NHS
Manchester University
NHS Foundation Trust

Board of Directors (Public)

Date: Wednesday 25th November 2026
Time: 2:00pm – 5:00pm
Location: Lecture Theatre 2, Education and Research Centre, Wythenshawe Hospital

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

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Interim Trust Chair	
2.	**Declaration of interest** (verbal)	Meeting admin	Interim Trust Chair	
3.	**Patient Story**		Deputy CEO / CNO	
4.	**Minutes of the previous meeting** (30th September 2026)	Meeting admin	Interim Trust Chair	
5.	**Action Log**	Discussion	Interim Trust Chair	
6.	**Matters Arising**	Discussion	Interim Trust Chair	
7.	**Trust Chair's report (verbal)**	Discussion	Interim Trust Chair	
8.	**Trust Chief Executive's report**	Discussion	Trust CEO	
9.	**Assurance Reporting**			
9.1	**Board Assurance Framework***	Discussion	Executive Directors	
9.2	**Integrated Performance Report***	Discussion	Executive Directors	
10	**Strategic aim 1: Work with partners to help people live longer, healthier lives**			
10.1	**North Manchester Board Committee (12/10/26) escalation and assurance report**	Discussion	NED (MG)	
10.2	**Strategic Development Update**	Discussion	CSO	
10.3	**Annual Planning Update**	Discussion	CSO	
11	**Strategic aim 2: Provide high quality, safe care with excellent outcomes and experience**			
11.1	**Quality, Safety and Performance Board Committee (27/10/26) escalation and assurance report**	Discussion	NED (JH)	
11.2	**National In-Patient Survey***	Discussion	Deputy CEO / CNO	

11.3	**National Cancer Survey***	Discussion	Deputy CEO / CNO	
11.4	**Annual Safeguarding Report ***	Discussion	Deputy CEO /CNO	
12	**Strategic aim 3: Be the place where people enjoy working, learning and building a career**			
12.1	**People Board Committee (27/10/26) escalation and assurance report**	Discussion	NED (AA)	
12.2	**Safer Staffing Report (nursing and AHP) ***	Discussion	Deputy CEO / CNO	
12.3	**Bi-annual Safer staffing report (midwifery and newborn services) ***	Discussion	Deputy CEO /CNO	
12.4	**Annual Provider Self-Assessment Return**	Approval	JCMO	
13	**Strategic aim 4: Ensure value for our patients and communities by making best use of resources**			
13.1	**Finance Board Committee (26/10/26) escalation and assurance report**	Discussion	Interim Trust Chair	
13.2	**Chief Finance Officer's report ***	Discussion	CFO	
13.3	**Audit and Risk Committee (03/11/26) escalation and assurance report**	Discussion	NED (NG)	
Good Governance				
14.	**Board of Directors' Register of Interests**	Discussion	Interim Trust Chair	
15.	**Any Other Business** (verbal)	Discussion	Interim Trust Chair	
16.	**Meeting Evaluation** (verbal)	Meeting admin	Interim Trust Chair	
Date of next meeting: Wednesday, 3 February 2027 at 2:00pm				

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Board of Directors (Public)

Wednesday 30th September 2026

Present:	Trevor Rees (TR) Angela Adimora (AA) Darren Banks (DB) Mark Cubbon (MC) Vanessa Gardener (VG) Mark Gifford (MG) Jackie Hanson (JH) Sam Liscio (SL) Matt Makin (MM) Chris McLouglin (CM) Meera Nair (MN) Tom Rafferty (TRa) Kimberley Salmon-Jamieson (KSJ) David Walliker (DW) Claire Wilson (CW)	Interim Trust Chair Trust Non-Executive Director Deputy Chief Executive Trust Chief Executive Chief Delivery Officer Trust Non-Executive Director Trust Non-Executive Director Trust Non-Executive Director Interim Joint Chief Medical Officer Trust Non-Executive Director Chief People Officer Chief Strategy Officer Deputy Chief Executive/ Chief Nursing Officer Chief Digital and Information Officer Chief Finance Officer
In attendance:	Nick Gomm (NGo)	Director of Corporate Business / Trust Board Secretary
	Kathy Murphy (KM) (Item 11.2)	Director of Nursing and Midwifery
	Kim Macleod (KMac) (Item 11.2)	Clinical Head of Division, Maternity

Public questions

TR noted that, in advance of the meeting, the Trust had received a question from Mike Reed from Amnesty International expressing concern regarding the Trust's use of the Federated Data Platform which had been secured via an NHS England contract with the company Palantir to provide the service for the NHS. The Trust had sent Mike a response to the question explaining that MFT has no direct contract with Palantir and that all Trusts are expected by NHS England to use the Federated Data Platform. The Trust retains control of our interface with the system and Palantir can only process data to perform the tasks that the Trust has instructed them to do and cannot use the data for any other purpose. The Platform is not linked into the Electronic Patient Record or Electronic Staff Record.

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

Apologies were received from Matt Bonam and Ashley Blom

2.	**Declarations of Interest**

No interests were declared.

3.	**Patient Story**

KSJ introduced the patient story which described the experience of Sara who had received Trust services for cancer. The story included coverage of the contribution of the Macmillan service to Sara's care.

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

4.	**Minutes of previous meeting held on 30th July 2026**

The minutes of the Board of Directors' (Board) meeting held on the 30th July were approved as a true record of the meeting.

5.	**Action Log**

CW confirmed that the National Cost Collection item would be discussed at the Finance Board Committee (FBC) in December 2026.

6.	**Matters arising**

There were no matters arising.

7.	**Trust Chair's Report**

TR provided a verbal report on matters of interest since the last Board meeting and drew attention to:

- Board focus remains on strategy delivery with an H2 re-forecast underway to support delivery of this year's Annual Plan
- The Trust's Annual Member's Meeting which had taken place the day before. TR thanked all staff who contributed, the Governors who helped shape the day, and the clinicians who had delivered presentations.
- The success of the CommonHealth games programme and the enthusiasm of staff and patients who had taken part in the many activities which have taken place.
- The success of the Manchester Pride festival and the contribution made by MFT and NHS staff.
- The Red Arrows fly-past which had taken place in August 2026.

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

8.	**Trust Chief Executive's Report**

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

- Recent operational pressures associated with periods of exceptionally hot weather were highlighted. It was reported that significant effort had been required across the organisation to maintain safe services throughout the period and thanks were expressed to staff for their response. The resilience demonstrated by teams during these pressures was recognised.
- Recent developments at national level, including the increased focus on maternity improvement, safety and quality. Maternity services would continue to receive significant organisational attention and oversight.
- The results of the National Inpatient Survey and the National Cancer Patient Experience Survey. From the former, positive feedback continued to be received in many areas, opportunities for further improvement were identified, particularly in relation to communication, patient experience and how patients felt informed and involved in their care. From the latter, positive feedback had been received from cancer patients across a range of domains and the contribution of clinical and support teams involved in cancer pathways was recognised. Opportunities to build upon this performance were also identified.
- A number of recent visits from external stakeholders to MFT had provided opportunities to showcase the scale of the organisation, the quality of services provided and the innovation taking place across the Trust. The feedback received from visitors had been positive.
- The recent launch of the MHRA Innovation Sandbox would support the testing of innovative technologies within NHS settings, including emerging digital technologies, ambient voice technology and wearable devices. The learning generated would contribute not only to MFT but also to the wider NHS. TR noted that the work would continue to be overseen by the Research, Innovation and Population Health Board Committee.
- The work of the Culture and Staff Experience Forum. Recent discussions had focused particularly on disability, staff experience and inclusion. Feedback received through the Forum was being used to shape actions and improvements relating to staff experience and organisational culture.
- Progress following the Ignite programme and wider cultural development work with continued effort was being directed towards maintaining visibility of the programme, embedding learning and sustaining staff engagement.

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

9.	**Assurance Reporting**
9.1	**Integrated Performance Report (IPR)**

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

For the Quality and Safety section, KSJ drew attention to

- Category 3 caesarean section rate not performed within 24 hours is above target. Demand has increased with 53% of births at MFT currently delivered through caesarean section. An increased number of theatre sessions have been put in place at Wythenshawe Hospital to support the increased demand. None of the women whose caesarean was carried out after 24 hours has come to harm.

- Maternity triage performance had improved since the period covered by the IPR,, with performance in July and August returning to c.80%. No adverse outcomes had been identified as a consequence of delays with affected women appropriately supported throughout their care.
- A national change in the induction medication used across maternity services had created delays within induction pathways. These delays had been observed nationally and had been carefully monitored locally.
- The growing use of artificial intelligence tools, may be contributing to an increase in the volume and complexity of complaints received across public services, including MFT, other healthcare providers, schools and policing organisations. Within MFT, complaint themes continued predominantly to relate to appointment waiting times and communication.

JH confirmed that the maternity metrics had been discussed in detail at the last Quality, Safety and Performance Board Committee (QSPBC).

For the Quality and Safety section, SM added::

- A significant programme of work was being undertaken in relation to infection prevention and control. Particular attention was being directed towards reducing bacteraemia and healthcare-associated infections, with a specific focus on vascular access devices and catheter-associated infections.
- A clinical prioritisation process had been established to ensure that patients on waiting lists remained safe whilst awaiting treatment and that those with the greatest clinical need were identified appropriately. This work was being undertaken alongside ongoing efforts to reduce long waits, particularly in the context of reducing 52-week waits and improving referral-to-treatment performance.
- The Trust's overall mortality position compared favourably with both the Shelford Group, Greater Manchester providers and national comparators. Members were advised that performance had improved further during the year. Enhanced digital capabilities, including the use of a mortality portal, were enabling a more detailed review of mortality information at divisional and service level.

For the Operational performance section, VG drew attention to:

- The latest National Oversight Framework results with the Trust continuing to perform strongly against the revised national methodology and remaining in a comparatively favourable position nationally, being ranked 29th of 134 organisations.
- FT continued to perform well against a number of key national access and quality indicators. Particular attention was drawn to performance relating to 12-hour waits in Emergency Departments, reduction of 52-week waits and diagnostic performance within six weeks, all of which compared favourably with national benchmarks.
- Urgent and emergency care, Referral-to-Treatment performance, and 62-day cancer performance remained key areas requiring continued improvement.
- The summer period had been exceptionally busy across the NHS and that MFT had experienced attendances above planned levels during periods of hot weather. Despite these pressures, MFT had remained the highest-performing acute provider in Greater Manchester during August, achieving urgent and emergency care performance of 74.4%.
- Emergency Department attendance increase of approximately 3% year-to-date This had peaked at approximately 7% during June and remained around 5% during September. Variations between hospital sites were highlighted. September activity has seen approximately 2,700 additional patient attendances, representing the equivalent of around two additional days of emergency activity. Despite increased attendances, emergency admissions had reduced against plan. In response to a question from Tr, VG confirmed that this likely reflected the impact of the Trust's Care Closer to Home programme.
- For planned care, a 2% increase in external and GP referrals had been identified with some specialties showing an up to 20& increase. Work was being undertaken with Integrated Care Board colleagues to understand the drivers of this growth and to identify appropriate interventions..

- Improvements were being sustained within the front end of the cancer pathway, however continued focus was required on compliance with the 62-day target. Each hospital site faced different challenges and that targeted improvement plans had been developed by Clinical Groups.

For the People section, MN drew attention to:

- The continued level of sickness absence and a deeper analytical review being undertaken to identify the factors contributing to ongoing absence levels. Discussions had commenced with Clinical Groups, workforce teams and operational leaders to review the Trust's current approach across three principal areas: application of policies and procedures, support available for staff health and wellbeing, and the promotion of preventative health measures within the workforce.
- Appraisal performance, particularly within non-clinical staff groups. Whilst strong performance continued to be achieved for medical and dental appraisal processes, performance in relation to appraisals for non-medical staff had fallen. The same level of organisational rigour that had previously been applied successfully to mandatory training compliance was now being applied to appraisal compliance.

For the Finance section, CW drew attention to:

- The Trust's liquidity position remained under significant pressure with cash balances approximately £30 million below plan at this stage of the financial year, equating to approximately 2.6 working days of cash coverage compared with a planned position of 6.4 days. NHS England's expectation remained a minimum of four working days' cash cover. At the end of the previous financial year, the Trust's cash position had reduced to approximately one working day's cover and so the current position represented some recovery against that baseline.
- Despite the cash pressures, strong payment performance continued to be maintained. Payment practice performance remained above 90%, providing assurance that suppliers continued to be paid within expected timescales.
- The Trust's liquidity position remained closely linked to delivery of the Value for Patients programme and the organisation's ability to generate recurrent cash-releasing savings. Delivery of the programme therefore remained a critical component of the Trust's financial recovery plans.
- Agency expenditure continued to be reported as an adverse variance within the IPR however the variance reflected the fact that the Trust's target had been set at zero and that the actual reported position of 0.3% represented a very small level of agency expenditure.
- Delivery in full of the Value for Patients programme continued to represent the Trust's most significant financial risk and substantial work was being undertaken across Clinical Groups and corporate departments to deliver the programme.
- The overall financial position was not currently being reported as a formal variance against plan because delivery had been maintained through the use of additional non-recurrent measures.

