Manchester University NHS Foundation Trust

Annual Report and Accounts

1st April 2025 to 31st March 2026

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Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

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INTRODUCTION

Introduction from the Interim Trust Chair

It is my privilege, as Interim Chair of Manchester University NHS Foundation Trust, to introduce this Annual Report for 2025/26. This has been another successful year for the Trust, marked by strong performance, continued progress against our strategic objectives, and – most importantly – the sustained commitment of our staff to delivering high-quality, compassionate care to the communities we serve.

MFT continues to operate at significant scale and complexity, serving a diverse and growing population across Manchester and beyond. Against a backdrop of ongoing pressures faced by the NHS nationally, the Trust has demonstrated resilience, adaptability, and a clear focus on patient outcomes. Throughout the year, we have maintained our commitment to improving quality, strengthening governance, and delivering safe, effective services across all of our hospitals and community settings.

This year has seen a number of important achievements and areas of progress. We have continued to invest in our clinical services and infrastructure, ensuring that we are well placed to meet the demands of a modern healthcare system. Major strategic programmes, including estate redevelopment and service transformation, continue to move forward at pace, supporting our ambition to provide outstanding care in environments that are fit for the future. Alongside this, we have further embedded our approach to quality improvement, with a focus on learning, safety, and continuous development across our Clinical Groups.

This year has also reinforced the importance of strong leadership and governance. The Board of Directors, supported by its committees, has continued to focus on providing robust assurance, maintaining oversight of performance, and supporting the executive team in delivering the Trust's priorities. We remain committed to transparency, accountability, and continuous improvement in all aspects of our governance arrangements.

Partnership working has remained central to our success. As a key partner within the Manchester and Greater Manchester health and care system, we have continued to work collaboratively with the Integrated Care Board, other NHS Trusts, local authorities, primary care, the voluntary sector, and our academic partners. These relationships are vital in enabling us to deliver joined-up care, address health inequalities, and support the wider determinants of health for the populations we serve.

Above all, I want to acknowledge the extraordinary efforts of our staff. Across every role and every setting, our colleagues continue to demonstrate professionalism, compassion, and an unwavering commitment to our patients. The dedication shown by our clinical and non-clinical teams alike is the

foundation of everything we achieve as an organisation. Whether delivering frontline care, supporting essential services, or enabling the effective running of the Trust, their contribution is both vital and deeply valued. We also understand the challenges faced by some of our staff and an example of this was highlighted at the Board when we heard from colleagues affected by changes to immigration law and visa requirements. In that case, and all others, we will continue to listen first-hand to our staff and do all that we can to help. Our people are MFT's greatest asset.

I would also like to take this opportunity to recognise and thank our previous Chair, Kathy Cowell CBE DL, who left the Trust on the 30th April 2025 to become the Regional Chair of NHS (North West). Kathy has provided strong and thoughtful leadership to the Board of Directors over the last nine years, guiding the organisation through a period of opportunity and challenge. Her commitment to high standards of governance, her support for our staff, and her dedication to the values of the NHS have been instrumental in the Trust's continued success.

In closing, I would like to thank our patients, their families, our staff, our governors, our volunteers, and all of our partners for their ongoing support. Together, we have delivered another successful year for Manchester University NHS Foundation Trust. Looking ahead, we are conscious of the challenges that remain, but we approach the future with confidence. The strength of our people, the clarity of our strategic direction, and the depth of our partnerships provide a solid foundation on which to build further progress.

Trevor Rees
Interim Trust Chair

Introduction from the Trust Chief Executive

This year has been one of clear progress at MFT, as we have continued to deliver our strategy and strengthen our foundations for the future.

In the last 12 months, we have refreshed our strategic direction to ensure it reflects the scale of our ambition and the realities we face as one of the largest providers of healthcare in the country. Our refreshed strategy – *Where Excellence Meets Compassion* – provides a clear framework for how we improve outcomes, reduce inequalities, support our colleagues and teams, and use our resources responsibly. The progress teams have made on behalf of our population this year shows that we are moving in the right direction.

A key focus has been improving access and experience. We reduced our waiting list by 26,000 patients and treated 23,000 more people within 18 weeks compared to the previous year. Cancer pathways have strengthened, with a sustained improvement in the number of people receiving a diagnosis or having cancer ruled out within 28 days – representing our highest level of performance in a decade.

Urgent and Emergency care access continues to improve despite high levels of demand, with over half a million attendances across our Emergency Departments. Alongside this, we are strengthening quality and experience, with improvements reflected in more positive results across key national patient surveys.

While these improvements are encouraging, we are not yet where we want to be. Demand remains high and improving safe and timely access will remain one of our most important priorities for the coming year, alongside a renewed focus on patient experience. We must also continue to listen and act on colleague feedback, ensuring that every working environment at MFT is safe, respectful and supportive.

As well as a focus on continuous improvement, we are committed to driving a step change in how care is delivered. Through our One MFT operating model, service transformation programmes, and the growing use of digital and data, we are redesigning patient pathways in line with the ambitions set out in the NHS 10 Year Plan – bringing care closer to home and making it more convenient. Initiatives such as our community Single Point of Access are supporting more patients to receive urgent and emergency care away from Emergency Departments. The expansion of our Hospital at Home service to over 200 beds, is also key. We are treating more patients in the right place for their needs first time - improving outcomes, experience and sustainability. Our network of Community Diagnostic Centres has now delivered over 500,000 tests, supporting faster diagnosis and bringing

care closer to communities.

We have also made strong progress in digital transformation to support care. Over the past year, uptake of the MyMFT app has grown to more than 620,000 users, alongside the expansion of digital booking tools to improve convenience and reduce missed appointments. Ambient Voice Technology is being used to capture consultation notes – supporting clinicians to focus on the patient interaction - and continue to optimise our electronic patient record to release clinical time, improve coordination of care and support better access.

In what continues to be a significantly challenging financial environment nationally, the delivery of a break-even financial position reflects strong financial discipline and a clear focus on value for patients and communities. We will further strengthen this discipline in the year ahead, ensuring we live within our means and make best use of our resources.

Partnership working is vital. We are grateful for our strong working relationships with NHS partners, local authorities, the voluntary and community sector and academic and industry colleagues across Greater Manchester. Together, we are developing more integrated models of care that improve access, whilst tackling inequalities and supporting one of the largest research and innovation portfolios in the country to bring the latest treatments to our patients, faster.

None of this would be possible without the incredible commitment, skill and compassion of our teams. I would like to thank everyone at MFT for all they do for our patients and communities. I would also like to thank the Board of Directors and Council of Governors for their continued leadership, support and constructive challenge.

The pressures facing the NHS remain significant, but thanks to the diverse talent in our organisation, we are making real progress. By maintaining our focus on access, accelerating transformation, and working together as One MFT, we are building the foundations for a step change in how we deliver care in the years ahead.

Mark Cubbon
Trust Chief Executive

Introduction to Manchester University NHS Foundation Trust

Manchester University NHS Foundation Trust (MFT) was formed in 2017 when Central Manchester Foundation Trust and the University Hospital of South Manchester Foundation Trust merged. In April 2018, Manchester Local Care Organisation was formed with Trafford Care Organisation following in October 2019. North Manchester General Hospital joined the MFT family on the 1st April 2021.

We employ over 30,000 staff and provide a comprehensive range of services across 10 hospital sites and through multiple community services. We provide care for people before they are born right through to the end of their lives.

We provide local hospital services to a diverse population of almost 1 million people, including accident and emergency, diagnostic tests, outpatient appointments and day case surgery.

We are the biggest provider of specialised services in England – which includes major surgery and highly specialised medicine. People come from across the United Kingdom to receive care at MFT. Our teams support people with both their physical and mental health, including mental health services for children and young people.

We recruit more people to research studies than any other provider in the North West region, with the second highest number of participants nationally. This allows us to give the people who access our services and our communities access to the very latest treatments and innovations.

Our annual budget is approximately £3bn.

Our services

MFT's hospitals and community services are grouped together into six clinical groups, each with their own leadership team. Clinical groups are accountable and responsible for the management and governance of their sites and services and, in some case for 'single services' which operate across multiple sites.

Manchester Royal Infirmary (MRI) Clinical Group

MRI is an acute teaching hospital and provides general and specialist services including vascular, major trauma, kidney and pancreas transplant, haematology and cardiac services.

North Manchester General Hospital (NMGH) Clinical Group

NMGH provides a full range of general hospital services to its local population and is the base for the region's specialist infectious disease unit.

Specialist Hospitals Clinical Group

This group is comprised of Royal Manchester Children's Hospital (RMCH), Saint Mary's Managed Clinical Service (SMMCS) and Manchester Royal Eye Hospital (MREH).

- RMCH is a specialist children's hospital and provides general, specialised and highly specialist services for children and young people across the whole of MFT.
- SMMCS is a specialist women's hospital as well as being a comprehensive Genomics Centre and provides general and specialist medical services for women, babies and children across MFT.
- MREH is a specialist eye hospital and provides inpatient and outpatient ophthalmic services across MFT.

Wythenshawe, Trafford, Withington and Altrincham (WTWA) Clinical Group

Wythenshawe is an acute teaching hospital and provides specialist services including cardiac services, heart and lung transplantation, respiratory conditions, breast care services. Trafford General Hospital is home to the Manchester Elective Orthopaedic Centre as well as specialist rehabilitation services. Withington and Altrincham hospitals principally provide out-patients services.

Local Care Organisation's and Dental (LCO and Dental) Clinical Group

This group incorporates Manchester Local Care Organisation (MLCO) and Trafford Local Care Organisation (TLCO) that provide NHS Community Health and Adult Social Care services. The group also includes University Dental Hospital of Manchester (UDHM, which is a specialist dental hospital and provides dental services across MFT.

Clinical and Scientific Services (CSS) Clinical Group

CSS provides laboratory medicine, imaging, allied health professional services, critical care, anaesthesia and perioperative medicine and pharmacy across MFT.

Research and Innovation (R&I)

Research and Innovation activity is conducted across all our Clinical Groups supported by more than 600 R&I colleagues, including our integrated Research Office, Clinical Delivery and Operational Management teams, Innovation services, and MFT-hosted organisations. These include Health Innovation Manchester and one of the largest National Institute for Health and Care Research (NIHR) portfolios in the country, comprised of:

- NIHR Applied Research Collaboration Greater Manchester (ARC)
- NIHR Manchester Biomedical Research Centre (Manchester BRC)
- NIHR Greater Manchester Commercial Research Delivery Centre (CRDC)
- NIHR Manchester Clinical Research Facility (CRF)
- NIHR HealthTech Research Centre in Emergency and Acute Care (HRC)
- NIHR North West Regional Research Delivery Network (RRDN)

Our Values

The way that we work at MFT is underpinned by our values.

We are compassionate. We will:

- Care about people, focusing on the needs of all our patients and staff.
- Reduce our impact on the environment.
- Support local people and the local economy in our role as a large local employer and consumer.

We are curious. We will:

- Use digital technology and other innovations to improve the way we work for patients and our colleagues.
- Use data, insight and evidence to inform the way we deliver services and make decisions.

We are collaborative. We will:

- Involve patients and our communities in the planning and delivery our services.
- Work together as one team across MFT.
- Work together with partners across Greater Manchester.
- Use our influence locally and nationally to the benefit of our patients, our communities and our partners.

We are open and honest. We will:

- Listen and respond to feedback from staff, patients, communities and partners.
- Celebrate our successes.
- Be honest about where things can be better and share learning to make improvements.

We are inclusive. We will:

- Address health inequalities, ensuring everyone can get the care they need and the best possible outcomes whatever their identity or background.
- Build a diverse workforce at all levels in which everyone can belong, and which reflects the people who use our services, helping us to deliver better care and build trust with our communities.

Our strategy: Where Excellence Meets Compassion

Our five-year strategy confirms our mission to work together to improve the health and quality of life of our diverse communities. It sets out:

- Five strategic aims and the difference that we will make in delivering them. They are:
    - Work with partners to help people live longer, healthier lives.
    - Provide high quality, safe care with excellent outcomes and experience.
    - Be the place where people enjoy working, learning and building a career.
    - Ensure value for our patients and communities by making best use of resources.
    - Deliver world-class research and innovation that improves people's lives.
- 11 objectives that describe the things that we will do in the coming years to deliver our aims.
- Specific actions under each objective that we will prioritise as we deliver our strategy. These actions do not cover everything that we are doing as an organisation, but they will be our areas of focus in the coming years as we believe they will make the biggest difference.

Our aims, objectives and actions shape the work that we do over as an organisation, both as teams and as individuals.

Whilst our objectives and actions refer to specific services and programmes of work, they also provide a framework to guide all our plans across the whole of MFT.

We refreshed our Strategy mid-year to ensure continued alignment with the NHS 10-Year Health Plan, the Life Sciences Sector Plan and the Greater Manchester Strategy. Overall, there was good alignment between the MFT Strategy and these national and system priorities, however we identified areas where our strategy could go further, in particular around our ambitions relating to community services and digital innovation. The refresh also incorporated stakeholder feedback, strengthening our focus on prevention, digital transformation and patient experience, and ensuring the strategy remains responsive, relevant and forward-looking.

Delivering our strategy in 2025/26

Below are examples of our work during 2025/26 to deliver our strategy. Further details of our performance during 2025/26 can be found in the Performance Report section of this report.

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

- We have grown the **Citizens Advice services** available on our hospital sites. Up to 90 referrals are made on average each month and people have been supported to access over £3m of financial support since the initiative began.
- We are working with partners as part of the **Work Well programme**, with over 1,500 people

accessing employment support following referrals from MFT services.

- For patients needing emergency and urgent care our **Single Point of Access** (SPoA) model went live in November and has seen over 53% of patients safely redirected to community services or Same Day Emergency Care, rather than our emergency departments.
- We developed our **Hospital at Home service** further with up to 200 virtual beds in place over winter providing an alternative to hospital admission, supporting timely discharge and reducing pressure on inpatient beds.
- In 2025/26 we reached the milestone of 500,000 tests though our **Community Diagnostic Centres** (CDCs) and expanded the range of tests offered at Harpurhey CDC to include MR and CT scanning. We were successful in a bid to establish a further CDC at Gorton Hub, providing imaging and ophthalmic appointments, with plans to deliver a greater range of tests in the future.
- Trafford Local Care Organisation musculoskeletal team have redesigned the referral-to-treatment journey for patients through **Community Appointment Days**. Patients now receive assessment, treatment and advice on the same day in convenient community venues with shorter waits, faster access to imaging and treatment and around 70% of patients safely discharged to self-manage.
- We are working with partners to develop a **new model for brain health** in Manchester, focused on much earlier and more accurate diagnosis of dementia and cognitive decline and addressing the risk factors that can influence the progression of dementia.
- MFT is the first **HIV-competent organisation** in the North West which forms part of a wider action plan developed by the Department for Health and Social Care.
- Our **Roots to Dental programme** supports people experiencing long-term unemployment to overcome oral health barriers and move closer to work, with dental students providing the treatment. Following a successful initial pilot of 200 Manchester residents, it is now expanding to reach more people, whilst also training the next generation of dentists.

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

- Improved results in key **patient surveys**, including maternity, adult inpatients and cancer.
- There was a 6% increase in the number of clinical areas that achieved Gold awards through the **MFT Clinical Accreditation Programme**.
- Our **Child and Adolescent Mental Health Services**, who look after the mental health of children and young people was assessed as good by the Care Quality Commission.
- A Trust-wide **Active Hospital programme** was launched to prevent the avoidable harm of deconditioning during hospital stays, training 350 colleagues as Physical Activity Clinical Champions and 1,760 on the importance of active mobilisation, resulting in the establishment of active champion networks across all Clinical Groups.
- In 2025/26 the **number of people waiting for treatment** had reduced by 26,000, with 23,000 more people treated within 18 weeks – a 12-percentage point improvement since March 2025.

- Our **Care Closer to Home** programme helped to deliver a 14-percentage point improvement in the number of people seen and treated within 4 hours in our Accident and Emergency Department at the MRI whilst also reducing the number of people admitted to the hospital as an emergency.
- MFT is now one of the top performers for **ambulance handover performance** in the country meaning that ambulances are able to get back onto the roads and responding to emergency patients faster.
- Our **expanded robotic surgery programme** is improving access to precision procedures across Wythenshawe Hospital, Saint Mary's Hospital, Manchester Royal Infirmary, Royal Manchester Children's Hospital, and Trafford General Hospital.
- Thanks to a successful appeal by the MFT Charity, a new **MediCinema** is due to open on the Oxford Road Campus, screening films to children and adults staying in our hospitals.
- MFT has been successfully awarded the contract to provide the **new regional North West Genomic Medicine Service (NW GMS).**

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

- We support a wide range of **staff networks** and forums, including race equality, disability, LGBTQ+ and faith networks, which provide safe spaces for lived experience, peer support and organisational influence.
- Ranked the top performing Trust in England in response to 10 Point Plan for **Working Lives of Resident Doctors.**
- Our **Removing the barriers programme** focuses on tackling race inequality. Through this programme we have improved our recording of ethnicity data and implemented targeted mentoring and development opportunities for ethnically diverse colleagues.
- Through our **Widening Participation Programme**, we now host more than 900 work experience placements annually.
- The number of new **apprentices** increased by over 100 to 361 in 2025, with the total number of apprentices in post across MFT up to more than 750.
- The Trust has recently launched its **LGBTQ+ Inclusion Plan**, setting out a framework to improve experiences for LGBTQ+ patients, colleagues and communities, and reinforcing MFT's commitment to visibility, safety and belonging.
- We went live with our new **clinically-led operating model** across MFT.
- We recruited over 100 people from **community recruitment days**, to get local people into MFT jobs. This work continues and we are continuing to reduce barriers to employment/progression for local people.
- We have over 350 **volunteer career ambassadors**, delivering 79 engagement sessions over the last year, including sessions with local schools highlighting NHS career opportunities. We now host over 900 placements across work experience and widening participation programmes.

Strategic Aim 4: Ensure value for our patients and communities by making best use of resources.

- We delivered our financial plan and a **break-even position** in 2025/26.
- We were ranked as the **most digitally mature acute trust** in the country by NHS England.
- More than 620,000 people are now using our **MyMFT app**, giving them greater access to their records and control of their care. We have rolled out a range of digital letters and booking tools, providing a more convenient experience and helping people to attend appointments at a convenient time for them.
- We have piloted the use of **Ambient Voice Technology** in clinics and our emergency departments, improving the experience of patients and clinicians and allowing us to care for more people.
- Over the last 12 months, we have delivered our largest **reduction in carbon footprint** at MFT in five years putting us on track for a 20% emissions reduction from our 2019/20 baseline.

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

- Following a competitive funding award process during 2025, the MFT-hosted **NIHR Applied Research Centre** (ARC-GM) will be funded for a further five years from April 2026, with an award of nearly £16.3 million. This funding will enable ARC-GM to continue shaping policy, improve services, and deliver meaningful change in areas including reducing health inequalities, transforming healthy ageing and long-term conditions care, and digital and data innovation across the city region.
- A patient at Manchester Royal Infirmary (MRI) became the first in the UK to receive Obe-cel - a **revolutionary stem cell treatment** for acute lymphoblastic leukaemia, following NICE approval. MFT was the top site globally for patient recruitment to trials of Obe-cel, playing a key role in securing NICE approval.
- Over the course of 2025, a three-year old boy became the first person in the world to receive a revolutionary **new stem cell gene therapy** for the rare life-limiting genetic condition Hunter syndrome at Royal Manchester Children's Hospital (RMCH). The revolutionary treatment involves removing a patient's stem cells, replacing the faulty gene which causes Hunter syndrome, and reinjecting the modified cells.
- Researchers from MFT, collaborated with scientists globally to analyse the genetic data of thousands of individuals to help discover two **new neurodevelopmental disorders**, paving the way for improved diagnosis and opening new doors for future treatments.
- A new once-daily **cystic fibrosis treatment** trialled at Wythenshawe Hospital was approved for use on the NHS by the National Institute for Health and Care Excellence. It is hoped that the treatment could make a big difference to people with cystic fibrosis, with more convenience and flexibility, helping to simplify their treatment.
- Teams across MFT celebrated the recruitment of the 1,000th baby to the **Generation Study**. Led by Genomics England in partnership with NHS England, the study offers whole genome sequencing testing for newborn babies to help identify more than 200 rare genetic conditions

that can be treated early in life.

- Research published in the Journal of Thoracic Oncology demonstrated the impact that the **Lung Cancer Screening Programme** – pioneered at Wythenshawe Hospital – with a 22% reduction in lung cancers diagnosed at a late stage. Thanks to the screening programme, 79% of lung cancers in Greater Manchester are now diagnosed at Stage 1 or 2, helping to improve treatment and outcomes for people.

Supporting delivery of Greater Manchester Integrated Care Board's plans

We are a key partner within the Greater Manchester health and care system. During both the development and the refresh of our strategy we worked closely with all partners, including Greater Manchester ICB, to ensure that our aims and objectives were closely aligned with those of the partner organisations. The table below shows how our strategic aims link to the six missions that are the basis of Greater Manchester ICB's strategy. Aligning our strategies in this way means that delivering our MFT aims and objectives also contributes towards the achievement of the ICB's goals. Throughout this report you will see many examples of MFT achievements that also contribute towards delivering the six Greater Manchester missions.

MFT Strategic Aims	GM Integrated Care Strategy – Core Missions
Work with partners to help people live longer, healthier lives	Strengthen our communities Help people stay well and detect illness earlier
Provide high quality, safe care with excellent outcomes and experience	Recover core NHS and care services
Be the place where people enjoy working, learning and building a career	Helping people get into – and stay in - good work Support our workforce and our carers
Ensure value for our patients and communities by making the best use of our resources	Achieve financial sustainability
Deliver world-class research and innovation that improves people's lives	

PERFORMANCE REPORT

Overview of our performance

Summary of our performance

Throughout 2025/26, we have continued our efforts on improving against all national standards for elective and urgent care whilst maintaining a focus on patient safety and the quality of care received by those using our services.

Patient demand on our urgent and emergency care services has remained high with, on average, c.1,400 patients being seen in our Emergency Departments every day with a record over half a million patients being seen across our Emergency Departments in 2025/26. Despite more patients attending this year, 77.2% of patients were seen, treated and discharged within four hours during March 2026.

To support our elective recovery, we have maintained a relentless focus on treating patients in a timely manner and eliminated patient waits over 65 weeks. During 2025/26, we reduced the number of patients waiting over 52 weeks by almost 7,000 patients. By March 2026, 63% of patients were seen from referral to treatment within 18 weeks which is a 12% improvement through the year, resulting in a reduction in our waiting list size by 26,000 patients.

Significant progress has been made for our cancer patients this year. The number of patients receiving a confirmed diagnosis within 28 days has improved by 7.5% increasing from 76% in March last year to 83.5% in March. We have also seen a 13.2 % increase in patients being treated within 62 days on a cancer pathway, rising from 63.1% in March last year to 76.3%. This is over 700 patients more receiving cancer treatment within 62 days over the year. This improvement was achieved through our cancer tumour site clinical teams working together to manage patient patients, together with collaborative working with other providers across Greater Manchester, giving greater choice for our patients and enabling them to be seen, and treated, quicker.

Further information about the Trust's performance can be found in the sections that follow and a summary of our achievements during the year can be found in the 'Introduction to MFT' chapter of this report.

Monitoring and managing risk

During 2025/26 the Trust managed risk in accordance with the Risk Management Framework and Strategy ratified in May 2025. In line with the strategy, strategic risks are defined as those risks that have the potential to directly affect the Trust's ability to meet its strategic aims and objectives.

The strategic risks are actively managed through a strategic risk register and are used to contextualise assurance with the Board Assurance Framework. The Trust Risk Oversight Committee

reviews all strategic risks bi-monthly, ensuring risks are appropriately described, and controlled, reviewing the effectiveness of both preventative and mitigating controls. Each strategic risk is allocated to a Trust Executive-led Management Committee that provides operational oversight of the strategic risk, and a Board of Directors' Board Committee that monitors the strategic risk relevant to their scope, contributing to the level of assurance associated with the delivery of the Trust's strategic aims and objectives.

Strategic Risks

As at the end of March 2026, the Trust's strategic risks were as follows:

- Implications of national restrictions on capital resource
- Delivering financial sustainability in medium term
- Cyber Security
- Loss or instability of Digital Infrastructure
- Impact of under-delivery of our Annual Plans
- Inability to provide a fully compliant estate relating to estates infrastructure and services and fully comply with statutory safety legislation
- Failure to deliver Improvement Strategic Delivery Plan
- Delivery of Green Plan
- Inability to reduce health inequalities
- Implementation of the patient safety learning framework
- To provide high quality, safe care with excellent outcomes and experience to achieve the aims of the Mental Health Strategy
- Major Trauma
- Vascular Service Changes in Greater Manchester
- Genomics capital investment impacts upon productivity
- Safe disaggregation of complex services
- Sustaining a safe and supportive workplace culture
- Maximising the efficiency and effectiveness of workforce systems and processes
- Organisational Change
- Hosting of multiple National Institute for Health and Care Research (NIHR) infrastructure centres

More information about the risk management process is available in the Annual Governance Statement in this report.

Going concern disclosure

After making enquiries, the directors have a reasonable expectation that MFT has adequate resources to continue in operational existence for the foreseeable future. For this reason, they

continue to adopt the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

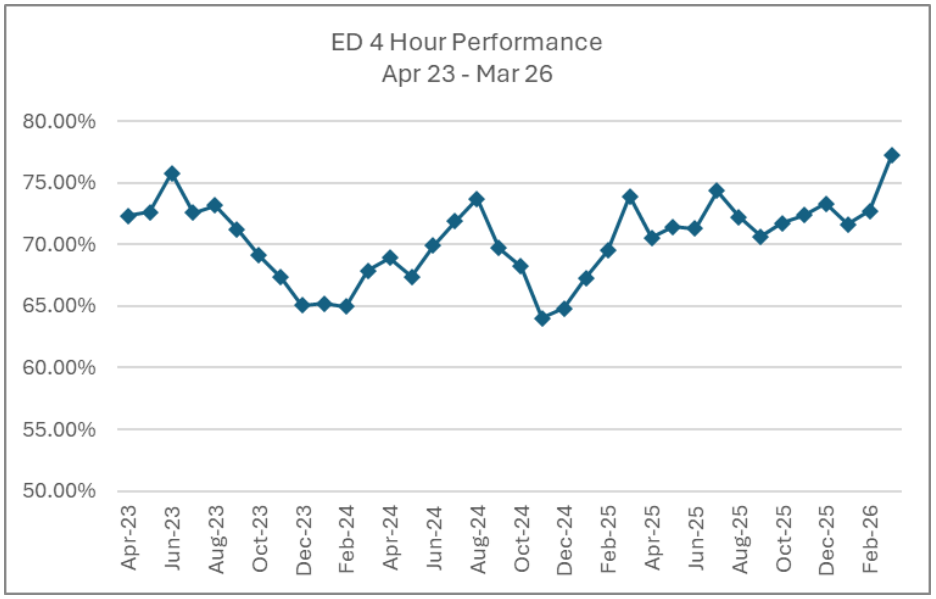
Analysis of our performance: Operational targets

Urgent and emergency care

In 2025/26, we aimed to achieve an increase to 78% patients being seen within 4-hours with Accident and Emergency (A&E) Emergency Departments (EDs) by March 2026 from our April 2025 position of 70.5%. In March 2026, performance was 77.2% against this ambition, representing a 7.5 percentage point improvement on April's 2025 position, which was 1,500 more patients seen within 4 hours and one of the most improved Trusts nationally. The number of patients waiting over 12 hours in our emergency departments continued to reduce this year, reaching 4.1% of all admission by March 2026 down from 4.9% for March 2026. We will maintain our focus on further reducing waiting times for patients in 2026/27. In addition, our Urgent Treatment Centres across MFT improved by 2% compared to March 2025 to 97.6% of all patients attending for minor illnesses and injuries being seen within 4 hours.

Ambulance handover remained a priority across the Trust, in line with our safety and quality ambitions against national guidance. 54.4% of patients arriving by ambulance were handed over to Emergency Department (ED) staff within 15 minutes. All MFT sites met the improvement ambitions set by the North West Ambulance Service (NWAS) to improve regional ambulance performance, with an average handover time of 15 minutes 50 seconds in March 2026. North Manchester General Hospital was the top performer across the North West for handovers within 15 minutes during March 26, with the overall MFT position 2nd across both Greater Manchester and the North West.

Figure 1: Performance against the 4-hour standard



Looking ahead to 2026/27, we remain focused on achieving the national ambition of 82% of patients seen within 4 hours (95% for children), building on the momentum gained in 2025/26. We are seeking to improve ambulance handover times by an average of 50 seconds across all sites, and to reduce

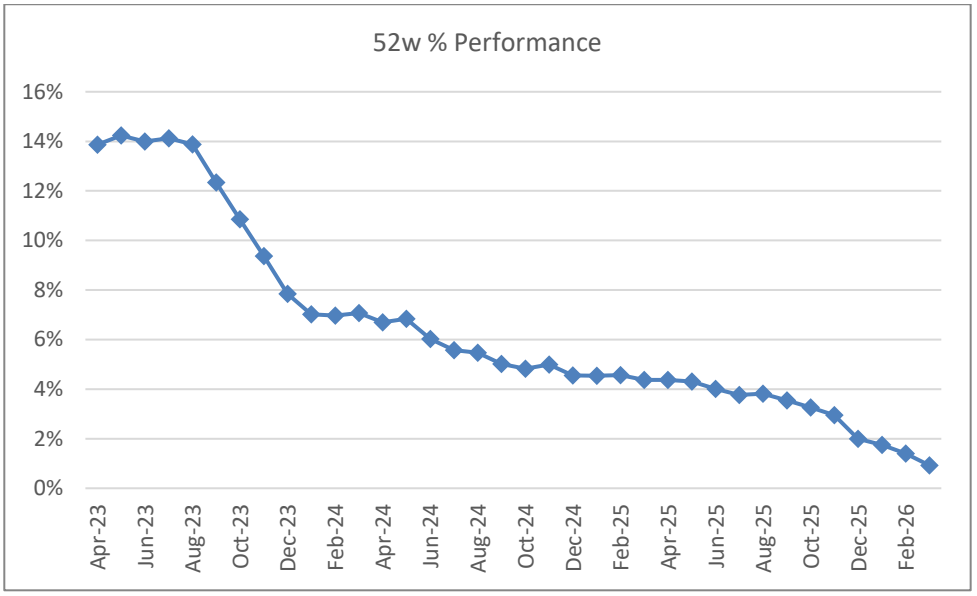
patient waits over 12 hours to fewer than 1.5% of attendances. We are rolling out our Care Closer to Home Programme, which is a system-wide programme focusing on ensuring patients receive the care they need in the most appropriate setting, including community or primary care settings, as well as aiming to reduce the time patients spend in our hospitals.

Elective Care

This year, the Trust remained focussed on improving elective referral to treatment within 18 weeks, reducing the longest wait patients over 52 weeks.

The March 2026 month end position reported 1,530 patients waiting over 52-week waits, down from 8,432 in March 2025. We plan to continue to reduce the longest waits for planned treatment to less than 0.5% of total waits during 2026/27.

Figure 2: Patients waiting over 52 weeks for elective care



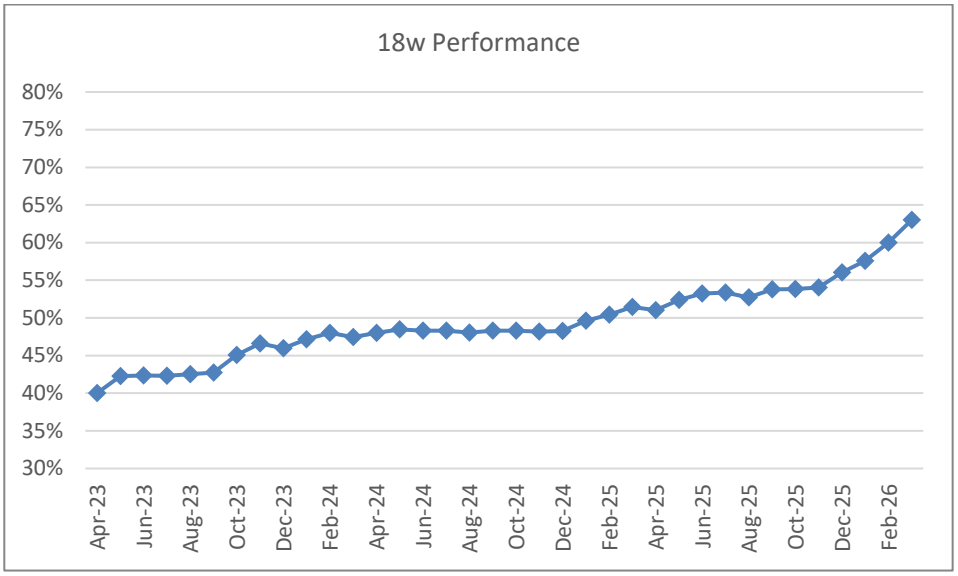
Alongside reducing long waits, the Trust has renewed focus on achievement of the 18-week standard for referral to treatment, where performance was low compared to the NHS average. In March 2025, the reported position was 51.5%, however this has increased to 63% in March 2026 and is now in line with the national position.

The Trust plans to improve performance by a further 10% by March 2027 as part of returning to the constitutional standard of 92% by March 2029. To support this ambition, we have our elective Care on Time improvement programme which sets out how we plan to reduce our waiting times for elective care, in turn improving the quality of our services and the experience of those who use them.

There is a significant amount of work being led by our clinicians to improve how we deliver planned care and reduce waiting times – from streamlining processes and redesigning patient pathways to

introducing new digital tools. The programme builds on this excellent work and will help us to deliver care more efficiently and effectively putting the patient at the heart of all we do.

Figure 3: Performance against the 18-week referral to treatment standard



Cancer Care

This year, the Trust has built upon sustaining improvements made in 2024/25 to cancer performance and pathways, as well as improving performance in the Faster Diagnosis and 62-day treatment standards.

The latest data available for both the Faster Diagnosis Standard (FDS) and cancer 62-day standard is for March 2026. 83.5% of patients referred received a diagnosis within 28 days (FDS), and 76.3% of patients were treated within the 62-day standard. This represents an improvement of 13.2% from delivery in the same month last year when 63.1% of patients were treated within 62 days. This is 147 more patients receiving cancer treatment within 62 days month on month. Challenges remain across gynaecology, haematology, upper GI and lower GI tumour group pathways. These tumour groups will be a continued area of focus in 2026/27, with each having improvement plans in place. A Trust Cancer Collaborative is well established to support delivery of the improvement plans, with additional capacity initiatives also in place supported by the GM Cancer Alliance.

Figure 4: Performance against the 62-day cancer standard

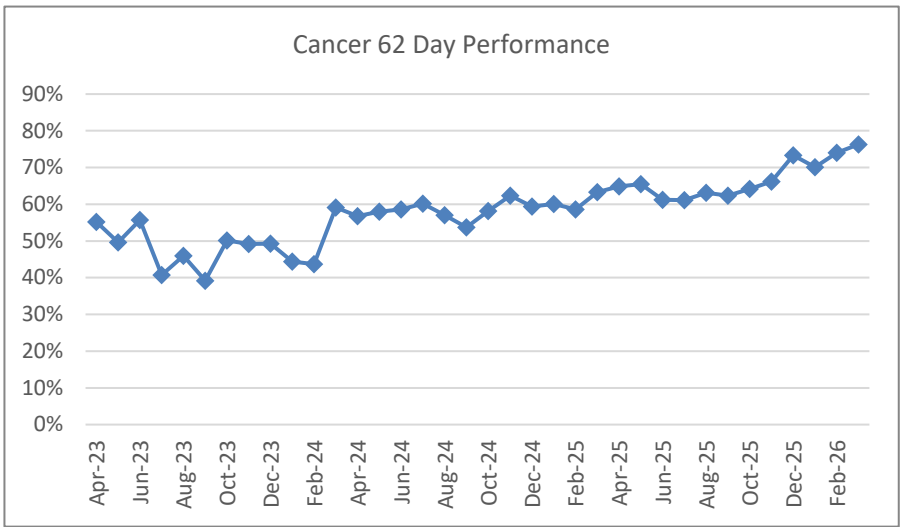
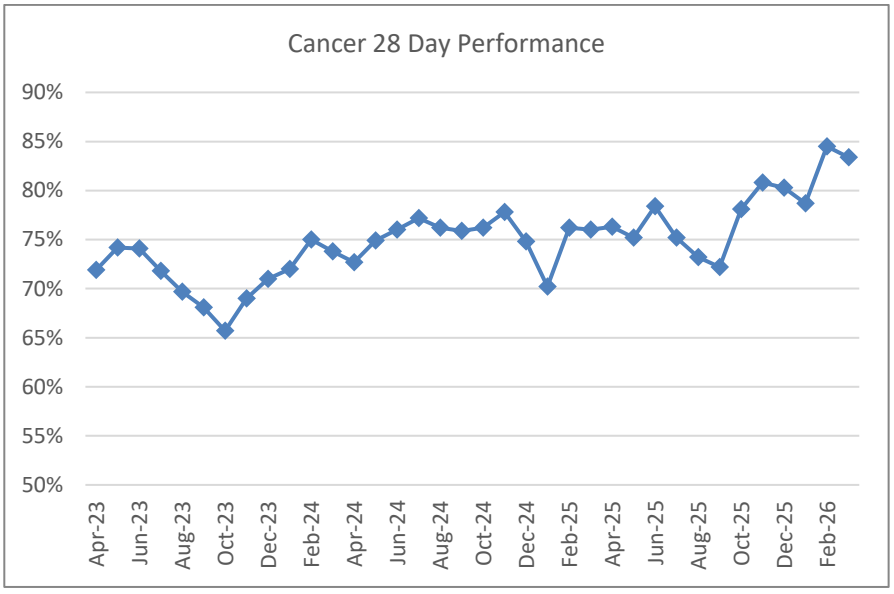


Figure 5**:** *Performance against the Faster Diagnosis cancer standard*



In 2026/27, the Trust aims to achieve above 80% of patients against the Faster Diagnostic Standard (FDS) and 80% of patients treated within 62-days with continued focus on single point of access, improving diagnostic pathways to expedite identification and treatment of cancer patients to ensure we have sustainable cancer pathways at every tumour site.

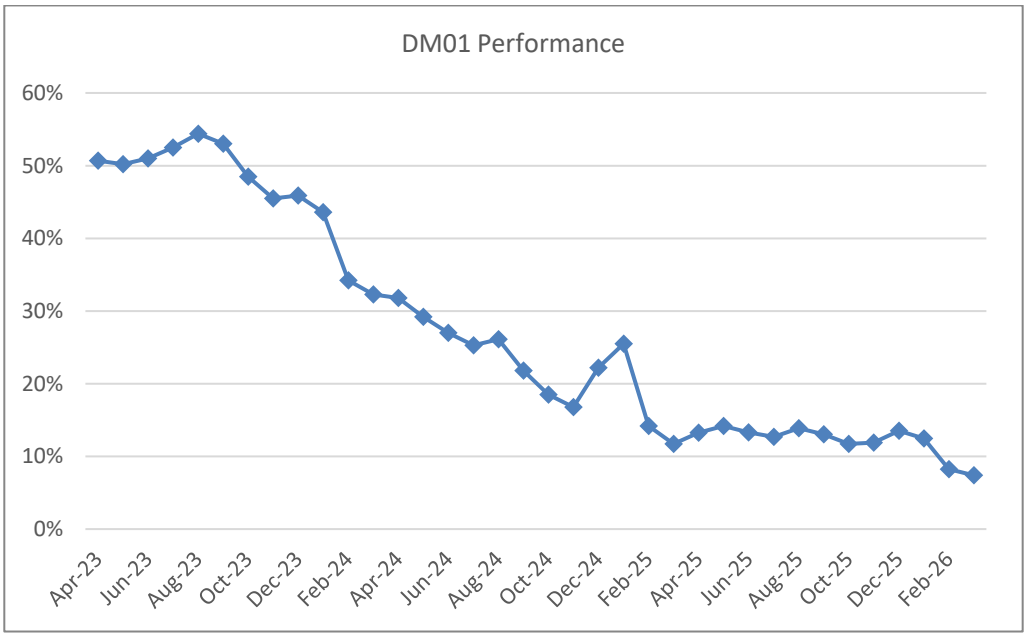
Diagnostics

At the end of March 2026, across all reportable diagnostic modalities, 7.4% of patients were waiting over 6 weeks for a diagnostic test, against a plan of 5.5%. The position in March 2025 was 11.7%, representing a 4-percentage point improvement made throughout the year, and meaning that 1,300 fewer patients are waiting over 6 weeks for their test and making us the most improved Trust for diagnostic waits nationally. Across the year, 10% more tests were undertaken compared to the prior year which means over 4,000 more patients received a diagnostic test. This contributed to reduced

waiting times and enabled the Trust to meet the increases in demand seen for certain modalities and improve waits for children and young people.

