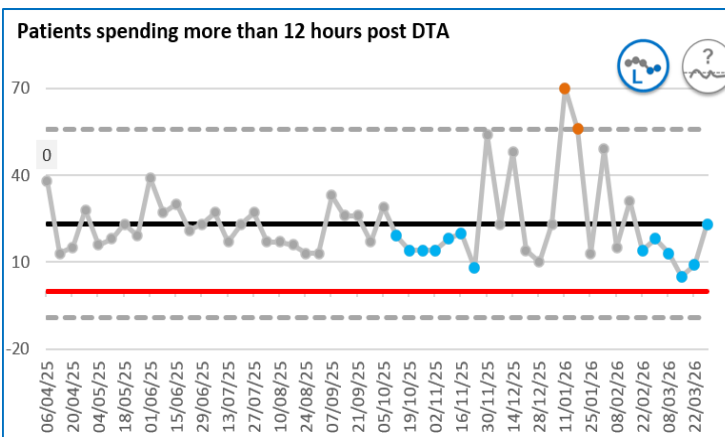
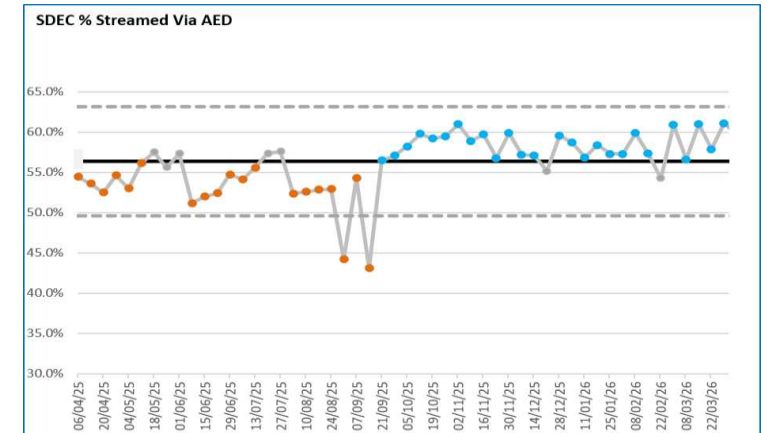
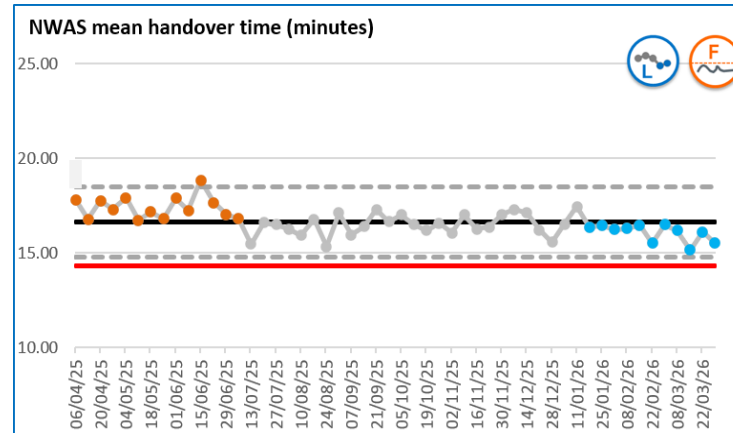
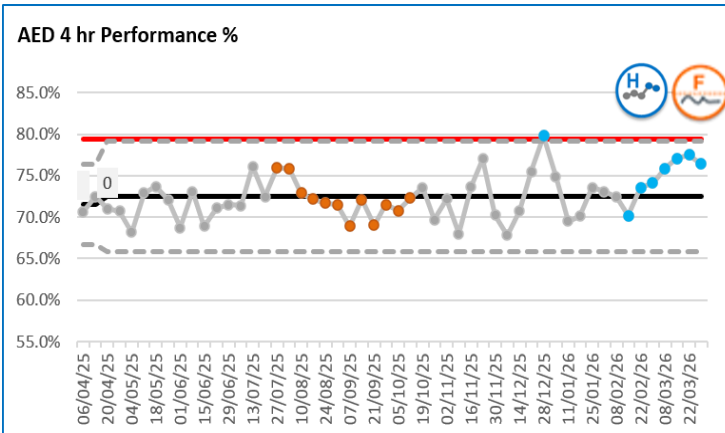


Ambulances Jan - Mar 2026

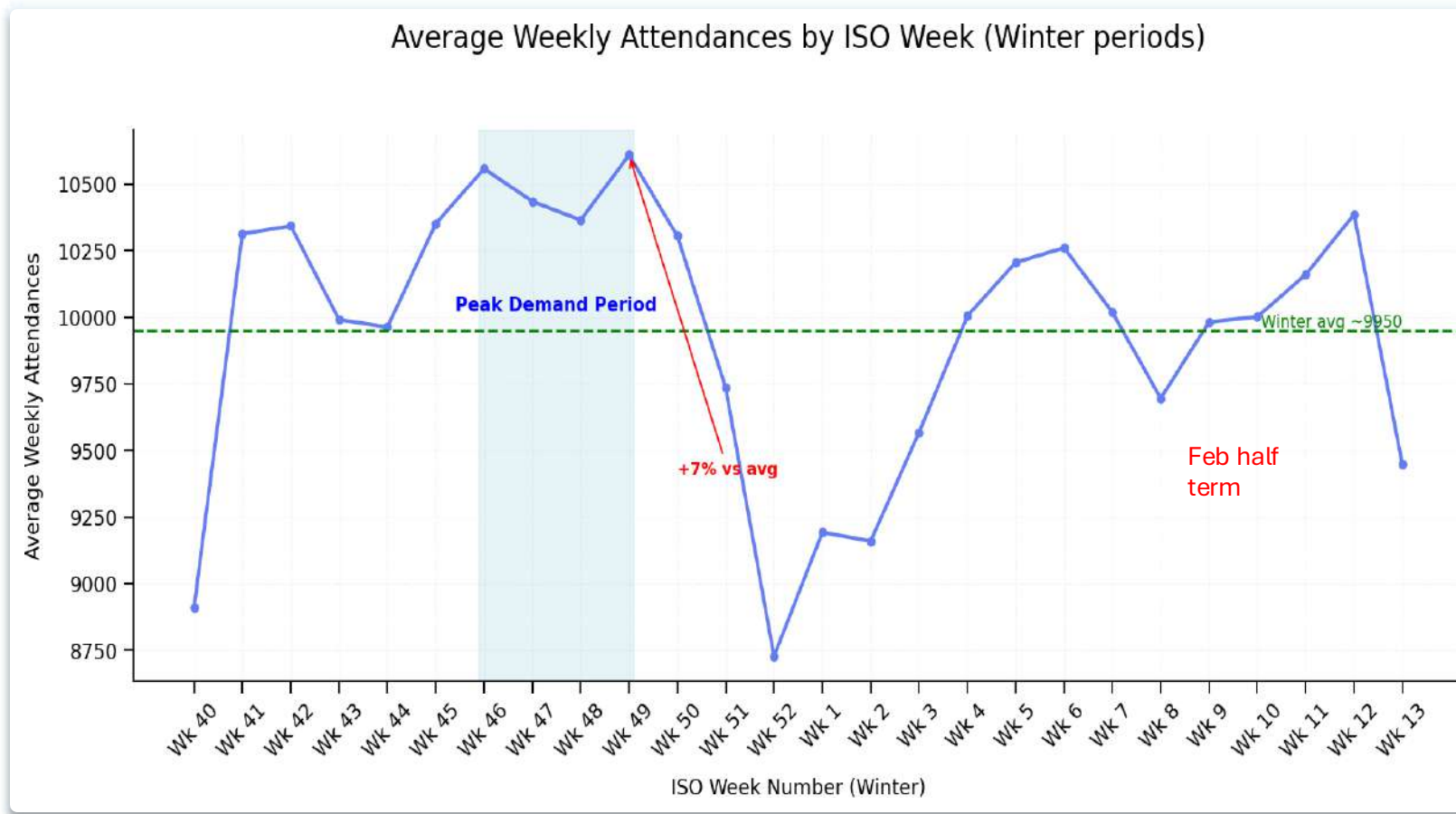


Winter 2025/26 ED performance

If the 4-hour standard is a barometer for safety and system pressure, November to January are the pressurised months with performance improving from February. 12-hour Trolley waits peaked in January at c188 patients (compared to 750 in 2024/25) before returning to approximately 50 patients (compared to 200 in 2024/25), with the majority of these being Mental Health patients.



Activity demand profile through Winter Period

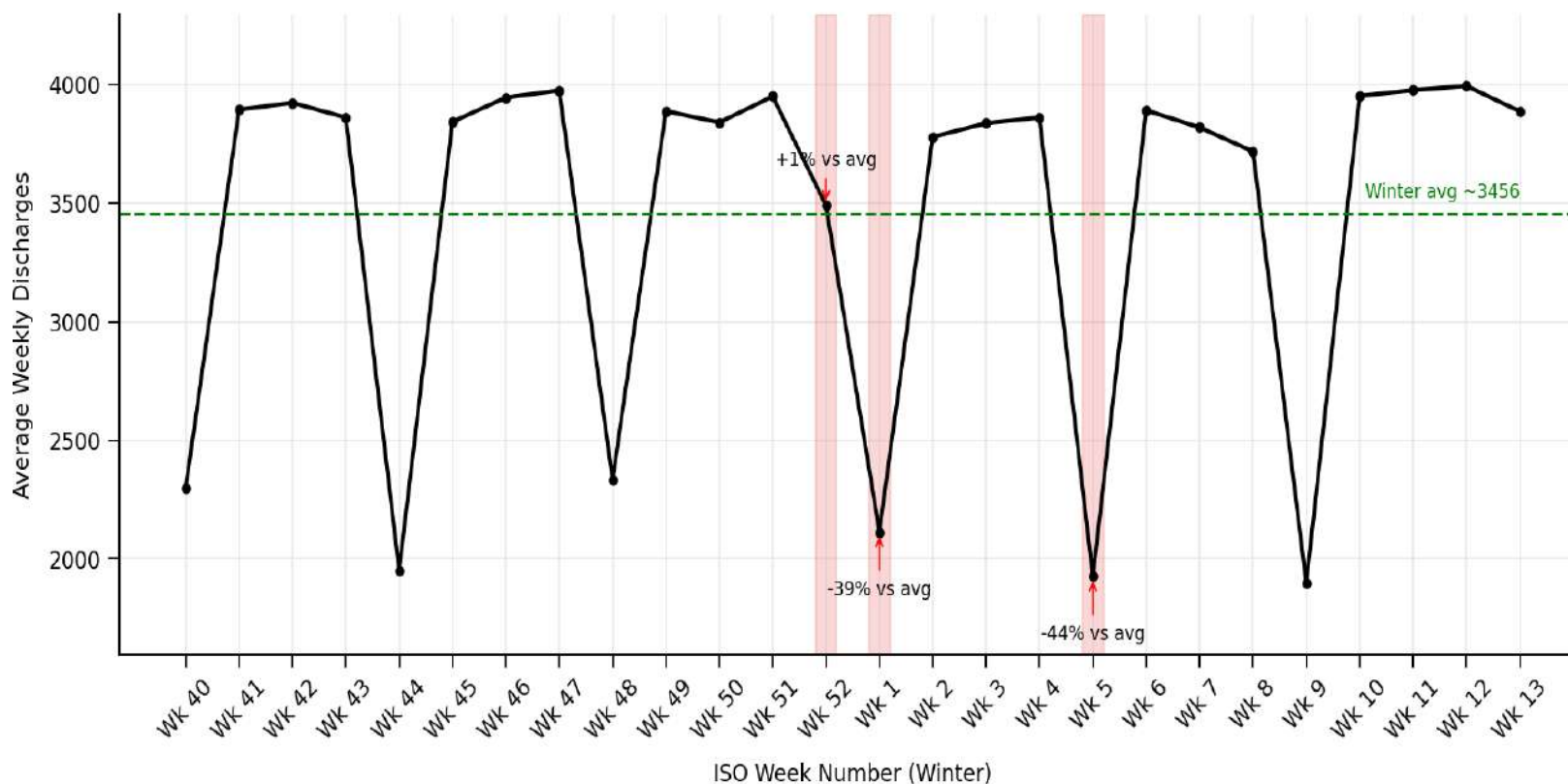


Demand Profile

- ☼ November to mid December is consistently the highest attends through Winter.
- ☼ The season often brings a rise in infectious diseases such as Norovirus, Influenza, and Respiratory Syncytial Virus (RSV), along with the potential emergence of more severe threats like pandemic flu or COVID-19.

Discharge profile through Winter Period

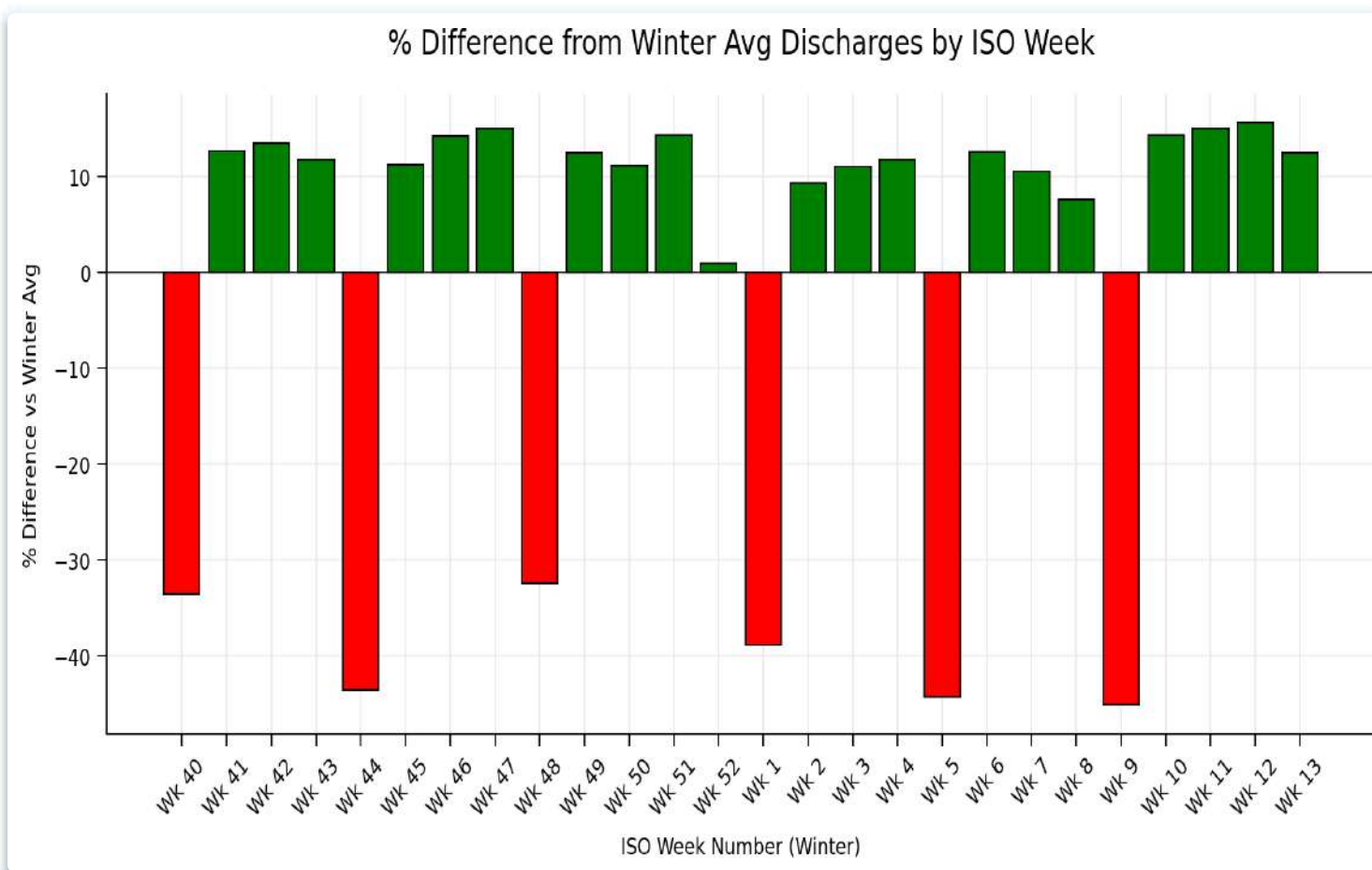
Average Weekly Discharges by ISO Week (Winter periods)



Discharge Profile

- System copes at peak demand; pressure occurs when discharges fall.
- Discharges fall up to 40% post Christmas and early February, driving flow pressure
- Maintaining flow in these periods would significantly reduce winter pressure

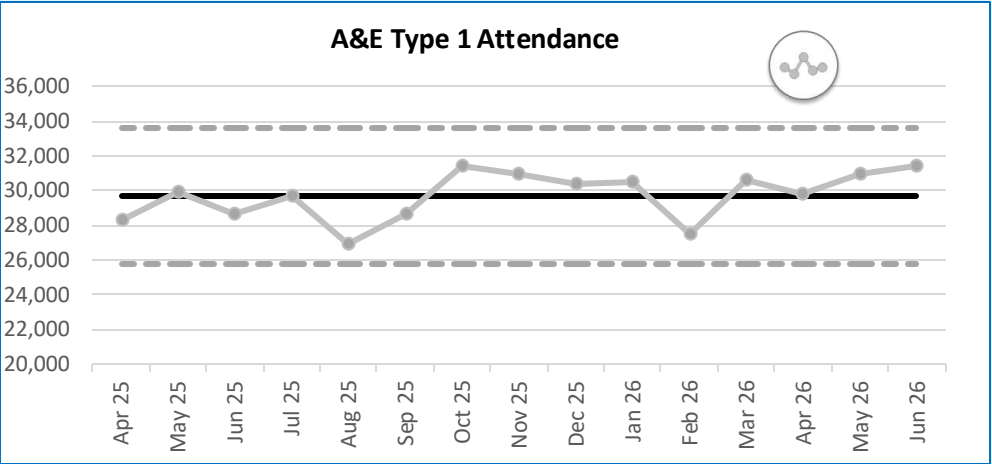
Discharges review by week



Demand Profile

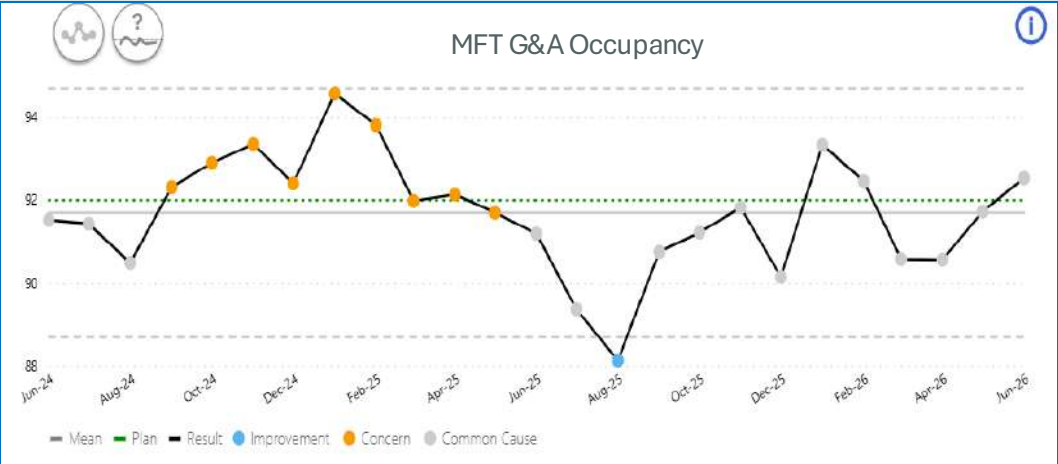
- System pressure during winter is not driven by peak demand alone, but by predictable reductions in discharge flow.
- While discharge capacity remains high during peak demand periods in November and December, it reduces by up to 40% during Christmas and February.
- This creates a mismatch between demand and flow, leading to accumulation of patients and sustained operational pressure into January and beyond.
- Last year was generally better than the average for these historically weakest weeks, with the strongest uplift in week 48 and only week 5 slightly below average.

UEC Attendances



- MFT expects to see between 42,093 patients in February of 2027 and 48,025 in October 2026. This level of variation can also be seen in Type 1, where we see the greatest pressure on bed demand and ED acuity.
- Type 1 is expected to vary September 26 29,193 attends through to December 26 with 31,250. Managing this demand places pressure on our bed capacity and achieving the 4-hour standard.
- Clinical Groups are responding to rising ED attendances in 2026/27 by strengthening front-door assessment and streaming, expanding SDEC and admission avoidance services, increasing use of redirection pathways such as UTCs and SPOA where appropriate, and progressing the implementation of Model ED ahead of winter to ensure patients are assessed and managed in the most appropriate setting and reduce pressure on ED services.

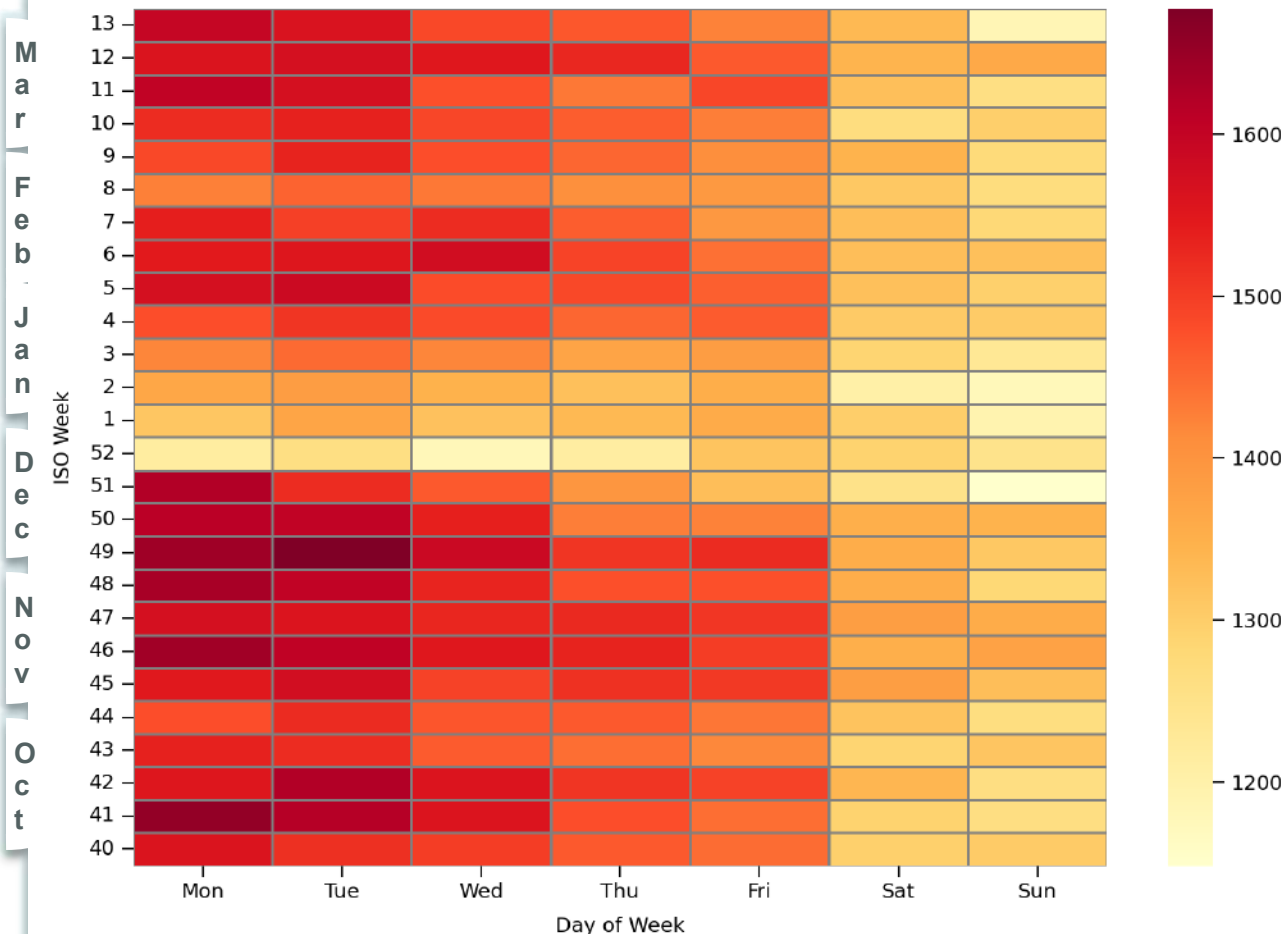
Bed Occupancy



	Nov-25	Dec-25	Jan-26	Feb-26
Of total G&A beds open, number occupied	2080	2090	2078	2030
Total G&A Beds Open	2186	2174	2162	2131
Percentage Occupied	95.15%	96.14%	96.11%	95.26%
Beds occupied to achieve 94%	2055	2044	2032	2003
Differential to be addressed	-25	-46	-46	-27

- Aligned to the increase in acuity expected during Winter 26/27 the chart above describes the bed occupancy rising to 96% during December and January.
- Reducing our bed occupancy to 94% this will require additional targeted actions to affect November 26 to February 27 with a peak deficit of -46 beds.
- Clinical Groups are reducing bed occupancy through First 72 Hours initiatives, long length of stay improvement programmes, delivery of no criteria to reside trajectories with system partners, strengthened discharge processes, and expansion of Care Closer to Home and Hospital at Home services, supporting earlier discharge and reducing avoidable inpatient bed utilisation ahead of winter.

Average Weekly Attendances by ISO Week and Day of Week (Winter periods)



Demand Profile:

- Heatmap analysis of attendances 2022-2026 demonstrates that demand is not evenly distributed across either the winter period or the week.
- The highest activity consistently occurs during Mondays and Tuesdays within peak winter weeks (mid-November to early December), representing the point of maximum system pressure. Some of this may be compounded by the impact of weekend flow reduction.
- Week 49 shows sustained increase attends across the week. The weather across the last 3 years identifies a notable reduction in temperature and therefore an associated increase in respiratory presentations. Week 49 for 2026 is 30th November to 6th December and worthy of specific attention in staffing and flow plans.
- Weekend demand remains significantly lower throughout the period, and early January activity is notably less intense than late November and December, despite perceived operational pressure.
- Winter 2025/26 attendances broadly mirrored the historical demand profile, with peak weeks in late November and early December recording slightly higher attendances than the historical average, reinforcing Week 49 as a key period of winter pressure.

Appendix 2 – Creating Capacity to Meet Demand – plans and trajectories

Model ED and First 72 Hours will provide the operational foundation for Winter 2026/27 by standardising pathways, strengthening early clinical decision-making, improving inpatient flow and discharge, and reducing unwarranted variation across MFT.

Programme	Current Position (Q1)	Key Actions	Expected Position by End of Q2	Winter Benefit
Model ED – Single Operating Model	Baseline assessment completed across all Clinical Groups; variation remains in pathway design and operational models.	Develop and approve a single MFT Model ED operating model with common standards and definitions.	Trust-wide operating model agreed with standardised definitions, streaming principles, SDEC, EEMAC and flow standards.	Consistent emergency care model across all sites.
Streaming & Early Clinical Decision-Making	Strong local practice but variation in streaming and specialty access.	Expand direct-to-specialty pathways, standardise streaming criteria and strengthen senior clinical decision-making.	Agreed priority specialty pathways and standardised front-door streaming arrangements.	Faster assessment and reduced ED congestion.
EEMAC & Ambulatory Care	EEMAC established at some sites and under development at others.	Deliver Clinical Group EEMAC plans and align EEMAC with SDEC pathways.	Trustwide EEMAC principles, referral criteria & implementation plans in place.	More patients managed without admission.
Demand Deflection & Alternatives to ED	SDEC, SPOA, Hospital at Home and community alternatives already contributing to improved performance.	Refine SPOA arrangements, improve referral routes and integrate community alternatives.	Review completed with agreed improvements to demand deflection pathways.	Reduced unnecessary ED attendances and admissions.
First 72 Hours – Acute Pathway Standards	First 72 Hours identified as a core priority for winter resilience and inpatient flow.	Embed First 72 Hours standards across sites and align with flow and discharge programmes.	Agreed standards, governance and reporting established across Clinical Groups.	Improved inpatient flow and reduced delays.
Specialty Response & Senior Review	Variation remains in specialty response, seven-day services and decision-making.	Strengthen specialty response arrangements and improve senior review standards.	Reduced unwarranted variation and clearer response expectations across sites.	Faster decision-making and reduced inpatient delays.
Post-Decision Flow & Discharge	Flow disruption remains the biggest driver of winter pressure.	Align Model ED, First 72 Hours, discharge improvement and NC2R programmes.	Agreed post-decision transfer standards and escalation processes.	Lower bed occupancy and improved discharge performance.
Clinical Leadership & Assurance	UEC Clinical Leadership Community established.	Monitor delivery against standards and operate a Trust-wide assurance framework.	Trust-wide reporting and assurance process established.	Stronger oversight and delivery of winter priorities.

Winter 2025/26 demonstrated that performance improvements were achieved through stronger front-door models, early senior decision-making, SDEC expansion, Hospital at Home and improved patient flow. For Winter 2026/27, MFT will build resilience by implementing a single Trust-wide Model ED operating model and embedding First 72 Hours standards, reducing variation between sites, improving flow through ED and inpatient pathways, reducing bed occupancy and supporting safer care throughout winter.