For the Research and Innovation section, SM drew attention to:

- Research performance continued to be strong, with the Trust maintaining an active research portfolio of almost 1,000 studies.
- Performance remained consistent across the principal research measures and that activity continued to be monitored through established governance arrangements.

Board members welcomed the development of Population Health metrics which were discussed at the recent RIPHBC meeting.

DW noted that the Digital metrics were showing as ‘Green’ due to continuing delivery of the Freedom of Information and Subject Access Reviews’ metrics. Agentic AI has proven effective in maintaining high performance in these areas.

TR questioned the increased numbers of metrics in the ‘Alert’ section when compared to July’s IPR. MC noted that operational demand had increased over the last few months and that had had an impact on a number of the metrics.

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

10.1	**Research, Innovation and Population Health Board Committee (RIPHBC) (01/09/26) escalation and assurance report.**

In AB's absence, SM introduced the escalation and assurance report from the RIPHBC held on the 01/09/26 and drew attention to:

- Patient and public involvement mechanisms to support research.
- The overview of the Manchester Rare Conditions Centre provided to the Committee.
- The development of further population health metrics to strengthen the Committee's oversight.
- A broader update on population health statistics and outcomes was requested for a future meeting.

CM commended the momentum behind the Committee's work and the link with the Greater Manchester Prevention Demonstrator programme.

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

10.2	**North Manchester Board Committee (NMBC) (18/08/26) escalation and assurance report**

MG introduced the escalation and assurance report from the NMBC held on the 18/08/26 and drew attention to:

- The significant progress made on the New Hospital Programme was recognised by the Committee, and particular praise was recorded for the work undertaken in preparing the Stage 1 submission and establishing the governance arrangements required to support subsequent phases of the programme.
- Positive assurance was provided regarding staff engagement activity, including workshops and events involving staff.
- Consideration may be required in future regarding the programme branding and messaging, including the "Our Hospital, Our Future" title, as the transformation programme would ultimately affect a wider range of services and staff across MFT, not solely those directly connected with the North Manchester Hospital development.
- The Committee had undertaken detailed scrutiny of key programme workstreams, including the transformation workstream, and noted the extensive work being undertaken to support delivery of the future hospital model.
- A high-level programme timeline had been reviewed, highlighting the pace of delivery required, with construction expected to commence during the following year and outpatient facilities planned to open in 2029.
- Risks within the Committee's risk register had demonstrated an increasing dependency on transformation and masterplan workstreams, some of which were reliant on external health and care partners. The importance of maintaining momentum across all stakeholders had been emphasised.
- Several key programme leads were also carrying significant operational responsibilities. Assurance would continue to be sought regarding programme capacity, resource requirements and arrangements to mitigate reliance on a small number of individuals.

- Extensive work was being undertaken to reduce the programme's estimated funding gap, with stakeholders working collaboratively to identify solutions.

Board members noted that appropriate leadership capacity and clinical input, and ongoing staff and stakeholder engagement, would be critical to ensuring that the required service changes were delivered successfully and that the full benefits of the new facilities were realised.

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

10.3 Strategic Developments

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

- New ministerial appointments in the Department of Health.
- Public consultation relating to vascular and cardiac service changes across Greater Manchester. The consultation process had concluded and that commissioners were considering responses received as part of the formal consultation process. Vascular service changes would establish single arterial centres across Greater Manchester. Cardiac service changes had already been implemented on a temporary basis during the COVID-19 period, with the current process providing retrospective approval for those arrangements.
- Progress on delivering more care closer to home and within community settings across a number of established service areas, with additional work underway to develop new models of care in other specialties including frailty.
- Planning work continued in relation to the development of future locality-based and community-focused service models, with further work being undertaken to define how these arrangements would operate in practice.
- The annual planning process had begun for 2027/28 with activity and workforce plans being developed.

Board members:

- Welcomed the recent media coverage of the Manchester Brain Health Programme and expressed support for the initiative.
- Requested additional information regarding the palliative care and end-of-life care programme including performance data relating to preferred place of death. TRa committed to providing further information to QSPBC.
- Clarification was sought regarding the timescales associated with pilots and the development of new frailty care models, together with an update on progress towards wider implementation. SM confirmed that they would likely mobilise this financial year but may not be in place in time for the beginning of the winter period.
- Welcomed the progress being made through the locality programme and recognised the importance of both internal and external engagement in supporting delivery of the programme's objectives. TRa confirmed that service model development was being supported through a range of governance arrangements, including engagement through the Manchester Clinical Professional Advisory Group (CPAG), which enabled proposed service changes and clinical models to be tested with clinicians from across the wider system.

Decision	Action	Lead	Complete / date for completion

The Board of Directors noted the report.	Reporting on end-of-life care performance metrics to be provided to QSPBC.	TRa	December 2026

11.1 Quality, Safety and Performance Committee (QSPBC) (25/08/26) escalation and assurance report

JH presented the escalation and assurance report from the QSPBBC held on the 25/08/26 and drew attention to:

- The Committee had undertaken detailed scrutiny of a number of reports scheduled elsewhere on the Board agenda and that these items would be considered later in the meeting.
- An update received on the Human Tissue Authority (HTA) evidential compliance assessment, which was being undertaken as part of a national regulatory requirement for all HTA post-mortem licence holders. Assurance was provided that MFT remained on track to complete the initial review phase, following which a detailed review of incidents would be undertaken and the required declaration submitted.
- An update regarding the Regulation 28 Prevention of Future Deaths notification issued by the Coroner in July. Committee members were advised of the immediate actions implemented in response to the notification, together with the ongoing work to ensure learning was embedded and recurrence prevented. The Trust's formal response has been submitted.
- The Patient Administration programme was moving from an approach based primarily on issue identification and monitoring to a structured assurance and delivery model. A new strategic risk had been introduced to reflect the significance of the programme and its associated risks, with oversight to be provided by the Digital and Estates Board Committee and regular reporting provided to QSPBC. A separate briefing session had also been provided to Non-Executive Directors to support understanding of the issues and improvement programme.
- Outcomes from the Senior Leadership Visit Programme, which had been relaunched in January. 17 visits had been undertaken to date and themes identified included high levels of compassionate care and effective team communication. The value of the programme as a mechanism for engaging directly with staff, understanding areas of success and improvement, and triangulating assurance information was highlighted.
- A positive position against national objectives for IPC was reported, with ongoing improvement work focusing on prescribing practice, bloodstream infections, duration of therapy, penicillin allergy de-labelling and the use of high-risk antibiotics.
- The Gynaecology Cancer Improvement Programme, including the recovery plans implemented to improve performance against the 62-day referral-to-treatment diagnostic standard. Performance was expected to return to trajectory by September 2026 and was currently ahead of the planned recovery profile.
- The Urgent and Emergency Care Quality and Safety Programme with key risks relating to ambulance delays, the care of people with mental health needs, and corridor care.
- A thematic review of Never Events occurring during the preceding 12-month period. Themes relating to human factors, digital safety controls, learning dissemination and reporting culture were discussed. Further focus would be placed on evidencing learning and ensuring dissemination of that learning across the organisation with updates being provided to QSPBC on a regular basis..

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

11.2	**Trust response to Maternity and Neonatal 10-point plan**

KM and KMac introduced the report which presented the Trust's baseline assessment and supporting evidence for submission to NHS England. KM and KMac drew attention to:

- The submission had previously been considered in detail by the Quality, Safety and Performance Committee and had also been circulated to Board members in advance to enable the Trust to meet the national submission deadline whilst ensuring appropriate Board oversight. It was confirmed that the submission had been made within the required timeframe.
- Evidence had been submitted against each of the ten requirements within the plan. Full compliance had been assessed against two requirements, including the review of consultant services. Six requirements had been assessed as partially compliant and maternity triage had been assessed as non-compliant at the point of submission.
- The requirement for dual Board-level accountability between the Joint Chief Medical Officer and Chief Nursing Officer. It was noted that this had been assessed as partially compliant solely because formal Board approval was required. Assurance was provided that arrangements were already in place and that full compliance would be reported by December.
- The work being undertaken to address inequalities in maternity outcomes, including delivery of the Perinatal Equity Programme.
- The national maternity triage specification had only recently been received. An assessment against the new specification had been completed and would be reported through QSPBC. The maternity triage position differed across MFT sites. Oxford Road Campus was reported to be close to full compliance, whilst further work relating to the care environment, estates and facilities arrangements was required at North Manchester General Hospital. It was anticipated that the Trust would move to partial compliance by December with full compliance in 2027. SM supported the ongoing work regarding triage arrangements and the learning being shared across Clinical Groups.
- The additional report in the Board pack referred to implementation of the national Maternity and Neonatal Care Bundle. The Trust had developed an implementation plan to achieve full compliance by March 2027. Four of the five elements were currently assessed as partially compliant, and one element remained non-compliant due to ongoing regional work. No significant barriers to delivery were anticipated. The Board is separately asked to approve the Maternal Care Bundle implementation plan and trajectory of compliance by March 2027. This will form part of year 8 of the Maternity Incentive Scheme which will be reported to the Board in January 2027.

CM explained that she had had one-to-one meetings with maternity colleagues regarding the 10-point plan compliance and a discussion had also been held with the Maternity Voices Partnership. In her role as Maternity Board Safety Champion, CM carries out monthly walkrounds of maternity services to triangulate patient and staff views with the reported data.

Decision	**Action**	**Lead**	**Complete / date for completion**
The Board of Directors received and ratified the 10-point plan baseline assessment for onward submission and approved the dual Board-level accountability for perinatal issues, the Maternal Care Bundle implementation plan and trajectory of compliance by March 2027.	None	n/a	n/a

11.3	**Complaints Annual Report***

KSJ presented the Annual PALS and Complaints Report for 2025/26, providing an overview of activity, performance, learning and improvement across the Trust from 1 April 2025 to 31 March 2026. KSJ drew attention to:

- The report had been discussed in detail at the QSPBC meeting in August.
- Almost 10,000 concerns had been received during the reporting period, alongside just over 2,000 formal complaints. It was noted that complaint volumes had increased nationally and that MFT had experienced a similar trend. The overall management and handling of complaints was performing strongly.
- A significant proportion of complaints continued to relate to delays and waiting times, reflecting wider pressures experienced across the NHS.
- Six Parliamentary and Health Service Ombudsman (PHSO) cases had been concluded during the period, of which four had related to maternity services and two had been partially upheld.
- The arrangements for sharing learning arising from complaints were outlined with local action plans implemented and managed within services and learning disseminated through clinical groups, senior leadership communications and other governance mechanisms. Work is underway to further strengthen organisational learning from complaints.
- There had been an increase in complaints submitted directly to the Chief Executive and work was being undertaken to ensure such complaints were managed effectively and consistently and in line with the Complaints policy.

Board members welcomed the fact that over 4000 staff had attended Safe and Thyme training to enhance customer care skills.

Decision	Action	Lead	Complete / date for completion
The Board of Directors approved the MFT Annual Complaints Report 2025/26.	None	n/a	n/a

11.4	**Patient Experience Annual Report***

KSJ presented the Patient Experience Annual Report 2025/26 which set out the Trust's position on patient experience and the progress made during the year to strengthen how patient feedback is captured and understood to support improvement. KSJ drew attention to:

- The report had been discussed in detail at the QSPBC meeting in August.
- Patient engagement and feedback continued to increase, with more than four million Friends and Family Test responses now having been received and in excess of 100,000 local survey responses collected. The range of methods available for patients and carers to provide feedback continued to expand and particular attention has been given to addressing language barriers and improving access to services for diverse patient groups.
- There has been an increase in volunteer involvement across the organisation and volunteers are continuing to make a positive contribution to supporting patients and improving patient experience.
- Waiting remains the most consistent theme emerging from patient feedback. Waiting-related concerns present in multiple forms, including waits for appointments, treatment, communication and clinical processes. A significant focus therefore continues to be placed on reducing waiting times and addressing variation across services and clinics.
- Future work is focusing on embedding learning throughout the organisation and ensuring that patient experience became an integral element of organisational culture rather than a standalone initiative.

Board members:

- Commended the clarity of the report and the range of information provided.
- Welcomed the content on chaplaincy services and volunteers and recognised the valuable role they play within the Trust.

Decision	Action	Lead	Complete / date for completion
The Board of Directors received the Annual Quality & Patient Experience Report 2025/26	None	n/a	n/a

11.5	**Emergency Planning and Business Continuity including; EPRR Core Standards Statement of Compliance*; EPRR policy*; Business Continuity Policy***

VG presented the report which provided an update on MFT's 2026/27 NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards submission. VG drew attention to:

- The annual EPRR compliance assessment was a mandatory requirement, and the report had been discussed in detail and supported at the QSPBC meeting in August.
- The Trust remained substantially compliant with EPRR requirements. Compliance against the core standards had increased by 1% during the year to 96%.
- Full compliance was expected to be achieved within the next 15 to 18 months through the continued development of business continuity arrangements, supporting processes and the implementation of a new electronic system.

MG noted the importance of organisational resilience and sought clarification regarding how risks identified through supplier resilience assessments would be escalated and reflected within the Trust's risk management and assurance framework. VG and DB confirmed that supplier resilience was being assessed through a programme of work that included reviewing key suppliers and identifying areas of greatest risk. It was noted that these risks were considered through the appropriate management and governance arrangements with a route for escalation and oversight where required.