In 2026/27, the Trust will focus on sustaining improvements in waits for routine diagnostics, with additional emphasis on reducing waits for cancer tests and for diagnostics required to enable planned treatment. Demand continues to rise, and improvements have been driven by increased test activity and targeted recovery plans across modalities, such as maximising use of Community Diagnostic Centres, additional scanning capacity and increasing straight to test and diagnostic bundles. In 2026/27 we will maintain overall gains while focusing on complex diagnostics and children's pathways, including expanding alternatives to general anaesthetic where appropriate and working with referrers to reduce avoidable demand.

Figure 6: Diagnostic 6-week performance



At each meeting of the Boad of Directors, an Integrated Performance Report is discussed which provides an up-to-date position against all the metrics the Board of Directors monitor, including those above. The Integrated Performance Report can be found within our Board papers for each meeting here.

Analysis of our performance: Finance

During the financial year ended 31st March 2026, after making adjustments as required by NHS England (NHSE) to determine the Provider System performance measure, MFT had income of £3.263bn, expenditure of £3.258bn and, as such, delivered an adjusted financial performance surplus of £5.0m. This position reflects full delivery of the Trust's 2025/26 financial plan. These figures are reconciled to the annual accounts at the end of this report and summarised in the table below.

Figure 7: Summary table of reconciled accounts

	Statement of Comprehensive Income and Expenditure	Adjustment	Adjusted Provider System Performance	Adjustment Notes
Income	£3.284bn	(£20.790m)	£3.263bn	Donations/Grants
Pay	(£2.023bn)		(£2.023bn)	
Non-Pay	(£1.287bn)	£105.797m	(£1.181bn)	Impairments/Depreciation
Non-Operating Items	(£50.011m)	(£4.770m)	(£54.781m)	Removal of PFI revene costs on an IFRS16 basis then add back PFI revenue costs on a UK GAAP basis
Surplus/(Deficit)	(£75.270m)	£80.237m	£4.967m	

When we consider the statutory financial accounts for MFT, the Trust's financial outturn for the year to 31st March 2026, including those items that are excluded from our control total by NHSE, was a deficit of £75.3m (2024/25 £17.6m deficit). This includes the following items which are not considered by NHSE in their assessment of our financial performance against our control total:

- £104.0m (2024/25 £35.0m) of impairment charges.
- £4.8m (2024/25 £8.8m) benefit from technical adjustments relating to accounting for the Trust's PFI liabilities under IFRS 16
- £19.0m benefit (2024/25 £5.0m) relating to donated and granted asset income (net of impairment and depreciation).

The NHSE financial regime for 2025/26 continued to focus on elective activity, reducing waiting lists and the continued drive to prevent unnecessary hospital admissions. National elective recovery fund (ERF) payment arrangements ended in March 2025 and were replaced in 2025/26 by local variable contract payments with each relevant Commissioner.

During the year to 31st March 2026, the Trust delivered £158.5m of Value for Patients opportunities against a plan of £165.8m.

In 2025/26, capital schemes amounted to £155.4m (including £20.8m from donated and granted

assets and a net credit of £9.0m on assets capitalised as Right of Use Assets under the leasing standard, IFRS 16, due to a number of lease disposals in year and reductions in lease terms). Of the overall £155.4m spend, £118.6m was on buildings, £28.0m was invested in new equipment, and £8.8m was spent on information technology.

Following successful delivery of the 2025/26 financial plan, the Board has approved a break-even plan for 2026/27, and achievement will be dependent on delivering a Value for Patients programme of £175m for the year. This will require the Trust to make savings through improved efficiency and increased productivity across clinical and corporate services.

The Trust's cash balance at 31st March 2026 was £9.5m (£60.5m at 31st March 2025). This reflects a significant decrease in cash during 2025/26. The cash balance is expected to continue to be challenging in 2026/27 whilst plans to deliver the savings required are implemented.

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Important events after the 2025/26 financial year end

There were no events following the Statement of Financial Position date, either requiring disclosure, or resulting in a change to the financial statements of the Trust.

Analysis of our performance: Quality of services

All NHS providers in England have a statutory duty to be open and transparent about the quality of the services they deliver by producing an annual Quality Account. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

The Quality Account aims to drive quality improvement within the NHS and increase public accountability. This is done by getting NHS organisations to review their performance over the previous year, identify areas for improvement and publish that information, along with a commitment about how those improvements will be made over the next year. Our Quality Account is available on the Trust's website www.mft.nhs.uk.

Care Quality Commission

MFT is required to register with the Care Quality Commission (CQC), and its current registration status is fully registered with no conditions. The CQC did not take enforcement action against MFT during 2025/26. MFT has not participated in any CQC investigations.

The CQC assessed our Child and Adolescent Mental Health Services (CAMHS), Galaxy House, on 13 January 2026. The service was awarded an overall rating of Good.

The Trust works closely with all external regulators and inspection bodies and will use regulatory findings to make improvements where needed and as an assurance of quality.

Analysis of our performance: Health inequalities and equality of service delivery

Health Inequalities

Reducing health inequalities and preventing ill health remain core priorities for MFT, reflecting both our Trust values and our statutory duties under the NHS Act 2006 and the latest NHS England Statement on Health Inequalities.

During 2025/26, MFT continued to drive forward with its population health agenda, building on the successes of previous years. Our key achievements are as follows:

- development and delivery of health and well-being plans in each Clinical Group, which include population health related actions.
- appointed a senior medic within each clinical group to provide funded leadership time for population health.
- expansion of the Citizens Advice Offer to Manchester Royal Infirmary and the Damp and Mould referral pathway previously launched in 2025.
- with support from National Energy Action, we have added further capacity to support Maternity Services and demand at the children's hospital and our accident and emergency departments (A&Es) across MFT, with over 1,600 patients and families supported, generating over £3m in financial benefit for financially vulnerable families in the city, as well as multiple cases of homelessness averted.
- continued to work on our ambition to become a Health Literate Organisation.
- developed the Population Health chapter of our Integrated Performance Report, with a focus on missed appointments, waiting list performance, data quality of key demographic (e.g. sexual orientation) and key physiological (e.g. BMI) data. Data relating to hospital admissions for conditions that could have been prevented will follow.
- hosted training sessions on the Working with People and Communities Toolkit to highlight the importance of involving communities in our work and how to do it well.
- established a prevention working group to work through the key enablers to MFT frontline teams being able to deliver on the prevention agenda, with good progress made in establishing referral pathways, with the electronic patient record (HIVE) and in developing training resources.
- undertaken a pilot at North Manchester General Hospital using the Social Drivers of Health functionality too within HIVE, to make it easier for clinicians to ask about and record issues relating to social need and lifestyle factors such as smoking and physical activity.
- launch of a Trust-wide programme aimed at engaging front line teams with reducing inequalities and the prevention agenda, though focusing on embedding prevention and health inequalities awareness into everyday practice.
- worked in partnership with Manchester City Council (MCC) and the Growth Company to increase the number of dedicated Work and Health Coaches, embedding them into core programmes, including within Musculoskeletal (MSK), cancer, paediatrics (for young adults and

carers), respiratory, gynaecology and rheumatology pathways.

- worked in partnership with Geneal Practice to improve the timeliness and outcomes from GP referrals where specialist advice and guidance can improve patient outcomes and provide care closer to home, including a pilot in Gastroenterology.
- enabled, through the hospital to community programme, early intervention in the community which ensures that those people who need hospital treatment receive it in a timely and efficient way and reduces demand on hospital services

Overall, MFT, in collaboration with its key partners, is continuing to make progress in embedding population health and prevention across the organisation. The expansion of leadership, partnerships, and innovative pathways is driving tangible improvements for patients and communities. Continued collaboration and investment will be key to sustaining and scaling these successes throughout 2026 and beyond.

Responding to NHS England's Guidance on understanding population health need and inequality

MFT has also delivered against the requirement outlined by NHS England with regards to the collection, analysis, use and publication of information on health inequalities[1]. Further details in respect to each of the requirements is below:

Understanding population health needs – *how has MFT considered the needs of marginalised and vulnerable populations in decision making and planning, commissioning and delivery of services.*

MFT has met this objective through:

- Delivery of an urgent care needs assessment. This was a 100-page review of various data sets and included insight from residents on access to urgent care and services that would reduce reliance on urgent care. The work looked at how this differed for different populations and resulted in a range of actions. For example, on the back of this work MFT have been working closely with University of Manchester to help students, including international students, navigate the health system.
- Developed strong links with local authority partners who share new and existing needs assessments with MFT colleagues to inform service delivery. Two examples during 2025/26 include the Sight Loss Needs Assessment and the detailed work, led by MCC, to forecast population growth in the city over the next 10 years.
- The social drivers of health tool has now been launched in our patient record which will provide an ongoing way of collecting more information on population need (E.g. income, housing, employment, lifestyle factors) so that care can be delivered appropriately to the individual and wider factors influencing health can be supported.

[1] https://www.england.nhs.uk/long-read/nhs-englands-statement-on-information-on-health-inequalities/

Improving data quality, collection and analysis – *how has MFT identified issues with data quality linked to inequalities and made improvements.*

MFT has met this objective through:

- In person and virtual training administrative and clerical teams throughout January, February and March on the importance of demographic coding, why we collect data and how.
- Changed how HIVE asked for demographic information, making it more difficult (not impossible) to not collect core demographic information including sexual orientation and ethnicity.
- Included data quality of core demographic information in our Integrated Performance Report (IPR) so improvement in data quality can be measured overtime. Clinical Groups' data quality and how data is used is reviewed through MFT's population health management committee.
- MFT has had a health inequalities dashboard for two years which can be accessed from across the organisation to support an understanding of inequalities. Improving underpinning data quality, as described above, will support the way that this dashboard can be used.

Understanding healthcare access, experience and outcomes – *how has MFT used data to understand differences in access, experience and outcomes by demographic.*

MFT has met this objective through:

- MFT's health inequalities dashboard analyses operational data by gender, deprivation, ethnicity, primary language, learning disability (LD) status and religion. The following operational metrics are included:
    - Outpatient missed appointment rates (DNAs)
    - GP referral rates
    - Patient cancellation rates
    - PIFU rates (from April-26)
    - UEC demand and ED waiting times
    - Frequent attenders
- MFT's Population Health IPR includes four primary measures, which will be built upon during 2026/27 with further measures:
    - Admissions for ambulatory related conditions
    - Missed appointment rates (DNAs); gap metric for ethnicity and deprivation (what the is the gap in the missed appointment rate by ethnic group or by deprivation, as opposed to the crude average)
    - RTT performance; gap metric for ethnicity and deprivation
    - Data quality of demographic data collected (described above).

Using information to take action on health inequalities *- how has MFT used health inequalities information to inform decision making and strategy:*

MFT has met this objective through:

- Population Health IPR being presented to the executive and non-executive directors.
- Using available data to inform the Equality Impact Assessment process.
- In December 2025 MFT appointed a medical lead for Population Health to help ensure services are acting on the information available and making positive change.
- Executive Lead (Joint Chief Medical Officer), Public Health Consultant and wider colleagues attend various aspects of the Trust governance and constructively challenge around understanding the impact on health inequalities.

Publishing information on health inequalities – *how has MFT publicly published data about inequalities within services:*

MFT has partially met this objective through:

- Making data available for the last 2 years and included within this 2025/26 annual report the set of metrics as specified by NHS England.

MFT has not been able to make the additional metrics, as published in NHS England's statement of information on health inequalities, available for inclusion in this annual report but work is underway to ensure these are available for future reports.

Figure 8: Health Inequality Metrics

Metric	Demographic	*23/24*	24/25	25/26	Interpretation
Missed Appointment (Did Not Attend) Rates for outpatient appointments	**MFT average**	***8.6%***	**8.7%**	**8.5%**	MFT metric, not requested by NHSE Higher rates amongst more deprived groups and some minority ethnic groups.
	Most deprived	*11.2%*	11.6%	**11.4%**	
	Least deprived	*4.1%*	4.3%	**4.2%**	
	White British	*7.7%*	7.7%	**7.5%**	
	Minority ethnic group	*9.8%*	10.1%	**9.8%**	
Urgent Care 4-hour performance (unadjusted)	**MFT average**	***68.2%***	**78.3%**	**72.3%**	MFT metric, not requested by NHSE Some small variation across groups. Ethnic minority groups appear less likely to breach the 4hr target than White British.
	Most deprived	*65.5%*	77.5%	**70.9%**	
	Least deprived	*64.9%*	77.6%	**72.2%**	
	White British	*64.1%*	75.6%	**68.3%**	
	Minority ethnic group	*76.1%*	80.6%	**75.3%**	
Care pathways closed at 52 weeks or more	**MFT average**	***21.5%***	**16.5%**	**10.9%**	MFT metric, not requested by NHSE Slight over representation for more deprived and non-white British waiting longer for their care pathways to be completed.
	Most deprived	*22.1%*	16.9%	**11.3%**	
	Least deprived	*20.1%*	15.2%	**9.8%**	
	White British	*21.2%*	15.9%	**10.4%**	
	Minority ethnic group	*21.8%*	17.5%	**11.5%**	
Elective Recovery	**Average monthly activity:**				NHS England requested

Metric	Demographic	*23/24*	24/25	25/26	Interpretation
	Over 18s	*19,607*	*18,208*	**21,491**	metric. The most deprived population account for the most activity, which is what we expect given the deprivation profile of Manchester. OHIDs work estimates MFTs catchment population is 89% white; this suggests that non-white groups are over-represented in terms of elective activity.
	Under 18s	*2,958*	*3,249*	**3,174**	
	Most deprived 20%	*8,659*	*8,125*	**9,671**	
	Least deprived 20%	*2790*	*2736*	**3,799**	
	White ethnicity	*13,733*	*12,450*	**12,986**	
	Minority ethnic group	*6,785*	*6,166*	**11,679**	
	Unknown ethnicity	*2,046*	*2,841*	**930**	
Surgery for Dental Extractions for <10s	Extractions during the year	*1046*	1344	1279	NHS England requested metric. Data shows that the most dental extractions are taking place in the most deprived 20% of the population, which aligns with what we know nationally. Challenging to interpret patterns by ethnicity to due to the large number of unknown / unrecorded ethnicity patients.
	Most deprived 20%	*624*	830	814	
	Least deprived 20%	*61*	88	68	
	White British	*379*	461	388	
	Minority ethnic group	*417*	578	539	
	Unknown ethnicity	*250*	305	352	
Smoking Cessation Referrals	All Patients	*4,542*	4,703	**4,755**	NHS England requested metric

Equality of Service Delivery

MFT is committed to delivering high-quality, safe, inclusive and equitable care for the diverse communities it serves. During 2025/26, the Trust continued to strengthen how equality, diversity and inclusion is embedded across service delivery, workforce experience, leadership, governance and organisational decision-making and also demonstrated due regard to the three aims of the Public Sector Equality Duty (PSED) under the Equality Act 2010: eliminating discrimination, harassment and victimisation; advancing equality of opportunity between people who share protected characteristics and those who do not; and fostering good relations between different groups. Further details are available in MFT's PSED Annual Equality Information Report, available here with examples summarised below:

- Supporting 161,740 interpretation and translation interactions across 136 languages and dialects including 62,372 face-to-face interpreter requests, 96,346 telephone interpreter calls, 551 written translation requests, 849 pre-booked video interpreter requests, 1,622 on-demand video interpreting calls and 2,332 British Sign Language interpreter requests.
- Launching the Interpreter on Wheels pilot in August 2025, deploying 15 devices across 17 clinical areas to provide rapid on-demand video interpreting.
- Improving compliance with the Accessible Information Standard through delivery of in-person and virtual training across Clinical Groups, introduced a two-stage hard-stop process in HIVE to strengthen patient information capture, and progressed work to standardise language fields,

improve dialect capture and better record reasonable adjustment and interpreter needs.

- The Adult Safeguarding, Learning Disabilities and Autism Team provided Easy Read materials to support patients with learning disabilities and autistic people to access healthcare information equitably. This supports informed decision-making, consent, appointment attendance, treatment understanding and follow-up care, while also helping to meet the Trust's duty to make reasonable adjustments.
- Completing 366 Equality Impact Assessments to support policy, pathway, service and workforce decision-making, including activity linked to health inequalities, clinical standards and the workforce operating model.
- Delivering targeted activity to improve access, safety and experience for patient groups who may experience barriers to care including identification of patients with learning disabilities on the elective surgical pathway at pre-operative assessment and ensuring reasonable adjustments to be made in advance.
- Improving access to Child and Adolescent Mental Health Services for looked-after children.
- Continuing to develop Transgender Patient Care Guidance to support staff in delivering respectful, person-centred and clinically appropriate care for transgender patients.
- Engaging the Disabled People's User Forum to provide an important mechanism for disabled patients and service users to influence decision-making, including the development of the new MFT EDI Strategy, communication and coordination of accessibility needs across sites, HIVE accessibility, patient catering, hospital signage, accessible waiting areas, disabled parking and wheelchair availability.
- Working to increase representation in research, reduce barriers to participation and ensure that innovation better reflects the needs of diverse communities.
- Increasing diversity in genomics research, recruiting over 2,000 volunteers from ethnically diverse backgrounds.
- Embedding inclusive respiratory research within community COPD care, enabling patients experiencing COPD flare-ups to take part in research within their own homes, removing the need for hospital-based research visits and supporting inclusion of people who may otherwise be excluded from research due to deprivation, long-term conditions, mobility barriers or complex needs.

Analysis of our performance: Sustainability

Here we outline the progress achieved against the strategic sustainability delivery plan 'Green Plan 2: Net Zero' and provide an overview of our environmental sustainability governance, carbon footprint, and highlights from the ten key areas of focus. Our Annual Sustainability Report (to be published in June 2026) provides further detail, including plans for the forthcoming financial year.

This financial year marks the first anniversary of MFT's five-year Green Plan. Highlights of this year's programme include:

- We achieved the largest single year percentage reduction in the last 5 years for our carbon footprint, with a reduction of 5% compared to 2024/25, saving of 3,990 tCO2e. The 2025/26 figures show a 20% reduction compared to the baseline year 2019/20, representing a drop of 17,088 tCO2e in annual emissions. This saving is a result of multiple years of work and investment across several workstreams, with the largest savings coming from energy, medical & anaesthetic gases, and waste.
- The history-making Trafford General Hospital (TGH) decarbonisation scheme works began on site. The scheme, which includes replacing end-of-life fossil fuel boilers with state-of-the-art heat pumps, as well as solar panel install, will turn Trafford General Hospital into the UK's first net zero inpatient retrofitted hospital.
- With the collective work on greening anaesthesia, 2025/26 is the first financial year we have experienced the full benefits of the decarbonisation work. Compared to our baseline year 2019/20, the medical & anaesthetic gas footprint has more than halved in 2025/26, saving the equivalent of 6,489 tCO2e per year.
- The MFT Sustainability Team hosted the third annual Sustainable MFT Conference at Wythenshawe Hospital, inviting over 100 staff and external participants to learn and engage with sustainability in healthcare. The Trust's former Chair, Kathy Cowell MBE, delivered the message 'we need to go further, faster'. In addition to our internal speakers sharing updates from public health, quality improvement, and green spaces, we invited external speakers Prof Richard Hixson, Hugh Montgomery OBE, Dr Joshua Parker and Dr Ganga Shreedhar to share their expertise across sustainable shipping, the impacts of climate change on health, ethics of green consent with patients, and theory-based behaviour change.

Task Force on Climate-Related Financial Disclosures (TFCD)

In line with the arrangements adopted by NHS England for all NHS bodies, MFT's TFCD disclosures, including arrangements in respect to the governance, risk management, and metrics and targets pillars, are set out within MFT's Green Plan 2 Net Zero, and are not provided within this annual report. Full details can be found in Appendix 4 of the refreshed MFT Green Plan 2 Net Zero, available here

2025/26 Carbon Footprint Summary

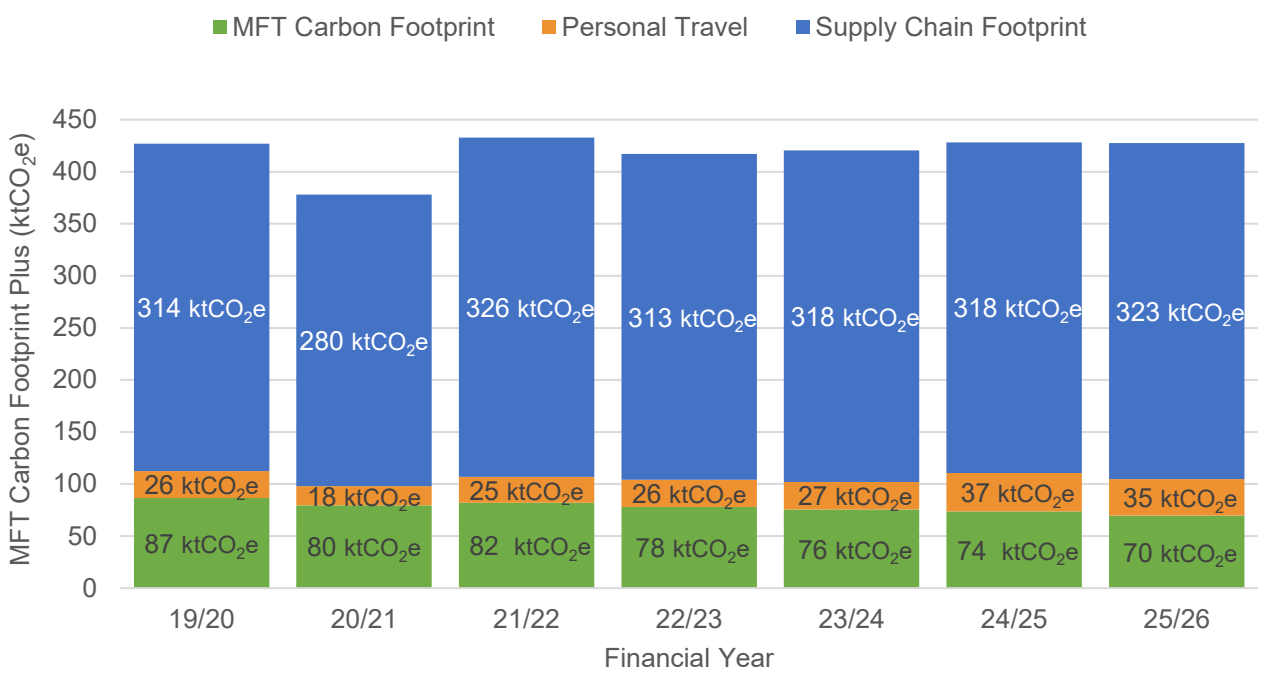
MFT's carbon footprint (the emission we directly control) has reduced by 5% since 2024/25 to approximately 69,620 tCO_2e (figure 9.)

- Energy remains the largest contributor, responsible for 87% of the direct carbon footprint. With the move to electrifying heat across the estates, there has been a slight increase in electricity demand and decrease in gas demand (1.7% increase and 2.9% decrease respectively compared to 2024/25). Combined with lower carbon intensity of the electricity grid, this has led to the largest carbon saving of the year at over 3,000 tCO_2e.
- Medical and anaesthetic gases represent the next largest proportion of the direct carbon footprint, and the full year impact of the decommissioning of pure nitrous oxide manifolds has led to further savings of 785 tCO_2e (12% reduction) compared to 2024/25 in the Medical & Anaesthetics gases footprint.
- Overall waste tonnage has reduced by 4%, with reductions visible in both the clinical and domestic waste streams. Better clinical waste segregation and reusable sharps bins roll out has helped achieve a 292 tCO_2e saving since last financial year (22% reduction in the waste footprint).
- The overall total business travel footprint has increased by 14%. Car-based business travel, the most prominent contributor to emissions, has increased, but vehicles becoming more efficient and a shift from air to train travel since last financial year has helped limit the increase to 125 tCO_2e.

The MFT Carbon Footprint Plus (figure 9) (the combination of the emissions we control and our indirect emissions) is 427,639 tCO_2e.

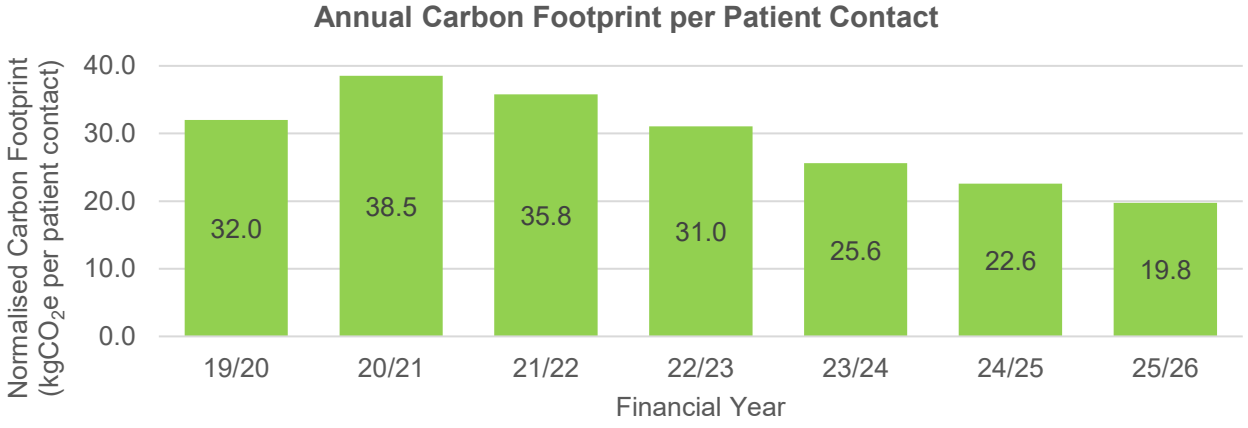
- The largest contributor is the Supply Chain footprint, which is 75% of the Carbon Footprint Plus. The categories of spend with the highest carbon emissions are commissioned health and social care, construction, and medical instruments/equipment.
- The Carbon Footprint Plus from baseline year 2019/20 can be seen in figure 9 below, however, the methodology to calculate the supply chain element is not designed for year-on-year comparison, but rather to demonstrate scale.
- The personal travel footprint, made up of staff commuting, patient and visitor travel, has dropped by 5% compared to last financial year, as a result of a reduction in the modelled distance staff are commuting (based on a recent staff travel survey in 2025).

Figure 9: MFT Carbon Footprint Plus from Baseline



The number of patient contacts in 2025/26 increased by 8% and the carbon emission per patient contact has decreased for the fifth consecutive year. The direct carbon footprint per patient contact is now 19.8 kgCO_2e compared to 22.6 kgCO_2e in 2024/25, a 12% drop (figure 10). While bed days, including via virtual wards using the Hospital at Home service, have remained consistent with last year, we have seen an increase in outpatient appointments with virtual outpatient attendances rising 10% versus 2024/25. NHS studies have shown that virtual methods of care delivery often have lower carbon footprints than traditional visits to our hospital sites. The drop in the carbon intensity of patient contacts shows that resources are being used more efficiency year on year.

Figure 10: Annual Carbon Footprint per Patient Contact



MFT Carbon Footprint Projections

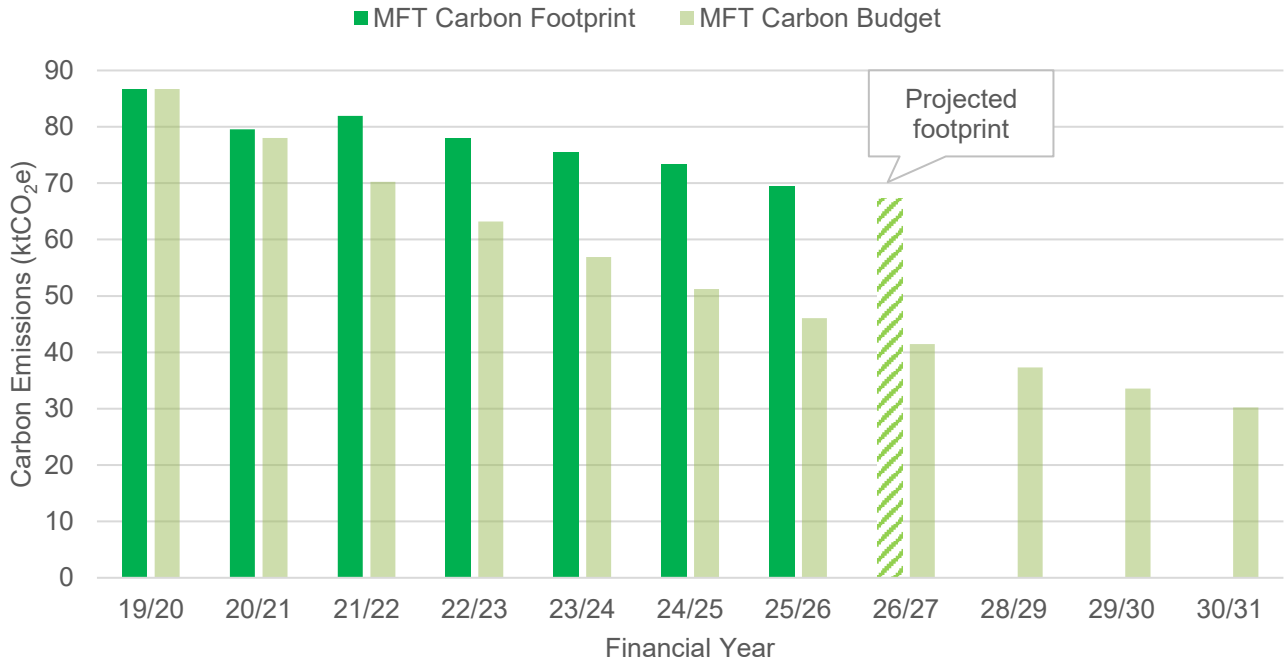
The carbon budget specifically relates to those emissions we directly control, the carbon footprint, and the budget requires an ambitious 10% year-on-year carbon reduction, in line with the Greater Manchester Combined Authority (GMCA) target. During our first Green Plan, we emitted an additional 68,772 tCO2e from our first interim carbon budget. The second interim carbon budget spans the period covered by our second Green Plan (2025/26 to 2029/30).

In 2025/26, MFT reduced its direct carbon footprint, continuing the overall downward trend since the 2019/20 baseline. However, as shown in Figure 11 below, emissions remain above the annual carbon budget trajectory, exceeding the 2025/26 target by 23,540 tCO_2e. This demonstrates that while meaningful progress has been made, the pace of reduction required to remain within the Trust's carbon budget is significantly greater than can be achieved through currently confirmed schemes alone.

Looking ahead, projected emissions for 2026/27 indicate a further reduction of approximately 2,000 tCO_2e, equivalent to around 3% compared with the 2025/26 carbon footprint. This forecast reflects known and planned actions, including grant-funded energy decarbonisation schemes, the roll-out of reusable sharps containers and the continued decarbonisation of the national electricity grid. These actions will deliver further improvement, but the projected reduction remains below the level required to align with the annual carbon budget trajectory.

The position therefore reflects both progress and challenge. MFT has established a strong foundation for reducing emissions and continues to deliver tangible improvements across energy, waste, anaesthetic gases and models of care. However, further acceleration will be required if the Trust is to remain as close as possible to its carbon budget and meet its longer-term net zero ambitions. This is consistent with the wider position across Greater Manchester, where large organisations are also finding that emissions reductions are not yet keeping pace with the regional science-based carbon budget. MFT will continue to identify, prioritise and deliver the actions with the greatest potential to reduce emissions, while working with partners locally and nationally to support the wider conditions needed for progress.

Figure 11: MFT Carbon Footprint (direct emissions) and Annual Carbon Budget from baseline year 2019/20, including a projection of emissions for financial year 2026/27 based on known projects.



Progress in Thematic Areas

Net Zero Clinical Transformation: The Time to Act for Greener Theatres campaign concluded in December 2025, with several case studies captured and sustainability training delivered to the theatres team at Manchester Royal Infirmary. Further engagement and sustainable quality improvement will be focused on Trafford Elective Surgery Hub as a pilot site. The Time to Act for Greener Community Care campaign launched in January 2026 to support sustainable action in the LCOs and Dental Clinical Group, a previously under-engaged area where action aligns with the NHS 10-year plan to deliver care closer to home. Work has taken place to embed sustainability within the work of the MFT Improvement Team, and to appoint a new 'Getting It Right First Time' (GIRFT sustainability fellow) to explore decarbonising 'the neck of femur' clinical pathway.

Digital Transformation, Research & Innovation: Patient uptake of the MyMFT app has continued to grow, with over 673,000 patients signed up at the end of March 2026. This reduces the Trust's reliance on paper-based communications. Furthermore, the process of reviewing and migrating historic paper patient records into our electronic patient record system, HIVE, is underway, which when complete, will lead to medical record building closure, helping reduce the energy and water footprint from unnecessary buildings. The 'Ordering Wisely' programme has rolled out to labs, imaging and medicines, with data analysis and prompts embedded in HIVE to reduce over-ordering in these services. A patient engagement forum was established by Research & Innovation to explore patient views of sustainability in healthcare and research, with conclusions due to be reported later in 2026.

Supply Chain & Procurement: Supply chain initiatives in 2025/26 prioritised re-use, waste prevention and social value. The Walking Aid scheme continued with 2,890 walking aids returned by patients to our hospitals for reissue in this financial year. After a successful trial, a re-upholstery service went live across the trust, allowing departments to commission an external tradesperson to repair damaged beds and other furniture on a same day basis, rather than disposing and purchasing new items. A fixed-term social value review role was established within the Public Health team to review the social value commitments of the Trust's highest value contracts. This role will improve management of supplier's contractual commitments to the Trust and to maximise collaboration for beneficial outcomes to communities across Greater Manchester.

Medicines: The Your Medicines Matter campaign went live at the Trust, led by MFT Pharmacy in collaboration with other NHS Trusts across Greater Manchester. The campaign encourages patients to bring their own medicines into hospital to reduce duplicate prescribing and impact monitoring is underway. Pharmacy is also working towards bronze accreditation at each large acute site using the Royal Pharmaceutical Society Greener Pharmacy Audit. Inhaler education was updated in line with the 2024 NICE guidance to include the environmental impact in inhaler choice. The learning package created by MFT staff was shared across Greater Manchester, and local audit on adherence is ongoing. After work in previous years to decommission pure nitrous oxide manifolds across the Trust, 2025/26 was the first year of full impact, showing a 95% reduction in annual carbon emissions (a 4,365 tCO_2e annualised saving) from gas procurement compared to baseline year 2019/20.

Food & Nutrition: The Trust strengthened the foundations for reducing food waste and supporting healthier, lower-carbon choices. Opportunities and frameworks for improved food waste monitoring were identified at all inpatient sites, and a Food Waste Task and Finish Group was established, with terms of reference drafted by the co-chairs based in Facilities. Inpatient menus at Oxford Road Campus and Wythenshawe Hospital adopted a plant-rich first menu approach to make lower-carbon options more visible and accessible. Procurement arrangements also supported the agenda during the tendering of a new inpatient dining contract. This included weighted social value questions focused on carbon labelling, reducing single-use plastics, and supplier net zero commitments.

Estates & Facilities: Multiple grant funded energy decarbonisation schemes were advanced across the estate, including the Trafford General Hospital decarbonisation scheme, multiple additional solar panel installations, battery storage, and building management system upgrades, with forecast annual savings of over 3,200 tCO_2e once complete (based on 2025/26 greenhouse gas emission factors). By financial year end, reusable sharps containers were rolled out fully across the trust, including large acute and community sites. This switch removes an estimated 76 tonnes of plastic per year from high temperature incineration treatment, the highest cost and carbon waste disposal route. The 'tiger waste segregation project' continued to increase correct clinical waste segregation across the trust, achieving 59% clinical waste segregation by the end of the financial year compared to 20% at the end

of 2023 when the campaign began. To date, these waste initiatives have reduced the waste footprint by 22% compared to 2024/25, saving 292 tCO_2e.

Travel & Transport: Despite business travel distances and patient contacts increasing, total travel and transport emissions have reduced, reflecting ongoing improvements in vehicle technology and increased electrification. 200 staff bikes were checked, serviced and maintained throughout 2025/26 as part of our free bike maintenance offer to staff. A staff travel survey was conducted in summer 2025, showing that travel by car is still the main method of staff commuting, with uptake of sustainable commuting modes remaining broadly static. This is consistent with the experience of other NHS organisations across Greater Manchester. To find collaborative solutions to this, the Trust has remained engaged with local transport stakeholders, including the Oxford Road Corridor Sustainable Travel Group, Transport for Greater Manchester and the NHS Greater Manchester team.

Climate Change Adaptation: Using the experience gained from previous input to the NHS Climate Adaptation Maturity framework, the Trust collaborated with other Greater Manchester NHS Trusts and the GM Integrated Care Board to create the Greater Manchester NHS Climate Change Adaptation Plan. This plan will define action at a regional level and inform the Trust's future adaptation plan. To build internal capacity, members of the Green Plan Oversight Group completed PlanIT training, a scenario-based climate change and adaptation training package aimed at improving understanding of climate risks and co-benefits of timely action. This activity supports the Trust's wider approach to service continuity and infrastructure resilience, ensuring that adaptation considerations are embedded alongside mitigation activity.

Green Spaces & Biodiversity: 2025/26 work focused on strengthening capacity and aligning green space activity with emerging legislative requirements. Biodiversity net gain regulations began to shape planning the North Manchester General Hospital redevelopment, with the Sustainability Team working to ensure benefits are delivered on the Trust estate or through local projects where possible. Concept designs for improvements at Baguley Woodland and Woodsend Clinic were progressed, with early engagement with stakeholders at Woodsend taking place throughout the year. The Trust also secured a two-year NHS Nature Recovery Ranger post, hosted by MFT from April 2026 as part of a national cohort employed by the Centre for Sustainable Healthcare.

Workforce, Networks & Systems Leadership: Senior leads were established across nine of the ten areas of focus, improving governance and accountability for the new Green Plan 2 Net Zero objectives. In addition to hosting monthly webinars on different sustainability topics in healthcare, the Trust hosted its third Sustainability Conference. We expanded the range of speakers and topics previously covered, including external speakers from anaesthetics, sustainable shipping, behaviour change, and healthcare ethics, as well as internal speakers sharing their work from public health, allied health professional-led pathway research, and green spaces for health. Carbon literacy training

was delivered in house, resulting in over 100 staff across the organisation trained as carbon literate, and a total of 144 staff have opted into the internal sustainability advocates' network.

Signed:

Trust Chief Executive
23 June 2026

ACCOUNTABILITY REPORT

Directors' Report

The MFT Board of Directors comprises Executive and Non-Executive Directors, who have joint responsibility for every decision of the Board, regardless of their individual skills or roles. The Board is collectively responsible for discharging the powers and duties of the Trust, and for its performance.

The Executive Directors were appointed because of their business focus and operational / management experience within, and outside, the health and care sector. Their skills are complemented by the business, finance, education, and other experience provided by the Trust Non-Executive Directors, who also have strong links with the local community. All Directors are subject to an annual review of their performance and contribution to the management and leadership of the Trust.

MFT regularly reviews the skills and expertise of the Board and considers there to be a balance of appropriate skills amongst the Board members, ensuring balance, completeness, and appropriateness to the requirements of the Trust.

The Board of Directors is responsible for determining the Trust's:

- strategy, business plans and budget
- accountability, audit, and monitoring arrangements
- regulation and control arrangements
- senior appointment and dismissal arrangements.

The Board is also responsible for approving the Trust's annual report and accounts and ensuring that MFT acts in accordance with the requirements of its NHS Provider Licence.

Board members (as at 31 March 2026)

<table>
<tr>
<td> 

Kathy Cowell CBE DL
Trust Chair

Read more

(stepped down 30 April 2026)</td>
<td> 

Trevor Rees
Deputy Chair & Non-Executive Director

Read more

(Interim Trust Chair from 1 May 2026)</td>
</tr>
<tr>
<td> 

Nic Gower
Non-Executive Director & Audit and Risk Committee Chair

Read more</td>
<td> 

Christine McLoughlin OBE
Non-Executive Director & Senior Independent Director

Read more</td>
</tr>
</table>

Angela Adimora

Non-Executive Director

Read more

Samantha Liscio

Non-Executive Director

Read more

Jackie Hanson MBE

Non-Executive Director

Read more

(from 22nd December 2025)

Mark Gifford OBE

Non-Executive Director

Read more

Professor Ashley Blom

Non-Executive Director

Read more

(from 1st July 2025)

Matt Bonam

Non-Executive Director

Read more

Mark Cubbon

Trust Chief Executive

Read more

Darren Banks

Interim Joint Deputy Chief Executive

Read more

Kimberley Salmon- Jamieson

Chief Nursing Officer / Interim Joint Deputy Chief Executive

Read more

Claire Wilson

Chief Finance Officer

Read more

Professor Matt Makin

Joint Chief Medical Officer (interim)

Read more

(from 1st September 2025)

Dr Sohail Munshi

Joint Chief Medical Officer

Read more

 **David Walliker** **Chief Digital and Information Officer** Read more	 **Meera Nair** **Chief People Officer** Read more
 **Tom Rafferty** **Acting Chief Strategy Officer** Read more	 **Vanessa Gardener** **Chief Delivery Officer** Read more

In addition to the above:

- Dr Toli Onon was Joint Chief Medical Officer until 14 September 2025.
- Dr Vinod Diwakar was Joint Chief Medical Officer from 20 November 2025 to 15th April 2026.
- Professor Luke Georghiou was a Non-Executive Director until 31 May 2025.
- Mr Damien Riley was a Non-Executive Director until 19 December 2025.