Developing the Winter Plan at Clinical Group level

The below provides the Improvement ambitions for each Clinical Group to support ensuring right sized capacity during Winter

	MRI	NMGH	WTWA	Specialist / RMCH	LCO / Community
Start/ strengthen for 2026/27	Consolidate a Winter Respiratory Pathway to support rapid identification, assessment and treatment of respiratory presentations, including use of Hospital at Home where appropriate.	Align site management systems to NHSE standards for corridor care and temporary escalation spaces.	Use capacity planning to understand likely peaks in demand and align escalation procedures to national OPEL and SCC arrangements.	Implement the RMCH/MCS winter and surge plan, including UEC, workforce, surge capacity, Hospital at Home and length-of-stay elements.	Maintain the agreed NCTR trajectory, with an ambition of no more than 259 patients with No Criteria to Reside by November 2026.
	Move to more predictive and proactive infection surveillance to inform activation of Covid/flu wards.	Develop clear steps for clinical teams to avoid corridor care, including HSSIB self-assessment actions.	Deliver the WTWA Urgent Care Improvement Group plan with workstreams focused on Focus on 4, SDEC / clinical pathway design, WTWA site response and shared mental health care.	Identify G&A surge beds, PICU surge processes, and re-establish a GM-wide approach to paediatric surge / mutual aid through Paediatric Cell when needed.	Update Hospital at Home capacity and community alternative capacity plans, including Crisis, H@H and IV integration through a OneMFT operating model.
	Include respiratory consultant in-reach to ACU / acute respiratory SDEC and ED, with targeted review of patients going home or awaiting a bed.	Develop EEMAC, paediatric CDU, CCTH and SDEC pathways as core Model ED delivery areas.	Use the Flow Improvement Group to eradicate the requirement for Temporary Escalation Spaces.	Increase referrals from NMGH and WTWA ED into community ACT, OPAT and acute respiratory hub pathways.	Strengthen discharge readiness through complex discharge referrals, transport, equipment / crisis clean coordination, 6/7 day offer, community service visibility and maximising all system capacity.
	Strengthen ARI planning across triage, POC testing, admission/discharge criteria, Hive order sets, and a daily respiratory hot clinic for Nov–Feb.	Expand ED consultant workforce to support senior presence to midnight and across key ED areas.			
Continue / change through winter	Continue staff wellbeing and attendance management, using local forums and daily reporting to support workforce resilience.	Improve ambulance handover performance by monitoring 30-minute turnaround, progressing toward 65% handovers within 15 minutes, and maintaining trolley stock for heightened demand.	Continue Care Closer to Home through four workstreams: Right Patient, Right Place; Reducing Days Away From Home; System Visibility and Active Leadership; and Supporting Independence Together.	Continue LoS improvement through SAFER relaunch, real-time tracking of EDD / NCDR / discharge before midday, weekly review of patients with LoS >30 days and complex discharge MDT reviews.	Continue Home First / NCTR grip through data-led planning, coordinated system response and learning from previous winter recovery work.
	Continue and refresh annual flu vaccination delivery, using roving clinics, static clinics and targeted clinics for areas below expected uptake.	Strengthen site governance through Gold / Silver / Bronze arrangements, harm review for 12-hour waits, ambulance turnaround, LLOS and corridor care, and leadership oversight of complaints and incidents.	Continue focus on reducing unnecessary admissions, reducing LoS, increasing Pathway 0 discharges and improving system visibility.	Protect elective activity by establishing early review and prioritisation during surge, plus smart scheduling of surgical elective activity.	Maintain focus on P1/P2 referrals, IMC delays, reablement, equipment, fast-track, care home capacity, housing assessment delays, GMMH and out-of-area flow.
	Use local communications and engagement routes to cascade winter workforce messages across large and diverse MRI staff groups.	Continue SDEC development, including a streamer role, medical SDEC capacity, frailty front door streaming and specialty referral criteria.	Continue monitoring of FIG and UCIG through action logs, measures and reporting cadence.]	Continue proactive staff vaccination education and vulnerable CYP prevention activity.	Continue LCO leadership of Hospital at Home trajectory, SPOA and community capacity inputs into winter resilience.

MFT, NHS GM Manchester and Trafford and GMMH have agreed a trajectory of performance improvement to achieve a plan of No Criteria to Reside reduction

The ambition is to have no more than

259
patients

with No Criteria to Reside by
November 2026

April to July performance validated actuals

System Partner Trajectory (HIVE snapshot output subject to variable change)

No Criteria to Reside - Unvalidated		% of NCTR target	Apr-26 Target	Apr-26 Actual	May-26 Target	May-26 Actual	Jun-26 Target	Jun-26 Actual	Jul-26 Target	Jul-26 Current	Aug-26 Target	Sep-26 Target	Oct-26 Target	Nov-26 Target	Dec-26 Target	Jan-27 Target	Feb-27 Target	Mar-27 Target
Acute	Integrated Discharge Team/Site	24%	84	119	86	103	74	106	69	103	66	62	61	60	60	60	60	60
	Therapies	14%	49		50		49		46		44	41	40	40	40	40	40	40
Local Authority	Control Room Combined	39%	137	94	140	115	88	108	83	101	80	73	71	70	70	70	70	70
	Out of Area - (GM Manchester & Trafford Locality to lead)	12%	41	72	42	57	37	58	35	66	33	31	30	30	30	30	30	30
Mental Health	MH Assessment	10%	34	23	35	23	31	31	29	33	28	26	25	25	25	25	25	25
	MH Awaiting bed	2%	5	3	6	6	5	4	5	2	4	4	4	4	4	4	4	4
Combined Total		100%	351	311	359	304	320	307	300	305	285	267	262	259	259	259	259	259

The System ambition is to reduce MFT NR2R to **259** patients by November 2026

We will focus on maintaining patient safety and flow by establishing a robust operational grip with all system partners.

We will apply a Home first ethos and three principles will guide our approach:

1. The system's plan will be data led, so that plans are realistic and we focus on high impact activity
2. The system's response will be co-ordinated
3. Lessons learnt from Winter 2025-26 focus on recovery eg IMC, reablement and equipment support

A period of planning will continue to run across Winter with specific focus on known periods of surge of capacity challenges, such as the Christmas period.

Discharge - The hospital sites will...

- Commence discharge planning from admission
- Submit referrals for complex supported discharge at agreed timeframes
- Secure extra transport
- Ensure resilience of discharge staffing – and the 6/7 day offer
- Ensure validation of NCTR for Data Quality
- Ensure all equipment and crisis clean/ VCSE requests are coordinated by therapy and IDT teams in advance of discharge date.

Discharge - The LCOD will...

- Focus on increasing discharge churn as part of readiness – weekly 165 target.
- Ensure that sites **have visibility of community service capacity** for discharge.
- Make sure that **all capacity in the system is appropriately utilised** to maximise flow.
- Ensure equipment teams are present on planning PTLs
- Increase P1 referrals

System risks to mitigate in advance

- Ascot House flow – Trafford
- Increased community flow linked to CCTH
- Housing Assessment delays – Manchester Council
- Fast Track
- Care Home capacity
- High-cost placements/packages – delays
- Staffing – what is the commitment and realistic staffing proposal for the bank holiday staffing
- GMMH & Out of Area

Hospital at Home Capacity Trajectory for Winter 2026/27

There are key action between April 2026 to March 2027 is to increase H@H capacity to 225 with 90% occupancy consistency. The LCO plan also maintains Crisis capacity whilst developing the model through harmonisation of community urgent care services

April-September 26

Focus on stabilising the capacity at 150 and occupancy at 90% given the workforce risks and mitigations. Workforce review to support staffing resilience through centralisation of telemedicine service.

September - December 26

Increase to 170 acute and community beds with 90% utilisation including Trafford provision

January 26 – March 27

Increase to 200 acute and community beds

National ambition

40–50 beds per 100,000 → MFT currently at ~50% of target

Current provision

200 beds across Manchester & Trafford (~20 beds per 100,000 population of ~1.0m)

Key issue

- Capacity not aligned to population need
- North over-provisioned, Central & South under capacity

Planned actions

- Redeploy 10 acute beds from North → Central (5) & South (5)
- Sept-Dec 26: Expand by +20 beds (total to 220; ~22 per 100,000)

Investment focus

- 10 new community beds (Trafford/South)
- 10 new acute beds (Central & South split)

Post-expansion position

- Improved locality equity (North 40 | Central 60 | South/Trafford 70)

Mar-26	Central	South	North	Total
GP Registered Population	457,542	383,516	161,176	1,002,234

Current Position	Central	South	North	Children's	COPD	Total
Community	20	20	20	7		67
Acute	30	30	30		43	133
Total	50	50	50	7	43	200

Initial Redeployment	Central	South	North	Children's	COPD	Total
Community	20	20	20	7		67
Acute	35	35	20		43	133
Total	55	55	40	7	43	200

Additional Beds Proposal	Central	South/Trafford	North	Children's	COPD	Total
Community	20	30	20	7		77
Acute	40	40	20		43	143
Total	60	70	40	7	43	220

Urgent Care SPOA Trajectory for Winter 2026/27

Trajectory for Call Volume Optimisation

Additional Health Care Professional (HCP) Pathway

Currently, the HCP pathway for Category 2 and Category 3 patients operates via a dedicated NWAS line. Under the enhanced model, General Practitioners and other community clinicians requesting conveyance to the Emergency Department — whether from a GP practice, community clinic, or patients' homes — will be automatically routed through the SPoA.

This redesigned pathway supports a shift away from default ED conveyance by enabling earlier clinical triage through SPoA, increasing opportunities for patients to be managed safely within primary care or community-based services where appropriate.

7-day service expansion

Live in July and will continue through winter

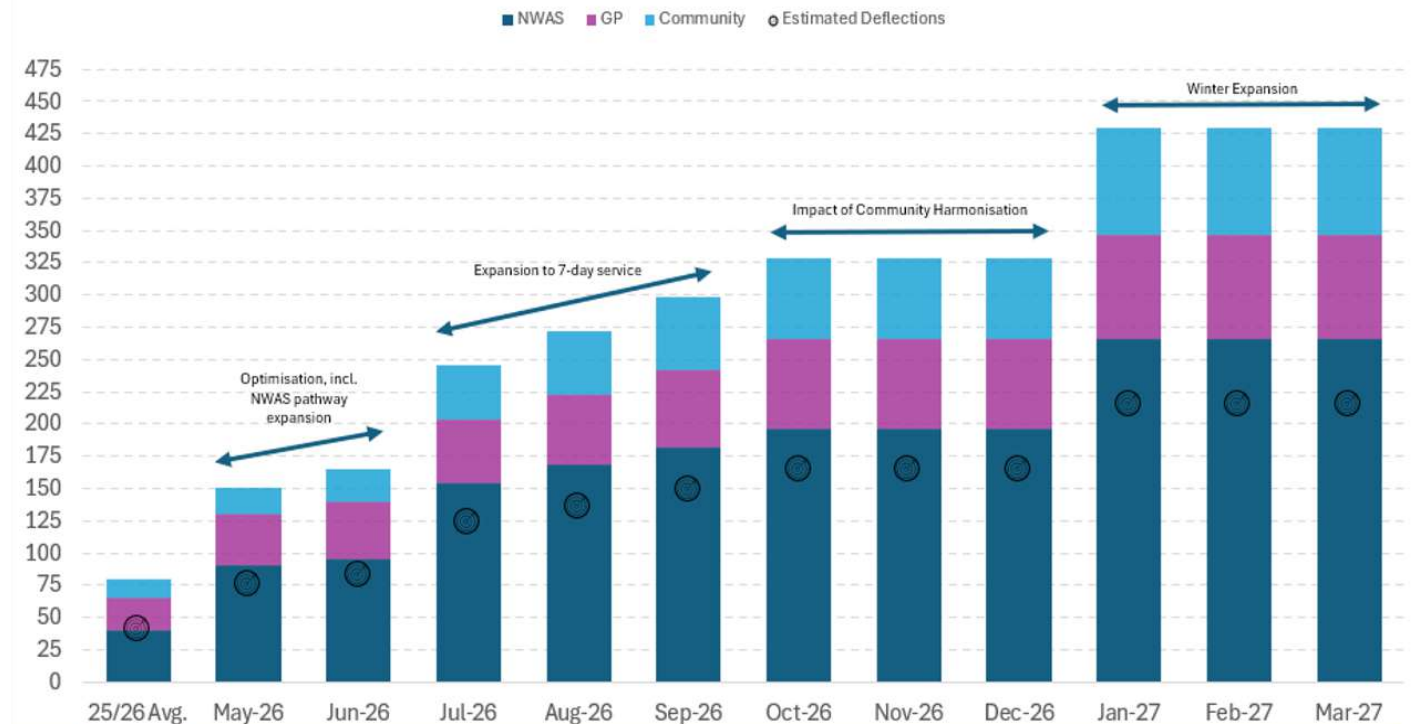
Harmonisation of community urgent care

Service utilising SPOA will further enhance call volume and deflections from ED.

Ongoing engagement and pathway design

With primary care, NWAS and care home partners

Weekly Avg. Call Volume Trajectory



Weekly Call Volumes	25/26 Avg.	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
NWAS	40	90	95	154	168	182	196	196	196	266	266	266
GP	25	40	45	50	55	60	70	70	70	80	80	80
Community	15	20	25	42	49	56	63	63	63	84	84	84
Total	80	150	165	246	272	298	329	329	329	430	430	430

Estimated Deflections @ 50%	40	75	83	123	136	149	165	165	165	215	215	215
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Appendix 3 – Supporting Documents

Supporting Documents

Document title	Embedded Document
Full Capacity Protocol	
OPEL - Acute	  OPEL MFT rdination Centre D 
OPEL - Community	 
OPEL – ICS and 111 action cards (NHS England Document) (<u>For reference</u>)	  
Mental Health – NHS England’s Winter 25/26 action cards	
Countdown to Christmas	TBA
Mental Health Emergency Department escalations	
Validation SOP	



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: 25/08/26

Key escalation and discussion points from the meeting

Alert

Sickness absence remains an alert, with the Integrated Performance Report noting a 6% rolling average and a July 2026 rate of 6.3%. Work continues through two priority workstreams focused on supporting disabled staff to remain well and in work, and prevention activity linked to mental health, musculoskeletal, women's health and cardiovascular conditions. A focus session with TLTC is planned for September 2026 to consider associated fast-tracking and wellbeing resources/business case.

The Committee also noted that **Agenda for Change appraisal** performance remains an alert, with initiatives continuing to be progressed to improve workforce availability alongside the need to sustain high-quality one-to-one conversations between line managers and staff (identified as key factors).

Workforce reduction and substantive WTE delivery: The Committee noted the Trust's 1,188 WTE reduction target and the reported position of 183 WTE ahead of plan. While top-line workforce reductions are tracking ahead of target, the reliance on temporary bank and agency cuts rather than substantive establishment reduction linked to mature VFP programmes creates a risk of non-recurrent delivery. More clarity is required on VFP driven establishment changes to ensure sustainable long-term savings.

Advise:

The Committee received the **Integrated Performance Report** and discussed the workforce implications of low turnover, in terms of new ideas and innovation, noting that further work is required to understand the drivers of the position. Vacancy control and internal redeployment arrangements continue to support the Trust's approach to managing workforce change.

Risk Appetite Statement: The Committee reviewed the updated Risk Appetite Statement and supported the relevant domains prior to presentation to Board in September 2026. Feedback was provided on the culture, behaviour and inclusion domain, including the need to reference staff alongside patients, and on the terminology used to describe risk appetite levels.

Workforce strategic risk report: The Committee noted that strategic workforce risks are now aligned with the Board Assurance Framework with the two strategic risks being in relation to absence and engagement, and headcount reduction. Future reports will include the position of each risk against the approved risk appetite statement.

Chief People Officer's report: The Committee noted updates on the new NHS leadership framework, the Board's support for the Lord Mann Review recommendations, the collective cultural leadership programme and the reward and recognition review. Further detail on the Trust's reward and recognition programme will be presented to a future Committee meeting.

Mobilisation Plans for NHS Staff Survey 2026: The Committee noted the planned mobilisation campaign, to support improvements in relation to the staff return rate (previously 35%). The campaign will

focus on “you said, we did” communications and sustained promotion of confidentiality and anonymity.

ED&I Progress Update: The Committee noted progress across the Equality, Diversity and Inclusion portfolio, including Ignite, the Global Health Unit, the Diaspora Workforce Report, preparatory work relating to Equality and Human Rights Commission guidance and Veterans Aware reaccreditation. The Committee noted the significant delivery expectations following Ignite and the poorer experience reported by disabled staff across a range of metrics.

WRES and WDES Action Plan Sign Off: The Committee endorsed the Trust-wide WRES and WDES Action Plan, subject to approval at the Trust Board of Directors’ meeting (30th September 2026). The action plan focuses on recruitment, employee relations, support for disabled staff, bullying and leadership. The Committee requested future metrics on concerns raised by inclusive recruitment panel members and the learning resulting from those concerns.

M03 WTE VFP Performance to Plan: The Committee noted that the Trust was 183 WTE ahead of plan at the time of reporting, driven largely by temporary workforce grip and control. The Committee noted that the substantive workforce position remained 110 WTE lower than plan and that further work is required to sustain and embed substantive workforce schemes with oversight and scrutiny continuing through senior management governance routes.

Violence and Abuse Update: The Committee noted progress in implementing the Trust’s Prevention and Reduction of Violence and Abuse Programme, including the ‘No Excuse for Abuse’ campaign and strengthened preparedness for the NHS violence prevention standard. Further updates are to be provided around the tracking of staff safety measures within the new security contract, including staff feedback in high-risk areas.

Freedom to Speak Up: The Committee received the Quarter 1 Freedom to Speak Up report and noted progress with the NHS England mandated reflection and planning tool with clinical groups currently collating supporting evidence for their self-assessments (deadline October 2026). The Committee noted strengthened reporting on detriment, described nationally as disadvantageous behaviour following speaking up, and the work being progressed through the Northwest Freedom to Speak Up Guardian Network to improve consistency of data interpretation and recording.

Guardian of Safe Working: The Committee noted the Quarter 1 Guardian of Safe Working report, including 156 more exception reports compared with Quarter 4, with 43 more doctors reporting. No detriment directly linked to exception reporting was reported. The Committee noted revised reporting arrangements and further work to encourage narrative detail in exception reports and regular local conversations between resident doctors and supervisors.

Specialities under enhanced monitoring with NHSE/GMC: The Committee noted the update on Obstetrics and Gynaecology at North Manchester General Hospital. The service remains in enhanced monitoring, with GMC conditions retained at present. Positive trainee survey results were noted, including no GMC red flags reported by O&G trainees at North Manchester General Hospital. NHSE and GMC have confirmed a visit is anticipated within the next 12-month cycle.

Improving Resident Doctors’ Working Lives: The Committee noted progress against the NHSE 10-point action plan. The Trust is fully compliant with six of the eight elements within its responsibility, with ongoing focus required on payroll accuracy and rota communication. The programme continues to be used for broader cultural improvement in the working lives of resident doctors.

Medical Appraisal and Revalidation and Annual Statement of Compliance: The Committee noted the assurance provided on statutory arrangements for medical appraisal, revalidation and wider professional governance. Overall appraisal performance remains strong, with 2,914 connected doctors supported and all revalidation recommendations submitted on time. The Committee supported progression of the Annual Statement of Compliance to the Board of Directors in September 2026.

Assure:

The Committee received assurance through the Integrated Performance Report that **Level 1 mandatory training** remains above target, with **Levels 2 and 3 mandatory training** continuing to improve. **Bank and agency WTE** reductions continue to demonstrate the impact of grip and control arrangements. **Turnover** remains low, with the Committee noting both the positive staff retention position and the need to understand the wider implications for workforce reduction and organisational renewal.

Bi-monthly safer staffing report – Nursing and Allied Health Professionals: The Committee received assurance that nursing services across the Trust remain compliant with national safer staffing guidance (NQB 2026; DWS 2018). The Committee noted the continued reduction in temporary staffing costs and the work underway to review Band 5 job profiles in response to national guidance. The Committee supported presentation of the report to the Board of Directors in September 2026.

The Perinatal Equity and Anti-Discrimination Programme – Maternity and Neonatal services: The Committee noted participation in the mandated programme, to build on cultural improvement within maternity and neonatal services, with 70 colleagues participating. The programme supports culture, equity and safety improvement and links to maternity safety reporting and delivery of one of the NHSE 10-point plan requirements.

Risks discussed at the meeting

Workforce Strategic risks: The Committee reviewed the updated workforce risks and noted alignment with the Board Assurance Framework. The strategic risks relate to absence and engagement, and headcount reduction. The Committee noted that future reporting will include the risk appetite position for each strategic risk once the Risk Appetite Statement has been approved by Board.

Sickness absence and wellbeing: Sickness absence remains an area of ongoing risk, with the Integrated Performance Report noting a 6% rolling average and a July 2026 rate of 6.3%. Prevention work is focused on mental health, musculoskeletal, women's health and cardiovascular conditions, with further consideration of resources and business case requirements planned through TLTC.

Workforce reduction and substantive WTE delivery: The Committee noted the Trust's 1,188 WTE reduction target and the reported position of 183 WTE ahead of plan. The Committee also noted that the substantive workforce position remained 110 WTE lower than plan and that reliance on temporary workforce reductions alone may increase delivery risk in the second half of the year and into future planning cycles.

National band 5 (nursing) financial risk: The Committee noted the potential financial pressure associated with the national Band 5 job profile review, with the national funding position remaining materially below the estimated requirement.

Report approved by: Angela Adimora

Agenda



Manchester University
NHS Foundation Trust

People Board Committee

Date: Tuesday, 25th August 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 (30 th June 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	Risk Appetite Statement.	Support	Deputy Director of Clinical Governance and Risk	2.15pm
7.3	Workforce strategic risk report.	Approval	Deputy Chief People Officer	2:20pm
Strategic aim 3: Be the place where people enjoy working, learning and building a career				
8.	Chief People Officer report.	Discussion	Chief People Officer	2:25pm
9.	Mobilisation Plans for NHS Staff Survey 2026	Discussion	Deputy Chief People Officer	2.30pm
10.	ED& I Progress Update.	Discussion	Deputy Chief People Officer	2.40pm

11.	WRES & WDES – Action Plan Sign Off.	Approval	Deputy Chief People Officer	2:50pm
12.	M03 WTE VFP Performance to Plan Report	Discussion	Deputy Chief People Officer	3:00pm
13.	Violence and Abuse Update	Discussion	Head of Security and Car Parking	3:10pm
14.	Freedom to Speak Up Quarterly Report (Q1).	Discussion	Freedom to Speak Up Guardian	3:15pm
15.	Guardian of Safe Working Quarterly Report (Q1).	Discussion	Guardian of Safe Working	3:20pm
16.	Specialities under enhanced monitoring with NHSE/GMC including Obstetrics and Gynaecology NMGH review update.	Discussion	Medical Director – Specialist Hospitals/ Associate Director of Medical Education	3:25pm
17.	Improving Residential Doctors' working lives - 10-point plan.	Discussion	Joint Chief Medical Officer	3:35pm
18.	Medical Appraisal and Revalidation and Annual Statement of Compliance	Discussion	Joint Chief Medical Officer	3:40pm
19.	Bi-monthly safer staffing report (Nursing and AHP).	Discussion	DCE / Chief Nursing Officer	3:45pm
20.	The Perinatal Equity and Anti-Discrimination Programme – Maternity and Neonatal Services	For Noting	DCE / Chief Nursing Officer	3:50pm
Committee business				
21.	Escalation report.	Approval	Chair	3:50pm
22.	Workplan review.	Meeting admin	Chair	3:50pm
23.	Any Other Business (verbal).	Discussion	All	3:55pm
24.	Meeting Evaluation (verbal).	Meeting admin	Chair	3:55pm
Date of next meeting: Tuesday, 27 th October 2026 at 2.00pm in the Main Boardroom, near Cobbett House				
Papers for Information: Workforce Education and Management Committee Escalation Report				

Public Board of Directors

Wednesday, 30 September 2026

Paper Title:	Bi-Monthly Safe Staffing Report (Nursing and AHP) (data for May and June 2026)	Agenda Item 12.2
Presented by:	Kimberley Salmon-Jamieson, Deputy Trust Chief Executive / Chief Nursing Officer	
Prepared by:	Mark Keegan, Corporate Director of Nursing – Workforce and Education	
Meetings where content has been discussed previously	People Board Committee on 25 th August 2026	
Purpose of the paper Please check <u>one</u> box only:	☐ For approval☐ For support ☒ For discussion☐ For noting	

Executive summary / key messages for the meeting to consider

This bi-monthly Safe Staffing Report provides assurance that MFT remains compliant with national safer staffing guidance for nursing for May and June 2026, with ongoing development of a strengthened assurance approach for AHP safe staffing in the absence of a nationally validated AHP framework.

At the end of June 2026, nursing bank spend was 26.8% (£4.1m) lower than 2025/26 YTD, against the NHSE target of 10%, mainly due to additional corporate and senior leadership actions implemented by each Clinical Group through May and June 2026. This included Practice Based Educators and other senior colleagues working clinical shifts and supporting Ward Managers with managerial activities to enable them to work more clinical shifts.

AHP agency spend has reduced by 45.2% year to date, through migration to NHSP bank. AHP premium overtime remains concentrated in CSS Clinical Group, particularly imaging, and remains a priority area for the AHP Value for Patients programme.

Registered nursing vacancies reduced to its lowest level in recent years in February and March 2026 following the 2 main graduate recruitment windows in Q3 and Q4 of 2026/27. Vacancies have increased overall to 193.1WTE (2.1%) in June 2026, pending the recruitment of graduate nurses in September, and remains significantly lower than the current national vacancy rate at 5.0%.

Support to nursing vacancies have reduced from an annual mean average of 464WTE to 335WTE (9.6%) in June 2026 reflecting the reduction in funded establishment associated with non-nursing roles being removed from establishments by finance teams as part of a data quality exercise and planned ward closures. The recruitment pipeline for Quarter 2 remains positive, with 22 confirmed starters and a further 85 projected starters, supporting continued vacancy reduction over the coming months. The turnover rate has reduced from a high of 12% in May 2025 to 10.2% in June 2026, the same as national average of 10.2%, and the rolling average sickness rate has reduced from of 10.2% in May 2025 to 8.1% in June 2026, compared to a national average of 7.9%.

Nurses working in Critical Care and Theatre at Northern Care Alliance NHS Trust have taken industrial action in the form of several strikes in protest about the removal of enhanced bank rates and the removal of access to overtime payments. Unison have now commenced a period of consultation with their members at MFT following contact from colleagues in Theatres about the same issues. Vacancy rates and bank usage across Critical Care and Theatre services is being closely monitored to assess the potential impact of industrial action.

A programme to review all Nursing and Midwifery (N&M) job descriptions against the revised N&M job profiles is progressing, with a series of focus groups with band 5 colleagues commencing in July 2026 to review of all band 5 job descriptions. The Royal College of Nursing (RCN) has stated its position that nursing is a band 6 profession with progression to Band 6 after 2 years post registration. The impact of this on the annual wage bill would be an increase of c£9.0m to c£12.3m. National funding is yet to be confirmed. The Nursing Workforce Implementation Team, Nursing Directorate, NHS England issued a Band 5 Nursing Role Review Programme delivery plan template assurance submission for all Trusts to complete and this was returned by the deadline of 31st July 2026 following approval at Trust Leadership Team Committee.

The Enhanced Therapeutic Observation and Care (ETOC) Improvement Programme has seen A reduction in the mean average of patients receiving ETOC per month by 342 from 1393 to 1051 per month, and the average NHSP filled WTE to support ETOC requirements has reduced from 178WTE to 139WTE per month. This equates to a cost saving of £130,373 per month.

Recommendation(s)

The Board of Directors is asked to:

- Receive this report and note that Nursing and AHP services across MFT remain 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 25th August 2026.
- Receive assurance of safe nurse staffing as described in sections 5, 6, 7, 8 and 9.
- Note that at the end of June 2026, nursing bank spend was 26.8% (£4.1m) lower than 2025/26 YTD, against the NHSE target of 10%.
- 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 the 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 within this report links to the following strategic, corporate, or operational risks: •
Care Quality Commission domains Please check <u>all</u> that apply	☒ Safe ☐ Caring ☐ Effective ☒ Well-Led ☐ Responsive
Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the 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

1. Introduction

This bi-monthly Safe Staffing report provides assurance that MFT remains compliant with the national guidance in relation to safer staffing for nursing for the period of May and June 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).

There is no nationally validated framework for AHP safe staffing, and this report utilises advisory benchmark standards.

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 Quarter 1 2026/27, nursing and midwifery bank spend was 26.8% (£4.1m) lower than the same period in 2025/26, which is higher than the NHSE target of 10% (appendix A), due to additional corporate and senior leadership actions implemented by each Clinical Group through May and June 2026. This included Practice Based Educators and other senior colleagues working clinical shifts and supporting Ward / Team Managers with managerial activities to enable them to work more clinical shifts. Quality Impact Assessments have been undertaken by all Clinical Groups and have demonstrated that the measures taken to reduce bank usage are not sustainable at current levels due to the impact on training provision and managerial activities, with appraisal rates reducing to 85.8% which is below the trust target of 95%. Managerial time for Ward / Team Managers is being gradually reintroduce, essential training is being prioritised, and the impact will be monitored.

Nursing and midwifery premium overtime remains at a very low level, averaging 11k in May and June 2026 (appendix A). This equates to an approximated 0.002% of the monthly nursing and midwifery budget of c£50m is mainly due to supporting overruns in Theatre units.

Demand for AHP premium overtime spend continues at similar level to 2025/2026, at the end of June 2026 (£2k) higher YTD, mainly attributed to additional clinical activity (appendix A). 99.9% is utilised in Clinical Scientific Services (imaging services 80.9% and AHP services 19.1%). NMAHP corporate team are supporting CSS CG with a programme of work to migrate imaging staff to NHSP bank contracts. LCOA AHP Therapy services have stopped all premium overtime spend.

AHP agency spend has decreased by 45.2% YTD compared to previous financial year, equivalent to £383k, 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 with a trajectory/expected delivery by the end of quarter 3 2026/27.