Decision	Action	Lead	Complete / date for completion
The Board of Directors noted the report and approved the contents of the EPRR Policy and the Business Continuity Policy.	None	n/a	n/a

11.6	**Winter Plan – Board Assurance Statement***

VG presented the Trust's Winter Plan which prioritises early clinical decision-making, stronger inpatient flow, timely discharge and care closer to home. VG drew attention to:

- The Plan had been discussed in detail and supported at the QSPBC meeting in August.
- The Winter Plan had been developed using learning from the previous winter period and was structured around four key priorities. Clear interventions, agreed programmes of work, identified risks and corresponding controls were included within the plan.
- Following consideration by QSPBC, the plan had been tested through two exercises. These comprised a regional system-wide exercise held on 18 September, and a local Trust exercise held on 22 September. These exercises had provided an opportunity to test the effectiveness of the arrangements and had demonstrated the robustness of the plan.

- The Board Assurance Statement had previously been supported by QSPBC. Following feedback from the regional team, the document had been updated to include site-specific risks, and the revised version was included in the report.
- Board approval was required to enable submission of the Winter Plan and associated Board Assurance Statement within the required timescale.

SL asked how planning was being affected by the potential for extreme weather conditions over the next year. VG explained that a separate adverse weather plan was in place and would be activated in the event of significant weather-related incidents. The unusually high temperatures experienced during the summer had tested the resilience of the Trust's estate and highlighted the growing importance of preparedness for extreme weather conditions.

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

12.1	People Board Committee (PBC) (25/08/26) escalation and assurance report

AA presented the escalation and assurance report from the PBC held on the 25/08/26 and drew attention to:

- Discussions regarding the draft Risk Appetite Statement, which had been considered by all Board Committees.
- The organisation had recently managed a significant volume of Equality, Diversity and Inclusion programme activity over a sustained period and resource constraints for this area of work would remain a strategic and operational consideration going forward.
- The Committee commended the Ignite programme and recognised the positive impact that the initiative had generated across the organisation.
- Statutory medical appraisal arrangements remained strong and continued to be delivered across the Trust's medical workforce of almost 3,000 doctors.

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

12.2	Safer Staffing Report (nursing and AHP) *

KSJ presented the report and drew attention to:

- The report had been discussed in detail at the PBC meeting in August.
- Sustained progress continued to be made in reducing temporary staffing expenditure, particularly through reductions in nursing bank usage.
- The Trust continued to perform favourably against national benchmarks and that improvements had been achieved across a number of workforce indicators.

- There are ongoing national reviews affecting nursing workforce arrangements and funding and work is underway with Finance colleagues and national teams to understand the implications of these developments and any associated financial risks.
- Nursing and maternity services remained compliant with national safe staffing requirements and that safe staffing arrangements continued to be closely monitored through established governance processes.
- At the end of June 2026, nursing bank spend was 26.8% (£4.1m) lower than 2025/26 YTD, against the NHSE target of 10%.

NG sought clarification regarding the nurse-to-patient ratio information presented within the report with one figure suggesting a reduction in the ratio over time, whilst benchmarking information appeared to show a different comparative position. KSJ explained that benchmarking was undertaken against comparable organisations, although differences in organisational structures and services meant that direct comparisons were not always meaningful. Trends were reviewed alongside peer benchmarking to provide an appropriate context for performance assessment. The reduction reflected changes in actual staffing numbers and was principally attributable to changes made to ward establishments.

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

12.3	**Medical Appraisal and Revalidation and Annual Statement of Compliance***

MM presented the report which presented the outcomes of the 25/26 appraisal and revalidation process for the 2914 licensed doctors and 89 GDC-only dentists at MFT. MM drew attention to:

- The report had been discussed at the PBC meeting in August.
- The appraisal and revalidation framework provided assurance to the General Medical Council, NHS England, regulators, staff and patients regarding the competence and professional standards of the medical workforce.
- The Trust continued to meet its responsibilities in relation to the medical appraisal and revalidation process and robust governance arrangements remained in place to support the Responsible Officer in making revalidation recommendations. The Trust remained in a strong position in relation to medical professional governance and revalidation requirements.
- Compliance data would be submitted as part of the Trust's annual return at the end of October.
- Although performance remained strong, a number of improvement actions had been identified for the forthcoming year. These included further work on the allocation of appraisers, closer alignment with job planning processes and strengthening the reliability of links between patient safety information and appraisal documentation. This work was being undertaken in collaboration with Oxford University.
- Bernard Clarke’s contribution in maintaining strong appraisal and revalidation performance and supporting the reliability of the processes in place. Bernard is stepping down from the role of Responsible Officer in October.

CM ought clarification regarding the extent to which feedback from doctors was obtained and utilised within the appraisal process. MM confirmed that statistically significant levels of feedback were obtained and monitored and trends could be tracked over time. This information would continue to support ongoing improvements to the appraisal and revalidation process.

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

of the Annual Statement of Compliance.			

12.4	**Workforce Race Equality and Disability Equality Schemes' update and action plans***

MN presented MFT's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) returns and the associated action plan for 2026/27. MN drew attention to:

- The reports drew on a range of data sources including staff declaration data, staff survey results, recruitment information, training records and employee relations data. The indicators included measures relating to staff experiences of bullying, harassment and discrimination, as well as data relating to recruitment, career progression and disciplinary processes.
- Several of the indicators were expressed as likelihood ratios, with a ratio between 0.8 and 1.2 generally representing an equitable position. These measures provided an indication of the extent of disparity experienced by different staff groups.
- The likelihood ratio relating to recruitment outcomes was approximately 1.22 and had continued to improve. However, staff survey findings indicated that some staff from ethnically diverse backgrounds continued to lack confidence in recruitment and career progression processes despite improvements shown within the workforce data.
- The inclusive recruitment programme was currently focused on supporting staff in Bands 6 and 7 to progress into higher graded roles, recognising that these grades represented a key transition point within career pathways. Approximately 230 expressions of interest had already been received, and panel members were being trained to participate in recruitment processes and provide challenge, insight and support for inclusive recruitment practices. It was anticipated that the programme would make a significant contribution to improving representation across the organisation over the next 12 months.
- Whilst overall indicators presented a generally positive picture, the experiences reported by staff with disabilities continued to indicate a less positive experience than that of other staff groups. This was also reflected in staff survey findings and had been identified as a priority area through workforce and culture discussions.
- A range of actions had been developed in response to staff feedback relating to disability inclusion. These actions were reflected within the WDES action plan and would be overseen through established governance groups and sub-groups.

DB reflected on feedback from the Diverse Abilities Staff Network that access to workplace adjustments was improving but the time taken to secure adjustments remained a key concern.

Decision	**Action**	**Lead**	**Complete / date for completion**
The Board of Directors noted the findings of the 2025/26 WRES and WDES submissions and approve the proposed action plan for implementation across MFT.	None	n/a	n/a

13.1	**Finance Board Committee (26/08/26) escalation and assurance report**

TR presented the escalation and assurance report from the FBC held on the 26/08/26 and drew attention to:

- The Committee had considered the draft Risk Appetite Statement and was recommending a moderate risk appetite in relation to this area. It was acknowledged that the Trust was currently operating outside of its desired appetite due to prevailing circumstances; however, the intention remained to return to the agreed risk position whenever possible.

- The contract award for blood gas analysers, which had been considered in private session by the Board, had been supported by the Committee.
- A deep dive had been undertaken into the Clinical Scientific Services Clinical Group as part of the Committee's ongoing programme of detailed reviews of individual Clinical Groups. The session had provided an opportunity for Committee members to gain a deeper understanding of the challenges, opportunities and performance of the Clinical Group.
- An update was received on commercial activity across the Trust. Commercial development was expected to become increasingly important to the organisation and positive progress was being made in a number of areas. The Committee had expressed support for the work underway..

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

13.2 Chief Finance Officer's report*

CW introduced the report and drew attention to:

- At the end of Month 4, the Trust had achieved a small surplus and remained on plan against the £2 million surplus target. A number of non-recurrent measures contributed to the reported position. The underlying financial position had been examined in detail by the FBC.
- NHS England was undertaking its mid-year forecasting exercise and requiring organisations to reconfirm confidence in their year-end capital plan. The Trust will confirm full delivery of the plan is expected.
- The Executive Team had established a more detailed review of operational and financial plans for the remainder of the financial year, and the outcomes of that work would be reported through the FBC over the coming weeks. FBC's focus would be on major productivity and improvement workstreams as part of the Trust's "H2 Reset" programme for the second half of the year.
- Dedicated workstreams were being established to identify and deliver large-scale productivity opportunities. Enhanced governance, focus and resource would be applied to these programmes to strengthen delivery and oversight.
- Matters relating to cash management had been addressed during the IPR discussion earlier in the meeting.

Board members:

- Commended the significant effort being undertaken across the organisation to manage the Trust's financial position. Particular recognition was given to the extensive financial management arrangements in place, including frequent reviews of cash and financial performance.
- Welcomed the clarity of the report.

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

13.3 Audit and Risk Committee (ARC) (09/09/26) escalation and assurance report

NG presented the escalation and assurance report from the FBC held on the 09/09/26 and drew attention to:

- The Committee approved the revised Anti-Bribery and Corruption Policy. The policy had been updated and presented in the revised corporate format.

- The Committee had received the six-monthly Risk Management Report. Risk management arrangements across the Trust continued to mature and strengthen with further development work underway to ensure consistent application across the Trust.
- A substantial programme of audit work was underway and internal audit activity continued to provide valuable assurance and support to the organisation. Progress continued to be made in implementing agreed audit recommendations and no backlog of overdue audit actions had accumulated.
- The Committee received updates relating to counter fraud activity and external audit matters as part of its routine assurance responsibilities.

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

13.4 Digital and Estates Board Committee (DEBC) (10/09/26) escalation and assurance report

SL presented the escalation and assurance report from the FBC held on the 10/09/26 and drew attention to:

- The Patient Administration programme, referred to during the QSPBC escalation report, was discussed in detail and oversight of the related strategic risk would remain with DEBC alongside reporting to QSPBC as a result of the potential impact on patient care. The immediate focus of the programme was on assurance, risk reduction and strengthening controls and the programme also represented an important enabling platform for future transformation.
- Work continued with partner organisations regarding the Oxford Road sit's PFI arrangements and external advisers had been engaged. A new strategic risk relating to the PFI arrangements had been approved. The Committee had requested a clearer delivery timeline and greater clarity regarding accountability across all partner organisations, with further information to be presented at the next Committee meeting.
- The position relating to end-user devices. Previous investment decisions had appropriately prioritised cyber security, network resilience and major digital programmes. The Committee had therefore accepted an unfunded exposure associated with the related risk.
- The continued rollout of ambient voice technology across clinical specialties with the technology was now being used by over 400 colleagues on a daily basis. Positive feedback had been received from both clinicians and patients, and further evaluation and rollout activity would continue across 19 specialties.
- The Research and Innovation Team had secured designation for the Trust as an MHRA AI Innovation Sandbox site. This status would enable innovative technologies, including ambient voice technologies and wearable devices, to be tested within NHS settings and the learning generated through this work would be shared across the wider NHS.

Board members welcomed the achievement of securing MHRA AI Innovation Sandbox designation and commented on the significant opportunities that the programme presented for innovation and service improvement. An item on this was requested for a future Board seminar.

Decision	Action	Lead	Complete / date for completion
The Board noted the report.	MHRA AI Innovation Sandbox to be scheduled for a future Board seminar.	NGo	Complete. Scheduled for December Board seminar

14. Risk Appetite Statement*

KSJ presented the amended Risk Appetite Statement for the Board to approve. It has been discussed at each Board Committee during August and September with feedback used to inform the final product.

- The Risk Appetite Statement had been developed through a collaborative process involving Board members and Committees and had been reviewed by all Board Committees.
- The proposed statement sought to articulate the Trust's appetite for risk across different domains. A higher appetite was proposed in areas associated with innovation and transformation, whilst a lower appetite was proposed in relation to patient safety, organisational culture, governance and the Trust's responsibilities to its communities.
- Approval of the Risk Appetite Statement should be regarded as the beginning of the process rather than its conclusion. The statement was intended to become an integral part of strategic decision-making and should be routinely considered in future Board and Committee discussions.

TR thanked those who had been involved in the Statement's development.

Decision	**Action**	**Lead**	**Complete / date for completion**
The Board noted the report and approved the Risk Appetite Statement.	None	n/a	n/a

15.	**Any Other Business**

There were no further items of business.

16.	**Meeting Evaluation**

TR sought views regarding the format, structure and contents of the meeting.