Figure 12: Board meeting attendance 2025/26 (Key : ✓ attended X did not attend).
* Meeting date changed impacting on availability of all colleagues to attend

Board member / role	May 25	Jul 25*	Oct 25	Nov 25	Jan 26	Mar 26
Kathy Cowell Trust Chair	✓	✓	✓	✓	✓	✓
Angela Adimora Non-Executive Director	✓	✓	X	✓	✓	✓
Darren Banks Joint Deputy Trust Chief Executive	✓	✓	✓	✓	✓	✓
Ashley Blom Non-Executive Director	n/a	X	✓	✓	X	✓
Matt Bonam Non-Executive Director	✓	✓	✓	✓	X	X
Vin Diwakar Joint Chief Medical Officer	n/a	n/a	n/a	✓	X	X
Mark Cubbon Trust Chief Executive	✓	✓	✓	✓	✓	✓
Vanessa Gardener Chief Delivery Officer	✓	X	✓	✓	✓	✓
Luke Georghiou Non-Executive Director	✓	n/a	n/a	n/a	n/a	n/a
Mark Gifford Non-Executive Director	X	X	✓	✓	✓	✓
Nic Gower Non-Executive Director	X	✓	✓	X	X	✓
Jackie Hanson Non-Executive Director	n/a	n/a	n/a	n/a	✓	✓
Sam Liscio Non-Executive Director	X	X	✓	✓	✓	✓
Matt Makin Interim Joint Chief Medical Officer	n/a	n/a	✓	✓	✓	✓
Chris McLoughlin Non-Executive Director	X	✓	✓	✓	X	✓
Sohail Munshi Joint Chief Medical Officer	✓	✓	✓	✓	X	X
Meera Nair Chief People Officer	✓	✓	✓	✓	✓	✓
Toli Onon Joint Chief Medical Officer	✓	✓	n/a	n/a	n/a	n/a
Tom Rafferty Acting Chief Strategy Officer	✓	X	✓	✓	✓	✓
Trevor Rees Non-Executive Director	✓	X	✓	✓	✓	✓
Kimberley Salmon-Jamieson Chief Nursing Officer / Joint Deputy Chief Executive	✓	✓	✓	✓	✓	✓
David Walliker Chief Digital and Information Officer	X	✓	✓	✓	✓	✓

Board member / role	May 25	Jul 25*	Oct 25	Nov 25	Jan 26	Mar 26
Claire Wilson Chief Finance Officer	✓	✓	✓	✓	✓	✓

Information about the Committees of the Board of Directors can be found in the Annual Governance Statement section of this report.

Board of Directors' Register of Interests

Each year, at the May and November Board meetings, the Board of Directors receive a register of the interests of all Board members. These registers can be found on the Trust's website.

Political donations

No political donations have been made during 2025/26.

Income

For the 2025/26 financial year, the Trust's income for the provision of goods and services for the purposes of the health service was £2.9bn and therefore was greater than its income from the provision of goods and services for any other purposes of £369m.

Better Payment Practice Code

NHSE places a focus on all organisations' performance against the Better Payment Practice Code (BPPC). The target for all NHS organisations is to pay 95% of invoices within payment terms. An extract of MFT's submission for year-to-date on 31st March 2026 is shown in Figure 13 below.

Figure 13: Better Payment Practice Code compliance

Better Payment Practice Code (BPPC)	YTD 31/03/2026 By number	 By £'000
Non NHS		
Total bills paid in year	349,306	1,812,558
Total bills paid within target	317.019	1,705,692
Percentage of bills paid within target	**90.8%**	**94.1%**
NHS		
Total bills paid in year	9,955	404,482
Total bills paid within target	5,631	345,823
Percentage of bills paid within target	**56.6%**	**85.5%**
Total		
Total bills paid in year	359,261	2,217,040
Total bills paid within target	322,650	2,051,515
Percentage of bills paid within target	**89.8%**	**92.5%**
Target	95%	95%
Distance from target	**(5.2%)**	**(2.5%)**

There was no liability to pay interest accrued by virtue of failing to pay invoices within the 30-day period.

External auditor

Grant Thornton UK LLP are the appointed external auditors for the Trust and the Group for the 2025/26 financial year. The contract commenced in December 2024, on a three-year contract with the option to extend for two further 12-month periods. The audit fee for the 2025/26 audit of the Trust is £550,000 +VAT.

Forvis Mazars LLP are the appointed external auditors for the MFT Charity. Audit fee details are included in the MFT Charity Annual Report.

In 2025/2026, non-audit services provided by the external auditors, Grant Thornton UK LLP totalled £47k. There were no other non-audit services. All these non-audit services were reviewed and approved by the Audit and Risk Committee as part of their consideration of non-audit services provided by the auditor.

Counter Fraud

KPMG were appointed as the Trust's Counter Fraud Service providers from 1st April 2025, replacing Grant Thornton UK LLP.

Internal auditor

KPMG are the Trust's Internal Auditors. They were appointed on the 1st April 2022 on a three-year contract with the option to extend for a further 2-year period; the option was exercised to extend the contract to 31st March 2027. The internal auditors are responsible for undertaking the internal audit functions on behalf of the Trust. The Head of Internal Audit reports to each meeting of the Audit and Risk Committee on the audit activity undertaken. The Committee reviews and approves the Internal Audit Strategy and Plan and monitors progress including rigorous follow-up of recommendations. Additional information about internal audit is set out in the Annual Governance Statement within this report.

NHS England's well-led framework

NHS England and the Care Quality Commission define a well-led Trust as one where:

> *'There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities, and all leaders and staff share this. Leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities*.'

In order to independently assess MFT's culture, leadership, and governance against this, an external developmental review was commissioned in 2023 from GGI. The recommendations from this led to the Board of Directors overseeing delivery of a programme of organisational change and development.

In March 2024, the Board of Directors approved 'Where Excellence Meets Compassion', MFT's new 5-year organisational strategy. The deployment of the strategy has been ongoing since then and has included:

- Realignment of Board and management governance structures to reflect the strategic aims of the organisation.
- Restructuring of Board and management committee meetings' agendas around the strategic aims.
- Aligning key assurance mechanisms with the strategic aims e.g. the Delivery Oversight Framework, the Integrated Performance Report, Risk Management Framework and Strategy, and the Board Assurance Framework
- Establishing the strategic aims and objectives as the starting point for strategic delivery plans and the annual planning process for 2025/26.
- Raising and maintaining awareness of the strategy through frequent internal and external communications and engagement activity.

As a result of the adoption of a new organisational strategy and the recognition of the unprecedented demands on the Trust, both operationally and financially, the Board agreed to review and enhance the organisation's operating model. The One MFT programme was established to manage the process of organisational change with a Board Committee, the Organisational Development Board Committee, established to ensure oversight from the Board of Directors.

Phase 1 of the One MFT programme (June – October 2024) saw the grouping together of the Trust's hospitals and community services in to six Clinical Groups, each led by a Chief Executive and senior leadership team. The Clinical Groups are accountable and responsible for the management and governance of hospital sites and/or community-based services and, in some cases, for 'Single Services' which operate across multiple sites but are managed and governed by one Clinical Group.

The Clinical Groups are supported by the Trust's corporate services which are led by the Executive Directors. Phase 2 saw a redesign of Corporate Services to ensure they were fit for purpose for the new organisational environment.

Phase 3 (January 2025 to October 2025) saw the implementation of consistent clinically-led operating

models across MFT, which reduced duplication of roles and cross-site inconsistencies in accountability. This in turn is contributing to more effective and efficient delivery of services.

The Trust is focused on continuing to develop its leadership and fostering a culture in which staff feel valued and engaged. To this end, a Collective Leadership – Culture Programme is being delivered and a Strategic Framework for staff engagement has been approved. At the heart of the framework is a Trust Chief Executive-led Staff Engagement & Culture Forum, which will act as the Trust's primary mechanism for hearing the collective staff voice, identifying Trust-wide themes, setting priorities, and ensuring feedback results in visible and measurable improvement. This Forum will support Clinical Group-led engagement ensuring that local insight shapes Trust-level action and that Trust-wide priorities are meaningfully owned and delivered locally.

The Trust continues to involve patients and the public in the development of our services and to assess the quality of our services through a range of mechanisms. To supplement this, a new Patient Experience digital platform was launched in April 2026 which will enable data to be centralised with improved reporting features creating a more accessible platform to support continuous improvement. Alongside this internal activity, engagement continues with bodies which represent local people including our own Governors, Healthwatch, and local councilors.

To support the delivery of change, the Trust has adopted a single approach to improvement built on consistent application of NHS Impact's five components:

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity
- Embedding improvement unto management systems and processes.

A single improvement team, working to an aligned model across Clinical Groups and Corporate Services, has been created to support the work.

Work relevant to each of the Well-led framework's quality statements is overseen through the Trust's Board committees and the Board Of Directors itself. Bi-monthly Board Seminars allow time for the Board of Directors to horizon-scan, have in-depth discussions on strategic issues, and to participate in learning and development sessions ensuring they are up to date with changes to guidance and legislation. Reports and assessments are commissioned from external organisations and experts when the Trust's leadership wish to have an independent view on a specific area of Trust business. The internal audit plan for each year focuses on testing the controls in place for key operational areas including those areas where evidence indicates there may be some weaknesses in current

arrangements.

In the autumn of 2025, the Trust undertook NHS England's Provider Capability self-assessment exercise. The Trust Leadership Team considered the national guidance at their meeting in September 2025 and instigated a self-assessment process using a bespoke internal template structured around the domains, criteria, and indicative evidence/lines of enquiry included in the guidance. Following discussion at the Board of Directors, also in September 2025, the following declarations were approved with a statement to NHS England confirming that, for 'Partially confirmed' areas, governance, systems, processes and information flows are in place and functioning, but risks to delivery remain significant.

- Strategy, leadership and planning: Confirmed
- Quality of care: Confirmed
- People and culture: Partially confirmed
- Access and delivery of services: Partially confirmed
- Productivity and value for money: Confirmed
- Financial performance and oversight: Partially confirmed

During November 2025, the regional team reviewed the Trust's submission statements and evidence and triangulated this information with their own views, the Trust's historical track record of delivery, recent regulatory history, and relevant third-party information to assign a single overall capability rating from one of four categories, using national indicative criteria. Following a national moderation process, the Trust's overall capability rating was assessed as 'Amber-Green' for 2025/26, in line with the Trust's self-assessment.

Our Partners

MFT works closely with a number of other organisations to support delivery of our strategy. These partnerships include collaboration with colleagues from across primary care (for example, GPs), other hospitals, and Local Authorities, as well as from the voluntary, charitable, and social enterprises sector, through the Greater Manchester Integrated Care Partnership.

- Manchester and Trafford Local Care Organisations work alongside Local Authority colleagues to provide NHS and adult social care to local people. Through our Neighbourhood Teams and Hospital at Home services, we collaborate with primary care networks to establish more streamlined services and outcomes for patients.
- We work closely with local NHS and voluntary, community and social enterprise (VCSE) colleagues as part of Locality Boards in Manchester and Trafford, as well as with other Greater Manchester localities.
- We are part of the Greater Manchester Trust Provider Collaborative which brings together NHS providers from across the city-region.
- We have strong relationships with our university partners, working together on research and

education.

- Our size, scale and expertise allow us to proudly host organisations such as Health Innovation Manchester, with which we work closely on research and innovation.
- Various National Institute for Health Research (NIHR) programmes including the Manchester NIHR Biomedical Research Centre, the Manchester NIHR Clinical Research Facility, the NIHR HealthTech Research Centre and NIHR North West Regional Research Delivery Network.
- The North West Genomic Laboratory Hub and Genomic Medicine Service Alliance.
- We work with a range of strategic partners on research, innovation, and local development, for example through our Citylabs developments.

Modern Slavery Act 2015

The Trust's Modern Slavery and Human Trafficking Statement 2025/26 can be found here. This details the steps the Trust takes to ensure that slavery and human trafficking is not taking place in any part of our business or in any of our supply chains.

Signed:

Trust Chief Executive

23 June 2026

Remuneration report

Annual statement on remuneration

This Remuneration Report describes how the Trust applies the principles of good corporate governance in relation to Directors' remuneration, as required by the Companies Act 2006, Regulation 11 and Schedule 8 of the Large and Medium-Sized Companies and Groups (Accounts and Reports) Regulations 2008 and elements of the NHS Foundation Trust Code of Governance.

Remuneration and Nominations Committee

The Trust has a Remuneration and Nominations Committee that advises the Board on appropriate remuneration and terms of service for the Trust Chief Executive and Trust Executive Directors. The Committee is a sub-committee of the MFT Board of Directors, and the Committee is chaired by the Trust Chair.

The Committee's main purpose regarding remuneration is to set rates of remuneration, terms and conditions of service for any staff on locally determined conditions of service including: the Trust Chief Executive, Trust Executive Directors, Clinical Group Chief Executives and Directors.

The Trust Chief Executive and the Chief People Officer are also in attendance, when required, to provide information on Directors' performance and review general pay and reward intelligence, including comparative data on Directors' salaries and NHS guidance on pay and terms and conditions. Individuals do not participate in any discussion relating to their own remuneration.

For clarity, the components of remuneration are:

- Base salary - individual base salaries are reviewed annually. For Trust Executive Directors, the Department of Health and Social Care guidance on Very Senior Managers' Pay is taken into account.
- Pensions - some, but not all, Trust Executive Directors participate in the NHS Superannuation Scheme.

The Committee has clear terms of reference that are regularly reviewed, most recently in May 2026 at the Board of Directors meeting. The membership of the Committee is:

- The Trust Chair of the Trust's Board of Directors
- All Trust Non-Executive Directors.

The following meetings of the Committee have taken place during 2025/26:

Remuneration and Nominations Committee – 16th May 2025

Members present: Kathy Cowell (Chair), Luke Georghiou, Mark Gifford, Samantha Liscio, Matthew Bonam, Angela Adimora

The following agenda items were considered at the meeting:

- Performance of the Trust Executive Directors 2024/25
- Performance of the Trust Chief Executive 2024/25
- Trust Chief Executive secondment arrangements
- Redundancy/settlement agreements at Health Innovation Manchester
- VSM Salary for the Chief Executive - LCO/UDHM Clinical Group
- Summary confirmation of Very Senior Manager (VSM) appointments and salary approvals (October 2024 – 31 March 2025)

The Committee noted the exemplary performance of the Trust Executive Directors and the Trust Chief Executive in 204/25 and recommended no recovery of pay. The Committee ratified the Chair's action to agree to the release of the Trust Chief Executive, for 2.5 days a week, to NHS England and the acting up arrangements to cover the time when he was not working for the Trust. The Committee ratified the Chair's action related to a settlement agreement at Health Innovation Manchester. The Committee approved the proposed salary for the Chief Executive of the LCO/Dental Clinical Group and received the summary report on VSM appointments during 2024/25.

Remuneration and Nominations Committee 9th June 2025

Members present: Kathy Cowell (Chair), Mark Gifford, Samantha Liscio, Damian Riley, Nic Gower, Trevor Rees, Angela Adimora

The following agenda items were considered at the meeting:

- MFT Pay Framework for Associate Medical Directors in the Clinical Groups.

At their meeting in March 2025, the Committee had approved a standard pay framework for Clinical Leaderhsip and Deputy Medical Director roles. At the Committee meeting on 9th June 2025, the Committee approved revised Responsibility Allowances for Associate Medical Directors and Clinical Group portfolio leads and revised tenure limits for clinical leadership appointments.

Remuneration and Nominations Committee – 24th June 2025

Members present: Kathy Cowell (Chair), Samantha Liscio, Damian Riley, Nic Gower, Trevor Rees, Angela Adimora

The following agenda items were considered at the meeting:

- Very Senior Manager framework

- Mutually Agreed Resignation Scheme
- Fit and Proper Test

The Committee approved the MFT VSM Pay Framework Policy and Principles which had been designed to reflect the requirements of the new NHS Very Senior Management Framework. As part of this, the Committee approved that Clinical Group Chief Executive are classified as level 2. The Committee also supported the proposal to run a Mutually Agreed Resignation Scheme and noted the outcome of the 2025 Fit and Proper Person Test (FPPT) process and approved changes to the Trust's FPPT policy following amendments to the national FPPT Framework.

Remuneration and Nominations Committee – 19th March 2026

Members present: Kathy Cowell (Chair), Samantha Liscio, Nic Gower, Trevor Rees, Angela Adimora

The following agenda items were considered at the meeting:

- NHS pay framework – impact of VSM pay award 2025/26
- VSM pay award proposal
- Mutually Agreed Resignation Scheme
- Joint Chief Medical Officer appointment

The Committee approved the inclusion within the MFT VSM pay framework of Very Senior Managers who fall outside of the national VSM pay framework, with new employees in this category moving to the Agenda for Change scale and approved the 2025/26 national VSM pay award including for six individuals who fall outside of the national VSM pay framework. The Committee approved the Mutually Agreed Resignation Scheme, supported in principle at the previous meeting. The Committee also approved the salary for the new Joint Chief Medical Officer.

Trust Non-Executive Directors

The Council of Governors' Remuneration and Nominations Committee is, with external advice as appropriate, responsible for the identification and nomination of new Non-Executive Directors and considering their remuneration.

In keeping with statutory requirements, whilst the Council of Governors' Remuneration and Nominations Committee makes recommendations, it is the Council of Governors who are responsible at a general meeting for the appointment, re-appointment, and removal of the Chair and the other Non-Executive Directors, and for approval of their remuneration.

The Non-Executive Directors receive no benefits or entitlements other than fees and are not entitled to any termination payments. The Trust does not make any contribution to the pension arrangements of Non-Executive Directors.

The terms of office for Non-Executive Directors at the Trust are managed in accordance with NHS England's Code of Governance, i.e. any term beyond six years (two three-year terms) is subject to rigorous annual review and approval by NHS England.

There is a clear, fair and open performance review (appraisal) process for all Non-Executive Directors that takes account of both individual accountability lines and the essential input of Governors.

The appraisal process for the Trust Chair and Non-Executive Directors is a tried-and-tested process and is in keeping with NHS England guidance. An external appraisal specialist was appointed by the Trust Board Secretary (with support from the Lead Governor) to undertake an independent 360° appraisal of the Trust Chair during April 2026. This individual is a Chartered Member of the CIPD and provides a Resourcing & Human Capital Solutions Consultancy Service established in 2005. She is known to the organisation and has been involved in Chair Appraisals for a number of years. The fee for the independent input received was £2100 +VAT.

Governors submitted their views on Trust Non-Executive Directors and the Trust Chair to the Lead Governor and Trust Senior Independent Director respectively. The Trust took notice of the Leadership Competency Framework guidance from NHS England and included it in the templates used for the appraisals of the Trust Chair and Non-Executive Directors

The Senior Independent Director confirmed the process adopted and the key headlines covered in the report were shared with the Council of Governors' Remuneration and Nominations Committee at its meeting on 8th July 2026.

Assurance by the Senior Independent Director and Lead Governor (on behalf of the Council of Governors' Remuneration and Nominations Committee) is presented to the Council of Governors at their general meeting in July each year..

Extension of the Terms of Office of Trust Non-Executive Directors

At the Council of Governors meeting on the 23rd July 2025, on advice from the Council of Governors' Remuneration and Nominations Committee, Governors approved the extension of the Trust Chair's Term of Office for a further year until the 19th December 2026, subject to agreement by NHS England which was later provided.

At the Council of Governors meeting on the 19th November 2025, on advice from the Council of Governors' Remuneration and Nominations Committee following a succession planning workshop held on the 19th August 2025, the Council of Governors approved a 12-month extension for Trevor Rees (Deputy Chair) to 19th December 2027, and a 6-month extension for Chris McLoughlin (Senior

Independent Director) to 19th June 2027.

At the Council of Governors meeting on the 18th February 2026, on advice from the Council of Governors' Remuneration and Nominations Committee, Governors approved the reappointment of Mark Gifford as a Trust NED for a second term of office of 3 years until the 28th February 2029

Appointment of a new Trust Non-Executive Director

At the Council of Governors meeting on the 14th May 2025, on advice from the Council of Governors' Remuneration and Nominations Committee, Governors approved the appointment of Professor Ashley Blom as the University of Manchester's representative on MFT's Board of Directors for a 3-year period starting from 1st June 2025.

At the Council of Governors meeting on the 23rd July 2025, on advice from the Council of Governors' Remuneration and Nominations Committee, Governors approved the appointment of Jackie Hanson as a Non-Executive Director for a 3-year period. Jackie started in her role on the 22nd December 2025.

Remuneration of the Trust Chair and Non-Executive Directors

At their meeting in September 2025, the Trust's Remuneration and Nominations Committee accepted NHS England's recommendation to award a pay increase of 3.25% to staff on Very Senior Managers (VSM) pay scales.

At their meeting on 19th November 2025, the Council of Governors approved a recommendation from the Council of Governors Remuneration and Nominations Committee to award the same 3.25% increase to Trust Non- Executive Directors.

Senior managers' remuneration policy

The remuneration of the Trust Chief Executive, Executive Directors, and Very Senior Managers (VSM) is determined by the MFT Remuneration and Nominations Committee. Since 1st April 2025, any new appointments have been aligned to the new Very Senior Manager Pay Framework, published by NHS England.

MFT's Executive Directors and Very Senior Managers are employed on contracts of employment whose provisions are consistent with those relating to other employees within the Trust. There are no components within the remuneration relating to performance measures or bonuses. Contracts for Directors do not contain any obligations which could give rise to or impact on remuneration payments or payments for loss of office.

The MFT pay structure for Directors comprises basic pay and pension related benefits. Directors are

also entitled to receive on-call payments, business mileage and are able to access salary sacrifice schemes consistent with all other employees. All pay is taxed at source.

Director and VSM salaries appointed prior to the publication of the new NHSE VSM Pay Framework were benchmarked using NHSE guidance and benchmarking data from comparative teaching hospitals. MFT's senior managers' remuneration policy provides a progression ladder between the pay of other employees and that of Executive Directors. MFT did not consult with employees when preparing the senior managers' remuneration policy but did consult with individuals about how the application of the policy would apply to them.

Director and VSM salaries appointed following the publication of the NHSE VSM Pay Framework were appointed utilising the confirmed pay thresholds.

Where salaries of very senior managers exceed £150,000 per annum, this is in accordance with NHS England guidance, relevant benchmarks and market conditions.

Performance of Directors is assessed and managed through annual appraisal against predetermined objectives linked to the delivery of MFT Strategy along with one-to-one reviews. Any deficit in performance is identified during these regular meetings. Serious performance issues are managed via our organisational performance capability management policy.

Performance of the Trust Non-Executive Directors (including the Deputy Chair) is assessed and managed through annual appraisal by the Trust Chair against predetermined objectives along with regular one to one reviews. Any deficit in performance is identified during these regular meetings along with opportunities for regular professional development. Appraisals led by the Trust Chair - for the Chief Executive and Trust Non-Executive Directors – are used as an opportunity to identify continuing professional development needs.

No performance payment element has been paid to any of the Trust's Executive Directors during 2025/26. Equally, there have been no payments to either Executive or Non-Executive Directors for loss of office.

There are no special contractual compensation provisions for early termination of Directors' contracts. Early termination by reason of redundancy is subject to the normal provisions of the Agenda for Change (AfC): NHS Terms and Conditions of Service Handbook. For those above the minimum retirement age, early termination by reason of redundancy is in accordance with the NHS Pension Scheme. Employees above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme.

The MFT Remuneration and Nominations Committee operates in accordance with the Trust' Equality & Diversity Policy in Employment'. This policy sets out our approach to equality in the workforce, including the use of equality impact assessments to underpin all policies/procedures and service changes.

Equality, diversity and inclusion are monitored by the Workforce & Education Management Committee and the People Board Committee on behalf of the MFT Trust Board. The Trust Board annually accepts the Gender Pay report which outlines how MFT is performing against the national Gender Pay reporting framework.

Figure 14: Future Policy Table

The table below provides detail on each element of Executive Directors' remuneration packages for 2025/26, how the level of pay is determined, how change is enacted and how Executive Directors' performance is managed.

How the component supports the strategic aims of the Trust	How the component operates	Maximum potential value of the component	Description of framework used to access performance
Basic Pay			
Ensures recruitment, retention of directors of sufficient calibre to deliver the Trust's objectives.	Basic pay is remunerated monthly and reviewed annually. Any changes are normally effective from 1 April each year. Such changes are proposed and approved via the Trust's Remuneration and Nominations Committee. In exceptional circumstances, reviews of salary may take place outside of this cycle but are made by MFT Remuneration and Nominations Committee.	Change to basic salary is usually enacted as a percentage increase in line with national pay award guidance.	All Directors participate in annual performance reviews. The individual's agreed objectives are linked to the Trust' Strategic Aims and objectives. The Trust does not operate a system of performance-related pay. Failure to meet objectives is managed via Trust policies and performance frameworks.
Pension-related benefits			
Pension benefits (which may be opted out of) are part of the total remuneration of directors to attract high-calibre staff to enable the Trust to meet its strategic objectives.	Pension is available as a benefit to directors and follows the national NHS Pension Scheme contribution rules (or alternative pension provider).	Pension is available as a benefit to directors and follows the national NHS Pension Scheme contribution rules (or alternative pension provider). Pension entitlements are determined in accordance with HMRC.	Not applicable.
On-call payment			
Senior managers are entitled to receive on-call payment in line with on-call responsibilities, as per Trust policy			
Benefits			
The Trust operates a number of salary sacrifice schemes including childcare vouchers, bikes and a lease car scheme. These are open to all members of staff.			
Travel expenses			
Appropriate travel expenses are paid for business mileage in line with Trust policy			

Figure 15: Directors Remuneration 2025/26 **(subject to audit)**

	Salary	Taxable benefits in kind	Annual performance related bonuses	Long-term performance related bonuses	All pension related benefits	Total
	(Bands of £5,000)	(Rounded to nearest £100)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
	£000,	£s	£000,	£000,	£000,	£000,
Kathy Cowell Trust Chair	75-80	0	0	0	0	75-80
Angela Adimora Trust Non-Executive Director	20-25	0	0	0	0	20-25
Matthew Bonam Trust Non-Executive Director	15-20	0	0	0	0	15-20
Samantha Liscio Trust Non-Executive Director	20-25	0	0	0	0	20-25
[1]Prof Luke Georghiou Trust Non-Executive Director	0	0	0	0	0	0
Nic Gower Trust Non-Executive Director	20-25	0	0	0	0	20-25
Chris McLoughlin Trust Non-Executive Director	20-25	0	0	0	0	20-25
Trevor Rees Trust Non-Executive Director	20-25	0	0	0	0	20-25
Mark Gifford Trust Non-Executive Director	20-25	0	0	0	0	20-25
[2]Damien Riley Trust Non-Executive Director	10 - 15	0	0	0	0	10-15
[3]Prof Ashley Blom Trust Non-Executive Director	10 - 15	0	0	0	0	10-15
[4]Jacqueline Hanson Trust Non-Executive Director	5-10	0	0	0	0	5-10

	Salary	Taxable benefits in kind	Annual performance related bonuses	Long-term performance related bonuses	All pension related benefits	Total
	(Bands of £5,000)	(Rounded to nearest £100)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
	£000,	£s	£000,	£000,	£000,	£000,
Mark Cubbon Trust Chief Executive	315 - 320	0	0	0	95-100	415-420
[5]Darren Banks Interim Trust Deputy Chief Executive	235 - 240	0	0	0	70-75	310-315
[6]Kimberley Salmon-Jamieson Chief Nursing Officer / Interim Trust Deputy Chief Executive	225 - 230	0	0	0	305-310	530-535
Vanessa Gardener Chief Delivery Officer	210 - 215	0	0	0	70-75	280-285
[7]Tom Rafferty Acting Chief Strategy Officer	175 - 180	0	0	0	180-185	355-360
David Walliker Chief Digital and Information Officer	210 - 215	0	0	0	0	210-215
Claire Wilson Chief Finance Officer	225 - 230	0	0	0	145-150	370-375
Meera Nair Chief People Officer	205 - 210	0	0	0	225-230	435-440
Sohail Munshi Joint Chief Medical Officer	245 - 250	0	0	0	0	245-250
[8]Toli Onon Joint Chief Medical Officer	100 - 105	0	0	0	80-85	185-190
[9]Dr Vinod Diwakar Joint Chief Medical Officer	90 - 95	0	0	0	225-230	320-325
[10]Prof Matthew Makin Joint Chief Medical Officer (interim)	135 - 140	0	0	0	220-225	355-360

Notes for Figure 15

[1]Professor Luke Georghiou commenced role as Group-Non-Executive Director on 1st June 2018 and has elected not to receive his remuneration for this post but has nominated that the University of Manchester receive it on his behalf. - Leaver 31/05/2025.

[2]Damien Riley - Leaver 19/12/2025

[3]Professor Ashley Blom commenced role as Non-Executive Director 01/07/2025

[4] Jacqueline Hanson commenced role as Non-Exec Director from 22/12/2025

[5] Darren Banks, Interim Trust Deputy Chief Executive from 01/01/2025

[6] Kimberley Salmon-Jamieson, Interim Trust Deputy Chief Executive from 01/04/2025

[7]Thomas Rafferty Acting Chief Strategy Officer from 01/01/2025

[8]Toli Onon, Joint Chief Medical Officer 01/04/2025 - 14/09/2025

[9]Dr Vinod Diwakar, Joint Chief Medical Officer from 20/11/2025

[10]Professor Matthew Makin, Joint Chief Medical Officer (interim) 01/09/2025 - 31/03/2026

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual.

The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

***Figure 16: Pensions 2025/26* (subject to audit)**

	Real increase/ (decrease) in pension at age 60	Real increase/ (decrease) in pension lump sum at age 60	Total accrued pension at age 60 at 31st March 2026	Lump sum at age 60 related to accrued pension at 31st March 2026	Cash Equivalent Transfer Value at 31st March 2026	Cash Equivalent Transfer Value at 31st March 2025	Real increase in Cash Equivalent Transfer Value
	Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	To the nearest £1000	To the nearest £1000	To the nearest £1000
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Mark Cubbon Trust Chief Executive	5-7.5	7.5-10	95-100	225-230	1,970	1,818	111
Darren Banks Interim Joint Trust Deputy Chief Executive	2.5-5	2.5-5	70-75	185-190	1,640	1,509	80
Kimberley Salmon-Jamieson Chief Nursing Officer / Interim Joint Trust Deputy Chief Executive	15-17.5	32.5-35	85-90	215-220	1923	1550	320
Vanessa Gardener Chief Delivery Officer	2.5-5	2.5-5	80-85	200-205	1,793	1,660	80
Tom Rafferty, Acting Chief Strategy Officer	7.5-10	17.5-20	35-40	85-90	695	525	141
Claire Wilson Chief Finance Officer	7.5-10	10-12.5	70-75	170-175	1,502	1,313	139
Meera Nair Chief People Officer	10-12.5	22.5-25	60-65	135-140	1,380	1,094	243
Toli Onon Joint Chief Medical Officer	2.5-5	7.5-10	100-105	255-260	617	2347	0
Dr Vinod Diwakar Joint Chief Medical Officer	10-12.5	20-22.5	105-110	270-275	2,590	2,270	270
Prof Matthew Makin Joint Chief Medical Officer (interim)	10-12.5	0	10-15	0	185	0	172

The above tables only include details for directors who are currently members of the NHS scheme. The following directors have chosen not to be part of the pension scheme: Sohail Munshi, David Walliker.

Figure 17: Directors' remuneration (2024/25) **(audited)**

	Salary	Taxable benefits in kind	Annual performance related bonuses	Long-term performance related bonuses	All pension related benefits	Total
	(Bands of £5,000)	(Rounded to nearest £100)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
	£000,	£s	£000,	£000,	£000,	£000,
Kathy Cowell Trust Chair	75-80	0	0	0	0	75-80
Angela Adimora Non- Executive Director	15-20	0	0	0	0	15-20
[2]Matthew Bonam Non- Executive Director	10 - 15	0	0	0	0	10-15
Samantha Liscio Non- Executive Director	15-20	0	0	0	0	15-20
[1]Prof Luke Georghiou Non-Executive Director	0	0	0	0	0	0
Nic Gower Non- Executive Director	20-25	0	0	0	0	20-25
Chris McLoughlin, Non-Executive Director	20-25	0	0	0	0	20-25
Trevor Rees Non- Executive Director	20-25	0	0	0	0	20-25
Mark Gifford Non- Executive Director	15-20	0	0	0	0	15-20
Damian Riley Non- Executive Director	15-20	0	0	0	0	15-20
Mark Cubbon Trust Chief Executive	305 - 310	0	0	0	120 - 122.5	425 - 430
[3]Darren Banks Interim Deputy Chief Executive	210 - 215	0	0	0	140-142.50	350 - 355
[4]Peter Blythin, Group Executive Director of Workforce & Corporate Business	80 - 85	0	0	0	0	80 - 85
[5]Julia Bridgewater Group Deputy Chief Executive	160 - 165	0	0	0	0	160 - 165

	Salary	Taxable benefits in kind	Annual performance related bonuses	Long-term performance related bonuses	All pension related benefits	Total
	(Bands of £5,000)	(Rounded to nearest £100)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
	£000,	£s	£000,	£000,	£000,	£000,
[6]Prof Jane Eddleston, Joint Chief Medical Officer	35 - 40	0	0	0	0	35 - 40
[7]Jenny Ehrhardt Chief Finance Officer	60 - 65	0	0	0	0	60 - 65
[8]Norma French Interim Chief People Officer	60 - 65	0	0	0	20 - 22.5	80 - 85
[9]Meera Nair Chief People Officer	20 - 25	0	0	0	57.5 - 60	80 - 85
[10]Marcus Thorman Interim Chief Finance Officer	160 - 165	0	0	0	155 - 157.5	315 - 320
[11]Claire Wilson Chief Finance Officer	65 - 70	0	0	0	120 - 122.5	190 - 195
Vanessa Gardener Chief Delivery Officer	200 - 205	0	0	0	75 - 77.5	280 - 285
[12]Sohail Munshi Joint Chief Medical Officer	55 - 60	0	0	0	0	55 - 60
[13]Tom Rafferty Interim Chief Strategy Officer	35 - 40	0	0	0	2.5 - 5	35 - 40
Kimberley Salmon-Jamieson Chief Nursing Officer	185 - 190	0	0	0	165 - 167.5	355 - 360
[14]David Walliker Chief Digital and Information Officer	185 - 190	0	0	0	0	185 - 190
[15]Bernard Clarke Joint Chief Medical Officer	145 - 150	0	0	0	0	145 - 150
Toli Onon Joint Chief Medical Officer	230 - 235	0	0	0	60 - 62.5	290 - 295

Notes for Figure 17

[1]Professor Luke Georghiou commenced his role as Non-Executive Director on 1st June 2018 and has elected not to receive his remuneration for this post (Band £15000-£20000) and has nominated that the University of Manchester receive it on his behalf.

[2]Matthew Bonam, Non-Executive Director from 02/09/2024

[3] Darren Banks, Interim Deputy Chief Executive from 01/01/2025. Prior to this, he held the role of Chief Strategy Officer which remains his substantive post.

[4]Peter Blythin, Group Executive Director of Workforce & Corporate Business to 08/09/2024. Following his departure, the role title changed to Chief People Officer to reflect the new nomenclature adopted for Executive Directors.

[5]Julia Bridgewater, Deputy Chief Executive to 31/12/2024

[6]Prof Jane Eddleston, Joint Chief Medical Officer to 31/05/2024

[7]Jenny Ehrhardt, Chief Finance Officer to 04/08/2024

[8]Norma French, Chief People Officer for period 09/09/2024 - 28/02/2025.

[9]Meera Nair, Chief People Officer from 17/02/2025.

[10]Marcus Thorman, Chief Finance Officer for period 03/06/2024 - 31/12/2024

[11]Claire Wilson, Chief Finance Officer from 09/12/2024

[12]Sohail Munshi, Joint Chief Medical Officer from 01/01/2025

[13]Tom Rafferty, Interim Chief Strategy Officer from 01/01/2025, acting into Darren Banks role while he is Interim Deputy Chief Executive.

[14]David Walliker, Chief Digital and Information Officer from 29/04/2024

[15]Bernard Clarke, Interim Joint Medical Director for period 01/06/2024 - 31/12/2024

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, minus the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

Figure 18 provides further information on the pension benefits accruing to the individual.

The 'Taxable benefits' column in the table refers to the gross value of such benefits before tax. It includes expenses allowances that are subject to UK income tax and paid or payable to the person in respect of qualifying services and benefits received by the person (other than salary) that are emoluments of the person and are received by them in respect of qualifying services.

The overlap between Norma French and Meera Nair holding the Chief People Officer role was implemented to ensure a full handover of Chief People Officer duties could be optimally undertaken.

The Trust has always employed two Joint Chief Medical Officers to ensure the full range of duties can be effectively undertaken. The remuneration for Joint Chief Medical Officers includes the remuneration received for both their Board role and any clinical duties they undertake.

Figure 18: Pensions (2024/25) **(audited)**

	Real increase/ (decrease) in pension at age 60	Real increase/ (decrease) in pension lump sum at age 60	Total accrued pension at age 60 at 31st March 2025	Lump sum at age 60 related to accrued pension at 31st March 2025	Cash Equivalent Transfer Value at 31st March 2025	Cash Equivalent Transfer Value at 31st March 2024	Real increase in Cash Equivalent Transfer Value
	Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	To the nearest £1000	To the nearest £1000	To the nearest £1000
	£000	£000	£000	£000	£000	£000	£000
Mark Cubbon Trust Chief Executive	5 to 7.5	10 to 12.5	80 to 85	215 to 220	1,818	1,563	135
Darren Banks Interim Deputy Chief Executive	7.5 to 10	10 to 12.5	65 to 70	180 to 185	1,510	1,253	148
Norma French Interim Chief People Officer	0 to 2.5	0	55 to 60	85 to 90	1,204	1,088	36
Vanessa Gardener Chief Delivery Officer	2.5 to 5	2.5 to 5	75 to 80	195 to 200	1,660	1,456	82
Toli Onon Joint Chief Medical Officer	2.5 to 5	0 to 2.5	90 to 95	245 to 250	2,347	2,099	83
Tom Rafferty Interim Chief Strategy Officer	0 to 2.5	0	5 to 10	15 to 20	129	116	2
Kimberley Salmon-Jamieson Chief Nursing Officer	7.5 to 10	15 to 17.5	65 to 70	180 to 185	1,550	1,269	174
Claire Wilson Group Chief Finance Officer	5 to 7.5	5 to 7.5	60 to 65	155 to 160	1,313	1,112	118
Bernard Clarke Joint Chief Medical Officer	0	0	0	0	0	0	0
Marcus Thorman Interim Chief Finance Officer	7.5 to 10	15 to 17.5	80 to 85	215 to 220	1,811	1,523	166
Jenny Ehrhardt Chief Finance Officer	0	0	65 to 70	170 to 175	1,324	1,245	0
Meera Nair Chief People Officer	2.5 to 5	0	45 to 50	115 to 120	1,094	965	61

Notes for Figure 18

All are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the

1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

Real increase values based on period in Executive role only.

The above tables only include details for directors who are currently members of the NHS scheme. The following directors have chosen not to be part of the pension scheme: Peter Blythin, Julia Bridgewater, Professor Jane Eddleston, Sohail Munshi, David Walliker.

There have been no employer contributions to the NHS Stakeholder Pension on behalf of directors.

Directors' expenses

The total number of Directors in office during 2025/26 was 24 (2024/25,26).
The number of Directors receiving expenses in 2025/26 was 1 (2024/25,3).
The total amount of expenses paid to Directors in 2025/26 was £134.48 (2024/25, £589.99).

Governors' expenses

The total number of Governors in office during 2025/26 was 30 (2024/25,30).
The number of Governors receiving expenses in 2025/26 was 1 (2024/25,3).
The total amount of expenses paid to Governors in 2025/26 was £186.78 (2024/25, £164.00).

Fair pay multiples (subject to audit)

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the Manchester University NHS Foundation Trust in the financial year 2025/26 was £315,000 to £320,000 (£305,000 to £310,000 2024/25) –This is a change between years of 3.2% (2024/25 5.3%). This was 8.4 times the median remuneration of the workforce which was £37,796 (2024/25 8.4 times and £36,483).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and cash equivalent transfer value of pensions. There were no bonuses or other payments made during 2025/26 relating to performance (2024/25, £Nil).

For employees of the Trust as a whole, the range of remuneration in 2025/26 was from £24,465 and £320,000 (2024/25, £23,615 to £310,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 5.7% (2024/25, 5.5%). 0 employees received remuneration in excess of the highest-paid director in 2025/26 (2024/25, 0).