During financial year 2025/26 enhanced bank rates of pay were removed in all provider Trusts across Greater Manchester, following agreement at the Greater Manchester Trust Provider Collaborative. Since then, nurses working in Critical Care and Theatre at Northern Care Alliance NHS Trust (NCA) have taken industrial action in the form of several strikes in protest about the removal of enhanced bank rates and the removal of access to overtime payments. There has not been any direct impact on MFT services because of the industrial action at NCA and there has not been a reduction in fill rates. Unison have now commenced a period of consultation with their members at MFT following contact from colleagues in Theatres about the same issues. The Chief People Officer and her team have an open dialogue with Staff side colleagues in relation this matter, and further updates will be provided as the situation develops.

There is a reliance on bank staff across Theatre services with an average of 49WTE per month (6.2% of total theatre establishment), and 77% of bank shifts are filled by MFT substantive staff working additional hours through NHS Professionals. There are currently 1.71WTE vacancies at NM Theatres and 4.73 at SH Theatres, and no reported theatre registered nursing/ODP vacancies at WTWA and MRI Theatres. (see Appendix H for further detail).

Reliance on bank staff has significantly reduced in critical care roles, in the last two months down to an all-time low 7.8WTE (0.96% of total critical care establishments) between May and June 2026. This low position is attributed to significant scrutiny on booking practices and alternative staffing cover to NHSP bank. The vacancy position in critical care services is also very positive, currently reported as no vacancies and any upcoming vacancies will be filled with scheduled graduate recruitment.

4. Nursing and Midwifery National Job Profiles

A programme to review all Nursing and Midwifery (N&M) job descriptions against the revised N&M job profiles commenced in October 2025 and has an associated comprehensive delivery plan. Meera Nair, Chief People Officer, is the board-level Senior Responsible Officer for Job Evaluation, and Kimberley Salmon-Jamieson, Deputy Trust Chief Executive & Chief Nursing Officer, is the board-level Senior Responsible Officer for the N&M Job Profiles Programme.

The N&M Job Profiles Oversight Group was established in October 2025, and the membership includes the Corporate NMAHP Workforce Team, Corporate Workforce Team and Staff side representatives from all the N&M related unions represented at MFT. The purpose of the oversight group is to manage the review of all N&M job descriptions against the revised N&M Job Profiles published in June 2025. It reports into the Trust Joint Negotiating Consultative Committee, and the Workforce and Education Management Committee.

All recognised trade unions representing nurses are members of the N&M Job Profiles Oversight Group and are full partners in developing and overseeing the plan. All aspects of the programme plan are considered at the Oversight Group, with all decisions taken in the spirit of partnership, including design and content of communication materials.

The programme plan includes a range of approaches to engage with all nursing colleagues. During July 2026 a series of focus groups commence for nursing colleagues currently employed at a Band 5 level, followed up by speciality specific focus groups to refine job descriptions. All colleagues will receive draft job description and have opportunity to comment including 1to1 meeting with line manager to confirm. A range of communication methods are being deployed to ensure all colleagues are informed, including all

staff groups communication messages eg. weekly bulletins; bi-monthly Chief Nursing Officer Bulletin; briefings disseminated at ward/team meetings; direct email to band 5 colleagues; drop-in sessions; posters.

On 2nd June 2026 NHS England issued 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. A delivery plan template was issued by Nursing Workforce Implementation Team, Nursing Directorate, NHS England on 18th June 2026. The completed template was presented and approved at Trust Leadership Team Committee prior to being submitted by the deadline on 31 July 2026.

The review of Band 5 roles commenced during July 2026, with job descriptions being subject to job evaluation during quarter 4 of 2026/27 and publication of the suite of revised job descriptions by the end of quarter 1 of 2027/28.

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 at 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%.

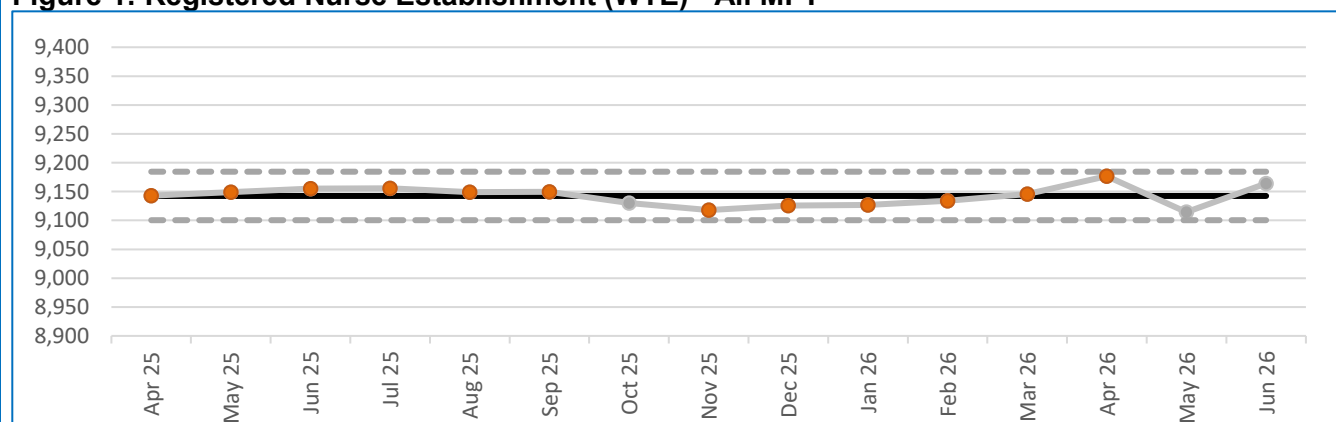
The potential worst-case impact on the annual wage bill, of band 5 colleagues being uplifted to band 6 as a result of the job profiles programme, could be an increase of between c£9.0m and c£12.3m. National funding to support pay uplift is yet to be confirmed by NHSE.

5. Achieving the set establishment

Registered Nursing

The registered nursing establishment for all roles band 5 and above in June 2026 is 9,163.8WTE (figure 1). The variance of -12.87WTE noted between since April 2026 and June 2026 is due to adjustments made by financial account teams to correct inaccuracies in financial budgets, and there has not been any impact on safer staffing establishments.

Figure 1: Registered Nurse Establishment (WTE) - All MFT

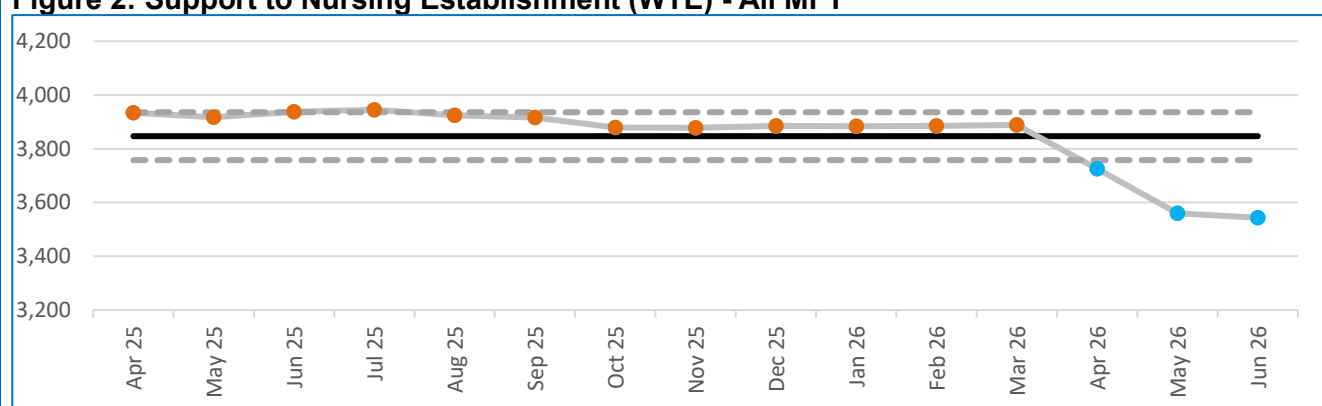


Support to Nursing

The current support to nursing establishment in June 2026 was 3543.7WTE (figure 2). Establishment has reduced by a total of -182.3WTE since April 2026. Within each Clinical Group reductions have been transacted due to non-nursing roles being identified in establishments and corrected by finance teams, this is part a wider exercise to improve the accuracy of establishment data in the ledger system to support the establishment control programme. A summary of these reductions by Clinical Group is provided below and include roles such as ward based housekeepers being re-aligned to facilities staff groups.

- CSS (-5.0WTE)
- LCOD (-23.0WTE)
- MRI (-55.3WTE)
- NMGH (-22.4WTE)
- SPEC (-49.6WTE)
- WTWA (-21.8WTE)

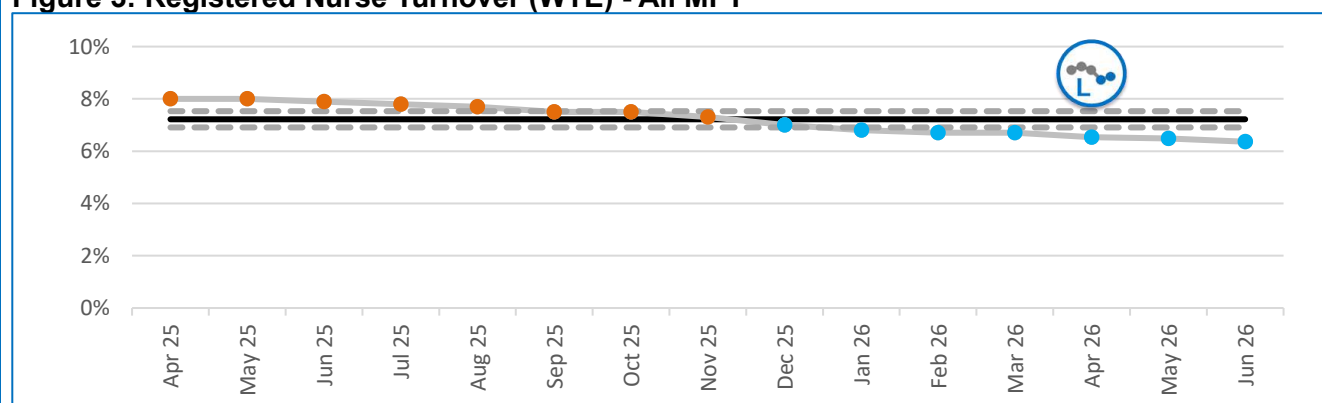
Figure 2: Support to Nursing Establishment (WTE) - All MFT



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 6.4% compared to the national turnover rate currently reported at 6.3%.

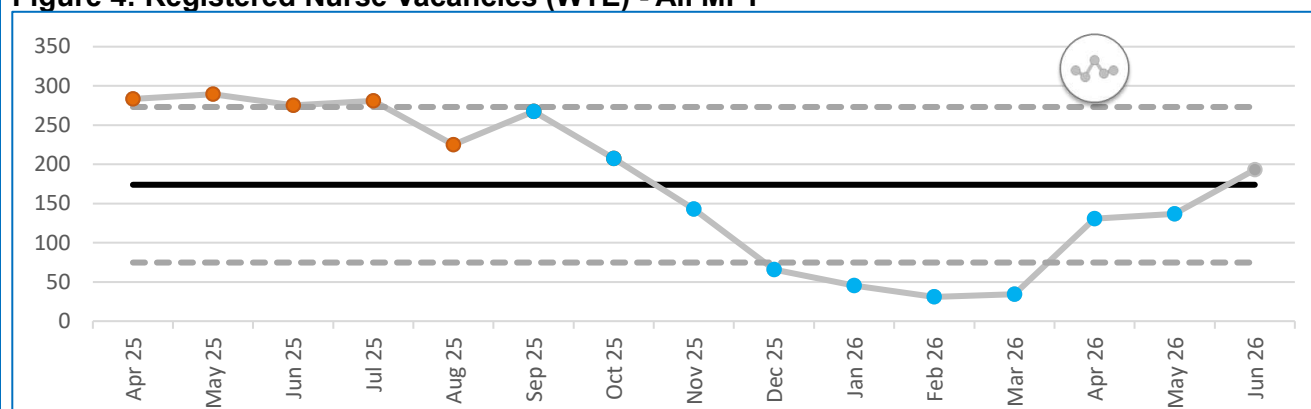
Figure 3: Registered Nurse Turnover (WTE) - All MFT



Registered nursing vacancies reduced to its lowest level in recent years in February and March 2026 following the 2 main graduate recruitment windows in Q3 and Q4 of 2026/27. Vacancies have increased overall to 193.1WTE (2.1%) in June 2026, and remains significantly less than the current national vacancy rate at 5.0%. This increase is attributed to posts being held for planned recruitment activity for band 5 graduates in quarter 3 2026/27 (Figure 4). Further detailed breakdown of current registered nursing

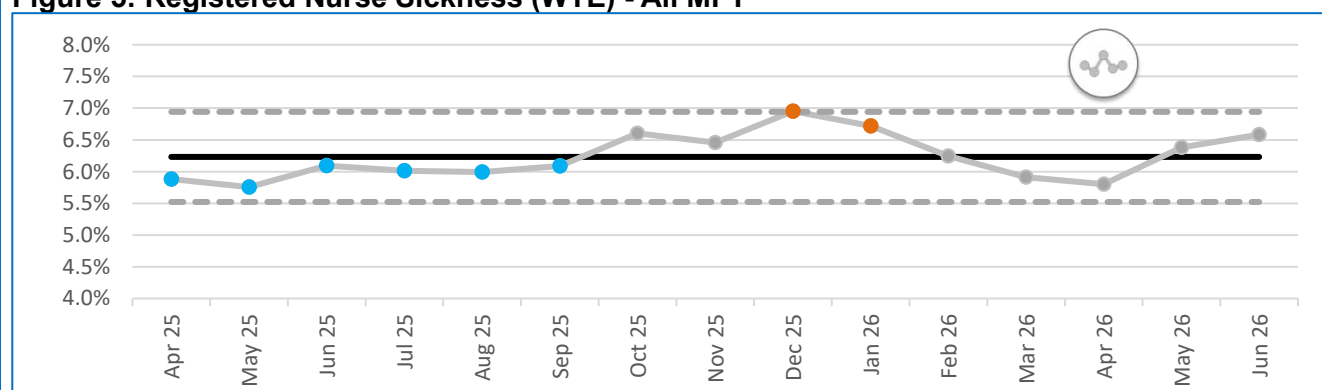
vacancies by Clinical Group and speciality can be found in Appendix C. Clinical Groups are progressing internal recruitment into band 6 positions to create a larger pool of band 5 vacancies for student nurses and nursing associates graduating in September 2026.

Figure 4: Registered Nurse Vacancies (WTE) - All MFT



Additional factors impacting the availability of registered nurses are sickness and maternity leave, which continues within a pattern of normal variation. (Figure 5). There is currently an unbudgeted pressure on nursing workforce due to maternity leave of 442.4WTE (4.6%). 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

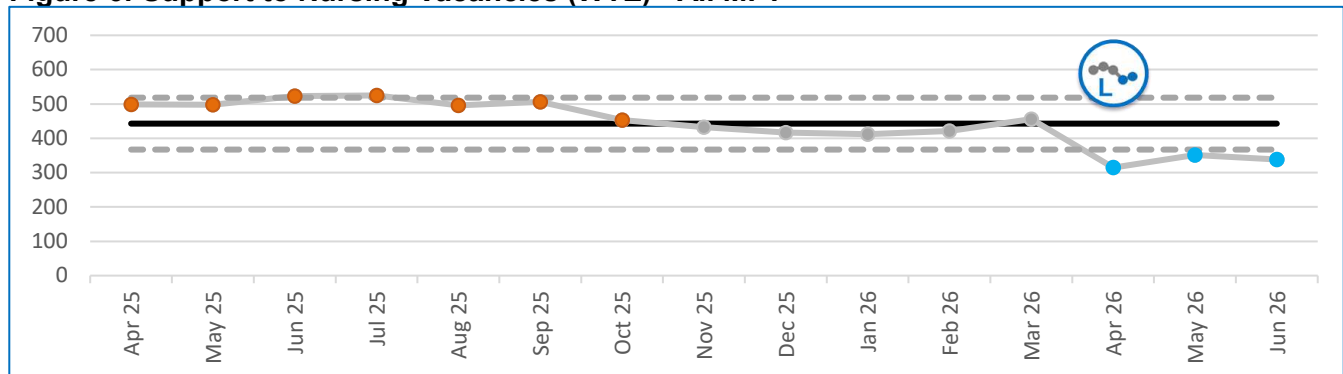


Support to Nursing

There has been a reduction in support to nursing vacancies down from a mean average for the year 2025/26 from 464WTE to 335WTE (9.6%) in June 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 recruitment pipeline for Quarter 2 remains positive, with 22 confirmed starters and a further 85 projected starters, supporting continued vacancy reduction over the coming months.

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 June 2026, the same as national average of 10.2%, and the rolling average sickness rate has reduced from of 10.2% in May 2025 to 8.1% in June 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 progressing local recruitment plans to attract and appoint nursing assistants. This work is supported by the Talent Attraction Team through a range of targeted approaches, including social media promotion, short videos featuring nursing assistants describing their roles, and engagement with community groups and colleges.

The first pilot cohort of the Nursing Assistant Apprenticeship programme commenced in February 2026. As part of the attraction campaign, the programme was advertised on the Find an Apprenticeship website and received more than 380 applications. Of these, 53 candidates (13%) met the entry criteria for the apprenticeship pathway and progressed to interview and a review of the advert and accompanying information has been reviewed to support prospective applicants. Interviews have been completed for MRI, WTWA and RMCH, resulting in 17 candidates being recruited to the apprenticeship pathway. In addition, 143 candidates were shortlisted for direct recruitment into nursing assistant roles. Interviews are progressing, with 39 candidates recruited to date from those interviewed at MRI, WTWA and RMCH.

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.

Following the successful completion of the pilot in March 2026, the Trust-wide rollout of the 1:1 conversations initiative commenced across all wards and departments during July 2026 through Clinical Groups a phased approach covering the Divisions of Medicine at NMGH and MRI, all Divisions at RMCH, and WTWA, with further expansion planned across the organisation.

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 86% in June 2026 against a target is 90%.

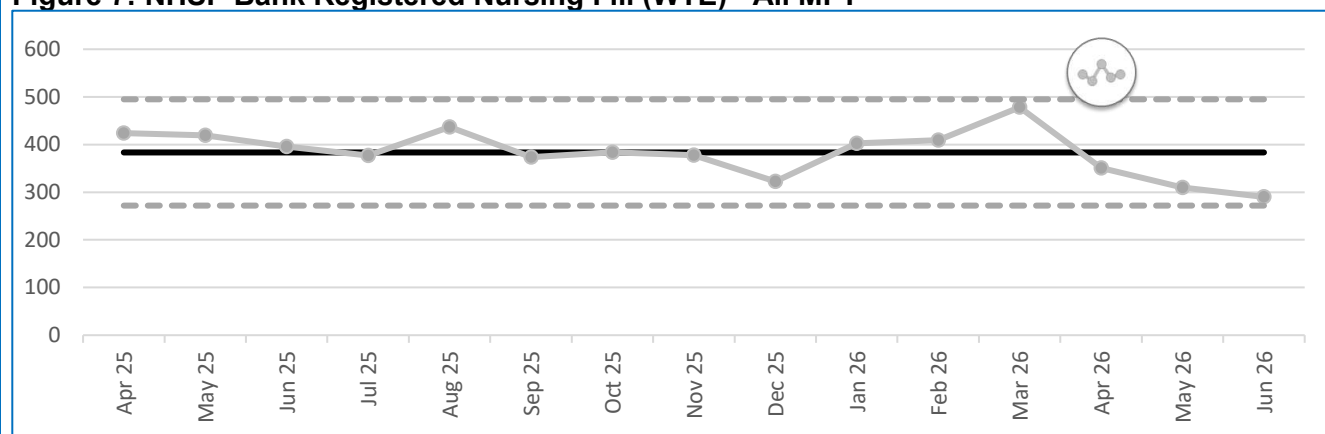
MRI Clinical Group commenced the first full implementation of SafeCare in July 2026 embedding the system within daily nurse staffing oversight processes. Following completion of the MRI implementation, the NMAHP Corporate Team will work with each Clinical Group to assess local implementation requirements and support the phased roll-out of full SafeCare functionality across the Trust.

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 88.1%. A further detailed overview of nursing NHSP bank fill can be found in Appendix D.

The volume of registered nursing filled shifts decreased for the last three months down to 290.1WTE in June 2026 (Figure 7). Fill rates for each individual Clinical Group are provided in appendix E.

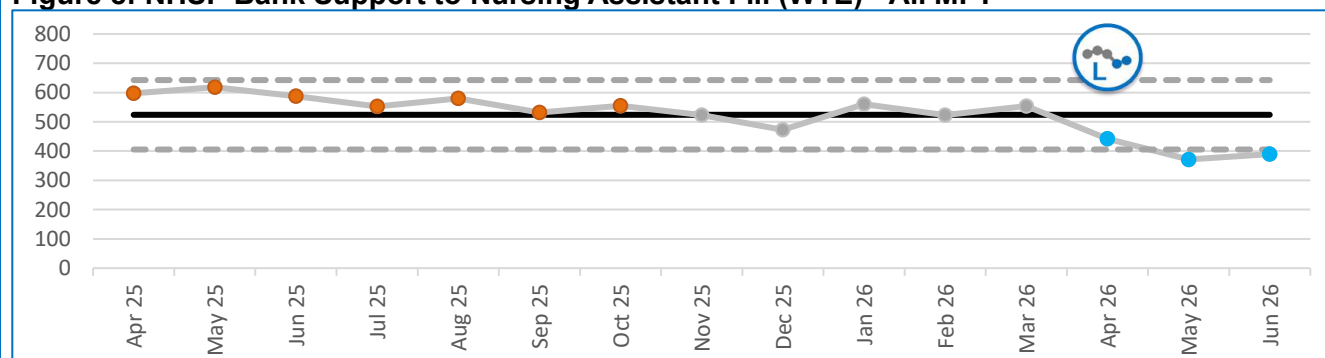
Figure 7: NHSP Bank Registered Nursing Fill (WTE) - All MFT



In the last two months, support to nursing usage has reduced by 52.4WTE (Figure 8). 19.7% 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



As mentioned in section 3 Quality Impact Assessments have been undertaken by all Clinical Groups and have demonstrated that the measures taken to reduce bank usage are not sustainable at current levels due to the impact on training provision and managerial activities, with appraisal rates reducing to 85.8% which is below the trust target of 95%. Managerial time for Ward / Team Managers is being gradually reintroduced, essential training is being prioritised, and the impact will be monitored.

Enhanced Therapeutic Observations and Care.

The Enhanced Therapeutic Observation and Care (ETOC) Improvement Programme continues aligned with the NHS England National ETOC Improvement Collaborative. The programme supports safe observation, effective risk management, and therapeutic care for patients, helping to reduce patient harm and associated staffing costs.

The research project to develop a validated screening tool has seen the completion of the first round of the Delphi survey, with strong engagement and valuable feedback received. Responses are currently being analysed, and specialist teams have supported the refinement of the questionnaire for the second survey round.

The content of clinical induction and face-to-face training, has now been standardised across MFT, providing a consistent approach to equipping staff with the knowledge and skills to assess patients, deliver therapeutic care, and effectively review and oversee ETOC. An e-learning module is also in development to further support consistent practice and provide ongoing access to training.

The new Ward Assurance Dashboard, developed with the HIVE team, is now live and provides real-time visibility of key metrics, including ETOC risk assessment compliance and senior nurse review compliance, strengthening assurance and governance processes.

Between the start of improvement programme from April 2025 to June 2026 the mean average of patients receiving ETOC per month reduced by 342 from 1393 to 1051 per month, which is a consequence of increased oversight and implementation of senior nurse review with some patients being stepped down from requiring ETOC by repeating the risk assessment alongside applying professional judgement.

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 from 178WTE to 139WTE per month. This equates to a cost saving of £130,373 per month. The reduction in bank usage in May and June 2026 coincides with the bank control measures implemented across Clinical Groups in combination with the reduction in patients requiring ETOC.

7. Fill rate

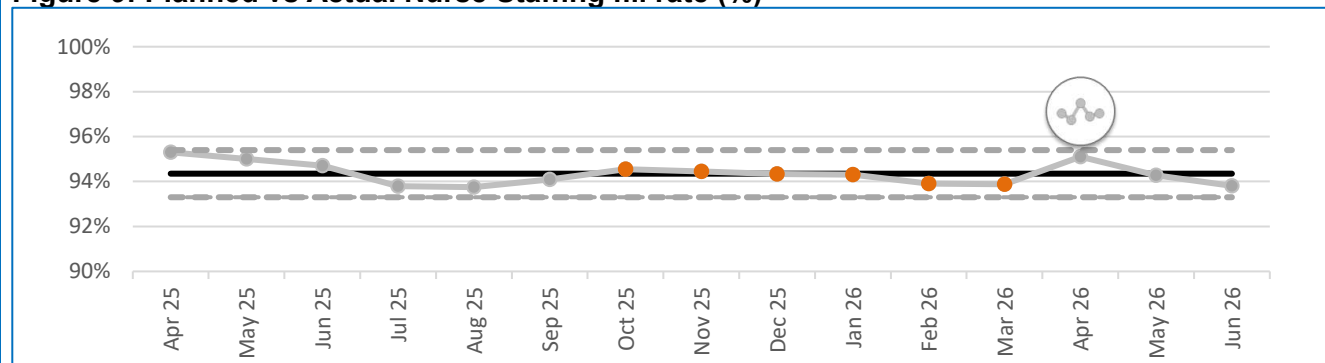
MFT is required to submit a monthly Safe Staffing Unify Report to NHS England detailing actual registered nurse staffing levels as a percentage against those that were planned. The fill rates are based on the budgeted bed base of each area and do not take account of any additional beds that are open 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 June 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)

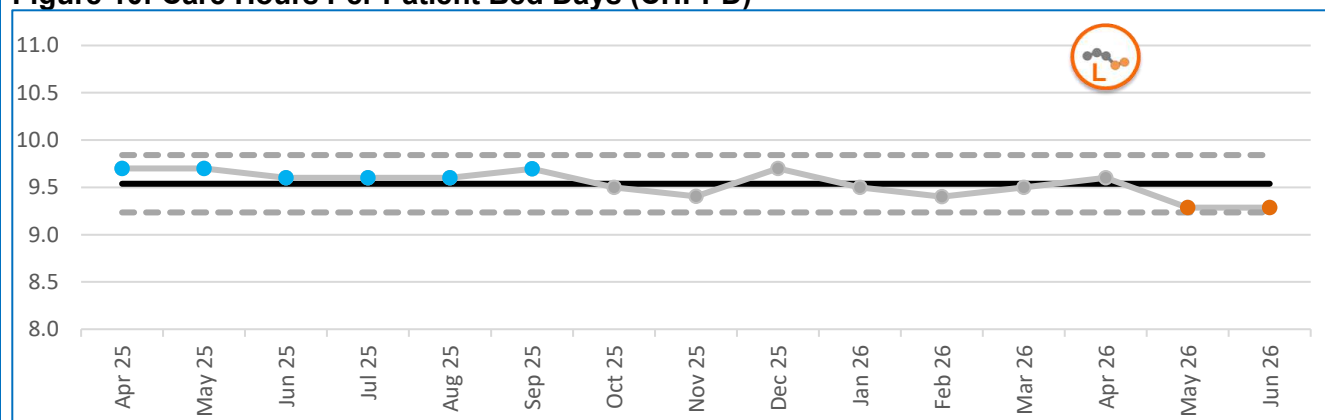
Care hours per patient day (CHPPD) is the principal measure of workforce deployment in ward-based settings since April 2016 and is calculated by taking all the shift hours worked over the 24 hours period by registered nurses and nursing assistants and dividing this by the number of patients occupying 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 standard for CHPPD, and 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 June 2026 was 9.3 against a Shelford Group rolling average of 9.8 hours. Reduction in CHPPD in May and June 2026 is associated with the reduction in temporary staffing usage.

Figure 10: Care Hours Per Patient Bed Days (CHPPD)



On further review of the latest available NHSE model hospital published data (April 2026), 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	11.3
Guy's and St Thomas' NHS Foundation Trust	11.3
Imperial College Healthcare NHS Trust	10.4
King's College Hospital NHS Foundation Trust	10.4
Oxford University Hospitals NHS Foundation Trust	9.9
Newcastle Upon Tyne Hospitals NHS Foundation Trust	9.8
Manchester University NHS Foundation Trust	9.6
Cambridge University Hospitals NHS Foundation Trust	9.1
University Hospitals Birmingham NHS Foundation Trust	8.7
Sheffield Teaching Hospitals NHS Foundation Trust	8.1

9. Safe Staffing Incidents

During May and June 2026, a total of 310 and 283 incidents respectively were reported where colleagues have indicated that staffing was a factor. The majority of incidents that were related to staffing were recorded as no harm (80.9%), and the appropriate actions were taken at the time following local investigation (Table 2).

Table 2 – Safe Staffing Incidents

Incident Actual Impact	May 2026	June 2026
Level 1 – No harm	256	224
Level 2 – Low Harm	54	59
Overall	310	283

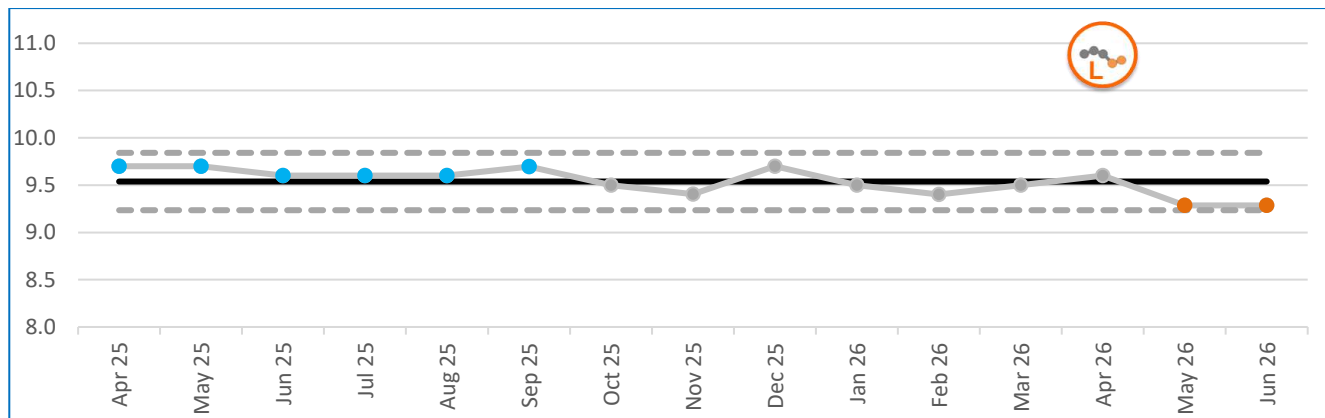
Pressure Ulcers

There were 24 attributable Category 3 and 4 pressure ulcers reported in May 2026 and, following validation, staffing was not identified as a direct or contributory factor.