Date and time of next meeting: 25th November 2026 at 2:00pm

Public Board of Directors
Action Log

Meeting Date	Action No	Action ID	Agenda Item	Action	Owner	Updates	Target Date	Status
	1	BOD-00000000-01		Analysis of national cost collection to be presented to a future Board Seminar session	Claire Wilson	Added to Board Seminar forward plan - scheduled for February 2027	24/02/2027	In Progress
30/07/2026	1	BOD-30072026-01	10.3 Strategic Developments	Board Seminar Item on Advanced Foundations Trust to be scheduled	Nick Gomm	Discussed at Board Seminar on 28 October 2026.	28/10/2026	Complete
30/09/2026	1	BOD-30092026-01	10.3 Strategic Development	Reporting on end-of-life care performance metrics to be provided to QSPBC.	Tom Rafferty	Action transferred to QSPBC. Update to be provided to QSPBC in December 2026 along with the End of Lide Annual Report.	25/11/2026	Transferred
30/09/2026	2	BOD-30092026-02	13.4 Digital and Estates Board Committee (DEBC) (10/09/26) escalation and assurance report	MHRA AI Innovation Sandbox to be scheduled for a future Board seminar.	Nick Gomm	Added to Board Seminar forward plan - scheduled for December 2026 Board Seminar session	16/12/2026	In Progress

NHS
Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday, 25 November 2026

Paper Title:	Trust Chief Executive Report	**Agenda Item 8**
Presented by:	Mark Cubbon, Trust Chief Executive	
Prepared by:	Leo Clifton, Senior Business Manager	

Meetings where content has been discussed previously	Trust Leadership Team Committee	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For discussion	☐ For support ☒ For noting

Executive summary / key messages for the meeting to consider

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

Recommendation(s)

The Board of Directors is asked to note this report.

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

Relationship to the strategic objectives

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

☒ LHL Objective 1	☒ LHL Objective 2
☒ HQSC Objective 1	☒ HQSC Objective 2
☒ HQSC Objective 3	☒ PEW Objective 1
☒ PEW Objective 2	☒ VfP Objective 1
☒ VfP Objective 2	☒ R&I Objective 1

☒ R&I Objective 2	☒ Good Governance
Links to Trust Risks	The work contained within this report links to the following strategic, corporate, or operational risks: • All strategic objectives in the Board Assurance Framework.
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Caring ☒ Effective ☒ Well-Led ☒ Responsive
Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the report: • None

Main report

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

Contents

1. Work with partners to help people live longer, healthier lives 3
2. Provide high quality, safe care with excellent outcomes and experience 5
3. Be the place where people enjoy working, learning and building a career 8
4. Ensure value for our patients and communities by making the best use of our resources 10
5. Deliver world-class research and innovation that improves people's lives ... 11
6. Strategic Updates and Policy Developments 11
7. Leadership Updates 14
8. Top concerns 15

Full content of the report is included as Appendix A.

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

Annual Planning

Work is underway to develop our plans for 2027/28 and subsequent years, as part of this year's planning round. The first phase of work is focussed on developing our activity, workforce and finance plans ahead of a first submission to NHS England in December. During the December to March period we will develop action plans to support delivery and ensure key elements are in place ready for the start of the new financial year.

We await more detailed national planning guidance, and further information about potential changes to the national tariff and funding flows due to be published in November. However, the multi-year approach taken last year by NHS England provides a helpful framework, as do key national documents published over the last 12 months such as the Neighbourhood Health Framework and the National Quality Strategy. We are working closely with commissioning colleagues throughout to ensure our processes and plans are aligned.

Community Diagnostic Centres

MFT continues to develop its Community Diagnostic Centre (CDC) network to ensure patients are able to access a greater range of tests and scans closer to home. On 29 October, Minister of State for Health, the Rt Hon Karin Smyth MP, and Withington MP Jeff Smith, joined us to officially open the new purpose-built Manchester and Trafford Community Diagnostic Centre at Withington Hospital.

This marks an important milestone in the development of our community diagnostic services, offering single diagnostic pathways as well as tests. The new centre builds on the activity already being delivered through MFT’s CDC network, with the Manchester and Trafford and North Manchester centres providing around 142,400 diagnostic tests during 2025/26. The next phase of development at Gorton will provide a further opportunity to expand access to diagnostics for communities in East Manchester.

CDCs and our wider community facilities will play an increasing role in neighbourhood health and wider service transformation. The focus is increasingly on joining up diagnostic services with primary care, community and hospital services, including more one-stop and straight-to-test pathways. This supports earlier diagnosis, reduces unnecessary hospital visits and improves access to care, particularly for communities experiencing health inequalities.

Frailty and Care Homes

MFT is currently developing a more consistent and proactive frailty pathway across Manchester and Trafford, delivered in partnership with primary care, adult social care, care homes and wider partners including the North West Ambulance Service. The model will

strengthen earlier identification of frailty, proactive multidisciplinary management, personalised and anticipatory care planning and access to specialist geriatric expertise. Hospital at Home, urgent community response and acute frailty services will provide escalation when required. The aim is to move from predominantly reactive intervention towards prevention, maintaining independence and providing more care closer to home for frail patients.

Led by colleagues from our LCO & UDHM Clinical Group, key next steps will be to co-design the community frailty model with primary care, local authorities and patients, and progress a pilot and phased rollout during 2027/28 subject to business case approval.

Prevention Demonstrator

MFT continues to develop its contribution to the Greater Manchester Prevention Demonstrator, with cardiovascular, renal and metabolic health all major areas of clinical focus. The work will bring together Cardiovascular, Renal and Metabolic (CVRM) prevention, population health analytics, neighbourhood delivery and outpatient transformation, with a focus on earlier identification and optimisation of hypertension, lipids, atrial fibrillation, Chronic Kidney Disease, obesity and wider cardiovascular risk.

This will be complemented by development of GLP-1 pathways for targeted high-risk cohorts, with evaluation of clinical outcomes, cardiovascular risk reduction, equity and service utilisation. Together, these programmes aim to demonstrate how MFT's specialist expertise, digital capability and innovation can support prevention at population scale while shifting appropriate care closer to home. Opportunities to link into our innovative work on brain health with partners are also being evaluated with colleagues from Greater Manchester Mental Health (GMMH) as well as other providers and the universities.

Brain Health

Following the launch of the two-year Brain Health Clinic pilot, work continues to develop the longer-term vision for a Manchester Brain Health Centre. The pilot, funded by the Alzheimer's Society, brings together MFT, Greater Manchester Mental Health, the University of Manchester and partners to improve earlier diagnosis and treatment of dementia, provide personalised support and establish the clinical and research infrastructure needed for a new model of brain health care.

A business case for a permanent Centre is being developed considering the future clinical model, estate, governance, capital requirements and a sustainable long-term revenue model. A prospectus is also developed to articulate the wider ambition, strengthen alignment between partners and support future fundraising. Discussions are continuing about how the programme could connect with wider specialist services and the development of a broader Greater Manchester approach to brain health.

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

Operational Delivery

Urgent Care

This year we aim to achieve 82% performance for the 4-hour standard across all types by March 2027. For the month of October performance was 70.4% against a plan of 77.8%.

In October, 49,810 patients required emergency care, 1,785 (3.7%) more than forecast and 5.3% higher than October 2025. Sustained demand, together with pressures on assessment, bed capacity and discharge, continued to affect patient flow and the experience of patients requiring admission. Performance varied across sites, with a greater challenge for patients on admitted pathways, reflecting wider constraints in hospital flow rather than demand alone.

Ambulance handover within 15 mins during October was 54.9%, against the national standard of 65%, which the Trust is planning to achieve by March 2027. Average handover time in October was 15 minutes 49 seconds against the Trust’s plan for the month of 15 minutes.

Improvement priorities include embedding the Model Emergency Department across our acute sites, strengthening early senior decision-making, increasing the use of alternatives to admission, and improving discharge and flow through hospital. These actions form part of our wider programme to improve urgent and emergency care performance and reduce variation between our MFT sites which we are mobilising ahead of winter.

Elective Care

The most recent reported data for elective care is September, when the month end position for 18-week referral to treatment (RTT) reported 65.06% performance against our plan of 65.67%. We reported 1,394 patients waiting over 52-weeks for elective treatment against our plan of 1,303. The elective waiting list remained above trajectory in September as increased demand continues, with referrals around 2% higher year-on-year overall and materially greater growth in several high-volume specialties.

Our dual focus is therefore on maintaining progress for our longest-waiting patients and further improving the proportion of patients treated within 18 weeks. The Trust's Care on Time transformation programme continues to support this through pathway transformation, strengthened validation and proactive management of capacity and waiting lists.

Cancer Care

The latest reported data for cancer is September, where our performance against the 62-day standard reported 71.8% against a plan of 77.76%. Performance against the Faster Diagnosis Standard (FDS) was 80.22% against a trajectory of 80.01%. Performance against the 31-day Decision to Treat (DTT) standard was 90.63% in September, against a plan of 92.36%

Improving the timeliness of cancer diagnosis and treatment remains a key priority for the Trust. We continue to work across our cancer services to reduce variation, improve the efficiency and resilience of pathways and address the underlying causes of delay, supported by focused improvement plans in those tumour pathways with the greatest challenges.

Diagnostics

Performance for the month of September across all DM01 modalities was 12.75% against a plan of 7.89%. Diagnostic performance remains above trajectory, with pressures concentrated particularly in Sleep Studies, MRI, Cardiac CT/MR and endoscopy pathways for children and young people. The diagnostic waiting list also remains above plan, reflecting both increased demand and capacity constraints in a number of services. Recovery actions include additional endoscopy capacity, increased activity within Sleep Studies and Cardiac CT/MR, and use of additional Community Diagnostic Centre capacity. Performance is being closely monitored as these measures take effect.

Winter Preparedness

The Trust is progressing with preparations for winter 2026/27, with plans focused on maintaining safe services through periods of increased demand and operational pressure. Learning from last winter has reinforced the importance of maintaining patient flow, particularly timely discharge, as pressures on flow and high bed occupancy have a direct impact on Emergency Department performance, ambulance handovers and our ability to maintain planned care. Our winter plan therefore has a strong focus on reducing avoidable admissions, improving flow through our hospitals and supporting patients to leave hospital as soon as they are clinically ready, working closely with health and care partners.

We have already seen sustained pressure across our Emergency Departments as we move into winter. Enhanced oversight of demand, capacity, occupancy, discharge and patient flow is in place, supported by Trust and system escalation arrangements so that emerging pressures can be identified and acted upon early. Priorities include improving discharge, maximising Hospital at Home and other alternatives to admission, and reducing variation in flow between sites, with performance and risks closely monitored throughout the winter period.

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Submission and Outcome

The Trust has completed its 2026/27 NHS EPRR Core Standards self-assessment, achieving 97% compliance and an overall rating of Substantially Compliant, an improvement from 95% in 2025/26. Of the 62 standards applicable to MFT, 60 are fully compliant, two partially compliant and none non-compliant. The remaining areas for improvement relate to business continuity, with continued focus on strengthening Business Impact Assessments and Business Continuity Plans. The year has also seen wider improvements in organisational resilience, including implementation of a new cascade system to strengthen emergency communications and cascade arrangements, and further strengthening of EPRR planning, exercising and governance. The outcome provides positive assurance on the Trust's overall preparedness and resilience, while maintaining a clear improvement programme to address the remaining areas of partial compliance and further mature arrangements across the organisation.

Thirlwall Inquiry Recommendations

Following publication of the Thirlwall Inquiry Report on 15 September, plans are progressing regarding the Trust’s response to the recommendations and associated national requirements. Immediate actions required to date have been completed, including those relating to Sudden Unexpected Death in Infancy and Childhood (SUDIC), bereavement care and safeguarding compliance. A Thirlwall Inquiry Task and Finish Group, chaired by the Deputy Trust Chief Executive and Chief Nursing Officer, has been established to coordinate delivery and provide oversight and assurance, with a particular focus on ensuring that the learning from the Inquiry is applied more widely across the Trust. This includes work around patient safety, safeguarding, leadership, governance and culture. Progress, risks and assurance will continue to be reported through established governance routes to the Board, supporting oversight of implementation and evidence that learning is embedded and sustained across MFT.

Information Governance and Unauthorised Access to Patient Records

Following updated NHS England guidance on inappropriate access to patient records, we are undertaking a review of our existing controls and assurance arrangements. Our Hive Electronic Patient Record (EPR) provides MFT with comprehensive auditing of access to patient records, underpinned by individual authentication, role-based access and enhanced break the glass controls where additional protection is required. Where concerns are identified, activity can be investigated through the system audit trail and managed through established Trust processes. We are building on this by considering additional risk-based proactive monitoring and reviewing opportunities to further strengthen automated surveillance and alerting within Hive. This sits alongside continued staff awareness, training and clear arrangements for investigating and responding to inappropriate access. The objective is to ensure that we continue to provide strong

protection for patient confidentiality while increasing the level of proactive assurance available to the Trust.

Patient Experience Strategic Delivery Plan

The Trust's Patient Experience Strategic Delivery Plan 2026–2028 has now been approved. The plan sets out our ambition to deliver an outstanding patient experience, making this an integral part of how we deliver and improve care across MFT. The plan has a strong emphasis on co-production, ensuring that patients, families and communities play a meaningful role in shaping our services, together with stronger partnership working, person-centred care and better use of near real-time feedback to understand and respond to people's experiences.

To support this, MFT has entered into a partnership with Think Local Act Personal (TLAP), bringing national expertise and the Making It Real framework into our ways of working. The programme will strengthen co-production, supporting patients, carers, communities and colleagues to work as equal partners and ensuring lived experience has a visible influence on how services are designed and improved.