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

Figure 19: Fair pay multiples 2025/26 (subject to audit)

2025/26	25th percentile	Median	75th percentile
Salary component of pay	£27,485	£37,796	£50.273
Total pay and benefits excluding pension benefits	£27,485	£37,796	£50,273
Pay and benefits excluding pension: pay ratio for highest paid director	11.6:1	8.4:1	6.3:1

Figure 20: Fair pay multiples 2024/25 (audited)

2024/25	25th percentile	Median	75th percentile
Salary component of pay	£26,530	£36,483	£48,526
Total pay and benefits excluding pension benefits	£26,530	£36,483	£48,526
Pay and benefits excluding pension: pay ratio for highest paid director	11.6:1	8.4:1	6.3:1

Consultancy and other costs

During the year, MFT spent £2.6m on consultancy (see note 7.1 of the Annual Accounts). The corresponding figure for 2024/25 was £2.3m.

Signed:

Trust Chief Executive

23 June 2026

Staff Report

The following tables include information regarding our staff.

Figure 21: Average number of employees (WTE basis) (subject to audit)

	Total 2025/26	Permanent 2025/26	Other 2025/26	Total 2024/25	Permanent 2024/25	Other 2024/25
Medical and dental	**4,066**	2,423	1,643	**4,026**	2,884	1,142
Administration and estates	**3,646**	3,632	14	**3,586**	3,575	11
Healthcare assistants and other support staff	**7,998**	7,183	815	**7,933**	7,060	873
Nursing, midwifery and health visiting staff	**10,004**	9,557	447	**9,492**	8,974	517
Scientific, therapeutic and technical staff	**1,316**	1,296	20	**1,274**	1,244	29
Healthcare science staff	**3,018**	2,980	38	**2,898**	2,844	54
Total average numbers	**30,048**	**27,071**	**2,977**	**29,209**	**26,581**	**2,627**

Figure 22: Staff turnover

	1st April 2025 to 31st March 2026	1st April 2024 to 31st March 2025	1st April 2023 to 31st March 2024
Staff Turnover	8.4%	10.0%	11.2%

Figure 23: Workforce numbers and demographics as at 31st March 2026

WORKFORCE DEMOGRAPHICS	**31-Mar-26**		**31-Mar-25**		**31-Mar-24**	
	Headcount	% of Total Headcount	Headcount	% of Total Headcount	Headcount	% of Total Headcount
Additional Professional Scientific and Technical	994	3.1%	1,085	3.4%	1,200	3.9%
Additional Clinical Services	5,612	17.5%	5,602	17.7%	5,479	17.7%
Administrative and Clerical	6,040	18.8%	6,134	19.4%	6,283	20.3%
Allied Health Professionals	2,340	7.3%	2,244	7.1%	2,155	7.0%

WORKFORCE DEMOGRAPHICS	31-Mar-26		31-Mar-25		31-Mar-24	
	Headcount	% of Total Headcount	Headcount	% of Total Headcount	Headcount	% of Total Headcount
Estates and Ancillary	1,678	5.2%	1,685	5.3%	1,513	4.9%
Healthcare Scientists	1,419	4.4%	1,304	4.1%	1,121	3.6%
Medical and Dental	3,252	10.1%	3,034	9.6%	2,926	9.5%
Nursing and Midwifery Registered	10,704	33.4%	10,526	33.3%	10,181	33.0%
Students	47	0.1%	41	0.1%	22	0.1%
Grand Total	32,086	100.0%	31,655	100.0%	30,880	100.0%
Full Time/Part Time						
Full Time	21,358	66.6%	21,712	68.6%	21,202	68.7%
Part Time	10,728	33.4%	9,943	31.4%	9,678	31.3%
Gender (MFT's gender gap report is available here)						
Female	24,664	76.9%	24,367	77.0%	24,070	77.9%
Male	7,422	23.1%	7,288	23.0%	6,810	22.1%
Disability						
No	25,370	79.1%	24,522	77.5%	23,178	75.1%
Not recorded	4,804	15.0%	5,413	17.1%	6,307	20.4%
Yes	1,912	6.0%	1,720	5.4%	1,395	4.5%
Ethnicity						
BAME	10,764	33.5%	9,764	30.8%	8,699	28.2%
Not recorded	2,395	7.5%	2,682	8.5%	3,152	10.2%
White	18,927	59.0%	19,209	60.7%	19,029	61.6%
Age						
16-20	102	0.3%	112	0.4%	136	0.4%
21-30	6366	19.8%	6,524	20.6%	6,622	21.4%
31-40	9597	29.9%	9,369	29.6%	9,040	29.3%
41-50	7520	23.4%	7,242	22.9%	6,935	22.5%
51-60	6038	18.8%	6,118	19.3%	5,993	19.4%
61+	2463	7.7%	2,290	7.2%	2,154	7.0%

Figure 24: Gender of Senior Staff

Senior Staff Gender Breakdown	Male	Female
Executive Directors	7	5
Non-Executive Directors	5	4

Figure 25: Staff sickness absence

Staff Sickness Absence	**1st April 2025 to 31st March 2026**	**1st April 2024 to 31st March 2025**	**1st April 2023 to 31st March 2024**
Sickness %	6.0%	6.1%	6.1%
Average Working Days lost (per whole time equivalent)	21.6	22.0	22.0

Sickness Absence

Sickness absence continued to pose a significant challenge for the Trust throughout 2025/26, reflecting sustained operational pressures, increasing workforce complexity, and the ongoing impact of stress, anxiety, mental health conditions, and musculoskeletal issues. Although absence levels remained above the Trust's long-term ambition, there was a clear and consistent focus on strengthening attendance management, enhancing early intervention, and embedding a more preventative and data-driven approach to workforce well-being.

During the year, the Trust built on its wider Employee Health and Well-Being agenda by prioritising targeted interventions in areas with the highest levels of absence and by improving manager capability through additional training and greater consistency in attendance management practice. The Employee Health and Wellbeing department continued to provide support for a broad range of health conditions and further enhanced its offer around psychological well-being and musculoskeletal support. Early outcomes from the day-one call-back model for musculoskeletal absences have been positive, with staff reporting quicker returns to work as a result of timely and proactive intervention.

The Trust also continued to broaden its approach to workforce well-being beyond traditional initiatives, recognising that attendance is a critical component of workforce sustainability, patient care, and organisational performance. This included more sophisticated use of workforce intelligence and staff feedback to better understand the underlying drivers of absence and to target support where it would have the greatest impact. Through its networks of Mental Health First Aiders

and Health and Wellbeing Champions, the Trust strengthened its reach and engagement with staff, enabling more effective promotion of health interventions and well-being support. Work is also underway to develop new offers for the coming year, with a particular focus on women's health and neurodiversity, alongside continued collaboration with staff networks to ensure timely and effective responses to requests for reasonable adjustments.

Workforce well-being remains a key strategic priority for the Trust. Further work will continue throughout 2026/27 to reduce absence levels, enhance staff experience, and support the development of a healthy, resilient, and sustainable workforce.

Staff Policies and actions applied during the financial year

We have continued to work in partnership with Trade Union colleagues to review our employment policies, each of which is supported by a robust equality impact assessment. The following policies were either reviewed or updated during 2025/26:

- Apprenticeship
- Dress Code
- Freedom to Speak Up
- Pregnancy and Parenting
- Probation
- Supporting Improved Performance
- Support for Staff with Alcohol and Substance Misuse Concerns

In partnership with our Trade Union colleagues, we agreed an extension to a further 7 policies.

- Flexible Working
- Long Service
- Pay Progression
- Secondment
- Remote and Homeworking
- Recruitment and Selection
- Starting Salaries

Engagement and consultation takes place across the Trust through specialist groups and staff networks ensuring all feedback is gathered. This approach allows concerns to be addressed and policies to be modified as necessary before they go through the consultation and ratification process.

Policies are reviewed through regular meetings with joint union representatives, who are formally consulted on policy developments. Policies are formally agreed at the Trust Joint Negotiating and Consultative Committee (JNCC) prior to Trust ratification.

Policies, guidance and a wide range of supporting information is available to staff and managers on the Trust's People Place platform. There are several informal methods that staff can use to obtain information about the development of the organisation and raise any concerns or suggestions for improvement.

We have Freedom to Speak Up Guardians, who are vital in ensuring a culture where staff can speak up freely and openly without suffering any detriment. The Guardians reports to the People Board Committee on a regular basis and have direct access to a designated Non-Executive Lead, in line with the national guidance, as well as direct access to both the Chair and the Chief Executive.

As a Foundation Trust, staff have formal representation in the governance of the Trust, through the election of Staff Governors to the Council of Governors

Staff costs (subject to audit)

Figure 26: Staff costs – 2025/26 (full year)

	Total	Permanent	Other
	£000	£000	£000
Salaries and wages	1,475,313	1,475,313	0
Social Security costs	169,204	168,930	274
Apprenticeship Levy	6,627	6,627	0
Pension cost – defined contribution plans (employer's contributions to NHS pensions)	161,259	161,047	212
Pension cost – employer contribution paid by NHSE on provider's behalf (6.3%)	106,986	106,845	141
Pension cost - other	0	0	0
Temporary staff - external bank	99,505	0	99,505
Temporary staff - agency/contract staff	13,802	0	13,802
Total Trust staff costs	2,032,696	1,918,762	113,934
NHS charitable funds staff	0	0	0
Total Trust and Group Staff costs	2,032,696	1,918,762	113,934

Figure 27: Staff costs 2024/25 (full year)

	Total	Permanent	Other
	£000	£000	£000
Salaries and wages	1,385,372	1,385,372	0
Social Security costs	128,417	128,118	299
Apprenticeship Levy	6,324	6,324	0
Pension cost – defined contribution plans (employer's contributions to NHS pensions)	153,136	152,881	255
Pension cost – employer contribution paid by NHSE on provider's behalf (6.3%)	101,284	101,115	169
Pension cost - other	0	0	0
Temporary staff - external bank	114,367	0	114,367
Temporary staff - agency/contract staff	13,216	0	13,216
Total Trust staff costs	1,902,116	1,773,810	128,306
NHS charitable funds staff	0	0	0
Total Trust and Group Staff costs	1,902,116	1,773,810	128,306

Exit Packages (subject to audit)

Figure 28: Exit packages 2025/26

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies £000s	Number of other departures agreed	Cost of other departures agreed £000s
<£10,000	3	19	136	594
£10,001- £25,000	10	146	34	541
£25,001 - £50,000	7	258	15	573
£50,001 - £100,000	4	296	6	390
£100,001 - £150,000	5	583	0	0
£150,001 - £200,000	1	154	0	0
>£200,000	0	0	0	0
Total	**30**	**1456**	**191**	**2098**

Redundancy and other departure costs have been paid in accordance with the provisions of the 1995/2008 and 2015 NHS Pensions schemes. Exit costs in this note are the full costs of departures

agreed in the year. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table. This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Figure 29: Non-compulsory departure payments 2025/26 (subject to audit)

Exit packages 2025/26: Non-compulsory departure payments	**Agreements number**	**Total value of agreements** £000s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	49	1266
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	141	820
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval*	1	12
Total	**191**	**2098**

** No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.*

Figure 30: Exit packages 2024/25 (audited)

Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Cost of compulsory redundancies £000s**	**Number of other departures agreed**	**Cost of other departures agreed £000s**
<£10,000	3	22	142	562
£10,001- £25,000	5	94	11	154
£25,001 - £50,000	4	132	5	199
£50,001 - £100,000	5	345	0	0
£100,001 - £150,000	2	267	0	0
£150,001 - £200,000	1	160	0	0
>£200,000	0	0	0	0
Total	**20**	**1020**	**158**	**915**

Redundancy and other departure costs have been paid in accordance with the provisions of the 1995/2008 and 2015 schemes. Exit costs in this note are the full costs of departures agreed in the year. Where the Trust has agreed early retirements, the additional costs are met by the Trust and

not by the NHS Pensions Scheme. Ill- health retirement costs are met by the NHS Pensions Scheme and are not included in the table. This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Figure 31: Non-compulsory departure payments 2024/25 (audited)

Exit packages 2024/25: Non- compulsory departure payments	Agreements number	Total value of agreements (£000s)
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	155	883
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval*	3	32
Total	**158**	**915**

** No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.*
The maximum, minimum and median values of non-contractual payments requiring HMT approval are £12,546, £9,500 and £9,645, respectively.

NHS Staff Survey 2025

The National Staff Survey is a mandatory survey owned by NHS England and the Staff Survey Coordination Centre. The survey, aligned with the NHS People Promise, is one of the largest workforce surveys and is conducted annually to improve staff experiences across the NHS. MFT is within the benchmarking group Acute and Acute and Community Hospitals.

In preparation for the 2025 Staff Survey a robust and comprehensive communications and engagement plan was put in place in collaboration with the Clinical Groups' Workforce and OD teams and the organisational networks and by sharing resources and updates in a timely manner. The 2025 NHS Staff Survey closed on 28 November 2025 with 10738 responses and a 35% response rate. Despite an extended survey period and strong engagement activity, this represents a 10% decline in response rate since 2024.

The 2025 results present a mixed but important picture for MFT. While our overall scores have dipped in several domains, our relative position, nationally, has improved — showing that MFT has maintained stability during a challenging year for the NHS. The most notable shifts are the drop in response rate, significant changes in key domains such as We work flexibly (improved) and Staff

Engagement (declined), and the gap between MFT performance and national benchmarks narrowing. Overall, the results indicate that colleague experience remains under pressure, but targeted strengths provide a platform for renewed focus and improvement in 2026.

As part of the ongoing partnership with The Shelford Group, benchmarking against these ten Trusts is an important element of mutual learning, sharing best practice and measuring performance. Since 2024, MFTs ranking for We are safe and healthy has improved to 4th from 6th position. MFT ranks in 6th position for overall Staff Engagement. For all other People Promise domains, MFT ranks at either 6th or 7th position.

Within the six Trusts of the Greater Manchester acute benchmarking group, MFT results have improved since 2024 for We are always Learning, Morale and We work Flexibly. Our position within the group for We are Compassionate & inclusive has declined since 2024.

Overall Staff Engagement positions MFT joint 2nd with a score of 6.73.

Summary highlights from NHS Staff Survey 2025 results

Overall, MFT's results closely align with national averages across the People Promise domains, showing a pattern of stability with only marginal year on year change.

- MFT scores higher than the benchmarking average in four People Promise domains and lower than the average in five domains.
- Although the organisational scores declined in several areas in 2025, our relative position has improved — we are now closer to the national benchmark than in any previous year.
- One People Promise domain, We work flexibly, showed a positive, statistically significant change since 2024.
- Two domains showed significant declines; We each have a voice that counts and Staff Engagement. Six domains showed no statistically significant movement since 2024.
- Morale has improved since 2024, although not a statistically significant improvement.
- Of the 30 domains within the People Promise, MFT has declined in 24 and improved in 4 since 2024. We have maintained our score in 2 domains.
- 10% of colleagues from Sodexo responded to the 2025 survey, an improvement of 4% from last year. Sodexo performs above MFT in all People Promise domains, with the exception of We are always learning.

Figure 32: Summary table of NHS Staff Survey 2025 results

	2025/26		2024/25		2023/24	
	Score	**Benchmark**	**Score**	**Benchmark**	**Score**	**Benchmark**
We are compassionate and inclusive	7.27	7.28	7.22	7.21	7.16	7.24
We are recognised and rewarded	5.90	5.87	5.92	5.92	5.86	5.94
We each have a voice that counts	6.63	6.60	6.69	6.67	6.62	6.70
We are safe and healthy	6.16	6.07	6.15	6.09	6.06	6.06
We are always learning	5.55	5.57	5.59	5.64	5.48	5.61
We work flexibly	6.15	6.22	6.04	6.24	5.89	6.20
We are a team	6.72	6.75	6.75	6.74	6.67	6.75
Staff Engagement	6.73	6.74	6.79	6.84	6.76	6.91
Morale	5.86	5.84	5.85	5.93	5.77	5.91

Future priorities and targets

2026 priority areas identified through quantitative and qualitative data analysis are: Compassionate Culture, Flexible working, Career Progression, Recognition, and Wellbeing & burnout.

Performance against these priorities will be monitored through a combination of survey indicators, local pulse surveys, uptake and outcome measures from existing workstreams, and qualitative feedback from staff engagement routes. Governance will be supported through the TCE-led Staff Engagement and Culture Forum, the Organisational Development and Leadership Group, and the Workforce and Education Management Committee. This provides a clear framework for monitoring delivery, maintaining oversight of Clinical Group and Corporate action plans, and ensuring alignment between Trust-wide priorities and local improvement activity.

Staff engagement and support

Collective Leadership & Culture Programme

During 2025/26, MFT progressed the Collective Leadership & Culture Programme from insight gathering into a focused design and delivery phase centred on measurable cultural improvement and strengthened leadership accountability. Extensive staff engagement continued through Change Agents, Culture Corners, listening events, the Senior Leadership Summit and the inaugural Culture & Staff Experience Forum, engaging colleagues across clinical and non-clinical services across the Trust.

Insight gathered through this engagement activity was consolidated into 22 culture recommendations, which were refined through Board, senior leadership and staff engagement into a focused set of organisational priorities aligned to workforce experience, leadership capability, psychological safety, inclusion and organisational performance.

The programme also strengthened governance and accountability through the Senior Leadership Summit and Culture & Staff Experience Forum, supporting a clear organisational ambition to improve Staff Survey outcomes and staff engagement over the coming years. Key areas of focus now include compassionate and inclusive leadership, psychological safety, culture experiments, leadership development, recognition and reward, improved communication and strengthened staff voice.

Alongside this, work has continued on the development of the Culture Dashboard, intended to provide a single integrated view of workforce, EDI and Staff Survey data to support targeted improvement activity and ongoing organisational insight.

Freedom to Speak Up (FTSU)

Since the expansion of the FTSU Guardian team to three full-time Guardians in 2024, the service has worked to expand the awareness of FTSU across the Trust, hosting over 140 individual engagement sessions throughout 2025/26. This additional engagement activity has seen an increase in concerns of 8.9% in the last year, and 454% over the six years that the Trust has had a dedicated FTSU service.

This year has seen an increase in colleagues volunteering to become a FTSU Champion, with over 161 active Champions throughout the organisation.

Following the popularity of the Listen Up virtual workshops in 2024/25, the FTSU team launched the 'Follow Up' virtual workshop in September 2025, using learning from actual concerns to shape the content, designed to highlight the importance of feeding back to colleagues who raise concerns.

Employee Health and Wellbeing Services

The MFT Employee Health and Wellbeing (EHW) Service continues to provide specialist fitness for work advice and a comprehensive range of physical and psychological wellbeing programmes for all staff. This year the service supported managers and employees through 2,942 management referrals and over 600 work health assessments, alongside 1,942 staff attending EHW-delivered training on topics such as anxiety, sleep, burnout and neurodiversity.

The Psychological Wellbeing and Mental Health Service delivered approximately 330 psychological

wellbeing assessments and 335 trauma-focused therapy sessions, responding to rising levels of trauma and critical incident need across the Trust. Musculoskeletal services also expanded their impact, with 2,345 self-referrals and 4,135 day-one absence support calls, with 70% of staff reporting the service helped them stay in or return to work.

The Employee Assistance Programme saw continued high engagement, with 4,550 calls and over 4,000 active users of the Wisdom app.

The EHW Clinical Services Team delivered essential immunisation, vaccination and outbreak management activity, supporting safe working environments across MFT. Collectively, these multidisciplinary services continue to reduce sickness absence, prevent work-related ill-health and strengthen MFT's commitment to being a place where people feel supported, valued and able to thrive.

Violence Prevention & Sexual Safety

Since the introduction of the Violence Prevention Policy and Sexual Safety policy in September 2024 the Trust has continued to develop and progress actions to protect staff and patients.

We have an established violence and abuse (V&A) programme which includes a compliance working group focussed on the Trusts assessment and compliance against the VPR Standards. Our local security group tackles initiatives and product design to support localised V&A matters within wards and departments, reviewing incidents and lessons learnt. Body Cameras for clinical staff are being rolled out to inpatient areas. Ongoing work to ensure support and wellbeing initiatives are available for all staff including further direct training and support for line managers.

Sexual safety remains a priority with leadership from the Chief People Officer. The latest assurance report against the national guidance has shown sexual safety assurance actions have moved from predominantly amber/red to a stronger green position.

Equality Diversity & Inclusion

MFT is committed to creating an inclusive workplace where all colleagues feel heard, valued and able to contribute. In 2025, staff engagement and voice that counts both fell slightly, while the response rate reduced from 45% to 35%. Flexible working improved, but fewer colleagues said they would recommend MFT as a place to work or receive care.

MFT continues to perform around the average for acute trusts in England, although its relative position has improved. Workforce Race Equality Scheme (WRES) findings show BME representation has risen to 30.9%, above the national average, but this reduces at senior levels. Board representation remains low at 5.26%, and disparities in recruitment and formal disciplinary

processes continue for BME staff.

Workforce Disability Equality Scheme (WDES) findings also show mixed progress. Disability declaration on the Electronic Staff Record (ESR) increased slightly to 5.43% but remains well below the 23.4% identified through the NHS Staff Survey. While there has been some improvement in bullying and harassment, career progression and reasonable adjustments, disabled staff remain underrepresented in senior roles, more likely to enter formal capability processes and report lower engagement. Across religion, disability, ethnicity, gender and sexuality, experiences are not felt equally, reinforcing the need for targeted support alongside Trust-wide action.

Staff Networks

MFT has five staff networks which bring together staff and allies to meet and discuss their individual needs and share experiences of living and working with diverse experiences and abilities.

The aims of the networks are:

- To support staff from different equality groups.
- To enable the Trust to gain a better understanding of issues faced by staff in the workplace.
- To influence Trust policy.
- To act as a consultative mechanism for the Trust.
- To assist the Trust in meeting its statutory obligations regarding its duty under the Equality Act 2010.
- To share experiences and provide mutual support.

The networks offer our staff the opportunity to learn new skills such as negotiating and leadership, and the space to feel confident sharing their experiences, worries and concerns**.**

Off-payroll engagements

MFT seeks assurance about the tax arrangements of individuals engaged off-payroll and the information is recoded centrally. No individuals with significant financial responsibility will be engaged off-payroll'. The Trust has a policy in this area that reflects HMRC IR35 Guidance along with best practice guidance from the Healthcare Financial Management Association.

MFT applies rigorous controls to all aspects of discretionary spend, including consultancy support that would potentially be captured as 'off-payroll.' All proposed engagements are reviewed and IR35 compliance confirmed prior to commencement.

The following tables apply to all off-payroll appointments engaged during the year ending 31st March 2026 and earning more than £245 per day.

Figure 33: Highly paid off-payroll worker engagements at 31 March 2026

Total number of existing arrangements as of 31st March 2026	37
Number that have existed for less than one year at time of reporting	13
Number that have existed for between one and two years at time of reporting	24
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

Figure 34: Off- payroll workers engaged during 2025/26

Number of off-payroll workers engaged during the year ending 31st March 2026	37
Not subject to off-payroll legislation	0
Subject to off-payroll legislation and determined as in scope of IR35	0
Subject to off-payroll legislation and determined as out- of-scope of IR35	37
***Number of engagements reassessed for compliance or assurance purposes during the year**	27
Number of reassessed engagements that saw a change to IR35 status following review	0

** This figure represents total HMRC IR 35 Assessments completed on new suppliers completed to enable status determination*

Our Members and Governors

Our Membership

Being an NHS Foundation Trust means MFT is directly accountable to the people and communities we serve. Our membership brings together public members, including patients, carers, local residents and the wider public, as well as staff members who work in, or provide services to, the Trust. Together, they play an important role in helping us stay connected to the people we serve.

All Members help shape our governance by electing Governors and, where eligible, standing for election themselves, to sit on the Council of Governors alongside Governors nominated by partner organisations. Together, the Council of Governors represents the interests of Members and the wider public and directly engages with the Board of Directors to share Members' views during decision-making processes and when formulating future plans. Additionally, the Council of Governors holds our Non-Executive Directors to account for the performance of the Board.

Membership Strategy, Aims and Priorities

Our Membership & Engagement Strategy outlines how patients, carers, local residents and the wider public can become more involved as a Member of our Trust. The Strategy defines our membership community, outlining how we recruit, retain, engage, support, and involve our membership in the work of the Trust. It also explains how we deliver effective member communication and evaluate membership recruitment and engagement success. In addition, the strategy also outlines the Governor role and duties alongside the key areas to support and develop the evolving role of Governors.

Through this strategy, our aim is for the Trust to have a representative membership which truly reflects the communities that it serves, with our Governors actively representing the interests of Members as a whole and the interests of the public.

Our key priorities are to:

- uphold our membership community by addressing natural attrition and membership profile short fallings.
- to develop and implement best practice engagement methods.
- to support the developing and evolving role of Governor by equipping Governors with the skills and knowledge in order to fulfil their role

By ensuring that our public membership is diverse and representative of the communities that we serve, we can ensure our Members' voice helps shape our future service provisions to more meet Members', and their family's needs.

Public Membership

Public membership is free of charge and on an opt-in basis. Anyone who is aged 11 years or over and resides in England and Wales is eligible to become a member. Our Public Member constituency is subdivided into five areas:

Public Constituencies	***Number of public members***
Manchester	7,543
Trafford	2,930
Eastern Cheshire	960
Rest of Greater Manchester	7,129
Rest of England & Wales	2,636
Total	**21,198**

Figure 35: Public Membership Analysis Table on 31st March 2026

Profile Group	Membership 2024/25	% 2024/25	Membership 2025/26
Age			
0-16	45	0.5	42
17- 21	932	4.6	829
22+	19,412	89.2	19,160
Not Stated	1,246	5.7	1,167
Ethnicity			
White	14,288	66.7	13,848
Mixed	528	2.4	534
Asian or Asian British	2,964	13.4	3,004
Black or Black British	1,327	6.0	1,360
Other	324	1.4	329
Not Stated	2,204	10.1	2,123
Gender			
Male	9,379	43.7	9,182
Female	11,254	51.8	11,065
Transgender	6	<0.1	5
Not Stated	996	4.4	946
Recorded Disability	2,090	9.2	2,170

Note: Of note, for the 0–16-year-old membership group figure, the Trust's membership base for this group is between the ages of 11-16 years.

Staff Membership

Staff membership is open to individuals who are employed by the Trust under a contract of employment including temporary or fixed-term (minimum of 12 months) or exercising functions for the Trust with no contract of employment (functions must be exercised for a minimum of 12 months). All qualifying members of staff are automatically invited to become Members, as we are confident that our staff want to play an active role in developing better quality services for our patients. Staff are, however, able to opt out if they wish to do so. The Staff Member Constituency

is subdivided into four staff classes:

Staff Classes	*Number of staff members*
Medical & Dental	3,208
Nursing & Midwifery	10,405
Other Clinical Staff	10,163
Non-Clinical & Support	7,645
Total	**31,421**

** This figure includes clinical academics, facilities management contract staff and full head counts which include bank staff and staff on zero hours contracts'*

On 31st March 2026, we had 21,198 public members and 31,421 staff members, giving an overall total membership community of 52,619 members. The Board of Directors monitor how representative our membership is and the effectiveness of membership engagement through this annual report.

Members' views are valued and their support and involvement are vital to our success. Regular and active communication and recruitment initiatives have been progressed throughout the past year to ensure our Members are informed on the work MFT is undertaking and to encourage members of the public to consider becoming a Member of MFT, including:

- Inviting Members to join us at the Annual Members' Meeting (September 2025) and Young People's Event (November 2025).
- Sharing information in respect to the role of a Governor and the election process, inviting Members to consider standing for election and encouraging Members to vote in the election.
- Engaging with our Members at our events to capture views around membership and planning priorities and sharing electronic surveys to seek feedback on bespoke Member sessions.
- Providing updated on the work of MFT through the MFTime staff newsletter and MFTV, intranet/website and other various social media platforms including WhatsApp, Twitter and Facebook etc.
- Providing details on the meetings of the Council of Governors, with meeting dates promoted on the Trust's website and in-person meetings being open to the public.
- Improving our communications with Members through the use of a Public Membership Welcome Letter and Involvement (preferences) Form and issuing personalised invite letters to events, tailored to meet individual Member's needs, based on identified involvement preferences.
- Inviting Members to join the Manchester Rare Conditions Centre and the Manchester Biomedical Research Centre Patient Public Involvement Group.
- Publishing an electronic Membership Newsletter to provide an insight into key Trust activities, information about membership events, Governor highlights and elections plus forward plan information and surveys.

- Providing film-clips and photos promoting:
    - our successful events to Members via our 'Membership news' webpage, accessed here
    - Public Member (Rosemary Donaldson) promoting our Annual Members Meeting https://vimeo.com/1143507894/c4019c9cf9?share=copy&fl=sv&fe=ci
    - Public Governor (Lynne Moore) Annual Members' Meeting Promotional Film - https://vimeo.com/1143507815/c3fa1cdd45
    - Public Governor (Dr Syed Nayyer Abidi) Annual Members' Meeting Promotional Film - https://vimeo.com/1143507766/67d3e36edf
    - Trust Chair (Kathy Cowell) Annual Members' Meeting Post-Event Promotional Film - https://vimeo.com/1143507848/99ef29a758?share=copy&fl=sv&fe=ci

Our annual Young People's Event, hosted by the Trust Chair is a key Membership Event. It was held on 26th November 2025 and designed to specifically engage with our young Members, alongside a wider range of children and young people.

Over 500 young people, students, teachers, staff, and their children attended this event with participants including groups of students from various schools, colleges and universities from across Manchester and Greater Manchester. Trust membership and involvement opportunities were promoted to participants with interactive stands being provided to highlight the Trust's Youth Forum, volunteering and NHS Careers Hub, alongside other NHS clinical and non-clinical services.

The role of Governor was promoted to young participants with attending Governors directly engaging with individuals to seek their views around the membership and involvement interests on offer, in addition to providing an opportunity to discuss their health priorities and improvement ideas. The feedback received was promoted by Governors in discussions around the Trust's forward plan development and decision-making processes. More information about our Young People's event can be found here or on our 2025 Young People's Event webpage here.

Our Council of Governors

The Board of Directors and Council of Governors have distinct roles. The Board of Directors is responsible for Trust strategy, all aspects of operation and performance, and for effective governance of the Trust, with the Council of Governors being responsible primarily for seeking assurance about the performance of the Board and representing the interests of Members and the public, at large. The Board of Directors is committed to understanding the views of Governors and Members by holding and participating in regular Governor and Members' Meetings and events.

Our Council of Governors was established following the creation of MFT on 1st October 2017. Currently, MFT has 32 Elected and Nominated Governors on our Council of Governors, the majority of whom (24 out of 32) are directly elected from and by our Members.

Figure 36: Composition of our Council of Governors and Governor Terms of Office:

Governor Constituency/ Class/ Partner Organisation		No. of Posts	Governor	Term of Office
Public	Manchester	7	Dr Syed Nayyer Abidi	3 years ending 2026
			Aysha Ahmad	2 years ending 2027
			Dr Ivan Benett	2 years ending 2027
			Jake Buckingham	2 years ending 2027
			Dr Helen Burgess	3 years ending 2026
			Dr Peter Gibson	3 years ending 2027
			Lynn Moore	3 years ending 2027
	Trafford	2	Ann Balfour	2 years ending 2027
			Dr Connie Chen	3 years ending 2026
	Eastern Cheshire	1	Chris Templar	3 years ending 2026
	Greater Manchester	5	Ashley Jones	3 years ending 2027
			Harold Myers	2 years ending 2027
			Colin Owen	3 years ending 2026
			Carol Shacklady	3 years ending 2027
			Vacant	-
	Rest of England & Wales	2	Stephen Smurthwaite	3 years ending 2027
			vacant	-
Staff	Nursing & Midwifery	2	Christopher Christopher	2 years ending 2027
			Sarah Jones	2 years ending 2027
	Other Clinical	2	Luke Carine	2 years ending 2027
			Geraldine Thompson	3 years ending 2026
	Non-Clinical & Support	2	Donald Dimitroff	2 years ending 2027
			Jerome Cook	3 years ending 2026
	Medical & Dental	1	Dr Khadija Ali	2 years ending 2027
Nominated	Local Authority (Manchester City Council and Trafford Council)	2	Cllr Julie Reid	3 years ending 2026
			Cllr Mike Cordingley	3 years ending 2026
	Manchester University	1	Prof Anne-Marie Glenny	2 years ending 2027
	GM Integrated Care Board	1	Prof Manisha Kumar	3 years ending 2026
	Trust Volunteer	1	Nazir Choonara	3 years ending 2026
	Trust Youth Forum	1	Lois Dobson	2 years ending 2026

Governor Constituency/ Class/ Partner Organisation		No. of Posts	Governor	Term of Office
	Manchester Council for Community Relations or Manchester BME Network	1	Rohina Oram	3 years ending 2026
	Third sector umbrella organisation (currently Caribbean & African Health Network)	1	Rev Charles Kwaku-Odoi	3 years ending 2027

At the 31st March 2026, there was:

- one vacant Governor seat for the Manchester Public Constituency.
- one vacant Public Governor seat for the Rest of England & Wales Constituency.

The following public governors departed the Council of Governors during 2025/26:

- Brian Baker (Rest of Greater Manchester) – Resigned (February 2026).
- Richard Harvey (Rest of Greater Manchester) – Stepped down (September 2025).
- Gill Hoad-Reddick (Manchester) – Stepped down (September 2025).
- Mustapha Koriba (Rest of England & Wales) – Resigned (February 2026).
- Christine Turner (Rest of England & Wales) – Stepped down (September 2025).

The following staff governors departed the Council of Governors during 2025/26:

- Aysha Ahmad (Non-Clinical and Support) – Left the Trust/Staff Governor Role (April 2025) following which was successfully elected as Public Governor (Manchester) in September 2025.
- Esther Akinwunmi (Other Clinical) – Stepped down (September 2025).
- Eunice Onwuamaegbu (Nursing & Midwifery) – Stepped down (September 2025).
- Karen Scott (Nursing & Midwifery) – Stepped down (September 2025).

Election Data

In 2025/26, elections for seven public and five staff governors were held. A nomination was also received for a Nominated Governor from the University of Manchester. The election and nomination processes for Governor seats were held in accordance with the election rules as stated in our Constitution (July 2023).

Successful candidates and nominees were announced at our Annual Members' Meeting on 29th September 2025 and formally commenced in post on 30th September 2025. More information about our Governor Elections and Annual Members' Meeting can be found here.

Figure 37: Public Governor election turnout data for 2025

Date of Election	Constituencies/Classes Involved	Number of Eligible Voters (Members)	Number of Seats Contested	Number of Contestants	Election Turnout
September 2025	**Public Governor Elections**				
	Rest of Greater Manchester	7,162	2	17	2.7%
	Manchester	7,627	3	21	4.0%
	Rest of England and Wales	2,657	1	3	2.9%
	Trafford	2,986	1	10	6.0%

Figure 38: Staff Governor election turnout data for 2025

Date of Election	Constituencies/Classes Involved	Number of Eligible Voters (Members)	Number of Seats Contested	Number of Contestants	Election Turnout
September 2025	**Staff Governor Elections**				
	Medical and Dental	2,868	1	8	10.3%
	Non-Clinical and Support	8,237	1	13	7.8%
	Nursing and Midwifery	10,255	2	9	4.1%
	Other Clinical	9,934	1	10	5.2%

Lead Governor elections were also held during October and November 2025 with Dr Ivan Benett (Public Governor – Manchester) being elected for a one-year term of office. Results were formally announced at the Council of Governors' Meeting held on 19th November 2025 with the Lead Governor formally commencing in post following closure of this meeting.

New Governor Introduction and Networking Session with the Trust Chair, Trust Non-Executive Directors and Governors

All new Governors are invited to participate in an introduction meeting with the Trust Chair alongside Trust Non-Executive Directors and fellow Governor colleagues. This session provides information in relation to the NHS and the Trust including its organisational structure and associated governance and support arrangements plus Trust's Governor Meeting Framework. In addition to the overview of MFT, Trust Non-Executive Director (NED) roles and assigned duties, other areas covered include MFT's Strategy, key strategic priorities and updates on several key areas including Population Health, MFT's Patient Safety and Quality matters, MFT's Performance and Delivery, MFT's People, MFT's Sustainability and Estate Plans including North Manchester Strategy and development, MFT's Digital and Innovative advances, MFT's Finances and MFT's Research and Innovation Strategy.

Governors also received a dedicated training focusing on the Governor role and duties alongside new developments across the wider NHS landscape. The training day is provided by external trainers from NHS Providers. In addition, a detailed overview of the Trust's Constitutional arrangements and associated governance requirements is provided to Governors including Code of Conduct, Fit & Proper Persons checks, Declaration of Interests, Communication, Engagement and Recruitment practices, Media and Social Media, Governor Meeting Framework and ground rules etc.

As part of the Trust's New Governor induction programme, networking opportunities between new Governors and existing Governor colleagues are regularly held with a Governor Buddy system also being established to provide additional support and engagement opportunities.

An engagement meeting is also held with the Trust Chair to provide any additional support to new Governors alongside providing an opportunity for key areas of the Governor role to be discussed and further learning and training provided as required.

Governor Training & Development

Governors' key skills, attributes and areas of interest are captured as part of the annual Governor skill-set survey, with the findings used to inform the development of a comprehensive programme of training and development.

During 2025/26, Summer and Winter Governor Development Sessions took place, to further enhance Governor knowledge and skills and to enable Governors to fulfil their statutory duties. Areas covered during these sessions included:

- Deep dive sessions in relation to MFT's Strategy and priorities refresh process including gathering Governor views and comments, in addition to a detailed review of the progress made against the 2025/26 strategic priorities.
- More in-depth learning and navigation of the Trust's Integrated Performance Report alongside the Value for Patients programme in addition to a Greater Manchester Dental Health session.
- Focused learning about Infection Prevention & Control including antibiotic stewardship, Never Events current position and improvement plans, alongside a Learning from Deaths and Mortality Data session.
- A dedicated Integrated Care Board - Clinical Strategy and Commissioning Plan session.
- A focused session on MFT's Quality Account including patient safety priorities.
- Increasing awareness and understanding around the Trust's Patient Advice and Liaison Service and Complaints Process, including the value of the Trust's Volunteers Service.

- A focus on the Trust's Culture Programme including Change Agents, Staff Health and Wellbeing including LIME Arts, and MFT's Freedom to Speak Up Service (FTSU) including FTSU Champions

Governor visits have also been held across a variety of hospital sites including the Research and Innovation facilities located at both the Oxford Road Campus, including St Mary's Hospital, Royal Eye Hospital and Royal Manchester Children's Hospital, in addition to key locations at the Wythenshawe Hospital site. A tour of Trafford General Hospital to see the Trafford Elective Surgical Hub and the Trafford Decarbonisation Scheme also took place.

Declaration of Interests

The Governors' Declaration of Interest Register is updated on an annual basis and formally recorded at a general meeting of the Council of Governors. The register discloses the details of any company directorships or other material interests held by Governors. None of our Council of Governors hold the position of Director and Governor of any other NHS Foundation Trust. The register is available on the Trust's website – Meet our Governors webpage (https://mft.nhs.uk/the-trust/governors-and-members/council-of-governors/).

Where a Governor has an interest in a matter to be considered at a meeting of the Council of Governors, the interest is declared to the Council of Governors and arrangements put in place, which may require the Governor to:

- withdraw from the meeting and play no part in the relevant discussion or decision; and / or
- not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

Fit and Proper Persons' Checks

As defined by regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and/or conditions on the Trust's Licence, Governors are required to meet the requirements of the Fit and Proper Persons Test. In keeping with legislation (NHSE's Code of Governance – October 2022, updated March 2023), the Governors' Fit and Proper Persons' Register is updated on an annual basis.

Our Governors have continued to carry out their role with commitment and enthusiasm. The Trust's robust governance processes ensured that all statutory requirements were met.

Council of Governor Meetings

As set out in the Health & Social Care Act (2012), the two key duties of the Council of Governors are:

- to represent the views and interests of Members of the Trust as a whole and the interests

of the public.

- to hold the Trust Non-Executive Directors individually and collectively to account for the performance of the Board of Directors..

The Health & Care Act 2022 also requires Governors to form a rounded view of the interests of the public at large and seeks to place the legal duties of the Council of Governors in the context of system working and collaboration.

The Council of Governors also has a number of statutory powers, including the appointment of the Trust Chair, Trust Non-Executive Directors and the Trust's External Auditors. These statutory duties are discharged at meetings of the Council of Governors.

Meeting dates are promoted on MFT's website (accessed here). Meetings are held in two parts, with a public part, which is open to staff and / or public Members, in addition to members of the general public and a private part which is open to Governors and designated Board members in order to approve (or not) key appointments. Members of the public may be excluded from all or part of a meeting for special reasons.

During 2025/26, four in-person/virtual meetings were held, in line with the requirements set out, with Governor participation set out below.