The majority (21) were reported in the Community, with a proportion of reported cases relating to pressure ulcers that were present on referral to the service or identified during initial assessment visits.

The single incident reported at WTWA was classified as low harm, as the patient was admitted to the Emergency Department with a pre-existing Category 4 pressure ulcer. The two incidents at MRI were

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The single incident reported at WTWA was classified as low harm, as the patient was admitted to the Emergency Department with a pre-existing Category 4 pressure ulcer. The two incidents at MRI were 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.

10.2 Proposed MFT Approach to Reporting AHP Safer Staffing

Bi-annual establishment and skill mix review

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. A working group has been established by the Chief AHP to develop 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 will include a phased approach with implementation of areas where safer staffing standards / guidance currently exists, eg. Critical Care, Stroke serviced, to commence in quarter 4 2026/27.

Job planning and deployment

Job planning, templates, and e-rostering systems are already in place. 98% of registered AHPs are registered on the job planning system and of those 52% (932/1,776) have a fully signed off job plan indicating that job plans 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 Direct Clinical Contact (DCC) and Supporting Professional Activity (SPA) which includes education, research and management time, alongside quality outputs, so assurance extends beyond workforce numbers to demonstrate impact on patient care, outcomes, and service sustainability. This will be overseen by the AHPs Deliver programme with final recommendations to be presented in January 2027.

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. The metrics included in section 10.3 are now available in the dashboard. 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 feedback discrepancies to the corporate workforce team to maintain accuracy.

10.3 Current MFT AHP Establishment

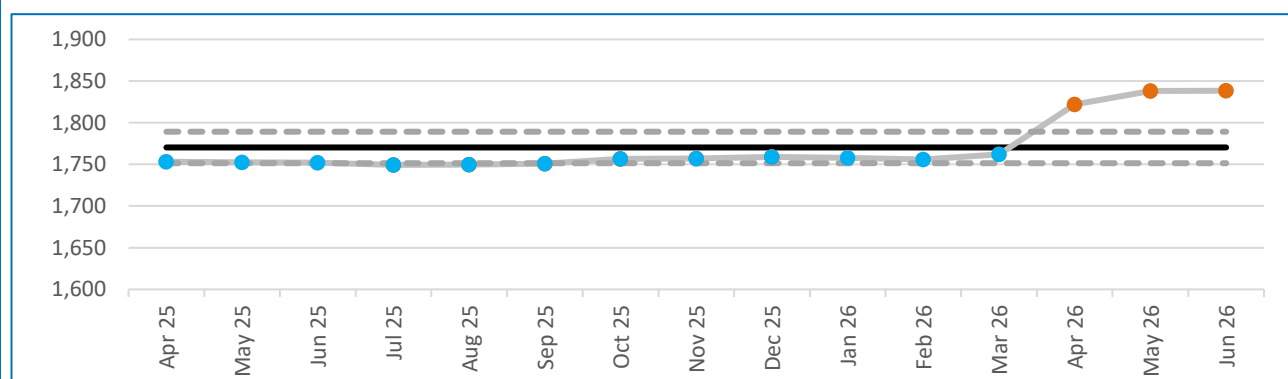
Registered AHP

The current registered allied health professional establishment WTE for roles band 5 and above in June 2026 is 1,838.4WTE (figure 15). The increase by 76WTE in total establishment is due to a range of factors across majority of Clinical Groups, with the main areas of increase itemised below.

- Increases in CSS imaging division (34WTE) to support reduction in reliance of premium overtime spend.
- Increases in CSS AHP therapies division (11WTE) due to reconciliation of budget changes at the later end of 25/26, changes arising from One MFT AHP structure in Q3 2025/26 and a wholesale review of budget alignment across the division.

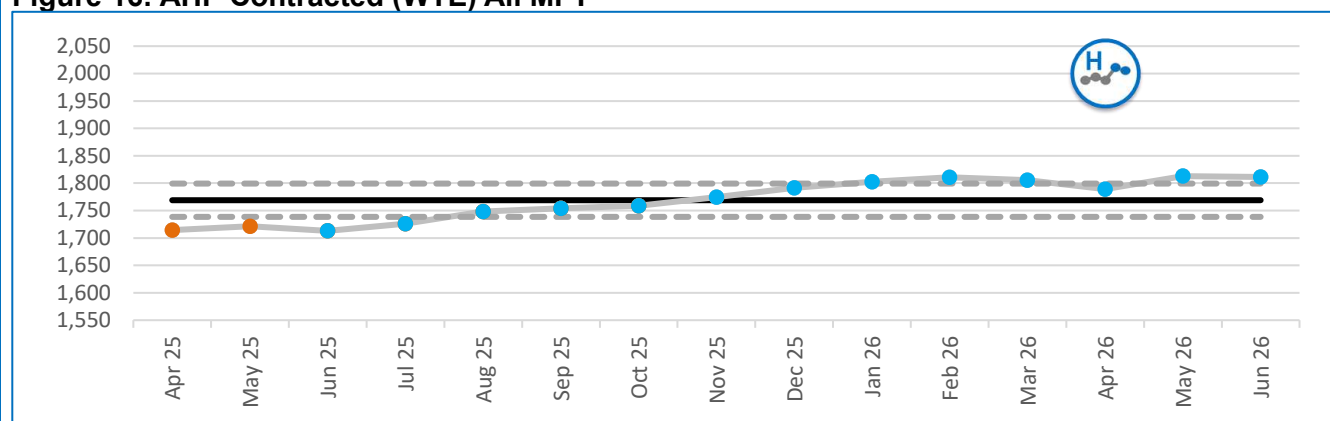
- Increase in Specialist Hospital CAHMS services (8WTE) due to introduction of 2 additional roles and recategorisation of AHP colleagues who have previously been incorrectly identified as psychologists (Non-AHP)
- Increase in Corporate Services (10WTE) due to recategorisation of AHP colleagues who have previously been incorrectly identified in non-AHP roles.

Figure 15: AHP Establishment (WTE) All MFT



The current registered allied health professional contracted WTE for roles band 5 and above in June 2026 was 1811.2WTE (figure 16). There has been an increase of 21.9WTE in the last two months following successful recruitment.

Figure 16: AHP Contracted (WTE) All MFT



Increases in establishment offset by an increase in contracted WTE have maintained the vacancy position in the last two months. In June 2026 there were 27.2WTE AHP vacancies at Trust level (figure 17). Within AHP services there are several professions with higher levels of vacancies most notably in radiography and occupational therapy, with a full breakdown by profession shown in table 3. CSS CG divisional teams are monitoring the vacancy position and associated variable pay pressure, and there are currently 15.0WTE radiographers and 2.0 occupational therapists in the recruitment pipeline with agreed or provisional start date. In contrast some roles are currently over established. Further details and breakdown of registered AHP vacancies by Clinical Group can be found in Appendix G.

Figure 17: AHP vacancies (WTE) All MFT

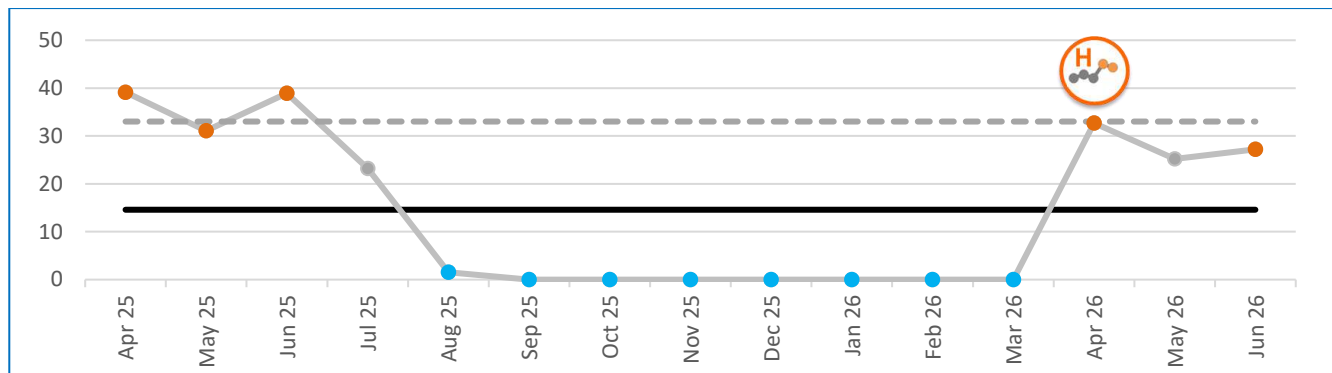


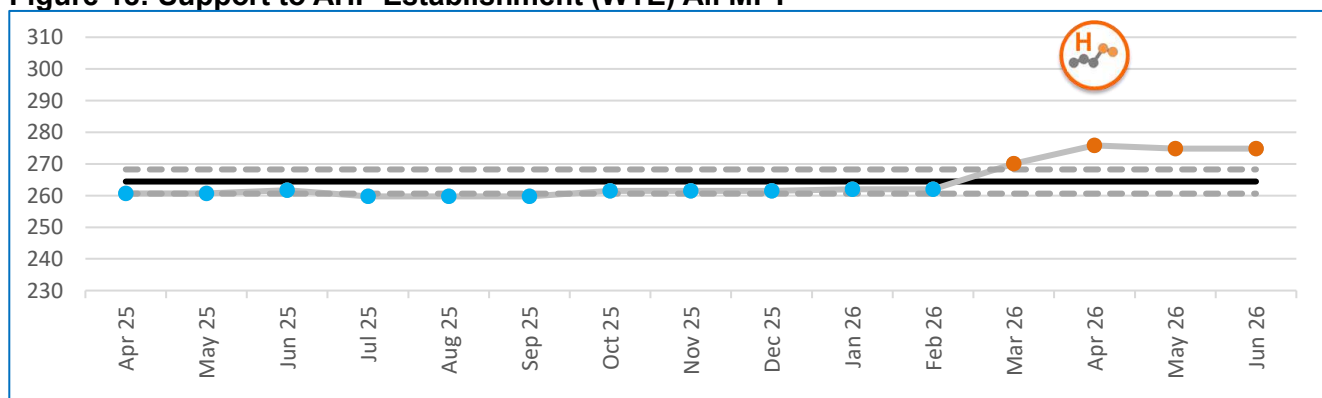
Table 3: AHP Vacancies by Profession – All MFT – June 2026

AHP Profession	Establishment WTE	Contracted WTE	Vacancies WTE
AHP General	35.33	37.82	-2.49
Chiroprody	67.14	63.08	4.06
Dietetics	141.15	144.12	-2.97
Occupational Health	306.25	287.71	18.54
Orthoptics	31.36	29.62	1.74
Physiotherapy	611.32	630.57	-19.25
Radiography	475.5	444.18	31.32
SALT	170.37	174.13	-3.76

Support to AHP

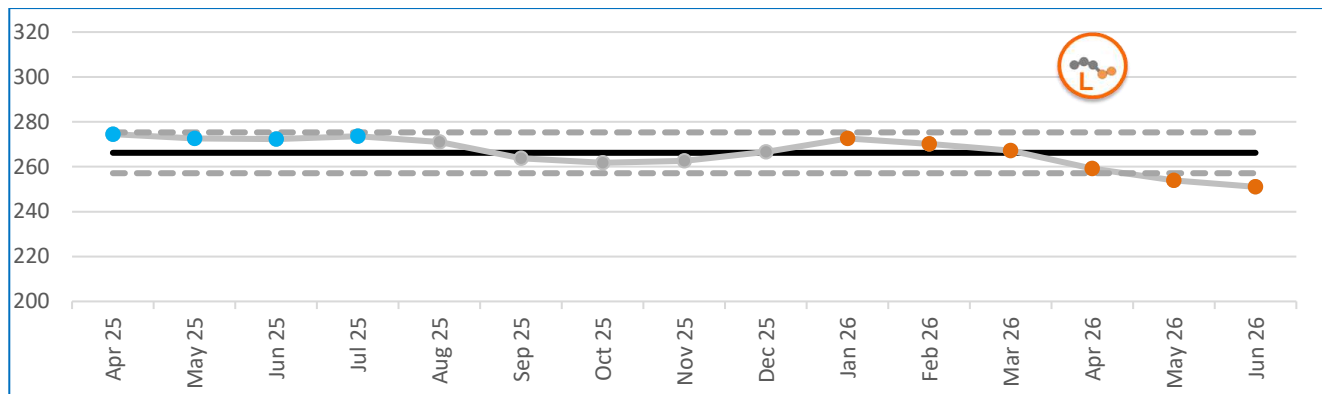
The current support to AHP establishment in June 2026 was 275.8WTE (figure 18). Establishment has remained within standard variation since April 2026 following an overall increase of 11WTE. Increase in establishment are in Support to Radiography roles in CSS imaging division to support the reduction in reliance of premium overtime spend.

Figure 18: Support to AHP Establishment (WTE) All MFT



The current support to AHP contracted WTE in June 2026 was 251.1WTE (figure 19). There has been a decrease of 8.2WTE in the last two months.

Figure 19: Support to AHP Contracted (WTE) All MFT



Recruitment into the increase in establishment shown in figure 18 has not been completed resulting in an increase in the vacancy position to 23.8WTE (figure 20), the current pipeline is not sufficient to fulfil these vacancies. A breakdown by AHP service is provided in table 4 and by Clinical Group can be found in Appendix G.

Figure 20: Support to AHP vacancies (WTE) All MFT

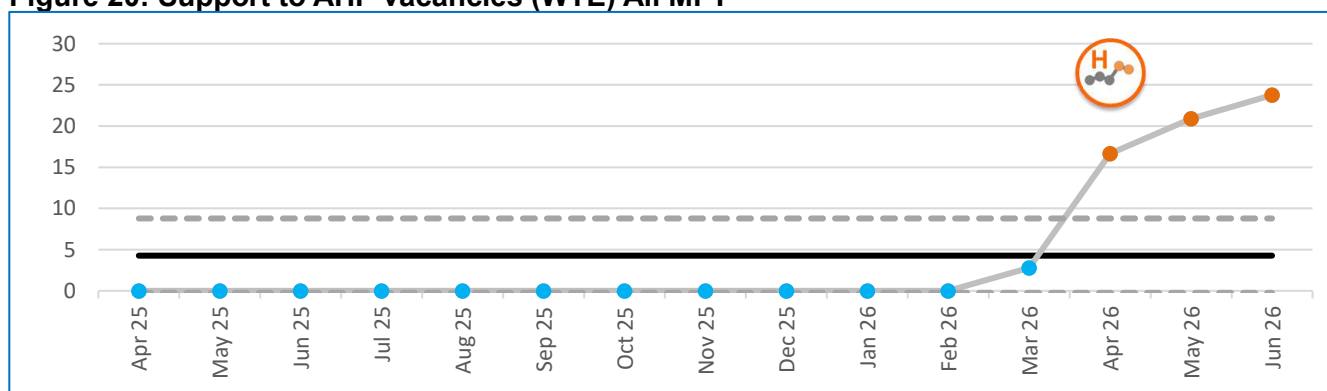


Table 4: Support to AHP Vacancies by Profession Type – All MFT – June 2026

AHP Profession	Establishment WTE	Contracted WTE	Vacancies WTE
Chiropody	5.17	2.37	2.80
Dietetics	17.99	18.04	-0.05
Occupational Health	31.21	29.17	2.04
Orthoptics	1.00	1.00	0.00
Physiotherapy	103.11	97.86	5.25
Radiography	93.88	78.56	15.32
SALT	22.45	24.05	-1.60

AHP Staffing Escalation and Managing Shortfalls against Current Establishment

AHP staffing levels are actively monitored across Clinical Groups, with risks identified in key services including adult and paediatric dietetics (particularly acute dietetics at WTTA), critical care (below GPICS standards), stroke services (below SSNAAP 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 with Divisional oversight to ensure risks are identified and immediate mitigations are implemented. 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.

10.4 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 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.

10.4.1 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.

11. Recommendations

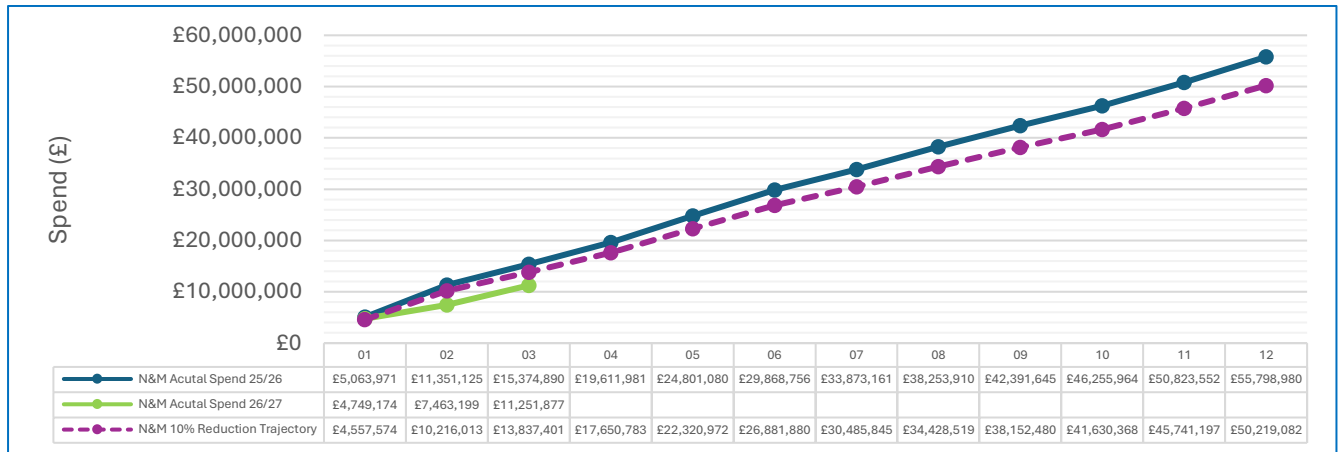
The Trust Board of Directors is asked to:

- Receive this report and note that Nursing and AHP services across MFT remain 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 25th August 2026.
- Receive assurance of safe nurse staffing as described in sections 5, 6, 7, 8 and 9.
- Note that at the end of June 2026, nursing bank spend was 26.8% (£4.1m) lower than 2025/26 YTD, against the NHSE target of 10%.

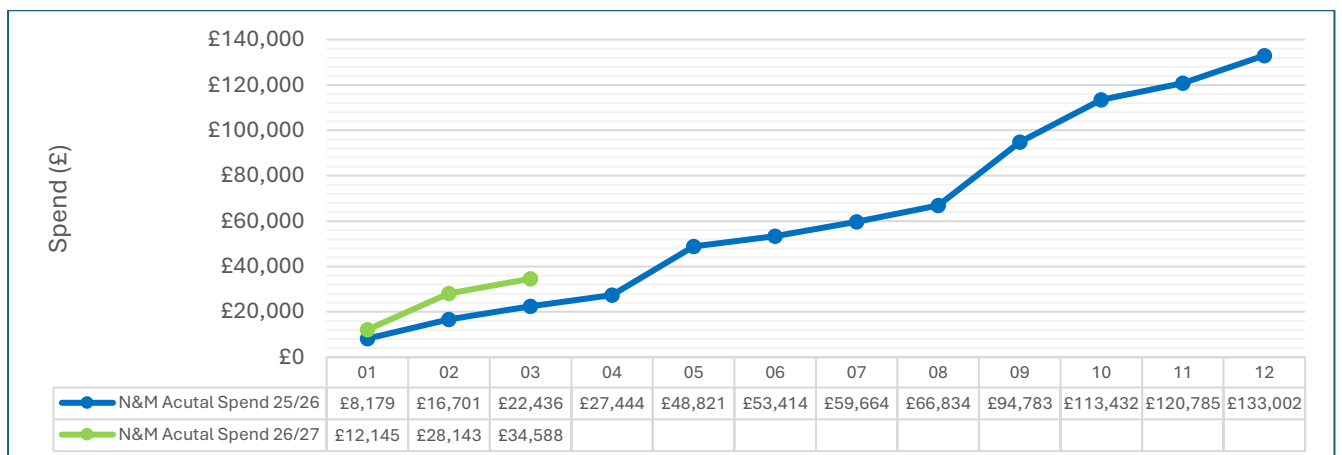
Note the risk of between c£9m and c£12.3m increase in the annual pay bill as a consequence of the review of band 5 job descriptions taking place during 2026/27.

Appendix A

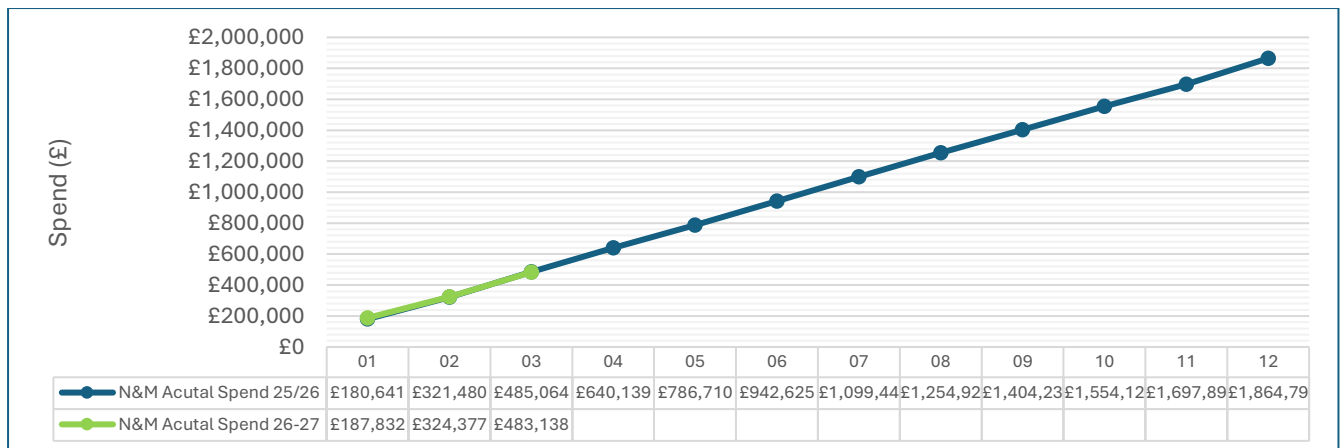
Nursing and Midwifery bank reduction 26/27 compared to 25/26 (£ spend)



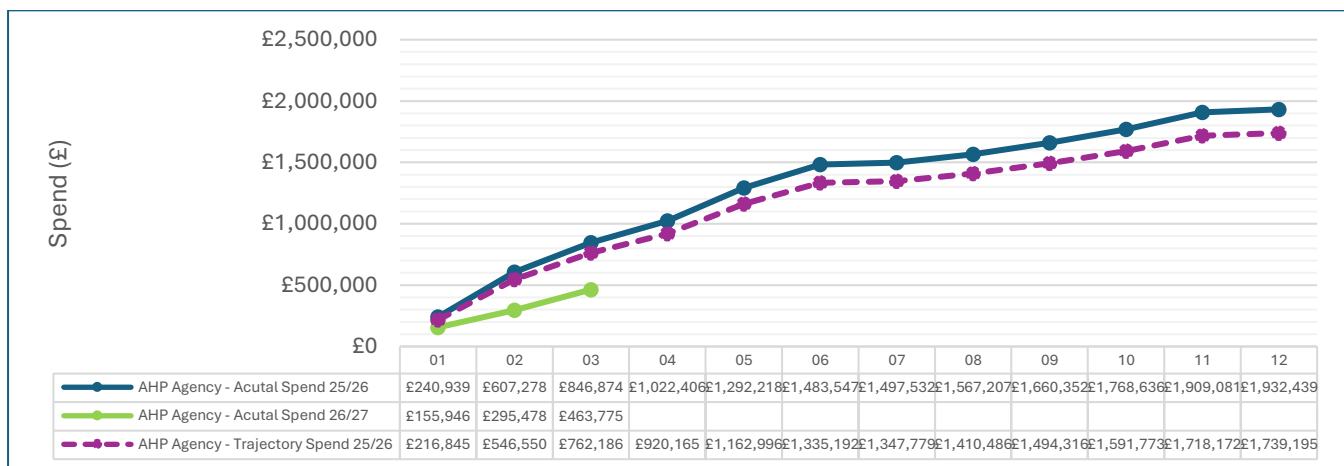
Nursing and Midwifery Premium Overtime spend (£ spend) All MFT



AHP Premium Overtime Spend (£ spend) All MFT



AHP Agency Spend reduction 26/27 compared to 25/26 (£ spend)



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

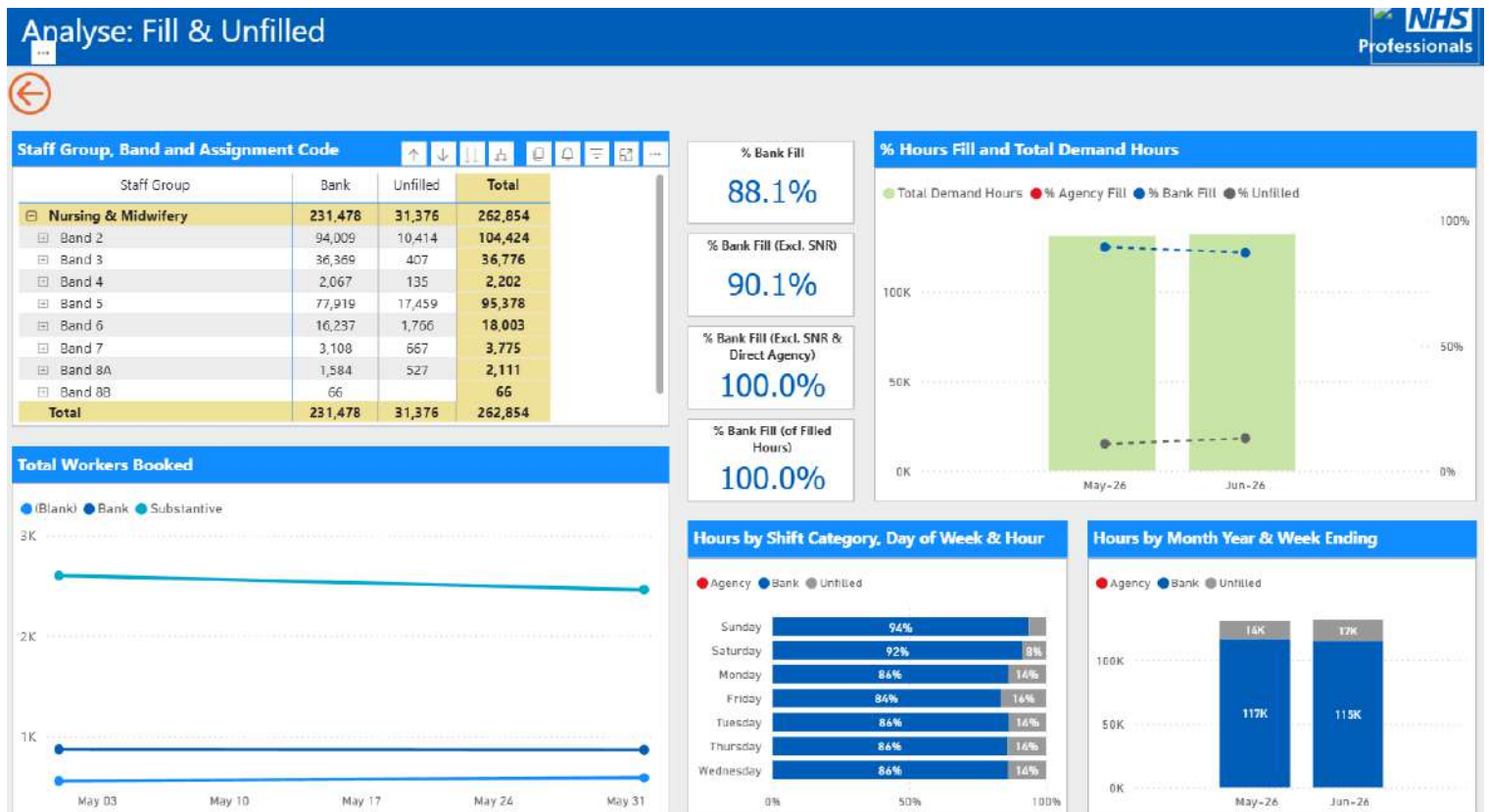
Registered Nursing - Workforce Metrics by Clinical Group (June 2026)

Clinical Group	Establishment (WTE)	Contracted (WTE)	Vacancies (WTE)	Vacancy Rate %	Turnover %	Maternity Leave %	Sickness %
CSS	1010.44	1010.91	0	0.0%	6.3%	4.4%	6.9%
LCOD	1146.37	1078.9	67.47	5.9%	8.1%	3.1%	8.5%
MRI	1744.52	1667.13	77.39	4.4%	4.8%	5.4%	6.3%
NMGH	861.1	847.03	14.07	1.6%	5.2%	5.5%	6.2%
SPEC	1977.5	1935.88	41.62	2.1%	6.9%	4.7%	6.1%
WTWA	1875.38	1896.2	0	0.0%	5.7%	4.9%	5.9%