These developments build on the discussions at our Patient Experience Senior Leaders' Summit on 19 October which brought senior leaders from across MFT together to share good practice and reinforce our collective responsibility to listen to, learn from and act on what matters most to patients and families.

Children and Young People's Cancer Survey

The results of the 2025 Children and Young People's Cancer Patient Experience Survey provide positive assurance regarding the experience of children receiving cancer care at MFT, with 96% of parents and carers rating their child's overall care as 8 or above out of 10. Positive feedback was also reported in relation to involvement in treatment decisions and communication, including 90% of parents and carers reporting that staff provided sufficient time to make decisions about their child's treatment. MFT's overall results placed the Trust fourth nationally. Local patient experience work at Royal Manchester Children's Hospital complements the national survey, providing additional insight to inform targeted improvement and further enhance the experience of children, young people and their families.

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

Culture and Staff Experience Forum

I was delighted to host our fourth Culture and Staff Experience Forum on 6 November, bringing together colleagues from across MFT to help shape improvements in staff experience around our three priorities: Safe and Healthy, Heard and Included, and Recognised and Rewarded. At the forum, colleagues from across the Trust shared their

views on how we can strengthen reward and recognition, highlighting the importance of simpler and more consistent appraisals, meaningful development conversations, clearer career progression - particularly for non-clinical colleagues - and greater recognition of everyday contributions. These insights will directly inform our improvement work, with progress shared through future “You Said, We Did” updates, providing a clear and visible link between colleague voice, action and measurable change.

One Born Every Minute

The E4 documentary One Born Every Minute is now being broadcast on Sundays at 9pm, having filmed at MFT's Saint Mary's Oxford Road site over the summer. The programme tells the diverse stories of women and families as their babies are born, reflecting considerable changes in modern maternity care since the series last aired.

Episodes so far have covered fertility challenges, miscarriage, health anxiety and multiple births. MFT's accompanying communications have focussed on social media messaging and informational videos linked to issues featured in the programme each week, helping to create trusted content around pregnancy and birth. We remain extremely grateful to the families who have taken part, and to our maternity services colleagues across MFT for their compassion, dedication and skill.

Events and Celebrations

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

- **Annual Members’ Meeting and Community Health Fair** – On 29 September, we welcomed hundreds of members, patients and local residents to Wythenshawe Hospital for this year’s Annual Members’ Meeting and Community Health Fair. The event showcased the breadth of services and expertise across MFT, with colleagues providing health checks, screening advice, vaccinations, physiotherapy support, menopause advice and demonstrations of innovative technologies. Presentations during the formal meeting highlighted developments including the Manchester Brain Health Centre, our work to tackle health inequalities, and the use of artificial intelligence to support earlier diagnosis. I would like to thank everyone involved, including our Council of Governors, volunteers and colleagues across multiple Clinical Groups, for helping to make the day such a success.
- **Honorary Appointment for Professor Sohail Munshi** – Congratulations to Professor Sohail Munshi, Joint Chief Medical Officer, on his appointment as Honorary Professor of Practice at the University of Manchester. The award recognises his significant contribution to healthcare leadership, research and innovation, and reflects the important role he continues to play in strengthening partnerships across MFT, the University and the wider health and care system. This is a well-deserved recognition of his longstanding commitment to improving care and outcomes for our patients.

- **National Recognition for Lime Arts** – Congratulations to the Lime Arts team, who recently won the Environment of Care category at the Picker Experience Network Awards. The recognition celebrates the success of Lime's Music for Health programme, which delivers live music sessions across our hospitals to support patient wellbeing, reduce anxiety and create positive care environments. Reaching more than 15,000 people over the last year, the programme continues to demonstrate the important contribution that arts and creativity can make to patient experience, recovery and staff wellbeing.

Consultant Appointments

Since our last Board meeting in September, 26 substantive consultants have been appointed to roles within the following specialties: Anaesthesia, Care of the Elderly Medicine, Child and Adolescent Psychiatry, Community Paediatrics, Haematology, Myeloma and Stem Cell Transplantation, Histopathology, Obstetrics and Gynaecology, Paediatric Gastroenterology, Paediatric Inherited Metabolic Disease, Paediatrics with expertise in Cardiology (PECSIG), Vascular Surgery.

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

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

Financial Recovery

During the second half of the year, the Trust has strengthened its approach to financial recovery through an organisation-wide recovery programme, bringing together our financial, operational and workforce plans. The emphasis is on improving productivity and making the best possible use of the resources already available to us, while continuing to protect the quality and safety of patient care. This includes ensuring that available clinical capacity is used effectively, and that improvements in activity and operational performance are delivered as efficiently as possible.

A particular focus is on a small number of areas where improvements can have an impact at scale, including theatres, outpatient services and workforce productivity, alongside strengthening delivery through our existing Value for Patients programme. We are increasingly using benchmarking and patient-level costing information to understand variation between services, identify opportunities and support clinical and operational teams to translate these insights into practical improvements. The latest productivity work shows the Trust delivering more activity at a lower unit cost, while further opportunities continue to be identified through national benchmarking and local data.

Our focus is on converting productivity improvements into recurrent financial benefits, supported by clearer accountability, stronger tracking of delivery, and the systematic spread of good practice across the Trust. This will provide an important foundation for our longer-term financial recovery and for developing the Trust's plans for 2027/28 and beyond.

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

Womb Cancer Check

A new test developed by researchers at MFT and The University of Manchester (UoM) to identify cells collected from urine and vaginal fluid could help rule out womb and other cancers in most women who experience bleeding after the menopause. The research, led by Professor Emma Davidson, Honorary Consultant in Gynaecological Oncology at Saint Mary's Hospital could make womb cancer investigations faster, simpler and less invasive for thousands of women.

Professor Davidson and her research team - Team Womb, were also recently awarded a prestigious NIHR20 Impact Prize for their outstanding research into the link between Lynch syndrome and endometrial cancer. Professor Davidson received the award on behalf of the team of researchers based at MFT and UoM, supported by the NIHR Biomedical Research Centre: Manchester.

MRC Centre of Research Excellence for Human Neural Development

MFT researchers are supporting a new £50m Medical Research Council (MRC) Centre of Research Excellence (CoRE) for Human Neural Development that will combine expertise from across the UK to address major gaps in our understanding of brain growth and development. Professor Shruti Garg, Centre Translational Lead and Deputy Director will work in collaboration with Royal Manchester Children's Hospital and Saint Mary's Hospital to lead this research in Manchester.

6. Strategic Updates and Policy Developments

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

Autumn Budget 2026

The Budget announced on 28 October included a further £190 million for the NHS in England to help manage winter pressures during the remainder of 2026/27. Other NHS and health related measures included a Department for Culture, Media and Sport 'AI challenge prize' which will award up to £2.5 million to incentivise UK-based innovators and businesses to develop AI solutions to a major challenge on the NHS frontline, use of quantum technologies which can undertake more sensitive diagnostic tests to cut NHS waiting lists, £100 million to accelerate the adoption of robotically assisted surgery and the removal of VAT on medicines donated free of charge, to help expand early access to innovative treatments.

The Government has also commissioned Mark Bailie, a non-executive director of NHS England and CEO of a price comparison website, to lead an independent review of how artificial intelligence (AI) and other technology could improve NHS productivity, with the review due to report in early 2027 and inform the next spending review.

Final report of the Independent Review into Mental Health Conditions, ADHD and Autism

The Government has published the final report of the Independent Review into Mental Health Conditions, ADHD and Autism, chaired by Professor Peter Fonagy. The review highlights a substantial rise in mental distress, particularly among children and young people, and growing demand for ADHD and autism assessment and long waits for support. This increase in demand is reflected at MFT in our Child and Adult Mental Health Services where we have seen a significant increase in referrals and in waiting times for assessment. The review recommends a shift towards earlier support based on an individual's needs, while retaining access to diagnosis where this is appropriate. It also recommends bringing mental health, ADHD and autism services closer together, strengthening specialist care for people with the greatest needs, and improving how services are planned and staffed.

GM ICB has recently commissioned a new service model for children and young people with neurodiversity, including a multidisciplinary needs-led assessment, which teams across MFT have been working to implement. As is consistent with the national trend, demand for these services has increased significantly and we continue to work with commissioning colleagues on ways in which we can improve access to the services offered across Greater Manchester.

Martha's Rule

Martha's Rule is now being rolled out across all emergency departments in England. The Rule is named after 13-year-old Martha Mills, who tragically died of sepsis in 2021 after her family's safety concerns were overlooked. It gives patients, families and staff a clear way to ask for a further clinical review if they are worried that someone's condition is getting worse and they feel their concerns are not being addressed. Following the initial rollout on inpatient wards, it is now to be expanded to all English emergency departments by March 2028.

At MFT, Martha's Rule is implemented across adult inpatient wards at NMGH, MRI and WTWA and across RMCH and associated paediatric sites. Maternity areas launched on the 21 September with Newborn Services launching on 16 November 2026. Planning for the next phase in MFT's Emergency Departments is now well underway, with site walkarounds and stakeholder engagement completed and a multidisciplinary Task and Finish Group established to develop and test an ED-specific model. The intention is to undertake phased testing during 2026/27, including an ED-adapted Patient Wellness

Question and clear escalation arrangements, working towards implementation across MFT EDs by March 2027, ahead of the national March 2028 deadline.

Quality Management Systems

On 17 September, NHS England published the ‘Implementing quality management systems in the NHS’ guidance. This sets out a whole-organisation approach to quality, bringing together quality planning, quality control, quality improvement and quality assurance within a single management system. The intention is to make quality integral to operational delivery and decision-making, with clearer connections between frontline care, organisational priorities and Board oversight. The approach will identify risks earlier, reduce duplication, and strengthen learning, leadership and colleague engagement. The guidance does not specify the design of a Quality Management System.

As Board members will be aware, following the Board seminar in March 2026, work is already underway to develop the Trust’s QMS for full launch and implementation from April 2027. A further update is planned for our December Board seminar.

Patient Experience

Also on 17 September, NHS England published the ‘Achieving excellent patient experience’ guidance. This establishes experience alongside safety and effectiveness as one of the three core domains of quality. The NHS Experience Excellence Framework emphasises the behaviours, systems and organisational culture required for people to feel listened to, respected, involved and supported. It places particular emphasis on leadership, equity, staff experience, learning and using different sources of experience intelligence to identify variation and inequalities.

The Trust’s Patient Experience Strategic Delivery Plan mentioned earlier in this report, aligns with this guidance with planned activity including developing patient-experience dashboards; testing Experience of Care Waiting through MyMFT; establishing a trained Patient Experience Volunteer cohort; strengthening ward and departmental leadership accountability; and developing a Trust-wide patient-centred customer care and compassionate communication programme. This work will be overseen at the Quality, Safety and Performance Board Committee.

NMGH New Hospital Programme

The North Manchester General Hospital New Hospital Project continues to make good progress. Following completion of RIBA Stage 1, the programme has moved into the next phase of design development and assurance, with detailed work progressing across both the new Acute Hospital and Outpatient Centre.

Since my last report, a key focus has been the onboarding of Bovis and the continued development of the design and enabling works in partnership with the New Hospital

Programme (NHP), including the identification of opportunities to improve programme efficiency and deliver value engineering.

Our next immediate priority is to progress the Outpatient Centre through the next NHP control points and towards submission of its Outline Business Case, scheduled for February 2027.

7. Leadership Updates

Trust Chair Appointment

Following an extensive search, recruitment and selection process, Nazir Afzal OBE has been appointed as MFT's new Chair and will take up the role on 4 January 2027. Nazir brings with him more than 30 years of experience in public service, safeguarding, governance and organisational leadership, including roles with the Crown Prosecution Service, the Association of Police and Crime Commissioners and the Welsh Government, and is currently Chancellor of the University of Manchester. Nazir is keen to listen and learn from colleagues and communities, ensuring their voices help shape the Trust's work and priorities. I would like to thank Trevor Rees for his significant contribution as Acting Chair; he will return to his Vice-Chair role when Nazir joins us in January.

Chief Strategy Officer Appointment

I am pleased to confirm that Tom Rafferty has been appointed substantively as Chief Strategy Officer following a competitive external recruitment process. Having overseen the refresh of our Trust organisational strategy, and more recently undertaking the role on an interim basis, Tom will continue to lead on the development and delivery of our strategic ambitions.

NMGH Clinical Group Chief Executive Appointment

I am delighted that Gareth Adams, currently Chief Executive of our Clinical and Scientific Services (CSS) Clinical Group, will take on the role of Chief Executive of North Manchester General Hospital Clinical Group on 1 April 2027, succeeding Jo Rowe, who retires at the end of March. Jo and Gareth will work together to ensure a smooth transition. Recruitment to the CSS Chief Executive post has commenced and the final selection scheduled for January 2027.

Chief Delivery Officer

Vanessa Gardner left MFT at the end of October to explore new opportunities, having worked at the Trust for 12 years and served as Chief Delivery Officer since 2024. I would like to personally thank Vanessa for her dedication and, on behalf of colleagues across the Trust, wish her every success for the future. The search and recruitment process for the Chief Delivery Officer position is currently underway, with final selection scheduled for

December. In the interim, David Walliker is overseeing the majority of the Chief Delivery Officer responsibilities alongside his substantive role as Chief Digital and Information Officer.