Figure 39: Governor participation at Council of Governor Meetings – 2025/26

Key Key: Not Applicable | ✓ - In Attendance | X - Non-Attendance	**2025**			**2026**
Governor Name/Title	**14 May**	**23 July**	**19 Nov**	**18 Feb**
Dr Syed Nayyer Abidi - Public Governor (Manchester)	x	✓	x	✓
Aysha Ahmad - Public Governor (Manchester)			x	✓
Dr Khadija Ali - Staff Governor (Medical and Dental)			x	x
*Brian Baker - Public Governor (Rest of Greater)			✓	✓
Ann Balfour - Public Governor (Trafford)	✓	x	x	✓
Dr Ivan Benett - Public Governor (Manchester) / Lead Governor	✓	✓	✓	✓
Jake Buckingham - Public Governor (Manchester)			✓	x
Dr Helen Burgess - Public Governor (Manchester)	✓	✓	✓	x
Luke Carine – Staff Governor (Other Governor)			✓	x
Dr Constance Chen – Public Governor (Trafford)	✓	✓	✓	✓
Nazir Choonara - Nominated Governor (Volunteer Services)	x	✓	✓	✓

Key Key: Not Applicable | ✓ - In Attendance | X - Non-Attendance **Governor Name/Title**	**2025**			**2026**
	14 May	**23 July**	**19 Nov**	**18 Feb**
Christopher Christopher - Staff Governor (Nursing and Midwifery)			✓	✓
Jerome Cook - Staff Governor (Non-Clinical & Support)	x	x	x	x
Cllr Mike Cordingley - Nominated Governor (Trafford Borough Council)	✓	✓	✓	x
Donald Dimitroff – Staff Governor (Non-Clinical and Support)			✓	✓
Lois Dobson - Nominated Governor (Youth Forum)	✓	x	x	✓
Peter Gibson - Public Governor (Manchester)	✓	✓	✓	✓
Prof Anne-Marie Glenny - Nominated Governor (Manchester University)	✓	✓	✓	✓
*Richard Harvey – Public Governor (Rest of Greater Manchester)	✓	✓		
*Dr Gill Hoad-Reddick – Public Governor (Manchester)	✓	x		
Ashley Jones - Public Governor (Rest of Greater Manchester)	x	✓	✓	✓
Sarah Jones – Staff Governor (Nursing and Midwifery)			✓	✓
*Mustapha Koriba – Public Governor (Rest of England and Wales)			x	
Prof Manisha Kumar - Nominated Governor (GM Integrated Care Board)	x	x	x	x
Rev Charles Kwaku-Odoi - Nominated Governor (Caribbean & African Health Network)	x	✓	x	✓
Lynn Moore - Public Governor (Manchester)	✓	✓	x	x
Harold Myers - Public Governor (Rest of Greater Manchester)	✓	✓	✓	✓
*Eunice Onwuamaegbu – Staff Governor (Nursing and Midwifery)	✓	✓		
Rohina Oram - Nominated Governor (Manchester BME Network)	✓	✓	x	✓
Colin Owen - Public Governor (Rest of Greater Manchester)	x	✓	x	✓
Cllr Julie Reid - Nominated Governor (Manchester City Council)	x	x	x	x
*Karen Scott – Staff Governor (Nursing and Midwifery)	✓	✓		
Carol Shacklady - Public Governor (Rest of Greater Manchester)	x	✓	✓	✓
Stephen Smurthwaite - Public Governor (Rest of England & Wales)	✓	✓	✓	✓
Chris Templar - Public Governor (Eastern Cheshire)	✓	✓	✓	x
Geraldine Thompson - Staff Governor (Other Clinical)	✓	✓	x	x
*Christine Turner – Public Governor (Rest of England and Wales)	x	✓		

**Individual left the organisation during 2025/26*

Governor participation is kept under review throughout the year. Where any Governor consistently and unjustifiably fails to attend and / or participate in the meetings of the Council of Governors,

arrangements, as set out in MFT's Constitution, are followed to support the removal of the Governor.

Under the leadership of the Trust Chair, the Council of Governors ensures that the views of Governors and Members are communicated to the Board of Directors. The interaction between the Board of Directors and the Council of Governors is a constructive partnership which enables both to work together in their respective roles. In the event that there is a disagreement between the Board of Directors and Council of Governors, MFT's Constitution and Standing Orders set out the process that will be followed.

To build effective relationships and support the partnership between the Board of Directors and Council of Governors, Board Directors are invited to attend, and provide updates on key matters, to each meeting of the Council of Governors. Board Director participation is detailed below.

Figure 40: Board of Directors' participation at Council of Governor Meetings – 2025/26

Key Key: Not Applicable | ✓ - In Attendance | X - Non-Attendance	**2025**			**2026**
Director Name/Title	**14 May**	**23 July**	**19 Nov**	**18 Feb**
Angela Adimora – Trust Non-Executive Director	✓	✓	✓	✓
Darren Banks – Interim Deputy Trust Chief Executive	✓	✓	✓	✓
Prof Ashley Blom – Trust Non-Executive Director		x	x	✓
Matthew Bonham - Trust Non-Executive Director	x	✓	x	✓
Kathy Cowell – Trust Chair	✓	✓	✓	✓
Mark Cubbon – Trust Chief Executive Officer	✓	✓	✓	x
*Dr Vinod Diwaker – Joint Chief Medical Officer				x
Vanessa Gardener – Chief Delivery Officer	x	✓	✓	x
*Professor Luke Georghiou – Trust Non-Executive Director	✓			
Mark Gifford – Trust Non-Executive Director	x	✓	x	✓
Nic Gower – Trust Non-Executive Director	x	✓	x	✓
Jackie Hanson - Trust Non-Executive Director				✓
Dr Samantha Liscio – Trust Non-Executive Director	✓	x	✓	✓
Chris McLoughlin – Trust Senior Independent Director	x	✓	✓	✓
Dr Sohail Munshi – Joint Chief Medical Officer	x	✓	x	✓
Meera Nair – Chief People Officer	✓	✓	✓	✓
*Dr Toli Onon – Joint Chief Medical Officer	x	x		
Tom Rafferty – Acting Chief Strategy Officer	✓	✓	✓	x
Trevor Rees – Trust Deputy Chair	x	x	✓	✓

Key Key: Not Applicable | ✓ - In Attendance | X - Non-Attendance Director Name/Title	2025			2026
	14 May	23 July	19 Nov	18 Feb
*Dr Damien Riley – Trust Non-Executive Director	✓	x	✓	
Kimberley Salmon-Jamieson – Interim Deputy Trust Chief Executive & Chief Nursing Officer	✓	✓	✓	x
David Walliker – Chief Digital & Information Officer	✓	✓	✓	✓
Claire Wilson – Chief Finance Officer	✓	✓	✓	✓

*Individual left the organisation during 2025/26

During 2025/26, the following items were presented to and considered by the Council of Governors:

- **Operational performance and delivery**: Urgent and emergency care performance, ambulance handovers and patient flow, elective recovery, waiting-list management and referral-to-treatment performance, diagnostic capacity and cancer pathways, and winter planning and resilience. System coordination, Hospital at Home and escalation structures were also outlined to demonstrate how the Trust manages seasonal pressure alongside periods of industrial action.
- **Patient safety and quality**: Internal quality assurance activity, mock Care Quality Commission inspections, the Patient Safety Incident Response Framework, harm-review work and targeted site action plans to support safety and compliance improvement programmes.
- **Strategy and forward planning:** The refreshed MFT Strategy and multi-year forward plans were presented, aligned to the National Health Service 10-Year Health Plan alongside key priorities for the Greater Manchester Integrated Care System.
- **Estates and sustainability:** Major capital programmes including the progress made around North Manchester General Hospital redevelopment and the Wythenshawe masterplan, alongside key elements of Trust's Green Plan including decarbonisation funding and projects.
- **Finance and value for patients**: The Annual Report and Accounts (2024/25) and external auditor key findings were formally received, together with the 2025/26 breakeven financial plan with regular Value for Patients programme requirements and delivery updates.
- **Workforce, leadership and change**: One MFT operating model implementation, leadership appointments and interim arrangements, apprenticeship and recruitment initiatives including the Greater Manchester single recruitment service, staff survey results, cultural change and wellbeing programmes.
- **Equality, diversity and inclusion:** Progress on equality, diversity and inclusion strategy, staff networks, Workforce Race Equality Standard and Workforce Disability Equality Standard reporting, and targeted inclusion and support activities.

- **Digital, data and Artificial Intelligence**: Developments in the HIVE electronic patient record and MyMFT patient portal, cyber security advances, digital patient communications alongside pilots using Artificial Intelligence (AI) for appointment attendance prediction and ambient voice transcription.
- **Research and innovation:** Clinical and research achievements and the Innovative Technology Adoption Programme.
- **Patient experience and involvement:** Patient survey results, the Patient Experience Strategy and targeted improvement work on areas such as food and accessible information.
- **Governance and assurance**: At each Council of Governors' Meeting, Trust Non-Executive Directors provide an overview of the key activities that have been undertaken by the Trust Board Committees and address related questions from the Governors. Updates are also provided in respect to integrated performance reporting improvements and the governance routes for monitoring quality, performance, workforce and finance are regularly reported.
- **Annual Report and Accounts**: In keeping with statutory requirements, the Council of Governors receive MFT's Annual Report and Accounts and any report of the auditors on them. An overview was also provided by Directors to Members at the Trust's Annual Members' Meeting on 29th September 2025.

In response to the information presented at key meetings, over the past year Governors, on behalf of Members, have again been instrumental in seeking assurance on:

- **Urgent & Emergency Care, Elective Recovery and Patient Flow:** Governors sought assurance on urgent and emergency care performance, including ambulance handovers, temporary escalation spaces, and delivery of the A&E 4-hour standard. They scrutinised elective recovery, waiting list reductions, cancer pathway improvements, diagnostic capacity, and sustainability of performance gains. Governors also explored patient non-attendance initiatives, interpretation support, and the embedding of the Waiting Well Safety Framework.
- **Quality, Safety and Patient Experience**: Governors continued to focus on quality and safety, including learning from never events, infection prevention and control, antimicrobial stewardship, and implementation of the Patient Safety Incident Response Framework (PSIRF). Maternity and neonatal safety, stroke and trauma pathways, urology improvements, and harm-review processes, were key areas of interest for Governors. Patient experience remained a priority, with questions on Friends and Family Test results, national surveys, food and drink provision, and real-time feedback through MyMFT.
- **Digital Transformation and Cyber Security**: Governors sought assurance on the stability and resilience of the HIVE electronic patient record, unplanned downtime management, and cyber security controls. The use of AI technologies such as Dragon Copilot, including accuracy, consent and data protection were key areas of interest. Questions around digital

inclusion, communication preferences, scanning of paper records, and future integration of MyMFT with the NHS App and wider GM digital systems were raised.

- **Financial Performance, Recovery and Governance**: Governors maintained oversight of the Trust's financial position, including delivery of the three-year recovery plan, Value for Patients programme, cash constraints, and capital programme delivery. They explored the impact of the new NHS Oversight Framework, block contract changes, industrial action, and income allocation across Clinical Groups. Governors also sought assurance on procurement, contract monitoring and financial governance through Board Committee reporting.
- **Workforce, Culture and Organisational Development**: Workforce remained a key area of enquiry, with Governors seeking assurance on staff survey findings, appraisal improvements, sickness absence reduction, equality and diversity metrics, and the impact of immigration and visa rule changes. They explored the apprenticeship programme, training rationalisation, compassionate leadership, staff networks, Freedom to Speak Up, and the One MFT organisational change programme. Questions were also raised about volunteer engagement and the development of the GM single recruitment service.
- **Strategic Programmes, Estates and System Working**: Governors monitored progress on major strategic programmes, including the refresh of the Trust's Strategy, Neighbourhood Health Services, the North Manchester redevelopment, and estate developments at Wythenshawe and across the Trust. They sought assurance on sustainability initiatives, net zero planning, RAAC remediation, and governance of the Green Plan. Governors also explored the Trust's role in the GM Integrated Care System, including prevention demonstrators, major trauma configuration, and collaboration with primary care and the voluntary sector.

Following Governor feedback, over the past year pre-Council of Governors' meeting sessions, led by the Trust's Lead Governor, have supported the Governors effective questioning processes with more dedicated time allocated during formal meetings to support and respond to Governor questions.

Governor involvement

In addition to the membership events highlighted earlier, Governors also participated in several other key Trust events during 2025/26 including:

- Patient Experience Strategy development (May 2025).
- Quality and Patient Experience Forum (July 2025).
- Youth Forum Session (October 2025).
- Patient Led Assessment for the Care Environment (PLACE) assessments (October and November 2025).

- Patient Safety Conference (November 2025).
- Patient Safety Priorities survey (December 2025).
- Patient Experience Oversight Meetings (December 2025, January and February 2026).

Governor feedback regarding their involvement events attended was regularly received with further opportunities continuing to be explored over the coming year ahead.

Governors and the Board of Directors

Governors hold MFT's Trust Non-Executive Directors (individually and collectively) to account for the performance of our Board of Directors. Governors directly observe meetings of the Board of Directors, including the scrutiny, challenge and support demonstrated by Trust Non-Executive Directors in relation to key performance metrics. Dedicated time is allocated following each Board of Directors' meeting for any associated questions in respect to matters raised to be forwarded and responded to by the Trust Non-Executive Directors. The Council of Governors' interaction and relationship with the Board of Directors have been appropriate and effective throughout the year.

Forward Plans

The Annual Plan for 2025/26 was developed with input from the Council of Governors, who shared the views of Members and the public at large.

Governors are actively involved in the development of the Trust's forward plans, with dedicated sessions alongside a Governors' Forward Planning Workshop being held to capture and consider views forwarded on behalf of members. Governors also receive a progress review update against the planning priorities that are set. Members views around health planning priorities were also invited as our Membership Events (Annual Members' Meeting and Young People's Event) and survey mail outs.

Views from Governors/Members have again been invited during the preparation of the 2026/27 planning round with key forward planning information being regularly presented/shared and comments invited.

Membership Engagement Group

Over the past year, Governors have regularly met to progress membership engagement and communication initiatives alongside supporting Governors to explore appropriate Trust involvement opportunities specifically related to Patient Experience matters. Key involvement information presented included the Trust's Cancer Improvement Collaborative, Youth Forum, Patient Quality and Experience, Patient Safeguarding, Winter Wellness Campaigns.

A key area of focus for this group was the planning of the Trust's Annual Members' Meeting to

progress arrangements that reflected membership and wider patient/public views gathered as part of the 2025 survey. The meeting was reformatted to include dedicated clinician talks, patient and staff stories alongside several interactive stand zones including activity, PALs and support, innovation, our people, involvement and patient experience, lifestyle and refreshments and presentation zones.

Several surveys have also been developed to support the Governor engagement concept including Annual Members' Meeting arrangements surveys, Young People's Engagement and Health Priorities survey, Foundation Trust Membership and Governor Engagement Activities survey, Governor Involvement and Skills Assessment survey, and a Membership Sessions and Engagement Preferences survey. The findings were presented and used to develop further the Trust's membership engagement calendar of events.

The Trust Chair supported the ongoing work of this Governor Group with key areas of focus over the coming year being around the development of new membership information sessions, to again support the planning of the 2026 Annual Membership Meeting alongside progressing membership recruitment and engagement initiatives including refreshing of the Trust's Membership Engagement Strategy. Support around patient experience involvement matters will also continue over coming year.

Council of Governors' Remuneration & Nominations Committee including Review the Performance of the Trust Non-Executive Directors

Each year, Governor feedback is invited via questionnaire, and/or Lead Governor contact, in relation to the performance of the Trust Chair and Trust Non-Executive Directors with feedback directly contributing into their respective appraisal process.

Chaired by the Lead Governor, as part of this process, a panel of Governors is also constituted each year (Council of Governors' Remuneration & Nominations Committee), which is supported by the Trust Senior Independent Director (in relation to the Trust Chair's 360-degree appraisal process), to receive detailed performance feedback. This Committee, in return, formally reports back to the full Council of Governors (formal Council of Governors' Meeting) the Committee's assurances and recommendations.

Other Council of Governors' Remuneration & Nominations Committees are also convened (as and when required) to consider Trust Chair and Trust Non-Executive Directors appointments, terms of office and remuneration, and External Auditor appointments. Reports are provided to the full Council of Governors to provide recommendations or assurance when undertaking statutory approvals at the general meetings of the Council of Governors.

Governor panels of the Council of Governors' Remuneration & Nominations Committee were held throughout the past year to support the Trust Non-Executive Director (NED) appraisals process, new NED appointments including updates on recruitment processes, NED reappointments, term of office extensions and succession planning, a NED appointment at another NHS organisation and NED remuneration. More information is available within the Remuneration Report.

Training sessions are provided to Governors including an overview of the NED recruitment, best practice methodology in assessment, bias in recruitment and key elements of the Governor role. More information is available in the *Remuneration Report* section of this Annual Report.

Contact Governors

Governors can be contacted through our Foundation Trust Membership Office in the following ways:

By Post: Freepost Plus,
RRBR-AXBU- XTZT,
MFT NHS Trust,
Oxford Road Manchester,
M13 9WL

By Phone: 0161 276 8661
(Office hours 9.00 am to 5.00 pm, Monday to Friday, answering machine outside these hours)

By E-mail: ft.enquiries@mft.nhs.uk
(All Membership and Governor related enquiries are directed through the Foundation Trust Membership Office)

Governance Report

NHS Provider Trust Code of Governance disclosures

Manchester University NHS Foundation Trust (MFT) has applied the principles of the NHS Provider Trust Code of Governance, as updated in February 2023. MFT's Board of Directors and Council of Governors are committed to continuing to operate according to the highest corporate governance standards.

In order to do this, the Board of Directors:

- Meets formally on a bi-monthly basis in order to discharge its duties effectively. Systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy, as well as the quality of its healthcare delivery. The Board of Directors is supported in its work by its Board Committees, each of which is chaired by a non-Executive director. Further details can be found in the Annual Governance Statement in this report.

- Regularly reviews the Trust's performance against regulatory and contractual obligations and approved plans and objectives. Relevant metrics, measures and accountabilities have been developed in order to assess progress and delivery of performance. Further details can be found in the Annual Governance Statement in this report.

- Assesses and monitors the culture of the organisation, taking notice of staff and patient feedback. Further details of this can be found in the *Governance Report* and *Staff Report* chapters of this report.

- Has a balance of skills, experience, knowledge and independence that is appropriate to the requirements of the Trust.

Throughout 2025/26, at least half the board of directors, excluding the Chair, were non-executive directors whom the board considers to be independent. The Joint Chief Medical Officers count as a single individual for membership, quoracy and voting purposes. This is stated within the Standing Orders of the Board of Directors which can be found in the Trust's Constitution.

All Directors have a responsibility to constructively challenge the decisions of the Board. Trust Non-Executive Directors scrutinise the performance of the Executive management in meeting agreed goals and objectives. If a Board member does not agree to a course of action, a record is made within the formal minutes of the meeting.

Trust Non-Executive Directors are appointed for an initial term of three years by the MFT Council of Governors. An extension to a Non-Executive Director's term of office for an additional period of three years requires approval by the Council of Governors and is dependent on satisfactory performance monitored through the annual Chair and Non-Executive Director appraisal processes. Any further

extension to a term of office requires approval by NHS England, in addition to approval by the Council of Governors, and is subject to a robust annual review/approval process. Details of the decisions taken by the Council of Governors in 2025/26 with regard to Trust Non-Executive Directors' terms of office can be found in the *Remuneration Report* section of this Annual Report.

The Council of Governors can appoint or remove the Trust Chair or the Trust Non- Executive Directors at a general meeting. Removal of the Trust Chair or another Non-Executive Director requires the approval of three-quarters of the members of the Council of Governors.

The Trust Chair ensures that the Board of Directors and the Council of Governors work together effectively, and that Directors and Governors receive accurate, timely and clear information that is appropriate for their respective duties.

The Council of Governors:

- Represents the interests of the Trust's Members and partner organisations in the local health economy in the governance of the Trust.
- Acts in the best interests of the Trust and adheres to its values and code of conduct.
- Holds the Trust Non-Executive Directors to account for the performance of the Board of Directors.

Governors are consulted on the development of forward plans for the Trust and any significant changes to the delivery of the Trust's business plan.

The Council of Governors meets on a regular basis, four times a year, so that it can discharge its duties. The Governors elected a Lead Governor (Dr Ivan Benett) In November 2025. The Lead Governor's main function is to act as a point of contact with NHS England, our independent regulator but they also work with the Trust Chair to discuss the functioning of the Council of Governors and their information and development needs.

Further details of the work of the Council of Governors can be found in the '*Our Members and Governors'* section of this annual report.

The Directors and Governors regularly update their skills, knowledge and familiarity with the Trust and its obligations, to fulfil their roles at MFT.

Our MFT Constitution is available here and was last reviewed and approved by the Board of Directors and Council of Governors in March 2026 and May 2026, respectively. It outlines the clear policy and fair process for the removal from the Council of Governors of any Governor, who

consistently and unjustifiably fails to attend the meetings of the Council of Governors or has an actual or potential conflict of interest that prevents the proper exercise of their duties.

The performance review process of the Trust Chair and Trust Non-Executive Directors involves the Governors, and the Senior Independent Director supports the Governors through the evaluation of the Trust Chair. Each Executive Director's performance is reviewed by the Trust Chief Executive who, in turn, is reviewed by the Trust Chair. The Trust Chair also holds regular meetings with Trust Non-Executive Directors without the Executives present.

Independent professional advice is accessible to the Trust Non-Executive Directors and the Trust Board Secretary if ever required. All Board of Directors and Board Committee meetings receive sufficient resources and support to undertake their duties.

The Trust Chief Executive ensures that the Board of Directors and Council of Governors of MFT act in accordance with the requirements of propriety or regularity. If the Board of Directors, Council of Governors or the Trust Chair contemplated a course of action involving a transaction that the Trust Chief Executive considered infringed these requirements, he would follow the procedures set by NHS England for advising the Board and Council for recording and submitting objections to decisions. During 2025/26, there have been no occasions in which it has been necessary to apply the NHS England procedure.

MFT staff are also required to act in accordance with NHS standards and accepted standards of behaviour in public life. The Trust ensures compliance with the Fit and Proper Person (FPP) requirement for the Board of Directors. All existing Board Directors complete an annual self-attestation as to their FPP status and annual checks are carried out by the Trust Board Secretary. All new appointments are also required to complete the self-declaration and the full requirements of the FPP test have been integrated into the pre-employment checking process.

The Trust holds appropriate insurance to cover the risk of legal action against its Directors in their roles as Directors and as the corporate trustee of the MFT Charity.

Relationship with stakeholders and duty to co-operate

MFT has well-developed mechanisms for engagement with third party bodies at all levels across the organisation.

Greater Manchester (GM) Devolution changed the landscape significantly and a well- established set of governance arrangements ensure co-operation and close working across the whole of the GM health and social care system. They have been maintained, and added to, since the introduction of

the Greater Manchester Integrated Care Partnership (GMICP) and GM Integrated Care Board (GMICB), also known as NHS Greater Manchester Integrated Care (NHSGM) in July 2022.

The GMICP brings together all health and social care partners across Greater Manchester and wider public sector and community organisations to improve the health and wellbeing of the 2.8 million people who live in Greater Manchester. It connects NHS Greater Manchester, the Greater Manchester NHS Trusts and NHS providers across the whole of primary care with the Greater Manchester Combined Authority, 10 local councils and partners across the Voluntary, Community, Faith, and Social Enterprise (VSCFE) sector, the 10 local Healthwatch and the Trades Unions. NHS GM is the Integrated Care Board for Greater Manchester and is responsible for making decisions about health services across Greater Manchester and in the ten boroughs and cities.

MFT is an active member of the Greater Manchester Trust Provider Collaborative (TPC). The Chief Executive sits on the TPC CEO Group and MFT Directors are members of the relevant Director Groups. TPC is focused on delivering the benefits of working at scale across Greater Manchester. Through TPC we are working on a range of projects to tackle shared opportunities challenges including transforming corporate services and adopting innovation to support delivery of clinical services.

We are also partners in the local provider collaboratives in Manchester and Trafford. These include primary, social care and mental health providers. The local collaboratives are focused on vertical integration working together on issues such as urgent care, discharge and population health management.

The Manchester Partnership Board brings together the senior leaders of Manchester City Council, primary care, MFT, Greater Manchester Mental Health Trust and the VCSE from across the city. Its role is to focus on shared priorities; those areas where, by working together, we can improve the health and wellbeing of the people of the city of Manchester.

The Trafford Locality Board brings together the senior leaders of Trafford Local Authority, primary care, MFT and Greater Manchester Mental Health Trust and the VCSE from across Trafford. Its role is to focus on shared priorities; those areas where, by working together, we can improve the health and wellbeing of the people of Trafford.

Effective mechanisms are in place with our commissioners to agree and manage fair and balanced contractual relationships including Involvement in key meetings established by the GMICB and NHSE Specialised Commissioning team. MFT has a dedicated Contracts and Income team that liaises between the Trust, our Clinical Groups and our commissioners.

The Manchester Health and Wellbeing Board brings together representatives from Manchester City Council, MFT, Greater Manchester Mental Health NHS Foundation Trust and Healthwatch Manchester.

MFT's Board of Directors ensures that effective mechanisms are in place, and that collaborative and productive relationships are maintained with all stakeholders through:

- Direct involvement – e.g. attendance at Board–to–Board, Team-to-Team and Partnership Board meetings
- Chair involvement – e.g. attendance at the Manchester Health & Wellbeing Board
- Feedback – e.g. from the Council of Governors and, in particular, Nominated Governors
- Board updates on strategic developments
- The Integrated Performance Report and Board Assurance Framework which monitor delivery of key priorities (many of which rely on good working relationships with partners).

Academic institutions

The Trust has a strong relationship with its key academic partner, The University of Manchester (UoM), and there are joint committees that support activities, such as clinical appraisals, research and education.

MFT has established links with Manchester Metropolitan University and Salford University to support training of nurses, Allied Health Professionals (AHPs) and scientists and some specific research collaboration.

Industry

The Trust has a range of industry interfaces that encompass both large corporates and SMEs. These collaborations and partnerships enable us to acquire new equipment, facilities and services using a shared risk approach. Our approach to selecting and securing our industry partners is to choose the best partner to help us to further improve our delivery of care and business efficiencies.

NHS System Oversight Framework

NHS England's NHS Oversight Framework 2025/26 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments'.

Segmentation indicates performance and whether improvement is required, from high performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to

segment 5.

NHS England's oversight response to an organisation is based on:

a) its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)
b) considering financial override which may limit a segment to be no better than 3
c) contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and
d) capability assessments which consider the organisation's leadership and governance.

Segmentation

MFT is currently 65th out of 134 Acute Trusts which places the Trust in Segment 3 as at 18th March 2026 for data up to Q3 2025/26.

This segmentation information is the Trust's position as at 1st April 2026. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England website: https://www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/. The Trust is included on the acute trust dashboard.

Statement of the Accounting Officer's Responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Manchester University NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require Manchester University NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Manchester University NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the *Department of Health and Social Care Group* Accounting *Manual* and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manua*l) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking

reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

Signed

Trust Chief Executive
23 June 2026

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Manchester University NHS Foundation Trust's (MFT) policies, aims and objectives, whilst safeguarding the public funds and departmental assets, for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that MFT is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities, as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Manchester University NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Manchester University NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

The Trust implemented a new operating model from 30 September 2024. The Trust's governance structure, system of internal control, including the Risk Management Framework and Strategy, was redesigned to ensure that it was fit for purpose for the new model.

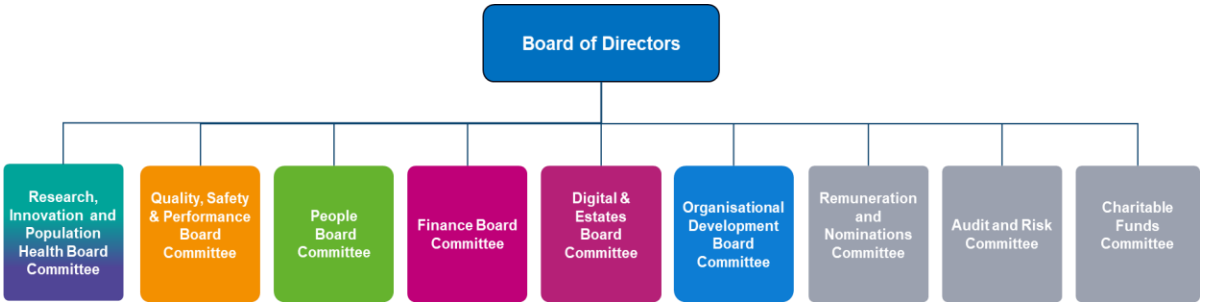
The Trust's governance structure

The Board of Directors provides strategic leadership and direction to the organisation. It is responsible for ensuring that the trust delivers high-quality healthcare services, meets its financial and operational targets, and complies with legal and regulatory requirements. The Board of Directors sets the Trust's vision, values, strategy and objectives, and holds the executive team accountable for their performance.

The Trust's governance structure, and flow of information through it, enables the Board to receive assurance that it is delivering its duties and the organisational strategy. The Integrated Performance Report, Board Assurance Framework, Strategic Risk Register, and escalation reports from each of its Board Committees, are key to providing the Board with assurance regarding delivery of its duties.

Complaints/patient experience reports, and evidence from staff survey/engagement exercises, combined with information gathered during Senior Leadership Observational Visits and other contact with staff and services, enable Board members to gain a rounded view of how the Trust is performing. In addition, external assurance is obtained through internal audit activity, externally managed patient and surveys, and visits and inspections from regulators.

The Board of Directors has established Board committees to support it in delivery of its duties and to receive assurance on matters related to their areas of work. Each Board committee is chaired by a Non- Executive Director and the agendas for each meeting are set by the committee Chair in consultation with the lead Executive Director(s) for the committee. The Board Committees which were in place during 2025/26 are depicted in the diagram below.



At their meeting on the 25th March 2026, the Board of Directors disestablished the Organisational Development Board Committee following completion of the One MFT organisational change programme. At the same meeting, the Board approved the establishment of a North Manchester Board Committee to oversee the programme to build a new hospital on the North Manchester General Hospital site.

The Board delegates specific areas of the Trust's responsibilities to the Board Committees for oversight, with each Committee's terms of reference specifying the areas of work delegated to it and the strategic objectives it is responsible for seeking assurance on. These delegations are specified within the Trust's Scheme of Reservation and Delegation. Each of the Board Committees is chaired by a Non-Executive Director.

The Board Committees seek additional levels of assurance not routinely available within the confines of Board of Directors papers and discussion, together with scrutinising the specific mitigation plans in relation to managing the scale and impact of the identified risks. The Board Committees monitor the strategic and corporate risks affecting their areas of responsibility and use the Integrated Performance Report to monitor progress against key metrics. Agendas are a combination of regular items, risk-related reports, reports requested by the committee chair on areas identified as requiring more detailed scrutiny, and actions referred from other committees. Each Board Committee provides an escalation report to the Board after each meeting. The terms of

reference for each Board Committee are reviewed annually with any amendments approved by the Board of Directors

The Trust's **Quality, Safety and Performance Board Committee (QSPBC)** meets every two months and is responsible for seeking assurance on delivery of the following 2025/26 strategic objectives:

- We will provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience wherever they are treated.
- We will strengthen our specialised services and support the adoption of genomics and precision medicine.
- We will continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.

Damian Riley, Non-Executive Director, was Chair of the QSPBC until his term of office ended in December 2025. Jackie Hanson, Non-Executive Director, took over chairing the Committee at that point and continues to do so.

The **People Board Committee (PBC)** meets every two months and is responsible for seeking assurance on delivery of the following 2025/26 strategic objectives:

- We will make sure that our staff feel valued and supported by listening well and responding to their feedback. We will improve the experience of all our staff experience by embracing diversity and fairness, helping everyone to reach their potential.
- We will offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here.

Angela Adimora, Non-Executive Director, is Chair of the PBC.

The **Finance Board Committee (FBC)** meets every two months and is responsible for seeking assurance on delivery of the following strategic objective:

- We will achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.

Trevor Rees, Non-Executive Director and Interim Chair of the Trust since the 1st May 2026, is Chair of the FBC.

The **Digital and Estates Board Committee (DEBC)** meets quarterly and is responsible for seeking assurance on delivery of the following strategic objective:

- We will deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships**.**

Samantha Liscio, Non-Executive Director, is Chair of the DEBC.

The **Research, Innovation and Population Health Board Committee (RIPHBC)** meets quarterly and is responsible for seeking assurance on delivery of the following strategic objectives**:**

- We will strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part.
- We will apply research and innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide.

Professor Ashley Blom, Non-Executive Director, is the Chair of RIPHBC.

The **Organisational Development Board Committee (ODBC)** was a time-limited Board committee to receive assurance on delivery of the Trust's organisational change programme to implement the new operating model and to monitor mitigation of any risks associated with the programme of work. The Committee met on a monthly basis and was chaired by Trust Non-Executive Director (Mark Gifford). The Committee was disestablished by the Board of Directors in March 2026 following completion of the organisational change programme.

The **Audit and Risk Committee** meet quarterly with a membership comprising solely of Trust Non-Executive Directors. It is chaired by Nic Gower, Non-Executive Director. The Trust's external auditor, internal auditor, anti-fraud specialist and Trust officials attend Committee meetings. The Trust Chair is not a member but attends selected meetings by invitation from the Chair of the Committee.

The Committee has primary responsibility for monitoring the integrity of the financial statements, assisting the Board of Directors in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards, and matters relating to external and internal audit.

The Committee provides the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across MFT. The Committee receives regular reports and updates from both the internal and external auditors to assist in assessing the extent to which robust and effective internal control arrangements are in place and regularly monitored.

The **Remuneration and Nominations Committee** meets four times a year with a membership

comprising solely of Trust Non-Executive Directors. Taking into account national pay frameworks, the Committee approves the remuneration, terms of service, and appointment of the Chief Executive, Executive Directors, and other senior managers of the trust. The committee also oversees the appraisal processes for executive directors, succession planning and leadership development of the Trust, and application of the Trust's Fit and Proper Person's policy. Details about the items considered during 2025/25, can be found in the *Remuneration Report* section of the Annual Report.

Foundation Trusts are accountable to their members and the wider public and this is done via the **Council of Governors** which is responsible for holding the Trust Non-Executive Directors to account for the performance of the Board of Directors. Governors also have responsibility to represent the views of the Trust's members and stakeholders, including the wider public, and partner organisations. The Council of Governors meets formally four times a year and receives assurance regarding the Board's performance from Executive Directors and Trust Non-Executive Directors at each of their meetings. The Council of Governors meet on a regular basis between Council of Governors' meetings to visit the Trust's different sites and to receive presentations on specific items of the Trust's business. The agendas for these meetings are developed through monthly meetings between the Trust Chair and the Lead Governor. More detail about the Council of Governors' activity during 2025/26 can be found in the *Our Members and Governors* section of this Annual Report.

The **Trust Leadership Team Committee (TLTC)** is the executive decision-making committee of the Trust, established by The Board of Directors to implement the decisions of the Board and to make management decisions to deliver the Trust's strategy. It is the forum where the Accountable Officer receives assurance from the Trust's Executive Directors and the Chief Executives of the Clinical Groups with regard to delivery of their responsibilities. The TLTC provides information and assurance to the Board, at each meeting, through the report of the Trust Chief Executive and specific reports provided by Executive Directors. The Executive Directors also provide reports, as required, to the Board committees on matters relevant to their scope of responsibility.

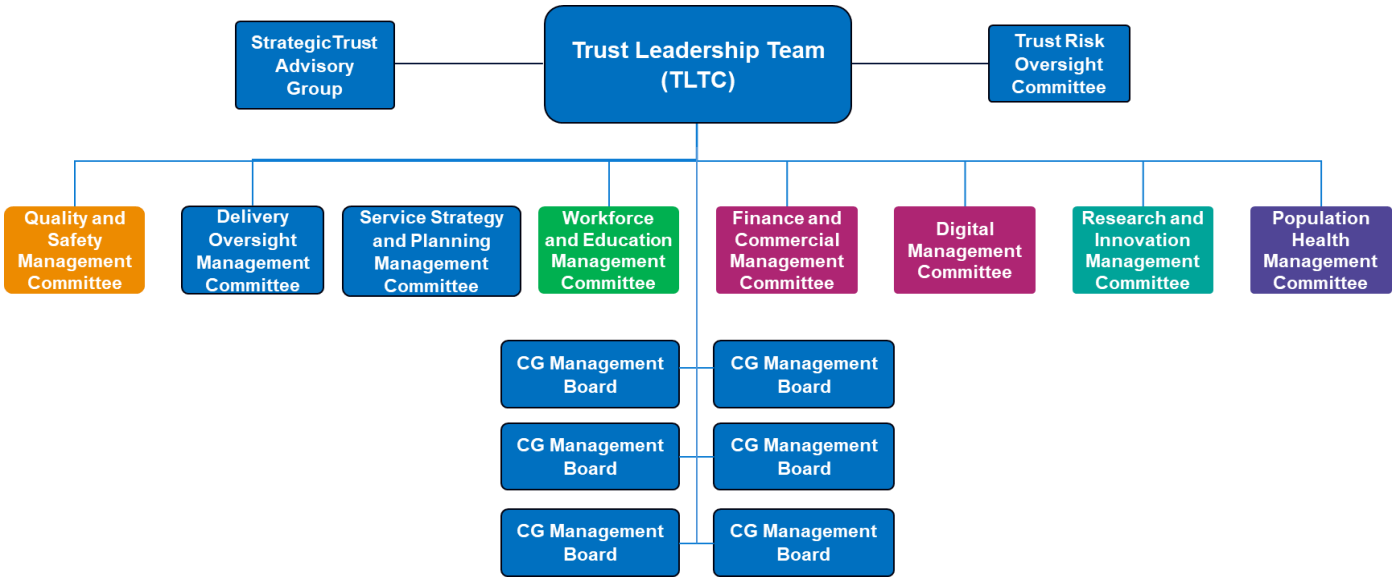
The TLTC has established **Management Committees** to lead on and oversee specific areas of work related to the delivery of the Trust's strategic aims. These enable the Executive Directors, who chair the Management Committees, to receive assurance that their programmes of work are delivering as planned and to escalate key issues to TLTC as required. Each Management Committee has a range of sub-groups reporting into it, focusing on specific areas of responsibility.

In addition to these Management Committees, TLTC has established:

- The **Trust Risk Oversight Committee**, chaired by the Deputy Trust Chief Executive, which oversees the delivery of the Trust's Risk Management Framework and Strategy and assesses the inter-relationship of risks. The management committees submit strategic risks

relevant to their scope to the Trust Risk Oversight Committee for approval. These risks are then presented to the Board of Directors and Board committees via the Strategic Risk Registers and the Board Assurance Framework.

- The **Strategic Trust Advisory Group** which monitors the progress of the whole of MFT's strategy and considers internal and external matters which may influence the strategy's future delivery.
- **Clinical Group Management Boards**, chaired by the Clinical Group Chief Executives and consisting of the Clinical Group's Senior Leadership Team, Divisional leaders, expert partners from the Trust's corporate functions, and an independent representative from outside the Clinical Group. The independent representative provides an additional layer of scrutiny within the Clinical Group Management Board.



Each Clinical Group has its own governance structure which oversees operational delivery and manages risk at a site/directorate/service level. The Clinical Group Management Boards oversee and manage the activities of the Clinical Groups in line with their delegated responsibility as described in the Scheme of Delegation. Assurance of the performance of each Clinical Group is provided at Trust level through the Delivery Oversight Framework which incorporates local Integrated Performance Reports to enable a consistent and comparable flow of assurance from ward to Board. During 2025/26, Clinical Group leadership structures were redesigned to strengthen clinical leadership and to ensure a consistent approach to leadership and accountability was embedded within each Clinical Group.

Capacity to handle risk

The Trust is committed to the principles of good governance and understands the importance of effective risk management as a fundamental element of its governance framework and system of internal control.

We recognise that healthcare provision, and the activities associated with caring for patients, employing staff, providing premises and managing finances will, by their very nature, involve a degree of risk. These risks are present on a day-to-day basis throughout the Trust. We take action to manage risk to a level that is tolerable. We acknowledge that risk can rarely be totally eradicated, and a level of managed residual risk will be accepted. Risk management is therefore an intrinsic part of the way we conduct business, and its effectiveness is monitored by both our performance management and assurance processes.

As Accounting Officer for the Foundation Trust, I have overall responsibility for ensuring effective risk management arrangements are in place. I am supported by the Interim Deputy Chief Executive/ Chief Nursing Officer, the Interim Deputy Chief Executive, the Director of Clinical Governance and the Director of Corporate Business / Trust Board Secretary. Overseen by the Interim Deputy Chief Executive/ Chief Nursing Officer, the Trust's Director of Clinical Governance develops and manages the corporate approach to the management of risk, including the Risk Management Framework and Strategy, and the Director of Corporate Business/ Trust Board Secretary oversees the completion of the Board Assurance Framework (BAF).

The Board of Directors, and its Board committees, routinely use the BAF, strategic risk register, local counter fraud service and internal and external audit, to ensure proper arrangements are in place for the discharge of our statutory functions and to detect and act upon any risks and ensure that the Foundation Trust is able to discharge its statutory functions in a legally compliant manner.