Support to Nursing - Workforce Metrics by Clinical Group (June 2026)

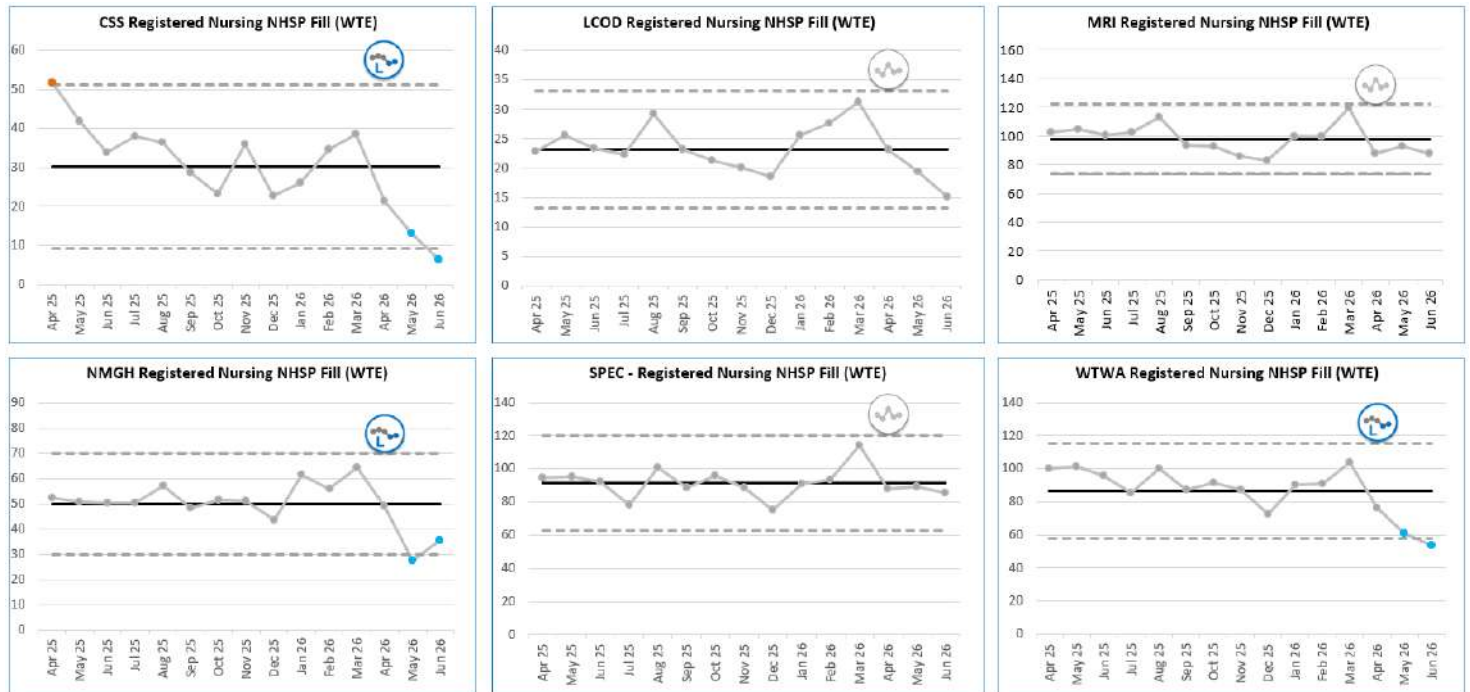
Clinical Group	Establishment (WTE)	Contracted (WTE)	Vacancies (WTE)	Vacancy Rate %	Turnover %	Maternity Leave %	Sickness %
CSS	86.26	81.6	4.66	5.4%			
LCOD	496.74	433.27	63.47	12.8%			
MRI	843.38	773.46	69.92	8.3%			
NMGH	583.24	548.69	34.55	5.9%			
SPE	525.92	448.41	77.51	14.7%			
WTWA	929.75	843.55	86.2	9.3%			

Appendix D - NHSP Fill Overview – Nursing



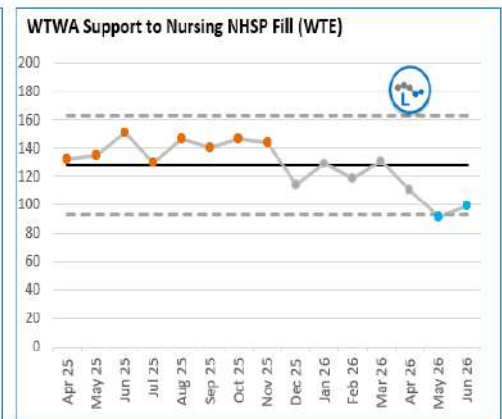
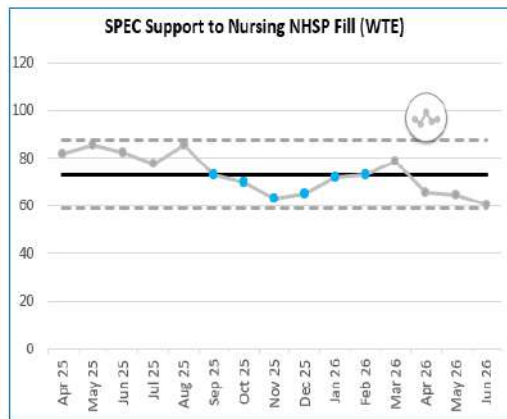
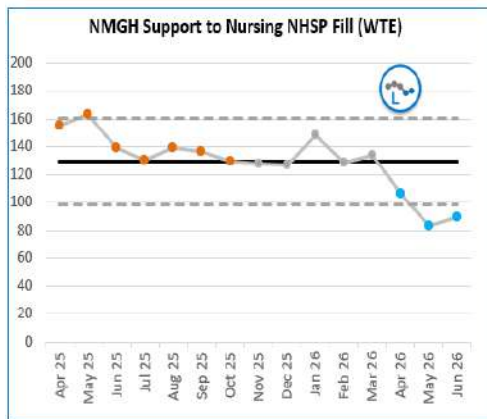
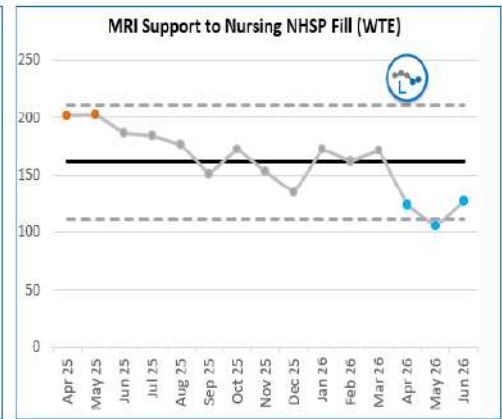
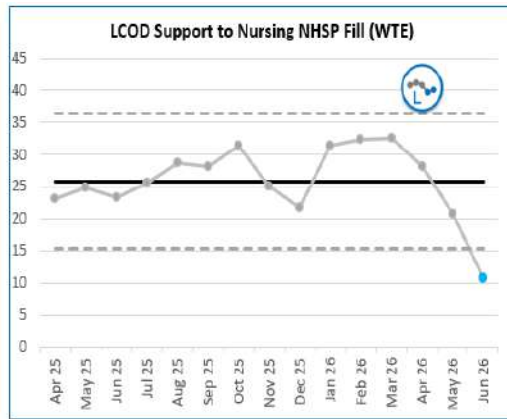
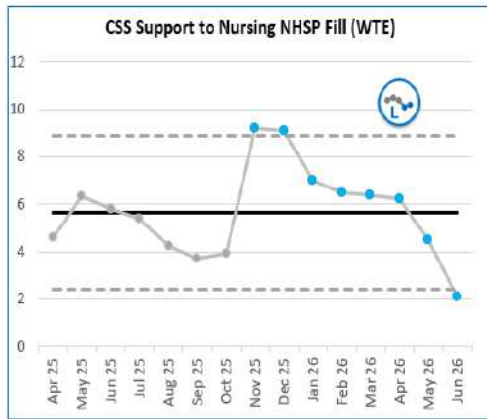
Appendix E

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 (June 2026)

Clinical Group	Establishment (WTE)	Contracted (WTE)	Vacancies (WTE)	Vacancy Rate %	Turnover %	Maternity Leave %	Sickness %
CSS	1130.87	1110.63	20.24	1.8%	8.0%	4.5%	3.9%
CSS AHP	656.67	667.75	0	0.0%	8.9%	4.6%	3.1%
CSS Imaging	468	440.08	27.92	6.0%	6.6%	4.4%	5.1%
LCOD	560.04	556.22	3.82	0.7%	6.0%	3.7%	5.2%
MRI	13.33	15.33	0	0.0%	5.8%	1.3%	4.4%
NMGH	4.95	4.08	0.87	17.6%	2.9%	0.0%	6.1%
SPEC	55.19	52.53	2.66	4.8%	6.1%	2.8%	4.1%
WTWA	58.93	55.86	3.07	5.2%	5.8%	3.3%	3.7%

Support to AHP - Workforce Metrics by Clinical Group (June 2026)

Clinical Group	Establishment (WTE)	Contracted (WTE)	Vacancies (WTE)	Vacancy Rate %	Turnover %	Maternity Leave %	Sickness %
CSS	186.88	167.59	19.29	10.3%			
CSS AHP	93.00	89.03	3.97	4.3%			
CSS Imaging	93.88	78.56	15.32	16.3%			
LCOD	79.32	71.86	7.46	9.4%			
MRI	0.00	0.00	0.00	0.0%			
NMGH	4.00	3.60	0.40	10.0%			
SPE	1.00	5.60	0.00	0.0%			
WTWA	3.61	2.40	1.21	33.5%			

Appendix H

Theatre and Critical Care Vacancy Position – June 2026

Theatre Vacancies by Clinical Group and Staff Type

Staff Type	Clinical Group				
	MRI	NMGH	SPEC	WTWA	TESH
REGISTERED NURSING	-8.04	1.71	4.13	-4.27	-2.8
RN Only	-8.2	2.71	4.91	8.92	-4.3
ODP Only	0.16	-1	-0.78	-13.19	1.5

Critical Care Nursing Vacancies by Clinical Group and Staff Type

Staff Type	Clinical Group
	CSS
REGISTERED NURSING	0.0

Public Board of Directors

Wednesday, 30 September 2026

Paper Title:	Medical Appraisal and Revalidation and Annual Statement of Compliance	Agenda Item 12.3
Presented by:	Professor Matt Makin, Interim Joint Chief Medical Officer	
Prepared by:	Cameron Chandler, Head of CMO Programmes	
Meetings where content has been discussed previously	People Board Committee - 25 August 2026	
Purpose of the paper Please check <u>one</u> box only:	☒ For approval ☐ For discussion	☐ For support ☐ For noting

Executive summary / key messages for the meeting to consider

Revalidation is the process by which all licensed doctors are required to demonstrate, on a regular basis, that they are up to date and fit to practise in their chosen field and able to provide an appropriate standard of care. The process of revalidation seeks to give extra confidence to patients, the public and the profession that a doctor is being regularly checked by both their employer and the General Medical Council (GMC). Licensed doctors must revalidate usually every five years, part of which is the requirement to have an annual appraisal based on the GMC's Good Medical Practice framework. The revalidation process is based on a recommendation from the Responsible Officer to the GMC, the regulator making the final decision about revalidating a doctor. As part of the revalidation process, all doctors must ensure that they undergo appraisal within each financial year and are responsible for the continuous collection of their portfolio of evidence covering their full scope of practice. Continued engagement with appraisal by GMC registered clinicians is necessary over the course of the five-year revalidation cycle.

Summary of key points:

- at the end of the last appraisal year (01 April 2025 – 31 March 2026), MFT had 2,914 doctors with a prescribed connection plus an additional 89 General Dental Council only dentists requiring an MFT appraisal
- 97.0% of connected doctors had an appraisal for the 2025/26 appraisal year
- appraisers were rated as 'Very Good' or 'Good' by 98.3% of appraisees who submitted feedback
- the process for allocating appraisers by Clinical Groups requires significant improvement in ownership and timeliness
- the Trust has been instructed to submit a signed Statement of Compliance to NHS England for 2025/26

Recommendation(s)

The Board of Directors is asked to:

- note the contents of this paper, progress made to date, challenges to be faced in the coming year and improvement plans
- note the requirement to approve submission of the Annual Statement of Compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013), signed on behalf of the designated body by the Trust Chief Executive Officer

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 the 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 within this report links to the following strategic, corporate, or operational risks:

-

Care Quality Commission domains

Please check **all** that apply

☐ Safe

☐ Caring

☐ Effective

☒ Well-Led

☐ Responsive

Compliance & Regulatory Implications

The following compliance and regulatory implications have been identified as a result of the work outlined in the report:

- n/a

Main report

Background

Revalidation was formally launched in the UK in January 2013 and is the process by which all licensed doctors are required to demonstrate, on a regular basis, that they are up to date and fit to practise in their chosen field and able to provide an appropriate standard of care. The process of revalidation seeks to give extra confidence to patients, the public and the profession that a doctor is being regularly checked by both their employer and the General Medical Council (GMC). Licensed doctors must revalidate usually every five years, part of which is the requirement to have an annual appraisal based on the GMC's Good Medical Practice framework. The Trust's appraisal and revalidation process is managed operationally by the team of the Responsible Officer (RO); a role established in statutory legislation and currently undertaken by Professor Bernard Clarke. The RO role is supported by Dr Emma Hurley, Associate Chief Medical Officer for Appraisal and Revalidation, in addition to the Deputy Associate Chief Medical Officer, Head of CMO Programmes, and the revalidation administration team.

The revalidation process is based on a recommendation from the RO to the GMC, the regulator making the final decision about revalidating a doctor. In order to make this recommendation, the RO must be assured that:

- the doctor has a track record of engagement with annual appraisals consistent with the guidance on strengthened medical appraisal and has been appraised on the full scope of their practice (including in the independent sector) at a single appraisal meeting
- any concerns about the doctor raised through the appraisal have been brought to the attention of the relevant medical line manager and successfully addressed
- the doctor has undertaken a multisource feedback evaluation of their work and professional behaviour, including feedback from both colleagues and patients, and that this has been discussed with their appraiser (one formal multisource feedback per five-year revalidation cycle)
- there are no outstanding concerns about the doctor's performance or professional conduct known to the Trust

Options available to the RO are to recommend revalidation, defer the recommendation for a period of up to 12 months (either due to insufficient information for a positive recommendation or because the doctor is subject to an ongoing process), or to notify the GMC of the doctor's non-engagement with the process.

Designated body

Manchester University NHS Foundation Trust is a designed body, as established in the Responsible Officer regulations; this also determines which doctors should be connected to the Trust for appraisal and revalidation. On 31 March 2026 (the end of the appraisal year), 2,914 doctors were connected; 1,743 consultant, 144 SAS grade doctors, 1,014 temporary and short-term contract holders (including clinical fellows and bank doctors), and 13 other doctors (such as

clinical trial physicians). There was an increase on the previous year of 157, primarily consisting of Clinical Fellows and consultants.

Doctors who work jointly within the Trust and the University of Manchester in an academic position are required to undergo a joint appraisal under the Follett Principles. These doctors connect to the Trust for revalidation. Additional doctors who work for the Trust, who are not connected for appraisal and revalidation, include GPs (who connected to one of the NHS England local teams), and doctors who undertake work at MFT but also with another NHS organisation, who is their main employer and designated body. Despite not connecting directly with these doctors, the Trust still has an obligation to monitor their fitness to practise and report any concerns to the doctor's RO. Doctors in a training grade are appraised and revalidated separately by NHSE Education.

Revalidation

For the appraisal year 01 April 2025 – 31 March 2026, 239 revalidation submissions were made. Of the doctors due, 202 doctors were recommended for revalidation, 37 doctors were deferred due to insufficient information and five due to involvement in an ongoing process. No submissions of non-engagement were made for the period. All of the recommendations were approved by the GMC. For the year April 2026 – March 2027, 639 doctors are due for revalidation.

Designated Body	Revalidated	Deferred: insufficient information	Deferred: ongoing process	Non-engagement	Late submissions
All DBs (England)	87.9%	11.3%	0.6%	0.2%	1.6%
All NHS Acute Trusts	79.9%	18.9%	1.0%	0.2%	3.9%
MFT	84.5%	13.4%	2.1%	0.0%	0.0%

Revalidations by submission approved date (01.04.25 – 31.03.26)

For those deferred due a lack of sufficient information, the primary reason is no longer the absence of patient feedback and the deferrals submitted for this reason have greatly decreased from previous years. The below shows the reasons for deferrals (note a doctor can have multiple reasons for deferral):

Reasons for Deferral	No. of Deferrals
QIA	20
Appraisal activity	19
Patient feedback	18
CPD	16
Colleague feedback	13
Compliments and complaints	10
Interruption to practice	10

Significant events	7
--------------------	---

Appraisal

All doctors must ensure that they undergo appraisal within each financial year and are responsible for the continuous collection of their portfolio of evidence covering their full scope of practice. For medical staff who are registered with the GMC as well as the General Dental Council, continued engagement with appraisal is necessary over the course of the five-year revalidation cycle.

On 31 March 2026, 2,914 connected doctors were due to have an appraisal within year (01 April – 31 March).

Group	Connected	Completed appraisal	Approved incomplete or missed appraisal	Unapproved incomplete or missed appraisal
Consultants	1,743	1,703 (97.7%)	39 (2.2%)	1 (0.1%)
SAS	144	140 (97.2%)	4 (2.8%)	0 (0%)
Temporary or short-term contract holders	1,014	973 (96.0%)	41 (4.0%)	0 (0%)
Other (e.g. Clinical Trials Physicians)	13	13 (100%)	0 (0.0%)	0 (0.0%)
Total	2,914	2,829 (97.1%)	84 (2.9%)	1 (0.03%)

Whilst the majority of appraisals have been completed, it should be noted that a large number of these were held late; the importance of maintaining a regular appraisal month each year is communicated to those undertaking a late appraisal as it allows for appraisals to be held evenly throughout the year and prevent overrun after the end of March. Overdue appraisals are being more proactively managed this year with formal escalation processes in place.

Approved missed appraisals

For those who have been granted an approved missed appraisal for the year, the following reasons apply:

Reason	Count
Maternity leave	26
New to the UK	23
Long term sickness	20

Career break	7
Due to retire	4
Not previously connected	4
Total	84

Unapproved missed appraisals

The one unapproved missed appraisal is currently part of an ongoing process which is being handled by the Clinical Group Medical Director.

Appraisers

The Trust has a responsibility to support appraisers in the maintenance and development of their skills, to assure the quality of medical appraisals, and to ensure that appropriate resources are available to support this. Those who undertake medical appraisals for the Trust must be adequately trained in this role. Refresher training should be undertaken every three years, with these sessions held virtually, facilitated by the Associate Chief Medical Officer. On 01 August 2026, 837 of the 844 appraisers are currently in date with training. The seven not currently compliant have been written to confirm if they wish to book onto a training session or come off the appraiser list if not; if there is no reply or training is not undertaken then they will be removed as an appraiser.

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
The objectives were clearly defined	64%	34%	2%	0%	0%
Participation and interaction were encouraged	77%	22%	0%	0%	0%
The topics covered were relevant	67%	30%	3%	0%	0%
The content was organised and easy to follow	60%	37%	2%	0%	0%
This training will be useful in my work	61%	38%	1%	0%	0%
The trainer was knowledgeable about the training topics	82%	18%	0%	0%	0%
The trainer was well prepared	82%	18%	0%	0%	0%
The training objectives were met	62%	35%	3%	0%	0%
The time allotted for the training was sufficient	46%	38%	10%	5%	0%

Appraiser training feedback (April 2025 – March 2026)

Appraisee feedback

Following each completed appraisal, appraisees are asked to submit feedback regarding their appraisal, appraiser, and the overall process. For the last appraisal year, a total of 2,194 feedback responses were received; individual reports for each appraiser are collated and added to their appraisal portfolios for discussion at their own appraisal. Of the responses received:

- 83.3% rated their appraiser overall as 'Very Good' and a further 15.0% as 'Good'
- 70.8% 'Strongly Agreed' that their appraisal discussion was important in their professional development and a further 23.0% 'Agreed'
- 65.3% 'Strongly Agreed' that the overall administration of their appraisal had been satisfactory and 28.9% 'Agreed'

Feedback about the individual appraisers was overwhelmingly positive. Respondents frequently described appraisers as supportive, approachable, well prepared and constructive. Many comments also highlighted that appraisal discussions helped appraisees reflect, feel valued, set realistic PDP goals and helped consider future career development. The main opportunities for improvement relate to operational processes rather than appraiser conduct.

Theme	Number of comments	Theme description
Access to supporting information / evidence	39	Difficulty obtaining job plans, governance data, complaints/incidents, patient feedback, certificates, or other evidence
Appraiser allocation, scheduling and delays	24	Problems getting an appraiser, booking dates, deadlines, late allocation, or repeated chasing
Time burden, workload and stress	17	Comments about the process being burdensome, stressful, repetitive, or hard to fit around work/life
Unclear appraisal process, guidance or expectations	16	Comments about SARD being confusing, hard to use, or technically difficult
Administrative communication and coordination	12	Issues with emails, local teams, revalidation/admin processes, reminders or coordination
Meeting logistics and interruptions	9	Issues with rooms, Teams, equipment, privacy, interruptions, or meeting format
Appraiser skills, feedback and support	7	Suggestions about appraiser, approach, feedback style, career planning, reflection or pastoral support

Quality assurance

The need for a robust Quality Assurance (QA) process for appraisal as part of the Medical Revalidation process is self-evident, but also explicitly expected by both NHS England, as the Senior Responsible Owner of the revalidation process, and the GMC. A need for oversight of both appraisers and appraisal outputs is necessary to ensure a consistent, effective and constructive appraisal system, benefiting both the doctor's development and the Trust assurance processes.

Appraisers are responsible for ensuring the quality of the appraisal outputs for the appraisals they undertake. They must ensure that both the appraisal summary and the Personal Development Plan (PDP) adhere to the required standards. Feedback is requested from doctors following an appraisal; this information is collated and used to assist appraisers with their development and gives an indication of how the process is progressing.

An appraisal quality tool ASPAT (Appraisal Summary and PDP Audit Tool) developed by NHS England has been incorporated within SARD so that randomised samples of appraisals can be audited online to assess the quality of the appraisal process. The process for this has previously been trialled and a regular audit of appraisal for the year has been undertaken. For appraisals in the period, 95 were audited using the ASPAT tool covering 3.4% of appraisals undertaken; the appraisers audited undertook 25% of appraisals in the cycle. It is intended that a greater number of appraisals are audited this year but will require additional support as only Dr Hurley and Dr Khurana currently undertake this exercise.

Overall appraisals were generally viewed positively, but written outputs need more specificity; particularly in relation to SMART PDPs, explicit reflection, revalidation status, evidence quality and scope of work context.

Section	Average Score
Setting the scene and overview of supporting information	72%
Reflection and effective learning	55%
The PDP and developmental progress	78%
General standards and revalidation progress	74%
Overall	72%

The findings from ASPAT are fed back into appraiser training to highlight required improvements, with individual feedback being sent to the relevant appraiser.

Future challenges

A key challenge for medical appraisal is the timely allocation of appraisers; appraisers are not linked to a management structure and also need to change after three consecutive years. This can lead to a delay in allocation of appraisers, as well as those for new starters, which can subsequently delay appraisals being held. It is currently Trust policy and NHSE guidance that appraisers are allocated rather than self-selected, helping to prevent bias in the system and doctors being unable to find an appraiser.

The process of allocating appraisers by Clinical Groups still needs embedding and the onus is often still being pushed back to individuals. Where possible, appraisers should be allocated ahead of the appraisal year, ideally linking in with the job planning process to ensure appraisee and SPA allocation equates. Lists are sent out by the Revalidation team each year before April to enable this process, but this is not routinely undertaken by sites. For any new positions being recruited to, an appraiser should be allocated in advance prior to the role commencing to prevent any delay, especially for any staff new to the UK who will require an appraisal within their first three months. Allocation is required only for consultant and SAS grade clinicians; appraisers for Clinical Fellows and other short-term staff should be undertaken by their Educational Supervisor. Appraisers for Associate Chief Medical Officers and Clinical Group Medical Directors are assigned centrally to avoid any potential conflicts of interest or appearance of management influence.

Work has been undertaken in conjunction with Medical Education to closer align the work of Educational Supervisors and the Revalidation team achieving a significant increase in appraisal rates, bringing them in line with other medic groups. Further work is required on this however, to universally recognise that appraisal is part of the job of an Educational Supervisor and is included within the SPA allocation for this role.

The Joint Chief Medical Officer and Responsible Officer team is working with Clinical Groups to put plans in place to address these issues so that further improvements can be achieved in 2026/27.

2025-2026 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **30 October 2026**

As this is a national deadline, failure to submit by this

date will result in a missed submission being recorded.

We are unable to grant any extensions.

2025-2026 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Manchester University NHS Foundation Trust
What type of service does your organisation provide?	Acute NHS Trust providing local hospital care, specialised services and community care

	Name	Email
Responsible Officer	Prof. Bernard Clarke (interim)	bernard.clarke@mft.nhs.uk
Chief Medical Officer (CMO)	Dr Sohail Munshi / Prof. Matthew Makin (interim)	sohail.munshi@mft.nhs.uk matthew.makin@mft.nhs.uk
Medical Appraisal Lead (ACMO)	Dr Emma Hurley	emma.hurley@mft.nhs.uk
Appraisal and Revalidation Manager	Cameron Chandler	cameron.chandler@mft.nhs.uk
Additional useful contacts	Dr Ramneet Khurana (Deputy ACMO)	ramneet.khurana2@mft.nhs.uk
	Andrea Johnson (Revalidation Manager)	andrea.roberts@mft.nhs.uk
	Yvonne Jenkinson (Revalidation Administrator)	yvonne.jenkinson@mft.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

No

If yes, who is this with?

Organisation: n/a
Please describe arrangements for Responsible Officer to report to the Board:
Date of last Responsible Officer Report to the Board:
Action from last year:

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher-Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 – Summary and conclusion

Section 4 – Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The Board/Executive management team of:

Manchester University NHS Foundation Trust

can confirm that:

- 1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer

Y/N	Yes
Action from last year:	None
Comments:	Professor Bernard Clarke assumed the role from 04 August 2025
Action for next year:	None

- 1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role

Y/N	Yes
Action from last year:	None
Comments:	
Action for next year:	None

- 1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained

Y/N	Yes
Action from last year:	None
Comments:	Revalidation Management System (SARD), ESR, regular auditing
Action for next year:	None

- 1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed

Y/N	Yes
-----	-----

Action from last year:	Ensure policy is ratified and distributed accordingly
Comments:	Latest policy has been ratified
Action for next year:	None

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation process

Y/N	Yes
Action from last year:	Finalise peer review arrangements
Comments:	Similar sized organisations are being approached to undertake this exercise; currently one has agreed and a third is required to prevent this being reciprocal. An internal audit of all appraisal processes (medical and non-medical) was undertaken by KPMG in 2021, which had an outcome of significant assurance with minor improvement opportunities
Action for next year:	Finalise peer review arrangements

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation and governance

Y/N	Yes
Action from last year:	None
Comments:	Appointment of Educational Supervisors; role of dedicated Associate Director of Medical Education for Locally Employed Doctors and International Medical Graduates. Access to same appraisal system and guidance as consultants; tailored portfolios and guidance on system specific to cohort of doctors.
Action for next year:	None

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes

account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes

Y/N	Yes
Action from last year:	None
Comments:	Portfolio template built into SARD based on previous MAG Form and contains the above specified criteria to ensure all relevant information included.
Action for next year:	None

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken

Y/N	Yes
Action from last year:	None
Comments:	Records are kept on the SARD appraisal system as to why appraisals are deferred or marked as exempt for a particular year. Any deferment request from a clinician is required to be submitted via a standardised proforma for approval or rejection as appropriate by the Revalidation team. Escalation process in place for appraisal non-compliance, concluding with the RO and then the GMC.
Action for next year:	None

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group)

Y/N	Yes
Action from last year:	None
Comments:	Appointment of Educational Supervisors; role of dedicated Associate Director of Medical Education for Locally Employed Doctors and International Medical Graduates. Access to same appraisal system and guidance as consultants; tailored portfolios and guidance on system specific to cohort of doctors.
Action for next year:	None

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners

Y/N	Yes
Action from last year:	None
Comments:	At year end there were 844 trained appraisers giving an approximate ratio of 2:7 for appraisers:appraisee. Per the policy, appraisers are expected to carry out between 3 and 12 appraisals annually (includes GDC only appraisals).
Action for next year:	None

1B(v) Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent)

Y/N	Yes
Action from last year:	None
Comments:	Appraisers are expected to undergo refresher training every three years. Modified ASPAT form has been incorporated into appraisal software to audit a representative sample. Appraisee feedback forms completed after each appraisal.
Action for next year:	None

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group

Y/N	Yes
Action from last year:	Increased number of ASPAT reviews carried out and results fed back into the appraiser training process

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work

Comments:	Modified ASPAT form has been incorporated into appraisal software to audit a representative sample; the number carried out has been increased and outputs will be included in the annual reports to the Board.
Action for next year:	None

1C - Recommendations to the GMC

- 1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood

Y/N	Yes
Action from last year:	None
Comments:	All recommendations were made on time
Action for next year:	None

- 1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood

Y/N	Yes
Action from last year:	None
Comments:	Doctors are emailed following a positive recommendation for revalidation to confirm this; if a deferral is being submitted, the doctor is notified of this in advance when possible. Additionally, an action plan template is completed and submitted to the doctor outlining the steps required to be undertaken before the new recommendation due date, and an agreement to this is asked for from the doctor.
Action for next year:	None

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors

Y/N	Yes
Action from last year:	None
Comments:	Sub-committees which report to the Board, and are chaired by Non-Executive Directors, including the Quality, Performance & Scrutiny Board Committee and People Board Committee. Data on complaints, incident reporting, appraisals, management of concerns, patient experience and outcomes, and clinical indicators are presented at Board sub-committees and reported to the Board. The RO attends Trust Board and provides input on matters relating to clinical governance for doctors. A culture of honesty, openness, learning, and improvement is promoted throughout the Trust including a duty of candour encouraging staff to report adverse incidents and near misses, give honest and open feedback on their colleagues, and be open and honest with patients if something goes wrong with their care.
Action for next year:	None

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation

Y/N	Yes
Action from last year:	None
Comments:	Quarterly Medical Professional Matters Oversight Group (MPMOG) meetings between RO, Associate Chief Medical Officers (Appraisal and Revalidation, Professional Matters) and Clinical Group Medical Directors and Directors of Workforce and Organisational Development, to discuss medical professional matters and concerns.
Action for next year:	Review Terms of Reference for MPMOG to ensure appropriate attendees and frequency of meeting to achieve adequate scrutiny.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal

Y/N	Yes
Action from last year:	None
Comments:	Incidents above an agreed outcome level attached to a specified consultant are automatically uploaded into portfolios. Appraisee feedback reports are automatically added. Data is available from the Hive EPR system and clinicians are being encouraged to sign up to NCIP (National Consultant Information Programme) with portfolio sections being added for this.
Action for next year:	None

- 1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns

Y/N	Yes
Action from last year:	None
Comments:	Handling Concerns about Medical Staff (MHPS) Policy
Action for next year:	None

- 1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, types and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification

Y/N	Yes
Action from last year:	None
Comments:	Register of MPMOG data maintained for each meeting. Overview of MHPS cases and numbers provided to Board of Directors.
Action for next year:	None

- 1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation

Y/N	Yes
Action from last year:	None
Comments:	Transfer of information process within NHS is managed by Revalidation Manager. Sharing of information with two main private providers in locality is managed by RO and Trust Associate Chief Medical Officers for professional matters. Quarterly assurance meetings are held with two main private providers to discuss any issues.
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#))

Y/N	Yes
Action from last year:	None
Comments:	All policies at MFT undergo an Equality Impact Assessment prior to being ratified and policies are reviewed on a rolling basis including review by staff side representatives at JLNCC. The Equality and Diversity team advise, guide and support MFT on equality, diversity and human rights issues and work to deliver the Equality, Diversity and Inclusion Strategy 'Diversity Matters'.
Action for next year:	None

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example[s] where possible.)