Responsible Officer

I'd like to thank Professor Bernard Clarke who has recently retired from his role as Associate Chief Medical Officer and MFT Responsible Officer. Bernard worked in this vital role for the past decade bringing invaluable leadership, professionalism, and dedication. I am pleased to say that Bernard will continue with his clinical work playing a leading role in our tertiary cardiology and maternity services.

From 1 October, Professor Matt Makin will undertake the role of MFT Responsible Officer, a statutory role with responsibility for medical regulation and revalidation, alongside his existing responsibilities as Joint Chief Medical Officer. Dr Kristin Tanney has also been appointed as the Interim Associate Chief Medical Officer and has been working closely with Bernard to ensure a seamless transition.

8. Top concerns

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

Financial Position

Although the Trust remains on plan at Month 7, the underlying financial position remains challenging and continues to be supported by additional non-recurrent measures. Our recovery work over the second half of the year is therefore increasingly focused on recurrent improvement through productivity, workforce and expenditure control, alongside stronger delivery of our Value for Patients programme. The priority over the remainder of the year is not only to improve the 2026/27 position, but to improve our underlying run rate and ensure that the changes we make now provide a stronger and more sustainable starting point for 2027/28.

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

Never Events

Never Events remain a patient safety priority for MFT. Executive oversight of the Trust-wide Never Event Elimination Plan has been strengthened, with clear Clinical Group accountability through site Chief Executive Officers, to ensure delivery of the programme and impact. The programme is focused on strengthening safety-critical controls and driving consistent compliance with established safety standards and processes, alongside addressing contributory system factors including human factors, safety culture and multidisciplinary simulation training. Compliance is being actively monitored to provide assurance that required controls are consistently applied and embedded in practice.

Work is also progressing to strengthen the use of digital solutions and devices to support safety-critical checks and reduce reliance on memory and individual vigilance. Progress, compliance, impact and emerging themes continue to be monitored through the Trust Quality and Safety Management Committee, providing oversight of delivery and assurance on improvement.

The above concern is relevant to strategic objective 5 in the Board Assurance Framework.

Winter Pressures

The early increase in demand for urgent and emergency care raises the risk of a prolonged period of winter pressure, with demand likely to remain high over the coming months. This will place sustained pressure on patient flow, capacity and our ability to maintain timely access to both emergency and planned care. We have robust winter plans in place, with a focus on avoiding unnecessary admissions, improving discharge and maintaining safe services. We will continue to work closely with system partners to coordinate our response, supported by enhanced oversight and escalation arrangements, while keeping patient safety and the wellbeing of our colleagues central to our approach.

The above concern is relevant to strategic objective 2 in the Board Assurance Framework.

NHS
Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday, 25 November 2026

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

Executive summary / key messages for the meeting to consider

The Board Assurance Framework (BAF) provides an overview of progress against MFT's five strategic aims, 11 strategic objectives and 16 Annual Plan priorities for 2026/27. It brings together delivery updates, strategic risks and assurance, including each risk's position against the risk appetite statement approved in September 2026.

The Trust's Board committees which met in October 2026 discussed the sections of the BAF relevant to their scope. The Digital and Estates Board Committee and the Research, Innovation and Population Health Board Committee did not meet in October. They will consider the sections of the BAF relevant to their scope at their meetings in December 2026.

The Board is asked to discuss the BAF and assurance provided, alongside the Integrated Performance Report and related papers, considering delivery progress, outstanding control and assurance gaps, and actions to reduce strategic risk.

Recommendation(s)

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

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

Relationship to the strategic objectives	
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)	
☒ LHL Objective 1	☒ LHL Objective 2
☒ HQSC Objective 1	☒ HQSC Objective 2
☒ HQSC Objective 3	☒ PEW Objective 1
☒ PEW Objective 2	☒ VfP Objective 1
☒ VfP Objective 2	☒ R&I Objective 1
☒ R&I Objective 2	☒ Good Governance
Links to Trust Risks	The work contained within this report links to all the Trust's strategic risks.
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Caring ☒ Effective ☒ Well-Led ☒ Responsive
Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the report: •

Main report

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

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

- An introductory page with details of how each strategic objective is led and overseen, the agreed ‘Impact statement’ for the strategic aim, the key metric(s) and the target for the end of the 2026/27.
- A section which lists the Annual Plan priorities aligned with the strategic aim, the key result sought for each priority, and an update on the current position.
- A final section which summarises the strategic risks associated with each strategic aim. The appendix to the BAF contains the risk appetite statement approved at the Board in September 2026. Each strategic risk summary includes a new ‘Risk Appetite Status’ cell which identifies whether the strategic risk is currently within appetite, approaching appetite, or outside of appetite, as defined within the Risk Appetite Statement.

1.3 The Trust’s Board committees which met in October 2026 discussed the sections of the BAF relevant to their scope. This included the detail of the strategic risks – the controls, gaps in controls, assurance sources, gaps in assurance and the actions being taken to close any gaps and further reduce the risk score. This detail is available to all Board members separately within the Team Papers app for this Board meeting.

1.4 The Digital and Estates Board Committee and the Research, Innovation and Population Health Board Committee did not meet in October. They will consider the sections of the BAF relevant to their scope at their meetings in December 2026.

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

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

APPENDIX: BOARD ASSURANCE FRAMEWORK

SUMMARY

Strategic Objectives	Overview	Rating
We will work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.	Population health delivery is progressing through strengthened governance, clinical leadership, health inequalities reporting and the development of Health and Wellbeing Hubs. However, employment support referrals totalled 1,076 at Q2 against 3,370 in 2025/26, with recovery to plan expected in Q3 following resolution of referral barriers. Further work is required to validate population health dashboard data, introduce ambulatory care measures and systematically monitor suppliers' social value commitments. The health inequalities risk remains at 12, approaching appetite, with a target of 9 by April 2027. Green Plan delivery continues through site decarbonisation planning, energy efficiency and waste reduction initiatives. Its risk remains at 9, within appetite, although the target date for reduction to 6 has moved to March 2030. Staff engagement and thematic leadership gaps remain.	
We will work with partners to redesign services so that more care is delivered in people's homes and neighbourhoods.	Service redesign is showing measurable progress in supporting care closer to home. Consultant-led triage is established in seven of ten Single Point of Access specialties, with the remaining three scheduled for implementation by the end of October. The 25% diversion target has been achieved, with 4,283 referrals returned to primary care. Manchester and Trafford neighbourhood operating models, agreed with partners, represent a substantive shift towards proactive, integrated neighbourhood care, rather than simply relocating services from hospital to community settings. Integrated Neighbourhood Teams (INTs) are central to this approach, linking proactive case finding with coordinated case management, prevention and earlier intervention to identify people at risk of deterioration and provide support before needs escalate. The intended benefits are improved outcomes and independence, care closer to home and reduced avoidable emergency attendance and hospital admission. Trafford's multidisciplinary INT model is being mobilised while a review of Manchester's neighbourhood teams and proactive case management is identifying further improvements within existing resources. Admissions from emergency departments among people aged over 65 fell by 5.5% between Q1 and Q2. The overarching admissions metric remains under development, with baseline data expected by January 2027 to inform target setting. No strategic risk is specifically identified against this objective.	

Strategic Objectives	Overview	Rating
We will provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience wherever they are treated.	Patient safety and patient experience remain broadly positive, with specific areas of focus, including surgical and invasive procedure safety following recent Never Events. Patient safety infrastructure continues to strengthen, with 207 Patient Safety Champions registered, and the Patient Experience Strategic Delivery Plan is due to launch in November, alongside continued improvement work on infection prevention and control including MRSA bacteraemia performance. Care on Time, Care Closer to Home and Model ED programmes are progressing, with strengthened oversight of delivery and benefits realisation. The urgent care Single Point of Access now operates seven days a week, diverting an average of 66.5% of appropriate patient calls away from Emergency Departments. Mental health capacity pressures and the potential for harm while patients wait remain a significant area of focus, with both strategic risks rated 16 and outside of the agreed risk appetite. Further work is underway to strengthen the assessment of individual risk with further discussions to take place alongside system partners.	
We will strengthen our specialised services and support the adoption of genomics and precision medicine.	Progress continues in specialised services and genomics with system decisions, workforce resilience and investment remaining key dependencies. Major trauma governance has strengthened, with MFT supporting the two-centre configuration. Further assurance is required on MRI's future designation, clinical pathways and neurosurgical, spinal and interventional radiology provision. Genomics development is supported by approximately £6 million of equipment investment secured in 2025/26. Diagnostic Whole Genome Sequencing go-live has moved to November 2026 following revised national timescales. The automation capital bid was unsuccessful; future funding opportunities and infrastructure capacity remain under review, with no immediate capacity pressure reported. Risk scores remain unchanged and within risk appetite: major trauma at 12; genomics at 9.	
We will continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.	Work to disaggregate services at North Manchester General Hospital (NMGH) is nearing completion. Following confirmation from NCA colleagues that they do not wish to progress with Colorectal Cancer disaggregation, work is now underway to agree other routes through which a service could be established at NMGH. Vascular reconfiguration towards a single arterial centre at MRI is progressing following public consultation. Outstanding issues include Oldham's interventional radiology provision, financial implications and implementation assurance. Risk scores remain unchanged and within risk appetite with vascular continuing to be rated at 12.	

Strategic Objectives	Overview	Rating
We will make sure that our staff feel valued and supported by listening well and responding to their feedback. We will improve the experience of all our staff by embracing diversity and fairness, helping everyone to reach their potential.	Progress continues in work to strengthen staff wellbeing, engagement and inclusion with a growing focus on ensuring staff voice directly informs organisational priorities and improvements. The CEO-led Culture and Staff Experience Forum is becoming a well-established routine within our staff engagement programme and brings together colleagues from across professions, services and staff groups to provide direct insight into what colleagues are seeing and experiencing and to help shape practical actions that will make a difference to staff. The forum is focused around the staff experience priorities of being safe and healthy, recognised and rewarded, and heard and included - all of which were highlighted as issues within our most recent Staff Survey results. Alongside this, work continues to strengthen an inclusive culture where colleagues feel valued, respected and able to belong, building on the EDI Ignite Festival, the staff co-produced Anti-Discrimination Pledge, and wider work on recognition, wellbeing, leadership and staff engagement. Current activity also includes the much wider visibility on how we recognise our staff, piloting one to one conversations with Healthcare Support Workers and work to better understand the causes of sickness absence to inform prevention action, all of which will support reduced absence rates. The absence and engagement risk remains at 12, while headcount reduction risk is rated 16, both of which are outside appetite. Delivery of workforce efficiencies and required WTE reductions needs to be balanced carefully with maintaining staff engagement and wellbeing and sickness absence remains a key workforce sustainability priority.	
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.	Work continues to broaden routes of employment into healthcare and strengthening opportunities for career and skills development. Work experience, widening participation, pre-employment programmes and apprenticeships are creating a clearer pathway into employment, with 687 work experience placements delivered in the first half of 2026/27 and 52 young people progressing into MFT employment through the King's Trust programme. Apprenticeship pathways are increasingly aligned to workforce priorities, alongside investment in digital, improvement and future-facing skills for existing colleagues. Positive appraisal discussions are intrinsically linked to career progression for staff and this is a key focus across quarters 3 and 4 with the implementation of a new Learning Management System as a key opportunity to support this. Recruitment of the Director of Strategic Learning will strengthen strategic leadership of apprenticeships, widening participation and our approach to learning, with further focus required on connecting entry routes, development opportunities and workforce need across MFT.	

Strategic Objectives	Overview	Rating
We will achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.	Delivery of financial sustainability remains challenging, with significant exposure relating to savings delivery, recurrent improvements and cash availability. Value for Patients plans total £147.2m against the £175m target, however this reduces to £90m after risk adjustment given maturity of schemes. Recurrent schemes represent 60% of planned savings against a 75% ambition. Underlying financial position is reviewed each month at TLTC and FBC. Work on 2027/28 VFP programme is already underway as part of the 2027/28 planning process; Transformation programmes are progressing in both Elective and Non-Elective pathways with the Care Closer to Home programme having released 36 beds towards its 120-bed target so far. Transformation programmes in Theatres, Outpatients, Workforce and AVT are being strengthened in H2 to accelerate delivery on run rate and capacity to delivery elective recovery plans. Enhanced cash management processes are in place with daily review, tight payment controls and focussed debtor recovery actions and cash balances have improved during the year (2 operating days at M6 26/27 compared to < 1 day at M12 25/26). Cash is reviewed by the Executive team each month. Some additional capital funding has been secured, although allocations remain insufficient to address infrastructure, equipment and digital replacement needs fully. The strategic risks concerning medium-term financial sustainability and national capital restrictions both remain rated 20 and outside risk appetite, reflecting continuing threats to liquidity, recurrent sustainability and investment capacity.	
We will deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships.	Progress is evident across estates redevelopment and digital modernisation, although delivery remains constrained by funding, workforce capacity and contractual dependencies. North Manchester's acute hospital and outpatient centre have secured RIBA Stage 1 approval, with business case development, partnership engagement and affordability work continuing. Estates compliance and PFI lifecycle delivery remain affected by maintenance backlogs, unresolved contractual matters and incomplete assurance. The proposed Community electronic patient record go-live is October 2027, subject to final Trust approval. Network improvements are planned across Trust sites with wider remediation phased to meet the available financial envelope. Patient administration controls require stronger standardisation, training and pathway visibility. Cyber governance, assurance and operating model proposals are developing with sustained risk reduction requiring investment and specialist recruitment. All six strategic risks aligned with this strategic aim —estates compliance, PFI lifecycle delivery, North Manchester redevelopment, cyber security, digital infrastructure and patient administration—are outside risk appetite.	