The Trust's Interim Deputy Chief Executive chairs the Trust Risk Oversight Committee whose role it is to oversee the development, management and mitigation of the Trust's strategic risks, supporting understanding of the inter-relationship of risks and the balance of risk taking and risk tolerance. The Trust Risk Oversight Committee reports into the Trust Leadership Team Committee which I chair. To support the implementation of the new risk management framework and strategy, the Board of Directors underwent externally-facilitated risk training sessions to ensure a shared understanding of the new framework and to consider and agree the articulation and application of the Trust's risk appetite. A further externally-facilitated Board of Directors' session to review the Trust's risk appetite statement is scheduled for June 2026.

The Trust provides a comprehensive mandatory training programme, which includes risk management awareness and training. Training is delivered centrally and within individual parts of the Trust. Training can be classroom-based with internal or external trainers, web-based or 'in-situ'; this sort of training is often developed following identification of potential risk in the way that care is being delivered through learning from incidents or proactive risk assessments. The Trust also has a clear commitment to individual personal development, and through all these mechanisms, staff are trained

and equipped to identify and manage risk in a manner appropriate to their authority, duties and experience.

There is regular reinforcement of the requirements of the Mandatory Training Policy, and the duty of staff to complete training deemed mandatory for their role is a key element of the annual appraisal process. Monitoring and escalation arrangements are in place to enable the Trust to ensure targeted action in relation to areas or staff groups where performance is not at the required level.
We have continued with our focus on developing awareness and skills in relation to high quality and focused risk assessments and business continuity planning, amongst both clinical and non-clinical staff.

The risk and control framework
The Trust is committed to a robust and transparent approach to risk management that aligns with our strategic, clinical and operational priorities and is implemented in line with the CQC Well Led Framework.

Our Risk Management Strategy supports the identification, assessment and response to risks that impact upon our ability to achieve our strategic objectives. We recognise that effective risk management practices and cultures support us to respond with agility to the risks that we face, thus enabling the Trust to be a safe and effective healthcare organisation that supports our staff, patients and communities.

Whilst strategic risks are identified, assessed and managed by the Trust Executive-Led Management Committees, it is recognised that effective risk management supports a culture where all staff feel confident and able to identify and minimise risk. Our organisational development programmes continue to focus upon maintaining an open and honest culture, where any risk, whether clinical, operational, financial or otherwise, are identified, appropriately escalated and responded to in a positive way.

The Trust's approach to risk management is articulated in the Trust Risk Management Framework and Strategy that was ratified by the Board of Directors in May 2025. The Strategy is aligned to the Trust's Strategy 'Where Excellence Meets Compassion' and supports delivery of the Trust values and objectives.

Sitting alongside the Strategy is a Risk Management Handbook that provides a resource to all staff to identify, assess and respond to risk. It provides operationally focused detail in relation to the stages of risk management, including the principles of risk management; identifying, analysing, evaluating, managing, monitoring and review of risk.

Risk Hierarchies

Within the Trust Risk Management Framework and Strategy and the Risk Management Handbook is detail regarding the hierarchy of risk that the Trust recognises. To support effective risk management the Trust organises risks into strategic, corporate and operational risks.

Risk Hierarchies	Description
Strategic Risks	Risks identified that have the potential to directly impact the Trust's ability to meet its strategic aims and objectives.
Corporate Risks	Risks that require a response across multiple Clinical Groups and Corporate Directorates or a Trust-wide response.
Operational Risks	Risks that are most effectively managed or mitigated within individual Clinical Groups or non-clinical services.

The Trust Risk Oversight Committee oversees the delivery of the Trust's Risk Management Framework and Strategy. At a strategic risk level, all risks are proposed by and allocated to a Trust Executive-led Management Committee, and a Board of Director's Board Sub-Committee. The Management Committees report strategic risks relevant to their scope to the Trust Risk Oversight Committee for approval and ongoing oversight.

Corporate risks can be identified by Clinical Group's or Management Committee sub-groups and are escalated to the relevant Management Committee for approval and to receive assurance on risk response.

Operational risks can be recorded and managed by wards, teams, directorates or at an overall Clinical Group or Corporate Directorate level. Dependent upon the risk assessment and scoring, the risk will be escalated based upon the principles outlined in the Trust Risk Management Framework and Strategy.

Risk Assessment and Scoring

All risks, whether strategic, corporate or operational are recorded on the electronic Trust Risk Management System, Ulysses. All identified risks are assessed and scored using a risk grading matrix that assesses the likelihood of the risk and the consequence of the risk on a scale of 1-5. The multiplication of likelihood score by consequence score gives the overall risk score, with a maximum score of 25.

Consequence (B)	Likelihood (A)				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic	Score 5	Score 10	Score 15	Score 20	Score 25
4 Major	Score 4	Score 8	Score 12	Score 16	Score 20
3 Moderate	Score 3	Score 6	Score 9	Score 12	Score15
2 Minor	Score 2	Score 4	Score 6	Score 8	Score 10
1 Negligible	Score 1	Score 2	Score 3	Score 4	Score 5

Within the Trust Clinical Groups and Corporate Directorates risks are identified, assessed and responded to on an on-going basis and in line with the score allocated to it.

All risks scoring 20 or above should be escalated to the relevant Trust Management Committee for discussion as to whether this should be managed locally with enhanced oversight at the Management Committee, or whether it needs to be managed on a Trust-wide basis and therefore should be added to the Corporate Risk register and managed by the Management Committee on behalf of the Trust.

All risks scoring 15 or above, where a catastrophic outcome is possible, a major outcome is likely, or a moderate outcome is certain, are escalated to the relevant Trust Management Committee for awareness and a discussion by exception (based on the confidence the Clinical Group / Corporate Directorate has in their mitigation plans) as to whether the Trust is willing to accept this level of risk. All risks scoring 15 or above should be reported for awareness to the Trust Leadership Team Committee and relevant Board Sub-Committee for awareness.

All risks scoring 12 or above, meaning that a major outcome is possible, and a moderate outcome is likely, are escalated for consideration and oversight at Clinical Group Risk Committees and Management Boards and within the senior management infrastructure corporately, including at Trust Management Committee sub-groups.

Strategic risks are not defined by their score, but are those risks which are considered to impact directly on the Trust's ability to achieve its strategic aims and objectives. Strategic risks are proposed by the Trust Management Committee on the basis of escalations and triangulation of information received from Management Committee sub-groups and the Senior Leadership structures of each Clinical Group. The proposed strategic risks are escalated to Trust Risk Oversight Group that provides scrutiny and assesses the inter-relationship of strategic risks. The Trust Risk Oversight Group provides assurance to the Trust Leadership Team Committee as part of the Strategic Risk Register and Board Assurance Framework.

Risk Appetite

The Trust Risk Appetite Statement was approved by the Board of Directors in May 2025. This statement sets out the level of risk we are willing to seek or accept in pursuit of our objectives. The Trust recognises that in order to successfully achieve our ambitions for our patients and staff, we must innovate, grow and make well-informed decisions that balance risks identified. To do so we must recognise the inherent risks that come from healthcare delivery in a complex and highly regulated system. The Trust Risk Appetite Statement therefore sets out our intent to manage the balance of risk, supporting decision-marking throughout MFT. The Trust Risk Appetite Statement will continue to be reviewed on an annual basis.

Risk Management Internal Audit Review

During Q4 2025/26, an Internal Audit review of risk management was undertaken, this focused upon Clinical Group risk management focusing upon risk recording and management, including scoring, identification of mitigating actions and frequency of risk reporting. The outcome of this review was a rating of 'significant assurance with minor improvement opportunities'. The recommendations from the review will be implemented in 2026/27 to further strengthen and develop our risk arrangements.

The responsibilities of Trust individuals in relation to the implementation of the Risk Management Framework and Strategy are as follows:

The **Board of Directors** is accountable for the delivery of the RMFS and has a collective responsibility to ensure that the risk management processes provide adequate and appropriate information and assurances relating to risks that threaten the achievement of the Trust's strategic aims and objectives.

Executive Directors are responsible for the identification, assessment and management of risk within their own area of responsibility as delegated by the Chief Executive.

The **Clinical Group Chief Executives** and their senior leadership teams are responsible for the implementation of the RMFS in their Clinical Groups.

Clinical Leads / Heads of Department and Clinical Governance Leads are responsible for ensuring that risks in their area are identified, monitored and controlled. They must allow time for risk issues to be included in governance meetings to support the effective identification, management and escalation of risk. Each service manager should identify a designated lead (Risk Guardian) for Risk Management for their service.

Risk Guardians ensure that the training needs of the service have been assessed, and (where the roles are separate) working with the service manager, that plans are in place to address these.

Department and ward managers are responsible for ensuring that colleagues in the workplace understand risk management issues, adhere to risk management policies and procedures, receive and provide feedback regarding incidents and risks, and adopt changes to practice accordingly.

All managers have a direct responsibility for the health, safety and welfare of colleagues and for ensuring a safe environment for the delivery of care.

All staff, including those on temporary or fixed term contracts, placements or secondments, and contractors, must keep themselves and others safe. They have a responsibility for managing incidents and risks within their area of responsibility. They must commit to being made aware of their responsibilities and of the risk management process through induction into the Trust or into a new role; discipline or department specific training; management and supervisory training; mandatory update training; awareness raising or ad-hoc events; Inclusion in personal development plans and Appraisal discussions**.**

The Trust's **Trust Risk Oversight Committee (TROC)** is attended by all Executive Directors and has responsibility for approving risks for adding to the Strategic Risk Register, ensuring that the rating of, response to, and mitigation of these risks is considered alongside all other Strategic Risks and in line with the Trust's risk appetite. The TROC delegates responsibility for overseeing the risk management plan for each Strategic Risk to one or more of the Management Committees as appropriate. Changes to the risk score for Strategic Risks once entered into the register will be proposed by the relevant Management Committee and approved by the TROC to enable them to continue to be considered 'in the round' at all stages of the risk management life cycle. The TROC provides an escalation report to the TLTC after each meeting summarising the decisions made. Any changes to the range of strategic risks, or the rating of them, are reported to the Board Committees through a strategic risk register relevant to their scope.

The **Board Committees**, chaired by Trust Non-Executive Directors, provide the Board of Directors with assurance that effective strategic risk management is taking place in place in relation to their areas of work. The Committees receive reports describing routine assurance in relation to the effectiveness of controls, and reports by exception where risks, gaps in assurance or negative assurance have been identified. The Board Committees monitor progress with the delivery of the Trust's strategic objectives and consider the related commentary and content within the Board Assurance Framework.

The **Audit and Risk Committee** review the establishment and maintenance of an effective system of audit, risk management and internal control across the whole of the organisation's activities that

supports the achievement of the organisation's objectives. Of particular relevance the Committee reviews the adequacy of:

- The processes supporting all risk and control related disclosure statements (in particular this Annual Governance Statement and declarations of compliance with the Care Quality Commission standards), together with any accompanying Head of Internal Audit statement, external audit opinion or any other appropriate independent assurance
- The underlying assurance processes that indicate the degree of the achievement of strategic objectives and the effectiveness of the management of strategic risks through consideration of the outputs from the Board Committees and the Trust Risk Oversight Committee.
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the counter fraud and security management service.

During 2025/26, the Committee considered the following reports related to the Trust's risk and control framework:

- Amendments to the Trust's Standard Financial Instructions and Scheme of Reservation
- Declarations of interest compliance
- Use of the Trust's seal
- Risk management arrangements
- Standards of Business Conduct policy
- Tenders waived (standing item)
- Losses and special payments (standing item)
- Data Quality: Integrated Performance Reporting (internal audit report)
- Core Financial Controls (internal audit report)
- Risk Management (internal audit report)
- Cyber Assessment Framework/ Data and Security Protection Toolkit (internal audit report)
- Patient Food and Catering (internal audit report)
- Continuity Controls: Instigation of offline processes (internal audit report)
- Continuity Controls: Supplier and Third-party IT Risk Management (internal audit report)
- Emergency Department: Temporary Escalation processes (internal audit report)
- Medical Workforce including insourcing controls (internal audit report)
- Ward senior nurse reviews (internal audit report)

Significant and key risks were considered by the Audit and Risk Committee in tandem with the presentation of the external audit plan, audit completion report, and discussions with the external auditor.

The Audit and Risk Committee reviewed the financial statements for 2025/26 at its meeting on the 23rd June 2026. There were no significant issues for the Audit and Risk Committee to consider.

The Trust's **Management Committees** have accountability for delivery of specific aspects of the Trust's operational delivery plan at a tactical level with each committee aligned to the Trust's strategic objectives. As part of this they have accountability for management of strategic risks associated with specific elements of the Trust's strategic objectives. They act as a forum for Executive Directors to receive assurance on mitigation of both strategic and corporate risks. They do this by considering the relevant elements of the Board level IPR (aligned to the specific strategic objectives delegated to them), reports from relevant management groups within Clinical Groups and from sub-groups of the Management Committees, and the Corporate Risk Register

The **Clinical Group Management Boards (CGMB)** are responsible for the management of the Clinical Group and for ensuring proper standards of corporate governance are maintained throughout the organisation. The CGMBs account for the performance of each individual organisation and receive exception reports against performance and quality standards and these assist in scrutinising areas of high risk**.** The work of the CGMBs is supported by a committee and governance infrastructure as defined in each Clinical Group's Governance Framework. The CGMBs are responsible for the escalation of risks scored at 15 or over or other risks that they believe may have an impact on the delivery of strategic objectives (for instance because they are cross cutting) to the relevant Management Committee for discussion and decision-making.

Each Clinical Group has a **Risk Management Committee** which is responsible for the overall oversight of risk exposure of the Clinical Group. They are responsible for effective escalation of risk to the CGMB and providing a risk profile to support the identification of cross-cutting risks and newly emergent threats.

The Trust's operating model is underpinned by the **Delivery and Oversight Framework** (DOF), which contributes to the overarching Board Governance Framework, enabling the Board of Directors to fulfil its obligations and effectively run the organisation. The DOF is one of the key enabling processes to support the delivery of the MFT vision, strategic objectives and operational plan, and consists of a performance framework, delivery oversight meeting cycle, corporate reviews and the integrated performance report.

Using a 1 – 4 tiering system, the **Performance Framework** combines a self-assessment by each Clinical Group against progress in delivering the Trust's strategic objectives with a review of delivery risk by Group Executives based on the level of risk and the support and intervention required for each Clinical Group.

The **Delivery Oversight Meetings** consist of quarterly reviews of each Clinical Group's progress in delivering their annual plan, chaired by the Trust Chief Executive, and monthly (or more frequent where required) performance reviews focused on specific areas of risk, led by the Chief Delivery Officer. Reports from the delivery oversight meetings are presented at the Trust Leadership Team Committee.

The **Corporate Reviews,** led by the Trust Chief Executive**,** are a bi-annual review of each corporate team's progress in supporting delivery of the trust annual plan and overall strategy.

The **Integrated Performance Report** is the monthly data pack containing metrics regarding MFT's performance across the full range of Trust business.

MFT also has established arrangements to advise and engage with both the Manchester and Trafford Scrutiny Committees when there are proposed service changes that may impact on the people who use our services.

The Trust endeavors to work closely with patients and the public to ensure that any changes minimise the impact on patients and public stakeholders. As a Foundation Trust, we also inform our Council of Governors of proposed changes, including how any potential risks to patients will be minimised.

In September 2025, the Audit and Risk Committee were presented with an update on implementation of the RMFS including delivery against a number of measures of success and effectiveness. A further report, providing an update on actions proposed in the September report, was discussed at the Audit and Risk Committee in February 2026.

Overview of the organisation's major risks

The Trust identified and managed a number of Strategic Risks throughout 2025/26 which were active in March 2026. These are listed below under the Management Committee which oversees the management and mitigation of the risks.

<u>Finance and Commercial Management Committee</u>

- Implications of national restrictions on capital resource
- Delivering financial sustainability in medium term

<u>Digital Oversight Management Committee</u>

- Cyber Security
- Loss or instability of Digital Infrastructure

Delivery Oversight Management Committee

- Impact of under-delivery of our Annual Plans
- Inability to provide a fully compliant estate relating to estates infrastructure and services and fully comply with statutory safety legislation
- Failure to deliver Improvement Strategic Delivery Plan

Population Health Management Committee

- Delivery of Green Plan
- Inability to reduce health inequalities

Quality and Safety Management Committee

- Implementation of the patient safety learning framework
- To provide high quality, safe care with excellent outcomes and experience to achieve the aims of the Mental Health Strategy

Service Strategy Planning Management Committee

- Major Trauma
- Vascular Service Changes in Greater Manchester
- Genomics capital investment impacts upon productivity
- Safe disaggregation of complex services

Workforce and Education Management Committee

- Sustaining a safe and supportive workplace culture
- Maximising the efficiency and effectiveness of workforce systems and processes
- Organisational Change

Research and Innovation Management Committee

- Hosting of multiple National Institute for Health and Care Research (NIHR) infrastructure centres

A range of mitigating actions have been developed and are recorded on the Risk Register, along with the details of the action plan lead and the date for completion of these actions.

These risks are monitored bi-monthly at the Trust Risk Oversight Committee, and at each meeting of the relevant Board Committee, and progress is also evaluated in line with the processes detailed elsewhere in this Annual Governance Statement.

Quality governance arrangements

The Joint Chief Medical Officers and the Interim Deputy Chief Executive / Chief Nursing Officer are the lead Executives and Joint Chairs of the **Quality & Safety Management Committee**. This Committee sets the strategic direction for quality and safety for MFT. It is responsible for developing the organisational strategy for quality and safety in line with national/international evidence-based practice and standards.

This Committee also ensures that MFT has the structures, systems and processes it needs in order to achieve its key clinical objectives, and that they are monitored and performance managed with risks being identified and managed on an ongoing basis. Compliance with Care Quality Commission (CQC) registration is monitored through this Committee.

The main committees are the Quality and Safety Management Committee; Quality, Safety & Performance Board Committee; and Trust Risk Oversight Committee – details of these can be found earlier in this section. The Trust has had an established Quality Review process in place since 2013/14, in response to the recommendations set out by the Francis, Keogh and Berwick reports earlier the same year (2013). Internal reviews are informed by extensive data packs that pull together key indicators reflecting the quality of care across each Clinical Group.

The Trust also has a well-established ward accreditation process in place that examines performance across four domains: leadership and culture of continuous improvement, environment of care, communication about and with patients and nursing processes, including medication management and the meals service.

Findings are mapped against agreed criteria for each standard and clinical areas are scored as white, bronze, silver or gold. Areas that consistently achieve a gold rating become eligible for an Excellence in Care Award, providing a gold rating is achieved in all domains. Patient experience survey data and quality of care data is used along with Accreditation outcomes to drive continuous improvement.

The Quality, Safety and Performance Board Committee and the Board of Directors seek and receive assurance on quality and safety related work at each of their meetings.

Further information about the Trust's work on improving quality and our governance arrangements and processes can be found in the *Quality Account* section of this report.

Care Quality Commission

Manchester University NHS Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

Managing conflicts of interest

The Trust has published an up-to-date register of interests on its website, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months, as required by the *Managing Conflicts of Interest in the NHS* guidance.

Compliance with the NHS Provider Trust License Condition 4

The Trust is required to comply with Condition 4 of the NHS Provider License, which relates to governance arrangements. Risks to compliance include the effectiveness of Board oversight, clarity of accountabilities, and the provision of timely and accurate information to support decision-making.

The Trust maintains a clearly defined committee structure, with Board Committees chaired by Non-Executive Directors and aligned to principal risk areas, ensuring independent scrutiny of executive performance. Strategic risks are mapped through the Board Assurance Framework (BAF), supporting alignment between Trust priorities and Board Committee oversight. Time-limited Board Committees are established to oversee major programmes of work, for example the Organisational Development Board Committee and the newly established North Manchester Board Committee.

Clearly defined terms of reference are in place for all Board and Management Committees, setting out delegated authorities and reporting arrangements. Executive Directors are assigned ownership of strategic risks and accountable for delivery through designated management committees. Governance arrangements are regularly reviewed and updated to reflect organisational and system changes.

Systems and processes are maintained to monitor performance, quality, and operational delivery, with routine reporting to the Board and its committees. Relevant metrics, performance indicators and accountabilities are established and routinely reviewed to support effective decision-making. Assurance is obtained through committee structures, internal reporting cycles, and triangulation of information across performance, quality, and workforce domains. The Trust continues to strengthen data quality and validation processes to support reliable reporting, including alignment with regulatory requirements (e.g. CQC and NHS England).

Risk management processes are described earlier in this Annual Governance Statement.

Equality, Diversity and Human Rights legislation

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Assurance of ongoing compliance is received within the People Board Committee and the Workforce and Education Management Committee. Further information on the Trust's work in this area can be found in the *Staff Report* section of this Annual

Report.

Net Zero

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS Programme. The Green plan was reviewed during 2024/25 with the new Green plan being approved at the Board of Directors in May 2025. Board Committee oversight of delivery of the Green Plan is carried out in the Research, Innovation and Population Health Board Committee with an annual update provided to the Board of Directors. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Further information on progress being made can be found in the *Sustainable Performance* section of this Annual Report.

Review of economy, efficiency, and effectiveness of the use of resources

We invest significant time in improving systems and controls to deliver a more embedded range of monitoring and control processes to ensure economy, efficiency and effectiveness. The implementation of our new operating model, described earlier in this Annual Governance Statement, has responded to these recommendations.

The in-year use of resources is closely monitored by the Board of Directors and the following committees:

- Audit and Risk Committee, including reports from internal and external auditors
- Remuneration and Nominations Committee
- Finance Board Committee
- Quality, Safey and Performance Board Committee
- People Board Committee
- Digital and Estates Board Committee
- Trust Risk Oversight Committee

MFT employs a number of approaches to ensure best value for money (VFM) in delivering its wide range of services. Benchmarking is used to provide assurance and inform and guide service redesign. This leads to improvements in the quality of services and patient experience, as well as financial performance.

The Trust is compliant with the principles and provisions of the NHS Foundation Trust Code of Governance, further details can be found in the *NHS Foundation Trust Code of Governance disclosures* section of this annual report.

Safe, sustainable and effective staffing

MFT ensures that robust short, medium and long-term workforce strategies and staffing systems are

in place through a combination of Board oversight, structured governance arrangements and embedded risk management processes, providing assurance that staffing is safe, sustainable and effective. The Board of Directors retains overall accountability for workforce strategy, supported by formal committee structures which provide dedicated scrutiny of workforce performance, culture and staffing risks. Workforce risks are incorporated within the Trust's strategic risk register and Board Assurance Framework, enabling the Board of Directors to understand both immediate staffing pressures and longer-term workforce sustainability challenges. The People Board Committee and Trust Risk Oversight Committee seek evidence regarding matters of safety and risk relating to safe staffing levels.

Our staffing governance processes have been developed in line with National Quality Board guidance and recommendations within Developing Workforce Safeguards, (NHSI 2018). This is to ensure that the Trust deploys sufficient suitably qualified, competent, skilled and experienced staff, that there is a systematic approach to determine staffing levels and that this reflects current legislation and guidance.

Patient quality, financial and workforce indicators are triangulated and reviewed alongside data from evidence-based staffing tools, including Safer Nursing Care Tool (SNCT) and Birthrate Plus, to inform twice yearly workforce reviews. The reviews then apply a professional judgement framework to agree staffing requirements which are then reported biannually through the People Board Committee to the Board of Directors.

Optimal staffing levels and skill mix on our wards and departments are under constant review to ensure that each ward / department area is staffed according to real-time need and with reference to evidence based practice staffing models. This includes dynamic systems and processes that function daily to ensure that any shortfalls in staffing are mitigated. These are further supported by senior oversight provided by twice daily nurse and midwifery staffing meetings to consider plans for staffing over the next 24 hours.

An electronic rostering system (Allocate) is embedded which provides an efficient platform for planning and reviewing staffing levels and includes direct interface with the Trust's bank provider (NHS Professionals). Rosters are available to all colleagues at least 6 weeks in advance and self-rostering solutions have been trialled with plans to expand across all areas.

The Corporate Risk Register Report provides a mechanism for operational staffing risks to be escalated. Throughout 2025/26 the Trust has continued to recruit registered nurses and midwives through graduate and local recruitment, as well as having commenced the nursing and midwifery assistant apprenticeship training programme.

The Trust's Freedom to Speak Up (FTSU) policy provides a further mechanism for staff to raise concerns, including those that relate to staffing processes and safe staffing is a standing agenda item at the Trust Joint Negotiating Consultative Committee

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Information Governance

The Trust is committed to protecting data by prioritising confidentiality and security in all aspects of handling personal data and business information. A well-established Information Governance (IG) framework underpins this commitment with policies and guidance to safeguard personal data in line with UK GDPR, Data Protection Act 2018, Data (Use and Access) Act 2025, Cyber Assessment Framework and other relevant legislation, and ensures personal data is managed legally and efficiently, empowering staff to handle information confidently to enable delivery of high-quality patient care.

Cybersecurity is a fundamental cornerstone of the IG framework. The Trust deploys comprehensive controls to maintain and continually enhance its cyber resilience, including active monitoring of IT assets. Ongoing initiatives are focused on increasing staff awareness and embedding secure-by-design principles, with an emphasis on proactively managing cyber vulnerabilities.
Each year, the Trust completes the NHS Data Security and Protection Toolkit (DSPT) to assess our compliance against the Cyber Assessment Framework (CAF) and data protection legislation. The 2024/25 self-assessment achieved the "Standards Met" status. The Trust is working towards completion of its next self-assessment of the 2025/26 CAF-aligned DSPT by 30th June 2026 deadline and is expecting to achieve DSPT 'Standards Met'. The mandated independent review required for the DSPT was completed in March 2026 and provided an overall rating of significant assurance with minor improvement opportunities, giving a high confidence level in the veracity of the self-assessment.

Oversight of the IG framework is provided by the Cyber Security and Assurance Board (CSAB), which reports through the Digital Oversight Committee to the Trust Leadership Team. CSAB also supports the Chief Executive and Senior Information Risk Owner (SIRO) in managing information risks.

All IG incidents, including data breaches, are logged, managed and investigated in accordance with Trust policies. The Trust uses the DSPT reporting tool for those IG incidents that meet or exceed the threshold for reporting externally to the Information Commissioner's Office (ICO), Department of Health and Social Care, NHS England, and the National Cyber Security Centre.

In 2025/26, one incident met the threshold for external reporting to the ICO. The incident related to a letter being sent to an incorrect recipient. A full investigation was completed to ensure that lessons are learnt and to prevent a future re-occurrence of a similar event.

Data quality and governance

The Integrated Performance Report (IPR) is produced every month using validated data. It provides a 'single version of the truth' regarding MFT's performance across the full range of Trust business. The production cycle of the IPR is aligned with the governance and reporting requirements of the Trust's operating model with each audience receiving the level of detail required for them to carry out their assurance role within the governance structure. The structure and content of the IPRs are aligned to the Trust's strategic aims.

Of the over 300 core metrics overseen within the Trust, each one is linked to management committee and a governance group which owns the metric on behalf of the management committee. The metric is escalated to the relevant management committee and included in the IPR if it meets agreed trigger points. Trigger points are escalated from management committees to TLTC if limited assurance continues.

The IPR which is presented to the Board Committees contains IPR metrics relevant to the strategic objectives being overseen by the Committee along with a one-page analysis of each metric which need particular attention from the committee. Benchmarking data between the Clinical Groups and comparing MFT to other Trusts in England; performance against the System Oversight Framework exit criteria; and other areas of material concern; are also included. The Board of Directors considers the IPR at each of its meetings.

MFT uses the Hive EPR system to support the management of services and performance. This system is available to all staff from Board to ward, who can view it on a daily basis and access up-to-date performance information. The system is used to support our internal governance structure and any performance reporting required internally and by external organisations.

In addition, our clinical and operational staff use the information to produce bespoke reports that analyse patient activity and assist with planning and administration, as well as performance management tracking. Using this information tool reinforces that performance management is part of

everyone's job.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.7% for admitted patient care,
- 99.8% for outpatient care, and
- 98.3% for accident and emergency care

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care.
- 99.8% for outpatient care, and
- 100% for accident and emergency care

In line with Public Sector Internal Audit Standards, the Trust's internal auditors review aspects of data quality every year in support of their Head of Internal Audit opinion.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within our Trust, who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, the Trust Risk Oversight Committee, and the Audit and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by other evidence such as:

- Internal Audit Reports
- External Audit Reports
- National Oversight Framework segmentation
- Patient Surveys
- The NHS Staff Survey
- Care Quality Commission inspection reports and accreditation reports
- Benchmarking reports

- PLACE assessments
- Senior Leadership Observational Visits
- Reports produced by external organisations who have been commissioned by the Trust during 2025/6 to review our current arrangements.

The Trust applies a robust process for maintaining and reviewing the effectiveness of the system of internal control. A number of key groups, committees and teams make a significant contribution to this process, including:

Board of Directors

The statutory body of the Trust is responsible for the strategic and operational management of the organisation and has overall accountability for the risk management frameworks, systems, and activities, including the effectiveness of internal controls.

The Terms of Reference and responsibilities of all Board Committees are reviewed annually in order to strengthen their roles in governance and focus their work on providing assurance to the Board on all risks to the organisation's ability to meet its key priorities.

Audit and Risk Committee

The Audit Committee provides an independent contribution to the Board's overall process for ensuring that an effective internal control system is maintained and provides a cornerstone of good governance. The Audit Committee monitors the work of all other Board Committees and the Trust Risk Oversight Committee through consideration of the escalation and assurance reports which they submit to the Board of Directors.

Internal Audit

Internal Audit provides an independent and objective opinion to the Accounting Officer, the Board of Directors, and the Audit and Risk Committee, on the degree to which MFT's systems for risk management, control and governance support the achievement of the Trust's agreed key priorities. The Internal Audit team works to a risk-based audit plan, agreed by the Audit Committee and covering risk management, governance, and internal control processes, both financial and non-financial, across the Trust. The work includes identifying and evaluating controls and testing their effectiveness, in accordance with Public Sector Internal Audit Standards.

A report is produced at the conclusion of each audit and, where scope for improvement is found, recommendations are made, and appropriate action plans agreed with management. Reports are issued and followed up with the Trust Executive Directors responsible.

The results of the audit work are reported to the Audit and Risk Committee, which plays a central

role in performance managing the action plans to address the recommendations from audits. Internal audit reports are also made available to the external auditors, who may make use of them when planning their own work.

In addition to the planned programme of work, internal audits provide advice and assistance to senior management on control issues and other matters of concern. Internal audit work also covers service delivery and performance, financial management and control, human resources, operational and other reviews.

Based on the work undertaken throughout the year, the Head of Internal Audit provides an 'Annual Conclusion' over four components: governance; risk management; financial reporting and management; and data captured and used by the organisation. These are aligned with the requirements of the Global Internal Audit Standards (GIAS) as applied to the public sector. A rating of 'Green', 'Amber- Green', 'Amber-Red' or 'Red' is applied to each component with Green reflecting the most positive overall assessment. For 2025/26, all components were rated as Amber-Green with the following comments:

- *Risk Management*: Overall findings on design show some controls to be effectively designed with some exceptions and our testing showed controls are operating effectively.
- *Financial reporting and management*: Overall findings on design show some controls to be effectively designed with some exceptions and our testing showed controls are operating effectively.
- *Governance*: Overall findings on design show some controls to be effectively designed with some exceptions and our testing showed some controls to be operating effectively and others could be more consistently applied.
- *Data captured and used by the organisation*: Overall findings on design show some controls to be effectively designed with some exceptions and our testing showed some controls to be operating effectively, and others could be more consistently applied.

Clinical Audit

The Clinical Audit teams in the Hospitals and MCS oversee the development and delivery of an annual Clinical Audit Plan. This plan includes mandatory national audits, locally agreed priority audits and monitoring audits in respect of external regulation and accreditation.

Data validation is undertaken through data quality checks, audits (internal and external), hospital scrutiny groups, variance checking, extensive daily reporting and analysis. These checks are reflected through the Data Quality dashboard. See the 'National and local clinical audits' section within the Quality Account which can be found on the Trust's website.

Conclusion

The system of internal control in place at Manchester University NHS Foundation Trust has been designed to deliver the key organisational objectives and minimise our exposure to risk. Our governance processes are tested on an annual basis by our external auditors and throughout the year by our internal auditors. Delivery of any required improvement actions is overseen by the relevant Management Committee and scrutinised and monitored through the relevant Board Committee. During 2025/26, an internal audit review of the risk management processes within our Clinical Groups concluded that there is significant assurance overall with some minor improvement opportunities which are being addressed. The Trust continues to review and update the governance assurance processes to further strengthen arrangements.

To the best of my knowledge, no significant internal control issues have been identified during 2025/26. For any internal control matters which have arisen, I am satisfied that actions are in place, or have already been implemented, to address recommendations for improvements to our systems and processes.

Signed:

Trust Chief Executive

23 June 2026

Key to acronyms

Within our Trust, and across the NHS, acronyms are used to shorten lengthy phrases or terms into more manageable abbreviations. Below is a list of the acronyms we commonly use within the Trust, including within this Annual Report, and the term / phrase they refer to.

AHP	Allied Health Professional
AOF	Accountability Oversight Framework
ARC-GM	NIHR Grater Manchester Applied Research Collaboration
ASC	Adult Social Care
BAF	Board Assurance Framework
BoD	Board of Directors (aka 'The Board')
BRC	NIHR Manchester Biomedical Research Centre
CAMHS	Child and Adolescent Mental Health Services
CDC	Community Diagnostic Centre
CDEL	Capital Departmental Expenditure Limits
CDI	Clostridium Difficile Infection
CoG	Council of Governors
CoI	Conflict of Interest
CPE	Carbapenamase-producing Enterobacterales
CQC	Care Quality Commission
CRDC	Greater Manchester Commercial Research Delivery Centre
CRF	NIHR Manchester Clinical Research Facility
CRN	Clinical Research Network
CSS	Clinical and Scientific Services
DEBC	Digital and Estates Board Committee
DHSC	Department of Health and Social Care
DNA	Did Not Attend
DoC	Duty of Candour

DoI	Declaration of Interest
DTA	Discharge to Assess
E & F	Estates and Facilities
ED	Emergency Department
EDI	Equality, Diversity and Inclusion
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
EPRSC	Electronic Patient Record Scrutiny Committee
ERF	Elective Recovery Fund
ESR	Electronic Staff Record
EQIA	Equality Impact Assessment
FDS	Faster Diagnosis Standard
FBC	Finance Board Committee
FFT	Friends and Family Test
FIT	Faecal Immunochemical Test
FPPT	Fit and Proper Person's Test
FTSU	Freedom to Speak Up
GIRFT	Getting It Right First Time programme
GM	Greater Manchester
GMCA	Greater Manchester Combined Authority
GMICB	Greater Manchester Integrated Care Board
GMICP	Greater Manchester Integrated Care Partnership
GMICS	Greater Manchester Integrated Care System
GMMH	Greater Manchester Mental Health NHS Foundation Trust
GNSBI	Gram Negative bacteraemia
GoSW	Guardian of Safe Working

TROC	Trust Risk Oversight Committee
HCA	Healthcare Assistant
HDU	High Dependency Unit
HEE	Health Education England
HInM	Health Innovation Manchester
HRC	NIHR Healthtech Research Centre
HRDs	Human Resources Directors
HSMR	Hospital Standardised Mortality Ratio
HWB	Health and Wellbeing Board
IFRS	International Financial Reporting Standards
INT	Integrated Neighbourhood Teams
IPC	Infection Prevention and Control
ISP	Independent Sector Provider
IQP	Improving Quality Programme
JSNA	Joint Strategic Needs Assessment
KLOEs	Key Lines of Enquiry
L & D	Learning and Development
LeDeR	Learning Disability Mortality Review
LHRP	Local Health Resilience Partnership
(M)(T)LCO	(Manchester)(Trafford)Local Care Organisation
LocSSIPS	Local safety standards for interventional procedures
LOS	Length of Stay
MCC	Manchester City Council
MCS	Managed Clinical Service
MESH	Manchester Elective Surgical Hub
MFT	Manchester University NHS Foundation Trust

MPB	Manchester Partnership Board

MREH	Manchester Royal Eye Hospital
MRI	Manchester Royal Infirmary
MSK	Musculo-skeletal
MVP	Maternity Voices Partnership
NA	Nursing Assistant
NCA	Northern Care Alliance NHS Foundation Trust
NED	Non-Executive Director
NHSCP	NHS Cervical Screening Programme
NHSE	NHS England
NHSP	NHS Professionals
NHSR	NHS Resolution
NICU	Neonatal Intensive Care Unit
NIHR	National Institute for Health Research
NMGH	North Manchester General Hospital
NWAS	North West Ambulance Service
ODBC	Organisational Development Board Committee
ORC	Oxford Road Campus
PACS	Picture Archiving and Communication System
PALS	Patient Advice and Liaison Service
PBC	People Board Committee
PCN	Primary Care Network
PDC	Public Dividend Capital
PED	Paediatric Emergency Department
PEOC	Patient Environment of Care
PFI	Private Finance Initiative

PFD	Prevention of Future Deaths report

PHM	Population Health Management
PHSO	Parliamentary and Health Service Ombudsman
PICU	Paediatric Intensive Care Unit
PIFU	Patient Initiated Follow-Up
PPIE	Patient and Public Involvement and Engagement
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Treatment List
PTS	Patient Transport Services
QIA	Quality Impact Assessment
QSPBC	Quality, Safety and Performance Board Committee
R & I	Research and Innovation
RCPCH	Royal College of Paediatrics and Child Health
RIBA	Royal Institute of British Architects
RIPHBC	Research Innovation and Population Health Board Committee
RMCH	Royal Manchester Children's Hospital
RMFS	Risk Management Framework and Strategy
RO	Responsible Officer
RTT	Referral to Treatment
SARC	Sexual Assault Referral Centre
SDEC	Same Day Emergency Care
SFIs	Standard Financial Instructions
SHMI	Summary Hospital-level Mortality indicator
SHS	Single Hospital Service
SMMCS	Saint Mary's Managed Clinical Service
SMH	Saint Mary's Hospital

SNCT	Safer Nursing Care Tool
SoRD	Scheme of Reservation and Delegation
SRO	Senior Responsible Officer
SUI	Serious Untoward Incident
TPC	Trust Provider Collaborative
UDHM	University Dental Hospital of Manchester
UEC	Urgent and Emergency Care
UoM	University of Manchester
UTC	Urgent Treatment Centre
VCSE	Voluntary, Community and Social Enterprise (organisations)
VfP	Value for Patients Programme
VRE	Vancomycin Resistant Enterococcus
VTE	Venous Thromboembolism
WDES	Workforce Disability Equality Standard
WMTM	'What Matters to Me' MFT patient experience programme
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
WTWA	Wythenshawe/Trafford/Withington/Altrincham hospitals
YTD	Year-to-Date

INDEPENDENT AUDITOR'S REPORT

Independent auditor's report to the Council of Governors of Manchester University NHS Foundation Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of Manchester University NHS Foundation Trust (the 'Trust') and its subsidiary (the 'group') for the year ended 31 March 2026, which comprise the consolidated statement of comprehensive income, the statement of financial position, the consolidated statement of changes in taxpayers' equity, the statement of cash flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26.

In our opinion, the financial statements:

give a true and fair view of the financial position of the group and of the Trust as at 31 March 2026 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended; and

have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26; and

have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the group or the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2025-26 that the group's and the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and the Trust. In doing so we had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and the Trust and the group's and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report and accounts, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report and accounts. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2025/26 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2025/26; and

based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or

we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2025/26, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of their services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance**,** but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the group and the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26).

We enquired of management and the audit and risk committee, concerning the group's and the Trust's policies and procedures relating to:

the identification, evaluation and compliance with laws and regulations;

the detection and response to the risks of fraud; and

the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

- We enquired of management, internal audit and the audit and risk committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

We assessed the susceptibility of the group's and the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and fraud in revenue recognition and management bias in making significant accounting estimates. We determined that the principal risks were in relation to:

journal entries posted during the annual accounts preparation process;

the occurrence of income:

management's estimates of the valuation of land and buildings; and

the completeness of expenditure.

- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on large value journals posted around the year end impacting on the Trust's financial performance;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations
  - evaluating the Trust's accounting policy for income recognition, updating our understanding of the Trust's system for accounting for income, evaluating estimates and the judgments made by management in respect of income accruals and testing substantively a sample of income and agreeing to supporting documentation to confirm correct accounting treatment, and;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the potential for fraud in revenue recognition. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.

The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the group and Trust audit team members included consideration of their:

understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation

knowledge of the health sector and economy in which the group and the Trust operates

understanding of the legal and regulatory requirements specific to the group and the Trust including:

the provisions of the applicable legislation

NHS England's rules and related guidance

the applicable statutory provisions.

In assessing the potential risks of material misstatement, we obtained an understanding of:

The group's and the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation process, expected financial statement disclosures and business risks that may result in risks of material misstatement.