Y/N	Yes
Action from last year:	None
Comments:	Information from wider governance system cascaded to Trust and Clinical Group leadership teams to be discussed at the relevant Patient Experience/Quality and Safety Committees and recommendations and actions fed up to the Quality and Safety Management Committee.
Action for next year:	None

- 1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#))

Y/N	Yes
Action from last year:	None
Comments:	
Action for next year:	None

1E – Employment checks

- 1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties

Y/N	Yes
Action from last year:	None
Comments:	Pre-employment checks undertaken as part of the TRAC system checklist including identity, criminal record, work health, professional registration and qualification, right to work, and employment history and references. Additionally, ESR-IAT occurs where they have previously been employed within the NHS; we also request and review previous appraisals on appointment. All overseas doctors undergo an induction appraisal within the first three months which enables learning and development requirements to be assessed.
Action for next year:	None

1F – Organisational culture

- 1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced

Y/N	Yes
Action from last year:	None
Comments:	Right to be accompanied for all clinicians attending formal meetings; signposting of self-help services to employees; ability for clinicians to ask a member of staff to provide pastoral care, mentorship and personal staff who will be support. All managers and directors who are involved in undertaking investigations or sitting on disciplinary/capability panels or appeals panels shall have undertaken formal equal opportunities training prior to undertaking such duties. Case Managers, Case Investigators and Panel members should be trained in the operation of the conduct, capability and ill health procedures. Training update in both is required every three years.
Action for next year:	None

- 1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels

Y/N	Yes
Action from last year:	None
Comments:	
Action for next year:	None

- 1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels

Y/N	Yes
Action from last year:	None
Comments:	MFT has a Freedom to Speak Up Guardian and a Deputy Guardian, to provide confidential, impartial support and advice to staff, students or volunteers who need to speak up. Additionally, there is a network of over 100 Freedom to Speak up Champions supporting the Guardians. These are staff members who have volunteered to help individuals raise concerns routinely and effectively using existing routes, processes and leadership structures. This is alongside their usual role at MFT and help to raise awareness of Freedom to Speak Up by being visible and

	accessible to staff. A programme of training exists for all levels of staff to support this 'Speak Up' – Core Training for all Workers.
Action for next year:	None

- 1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaint procedure)

Y/N	Yes
Action from last year:	None
Comments:	MHPS policy ratified by staff representatives at JLNCC. Policy contains appeals processes. Grievance policy in place to raise any concerns. Regular meeting with GMC ELA to discuss cases and ensure these are handled consistently.
Action for next year:	None

- 1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#)

Y/N	Yes
Action from last year:	None
Comments:	
Action for next year:	None

1G – Calibration and networking

- 1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending the network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes

Y/N	Yes
Action from last year:	None

Comments:	RO Networks attended by RO, Associate Chief Medical Officers for Appraisal and Revalidation, and Professional Matters, and the Head of CMO Programmes. Quarterly assurance meetings are held with two main private providers to discuss any issues.
Action for next year:	None

Section 2 – Metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	2,914
Total number of appraisals completed	2,829
Total number of appraisals approved missed	84
Total number of unapproved missed	1
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	239
Total number of late recommendations	0
Total number of positive recommendations	202
Total number of deferrals made	37
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	67
Total number of trained case managers	9
Total number of concerns received by the Responsible Officer ²	13
Total number of concerns processes completed	9
Longest duration of concerns process of those open on 31 March (working days)	1,300
Median duration of concerns processes closed (working days) ³	174
Total number of doctors excluded/suspended during the period	4
Total number of doctors referred to GMC	3
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or whether the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points

Total number of new doctors joining the organisation	610
Total number of new employment checks completed before commencement of employment	3,660
Total number of claims made to employment tribunals by doctors	1
Total number of these claims that were not upheld ⁴	1

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

The following actions from last year have been completed:

- ensure policy is ratified and distributed accordingly

Actions still outstanding

- Finalise peer review arrangements

Current issues

A key challenge for medical appraisal is the timely allocation of appraisers; this can lead to a delay in appraisals being held. It is currently Trust policy and NHSE guidance that appraisers are allocated rather than self-selected, helping to prevent bias in the system and doctors being unable to find an appraiser. The process of allocating appraisers by Clinical Groups still needs embedding and the onus is often still being pushed back to individuals.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1)

- Finalise peer review arrangements
- Review Terms of Reference for MPMOG to ensure appropriate attendees and frequency of meetings to achieve adequate scrutiny

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year)

- At the end of the last appraisal year (01 April 2025 – 31 March 2026), MFT had 2,914 doctors with a prescribed connection plus an additional 89 GDC only dentists requiring an MFT appraisal
- 97.0% of connected doctors had an appraisal for the 2025/26 appraisal year
- Appraisers were rated as 'Very Good' or 'Good' by 98.3% of appraisees who submitted feedback

- The process for allocating appraisers by Clinical Groups require significant improvement in ownership and timeliness

Section 4 – Statement of Compliance

The Board/Executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulation 2010 (as amended in 2013).

Signed on behalf of the designated body:

(Chief Executive or Chairman [or Executive if no Board exists])

Official name of the designated body:	Manchester University NHS Foundation Trust
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Name:	Mark Cubbon
Role:	Trust Chief Executive Officer
Signed:	
Date:	

Name of the person completing this form:	Cameron Chandler
Email address:	cameron.chandler@mft.nhs.uk

Public Board of Directors

Wednesday, 30 September 2026

Paper Title:	Annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report and Action Plan	Agenda Item 12.4
Presented by:	Meera Nair, Chief People Officer	
Prepared by:	Jismy Vellakunathu Kunjachan, EDI Practitioner Juliette Tait, Deputy Chief People Officer	
Meetings where content has been discussed previously	• People Board 25th August 2026 • Equality, Diversity & Human Rights Group 8th September 2026 • Workforce Education and Management Committee 8th September 2026	
Purpose of the paper Please check <u>one</u> box only:	☒ For approval ☐ For discussion ☐ For support ☐ For noting	

Executive summary / key messages for the meeting to consider

This paper presents MFT's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) returns and seeks Trust Board approval of the associated action plan for 2026/27.

The WRES and WDES are nationally mandated frameworks that enable the Trust to assess workforce equality, inclusion and staff experience for Black, Asian and Minority Ethnic staff and Disabled staff. Beyond compliance with NHS England requirements and the Public Sector Equality Duty, these standards provide important insight into the extent to which all colleagues experience fair access to opportunities, equitable treatment and an inclusive working environment.

The 2025/26 data demonstrates positive progress in a number of areas, including continued improvements in ethnicity and disability declaration rates, workforce representation, Board representation and access to non-mandatory training. These improvements reflect sustained organisational focus on inclusion, workforce profiling and colleague engagement.

Notwithstanding this progress, the data continues to identify disparities in key areas, including recruitment outcomes, employee relations and capability processes, career progression, experiences of bullying, harassment and discrimination, reasonable adjustments and wider staff experience indicators. These findings are consistent with themes identified through NHS Staff Survey results, national benchmarking and feedback received through the Trust's Staff Networks, Ignite Festival and wider equality, diversity and inclusion engagement activity.

A succinct Trust-wide action plan has been developed to address these issues and focuses on five priority areas: improving recruitment outcomes; strengthening fairness in employee relations processes; enhancing reasonable adjustments and the experience of Disabled staff; reducing bullying, harassment and discrimination; and strengthening leadership accountability, workforce representation and declaration rates.

The Equality, Diversity and Human Rights Group (EDHRG) has reviewed the findings and proposed actions and supports the plan, and this has further been considered and approved by the People Board. Robust

governance arrangements are in place, with progress to be monitored through EDHRG, Workforce Education Management Committee (WEMC) and People Board.

Recommendation(s)

The Board of Directors is asked to:

- The Board is asked to note the findings of the 2025/26 WRES and WDES submissions and approve the proposed action plan for implementation across MFT.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?

☒ **Yes**

The recommendations directly relate to protected characteristics, particularly race, disability and sex. The proposed action planning approach will support the Trust to respond to identified inequalities in recruitment, disciplinary and capability processes, career development, reasonable adjustments, bullying and harassment, staff experience and leadership representation.

☐ **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 within this report links to the following strategic, corporate, or operational risks:

- Risk of not delivering sustained improvement against WRES and WDES indicators if actions are not agreed, owned, delivered and monitored through a coordinated Trust-wide action plan.

Care Quality Commission domains Please check <u>all</u> that apply	☒ Safe ☒ Caring ☐ Effective ☒ Well-Led ☐ Responsive
Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the report: • The paper supports the Trust's responsibilities in relation to mandated WRES and WDES reporting, workforce equality improvement, Staff Survey-informed action planning, reasonable adjustments, bullying and harassment prevention, and fair recruitment, career progression, disciplinary and capability processes.

Main report
1. Background and purpose This report presents Manchester University NHS Foundation Trust's 2025/26 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data submission, together with the proposed Trust-wide action plan for Board approval. The WRES and WDES are mandatory NHS standards designed to measure and improve the experiences and outcomes of Black, Asian and Minority Ethnic staff and Disabled staff within the workforce. Compliance with these standards forms part of the NHS Standard Contract and supports the Trust's statutory responsibilities under the Public Sector Equality Duty. While submission and publication of WRES and WDES data is a regulatory requirement, the Trust recognises their wider value as critical indicators of organisational culture, inclusion, staff experience and leadership effectiveness. The findings provide important insight into whether colleagues experience equitable opportunities, fair treatment and an inclusive working environment, regardless of ethnicity, disability or long-term health condition. The Board has a key role in providing strategic oversight of equality, diversity and inclusion performance. Approval of the proposed action plan will provide assurance that the Trust has undertaken a comprehensive review of the data, benchmarked performance against peers, listened to colleague feedback, and identified targeted actions to address areas of inequity and improve workforce outcomes. Improving equity of experience is integral to delivering the Trust's strategic ambitions. Evidence consistently demonstrates that organisations which foster inclusive cultures, reduce discrimination and enable all colleagues to thrive are more likely to achieve higher levels of staff engagement, retention, patient safety and quality of care. 2. Data Summary WRES Indicators

The below table provides a summary of the progress against the WRES indicators. Please note that the number in brackets denotes the percentage score for the white staff who responded.

Indicator	2023/4	2025/6		2026/7
	MFT	MFT	Peer Avg	MFT
Ethnicity declaration	28.2%	30.9%	20.84%	33.5%
Likelihood of appointed from shortlisting BME staff	1.90	2.47	1.99	1.22
Likelihood of entering the disciplinary process	1.14	1.40	1.11	1.33
Likelihood of white staff undertaking non-mandatory training compared to BME staff	1.02	0.84	0.93	0.88
Likelihood of BME staff experiencing bullying from patients compared to white staff	23.17% (22.69%)	25.65% (21.74%)	26.84%	24.32% (22.06%)
Likelihood of BME staff experiencing bullying from staff compared to white staff	25.28% (20.43%)	23.14% (19.52%)	23.11%	23.24% (19.12%)
Likelihood of providing equal opportunity for career progression	46.87% (56.74%)	48.37% (58.4%)	49.52%	48.34% (56.26%)
Likelihood will experience discrimination at work	16.62% (6.99%)	16.13% (6.62%)	16.23%	14.98% (6.5%)
Board representation	5.88% (70.6%)	5.26% (52.6%)	12.13%	14.26% (80.95%)

WDES Indicators

The below table provides a summary of the progress against the WDES indicators. Please note that the number in brackets denotes the percentage score for the non-disabled who responded.

Indicator	2023/4	2025/6		2026/7
	MFT	MFT	Peer Avg	MFT
Disability declaration	4.5%	5.4%	6.75%	5.96%
Likelihood of appointed from shortlisting disabled staff	1.05	0.38	1.11	1.03
Likelihood of disabled staff entering capability process		2.51		2.10
Likelihood of disabled staff experiencing bullying from patients compared to non-disabled staff	27.8% (21.3%)	27.5% (21.56%)	26.95%	26.2% (21.7%)
Likelihood of disabled staff experiencing bullying from managers compared to non-disabled staff	15.5% (8.5%)	14.57% (7.37%)	13.56%	14% (7.4%)
Likelihood of disabled staff experiencing bullying from staff compared to non-disabled staff	24.2% (15.2%)	22.37% (14.87%)	21.69%	23.7% (14.7%)
Likelihood of disabled staff reporting latest incident of bullying	51.2% (47.7%)	50.17% (51.89%)	55.73%	54.3% (52.7%)
Likelihood of providing equal opportunity for career progression	47.5% (55.9%)	49.77% (56.55%)	52.25%	47.7% (52.2%)

Likelihood felt pressure from manager to come to work despite not feeling well	26.7% (18.4%)	26.69% (18.29%)	24.11%	28.8% (18.2%)
Satisfied with the extent to which organisation values their work	34.7% (45.7%)	35.43% (46.48%)	37.05%	34.2% (46.1%)
Employer made reasonable adjustments	70.1%	72.2%	74.58%	74.7%
Disabled staff engagement score	6.36 (6.89)	6.37 (6.93)	6.46	6.24 (6.89)
Board representation	5.88% (41.18%)	0.0% (42.11%)	0.06%	9.52% (85.71%)

3. Overview of Findings and Key Areas for Improvement

MFT submitted its 2025/26 WRES and WDES return to NHS England in May 2026 using workforce data as at 31 March 2026.

The submission demonstrates a number of positive areas of progress, including continued improvements in workforce representation, ethnicity declaration rates, disability declaration rates and access to non-mandatory training opportunities. These improvements reflect sustained organisational focus on inclusive recruitment, workforce profiling and colleague engagement.

However, the data also identifies a number of persistent inequalities which require continued attention and targeted intervention. In particular, the findings highlight ongoing disparities relating to:

- Recruitment outcomes for Black, Asian and Minority Ethnic applicants
- Disciplinary and capability processes.
- Career progression and development opportunities.
- Experiences of bullying, harassment and discrimination.
- Reasonable adjustments and the experience of Disabled staff.
- Staff engagement and organisational inclusion.

The data has been triangulated with NHS Staff Survey findings, benchmarking information, Staff Network intelligence, feedback from the Trust's Ignite Festival and wider engagement activity. This has provided assurance that the themes emerging from the data are consistent with the lived experiences shared by colleagues and represent the most significant opportunities for improvement.

Whilst MFT continues to perform favourably in several areas when compared with peer organisations, the persistence of some disparities demonstrates that further action is required to achieve equitable workforce outcomes and ensure all colleagues can thrive within the organisation.

4. Development of the proposed action plan

The proposed action plan has been developed through a comprehensive review of quantitative and qualitative evidence, ensuring that actions are informed by both workforce data and colleague experience.

Sources used to inform the action plan include:

- 2025/26 WRES and WDES submissions.
- NHS Staff Survey results and trend analysis.
- NHS England benchmarking against peer organisations.
- Evaluation of delivery and impact from previous WRES and WDES action plans.
- Feedback obtained through the Trust's Ignite Festival.
- Ongoing engagement with Staff Networks and EDI forums.
- Workforce intelligence relating to recruitment, employee relations, staff experience and organisational development.

This process has identified a consistent set of themes relating to recruitment, career progression, employee relations, reasonable adjustments, bullying and harassment, and organisational inclusion. The proposed actions have therefore been intentionally focused on those areas where the greatest inequalities currently exist and where the Trust can have the greatest impact.

The Equality, Diversity and Human Rights Group (EDHRG) has reviewed the findings and the proposed action plan and is satisfied that the priorities identified are supported by the available evidence and reflect the key issues raised by colleagues. The action plan presented for approval therefore represents a mature and evidence-based response to the identified inequalities rather than a preliminary engagement document.

Further engagement with Staff Networks, Staff Side representatives, Clinical Groups and corporate services will continue throughout implementation to strengthen local ownership, refine delivery approaches and support sustainable change.

5. Trust-wide action plan and Governance

The proposed WRES and WDES Action Plan is provided at Appendix 1.

The plan is focused on five strategic priorities where analysis indicates the greatest opportunity to improve workforce equality, staff experience and organisational outcomes:

1. Improving recruitment outcomes for Black, Asian and Minority Ethnic staff and Disabled staff.
2. Strengthening fairness and consistency within employee relations and capability processes.
3. Improving reasonable adjustments and the experience of Disabled staff.
4. Reducing bullying, harassment and discrimination.
5. Strengthening workforce representation, declaration rates, leadership accountability and inclusive leadership.

The plan is deliberately succinct to ensure resource and focus can be targeted to the schemes of work that can have the greatest impact. It has been designed to deliver measurable improvement and includes identified leads, defined delivery milestones, success measures and governance arrangements.

Progress will be monitored through the Trust's Equality, Diversity and Inclusion governance framework, with formal oversight provided through EDHRG, Workforce Education Management Committee (WEMC),

through to People Board. Delivery will be tracked through the EDI Activity Tracker, enabling routine monitoring of progress, risks, barriers and impact.

These arrangements provide assurance that implementation will be actively governed, that accountability for delivery is clearly defined, and that progress can be transparently monitored throughout the year.

Recognising that Trust-level data can mask variation across services and staff groups, the Equality, Diversity and Inclusion Team will further disaggregate WRES and WDES data to Clinical Group and workforce level. This analysis will support a deeper understanding of local workforce experiences and outcomes, enabling targeted interventions where disparities are identified. Any additional actions arising from this analysis will complement the Trust-wide action plan and will be monitored through EDHRG, providing ongoing assurance that equality, diversity and inclusion improvements are being addressed at both organisational and local levels.

6. Previous year action plan themes and progress

Progress against previous WRES and WDES action plans has been reviewed to identify achievements, ongoing challenges and areas requiring renewed focus. Notable progress includes improvements in declaration activity, Board representation, inclusive recruitment approaches and staff engagement through Staff Networks.

7. Assurance and Recommendation

The Board can be assured that the proposed action plan is informed by comprehensive workforce analysis, national benchmarking and direct colleague feedback; addresses the most significant inequalities identified through the WRES and WDES submissions; contains clear accountability and governance arrangements; and will be subject to ongoing monitoring through established Trust governance processes. This provides a robust framework for improving equality of experience and outcomes across MFT.

The Board is asked to note the findings of the Trust's 2025/26 WRES and WDES submissions and the progress made against previous action plans.

The Board is further asked to approve the proposed WRES and WDES Action Plan, recognising that it has been developed through comprehensive analysis of workforce data, staff survey results, national benchmarking and extensive colleague engagement. The plan has been reviewed through the Trust's Equality, Diversity and Human Rights governance arrangements and targets those areas where the most significant inequalities persist.

Approval of the action plan will provide a clear framework for improvement, supported by robust governance, identified accountability and ongoing performance monitoring. Delivery of the plan will contribute to reducing workforce inequalities, improving colleague experience, strengthening inclusive leadership and supporting the Trust's wider objectives relating to staff engagement, retention, organisational culture and patient care

Appendix 1

Priority	Why this matters	Action	Lead	Time	Governance and Assurance
Improve recruitment outcomes for Black, Asian and Minority Ethnic Staff and Disabled Staff	Whilst improvements have been noted within WRES outcomes in particular, inequality is still present and white staff remain 1.22 times more likely to be appointed after shortlisting than black, Asian and minority ethnic staff. Likelihood of disabled staff being appointed, when compared to non-disabled staff has worsened.	Devise new and refreshed Inclusive Recruitment Training modules	TASA Service Lead	31.8.26	Quarterly update through to EDHRG, then to WEMC and in EDI Update to People Board: - - Numbers of Inclusive Recruitment Panellists - Number of panels with Hiring Manager Trained - Qualitative feedback from Inclusive Recruitment Panellists - Repeat WRES Outcome 2 data
		Ensure all panels, commencing with Band 8a, have at least 1 trained panellist (Hiring Manager preferably) in Inclusive Recruitment practices	Associate Director of Resourcing	1.10.26	
		Develop a suite of questions for panels to utilise which are inclusive and values based	TASA Service Lead	31.8.26	
		Launch the Inclusive Recruitment Panellists Programme	Deputy Chief People Officer	24.8.26	
Strengthen fairness in employee relations and capability processes	Black, Asian and minority ethnic staff remain more likely than white staff to enter the formal disciplinary process. Disabled staff remain more than twice as likely as non-disabled staff to	Participation in National Employee Relations Investigations Development Programme (link to actions contained in the Employee Relations Improvement Plan)	Director of People	31.3.27	Oversight maintained at the bi-monthly Employee Relations Oversight Group (EROG) Quarterly update through to EDHRG, then to WEMC and in EDI Update to People Board: - - RAG rating monitoring of Employee Relations Improvement Plan - Repeat WRES and WDES Outcome 3 data
		Review NMC and HCPC referral numbers to increase visibility of referrals made by ethnicity	Director of Nursing – Workforce & Education	31.3.27	
		Ensure visible and transparent organisational learning of	Associate Director of	31.10.26	

	enter the formal capability process.	cases through publication of the Employee Relations Outcome Report	Human Resources		
Strengthen reasonable adjustments process and disabled staff experience	Reasonable adjustments improved to 74.7% but disabled staff experience remains a concern from the feedback we receive from the Staff Network. Disabled staff reported higher presenteeism at 28.8% compared to 18% of non-disabled staff. Lower “feeling valued” scores at 34.2% compared with 46.1% of non-disabled staff.	Together with the DAN Staff Network co-develop a Trust wide standard guide to “Implementing Reasonable Adjustments” and ensure far reaching promotion and communication	Deputy Chief People Officer	31.10.26	Reasonable Adjustments Task and Finish Group established to ensure relevant stakeholders are engaged and progress is made. Highlight report produced for EDHRG, then to WEMC and in EDI Update to People Board - Compliance in plan - Staff Survey results feedback - Feedback from members of DAN Network
		Ensure a central repository on People Place of all supporting materials for managers to have compassionate and supportive conversations with disabled staff	Senior EDI Practitioner	31.11.26	
		Agree an escalation route for Reasonable Adjustments that may have become “stuck” in the system	Deputy Chief People Officer	31.10.26	
		Undertake a full review of the Empactis Reasonable Adjustment process to assess ability to provide compassionate support versus the “Wellbeing Passport” route that is generally deemed best practice	Deputy Chief People Officer	31.11.26	
Reduce Bullying Harassment and Discrimination	Black, Asian and minority ethnic staff reported bullying from staff at 23.34% compared to 19% from white staff and discrimination at	Establish a comprehensive, targeted and iterative programme of activity to embed the Anti-Discrimination Pledge into the Trust's culture, policies, procedures and day-to-day practices to ensure that	Deputy Chief People Officer	31.10.26	Quarterly update through to EDHRG, then to WEMC and in EDI Update to People Board: - Actions to embed the Anti-Discrimination Pledge

	work at 14.98% compared with 6.5% white staff. Disabled staff reported bullying from staff at 23.7% compared to 14.7% for non-disabled staff	the principles of the Pledge are translated into clear behavioural expectations, integrated within existing people processes such as induction and appraisal, leadership frameworks and decision-making structures, and routinely reinforced through education, accountability, governance and continuous improvement.			Staff Network membership
		In partnership with each Staff Network establish growth plans to raise the voice of staff with protected characteristics and provide mechanisms of support that will help increase higher levels of reporting outside of the NHS Staff Survey	Chief People Officer	31.3.27	
		Assess and localise the recommendations as defined in the Lord Mann review of Anti-Semitism and other forms of Racism in the NHS	Deputy Chief People Officer	31.10.26	
		Test actions at a CEO Led Culture and Staff Experience Forum	Head of Organisational Development	31.12.26	
Sustain declaration, Board representation and	Black, Asian and minority ethnic Board representation increased from 5.26% to 14.29%, and unknown or null	Launch the “Nothing to Declare” Campaign across the Trust	EDI Practitioner	30.9.26	Quarterly update through to EDHRG, then to WEMC and in EDI Update to People Board
		Design and roll out the “3 Actions for Inclusion” Programme	EDI Practitioner	31.10.26	

leadership accountability	ethnicity declaration at Board level reduced from 42.11% to 4.76%.	Ensure EDI objective setting is in place across all senior leader posts	Deputy Chief People Officer	31.12.26	
Understanding of the data	Currently Trust level is provided at an organisational level which does not provide visibility of potential disparities which may lie at a more granular level	Provide each Clinical Group and Corporate Team with disaggregated data to support local action planning and visibility at Trust level of local issues.	EDI Practitioner	30.11.26	Report to EDHRG November 2026, then further reporting to be agreed upon understanding of the data.

WRES and WDES Action Plan

Appendix 2: Previous year WRES and WDES action plan 24/25 themes and progress update

Previous year action theme	Source	Progress/status	Link to current priority action
Improve workforce equality data quality and declaration, including ethnicity and disability declaration.	WRES and WDES 2024/25 reports	The ESR declaration and Data Matters campaign has supported improved equality data completeness and encouraged staff to update ethnicity and disability information. The approach also includes the “Nothing to Declare” campaign for staff who prefer not to declare, while supporting work to identify barriers that prevent colleagues from completing ESR declarations. BME workforce representation improved to 33.55% and disabled staff representation improved to 5.96% in the latest submission. Continued focus is required, particularly on disability declaration completeness and barriers to self-declaration.	Continue targeted ESR communications, Data Matters campaign activity, “Nothing to Declare” messaging, Staff Network engagement and clinical group monitoring through the EDI Activity Tracker.
Strengthen inclusive recruitment and improve fairness in shortlisting and appointment outcomes.	WRES and WDES 2024/25 reports	Work has continued on inclusive recruitment, including a review of recruitment practice and the role of equality panellists/advocates to strengthen fairness and challenge bias in recruitment and selection. Disabled recruitment outcomes remain a strength, with MFT ranked 1st in the NHSE benchmark and the latest WDES recruitment ratio remaining positive at 0.51. However, WRES recruitment disparity has worsened, with the latest WRES 2 ratio increasing to 4.29.	Accelerate work associated with the Inclusive Recruitment Programme, with clearly defined objectives.
Improve access to career progression, development and CPD for under-represented staff.	WRES and WDES 2024/25 reports	The Removing the Barriers programme provided opportunities for under represented groups to access development opportunities.	Review the Removing Barriers Programme as part of the Inclusive Recruitment Programme.
Address bullying, harassment and discrimination and strengthen staff	WRES and WDES 2024/25 reports	NHSE benchmarking shows continuing concerns for BME and disabled staff experiences of bullying, harassment and discrimination, including from staff, managers, patients and the public. Disabled staff	Align action with Staff Survey outputs, Staff Network feedback, Freedom to Speak Up themes, employee relations data and local clinical group interventions.

WRES and WDES Action Plan

confidence to report concerns.		reporting of the latest incident remains below peer average.	
Improve reasonable adjustments experience and consistency for disabled staff.	WDES 2024/25 report	Progress made but further improvement required. Reasonable adjustments improved in the NHSE benchmark but remained below peer average. Current work includes the reasonable adjustments profile and toolkit approach, but consistency and manager confidence remain areas for action.	Strengthen manager guidance, staff awareness, use of the reasonable adjustments profile and monitoring through Employee Health and Wellbeing and the EDI Activity Tracker.
Review employee relations fairness, including disciplinary and capability disparities.	WRES and WDES 2024/25 reports	The latest WRES submission shows BME disciplinary disparity improved slightly to 1.33 but remains above parity. The latest WDES submission shows disabled staff capability disparity improved to 2.10, but disabled staff remain more than twice as likely as non-disabled staff to enter the formal capability process.	Ensure learning from the National Employee Relations Improvement Programme is built in as part of the action plan.
Use Staff Networks and lived experience to shape actions and monitor impact.	WRES and WDES 2024/25 reports	Staff Network engagement remains central to understanding lived experience behind the data and co-producing meaningful actions. Development of the Staff Network Policy is underway to strengthen clarity on the role, governance, support and influence of Staff Networks in shaping and monitoring equality improvement activity.	Share benchmarked priorities with Staff Networks, use feedback to refine the action plan, align with Staff Network Policy development, and involve networks in reviewing progress through EDHRG, WEMC and People Board reporting.
Strengthen Board and senior leadership representation and declaration completeness.	WRES and WDES 2024/25 reports	The latest submission shows BME Board representation improved to 14.29% and disabled Board representation improved to 9.52%, supported by improved Board declaration completeness. Continued monitoring is required to sustain progress.	Monitor Board and senior leadership representation quarterly and report progress through the EDI Activity Tracker and governance routes.