Strategic Objectives	Overview	Rating
We will strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part.	Research delivery has improved, with compliance against the national 90-day clinical trial set-up target increasing from 32.3% in Q1 to 60.0% in Q2, exceeding the Q2 target of 48.4%. Partnership development with the University of Manchester continues, with an agreement drafted but not yet formally agreed. Existing NIHR infrastructure centres have received positive feedback on their performance and annual reporting. Maintaining this infrastructure remains a strategic priority, including preparation of the application to host the NIHR Manchester Biomedical Research Centre. The associated strategic risk remains at 12, approaching appetite; the target score has reduced from 12 to 8, to be achieved by June 2027.	
We will apply research and innovation, building on our position as a digital leader and embracing new technology such as artificial intelligence, to improve people's health and transform the services we provide.	Digital innovation is progressing through practical deployment and evaluation. An Ambient Voice Technology pilot involving more than 400 users has been completed, with an investment case progressing through governance approvals. Wider deployment of Ambient Voice Technology remains subject to investment approval. Remote hypertension monitoring through MyMFT has expanded from 680 patients in March to 845 in September, a reported 24% increase against the 5% growth target for Q3. AI applications are in place to support appointment attendance and the identification of patients at higher risk of lung and skin cancer. Further opportunities include planned research with the University of Manchester using Hive data and potential integration of wearable technology with MyMFT to support neighbourhood care.	

KEY

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

STRATEGIC AIM 1: ENSURE VALUE FOR OUR PATIENTS AND COMMUNITIES BY MAKING THE BEST USE OF OUR RESOURCES

STRATEGIC AIM 1	**ENSURE VALUE FOR OUR PATIENTS AND COMMUNITIES BY MAKING THE BEST USE OF OUR RESOURCES**	**GM mission**	Improve quality and safety and addressing inequalities	**Date of update**	October 2026	**Integrated Performance Report reference**	Pages 34-37 (Alert) Page 65 (Assure)

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

Impact statement	Key metrics for Strategic Aim	Target (March 2027)
More people being supported to live healthy lives in the community with fewer people needing to use healthcare services in an unplanned way	Admissions per 100,000 for ambulatory sensitive conditions for Manchester and Trafford	Target not yet confirmed (baseline data will be available by January 27 to inform the target)

ANNUAL PLAN DELIVERY

2026/27 priorities	Key result	Update
Support delivery of the GM Live Well programme. Increase public health interventions delivered across MFT to address both the major lifestyle drivers of illness and social determinants of health psychological safety and compassionate leadership.	Increase the number of referrals into the employment support programme by 100 referrals compared to 2025/26 levels by April 2027.	1076 referrals to date at Q2 (751 in Q1 and 325 in Q2). 25/26 referrals were 3,370. Issues limiting invitations to patients for employment support have been identified and resolved. August referral numbers remained low due to summer leave/reduced activity. The Growth Company team have been doing engagement events on sites as part of the Health and Wellbeing Hub launch. While this will drive demand in the long term, it has reduced their capacity to engage with service teams (which generates referrals) in the short term. Our MSK leads are focusing on generating more referrals within our core physio team. We expect September to pick up and Q3 to return to plan.
Deliver our integrated neighbourhood health plans – and develop the role of the Local Care Organisations – through place-based partnerships in Trafford and Manchester.	Standardise case management across Integrated Neighbourhood Teams (INT) and introduce pro-active case finding in at least 1 neighbourhood by Q3	Manchester and Trafford Neighbourhood operating models agreed through partner workshops. New Trafford INT MDT model agreed with GPs and LCO - in mobilisation. Detailed review of Manchester INT and proactive case management underway (concluding in October) to identify further enhancement with existing resource capacity.
	Reduction of non-elective admissions for care of the elderly and end of life care by at least 2%.	Non elective admissions in elderly medicine are reducing month on month and are lower than the average monthly rate for 25/26. Between Q1 and Q2, there has been a reduction of 5.5% in >65s admitted from ED.
Increase the range of integrated services offered to people of all ages in the community, transforming outpatient services and moving care out of a hospital setting where possible	Deliver a diversion rate of at least 25% through implementation of advice and guidance pathways in high impact specialties, with pathways live from Q1.	Consultant-led triage is established in 7 of 10 SPoA specialties and we are on track for implementing the 3 remaining specialities in T&O, OMFS and General Surgery for the end of October. MFT achieved the 25% diversion target, returning 4,283 referrals to primary care.

STRATEGIC RISKS

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

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
12	**12**	**9**	30/04/27	No change	Approaching appetite (Partnerships and integrated care delivery)

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

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
12	**9**	**6**	31/03/30 (previously 31/03/27)	No change	Within appetite (Strategic Transformation & Major Programmes)

STRATEGIC AIM 2: PROVIDE HIGH QUALITY, SAFE CARE WITH EXCELLENT OUTCOMES AND EXPERIENCE

STRATEGIC AIM 2	**PROVIDE HIGH QUALITY, SAFE CARE WITH EXCELLENT OUTCOMES AND EXPERIENCE**	**GM mission**	Recover core NHS and care services	**Date of update**	October 2026	**Integrated Performance Report reference**	Pages 11-26 (Alert) Pages 39-47 (Advise) Pages 53-55 (Assure)

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

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

ANNUAL PLAN DELIVERY

2026/27 priorities	Key result	Update
Strengthen our culture of patient safety by empowering and supporting staff with human factors training, encouraging psychological safety and compassionate leadership.	A minimum of 175 Patient Safety champions registered with the network by end of Quarter 1.	208 patient safety champions registered with representatives across all Clinical Groups and a variety of professions. The organisation has also now appointed 7 Patient Safety Partners (PSPs), lay colleagues who represent the patient voice with regard to patient safety. Each Clinical Group has an allocated PSP working closely with colleagues in that CG and one PSP is allocated to the corporate team. As well as supporting the CG led work PSPS are also active in representing patient voice as part of MFT wide activity including the HCAI Breakthrough Series Collaborative, World Patient Safety Day and Medicines Safety week as well as supporting PLACE assessments.
	Deliver 50% reduction at least in the number of MRSA bacteraemia by Quarter 4.	There has been a reduction in MRSA bacteraemia cases in the current reporting year. In 2025/26, 15 cases were reported, comprising 13 hospital-onset healthcare-associated (HOHA) cases and two community-onset healthcare-associated (COHA) cases. In the current year to date, six cases have been reported: four HOHA and two COHA. This represents a decrease in hospital-onset cases compared with the previous full year, while the number of community-onset cases remain unchanged. Systems and processes are in place to reduce the risk of further MRSA cases including senior nurse review for all patients identified as at risk, weekly IPC nurse review of all patients receiving MRSA decolonisation therapy, Hive dashboard development to support antimicrobial stewardship programme of work, and updated MRSA and ANTT policies to support practice and assessment. Breakthrough series collaborative to reduce Staphylococcus bloodstream infections commenced in July 2026 with a planned date of completion February 2027 comprising of 14 clinical teams in 5 Clinical Groups, each clinical team are implementing tests of change in line with local risk assessment.

2026/27 priorities	Key result	Update
Build a patient and carer experience framework to improve delivery of person-centred services, strengthening the way we obtain feedback and our approaches to co-production	Agree MFT's Patient and Carer Experience Framework by the end of Quarter 1.	A Trust Patient Experience Strategic Delivery Plan has been developed with a Trust-wide launch date planned for November. Patient Experience SDP approved. Trust wide socialisation of SDP and engagement for actions scheduled throughout Q3 & Q4. Workstream 1 Partnership Programme (creating a Trust-wide co-production framework) commenced with Think Local Act Personal partnership programme; Clinical Group, lived-experience, executive leadership baselining engagement planned to complete end Q3. Experience of Care Improvement Self-Assessment complete across all six Clinical Groups to give diagnostic baseline assessment to track improvements.
Continue to reduce waiting times – for adults and children – in a way that is safe and equitable.	71.5% of people will be waiting less than 18 weeks for their treatment by the end of Q4.	RTT 18 weeks performance at July has fallen below plan for the first time this year, with August also below plan. Each clinical group has their own recovery plan to return to trajectory in October with future delivery underpinned by the Trust-wide planned care work programme - Care on Time.
	80.09% of people will wait for less than 62 days for their first cancer treatment by the end of Q4.	In August 26 the Trust was 0.1% short of its external plan, but delivering above 77% for the first time since 2019. High level actions in place, including embedding the operational delivery meeting into formal governance. Pathway change, digital enhancement and transformation all continue. A work programme of pathway redesign and waiting time improvement is underway.
	82% of people will wait less than 4 hours in our Emergency Departments by Q4. 95% of children will wait less than 4 hours by the end of Q2.	Performance against the A&E 4-hour wait standard in August was 74.5%, 4.2% below plan. The Model ED improvement programme is being implemented across MRI, Wythenshawe and NMGH, including expanded same-day emergency care, improved CDU utilisation, streaming and UTC pathways, roster changes, frailty and specialty SDEC, and surgical in-reach. Performance against the A&E 4-hour wait standard for children and young people in August 26 has improved significantly to 93.1% which is 0.2% below plan. Focussed work continues to drive improvements in waiting times and deliver as planned at the end of Q2.

2026/27 priorities	Key result	Update
	Increase the operating hours of our Single Point of Access (SPoA) for UEC to include evenings and weekends in Q1, routing 200 people each week away from our A&E departments and into more suitable services by Q4.	SPoA is now open evenings and weekends (8.30am–6pm, seven days a week). Weekly call volume is currently 200 per week and plans to increase to 550 by end of December. Performance remains positive, with average 66.5% of appropriate calls successfully deflected from Emergency Departments.
Continue the development of Genomic Medicine across MFT and beyond, mainstreaming Genomics and building on our position as a national leader.	Launch Whole Genome Sequencing through the North West Regional Genomic Medicine Service by the end of Q2	NHSE Genomics Unit have revised the national roll out timescales for dWGS. NW GMS go-live has now changed from September 2026 to November 2026.

STRATEGIC RISKS

Strategic Risk	MENTAL HEALTH SERVICE CAPACITY AND DEMAND (MFT/009407)	Description	If system-wide mental health demand and capacity pressures continue then, medically optimised patients with mental health needs will remain in ED and inpatient settings that are not designed to meet their needs, resulting in increasing risks to safety, absconsion, poor experience, delayed flow and reduced capacity, higher costs, and regulatory escalation.
Lead Executive director	Deputy Trust Chief Executive/Chief Nursing Officer	Management Committee	Quality and Safety Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
16	16	12	28/11/27 (target date under review at MH sub-group and QSMC)	No change	Outside of appetite (Quality of care and patient safety)

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

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
12	16	6	30/04/27	No change	Outside of appetite (Quality of care and patient safety)

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

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
12	**12**	**8**	31/03/27	No change	Within appetite (Strategic transformation and major programmes)

Strategic Risk	IMPACT OF UNDER-DELIVERY OF OUR ANNUAL PLANS (MFT/009390)	Description	If demand for services outstrips our capacity to deliver or we do not use our resources efficiently then we will not deliver on the performance commitments outlined in our plans resulting in the Trust not meeting the performance standards and ambitions around patient care and experience we have set ourselves, with potential for increased regulatory oversight, and poorer access to care and patient experience.
Lead Executive director	Chief Delivery Officer	Management Committee	Delivery Oversight Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
12	**12**	**8**	31/03/27	No change	Outside of appetite (Operational performance & access including Flow, RTT, UEC)

Strategic Risk	VASCULAR SERVICE CHANGES IN GREATER MANCHESTER (MFT/008406)	Description	If a single arterial site at MRI is not agreed and implemented to agreed timelines, then a sustainable service for GMEC will not be delivered resulting in the inability to meet patient need across GM with an inability to address the changing nature, increased complexity and urgency in demand for vascular patients. In addition the estate at the Royal Oldham Hospital Arterial Centre - the hybrid theatre, will no longer be supported by the maintenance company after January 2027. If the equipment in the hybrid theatre fails then patients will not be able to receive care in the most appropriate clinical environment.
Lead Executive director	Acting Chief Strategy Officer	Management Committee	Service Strategy Planning Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
12	12	6	05/04/27 (previously 31/03/27)	Minor change to target date	Within appetite (Strategic Transformation & Major Programmes)

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

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
12	12	8	31/03/27	No change	Within appetite (Strategic Transformation & Major Programmes)

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

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
9	**9**	**6**	31/03/27	No change	Within appetite (Capital, Estates & Infrastructure)