The group's and the Trust's control environment, including the policies and procedures implemented by the group and the Trust to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Manchester University NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Chapter 10 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed the work necessary in relation to the Trust's consolidation schedules and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Sarah L Ironmonger

Sarah Ironmonger, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Manchester
23 June 2026

Manchester University NHS Foundation Trust

ANNUAL ACCOUNTS
for the period ended 31 March 2026

Foreword to the accounts

Manchester University NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Manchester University NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed

Mark Cubbon
Trust Chief Executive
23 June 2026

Consolidated Statement of Comprehensive Income

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	2,914,959	2,767,949	2,914,959	2,767,949
Other operating income	4	369,647	331,282	369,161	330,202
Operating expenses	7,9	(3,313,110)	(3,067,896)	(3,309,379)	(3,063,112)
Operating surplus/(deficit) from continuing operations		**(28,504)**	**31,335**	**(25,259)**	**35,039**
Finance income	11	6,167	9,601	5,742	8,904
Finance expense	12	(55,822)	(61,644)	(55,822)	(61,644)
PDC dividend expense		(1,809)	-	(1,809)	-
Net finance costs		**(51,464)**	**(52,043)**	**(51,889)**	**(52,740)**
Other gains/(losses)	13	1,882	783	1,878	139
Surplus/(deficit) from continuing operations		**(78,086)**	**(19,925)**	**(75,270)**	**(17,562)**
Surplus/(deficit) for the year		**(78,086)**	**(19,925)**	**(75,270)**	**(17,562)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	8	(26,674)	(15,173)	(26,674)	(15,173)
Revaluations	18	45,132	9,393	45,132	9,393
Other reserve movements		(2)	-	(2)	-
May be reclassified to income and expenditure when certain conditions are met:					
Fair value gains/(losses) on financial assets designated at fair value through Other Comprehensive Income	20	363	(225)	-	-
Total other comprehensive income for the period		**18,819**	**(6,005)**	**18,456**	**(5,780)**
Total comprehensive income / (expense) for the period		**(59,267)**	**(25,930)**	**(56,814)**	**(23,342)**

Statements of Financial Position

	Note	Group 31 March 2026 £000	Group 31 March 2025 £000	Trust 31 March 2026 £000	Trust 31 March 2025 £000
Non-current assets					
Intangible assets	14	7,354	10,345	7,354	10,345
Property, plant and equipment	16	966,379	940,073	966,350	940,037
Right of use assets	19	116,197	136,832	116,197	136,832
Investment property		3	3	0	0
Other investments / financial assets	20	16,210	14,250	2,419	806
Receivables	23	18,015	18,691	18,015	18,691
Total non-current assets		**1,124,158**	**1,120,194**	**1,110,335**	**1,106,711**
Current assets					
Inventories	22	33,342	31,666	33,342	31,666
Receivables	23	151,322	188,406	152,121	188,700
Non-current assets held for sale	25	210	210	210	210
Cash and cash equivalents	26	14,606	67,741	9,502	60,488
Total current assets		**199,480**	**288,023**	**195,175**	**281,064**
Current liabilities					
Trade and other payables	27	(326,146)	(380,396)	(325,825)	(380,214)
Borrowings	29	(38,902)	(37,476)	(38,902)	(37,476)
Provisions	30	(2,773)	(6,105)	(2,773)	(6,105)
Other liabilities	28	(25,728)	(29,338)	(25,728)	(29,338)
Total current liabilities		**(393,549)**	**(453,315)**	**(393,228)**	**(453,133)**
Total assets less current liabilities		**930,089**	**954,902**	**912,282**	**934,642**
Non-current liabilities					
Borrowings	29	(687,222)	(716,075)	(687,222)	(716,075)
Provisions	30	(9,617)	(9,401)	(9,617)	(9,401)
Other liabilities	28	0	(3,912)	0	(3,912)
Total non-current liabilities		**(696,839)**	**(729,388)**	**(696,839)**	**(729,388)**
Total assets employed		**233,250**	**225,514**	**215,443**	**205,254**
Financed by					
Public dividend capital		643,982	576,979	643,982	576,979
Revaluation reserve	18	190,559	172,102	190,559	172,102
Income and expenditure reserve		(619,098)	(543,827)	(619,098)	(543,827)
Charitable fund reserves	21	17,807	20,260	-	-
Total taxpayers' and others' equity		**233,250**	**225,514**	**215,443**	**205,254**

The notes on pages 160 to 223 form part of these accounts

Signed

Mark Cubbon
Trust Chief Executive
23 June 2026

Consolidated Statement of Changes in Equity for the year ended 31 March 2026

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**576,979**	**172,102**	**(543,827)**	**20,260**	**225,514**
Surplus/(deficit) for the year	-	-	(75,270)	(2,816)	**(78,086)**
Impairments	-	(26,674)	-	-	**(26,674)**
Revaluations	-	45,132	-	-	**45,132**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	363	**363**
Public dividend capital received	67,003	-	-	-	**67,003**
Public dividend capital repaid	-	-	-	-	**-**
Other reserve movements	-	(1)	(1)	-	**(2)**
Taxpayers' and others' equity at 31 March 2026	**643,982**	**190,559**	**(619,098)**	**17,807**	**233,250**

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**537,401**	**177,882**	**(526,265)**	**22,848**	**211,866**
Surplus/(deficit) for the year	-	-	(17,562)	(2,363)	**(19,925)**
Impairments	-	(15,173)	-	-	**(15,173)**
Revaluations	-	9,393	-	-	**9,393**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	(225)	**(225)**
Public dividend capital received	39,774	-	-	-	**39,774**
Public dividend capital repaid	(196)	-	-	-	**(196)**
Other reserve movements	-	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2025	**576,979**	**172,102**	**(543,827)**	**20,260**	**225,514**

Statement of Changes in Equity for the year ended 31 March 2026

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**576,979**	**172,102**	**(543,827)**	**205,254**
Surplus/(deficit) for the year	-	-	(75,270)	**(75,270)**
Impairments	-	(26,674)	-	**(26,674)**
Revaluations	-	45,132	-	**45,132**
Public dividend capital received	67,003	-	-	**67,003**
Other reserve movements	-	(1)	(1)	**(2)**
Taxpayers' and others' equity at 31 March 2026	**643,982**	**190,559**	**(619,098)**	**215,443**

Statement of Changes in Equity for the year ended 31 March 2025

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**537,401**	**177,882**	**(526,265)**	**189,018**
Surplus/(deficit) for the year	-	-	(17,562)	**(17,562)**
Impairments	-	(15,173)	-	**(15,173)**
Revaluations	-	9,393	-	**9,393**
Public dividend capital received	39,774	-	-	**39,774**
Public dividend capital repaid	(196)	-	-	**(196)**
Other reserve movements	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2025	**576,979**	**172,102**	**(543,827)**	**205,254**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 21.

Statements of Cash Flows

	Note	Group 2025/26 £000	Group 2024/25 £000	Trust 2025/26 £000	Trust 2024/25 £000
Cash flows from operating activities					
Operating surplus / (deficit)		(28,504)	31,335	(25,259)	35,039
Non-cash income and expense:					
Depreciation and amortisation	7.1	68,151	66,905	68,144	66,898
Net impairments	8	103,999	35,039	103,999	35,039
Income recognised in respect of capital donations	4	(16,747)	(4,413)	(20,790)	(6,715)
(Increase) / decrease in receivables and other assets		43,957	(45,720)	43,452	(46,072)
(Increase) / decrease in inventories		(1,676)	(4,070)	(1,676)	(4,070)
Increase / (decrease) in payables and other liabilities		(78,950)	(12,761)	(79,089)	(11,547)
Increase / (decrease) in provisions		(4,255)	(11,000)	(4,255)	(11,000)
Other movements in operating cash flows		(197)	-	(1)	-
Net cash flows from / (used in) operating activities		**85,778**	**55,315**	**84,525**	**57,572**
Cash flows from investing activities					
Interest received		5,722	8,884	5,722	8,884
Purchase and sale of financial assets / investments		445	8,493	-	
Purchase of intangible assets		(1,572)	(381)	(1,572)	(381)
Purchase of PPE and investment property		(145,872)	(104,403)	(145,872)	(104,403)
Receipt of cash donations to purchase assets		10,859	2,504	14,706	4,806
Finance lease receipts (principal and interest)		20	40	20	40
Net cash flows from / (used in) investing activities		**(130,398)**	**(84,863)**	**(126,996)**	**(91,054)**
Cash flows from financing activities					
Public dividend capital received		67,003	39,774	67,003	39,774
Public dividend capital repaid		-	(196)	-	(196)
Movement on loans from DHSC		(7,936)	(10,800)	(7,936)	(10,800)
Movement on other loans		(703)	(795)	(703)	(795)
Capital element of lease liability repayments		(11,626)	(10,879)	(11,626)	(10,879)
Capital element of PFI, LIFT and other service concession payments		(16,222)	(21,004)	(16,222)	(21,004)
Interest on loans		(2,150)	(2,444)	(2,150)	(2,444)
Interest paid on lease liability repayments		(2,285)	(1,802)	(2,285)	(1,802)
Interest paid on PFI, LIFT and other service concession obligations		(32,892)	(33,071)	(32,892)	(33,071)
PDC dividend (paid) / refunded		(1,704)	1,500	(1,704)	1,500
Net cash flows from / (used in) financing activities		**(8,515)**	**(39,717)**	**(8,515)**	**(39,717)**
Increase / (decrease) in cash and cash equivalents		**(53,135)**	**(69,265)**	**(50,986)**	**(73,199)**
Cash and cash equivalents at 1 April - brought forward		**67,741**	**137,006**	**60,488**	**133,687**
Cash and cash equivalents at 31 March	26	**14,606**	**67,741**	**9,502**	**60,488**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

The accounting policies being followed for 2025/26 are unchanged from 2024/25, except for the adoption of IFRS 17 (Insurance Contracts) which has not had an impact on the Trust.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of land, property and investments by reference to their most recent valuations. Plant, equipment, intangible assets, inventories and certain financial assets and financial liabilities are held at depreciated historic cost The Accounts are presented rounded to the nearest thousand pounds.

Going concern
After making enquiries, the Directors have a reasonable expectation that the Trust and the Group have adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the Going Concern basis in preparing these Accounts.

The Trust has robust processes relating to the management of cashflow and liquidity and has included in the financial plans for 2026/27 prepared for Board and NHSE a cashflow which demonstrates sufficient cash balances for twelve months from the date of signing the accounts. These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.2 Consolidation

NHS Charitable Fund
The Trust is the Corporate Trustee to Manchester University NHS Foundation Trust Charity (MFT Charity). The MFT Charity is a charity registered (No.1049274) with the independent regulator, the Charity Commission, to whom it is accountable. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund’s statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity’s assets, liabilities and transactions as follows:

- The Charity's individual statements and notes to the Accounts are adjusted for one difference in accounting policy. This relates to expenditure accounted for on a commitment basis which is not permitted under the Trust's and the Group's accounting conventions.

- The Charity's individual statements and notes to the Accounts are adjusted in respect of transactions and balances which have taken place between the Trust and the Charity. These intra company balances and transactions are eliminated on consolidation and the resulting figures for Income and Expenditure; gains and losses; assets and liabilities; reserves; and cash flows, are then consolidated with those of the Trust, to form the Group Accounts. The classification of the investments follows the accounting standard IFRS 9 and they are classified as designated at fair value through Other Comprehensive Income instruments.

The MFT Charity's latest audited accounts, which have been prepared in accordance with the UK Charities Statement of Recommended Practice (SORP), can be obtained from the Charity Commission website. Accounts for the financial year ending 31 March 2026 will be prepared by the Charity and will be submitted to the Charity Commission.

The MFT Charity is based at the following address:-
Cobbett House, Oxford Road, Manchester, M13 9WL

As a subsidiary of the Trust, the Charity is able to grant funds to the Trust, providing that this funding is over and above what the NHS would normally provide and is in line with the objectives of the Charity.

The MFT Charity is the Trust's sole subsidiary.

The Primary Statements of the accounts disclose both Group and Trust values separately. In the notes to the accounts the Group results are presented alone where the difference between the Group and Trust values are considered to be immaterial. Further details of the Charity position and results and their impact on the Group financial statements are set out in notes 37 and 38.

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust’s entitlement to consideration for those goods or services is unconditional, a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a

contract asset will be recognised to the extent that the further condition has been met at the balance sheet date. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability in note 5.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under this scheme is part of how care is provided to patients. As such, BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with no adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases, it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue

each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Other forms of income

Sale of Non-Current Assets
Income from the sale of Non-Current Assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

Grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust’s apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments, such as social security costs and the apprenticeship levy, are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share

of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Insurance Contracts (Trust as the Insurer)

An insurance contract is a contract under which the Trust has accepted significant pre-existing insurance risk from the policyholder by agreeing to compensate the policyholder if a specified uncertain future event adversely affects the policyholder.

IFRS 17 is effective from 2025/26 for the insurer accounting for such contracts. The standard is applied retrospectively with a transition date of 1 April 2024, restating prior periods as appropriate.

The Trust carried out a review process during 2025/26 to check the contracts held and identify any insurance contracts held within these contracts.

The Trust is content that there are no contracts held which contain insurance contracts as described in IFRS 17.

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly

different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front-line services or back-office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature that no active market exists from which to draw satisfactory transactional evidence. In this case, a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis. A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust's Private Finance Initiative (PFI) scheme where the construction is completed by the Trust's PFI partners and the VAT costs are recoverable by the trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or loss of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or loss of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued,

except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury’s *FReM*, are accounted for as ‘on-Statement of Financial Position’ by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury’s *FReM*, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

	Minimum life	Maximum life
	Years	Years
Buildings, excluding dwellings	6	90
Plant & machinery	5	25
Transport equipment	6	10
Information technology	3	10
Furniture & fittings	3	10

Note 1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance that are controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this recoverable amount is lower than the carrying value, an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

	Minimum life	**Maximum life**
	Years	**Years**
Intangible assets - internally generated		
Information technology	3	15
Development expenditure	3	7
Intangible assets - purchased		
Software	3	15

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value, with the exception of:
a) Pharmacy inventories - these are valued at average cost, and
b) Inventories recorded and controlled via the materials management system, these are valued at current cost.
This is considered to be a reasonable approximation to net realisable value due to the high turnover of stocks.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and, as a result, has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and is recognised in the Statement of Comprehensive Income as financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through Other Comprehensive Income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in Other Comprehensive Income except for the extent to which they represent impairment losses. On derecognition, cumulative gains

and losses previously recognised in Other Comprehensive Income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

The Trust has designated the equity investments that are held by the Charity as financial assets held at fair value through Other Comprehensive Income.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract, are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive Income.

The Trust holds equity investments as financial assets measured at fair value through profit and loss. For those investments that are quoted, the fair value of the equity investment is the share price at the balance sheet date.

Impairment of financial assets

For all financial assets measured at amortised cost, including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset’s gross carrying amount and the present value of estimated future cash flows discounted at the financial asset’s original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as lessee

Initial recognition and measurement

At the commencement date of the lease, being the date when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. As such, a nominal rate of 4.81% has been applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by the HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising, which is also charged to expenditure as a finance cost, and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (2024/25: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 30.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets but are disclosed in note 31 to the extent that an inflow of economic benefits is probable.

Contingent liabilities are not recognised but are disclosed in note 31. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as a public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Occasionally, specific Capital Expenditure can be funded by additional PDC being issued to the Trust. During the period ended 31 March 2026, the Trust has received £67.0m comprising £50.0m Buildings, £16.1m Medical Equipment and £0.9m IT (period ended 31 March 2025: £39.6m comprising £37.1m Buildings, £1.7m Medical Equipment and £0.8m IT).

Note 1.16 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Corporation tax

Under s519A ICTA 1988 Manchester University NHS Foundation Trust is regarded as a Health Service body and is therefore exempt from taxation on its Income and Capital Gains. Section 148 of the 2004 Finance Act provided the Treasury with powers to disapply this exemption. Accordingly, the Trust and the Group are potentially within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits exceed £50,000 per annum.

Activities such as staff and patient car parking and sales of food are considered to be ancillary to the core healthcare objectives of the Trust and the Group (and not entrepreneurial) and therefore are not subject to Corporation Tax.

Note 1.18 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.19 Foreign exchange

The functional and presentational currency of the Trust is sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Note 1.20 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.22 Transfers of functions to / from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss or gain corresponding to the net assets or liabilities transferred is recognised as Non-Operating Expenses or Income and was titled a Gain or Loss from Transfer by Absorption.. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and

future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £826m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a ‘modern equivalent asset’. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an ‘alternative site’ assumption for its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore, the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £826m on 31 March 2026.

Note 1.25 Critical judgements in applying accounting policies

In the application of the Trust’s and the Group's Accounting Policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities, and for other areas, where precise information is not readily apparent from any source. The estimates and associated assumptions are based on historical experience and other factors which are considered to be relevant. Actual results may differ from those estimates, and the estimates and underlying assumptions are continually reviewed and updated. Revisions to accounting estimates are recognised in the period in which the estimate is revised, if the revision affects only that period, or in future periods, as well as that of the revision, if required.

The specific judgements involving estimations that management has made in the process of applying the Trust’s accounting policies and that have the most significant effect on the amounts recognised in the financial statements is set out below.

Note 1.26 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Valuation of Land and Buildings

The valuation of the Trust's land and buildings is subject to estimation uncertainty. Independent valuers provided advice on valuations, as at 31 March 2026, of the Trust's and the Group's land and building assets (estimated financial value and estimated remaining useful life), applying a Modern Equivalent Asset method of valuation for an optimised building and alternate site with regards to land. This is based on a theoretical configuration of facilities on the Trust main hospital sites, providing a more efficient and compact design.

The valuation exercise was carried out in March 2026 with a valuation date of 31 March 2026, applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards and RICS UK National Supplement (‘Red Book’).

The Trust considers that, in line with the GAM, this is an appropriate basis. More detail of the full valuation and the carrying amounts of the Trust's Land and Buildings is included in note 16. An additional increase of 1% in the land and building net book value of £826m would result in a revised net book value of £834m and an increase of 5% would result in a revised net book value of £867m.

Note 2 Operating Segments

Under IFRS 8, the Trust and the Group are required to disclose financial information across significant Operating Segments, which reflect the way the management runs the organisation. A significant segment is one which:-

i) Represents 10% or more of the income or expenditure of the entity; or

ii) Has a surplus or deficit which is 10% or more of the greater, in absolute amount, of the combined surplus of all segments reporting a surplus, or the combined deficit of all segments reporting a deficit; or

iii) Has assets of 10% or more of the combined assets of all Operating Segments.

Significant central management and support services underpin all Trust activities, and the majority of activities are similar in nature. Research and Training (both less than 10% of turnover) similarly support the Trust's activities (with Training being integral to the provision of healthcare). The Trust therefore considers itself to operate with one segment, being the provision of healthcare services. This view is further supported by the fact that routine Finance Reports are presented to the Board on a Trust-wide basis, analysed by Pay, Non-Pay and Capital.

With regard to the Trust's subsidiary, the Manchester University NHS Foundation Trust Charity, for Group Accounting purposes the charity is considered to be a separate operating segment. The financial results of the Charity are separately disclosed in Notes 37 and 38 to these financial statements.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.

Note 3.1 Income from patient care activities (by nature)	2025/26 £000	2024/25 £000
Acute services		
Income from commissioners under API contracts - variable element*	544,287	468,690
Income from commissioners under API contracts - fixed element*	1,704,561	1,662,664
High cost drugs income from commissioners	329,096	301,274
Other NHS clinical income	14,493	20,912
Community services		
Income from commissioners under API contracts*	157,822	151,925
Income from other sources (e.g. local authorities)	45,644	45,236
All services		
Private patient income	1,992	1,911
National pay award central funding***	-	6,180
Additional pension contribution central funding**	106,986	101,284
Other clinical income****	10,078	7,873
Total income from activities	**2,914,959**	**2,767,949**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

****This includes injury cost recovery scheme and overseas patient income.

Commissioner Requested Services

The Trust is required by its Commissioners to provide services which ensure service users have continued access to vital NHS services, known as Commissioner Requested Services (CRS). CRS in the 12 months to date in 2025/26 amounted to £2.796 billion or 96% of Income from Activities (2024/2025: £2.657 billion and 96%). CRS is arrived at by excluding Private Patient Income and Other Clinical Income from Total Income Received from Activities.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2025/26 £000	2024/25 £000
NHS England	574,223	624,585
Integrated care boards	2,268,529	2,067,431
Other NHS providers	2,929	5,328
Local authorities	45,644	45,236
Non-NHS: private patients	1,992	1,911
Non-NHS: overseas patients (chargeable to patient)	4,549	2,262
Injury cost recovery scheme	5,529	5,611
Non NHS: other	11,564	15,585
Total income from activities	**2,914,959**	**2,767,949**
Of which:		
Related to continuing operations	2,914,959	2,767,949
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26	2024/25
	£000	£000
Income recognised this year	4,549	2,262
Cash payments received in-year	766	674
Amounts added to provision for impairment of receivables	2,200	357
Amounts written off in-year	2,038	166

Note 4 Other operating income (Group)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	112,561	-	**112,561**	98,776	-	**98,776**
Education and training	114,518	3,963	**118,481**	110,286	3,386	**113,672**
Non-patient care services to other bodies	40,226	-	**40,226**	40,276	-	**40,276**
Receipt of capital grants and donations and peppercorn leases	-	16,747	**16,747**	-	4,413	**4,413**
Charitable and other contributions to expenditure	-	420	**420**	-	492	**492**
Revenue from operating leases	-	6,352	**6,352**	-	1,772	**1,772**
Charitable fund incoming resources	-	4,529	**4,529**	-	3,382	**3,382**
Other income	70,331	-	**70,331**	68,499	-	**68,499**
Total other operating income	**337,636**	**32,011**	**369,647**	**317,837**	**13,445**	**331,282**
Of which:						
Related to continuing operations			369,647			331,282
Related to discontinued operations			-			-

Other Income (Group)	2025/26 £000	2024/25 £000
PFI support income	2,748	5,330
Other Income (a)	53,134	47,760
Clinical Excellence Awards	4,231	4,279
Car Parking	6,908	6,789
Staff accommodation rental	393	387
Non-clinical services recharged to other bodies	303	82
Crèche Services	1,362	1,047
Clinical Tests	230	849
Catering	749	1,588
Pharmacy Sales	273	388
Total Other Income	**70,331**	**68,499**

(a) In 2025/26 Other income includes £16.0m salary recharges (incl medical staffing) , £13.4m capital charge support, £6.0m income generation schemes, £6.0m other operation income including SLAs, £4.0m Council funding, and £7.5m other rental income . For 2024/25 Other income includes £16.8m salary recharges, £4.3m fire insurance claim, £7.4m capital charge support and £7.1m other rental income.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	29,338	33,744
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2026	31 March 2025
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
within one year	25,728	29,338
after one year, not later than five years	-	3,912
after five years	-	-
Total revenue allocated to remaining performance obligations	**25,728**	**33,250**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from
(i) contracts with an expected duration of one year or less and
(ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6 Operating leases - Manchester University NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where Manchester University NHS Foundation Trust is the lessor.

Lease income represents amounts paid by Greater Manchester Mental Health NHS Foundation Trust in relation to their occupancy of the mental health block at Wythenshawe Hospital

Note 6.1 Operating leases income (Group)

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	-	-
Variable lease receipts / contingent rents	6,352	1,772
Total in-year operating lease income	**6,352**	**1,772**

Note 6.2 Future lease receipts (Group)

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	6,651	1,832
- later than one year and not later than two years	6,818	1,878
- later than two years and not later than three years	6,988	1,925
- later than three years and not later than four years	7,163	1,973
- later than four years and not later than five years	7,342	2,023
- later than five years	23,146	7,202
Total	**58,108**	**16,833**

Note 7.1 Operating expenses (Group)

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	27,008	27,720
Purchase of healthcare from non-NHS and non-DHSC bodies	51,614	46,324
Staff and executive directors costs (a)	1,974,974	1,854,743
Remuneration of non-executive directors	287	276
Supplies and services - clinical (excluding drugs costs)	321,235	308,208
Supplies and services - general	10,883	16,115
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	331,101	304,639
Inventories written down	132	-
Consultancy costs	2,618	2,251
Establishment	17,442	18,785
Premises (e)	71,655	57,371
Transport (including patient travel)	8,573	9,970
Depreciation on property, plant and equipment	64,742	64,343
Amortisation on intangible assets	3,409	2,562
Net impairments	103,999	35,039
Movement in credit loss allowance: contract receivables / contract assets	(176)	415
Change in provisions discount rate(s)	(229)	24
Fees payable to the external auditor (b):		
audit services- statutory audit	691	690
other auditor remuneration (external auditor only)	47	201
Internal audit costs	498	259
Clinical negligence	67,755	58,133
Legal fees	2,272	2,308
Insurance (as a policy holder)	701	1,190
Research and development (c)	109,991	98,711
Education and training	11,329	10,829
Expenditure on short term leases (e)	490	386
Expenditure on low value leases (e)	99	30
Redundancy	1,456	1,020
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (PFI)	77,014	80,154
Car parking & security	4,477	7,492
Hospitality	367	62
Losses, ex gratia & special payments	12	-
Other NHS charitable fund resources expended	3,693	4,747
Other (d)	42,951	52,899
Total	**3,313,110**	**3,067,896**
Of which:		
Related to continuing operations	3,313,110	3,067,896
Related to discontinued operations	-	-

Explanatory Notes

a) Further details for pay expenditure are included in Note 9.

b) Fees payable to the external auditor are payments for Statutory Audit services and other auditor renumeration in relation to Local Counter Fraud Services, and are set out in more detail in Note 7.2

c) Research and development includes £46.4m staff costs (£43.8m in 2024/25)

d) In 2025/26 other costs include £28.7m computer software and £15.2m professional fees. In 2024/25 Other costs include £32.6m computer software, £12.4m professional fees and £4.3m license fees.

e) In 2025/26 £11.6m irrecoverable VAT on lease expenditure has been included in Premises costs. In 2024/25 the equivalent cost of £7.9m was included within lease expenditure.

Note 7.2 Other auditor remuneration (Group)

	2025/26	2024/25
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	47	201
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**47**	**201**

Grant Thornton UK LLP have been the appointed external auditors for the Trust and the Group for the 2025/26 financial year. The contract commenced in December 2024, on a three year contract with the option to extend for two further 12 month periods. Forvis Mazars LLP are the appointed external auditors for the Charity.

In 2025/2026, there were no services provided by the external auditors, Grant Thornton UK LLP, other than £6k in relation to legacy cases in relation to their previous appointment as the Trust's counter fraud advisors and £41k in relation to assurance work for a number of grant claims. This appointment ended on 31st March 2025. The non audit fees incurred in 2024/25 related to counter fraud advice provided as the incumbent counter fraud advisors and assurance work in relation to a number of grant claims.

The cost of auditing the Annual Accounts is shown under the heading of 'Fees payable to the external auditor audit services- statutory audit' in Note 7.1. This charge is inclusive of VAT.

Note 7.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £3,000k (2024/25: £3,000k).

Note 8 Impairment of assets (Group)

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price (a)	103,999	35,039
Total net impairments charged to operating surplus / deficit	**103,999**	**35,039**
Impairments charged to the revaluation reserve	26,674	15,173
Total net impairments	**130,673**	**50,212**

Explanatory Notes

(a) Further analysis of impairments due to changes in market price is given below:

Not adding to service potential	96,530	44,899
Reversal of previous downward valuations	(869)	(11,188)
Other Changes in market price	8,338	1,328
	103,999	35,039

Note 9 Employee benefits (Group)

	2025/26	2024/25 (restated)
	Total	Total
	£000	£000
Salaries and wages	1,475,313	1,385,372
Social security costs	169,204	128,417
Apprenticeship levy	6,627	6,324
Employer's contributions to NHS pensions	268,245	254,420
Temporary staff (including agency)	113,307	127,583
Total gross staff costs	**2,032,696**	**1,902,116**
Of which		
Costs capitalised as part of assets	9,864	2,569

This note does not include the remuneration for non-executive directors.

Explanatory Note

a.) Social security costs have been restated in year to reflect recoveries made by the Trust for Statutory Benefits funded by the Government, predominantly statutory maternity pay. These recoveries were previously disclosed as salaries and wages.
The impact of this has been to decrease social security costs by £9.2m in 2025/26, and by £8.4m in the 2024/25 comparative year. Salaries and wages have increased by a corresponding amount in both years.

Note 9.1 Retirements due to ill-health (Group)

During 2025/26 there were 17 early retirements from the trust agreed on the grounds of ill-health (25 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £1,453k (£2,189k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".
An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027

Note 11 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	5,722	8,884
Interest income on finance leases	20	20
NHS charitable fund investment income	425	697
Total finance income	**6,167**	**9,601**

Note 12.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	2,105	2,368
Interest on other loans	10	17
Interest on lease obligations	2,285	1,802
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	32,892	33,071
Remeasurement of the liability resulting from change in index or rate	18,356	24,208
Total interest expense	**55,648**	**61,466**
Unwinding of discount on provisions	174	178
Total finance costs	**55,822**	**61,644**

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses) (Group)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	265	139
Gains / losses on disposal of charitable fund assets	4	644
Total gains / (losses) on disposal of assets	**269**	**783**
Fair value gains / (losses) on financial assets / investments	1,613	-
Total other gains / (losses)	**1,882**	**783**

Note 14.1 Intangible assets - 2025/26

Group	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**14,678**	**2,540**	**17,219**
Additions	8	-	**8**
Reclassifications	2,951	(2,291)	**660**
Cost at 31 March 2026	**17,637**	**249**	**17,886**
Amortisation at 1 April 2025 - brought forward	**6,874**	**-**	**6,874**
Provided during the year	3,409	-	**3,409**
Impairments	-	249	**249**
Amortisation at 31 March 2026	**10,283**	**249**	**10,532**
Net book value at 31 March 2026	**7,354**	**-**	**7,354**
Net book value at 1 April 2025	**7,804**	**2,540**	**10,345**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 14.2 Intangible assets - 2024/25

Group	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**15,071**	**1,564**	**16,636**
Additions	-	1,315	**1,315**
Impairments	-	(139)	**(139)**
Reclassifications	(393)	(200)	**(593)**
Valuation / gross cost at 31 March 2025	**14,678**	**2,540**	**17,219**
Amortisation at 1 April 2024 - as previously stated	**4,312**	**-**	**4,312**
Provided during the year	2,562	-	**2,562**
Amortisation at 31 March 2025	**6,874**	**-**	**6,874**
Net book value at 31 March 2025	**7,804**	**2,540**	**10,345**
Net book value at 1 April 2024	**10,759**	**1,564**	**12,324**

Note 15.1 Intangible assets - 2025/26

Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**14,678**	**2,540**	**17,219**
Additions	8	-	**8**
Reclassifications	2,951	(2,291)	**660**
Cost at 31 March 2026	**17,637**	**249**	**17,886**
Amortisation at 1 April 2025 - brought forward	**6,874**	**-**	**6,874**
Provided during the year	3,409	-	**3,409**
Impairments	-	249	**249**
Amortisation at 31 March 2026	**10,283**	**249**	**10,532**
Net book value at 31 March 2026	**7,354**	**-**	**7,354**
Net book value at 1 April 2025	**7,804**	**2,540**	**10,345**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 15.2 Intangible assets - 2024/25

Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**15,071**	**1,564**	**16,636**
Additions	-	1,315	**1,315**
Impairments	-	(139)	**(139)**
Reclassifications	(393)	(200)	**(593)**
Valuation / gross cost at 31 March 2025	**14,678**	**2,540**	**17,219**
Amortisation at 1 April 2024 - as previously stated	**4,312**	**-**	**4,312**
Provided during the year	2,562	-	**2,562**
Amortisation at 31 March 2025	**6,874**	**-**	**6,874**
Net book value at 31 March 2025	**7,804**	**2,540**	**10,345**
Net book value at 1 April 2024	**10,759**	**1,564**	**12,324**

Note 16.1 Property, plant and equipment - 2025/26

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**21,338**	**774,489**	**57,396**	**128,643**	**239**	**70,060**	**1,218**	**127**	**1,053,510**
Additions	-	-	163,010	1,386	-	-	-	-	**164,396**
Impairments	-	(123,204)	-	(2,515)	-	(5,574)	-	-	**(131,293)**
Reversals of impairments	-	869	-	-	-	-	-	-	**869**
Revaluations	40	19,909	-	-	-	-	-	-	**19,949**
Reclassifications	-	133,047	(154,016)	9,849	-	10,258	202	-	**(660)**
Disposals / derecognition	-	-	-	(2,052)	-	-	-	-	**(2,052)**
Valuation/gross cost at 31 March 2026	**21,378**	**805,110**	**66,390**	**135,311**	**239**	**74,744**	**1,420**	**127**	**1,104,719**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**-**	**-**	**70,414**	**105**	**41,816**	**1,011**	**91**	**113,437**
Provided during the year	-	25,183	-	15,997	22	10,805	125	7	**52,139**
Revaluations	-	(25,183)	-	-	-	-	-	-	**(25,183)**
Disposals / derecognition	-	-	-	(2,052)	-	-	-	-	**(2,052)**
Accumulated depreciation at 31 March 2026	**-**	**-**	**-**	**84,359**	**127**	**52,621**	**1,136**	**98**	**138,341**
Net book value at 31 March 2026	**21,378**	**805,110**	**66,390**	**50,952**	**112**	**22,123**	**285**	**29**	**966,379**
Net book value at 1 April 2025	**21,338**	**774,489**	**57,396**	**58,229**	**134**	**28,244**	**208**	**36**	**940,073**

The Trust's Land and Buildings were revalued by the District Valuer in the year ending 31 March 2026. The above figures are as per the valuation dated 31 March 2026 which applied the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2017 ('Red Book').

Of the £826m net book value of land and buildings subject to valuation, £805m relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets.

£131m of impairment losses have been recognised, £123m relates to buildings where the capital expenditure incurred is not deemed to result in an increase in the service potential and therefore carrying value of the building. A reversal of previous downward revaluations previously recognised in expenditure totalling £1m has been recognised on those assets that have increased in value following the revaluation by the District Valuer as at 31 March 2026. Of these impairments, £27m has been taken to the revaluation reserve for impairment of assets where there has been a downward movement of assets per the valuation report and there is a corresponding revaluation reserve balance for that asset. The remaining balance of £104m has been recognised in the Statement of Comprehensive Income as operating expenditure. The 2025/26 Impairment charge of £123m shown under Buildings excluding dwellings includes £16m of impairment costs related to Assets under construction.

Note 16.2 Property, plant and equipment - 2024/25

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**19,933**	**760,247**	**51,690**	**115,672**	**239**	**70,577**	**1,218**	**127**	**1,019,703**
Additions	-	-	97,987	1,625	-	34	-	-	**99,646**
Impairments	(81)	(60,072)	-	(138)	-	(970)	-	-	**(61,261)**
Reversals of impairments	-	11,188	-	-	-	-	-	-	**11,188**
Revaluations	689	(16,174)	-	-	-	-	-	-	**(15,485)**
Reclassifications	797	79,300	(92,281)	12,358	-	419	-	-	**593**
Disposals / derecognition	-	-	-	(874)	-	-	-	-	**(874)**
Valuation/gross cost at 31 March 2025	**21,338**	**774,489**	**57,396**	**128,643**	**239**	**70,060**	**1,218**	**127**	**1,053,510**
Accumulated depreciation at 1 April 2024 - as previously stated	**-**	**-**	**-**	**55,445**	**83**	**30,137**	**882**	**84**	**86,631**
Provided during the year	-	24,878	-	15,843	22	11,679	129	7	**52,558**
Revaluations	-	(24,878)	-	-	-	-	-	-	**(24,878)**
Disposals / derecognition	-	-	-	(874)	-	-	-	-	**(874)**
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**	**70,414**	**105**	**41,816**	**1,011**	**91**	**113,437**
Net book value at 31 March 2025	**21,338**	**774,489**	**57,396**	**58,229**	**134**	**28,244**	**208**	**36**	**940,073**
Net book value at 1 April 2024	**19,933**	**760,247**	**51,690**	**60,227**	**156**	**40,440**	**337**	**43**	**933,072**

The Trust's Land and Buildings were revalued by the District Valuer in the year ending 31 March 2025. The above figures are as per the valuation dated 31 March 2025 which applied the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2017 ('Red Book').

Of the £796m net book value of land and buildings subject to valuation, £774m relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets.

£61m of impairment losses have been recognised, £60m relates to buildings where the capital expenditure incurred is not deemed to result in an increase in the service potential and therefore carrying value of the building. A reversal of previous downward revaluations previously recognised in expenditure totalling £11m has been recognised on those assets that have increased in value following the revaluation by the District Valuer as at 31 March 2025

Note 16.3 Property, plant and equipment financing - 31 March 2026

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	21,311	400,263	66,390	45,688	112	21,948	269	29	**556,010**
On-SoFP PFI contracts and other service concession arrangements	-	394,491	-	-	-	-	-	-	**394,491**
Owned - donated/granted	67	10,356	-	5,264	-	175	16	-	**15,878**
NBV total at 31 March 2026	**21,378**	**805,110**	**66,390**	**50,952**	**112**	**22,123**	**285**	**29**	**966,379**

Note 16.4 Property, plant and equipment financing - 31 March 2025

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	21,271	376,566	57,396	53,049	134	28,009	166	36	**536,626**
On-SoFP PFI contracts and other service concession arrangements	-	385,892	-	-	-	-	-	-	**385,892**
Owned - donated/granted	67	12,031	-	5,180	-	235	42	-	**17,555**
NBV total at 31 March 2025	**21,338**	**774,489**	**57,396**	**58,229**	**134**	**28,244**	**208**	**36**	**940,073**

Note 16.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	8,679	-	-	-	-	-	-	**8,679**
Not subject to an operating lease	21,378	796,431	66,390	50,952	112	22,123	285	29	**957,700**
NBV total at 31 March 2026	**21,378**	**805,110**	**66,390**	**50,952**	**112**	**22,123**	**285**	**29**	**966,379**

Note 16.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	8,440	-	-	-	-	-	-	**8,440**
Not subject to an operating lease	21,338	766,049	57,396	58,229	134	28,244	208	36	**931,633**
NBV total at 31 March 2025	**21,338**	**774,489**	**57,396**	**58,229**	**134**	**28,244**	**208**	**36**	**940,073**

Note 17.1 Property, plant and equipment - 2025/26

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**21,338**	**774,489**	**57,396**	**128,643**	**239**	**70,060**	**1,218**	**1,053,383**
Additions	-	-	163,010	1,386	-	-	-	**164,396**
Impairments	-	(123,204)	-	(2,515)	-	(5,574)	-	**(131,293)**
Reversals of impairments	-	869	-	-	-	-	-	**869**
Revaluations	40	19,909	-	-	-	-	-	**19,949**
Reclassifications	-	133,047	(154,016)	9,849	-	10,258	202	**(660)**
Disposals / derecognition	-	-	-	(2,052)	-	-	-	**(2,052)**
Valuation/gross cost at 31 March 2026	**21,378**	**805,110**	**66,390**	**135,311**	**239**	**74,744**	**1,420**	**1,104,592**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**-**	**-**	**70,414**	**105**	**41,816**	**1,011**	**113,346**
Provided during the year	-	25,183	-	15,997	22	10,805	125	**52,132**
Revaluations	-	(25,183)	-	-	-	-	-	**(25,183)**
Disposals / derecognition	-	-	-	(2,052)	-	-	-	**(2,052)**
Accumulated depreciation at 31 March 2026	**-**	**-**	**-**	**84,359**	**127**	**52,621**	**1,136**	**138,243**
Net book value at 31 March 2026	**21,378**	**805,110**	**66,390**	**50,952**	**112**	**22,123**	**285**	**966,350**
Net book value at 1 April 2025	**21,338**	**774,489**	**57,396**	**58,229**	**134**	**28,244**	**208**	**940,037**

The Trust's Land and Buildings were revalued by the District Valuer in the year ending 31 March 2026. The above figures are as per the valuation dated 31 March 2026 which applied the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2017 ('Red Book').

Of the £826m net book value of land and buildings subject to valuation, £805m relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets.

£131m of impairment losses have been recognised, £123m relates to buildings where the capital expenditure incurred is not deemed to result in an increase in the service potential and therefore carrying value of the building. A reversal of previous downward revaluations previously recognised in expenditure totalling £1m has been recognised on those assets that have increased in value following the revaluation by the District Valuer as at 31 March 2026. Of these impairments, £27m has been taken to the revaluation reserve for impairment of assets where there has been a downward movement of assets per the valuation report and there is a corresponding revaluation reserve balance for that asset. The remaining balance of £104m has been recognised in the Statement of Comprehensive Income as operating expenditure.