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): 26 August 2026

Key escalation and discussion points from the meeting

Alert:

The Committee reviewed the capital, estate and infrastructure and finance, sustainability and cash domains of the **Risk Appetite Statement**, both of which propose a measured appetite. The Committee supported onward presentation to the Board, subject to further review of the narrative on digital infrastructure and practical application.

The finance chapter of the **Integrated Performance Report** reflected principal areas requiring Board attention remained in respect to liquidity, agency expenditure and delivery of the Value for Patients (VfP) programme. These were further reflected and discussed in the **Chief Finance Officer's Report**, which confirmed a Month 4 position in line with plan. The Committee noted the impact of non-recurrent adjustments, industrial action costs and underperformance of the Value for Patients (VfP) Programme on the reported position. An update on progress of the contract performance discussion with the Oxford Road PFI contractor was also provided. The Committee noted the vulnerability of the forecast position and the requirement to improve recurrent delivery in the second half of the year.

The Committee considered a proposal in respect to a **Contract Award for Blood Gas Analysers** and supported recommendation to the Board of Directors, in line with the Scheme of Reservation and Delegation.

Advise:

The finance chapter of the **Integrated Performance Report** reflected that financial performance against year-to-date budget was in line with plan. The Committee noted that the level of financial risk remains high and that additional controls have been implemented, including implementation of a tiered financial oversight and support framework to provide additional executive focus and attention on areas with greatest delivery risk or support requirements.

The Committee received an update on the **3-year Financial Recovery Plan**, noting the underlying deficit at the end of 2025/26 increased the scale of the medium-term recovery challenge. The approach to developing a single strategic financial framework and Medium-Term Financial Plan was outlined. This was supported by the Committee, with a request to ensure cash and liquidity was explicitly reflected. A discussion at the Board Seminar in December 2026 has been scheduled.

A **Deep Dive of Clinical and Scientific Services' (CSS) Financial Position** was presented to the Committee. Month 4 reported an adverse variance to plan, largely attributable to under-delivery against the Clinical Group's Value for Patients target. The Committee received an explanation of the CSS budget position and operating constraints. Programmes of work to support improvement, including the alignment of Senior Leadership Team members to divisions, setting of divisional VfP targets, provision of resource

to support the identification of productivity improvements and consideration of automation and service redesign opportunities were also outlined.

The update on the **Value for Patients Programme** delivery confirmed risk-adjusted delivery had increased to £88.3m, which was reflective of increased scheme maturity. Year-to-date delivery was £22m adverse to plan. Governance and oversight arrangements continue to be refined, with tiering arrangements introduced for Clinical Groups and Corporate Functions to ensure focus is prioritised accordingly. The programme of work to ensure transformational and productivity opportunities are maximised heading into 2027/28 was outlined. The Committee emphasised the importance of accelerating these initiatives at pace, whilst also removing reliance on non-recurrent initiatives. The Committee welcomed the positive engagement of staff with the Share to Save initiative.

The Committee received an update on the **Commercial Activity** portfolio, including private patient growth, independent-sector partnership activity and the wider commercial portfolio. A structured opportunity framework was being developed to enable prioritisation of future commercial proposals, aligned to strategic fit, value and organisational impact, with due regard for reputational and ethical considerations.

Assure:

No matters to assure.

Key Risks Discussed:

The Committee reviewed the **strategic and corporate risks and noted:**

- Financial sustainability over the medium term remained scored at 20, with continued exposure arising from the underlying deficit, cash pressures and dependence on improved recurrent Value for Patients delivery.
- Capital resource availability remained scored at 20. The additional £50m Public Dividend Capital award was positive but did not materially alter the assessed exposure given the scale of capital need and backlog maintenance.
- Linked corporate risks relating to cash and commissioning remained under review. The Committee requested further consideration of whether in-year Value for Patients delivery should also be shown as a linked corporate risk.
- Service continuity mitigations were reported to be in place for estate-related risks, with highest-risk schemes prioritised through the Digital and Estates Board Committee.

Report approved by: Mr Trevor Rees, Interim Trust Chair and Chair of the Finance Board Committee

Agenda:

Finance Board Committee

Date: Wednesday 26th August 2026

Time: 2:00pm – 4:00pm

Location: Main Boardroom, Cobbett House

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 (1 st July 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	Risk Appetite Statement	Support	Deputy Director	2.15pm
6.3	Integrated Performance Report	Discussion	DCFO	2.25pm
7.	Strategic aim 4: Ensure value for our patients and communities by making best use of resources			
7.1	Chief Finance Officer’s Report	Discussion	CFO	2.35pm
7.2	3-year financial recovery plan update	Discussion	CFO	2.45pm
7.3	CSS Clinical Group Finance Plan Update and Deep Dive	Discussion	CSS CEO	2.55pm
7.4	Value for Patients Programme Update	Discussion	Interim DCEO	3.10pm
7.5	Commercial Update	Discussion	Commercial Director	3.25pm
7.6	Contract Award Recommendation Reports: 7.6.1 Contract Award for Blood Gas Analysers (Trust-Wide)	Support	Head of Purchasing – Clinical	3:35pm
Committee business				
8.	Escalation report	Approval	Chair	3.55pm

	Item	Purpose	Lead	Time
9.	Workplan Review	Meeting admin	Chair	
10.	Any Other Business (verbal)	Discussion	Chair	
11.	Meeting Evaluation (verbal)	Meeting admin	Chair	
Date of next meeting: Monday 26 th October at 2:00pm				
Papers for Information FCMC Escalation Report (July 2026)				

Public Board of Directors

Wednesday, 30 September 2026

Paper Title:	Chief Finance Officer's Report – M4 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, 26 th August 2026	
Purpose of the paper Please check <u>one</u> box only:	☐ For approval ☐ For support ☒ For discussion ☐ For noting	

Executive summary / key messages for the meeting to consider

- In month 4, the Trust delivered a **£5.7m surplus** against a **£5.9m surplus plan** – a **£0.2m adverse** position. The year to date position is a **£14k favourable 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 the 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 2026/27 and beyond.

Care Quality Commission domains

Please check **all** that apply

☐ Safe

☐ Caring

☒ Effective

☒ Well-Led

☐ Responsive

Compliance & Regulatory Implications

The following compliance and regulatory implications have been identified as a result of the work outlined in the report:

- n/a

Main report

See report.

CFO Report Month 4 2026/27

Where



Excellence

Meets

Compassion

Manchester University NHS
Foundation Trust

August 2026



Summary – M4 Position – July 2026

I&E Category	2026/27	Current Month - M4			YTD		
	Original Plan £000s	Original Plan £000s	Actual £000s	Variance £000s	Original Plan £000s	Actual £000s	Variance £000s
Total Clinical Income	2,819,419	240,848	242,577	1,729	941,897	957,048	15,151
Total Other Income	331,055	27,588	27,613	25	110,351	109,733	(618)
Total Income	3,150,474	268,436	270,190	1,754	1,052,248	1,066,781	14,533
Total Substantive Pay	(1,769,354)	(147,447)	(156,025)	(8,578)	(589,788)	(629,207)	(39,419)
Total Bank Pay	(90,138)	(7,511)	(5,895)	1,616	(30,044)	(26,878)	3,166
Total Agency Pay	(6,504)	(541)	(431)	110	(2,164)	(2,242)	(78)
Apprenticeship Levy	(6,655)	(555)	(600)	(45)	(2,219)	(2,341)	(122)
Total Pay Costs	(1,872,651)	(156,054)	(162,951)	(6,897)	(624,215)	(660,668)	(36,453)
Total Non Pay Costs	(1,221,003)	(101,697)	(96,881)	4,816	(406,892)	(385,542)	21,350
Total Financing Costs	(58,082)	(3,067)	(3,012)	55	(33,927)	(31,484)	2,443
Surplus / (Deficit) before adjustments	(1,262)	7,618	7,346	(272)	(12,786)	(10,913)	1,873
Adjust PFI revenue costs to UK GAAP basis	1,262	(1,756)	(1,691)	65	14,792	12,933	(1,859)
Surplus / (Deficit) for CT purposes	0	5,862	5,655	(207)	2,006	2,020	14
Total I&E Excluded from CT	(82,361)	442	245	(197)	1,764	664	(1,100)
Surplus / (Deficit) after CT excluded items	(82,361)	6,304	5,900	(404)	3,770	2,683	(1,087)

Summary

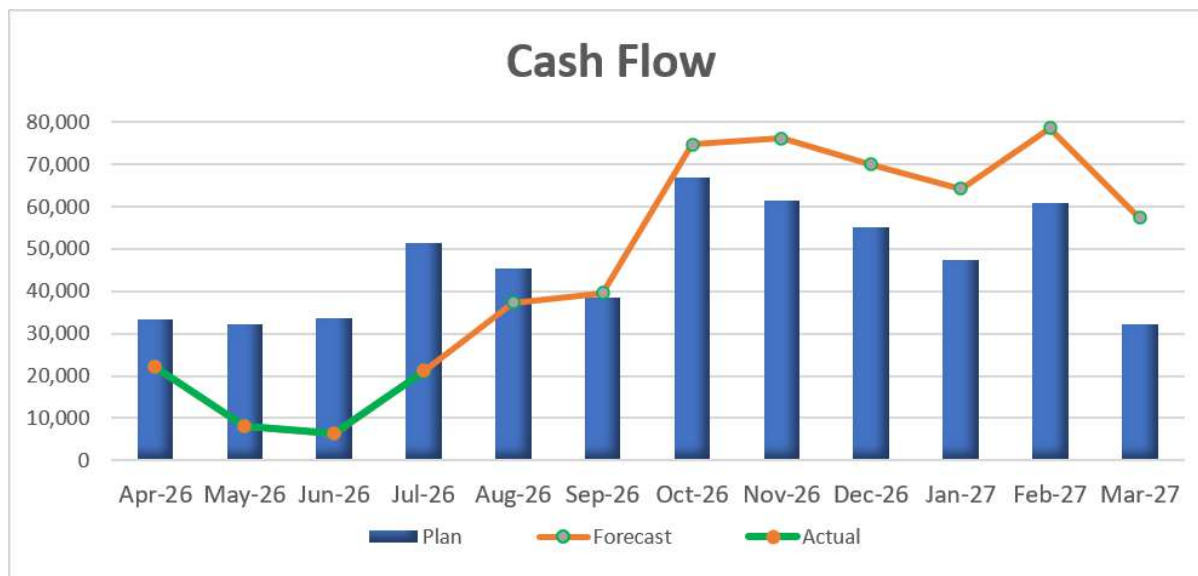
In month 4 2026/27 for NHSE reporting purposes, the Trust delivered a **£5.7m surplus** against a **£5.9m surplus plan** - £0.2m adverse. YTD the variance is **£14k** ahead of plan.

The key drivers of the YTD position are:

- April Resident Doctors Industrial Action costs of -£2.6m.
- Underperformance against the VfP programme plan by -£31.3m, the plan has been profiled in equal 12ths with higher actual delivery expected in later months.
- Non recurrent items that offset VfP in year under performance including PFI penalty deductions, VAT credits following the annual review of 25/26, and unused provisions no longer required in 26/27.

Both income and pay actuals include £0.8m YTD for the change to the CUF for the Resident Drs pay scale changes, estimated at an average increase of 1.4% on top of the 3.5% pay award. National CUF uplifts have not yet been notified to organisations so no budgetary uplift has yet been made.

Cash and Liquidity



Cash Plan vs Actuals - M4	£m
Plan Cash Balance	51.3
Actual Cash Balance	21.0
Variance - Higher/(Lower) than plan	(30.3)
Revenue Operating Cash Days	2.6
Monthly Low	20.9
Monthly High	209.0

Cash

The Trust cash balance of £21.0m at the end of July equates to 2.6 days of revenue operating cash (0.8 days June).

Adverse variances against plan include:

- Planned £45m revenue support cash was not drawn down.
- Receivables £31m higher than plan, largely due to PFI contract management actions.
- Net capital cashflows (invoice settlement less PDC funding) £10m adverse

Favourable variances against plan include:

- Active management of supplier payments, giving £37m benefit.
- Receipt of £15m SLA advance payment from MCC in July.
- Receipt of unplanned £10m payments on account from GM ICB.

Capital

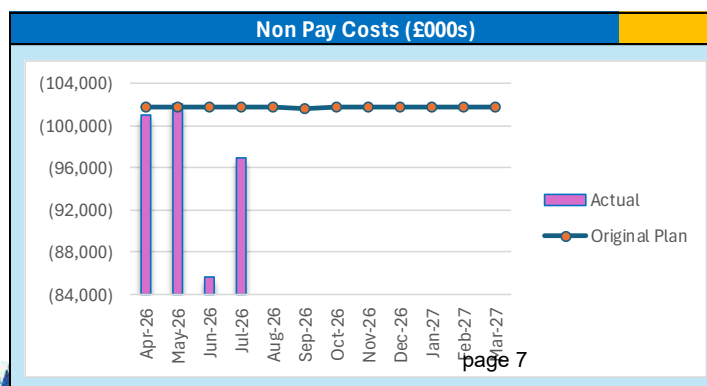
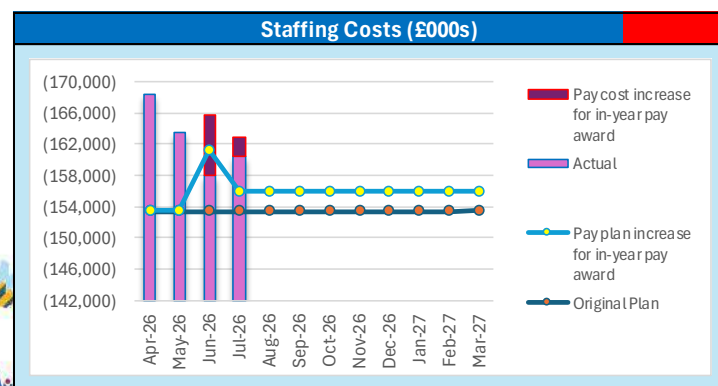
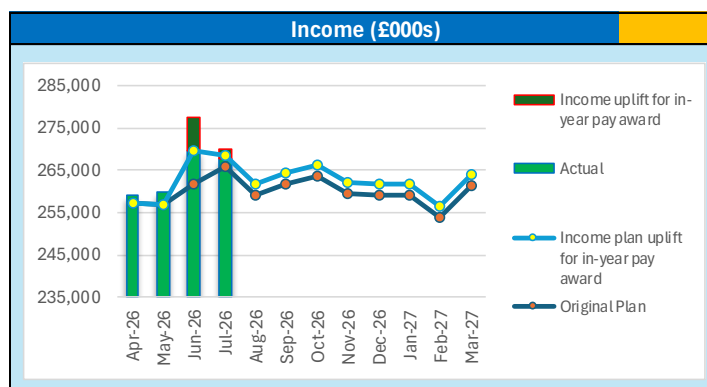
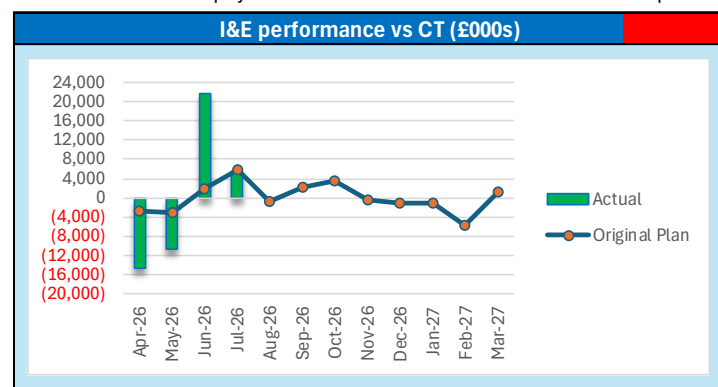
	Current Month - M4			YTD			Forecast		
	Original Plan	Actual	Variance	Original Plan	Actual	Variance	Original Plan	FOT @ M3	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
GM Envelope (including IFRS 16 Leases)	3,698	2,165	(1,533)	14,403	9,260	(5,143)	46,468	46,468	0
Other Capital (PDC, grant and charity, PFI)	8,529	6,547	(1,982)	31,443	22,299	(9,144)	100,803	150,815	(50,012)
Total Capital	12,227	8,712	(3,515)	45,846	31,559	(14,287)	147,271	197,283	(50,012)
CDEL (net of intra-DHSC group eliminations) included in Total Capital above	10,499	7,492	(3,007)	42,343	27,626	(14,717)	132,254	182,255	50,001

- 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.
- **Additional PDC** - £50.0m. As at M4, NHSE have confirmed additional PDC funding will be awarded to MFT in year relating to Estates Safety £9.8m, NHP £16.3m, RAAC £11.7m, Project Red £5.3m, plus £7.0m made up of various smaller schemes.
- **Year to date spend** - £13.5m 2026/27 PDC funding received as of M4 - 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 adjusted trust plan of £197.3m. This reflects the original plan of £147.3m, plus additional confirmed PDC funding of £50.0m.

I&E Run Rates vs CT – July 2026

I&E category	Apr-26 £'000	May-26 £'000	Jun-26 £'000	Jul-26 £'000
Income	259,290	259,795	269,809	267,625
Income uplift for in-year pay award			7,697	2,566
Staffing Costs	(168,428)	(163,561)	(158,031)	(160,386)
Pay cost increase for in-year pay award			(7,697)	(2,566)
Non Pay	(100,940)	(102,133)	(85,589)	(96,881)
Financing Costs	(22,550)	(3,013)	(2,909)	(3,012)
PFI revenue costs on a UK GAAP basis	17,887	(1,683)	(1,580)	(1,691)
I&E Performance vs CT	(14,741)	(10,595)	21,700	5,655

Note: increase due to pay award YTD in June is matched to income and plan



- 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 £0.8m YTD for the uplift to 3.3% for the AfC staff pay award and to 3.5% for medical staff pay awards that is in the plan at 2.1% as per original National guidance and also a 1.4% increase for Resident Drs change to nodal points on the pay scales.
- The impact of Resident Doctors industrial action in April is included in staffing costs at an estimated £2.6m. There is no national funding to support these costs.

Bank & Agency Expenditure vs Target

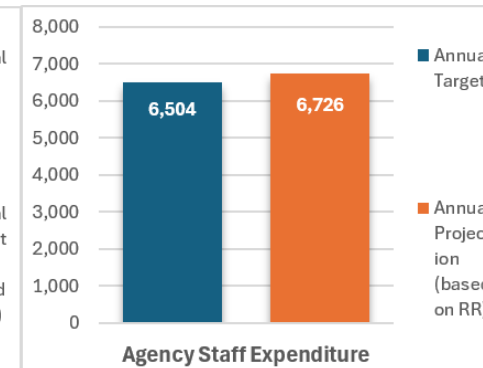
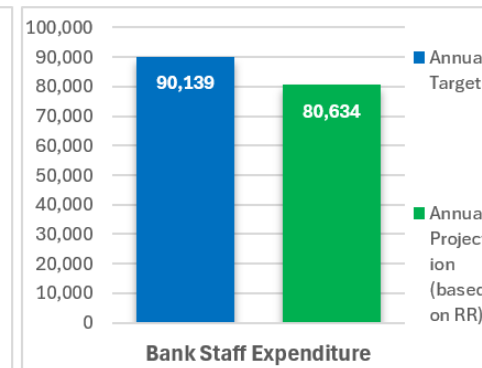
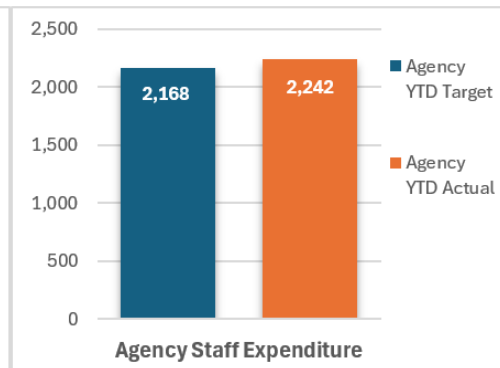
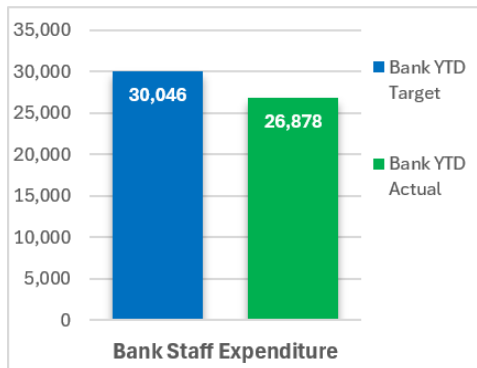
Clinical Group	Bank			
	YTD Target	YTD Actual	YTD Variance	YTD Variance
	£'000	£'000	£'000	%
Clinical & Scientific Services	2,479	1,918	561	22.6%
Corporate	756	737	19	2.5%
Facilities	664	876	(212)	(32.0%)
Exchequer Reserves & Central	0	17	(17)	0.0%
LCO & Dental	1,275	1,127	149	11.7%
Manchester Royal Infirmary	5,876	5,365	511	8.7%
North Manchester General Hosp	5,960	5,292	668	11.2%
Research & Innovation	44	72	(28)	(64.5%)
Specialist Hospitals	7,269	6,360	909	12.5%
WTWA	5,723	5,116	608	10.6%
Total	30,046	26,878	3,168	10.5%

Agency			
YTD Target	YTD Actual	YTD Variance	YTD Variance
£'000	£'000	£'000	%
485	830	(345)	(71.1%)
43	100	(57)	(133.3%)
36	0	36	100.0%
0	0	0	0.0%
14	40	(27)	(194.1%)
443	567	(124)	(28.0%)
625	319	306	49.0%
0	0	0	0.0%
216	90	126	58.2%
306	295	11	3.5%
2,168	2,242	(74)	(3.4%)

Bank	Agency
Annual Target	Annual Target
£'000	£'000
7,438	1,455
2,268	129
1,991	108
0	0
3,826	41
17,628	1,329
17,881	1,876
131	0
21,806	649
17,170	917
90,139	6,504

Bank	Agency
Projection (unmitigated)	Projection (unmitigated)
£'000	£'000
5,754	2,489
2,211	301
2,628	0
50	0
3,380	121
16,094	1,701
15,876	958
215	0
19,080	271
15,347	885
80,634	6,726

- Targets 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 M4 the Trust is underspent against the bank cap and marginally 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.



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): 8 September 2026

Key escalation and discussion points from the meeting

Alert

Committee members supported the governance, assurance and risk management domain within the developing **Risk Appetite Statement**. The Committee noted that the document was to be updated to reflect feedback received through all Board Committee reviews and emphasised the importance of careful Board scrutiny of the final version prior to approval. Members also reiterated that the value of risk appetite is realised only through its use in informing forward-looking decision-making.

The Committee reviewed and ratified the annual **Anti-Fraud, Bribery and Corruption Policy**, subject to minor amendments concerning terminology, equality impact considerations and clarification of contractor responsibilities.

Advise:

The Committee received the six-monthly **Risk Management Update**, noting the significant assurance outcome from the annual Internal Audit review of risk management and the progress being made to embed risk management maturity across the Trust. The Committee requested future reports include trend information and additional contextual analysis to support interpretation of risk management performance measures.

The **Internal Audit Progress Report** confirmed satisfactory delivery of the annual audit plan and reported three completed reviews. Partial assurance opinions were received for reviews of Health Inequalities and Paediatric Urology Additional Consultant Payments, whilst Infection Control Cleaning Compliance achieved a significant assurance with minor improvement opportunities rating. The Committee discussed the importance of ensuring management action plans remain subject to appropriate oversight and that learning arising from these reviews is applied more broadly across the organisation where relevant.

The Committee received an update on progress against the management actions identified in the **Internal Audit review of Health Inequalities**. Confirmation was provided on the arrangements in place to strengthen planning, performance measurement and oversight. Members noted that a detailed management action plan will be progressed through established Population Health governance arrangements, with strategic oversight provided by the Research, Innovation and Population Health Board Committee.

An update on agreed management actions detailed in the **Internal Audit review of Paediatric Urology Additional Consultant Payments** was provided, including programmes of work underway to review relevant policies. The Committee noted that the agreed actions have relevance beyond the specialty concerned and supported organisational learning being progressed through wider workforce governance mechanisms.

The Committee received an update on the outcome of the recent **Medicines Management Internal Audit Review**, which resulted in a partial assurance opinion and identified opportunities to strengthen aspects of the control environment. The Committee noted that no evidence of patient harm, fraud or diversion of medicines had been identified and was reassured that a comprehensive improvement programme, supported by Executive leadership and enhanced governance oversight, is underway. Continued monitoring of delivery against the agreed action plan will be maintained through established governance arrangements.

The **Local Counter Fraud Progress Report** highlighted increasing referral activity, completion of targeted fraud prevention activity and several successful interventions preventing attempted mandate fraud valued at approximately £70,000. Members discussed emerging risks associated with AI-enabled fraud and requested a future report on developing fraud risks and associated mitigations.

The Committee noted the **escalation and assurance reports from Board Committees**, as previously provided to the Board of Directors **and the Trust Risk Oversight Committee minutes**. The Committee requested new reporting arrangements from the next financial year, with assurance provided via the reports incorporated into the annual committee review and evaluation process.

The **External Audit Update** confirmed that formal closure of the 2025/26 audit and issue of the audit certificate remained dependent upon completion of the National Audit Office review process. The Committee also noted that no new issues of concern had been identified and that audit planning work for 2026/27 would commence imminently. A further update will be provided to the next meeting.

Assure:

The Committee received positive assurance from the **Infection Control: Cleaning Compliance Internal Audit Review**, which achieved a significant assurance with minor improvement opportunities rating. Whilst some minor improvement opportunities were identified, the review concluded that appropriate arrangements were operating effectively.

The Committee received positive assurance from the **Data Security and Protection Toolkit / Cyber Assurance Framework Submission**, which confirmed, through self-assessment, that all applicable national standards had been met and that MFT remains one of a small number of organisations able to demonstrate this level of compliance. An annual internal audit review is scheduled and will assess that position later in the year.

The Committee received the report on **Tenders Waived** and noted continued improvement in procurement compliance, evidenced by a reduction in waiver activity compared with previous reporting periods and the absence of retrospective waiver requests. Members considered this to provide positive assurance regarding the effectiveness of procurement governance and control arrangements.

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 8 September 2026

Time: 10:00am – 12:00 noon

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 (23 rd June 2026)	Meeting admin	Chair	
4.	Action Log	Discussion	Chair	
5.	Matters Arising / Hot Topics Medicines Management Internal Audit Review – Management Assurance Update (verbal)	Discussion	JCMO Chief Pharmacist	
6.	Assurance			
6.1	Bi-annual Risk Management Update	Discussion	Director of Clinical Governance	10:15am
7.	Internal Audit:			
7.1	Internal Audit Progress Report	Discussion	Internal Audit (KPMG)	10:30am
7.2	Update on Partial Assurance Internal Audits (verbal) - Health Inequalities - Paediatric Urology Additional Consultant Payments	Discussion Discussion	JCMO CFO/CPO	10:40am 10.45am
8.	External Audit:			
8.1	External Audit Update	Discussion	External Audit (GT)	10:55am
9.	Local Counter Fraud:			
9.1	Local Counter Fraud Progress Report	Discussion	Local Counter Fraud (KPMG)	11:00am
9.2	Counter Fraud, Bribery and Anti-Corruption Policy	Discussion	Chief Finance Officer	11:10am

	Item	Purpose	Lead	Time
10.	Items for Noting and / or Information			
10.1	Tenders Waived for the period 1 June 2026 to 31 July 2026	Noting	Procurement Director	11:20am
10.2	Data Security and Protection Toolkit / Cyber Assurance Framework Submission	Noting	CDIO	11:30am
Good governance				
11.	Escalation reports from Board Committees and Trust Risk Oversight Committee	Noting	Trust Board Secretary	11:40am
Committee business				
12.	Escalation report	Discussion	Chair	11:50am
13.	Workplan Review	Meeting admin	Chair	
14.	Any Other Business (verbal)	Discussion	Committee Members	
15.	Meeting Evaluation (verbal)	Meeting admin	Chair	
Date of next meeting: Tuesday 3rd November 2026 at 10:00am – 12:00pm, Main Boardroom, Cobbett House, ORC				



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: 10/09/25

Key escalation and discussion points from the meeting

Alert

The Committee received an update on the **Patient Administration programme**, as part of the Chief Digital and Information Officer's report. The programme has moved from identification and monitoring into a structured assurance and delivery model. The programme's connectivity to digital optimisation, patient safety, pathway visibility, RTT performance, operational management, and regulatory reporting was described. A briefing session had been held with Non-Executive Directors prior to DEBC and an associated strategic risk has been approved which will continue to be monitored at future DEBC meetings. To ensure robust monitoring of any potential implications for patient care and waiting list management, reporting on the programme will also be provided to the Quality, Safety and Performance Board Committee who considered the issue at their meeting in August 2026. The Committee requested that this additional reporting route be captured within the risk record.