Note 17.2 Property, plant and equipment - 2024/25

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**19,933**	**760,247**	**51,690**	**115,672**	**239**	**70,577**	**1,218**	**1,019,576**
Additions	-	-	97,987	1,625	-	34	-	**99,646**
Impairments	(81)	(60,072)	-	(138)	-	(970)	-	**(61,261)**
Reversals of impairments	-	11,188	-	-	-	-	-	**11,188**
Revaluations	689	(16,174)	-	-	-	-	-	**(15,485)**
Reclassifications	797	79,300	(92,281)	12,358	-	419	-	**593**
Disposals / derecognition	-	-	-	(874)	-	-	-	**(874)**
Valuation/gross cost at 31 March 2025	**21,338**	**774,489**	**57,396**	**128,643**	**239**	**70,060**	**1,218**	**1,053,383**
Accumulated depreciation at 1 April 2024 - as previously stated	**-**	**-**	**-**	**55,445**	**83**	**30,137**	**882**	**86,547**
Provided during the year	-	24,878	-	15,843	22	11,679	129	**52,551**
Revaluations	-	(24,878)	-	-	-	-	-	**(24,878)**
Disposals / derecognition	-	-	-	(874)	-	-	-	**(874)**
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**	**70,414**	**105**	**41,816**	**1,011**	**113,346**
Net book value at 31 March 2025	**21,338**	**774,489**	**57,396**	**58,229**	**134**	**28,244**	**208**	**940,037**
Net book value at 1 April 2024	**19,933**	**760,247**	**51,690**	**60,227**	**156**	**40,440**	**337**	**933,029**

The Trust's Land and Buildings were revalued by the District Valuer in the year ending 31 March 2025. The above figures are as per the valuation dated 31 March 2025 which applied the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2017 ('Red Book').

Of the £796m net book value of land and buildings subject to valuation, £774m relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets.

£61m of impairment losses have been recognised, £60m relates to buildings where the capital expenditure incurred is not deemed to result in an increase in the service potential and therefore carrying value of the building. A reversal of previous downward revaluations previously recognised in expenditure totalling £11m has been recognised on those assets that have increased in value following the revaluation by the District Valuer as at 31 March 2025

Note 17.3 Property, plant and equipment financing - 31 March 2026

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	21,311	400,263	66,390	45,688	112	21,948	269	**555,981**
On-SoFP PFI contracts and other service concession arrangements	-	394,491	-	-	-	-	-	**394,491**
Owned - donated / granted	67	10,356	-	5,264	-	175	16	**15,878**
Total net book value at 31 March 2026	**21,378**	**805,110**	**66,390**	**50,952**	**112**	**22,123**	**285**	**966,350**

Note 17.4 Property, plant and equipment financing - 31 March 2025

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	21,271	376,566	57,396	53,049	134	28,009	166	**536,590**
On-SoFP PFI contracts and other service concession arrangements	-	385,892	-	-	-	-	-	**385,892**
Owned - donated / granted	67	12,031	-	5,180	-	235	42	**17,555**
Total net book value at 31 March 2025	**21,338**	**774,489**	**57,396**	**58,229**	**134**	**28,244**	**208**	**940,037**

Note 17.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	8,679	-	-	-	-	-	**8,679**
Not subject to an operating lease	21,378	796,431	66,390	50,952	112	22,123	285	**957,671**
Total net book value at 31 March 2026	**21,378**	**805,110**	**66,390**	**50,952**	**112**	**22,123**	**285**	**966,350**

Note 17.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	8,440	-	-	-	-	-	**8,440**
Not subject to an operating lease	21,338	766,049	57,396	58,229	134	28,244	208	**931,597**
Total net book value at 31 March 2025	**21,338**	**774,489**	**57,396**	**58,229**	**134**	**28,244**	**208**	**940,037**

Note 18 Revaluations of property, plant and equipment

	2025/26 Trust and Group £000	2024/25 Trust and Group £000
Revaluation Reserve at the beginning of the year	172,102	177,882
Transfer by absorption	-	-
Net Impairments charged against the revaluation reseve	(26,674)	(15,173)
Revaluations	45,132	9,393
Other reserve movements	(1)	-
Revaluation Reserve at the end of the period	**190,559**	**172,102**

During 2025/26, a full valuation exercise was completed by the District Valuer with a valuation date of 31 March 2026.

Note 19.1 Right of use assets - 2025/26

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**131,321**	**36,466**	**285**	**168,072**	**56,158**
Additions	9,360	4,812	-	**14,172**	5,907
Remeasurements of the lease liability	(6,728)	-	-	**(6,728)**	(7,051)
Movements in provisions for restoration / removal costs	965	-	-	**965**	500
Disposals / derecognition	(19,471)	-	-	**(19,471)**	(6,754)
Valuation/gross cost at 31 March 2026	**115,447**	**41,278**	**285**	**157,010**	**48,760**
Accumulated depreciation at 1 April 2025 - brought forward	**19,449**	**11,583**	**208**	**31,240**	**8,259**
Provided during the year	7,734	4,805	64	**12,603**	3,674
Disposals / derecognition	(3,030)	-	-	**(3,030)**	(775)
Accumulated depreciation at 31 March 2026	**24,153**	**16,388**	**272**	**40,813**	**11,158**
Net book value at 31 March 2026	**91,294**	**24,890**	**13**	**116,197**	**37,602**
Net book value at 1 April 2025	**111,872**	**24,883**	**77**	**136,832**	**47,899**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	37,602

Note 19.2 Right of use assets - 2024/25

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**133,114**	**29,149**	**285**	**162,548**	**52,107**
Additions	5,758	7,317	-	**13,075**	1,014
Remeasurements of the lease liability	6,041	-	-	**6,041**	7,030
Movements in provisions for restoration / removal costs	122	-	-	**122**	-
Disposals / derecognition	(13,714)	-	-	**(13,714)**	(3,993)
Valuation/gross cost at 31 March 2025	**131,321**	**36,466**	**285**	**168,072**	**56,158**
Accumulated depreciation at 1 April 2024 - brought forward	**13,642**	**7,123**	**133**	**20,898**	**5,475**
Provided during the year	7,250	4,460	75	**11,785**	3,272
Disposals / derecognition	(1,443)	-	-	**(1,443)**	(488)
Accumulated depreciation at 31 March 2025	**19,449**	**11,583**	**208**	**31,240**	**8,259**
Net book value at 31 March 2025	**111,872**	**24,883**	**77**	**136,832**	**47,899**
Net book value at 1 April 2024	**119,472**	**22,026**	**152**	**141,650**	**46,632**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	47,899

Note 19.3 Right of use assets - 2025/26

Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**131,321**	**36,466**	**285**	**168,072**	**56,158**
Additions	9,360	4,812	-	**14,172**	5,907
Remeasurements of the lease liability	(6,728)	-	-	**(6,728)**	(7,051)
Movements in provisions for restoration / removal costs	965	-	-	**965**	500
Disposals / derecognition	(19,471)	-	-	**(19,471)**	(6,754)
Valuation/gross cost at 31 March 2026	**115,447**	**41,278**	**285**	**157,010**	**48,760**
Accumulated depreciation at 1 April 2025 - brought forward	19,449	11,583	208	**31,240**	**8,259**
Provided during the year	7,734	4,805	64	**12,603**	3,674
Disposals / derecognition	(3,030)	-	-	**(3,030)**	(775)
Accumulated depreciation at 31 March 2026	**24,153**	**16,388**	**272**	**40,813**	**11,158**
Net book value at 31 March 2026	**91,294**	**24,890**	**13**	**116,197**	**37,602**
Net book value at 1 April 2025	**111,872**	**24,883**	**77**	**136,832**	**47,899**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	37,602

Note 19.4 Right of use assets - 2024/25

Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**133,114**	**29,149**	**285**	**162,548**	**52,107**
Additions	5,758	7,317	-	**13,075**	1,014
Remeasurements of the lease liability	6,041	-	-	**6,041**	7,030
Movements in provisions for restoration / removal costs	122	-	-	**122**	-
Disposals / derecognition	(13,714)	-	-	**(13,714)**	(3,993)
Valuation/gross cost at 31 March 2025	**131,321**	**36,466**	**285**	**168,072**	**56,158**
Accumulated depreciation at 1 April 2024 - brought forward	**13,642**	**7,123**	**133**	**20,898**	**5,475**
Provided during the year	7,250	4,460	75	**11,785**	3,272
Disposals / derecognition	(1,443)	-	-	**(1,443)**	(488)
Accumulated depreciation at 31 March 2025	**19,449**	**11,583**	**208**	**31,240**	**8,259**
Net book value at 31 March 2025	**111,872**	**24,883**	**77**	**136,832**	**47,899**
Net book value at 1 April 2024	**119,472**	**22,026**	**152**	**141,650**	**46,632**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	47,899

Note 19.5 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 29.1.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April	**138,673**	**142,846**	**138,673**	**142,846**
Lease additions	14,172	13,075	14,172	13,075
Lease liability remeasurements	(6,728)	6,041	(6,728)	6,041
Interest charge arising in year	2,285	1,802	2,285	1,802
Early terminations	(16,706)	(12,410)	(16,706)	(12,410)
Lease payments (cash outflows)	(13,911)	(12,681)	(13,911)	(12,681)
Carrying value at 31 March	**117,785**	**138,673**	**117,785**	**138,673**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.
These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised in relation to on-SoFP lease liabilities are disclosed in the reconciliation above.

Note 19.6 Maturity analysis of future lease payments at 31 March 2026

	Group		Trust	
	Total 31 March 2026	Of which leased from DHSC group bodies: 31 March 2026	Total 31 March 2026	Of which leased from DHSC group bodies: 31 March 2026
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	14,035	3,927	14,035	3,927
- later than one year and not later than five years;	44,301	14,253	44,301	14,253
- later than five years.	77,879	26,010	77,879	26,010
Total gross future lease payments	**136,215**	**44,190**	**136,215**	**44,190**
Finance charges allocated to future periods	(18,430)	(6,271)	(18,430)	(6,271)
Net lease liabilities at 31 March 2026	**117,785**	**37,919**	**117,785**	**37,919**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		37,919		37,919

Note 19.7 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
	Total 31 March 2025	Of which leased from DHSC group bodies: 31 March 2025	Total 31 March 2025	Of which leased from DHSC group bodies: 31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	12,782	3,415	12,782	3,415
- later than one year and not later than five years;	41,983	13,544	41,983	13,544
- later than five years.	101,351	36,107	101,351	36,107
Total gross future lease payments	**156,116**	**53,066**	**156,116**	**53,066**
Finance charges allocated to future periods	(17,443)	(4,626)	(17,443)	(4,626)
Net finance lease liabilities at 31 March 2025	**138,673**	**48,440**	**138,673**	**48,440**
Of which:				
Leased from other NHS providers		3		3
Leased from other DHSC group bodies		48,437		48,437

Note 20 Other investments / financial assets (non-current)

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**14,250**	**21,279**	**806**	**806**
Acquisitions in year	16	52	-	-
Movement in fair value through income and expenditure	1,613	(225)	1,613	-
Movement in fair value through Other Comprehensive Income	363	-	-	-
Disposals	(32)	(6,856)	-	-
Carrying value at 31 March	**16,210**	**14,250**	**2,419**	**806**

The Trust reviews all investments on a regular basis to ensure the fair value is reported in the Statement of Financial Position.

Note 21 Analysis of charitable fund reserves

The reserves of Manchester University NHS Foundation Trust Charity have been consolidated within this set of accounts.

	31 March 2026	31 March 2025
	£000	£000
Unrestricted funds:		
Unrestricted income funds	3,685	4,703
Revaluation reserve	1,171	808
Restricted funds:		
Other restricted income funds	12,951	14,749
	17,807	**20,260**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 22 Inventories

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Drugs	7,945	10,059	7,945	10,059
Consumables	24,550	20,852	24,550	20,852
Energy	847	755	847	755
Total inventories	**33,342**	**31,666**	**33,342**	**31,666**
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £328,201k (2024/25: £304,421k). Write-down of inventories recognised as expenses for the year were £132k (2024/25: £0k).

Note 23.1 Receivables

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Contract receivables	122,581	157,725	123,437	158,251
Allowance for impaired contract receivables / assets	(6,426)	(8,887)	(6,426)	(8,887)
Prepayments (non-PFI)	26,051	32,508	26,051	32,508
VAT receivable	8,998	6,760	8,998	6,760
Other receivables	61	68	61	68
NHS charitable funds receivables	57	232	-	-
Total current receivables	**151,322**	**188,406**	**152,121**	**188,700**
Non-current				
Contract receivables	19,698	20,304	19,698	20,304
Allowance for impaired contract receivables / assets	(4,850)	(4,964)	(4,850)	(4,964)
Finance lease receivables	558	558	558	558
Other receivables - clinicians pension tax debtor (a)	2,609	2,793	2,609	2,793
Total non-current receivables	**18,015**	**18,691**	**18,015**	**18,691**
Of which receivable from NHS and DHSC group bodies:				
Current	54,316	103,927	54,316	103,927
Non-current	2,609	2,793	2,609	2,793

(a) This debtor has been created following guidance received from NHSE for future cost for tax on clinicians' pensions. This is to be funded by NHS England and has a matching provision included in note 30.

Note 23.2 Allowances for credit losses - 2025/26

	Group	Trust
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 Apr 2025 - brought forward	**13,851**	**13,851**
New allowances arising	-	-
Changes in existing allowances	(176)	(176)
Reversals of allowances	-	-
Utilisation of allowances (write offs)	(2,399)	(2,399)
Allowances as at 31 Mar 2026	**11,276**	**11,276**

Note 23.3 Allowances for credit losses - 2024/25

	Group	Trust
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 Apr 2024 - as previously stated	**13,841**	**13,841**
New allowances arising	-	-
Changes in existing allowances	415	415
Reversals of allowances	-	-
Utilisation of allowances (write offs)	(405)	(405)
Allowances as at 31 Mar 2025	**13,851**	**13,851**

Note 24 Finance leases (Manchester University NHS Foundation Trust as a lessor)

This note discloses future lease payments receivable from lease arrangements classified as finance leases where the Manchester University NHS Foundation Trust is the lessor.

The Trust has leased the land upon which the Citylabs 1.0 building has been built for a term of 175 years from 2014. Under that lease an annual ground rent is payable to the Trust.

Note 24.1 Reconciliation of the carrying value of finance lease receivables (net investment in the lease)

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Finance lease receivables at 1 April	**558**	**578**	**558**	**578**
Interest arising (unwinding of discount)	20	20	20	20
Lease receipts (cash payments received)	(20)	(40)	(20)	(40)
Finance lease receivables at 31 March	**558**	**558**	**558**	**558**

Note 24.2 Finance lease receivables maturity analysis as at 31 March 2026

	Group		Trust	
	Total	Of which leased to DHSC group bodies:	Total	Of which leased to DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2026	31 March 2026
	£000	£000	£000	£000
Undiscounted future lease receipts receivable in:				
not later than one year;	20	-	20	-
later than one year and not later than two years;	20	-	20	-
later than two years and not later than three years;	20	-	20	-
later than three years and not later than four years;	20	-	20	-
later than four years and not later than five years;	20	-	20	-
later than five years.	3,139	-	3,139	-
Total future finance lease payments to be received	**3,239**	**-**	**3,239**	**-**
Unearned interest income	(2,681)	-	(2,681)	-
Net investment in lease (net lease receivable)	**558**	**-**	**558**	**-**
of which:				
Leased to other NHS providers		-		-
Leased to other DHSC group bodies		-		-

Note 24.3 Finance lease receivables maturity analysis as at 31 March 2025

	Group		Trust	
	Total	Of which leased to DHSC group bodies:	Total	Of which leased to DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease receipts receivable in:				
not later than one year;	20	-	20	-
later than one year and not later than two years;	20	-	20	-
later than two years and not later than three years;	20	-	20	-
later than three years and not later than four years;	20	-	20	-
later than four years and not later than five years;	20	-	20	-
later than five years.	3,159	-	3,159	-
Total future finance lease payments to be received	**3,259**	**-**	**3,259**	**-**
Unearned interest income	(2,701)	-	(2,701)	-
Net investment in lease (net lease receivable)	**558**	**-**	**558**	**-**
of which:				
Leased to other NHS providers		-		-
Leased to other DHSC group bodies		-		-

Note 25 Non-current assets held for sale and assets in disposal groups

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	210	210	210	210
NBV of non-current assets for sale and assets in disposal groups at 31 March	210	210	210	210

Note 26.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	**67,741**	**137,006**	**60,488**	**133,687**
Net change in year	(53,135)	(69,265)	(50,986)	(73,199)
At 31 March	**14,606**	**67,741**	**9,502**	**60,488**
Broken down into:				
Cash at commercial banks and in hand	5,185	7,448	81	195
Cash with the Government Banking Service	9,367	60,293	9,367	60,293
Other current investments	54	-	54	-
Total cash and cash equivalents as in Statement of Financial Position	**14,606**	**67,741**	**9,502**	**60,488**
Total cash and cash equivalents as in Statement of Cash Flows	**14,606**	**67,741**	**9,502**	**60,488**

Note 26.2 Third party assets held by the trust

Manchester University NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2026	31 March 2025
	£000	£000
Bank balances	12	55
Total third party assets	**12**	**55**

Note 27.1 Trade and other payables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Trade payables	94,376	93,046	94,376	93,046
Capital payables	50,322	33,558	50,322	33,558
Accruals	108,589	185,720	108,589	185,720
Social security costs	21,118	15,884	21,118	15,884
VAT payables	-	-	-	-
Other taxes payable	20,122	17,984	20,122	17,984
PDC dividend payable	105	-	105	-
Pension contributions payable	22,955	21,810	22,955	21,810
Other payables	8,238	12,212	8,238	12,212
NHS charitable funds: trade and other payables	321	182	-	-
Total current trade and other payables	**326,146**	**380,396**	**325,825**	**380,214**
Total non-current trade and other payables	**-**	**-**	**-**	**-**
Of which payables from NHS and DHSC group bodies:				
Current	34,055	37,341	34,055	37,341
Non-current	-	-	-	-

(a) In 2025/26 Other payables include £5.4m relating to drug costs and £0.6m relating to temporary staff. In 2024/25 Other payables include £5.7m relating to drug costs, £1.8m relating to temporary staff and £1.2m relating to the University of Manchester.

Note 28 Other liabilities

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Deferred income: contract liabilities	25,728	29,338	25,728	29,338
Total other current liabilities	**25,728**	**29,338**	**25,728**	**29,338**
Non-current				
Deferred income: contract liabilities	-	3,912	-	3,912
Total other non-current liabilities	**-**	**3,912**	**-**	**3,912**

Note 29.1 Borrowings

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Loans from DHSC	8,271	8,306	8,271	8,306
Other loans	661	702	661	702
Lease liabilities	14,035	12,782	14,035	12,782
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	15,935	15,686	15,935	15,686
Total current borrowings	**38,902**	**37,476**	**38,902**	**37,476**
Non-current				
Loans from DHSC	58,445	66,381	58,445	66,381
Other loans	844	1,506	844	1,506
Lease liabilities	103,750	125,891	103,750	125,891
Obligations under PFI, LIFT or other service concession contracts	524,183	522,297	524,183	522,297
Total non-current borrowings	**687,222**	**716,075**	**687,222**	**716,075**

Note 29.2 Reconciliation of liabilities arising from financing activities (Group)

Group - 2025/26	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2025	**74,687**	**2,208**	**138,673**	**537,983**	**753,551**
Cash movements:					
Financing cash flows - payments and receipts of principal	(7,936)	(703)	(11,626)	(16,222)	**(36,487)**
Financing cash flows - payments of interest	(2,140)	(10)	(2,285)	(32,892)	**(37,327)**
Non-cash movements:					
Additions	-	-	14,172	-	**14,172**
Lease liability remeasurements	-	-	(6,728)	-	**(6,728)**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	-	18,356	**18,356**
Application of effective interest rate	2,105	10	2,285	32,892	**37,292**
Early terminations	-	-	(16,706)	-	**(16,706)**
Other changes	-	-	-	1	**1**
Carrying value at 31 March 2026	**66,716**	**1,505**	**117,785**	**540,118**	**726,124**

Group - 2024/25	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2024	**85,545**	**3,004**	**142,846**	**534,779**	**766,174**
Cash movements:					
Financing cash flows - payments and receipts of principal	(10,800)	(795)	(10,879)	(21,004)	**(43,478)**
Financing cash flows - payments of interest	(2,426)	(18)	(1,802)	(33,071)	**(37,317)**
Non-cash movements:					
Additions	-	-	13,075	-	**13,075**
Lease liability remeasurements	-	-	6,041	-	**6,041**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	-	24,208	**24,208**
Application of effective interest rate	2,368	17	1,802	33,071	**37,258**
Early terminations	-	-	(12,410)	-	**(12,410)**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2025	**74,687**	**2,208**	**138,673**	**537,983**	**753,551**

Note 29.3 Reconciliation of liabilities arising from financing activities

Trust - 2025/26	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2025	**74,687**	**2,208**	**138,673**	**537,983**	**753,551**
Cash movements:					
Financing cash flows - payments and receipts of principal	(7,936)	(703)	(11,626)	(16,222)	**(36,487)**
Financing cash flows - payments of interest	(2,140)	(10)	(2,285)	(32,892)	**(37,327)**
Non-cash movements:					
Additions	-	-	14,172	-	**14,172**
Lease liability remeasurements	-	-	(6,728)	-	**(6,728)**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	-	18,356	**18,356**
Application of effective interest rate	2,105	10	2,285	32,892	**37,292**
Early terminations	-	-	(16,706)	-	**(16,706)**
Other changes	-	-	-	1	**1**
Carrying value at 31 March 2026	**66,716**	**1,505**	**117,785**	**540,118**	**726,124**

Trust - 2024/25	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2024	**85,545**	**3,004**	**142,846**	**534,779**	**766,174**
Cash movements:					
Financing cash flows - payments and receipts of principal	(10,800)	(795)	(10,879)	(21,004)	**(43,478)**
Financing cash flows - payments of interest	(2,426)	(18)	(1,802)	(33,071)	**(37,317)**
Non-cash movements:					
Additions	-	-	13,075	-	**13,075**
Lease liability remeasurements	-	-	6,041	-	**6,041**
Remeasurement of PFI / other service concession liability resulting from change in index or rate				24,208	**24,208**
Application of effective interest rate	2,368	17	1,802	33,071	**37,258**
Early terminations	-	-	(12,410)	-	**(12,410)**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2025	**74,687**	**2,208**	**138,673**	**537,983**	**753,551**

Note 30.1 Provisions for liabilities and charges analysis (Trust & Group)

Group	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Re-structuring	Capitalised Lease Dilapidations	Clinicians Pension tax Reimbursement	Other	Charitable fund provisions	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2025	**3,816**	**3,450**	**814**	**4**	**122**	**2,861**	**4,439**	**-**	**15,506**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Change in the discount rate	(83)	(146)	-	-	-	(205)	-	-	**(434)**
Arising during the year	288	117	24	-	965	-	-	-	**1,394**
Utilised during the year	(519)	(264)	(97)	-	-	(61)	(1,135)	-	**(2,076)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	-	**-**
Reversed unused	(151)	-	(113)	-	-	(95)	(1,985)	-	**(2,344)**
Unwinding of discount	91	83	-	-	-	170	-	-	**344**
Movement in charitable fund provisions	-	-	-	-	-	-	-	-	**-**
At 31 March 2026	**3,442**	**3,240**	**628**	**4**	**1,087**	**2,670**	**1,319**	**-**	**12,390**
Expected timing of cash flows:									
- not later than one year;	504	257	628	4	-	61	1,319	-	**2,773**
- later than one year and not later than five years;	1,797	955	-	-	-	419	-	-	**3,171**
- later than five years.	1,141	2,028	-	-	1,087	2,190	-	-	**6,446**
Total	**3,442**	**3,240**	**628**	**4**	**1,087**	**2,670**	**1,319**	**-**	**12,390**

Pensions - relates to sums payable to former employees having retired prematurely or due to injury at work. The provisions are based upon current and expected benefits advised by the NHS Pensions Agency and the computed life expectancies of pension recipients.

Legal claims - based on professional assessments, which are uncertain to the extent that they are estimates of the likely outcome of individual cases. Due to the projected dates of settlement of claims, amounts are based on estimates supplied by NHS Resolution and/or legal advisors.

Lease Dilapidations - relates to expected future dilapidation costs at the end of specific property leases based on the current condition of the properties and the specific lease terms.

Clinician Pension Tax Reimbursement - This relates to the cost incurred by NHS Pensions Scheme due to changes in tax treatment of specific Clinicians Pensions. This is to be funded centrally by NHS England and the Trust has recognised a matching debtor with NHS England. It is anticipated to crystallise from 2023/24 and future years.

Other provisions are made in respect of a number of unconnected liabilities. The Trust has taken professional advice, and used its best estimates in arriving at the provisions. The expected timing of the cash flows shown above is estimated from the best information available to the Trust at this point in time, but these are uncertain.

Note 30.2 Clinical negligence liabilities

At 31 March 2026, £882,517k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Manchester University NHS Foundation Trust (31 March 2025: £842,187k).

Note 31 Contingent assets and liabilities

The Trust has no contingent assets (£0k at 31 March 2025).

The Trust also has a contingent liability of £292k (£275k at 31 March 2025) which represents amounts in respect of claims managed by NHS Resolution, and locally managed employment tribunal cases.

Note 32 Contractual capital commitments

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	33,661	41,925	33,661	41,925
Intangible assets	-	458	-	458
Total	**33,661**	**42,383**	**33,661**	**42,383**

Note 33 On-SoFP PFI, LIFT or other service concession arrangements

The predecessor Trusts entered into two PFI contracts which transferred to MFT on 1 October 2017.

In 1998, University Hospital of South Manchester NHS FT entered into 35 year PFI contract with South Manchester Healthcare Limited which expires in 2033. The contract covers the build and operation of two buildings at Wythenshawe hospital – the Acute Unit and the Mental Health Unit.

The Acute Unit consists of an Accident and Emergency department, a burns unit, coronary care unit, intensive care unit, six operating theatres, five medical and five surgical wards, an x-ray department, fracture clinic and renal department.

The Mental Health Unit provides adult and older people's outpatient and inpatient Mental Health services. The Trust sublets the Mental Health Unit to Manchester Mental Health and Social Care Trust. This agreement is treated as an operating lease and the income received is included within operating income.

In 2033, at the end of the PFI contract, the two buildings covered by the contract will transfer from South Manchester Healthcare Ltd to the Trust.

In December 2004, the Central Manchester University Hospital NHS Foundation Trust entered into a 38 year arrangement with Catalyst Healthcare (Manchester) Ltd.

The scheme involved the build and operation of four significant hospital developments on the Trust's Oxford Road Campus at an overall cost of approximately £500m.

In 2042, at the end of the agreement, ownership of the four properties (Manchester Royal Infirmary, Manchester Children's Hospital, Manchester Eye Hospital and St Mary's Hospital) transfers from Catalyst Healthcare (Manchester) Ltd to the Trust.

Note 33.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Gross PFI, LIFT or other service concession liabilities	**871,989**	**890,710**	**871,989**	**890,710**
Of which liabilities are due				
- not later than one year;	47,861	47,493	47,861	47,493
- later than one year and not later than five years;	199,952	190,391	199,952	190,391
- later than five years.	624,176	652,826	624,176	652,826
Finance charges allocated to future periods	(331,871)	(352,727)	(331,871)	(352,727)
Net PFI, LIFT or other service concession arrangement obligation	**540,118**	**537,983**	**540,118**	**537,983**
- not later than one year;	15,935	15,686	15,935	15,686
- later than one year and not later than five years;	83,555	73,274	83,555	73,274
- later than five years.	440,628	449,023	440,628	449,023

Note 33.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**2,666,428**	**2,887,315**	**2,666,428**	**2,887,315**
Of which payments are due:				
- not later than one year;	157,663	157,493	157,663	157,493
- later than one year and not later than five years;	675,477	671,066	675,477	671,066
- later than five years.	1,833,288	2,058,756	1,833,288	2,058,756

Note 33.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group		Trust	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Unitary payment payable to service concession operator	**156,823**	**153,642**	**156,823**	**153,642**
Consisting of:				
- Interest charge	32,892	33,071	32,892	33,071
- Repayment of balance sheet obligation	16,222	21,004	16,222	21,004
- Service element and other charges to operating expenditure	77,014	80,154	77,014	80,154
- Capital lifecycle maintenance	30,695	19,413	30,695	19,413
Total amount paid to service concession operator	**156,823**	**153,642**	**156,823**	**153,642**

Note 34 Financial instruments

Note 34.1 Financial risk management

IFRS 7 requires disclosure of the role which Financial Instruments have had during the period in creating or changing the risks which a body faces in undertaking its activities. Because of the continuing service provider relationship which the Trust has with its Commissioners, and the way in which those Commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, Financial Instruments play a much more limited role in creating or changing risk for the Trust than would be typical of listed companies. The Trust has limited powers to borrow or invest surplus funds and Financial Assets and Liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities. For the Group, the MFT Charity does hold investments, and is therefore exposed to a degree of financial risk. This risk is carefully managed by pursuing a cautious, low risk Investment Strategy, and by monthly reviews of the performance of investments.

The Trust's Treasury Management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions, and policies agreed by the Board of Directors. Similarly, for the Group the Treasury Management of the MFT Charity's investments is carried out by the Charity Finance Team, following the policies set down by the Trustee, and subject to the approval of the Charitable Funds Committee. The Trust's and the Group's treasury activities are also subject to review by Internal Audit.

Liquidity Risk

Net operating costs of the Trust are funded under annual Service Agreements with NHS Commissioners, which are financed from resources voted annually by Parliament. The Trust largely finances its capital expenditure from internally generated cash, and funds made available by the Department of Health and Social Care. Additional funding by way of loans has been arranged with the Independent Trust Financing Facility to support major capital developments. The Trust is, therefore, exposed to liquidity risks from the loan funding - however these risks are approved, and comply with NHSI's Risk Assessment Framework. For the Group, the Charity finances all of its expenditure from the resources which have been donated to it, and therefore faces no liquidity risk.

Currency Risk

The Trust and the Group are principally domestic organisations with the overwhelming majority of their transactions, assets and liabilities being in the UK and Sterling based. The Trust and the Group have no overseas operations, and therefore have low exposure to currency rate fluctuations.

Interest Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The Trust is not, therefore, exposed to significant interest rate risk. For the Group, the Charity has interest bearing bank balances, which are subject to variable rates of interest. However, all other financial assets, and 100% of financial liabilities, of the Charity carry nil rates of interest. The Charity's bank balances represent approximately 1% of the Group's total Net Assets, and so the Group is not exposed to significant interest rate risk.

Credit Risk

The majority of the Trust's Income comes from contracts with other public sector bodies, and therefore the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2026 is within Receivables from customers, as disclosed in the Trade and Other Receivables Note to these Accounts (Note 23.1). For the Group, the Charity's Income comes only from Donations, Legacies and Investment Income. Therefore the position of the Group is as for the Trust - the maximum exposure to Credit Risk is in respect of Receivables.

Market Price Risk

The Trust and the Group holds a number of investments at fair value and is therefore exposed to changes in the market price of these investments. This is not considered to be a significant risk to the Trust given the relative immateriality of the value of these investments and the Trust and Group's appetite to risk.

Note 34.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	134,231	-	-	**134,231**
Other investments / financial assets	-	2,419	-	**2,419**
Cash and cash equivalents	9,502	-	-	**9,502**
Consolidated NHS Charitable fund financial assets	5,161	-	13,791	**18,952**
Total at 31 March 2026	**148,894**	**2,419**	**13,791**	**165,104**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	167,565	-	-	**167,565**
Other investments / financial assets	-	806	-	**806**
Cash and cash equivalents	60,488	-	-	**60,488**
Consolidated NHS Charitable fund financial assets	7,485	-	13,444	**20,929**
Total at 31 March 2025	**235,538**	**806**	**13,444**	**249,788**

Note 34.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	134,231	-	-	**134,231**
Other investments / financial assets	-	2,419	-	**2,419**
Cash and cash equivalents	9,502	-	-	**9,502**
Total at 31 March 2026	**143,733**	**2,419**	**-**	**146,152**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	167,565	-	-	**167,565**
Other investments / financial assets	-	806	-	**806**
Cash and cash equivalents	60,488	-	-	**60,488**
Total at 31 March 2025	**228,053**	**806**	**-**	**228,859**

Note 34.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost
	£000
Loans from the Department of Health and Social Care	66,716
Obligations under leases	117,785
Obligations under PFI, LIFT and other service concessions	540,118
Other borrowings	1,505
Trade and other payables excluding non financial liabilities	261,525
Other financial liabilities	-
Provisions under contract	4,621
Consolidated NHS charitable fund financial liabilities	321
Total at 31 March 2026	**992,591**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost
	£000
Loans from the Department of Health and Social Care	74,687
Obligations under leases	138,673
Obligations under PFI, LIFT and other service concessions	537,983
Other borrowings	2,208
Trade and other payables excluding non financial liabilities	324,536
Other financial liabilities	-
Provisions under contract	8,118
Consolidated NHS charitable fund financial liabilities	182
Total at 31 March 2025	**1,086,387**

Trade and other payables excluding non financial liabilities for the financial year ending 31 March 2026 have been represented to exclude social security and other taxes payable.

Note 34.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost
	£000
Loans from the Department of Health and Social Care	66,716
Obligations under leases	117,785
Obligations under PFI, LIFT and other service concessions	540,118
Other borrowings	1,505
Trade and other payables excluding non financial liabilities	261,525
Other financial liabilities	-
Provisions under contract	4,621
Total at 31 March 2026	**992,270**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost
	£000
Loans from the Department of Health and Social Care	74,687
Obligations under leases	138,673
Obligations under PFI, LIFT and other service concessions	537,983
Other borrowings	2,208
Trade and other payables excluding non financial liabilities	324,536
Other financial liabilities	-
Provisions under contract	8,118
Total at 31 March 2025	**1,086,205**

Note 34.6 Fair values of financial assets and liabilities

The fair value of all assets and liabilities is reported as being equal to their book value which the Foundation Trust consider to be materially the same as the fair value.

Note 34.7 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
In one year or less	336,249	401,106	335,928	400,924
In more than one year but not more than five years	280,240	271,424	280,240	271,424
In more than five years	735,880	795,618	735,880	795,618
Total	**1,352,369**	**1,468,148**	**1,352,048**	**1,467,966**

Note 35 Losses and special payments

	2025/26		2024/25	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	-	-	-	-
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	753	2,408	401	411
Stores losses and damage to property	12	897	12	744
Total losses	**765**	**3,305**	**413**	**1,154**
Special payments				
Compensation under court order or legally binding arbitration award	4	55	5	108
Extra-contractual payments	-	-	-	-
Ex-gratia payments	72	54	60	37
Special severance payments	1	12	3	32
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**77**	**121**	**68**	**176**
Total losses and special payments	**842**	**3,426**	**481**	**1,331**
Compensation payments received				

Losses and Special Payments are reported on an accruals basis, excluding provisions for future losses.

There are no transactions reported within the table above in excess of £300K.

Note 36 Related parties

During the year some of the Board Members or members of the key management staff or parties related to them have undertaken material transactions with the Trust as presented below.

The Trust Chairman is a member of the General Assembly for the University of Manchester, one of the Non-Executive directors was the Deputy President and Deputy Vice-Chancellor, one of the Non-Executive directors is the Vice President and a Dean, and a Non-Executive Director was an Independent Co-opted member.

The Chief Executive is a director for Oxford Road Corridor and a board member of Health Innovation Manchester

A Group Non-Executive Director is a member of the Council of Governors at the University of Salford

Name of Organisation	Debtor	Creditor	Income	Expenditure
	£'000	£'000	£'000	£'000
University of Manchester	2,890	1,965	12,077	23,559

The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent department including:

Alder Hey Children's NHS Foundation Trust
Blackpool Teaching Hospitals NHS Foundation Trust
Bolton NHS Foundation Trust
Greater Manchester Mental Health NHS Foundation Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Liverpool University Hospitals NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
Northern Care Alliance NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
Pennine Care NHS Foundation Trust
Stockport NHS Foundation Trust
Tameside and Glossop Integrated Care NHS Foundation Trust
The Christie NHS Foundation Trust
Wrightington, Wigan and Leigh NHS Foundation Trust
East Cheshire NHS Trust
East Lancashire Hospitals NHS Trust
Mersey and West Lancashire Teaching Hospitals NHS Trust
NHS Cheshire and Merseyside ICB
NHS Derby and Derbyshire ICB
NHS Greater Manchester ICB
NHS Lancashire and South Cumbria ICB
NHS North East and North Cumbria ICB
NHS Staffordshire and Stoke-on-Trent ICB
NHS West Yorkshire ICB
UK Health Security Agency
NHS Resolution
Care Quality Commission
Supply Chain Coordination Limited
NHS Property Services
Community Health Partnerships
Department of Health and Social Care
Manchester University NHS Foundation Trust Charity

Manchester University NHS Foundation Trust Charity works closely with, and provides the majority of its grants, to the Trust. The Charity Trustee constitutes the members of the Trust Board and during the financial year £418k of financial costs were recharged (£418k in 2024/25). During the financial year, the Charity committed £4,021k (£2,533k in 2024/25) to MFT in furtherance of its objectives. As at the 31st March 2026 the Charity commitment to the Trust is £6,203k (£6,687k at 31st March 2025). The Charity had an amount of £856k owed to MFT at 31st March 2026 (£526k at 31st March 2025).

In addition, the Trust has had a number of material transactions with other Government Departments and other Central and Local Government bodies, with the greatest amounts relating to Manchester City Council, HM Revenue and Customs, and the NHS Business Services Authority (Pensions Division).

Note 37 Consolidation of Charitable Funds - Reconciliation of Charity Accounts to Consolidation Figures - Statement of Comprehensive Income

	Per Charity Accounts 2025/2026	**Consolidation Consistency Adjustments year to 31st March 2026**	**Figures Used in Consolidated Accounts 2025/26**	Per Charity Accounts 2024/2025	Consolidation Consistency Adjustments year to 31st March 2025	Figures Used in Consolidated Accounts 2024/25
	Total Funds £000	**Total Funds £000**	**Total Funds £000**	Total Funds £000	Total Funds £000	Total Funds £000
Income From:						
Donations and Legacies	**4,529**	**0**	**4,529**	3,382	0	3,382
Investments	**425**	**0**	**425**	697	0	697
Total	**4,954**	**0**	**4,954**	4,079	0	4,079
Expenditure on:						
Raising funds	**2,206**	**0**	**2,206**	2,373	0	2,373
Charitable activities	**5,098**	**470**	**5,568**	4,274	439	4,713
Total	**7,304**	**470**	**7,774**	6,647	439	7,086
Net (loss)/gain on investments	**367**	**0**	**367**	419	0	419
Net income/(expenditure)	**(1,983)**	**(470)**	**(1,513)**	(2,149)	439	(2,588)
Net movement in funds	**(1,983)**	**(470)**	**(1,513)**	(2,149)	439	(2,588)
Total Funds Brought Forward	**13,573**	**6,687**	**20,260**	15,722	7,126	22,848
Total Funds Carried Forward	**11,590**	**6,217**	**18,747**	13,573	6,687	20,260

Note 1.4 details the reason for the requirement to adjust the values relating to the Charity, when consolidating into the Group Accounts.

The main adjustment is due to the Charity Accounts being completed following the accounting rules detailed in the Statement of Recommended Practice (SORP). This includes accounting for expenditure including any commitments made. The Group accounts are based on International Financial Reporting Standards (IFRS), which does not include the commitment accounting. Therefore, for the purpose of the consolidation the Charity accounts are amended for this difference. These are the consolidation adjustments included in notes 37 and 38.

Note 38 Consolidation of Charitable Funds - Reconciliation of Charity Accounts to Consolidation Figures - Statement of Financial Position

	Per Charity Accounts 2025/26	Consolidation Consistency Adjustments year to 31st March 2026	Figures Used in Consolidated Accounts 31st March 2026	Per Charity Accounts 2024/2025	Consolidation Consistency Adjustments year to 31st March 2025	Figures Used in Consolidated Accounts 2024/25
	31st March 2026 £000	31st March 2026 £000	31st March 2026 £000	31st March 2025 £000	31st March 2025 £000	31st March 2025 £000
Fixed Assets						
Tangible Assets	**29**	**0**	**29**	36	0	36
Investments	**13,794**	**0**	**13,794**	13,447	0	13,447
Debtors	**0**	**0**	**0**	0	0	0
Total Fixed Assets	**13,823**	**0**	**13,823**	13,483	0	13,483
Current Assets						
Debtors	**57**	**0**	**57**	232	0	232
Cash at Bank and in Hand	**5,104**	**0**	**5,104**	7,253	0	7,253
Total Current Assets	**5,161**	**0**	**5,161**	7,485	0	7,485
Current Liabilities						
Creditors Falling Due Within One Year	**(7,344)**	**6,167**	**(1,177)**	(7,345)	6,637	(708)
Net Current Assets	**(2,183)**	**6,167**	**3,984**	140	6,637	6,777
Total Assets less Current Liabilities	**11,640**	**6,167**	**17,807**	13,623	6,637	20,260
Non - Current Liabilities						
Provision for Liabilities and Charges	**(50)**	**50**	**0**	(50)	50	0
Total Net Assets	**11,590**	**6,217**	**17,807**	13,573	6,687	20,260
Funds of the Charity						
Restricted Income Funds	**6,734**	**6,217**	**12,951**	8,062	6,687	14,749
Unrestricted Income Funds	**3,685**	**0**	**3,685**	4,703	0	4,703
Revaluation Reserve	**1,171**	**0**	**1,171**	808	0	808
Total Charity Funds	**11,590**	**6,217**	**17,807**	13,573	6,687	20,260