The Committee received an update on the Oxford Road Campus **PFI arrangements**. Work continues with partners and external advisers to strengthen contract performance, improve delivery of lifecycle works and support future service requirements. Enhanced escalation processes remain in place and progress will continue to be monitored through established governance arrangements. The Committee welcomed this and requested that a clear timeline was presented at the next meeting along with detail of the demarcation of accountabilities across all partners involved

The Committee reviewed the ongoing management of the Trust's **end user device** estate. Investment has appropriately prioritised cyber security, network resilience and major digital transformation programmes. As part of routine capital planning, a phased approach to device replacement continues to be developed to ensure infrastructure remains fit for purpose and supports service delivery. The Committee was requested to accept an unfunded exposure against the associated strategic risk and will continue to monitor progress through future reporting.

Advise:

Progress continues on development of the **Strategic Estates Plan**, providing a framework for future estate utilisation, capital investment and alignment with evolving models of care. Work remains on track for completion later in the year.

The Committee noted successful **external funding awards** supporting further development of the North Manchester Healthy Neighbourhood programme and Wythenshawe master planning work. Engagement with partners and stakeholders will continue as these programmes progress.

The Committee reviewed progress against the **Strategic Digital Plan**. 3 of the 20 objectives are rated red/deprioritised and 2 are rated amber. Where activities have been removed, replaced or rescheduled, this reflects agreed organisational prioritisation decisions and resource alignment.

The Committee received an update on **major digital programmes**, including:

- Continued roll-out of Ambient Voice Technology across clinical specialties.

- Progress with infrastructure modernisation and cloud migration activities.
- Delivery of the Local Care Organisation Epic programme.
- Ongoing cyber security improvements and implementation of the Digital Target Operating Model.
- Early feedback from clinicians and patients on Ambient Voice Technology remains positive and that evaluation work continues.

The Committee received an update on the Trust's designation as an MHRA-supported AI innovation **Sandbox** site. Members were reassured that appropriate governance and regulatory controls are in place and that the initiative supports the Trust's ambitions in research, innovation and patient benefit. The Committee requested a formal note of recognition for Catherine Boylan and the Research and Innovation team for leading this work.

The Committee was advised that there are currently no live **fire enforcement** notices across the Trust, which provides positive assurance on the current compliance position. A forthcoming Greater Manchester Fire and Rescue Service inspection of Crumpsall Vale ICU is scheduled for October 2026; whilst no material concerns were anticipated, an update will be provided to the Committee following the inspection rather than waiting until the next scheduled meeting.

The Committee noted that the **estates backlog** remains a significant pressure, driven by the age and condition of the estate and constrained levels of available capital. While associated risks are subject to active prioritisation and mitigation the gap between identified need and available funding continues to limit the pace at which estates risks can be reduced.

Assure:

The Committee noted strong performance across the digital indicators reported through the **Integrated Performance Report**, including sustained improvements in Information Governance performance and cyber security maturity measures. Development of Estates and Facilities indicators continues and these will be incorporated into future reporting.

The Committee noted successful completion of the Trust's **DSPT/CAF** submission, with a 'Standards Met' rating, and discussed preparations for the new national cyber assessment requirements.

Risks discussed at the meeting

The Committee reviewed the revised organisational **Risk Appetite Statement** ahead of submission to the Board. Members supported the approach and discussed future consideration of emerging technologies, including artificial intelligence, within the broader risk framework

The Committee reviewed the **Strategic and Corporate Risks** relevant to digital, estates and infrastructure matters. Members were assured that controls, assurances and action plans remain subject to regular review and challenge. The target date for reducing the digital infrastructure risk reflects affordability rather than risk tolerance and the Committee asked that this distinction be explicit in the risk record. A strategic risk related to the PFI issue referenced in 'Alert' above has been approved and was discussed at the meeting.

Report approved by: Sam Liscio, Non-Executive Director and Chair of the DEBC.

Agenda:



Manchester University
NHS Foundation Trust

Digital and Estates Board Committee

Date: Thursday 10th September 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 (2 nd June 2026)	Meeting admin	Chair	
4.	Action Log	Discussion	Chair	2:05pm
5.	Matters Arising	Discussion	Chair	2:10pm
6.	Assurance Reporting			
6.1	Strategic and Corporate Risks	Discussion	Trust Board Secretary	2:15pm
6.2	Risk Appetite Statement	Support	Deputy Director of Clinical Governance and Risk	2.25pm
6.3	Integrated Performance Report including: - Estate KPIs (verbal). - Cyber Security KPIs.	Discussion	Chief Delivery Officer and Chief Digital and Information Officer	2:35pm
Strategic aim 4: Ensure value for our patients and communities by making best use of resources				

7.1	Update on Strategic Estate.	Discussion	Acting Chief Strategy Officer	2:45pm
7.2	Chief Digital and Information Officer's report including: - Operational and BI performance. - Vertical KPIs. - Hive programme.	Discussion	Chief Digital and Information Officer	2:55pm
7.3	Mid Term Review of SDP year 2 of 3.	Discussion	Chief Digital and Information Officer	3:15pm
7.4	Corporate Risk update: Financial constraints and associated opportunity costs including: End User Devices linked to the strategic capital plan.	Discussion	Deputy Chief Digital Information Officer	3:25pm
7.5	Report of Director of Estates and Facilities: - GM Fire enforcement notice update. - Prioritisation of E&F backlog programme against reduced capital allocation including life cycle priority list/full report. - MFT's PFI agreements update.	Discussion	Director of Estates and Facilities	3:35pm
Committee business				
8.	Escalation report	Approval	Chair	3:50pm
9.	Workplan Review	Meeting admin	Chair	3:50pm
10.	Any Other Business (verbal)	Discussion		3:55pm
11.	Meeting Evaluation (verbal)	Meeting admin	Chair	3:55pm
Date of next meeting: To be rescheduled from 2nd December 2026 at 10:00am – format to be confirmed				
Papers for Information: Digital Management Committee Escalation Report				

Public Board of Directors

Wednesday, 30 September 2026

Paper Title:	Risk Appetite Statement	Agenda Item 14
Presented by:	Kimberley Salmon-Jamieson, Joint Deputy Trust Chief Executive and Chief Nursing Officer	
Prepared by:	Layla Alani, Deputy Chief Nursing Officer Natalie Davies, Deputy Director of Clinical Governance and Risk	
Meetings where content has been discussed previously	Board Seminar Session – 24 June 2026 Quality Safety and Performance Board Committee (QSPBC) – 25 August 2026 People Board Committee (PBC) – 25 August 2026 Finance Board Committee (FBC) – 26 August 2026 Research Innovation and Population Health Board Committee (RIPHBC) – 1 September 2026 Audit and Risk Committee (ARC)– 9 September 2026 Digital and Estates Board Committee (DEBC) – 10 September 2026 Trust Leadership Team Committee (TLTC) – 16 September 2026	
Purpose of the paper Please check <u>one</u> box only:	☒ For approval ☐ For support ☐ For discussion ☐ For noting	

Executive summary / key messages for the meeting to consider

The Risk Appetite Statement for the organisation has been reviewed and updated as part of the annual review cycle. The update is presented for Board approval following a dedicated Board development session held on 24 June 2026, and review of the proposed statement at the Board Committee's across August and September 2026. A final version is now presented for Board approval.

The revised statement reflects the Board development session and Committee discussions regarding the level of risk the organisation is willing to seek or accept in pursuit of its strategic objectives and provides a clearer framework for decision-making, governance, assurance and risk oversight across all levels of the Trust. Following presentation at the Board Committee's the risk appetite statement has been updated to reflect and respond to the discussions held. The main body of the report includes information on the changes made to the risk appetite statement following the committee meetings.

The proposed update enhances the Trust's risk management framework through revised risk domains, refreshed risk appetite descriptors and the introduction of indicative scoring thresholds. Together, these changes will support a more consistent approach to assessing risk across

strategic, corporate and operational risk registers. The changes will provide greater visibility of the risks operating within, approaching, or outside of agreed appetite enabling more focused discussion and oversight of the controls, assurances and mitigation plans in place.

The revised statement recognises the need for the Board to balance ambition and transformation with assurance and safety. It articulates a lower appetite for risks that could compromise patient safety, organisational culture, governance, cyber security or regulatory compliance. There is a more progressive and transformational approach to risk-taking to deliver strategic transformation, system leadership, partnership working, service re-design and long-term sustainability.

The Risk Appetite Statement provides a reference point for strategic and operational decision-making and will strengthen alignment between risk management and strategic objectives. This will ensure greater consistency in the assessment, escalation and management of risk across MFT.

Recommendation(s)

The Board of Directors is asked to:

- Review and approve the risk appetite statement at Appendix 1.

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 the 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 within this report links to the following strategic, corporate, or operational risks:

	The risk appetite statement is relevant to all risks identified and documented within the risk register. It is particularly relevant to the strategic risk register and Board Assurance Framework supporting identification of risks outside of the appetite of the Board and prompting scrutiny of controls and assurances in place.
Care Quality Commission domains Please check <u>all</u> that apply	☒ Safe ☒ Caring ☒ Effective ☒ Well-Led ☒ Responsive
Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the report: - Risk management is central to good governance and supports the CQC well-led standards. - The risk appetite statement provides a clear guide for decision-making in relation to governance, assurance and risk management including risk relating to compliance and regulatory risk.

Main report
1. Introduction Effective risk management is fundamental to the delivery of the Trust's strategic objectives. A clearly articulated risk appetite statement enables informed decision-making by defining the level of risk the organisation is willing to seek or accept in pursuit of its aims and objectives. The Risk Management Framework, and clear articulation of the risk appetite of the organisation supports wider governance arrangements and consistent, informed and strategically aligned decision making. The current Trust risk appetite statement was approved in May 2025 and is due for annual review. On 24 June 2026 the Board seminar session included a two-hour workshop focused upon risk appetite with the objective of updating the risk appetite statement of the Board. Across August and September 2026, the proposed risk appetite statement was presented to each of the Board committees for consideration and comment and is now presented to the Board of Directors for approval. 2. Definitions of risk appetite and risk tolerance

Risk appetite (strategic intent, set by the Board) defines the level and type of risk the Trust is willing to seek or accept in delivering its strategic objectives. Approved by the Board, it supports effective decision-making whilst maintaining a dynamic approach to risk management. This enables the Trust to respond appropriately to emerging opportunities and threats, ensuring that risks are managed proportionately, whilst supporting the delivery of organisational priorities.

Risk tolerance defines the acceptable level of variation or deviation from the Trusts risk appetite. It supports the identification of risks that remain within acceptable limits whilst supporting decision making where further action may be required.

3. Risk Domains

The risk appetite statement describes our appetite for different domains of risk. The risk domain headings have been reviewed as part of the statement update, with the table below describing the changes made compared to the previous statement approved in May 2025. Domain headers such as 'capital, estates and infrastructure' and 'digital, data and cybersecurity' support comprehensive consideration of risk appetite, especially considering the current strategic risks documented within the Board Assurance Framework (BAF).

Risk Domain (July 2026) statements	Comparison to Risk Domain (May 2025) statements
Capital, Estates and Infrastructure	New domain, added to support statement comprehensiveness.
Culture, Behaviour and Inclusion	Previously within the risk appetite domain of 'People' – this domain has been separated out into 'culture, behaviour and inclusion' and 'workforce, capacity and wellbeing' to support greater articulation of risk appetite.
Digital, Data and Cyber Security	New domain, added to support statement comprehensiveness.
Financial Sustainability and Cash	Amended from Financial/ VfP
Governance, Assurance and Risk Management	Amended from compliance and regulation to more broadly describe governance and assurance risk appetite relating to delivery of services.
Medical Equipment/ Devices	New domain, added following TLTC member discussion and agreement that this should be standalone within the risk appetite statement.
Operational Performance and Flow (including flow, RTT, UEC)	Previously risk appetite was described across two domains of 'performance' and 'delivery'. These have been brought together to reduce duplication.
Partnerships and Integrated Care Delivery	New domain, added to support statement comprehensiveness.
Quality of Care and Patient Safety	Amended from Quality and Safety

Strategic Transformations and Major Programmes	Amended from Research and Innovation
Systems working, Policy and External Change	New domain, added to support statement comprehensiveness.
Workforce, Capacity and Wellbeing	Previously within the risk appetite domain of 'People' – this domain has been separated out into 'culture, behaviour and inclusion' and 'workforce, capacity and wellbeing' to support greater articulation of risk appetite.

4. Risk Appetite Descriptors

The following descriptors are used to describe the risk appetite of the organisation as follows:

Risk Appetite	Descriptor
Averse	We adopt an extremely cautious stance towards risk. Exposure is accepted only where unavoidable or required to meet statutory, regulatory or safety obligations, and is subject to stringent controls, oversight and assurance.
Limited	We take a cautious approach accepting only low levels of risk. Risks must be well understood, tightly controlled and supported by strong assurance, with a clearly documented rationale for acceptance.
Measured	We are willing to accept moderate risk where there is clear and demonstrable evidence of benefit. Risks are actively managed through proportionate controls, robust mitigation plans, and effective governance and assurance arrangements.
Progressive	We are prepared to accept higher levels of risk where there is a strong strategic, operational or transformational benefit. Risks are carefully assessed, mitigations are robust, and the potential rewards outweigh the potential adverse impacts.
Transformational	We are willing to accept significant levels of risk where there is potential for substantial long-term benefit, innovation and transformation. Decisions are informed by comprehensive analysis, good governance and a clear alignment with the organisation's strategic objectives.

The descriptors have been updated from those utilised in the May 2025 risk appetite statement (none, averse, cautious, open, eager) to align with modern risk management practice and to provide a spectrum of risk appetite that better aligns with the language utilised in the NHS and the strategic objectives of MFT.

The risk appetite statements have been formed following the discussions that took place during the Board seminar session on 24 June 2026. Discussions included review of the risk appetite domains in place, and the narrative content of each of the domains. including where controls

and assurance are required in response to risk appetite level and to support robust risk management and oversight.

5. Indicative Scoring Thresholds

The risk appetite statement introduces indicative scoring thresholds for the first time. These provide a qualitative definition of when an individual risk is outside of risk appetite. Using the capital, estates and infrastructure domain as an example, any risk scoring 15 or above would be described as beyond the risk appetite set by the Board. This will support both the Board and operational teams to clearly identify risks where (i) treatment is required to either reduce the likelihood or impact of the risk; (ii) testing of the reliability of controls and assurance are important to ensure mitigation is robust and (iii) escalation is required through the organisation to seek support for management of the risk. The addition of qualitative thresholds will support application of risk appetite at Board, Clinical Group and operational team level.

Risk Appetite	Scoring thresholds
Averse	Within appetite: less than 6 Approaching appetite: 6-8 Outside of appetite: 8+
Limited	Within appetite: 8 or below Approaching appetite: 9 Outside of appetite: 10+
Measured	Within appetite: 9 or below Approaching appetite: 10 Outside appetite: 12+
Progressive	Within appetite: 10 or below Approaching appetite: 12 Outside of appetite: 15 or above
Transformational	Within appetite: 12 or below Approaching appetite: 15 Outside of appetite: 16 or above

6. Changes made following Board Committee consideration and review

The risk appetite statement has been presented to the Board committees held across August and September to give members opportunity for consideration, comment and update of the risk appetite statement. A summary of changes made from the original draft shared at committees to the final version is shown below. No changes were made to the statement following presentation at RIPHBC, DEBC

Committee	Feedback received on the draft statement	Changes made to statement
QSPBC/ FBC	Feedback from Nick Gower Non-Executive Director, that the risk appetite statements are primarily a decision-making tool and not to be used for retrospective judgement.	Additional narrative statement added within 'risk appetite philosophy' section to articulate this within the risk appetite statement.
QSPBC/ FBC	Feedback from Nick Gower Non-Executive Director, that there may be times when the Board accepts that despite agreed actions risk may remain outside of appetite. Discussions at committees agreed this point and requested addition of this point to the risk appetite statement.	Additional narrative statement added within 'risk appetite philosophy' section to articulate this within the risk appetite statement.
QSPBC	Feedback from Jackie Hanson Non-Executive Director, that the risk appetite descriptor of measured for quality of care and patient safety was not consistent with the limited risk appetite descriptor for operational performance and flow. Following committee discussions, it was agreed that the risk appetite descriptor for quality of care and patient safety should be amended to limited.	The risk appetite descriptor for quality of care and patient safety has been amended to limited, and the indicative scoring thresholds amended to reflect this.
FBC	Feedback from members that it would be useful if the definitions of risk appetite levels, available within the paper, are included within the risk appetite statement itself.	The definitions of the risk appetite level been added to the risk appetite statement.
FBC	Committee members fed back that the 'what this means in practice' statements included in the risk appetite statement were helpful. However, the 'what this means in practice' statement for capital estates and infrastructure should be strengthened to articulate the management of risk in capital decisions relating to estates, medical devices and digital.	The 'what this means in practice' statement was re-written to reflect discussion held at committee.
PBC	Feedback from Angela Adimora Non-Executive Director, asked that the risk appetite area of Culture, Behaviour and Inclusion be updated to refer to patients and colleagues (not staff).	The risk appetite statement for Culture, Behaviour and Inclusion was updated to reflect that safety, experience, dignity and compassion are all relevant

		to both patients and colleagues.
RIPHBC	Feedback from Chris McLoughlin Non-Executive Director, regarding the importance of drawing out relevant to working with long standing partners in relation to joint ownership and mitigation of risk – with Manchester City Council and Trafford Council referenced specifically.	The 'what this means in practice' section of the Partnerships and Integrated Care Delivery risk area was updated to reflect joint ownership and mitigation of risk with long standing partners. During Board approval consideration should also be given to agreement to share the risk appetite statement with long standing partners.
TLTC	The committee agreed that a key risk area of 'Medical Equipment' should be added to the risk appetite statement.	The risk appetite statement now includes a key risk area of medical equipment.
Comment across all committees	Feedback across the committees suggested that the risk appetite descriptors could be more specific with additional detail provided.	The risk appetite descriptors have been reviewed and enhanced. Whilst keeping the descriptors succinct additional information to help contextualise the descriptors has been provided.

7. Recommendations

The Board of Directors is asked to:

- Review and approve the risk appetite statement at Appendix 1.

Appendix 1: Risk Appetite Statement

Manchester University NHS Foundation Trust

Risk Appetite Statement

August 2026

Our risk appetite philosophy

Manchester University NHS Foundation Trust (MFT) operates in one of the most complex health and care environments in England. Our risk appetite reflects a balance between ambition and assurance: enabling transformation, partnership working and innovation, while protecting patient safety, care quality, workforce wellbeing, financial sustainability, and public trust.

Risk appetite is not about avoiding risk, it is about clarity of tolerance, confidence in control, and alignment with outcomes. We accept risk where it improves care, strengthens sustainability, or accelerates transformation, and we reject risk where it harms patients, de-stabilises services, or undermines accountability.

The risk appetite statement is primarily a decision-making tool, rather than a mechanism for retrospectively judging decisions. It is not a precise system, and there may be circumstances where risks sit outside the Board's stated appetite due to external factors or operational pressures. In these circumstances, the focus should be on understanding the rationale, identifying and understanding the controls in place and assurances received regarding control effectiveness, and ensuring clear actions are identified to manage or reduce the risk. Sometimes despite agreement of actions within Board control, risk may continue to sit outside of appetite.

This risk appetite statement sets out our intent as to how we manage this balance, supporting decision making throughout MFT from our colleagues who work with patients daily, to our Board of Directors who make decisions about the strategic direction of our organisation.

Our definition of risk appetite levels

Risk appetite is defined as ‘the amount and type of risk that an organisation is prepared to pursue, retain or take.’¹ The Board of Directors has considered the key risk areas faced by the organisation and articulated a risk appetite based on the definitions given below. Acknowledging that risk management is dynamic and decision-making in relation to risk and risk appetite must consider the context at any given time, we have documented our approach to risk utilising the risk appetite levels below, ranging from averse to transformational.

Risk Appetite	
Averse	We adopt an extremely cautious stance towards risk. Exposure is accepted only where unavoidable or required to meet statutory, regulatory or safety obligations, and is subject to stringent controls, oversight and assurance.
Limited	We take a cautious approach accepting only low levels of risk. Risks must be well understood, tightly controlled and supported by strong assurance, with a clearly documented rationale for acceptance.
Measured	We are willing to accept moderate risk where there is clear and demonstratable evidence of benefit. Risks are actively managed through proportionate controls, robust mitigation plans, and effective governance and assurance arrangements.
Progressive	We are prepared to accept higher levels of risk where there is a strong strategic, operational or transformational benefit. Risks are carefully assessed, mitigations are robust, and the potential rewards outweigh the potential adverse impacts.
Transformational	We are willing to accept significant levels of risk where there is potential for substantial long-term benefit, innovation and transformation. Decisions are informed by comprehensive analysis, good governance and a clear alignment with the organisation’s strategic objectives.

¹ International Standard ISO:31000:2018 Risk Management - Guidelines

Our risk appetite statements

Key Risk Areas	Risk Appetite	Risk Appetite Statement	What This Means in Practice	Indicative Scoring Thresholds
Capital, Estates & Infrastructure	Measured	MFT accepts prioritisation risk where capital decisions deliver safer environments, improved compliance, better patient experience, and more resilient infrastructure. Risk is acceptable when investment leads to clear improvements in estate safety, clinical environments, and operational reliability. Exposure that compromises statutory compliance or patient safety is outside of appetite.	Capital resources will be prioritised across Estates, Medical Devices and Digital to manage the Trust's most significant safety, compliance, operational resilience and transformation risks. Investment decisions must be evidence based, transparent and aligned to organisational priorities. Mitigation plans must be clear for backlog maintenance, autoclaved aerated concrete (RAAC), fire safety and ventilation issues. Where critical estates, equipment or digital risks cannot be mitigated within available resources, these must be subject to explicit Board oversight, agreed mitigation and define recovery trajectory.	Within appetite: 9 or below Approaching appetite: 10 Outside appetite: 12+
Culture, Behaviour & Inclusion	Averse	MFT has no appetite for cultural or behavioural risk that undermines safety, experience, dignity, or compassion, for our patients and colleagues, or impacts to psychological safety. Risk is acceptable only when cultural change leads to clear improvements in safety culture, leadership behaviours, inclusion, and team reliability. Cultural risk is outside appetite when it results in: - Compromised patient safety or experience - Psychological safety failures or fear of speaking up	Zero tolerance for behaviours that compromise safety, dignity, respect, or inclusion. Speaking-up concerns must be acted on quickly. Leadership behaviours must model values consistently. Cultural deterioration that impacts care quality triggers immediate intervention.	Within appetite: less than 6 Approaching appetite: 6-8 Outside of appetite: 8+

		- Discriminatory or exclusionary behaviours - Leadership behaviours that destabilise teams - Cultural deterioration that impacts care quality or reliability		
Digital, Data & Cyber Security	Progressive (Innovation) Averse (Cyber & Data)	MFT supports progressive digital risk where innovation delivers better decision-making, improved flow, stronger productivity, and enhanced clinical outcomes. Cyber and data risk is outside appetite unless controls ensure system reliability, data integrity, and uninterrupted clinical care. Exposure that threatens patient safety, system availability, or data accuracy is not tolerated.	Innovation (AI, automation, digital redesign) is encouraged with strong governance. Cyber controls must meet DSPT, NCSC, and NHS England standards. System outages or data loss require immediate escalation.	Innovation risk (Progressive): Within appetite: 10 or below Approaching appetite: 12 Outside of appetite: 15 or above Cyber/Data risk (Averse): Within appetite: less than 6 Approaching appetite: 6-8 Outside of appetite: 8+
Financial Sustainability & Cash	Measured (with targeted progressive exposure)	MFT accepts measured financial risk with targeted progressive exposure where investment delivers clear value, stronger productivity, improved sustainability, and long-term resilience. Risk is acceptable when decisions are commercially grounded, costed, and supported by credible return-on-investment. Financial risk is outside appetite when it threatens liquidity, solvency, regulatory confidence, or recurrent sustainability.	Investment decisions must be costed, commercial, and evidence-based. Non-recurrent savings must have a credible exit plan. Cash deterioration or liquidity risk is outside appetite.	Within appetite: 9 or below Approaching appetite: 10 Outside appetite: 12+
Governance, Assurance &	Limited	MFT has low tolerance for governance risk that weakens	Risks must be clearly articulated through the BAF with defined	Within appetite: 8 or below Approaching appetite: 9

Risk Management		visibility, escalation, accountability, or informed decision-making. Risk is acceptable only when governance reform leads to better assurance, clearer accountability, and stronger delivery confidence. Assurance gaps that obscure outcome risk are outside appetite.	trajectories. Escalation must be timely and evidence-based. Assurance gaps require immediate action. Committees must provide triangulated insight, not data volume.	Outside of appetite: 10+
Medical Equipment/ Devices	Limited	MFT has a limited appetite for risks relating to the availability, reliability and management of medical equipment and medical devices. We are willing to accept carefully managed risk where it supports innovation, replacement programmes, technological advancement improvements to patient safety and patient outcomes. However, we have a low tolerance for risks that could cause patient harm, or impact regulatory compliance, service continuity and ability of colleagues to deliver safe care.	Medical equipment must be maintained, tested, calibrated and serviced in accordance with statutory requirements, manufacturer guidance and local maintenance schedules. Equipment operating beyond recommended lifecycle, particularly critical equipment, must be subject to enhanced oversight, with clear understanding of reliability, maintenance requirements, availability of spare parts, manufacturer support arrangements and business continuity plans. Decisions regarding allocation of capital & revenue annual funding for decommissioning & replacement equipment & business cases for new equipment must be risk based and clinically informed to ensure safe prioritisation.	Within appetite: 8 or below Approaching appetite: 9 Outside of appetite: 10+
Operational Performance & Access (including	Limited (with targeted, time-bound measured exposure)	MFT accepts only targeted, time-bound measured exposure where doing so will deliver clear improvements in flow, reduced overcrowding, shorter waits, and	Recovery plans must be credible, costed, and time-limited. Flow deterioration or RTT harm must trigger rapid intervention.	Within appetite: 8 or below Approaching appetite: 9 Outside of appetite: 10+

Flow, RTT, UEC)		more reliable access. Risk is acceptable only when recovery plans are credible, costed, time-limited, and actively governed. Performance risk is outside appetite when deterioration is persistent, unfunded, harms patients, or lacks a deliverable recovery trajectory.	Performance outside appetite requires explicit Board acceptance.	
Partnerships & Integrated Care Delivery	Progressive	MFT supports ambitious partnership risk where collaboration demonstrably improves flow, strengthens community capacity, reduces avoidable admissions, and narrows health inequalities. Risk is acceptable when partners commit to shared accountability for outcomes, with clear objectives, measurable impact, and joint ownership of delivery. Partnerships are outside appetite when: • MFT cannot influence or shape outcomes • Accountability is diffuse or contested • Governance is unclear or ineffective • Measurable improvement cannot be demonstrated • Partners do not share responsibility for delivery or consequences	Partnerships must have shared accountability for outcomes and deliver measurable improvement. MFT will work with long term partners to understand shared risk and agree their joint ownership and mitigation. MFT will withdraw or redesign partnerships that do not deliver outcomes. Governance must be clear, effective, and jointly owned.	Within appetite: 10 or below Approaching appetite: 12 Outside of appetite: 15 or above
Quality of Care & Patient Safety	Limited (Low tolerance for harm)	MFT accepts time-limited variation only where there are clear benefit, strong evidence, and robust controls. There is very low tolerance for avoidable harm, including	Safety risks must be identified early and mitigated quickly. Never Events, deterioration, or infection control failures require immediate action. Data and learning systems must	Within appetite: 8 or below Approaching appetite: 9 Outside of appetite: 10+

		deterioration, infection, delays, or reliability failures. Risk is acceptable only when it enables safer care, earlier intervention, improved reliability, and better outcomes. Normalisation of harm or unmanaged deterioration is outside appetite.	support early detection and intervention.	
Strategic Transformation & Major Programmes	Transformational	MFT accepts significant delivery risk where transformation programmes deliver material improvement in patient outcomes, workforce experience, productivity, and long-term sustainability. Risk is acceptable when transformation is realistically resourced, governed through strong assurance, and delivers clear, evidenced benefits. Stop Rules: Transformation must pause, reset, or escalate when: • Care standards deteriorate • Operational performance declines without credible recovery • Workforce wellbeing or leadership resilience is harmed • Benefits cannot be evidenced or tracked • Governance weakens or milestones repeatedly slip • Financial exposure increases without clear return • System dependencies cannot be secured Transformation must strengthen not destabilise everyday care.	Transformation must be realistically resourced and governed through SPMO. Benefits must be evidenced, tracked, and reported. Programmes must pause or reset when care standards decline. Transformation must strengthen not destabilise everyday care.	Within appetite: 12 or below Approaching appetite: 15 Outside of appetite: 16 or above

System Working, Policy & External Change	Progressive	MFT accepts higher levels of strategic risk where system collaboration and policy change deliver better access, improved population health, reduced inequality, and a more sustainable care model. Risk is acceptable when decisions are evidence-led, system-aligned, and outcome-driven, with clear ownership and strong governance. Uncoordinated change, unmanaged system instability, or policy shifts that do not improve outcomes are outside appetite.	Decisions must be evidence-led and system-aligned. MFT will lead and shape system change where outcomes improve. Uncoordinated or weakly governed system change is outside appetite.	Within appetite: 10 or below Approaching appetite: 12 Outside of appetite: 15 or above
Workforce, Capacity & Wellbeing	Measured	MFT accepts moderate, time-limited workforce risk where doing so will improve recruitment, strengthen retention, stabilise staffing, and enhance wellbeing. Risk is acceptable when it enables better rostering, improved leadership capability, reduced agency reliance, and clear improvements in team stability and safety. Workforce risk is outside appetite when it results in unsafe staffing, burnout, leadership fragility, or deterioration in care quality.	Workforce redesign must deliver clear improvements in stability and safety. Agency reliance must reduce with a credible exit plan. Burnout, unsafe staffing, or leadership fragility are outside appetite. Investment must strengthen leadership capability, wellbeing, and retention.	Within appetite: 9 or below Approaching appetite: 10 Outside appetite: 12+