CORPORATE RISKS RELATED TO STRATEGIC AIM

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
Deprivation of Liberty Safeguards Authorisation Process	10	4	31/03/27
Implementation of Mental Capacity Act 2005	12	4	31/03/27
Use of Ligature(s) as a means to ending life through suicide/ form of self-harm	12	8	30/04/27
Safe and Secure Storage of Medicines	12	8	30/04/27 (previously 30/09/26)
Application of the Mental Health Act 1983	12	6	30/04/27
Meeting recommendations from national maternity reports (3-year maternity and neonatal delivery plan, Maternity incentive scheme)	8	4	31/03/27
CQC Recommendations Following Issuance of Section 29A Warning	16 (previously 20)	8	Under review
Adult and Children Safeguarding Training at Level 3 is not meeting Trust wide standard of 90% of mapped workforce completing the training.	6 (previously 9)	3	30/04/27
Safeguarding (Restraint Reduction Network (RRN) standards)	12	9	31/05/27
Inability to Monitor CSF biomarkers (amino acids, neurotransmitters, glucose) in Paediatric Metabolic Patients	6 (previously 12)	2	Under review
Restrictive Intervention Reduction Programme	12	9	31/05/27
Delays in Intravenous Heparin Treatment Leading to Thrombosis, Bleeding and Patient Harm.	12	4	31/12/26
Failure to comply with the Civil Contingencies Act 2004 as a Category 1 organisation.	8	4	30/10/26
Trust CBRN Preparedness and Response Capability.	12	9	29/01/27

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
Supplier resilience	12	9	01/07/29
Safe disaggregation of complex services	4	2	31/03/27
Application of Mental Health Act 1983	12	6	30/04/27
Implementation of Mental Capacity Act 2005	12	4	31/03/27
Deprivation of Liberty Safeguards Authorisation process	10	4	31/03/27
Use of Ligature(s) as a means to ending life through suicide/ form of self-harm	12	8	30/04/27
Delays to diagnosis with patients waiting >6 weeks for diagnostic tests	12	6	31/03/27
Overcrowding in A&E and flow delays across Urgent Care pathways	12	8	31/03/27
Eliminating our longest waits for scheduled care admitted and non-admitted	16	9	31/03/27
Delays to diagnosis and treatment for patients on a Cancer Pathway.	12	6	31/03/27
Urgent and Emergency Care Capacity and Demand (Paediatric)	9	6	19/08/27 (previously 18/08/26)
Mental Health Waiting Times in the Emergency Department	20 (previously 16)	4	01/09/28 (previously 01/09/26)

STRATEGIC AIM 3: BE THE PLACE WHERE PEOPLE ENJOY WORKING, LEARNING AND BUILDING A CAREER

STRATEGIC AIM 5	**BE THE PLACE WHERE PEOPLE ENJOY WORKING, LEARNING AND BUILDING A CAREER**	**GM mission**	Support our workforce and our carers	**Date of update**	October 2026	**Integrated Performance Report reference**	Pages 27-29 (Alert) Page 50 (Advise) Pages 56 – 57 (Assure)
Linked Strategic Objectives	**We will make sure that our staff feel valued and supported by listening well and responding to their feedback. We will improve the experience of all our staff by embracing diversity and fairness, helping everyone to reach their potential.**		**We will offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here.**				
Lead Executive Directors	Chief People Officer		Chief People Officer				
Board Committees	People Board Committee		People Board Committee				
Management Committee(s)	Workforce and Education Management Committee		Workforce and Education Management Committee				

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

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2026/27 priorities	Key result	Update
Enable teams to create workplaces where people feel safe and well	Exceed the national average in the 'We are Safe and Healthy' domain in the National Staff Survey	This is an annual metric based on the national staff survey results. The Trust continues to work to support improvement to wellbeing for our workforce. Work underway to support this includes: agreement of approach to recognition; piloting 121 conversations with Health Care Support Workers. More specifically a deep dive has been undertaken in relation to sickness absence to explore reasons for absence of our workforce to help inform strategies to prevent sickness.
	Reduce the percentage of people stating that they have personally experienced violence	This is an annual metric based on the national staff survey results. However, work to improve this metric continues with a range of workstreams underway to address key issues. This includes work to reduce violence and abuse through a specific piece of work undertaken at the MRI is underway in relation to body worn cameras, the No Excuse for Abuse campaign was launched in September 2026.
	Increase the percentage of those who believe the organisation takes a positive interest in health and wellbeing.	This is an annual metric based on the national staff survey results. See update provided above.
Enable teams to create workplaces where people feel safe and well	Reduce sickness absence to 5.4% by Q4.	Sickness absence continues to present a challenge with the rolling 12-month average at 6.1%. A deep dive has taken place and we are currently strengthening plans to support a reduction in sickness.
Enable people to develop the skills needed to deliver high quality care in the future, including digital and improvement skills. Ensure we are data-driven,	Achieve 90% essential user personalisation in Epic by end of Q4 through delivery of the Thrive training offer	61% complete as at 03/09/26 and on-track to deliver by Q4.
	Achieve 25% advanced user personalisation in Epic by end of Q4 through delivery of the Thrive training offer	13% complete as at 03/09/26, actions planned to ensure delivery by Q4.

2026/27 priorities	Key result	Update
providing people with the information they need to improve their services	650 colleagues will have been enrolled in the Improvement Academy by Q4.	365 colleagues completed or enrolled on courses at Q2.
Embed our new, clinically-led operating model, continuing to build an inclusive, engaged organisation where everyone has a sense of value and belonging	Improve our response rate to the 2026 National Staff Survey by at least 10 percentage points and exceed the national average with our Staff Engagement score.	The National Staff Survey has launched. High volume of activity is underway to support completion. Current response rate is presently higher than this time last year.

STRATEGIC RISKS

Strategic Risk	ABSENCE AND ENGAGEMENT (MFT/009513)		Description	If the Trust is unable to sustain a happy, supported and healthy workforce, including effectively managing sickness absence and workforce wellbeing then delivery of the MFT Strategy will be compromised, resulting in reduced workforce availability, reduced staff engagement, increased reliance on temporary staffing, reduced productivity and financial pressure and an inability to consistently deliver safe, high quality patient care.	
Lead Executive director	Chief People Officer		Management Committee	Workforce and Education Management Committee	
Initial Risk score	**Current Risk Score**	**Target Risk Score**	**Target date**	**Change since last presented**	**Risk appetite status**
12	**12**	**8**	31/03/27	No change	Outside appetite (Workforce, capacity & wellbeing)

Strategic Risk	HEADCOUNT REDUCTION (Ref. MFT/009514)		Description	If the Trust is unable to deliver the planned workforce reduction of 1,188 Whole Time Equivalents (WTEs) linked to the Value for Patients (VfP) programme, workforce costs will remain above plan and anticipated productivity improvements will not be realised. This will result in a failure to deliver required financial savings, a sustained financial deficit, and a reduced ability to maintain safe, high-quality patient care. Additionally, the management of headcount reductions may negatively impact staff morale, wellbeing and engagement, increasing the risk of reduced motivation, higher sickness absence and turnover, and reduced service resilience.	
Lead Executive director	Chief People Officer		Management Committee	Workforce and Education Management Committee	
Initial Risk score	**Current Risk Score**	**Target Risk Score**	**Target date**	**Change since last presented**	**Risk appetite status**
12	**16**	**8**	31/03/27	No Change	Outside appetite (Workforce, capacity & wellbeing and Finance sustainability and cash)

CORPORATE RISKS RELATED TO STRATEGIC AIM

Corporate Risks	Current Risk Score	Target Risk Score	Target date
Maximising the efficiency and effectiveness of workforce systems and processes.	6	6	Being considered for closure at the next Workforce and Education Management Committee
Corporate and Clinical Group Induction and On-boarding	6	4	Target date under review
Completion of workforce appraisals	6	4	Target date under review
Mandatory training compliance	6	4	Target date under review
Digitalisation and automation	9	6	Target date under review
Sickness Absence	12	9	31/03/27
Recruitment and attraction as an employer of choice	9	6	31/12/26
Delivery of effective apprenticeship programme	9	4	01/03/27
GM Transforming People Services: Recruitment - Host model and delivery for a GM Recruitment service	20	8	Target date under review
Improving resident Doctor in Training CSF Compliance	4	4	Being considered for closure at the next Workforce and Education Management Committee
Inability to reliably confirm workforce immunisation status exposes MFT to regulatory non-compliance, patient safety risk, and reputational harm.	16	9	31/10/26

STRATEGIC RISK 4: ENSURE VALUE FOR OUR PATIENTS AND COMMUNITIES BY MAKING THE BEST USE OF OUR RESOURCES

STRATEGIC AIM 4	**ENSURE VALUE FOR OUR PATIENTS AND COMMUNITIES BY MAKING THE BEST USE OF OUR RESOURCES**	**GM mission**	Achieve financial sustainability	**Date of update**	October 2026	**Integrated Performance Report reference**	Pages 30-32 (Alert) Pages 48-49 (Advise) Pages 58 – 59 (Assure)

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

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

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2026/27 priorities	Key result	Update
Improve our productivity and increase commercial income to deliver our financial plan	Increase the average cases per 4-hour theatre session in nationally benchmarked specialties to 2.2 by Q4.	The average number of cases per session for MFT at August 26 was 1.9. Continued improvements in theatre utilisation through the Care on Time programme, elective hub productivity and scheduling efficiency are increasing surgical capacity and supporting the reduction of long waiting times.
	Reduce DNAs to at least 7% by Q4.	Outpatient DNA rate at August 26 was 9.8%. There are a number of key actions in place under the Care on Time programme to support reduction in DNAs, including patient self-scheduling, validation and expanding patient-initiated follow ups.
	Reduce urgent and emergency care demand through an expansion of the Care Closer to Home programme to Wythenshawe and NMGH, releasing 120 beds by Q4.	The programme has progressed into delivery, with reductions in non-elective bed demand now being realised and bed capacity release plans underway across both NMGH and Wythenshawe - in the year to date 36 beds have been released. System visibility and improvement cycle disciplines have been embedded to support performance management, benefits tracking and the management of complex discharge pathways. Positive movement has been seen in discharge outcomes, particularly at NMGH, alongside continued progress against No Criteria to Reside measures. An integrated UEC improvement programme has been agreed, with targeted interventions now in implementation to support recovery and delivery of programme benefits.
	Deliver £175m of Value for Patients schemes, with 75% as recurrent improvements by Q4.	At the end of Q2 we have identified c. £147.2m in plan against a target of £175m. On a risk-adjusted basis, this reduces to £90.0m, resulting in an adverse variance of £27.8m, or £85.0m on a risk-adjusted basis. Of the total planned value, £88.2m, or 60%, is recurrent, with a full-year effect value of £114.1m.

		For Q2, plans total £22.8m against a target of £43.8m, representing 52% delivery. On a risk-adjusted basis, this reduces to £19.2m. Delivery to date in Q2 is £14.0m, with a further £8.8m planned for M6. This results in an adverse variance of £21.0m, or £24.5m on a risk-adjusted basis. Work continues to increase the maturity of existing plans and to identify further initiatives to support mitigation of the shortfall. A tiered escalation framework has been implemented to focus assurance and support on the areas currently presenting the greatest risk to delivery.
Progress plans to redevelop the NMGH campus, delivering a refreshed Outline Business Case whilst making best use of existing estate across MFT	Develop the business case for the redevelopment of North Manchester General Hospital, achieving RIBA Stage 1 by the end of Q2 and Stage 2 by the end of Q4.	RIBA Stage 1 has been completed for both the New Acute Hospital and the Outpatient Centre on 14 September 2026. We have commenced RIBA Stage 2 whilst addressing the conditions set out by NHP as part of the Checkpoint 1 process. A revised programme is being jointly finalised with NHP which supports a timeline for the submission of the OPC OBC in February 2027. RIBA Stage 2 for the main acute will be complete in Q1 2027/2028.
Take forward plans to implement a digital solution for community services and to support digital integration with the wider system.	We will commence implementation of a new EPR for the Local Care Organisations by Q2, with system configuration finalised by Q4.	A proposed go live date of Tuesday 12th October 2027 was approved at the July LCO EPR Programme Board and will be submitted for final approval through the Trust governance processes.

STRATEGIC RISKS

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

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
6	**20**	**12**	31/03/27	No change	Outside of appetite (Capital, estates & infrastructure)

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

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
20	**20**	**10**	31/03/27	No change	Outside appetite (Financial Sustainability & Cash)

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

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
20	20	8	31/03/30	No change	Outside of appetite (Capital, Estates & Infrastructure)

Strategic Risk	UNTIMELY DELIVERY OF PFI LIFECYCLE PROGRAMME AND IMPACTS (MFT/009125)	Description	If the PFI Lifecycle works are not delivered on time and in line with an agreed programme, then assets and infrastructure will fall below the required performance, safety and compliance standards, resulting in the estate not meeting contractual hand back requirements (Condition B), higher long term costs, large immediate capital costs at hand back, clinical and operational disruption and service failure, reduced site resilience and negative reputational damage and an likely increase in regulatory enforcement.
Lead Executive director	Deputy Chief Executive	Management Committee	Delivery Oversight Management Committee

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
20	20	8	31/10/26	No change	Outside of appetite (Capital, Estates & Infrastructure)

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

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
20	20	15	31/03/28	n/a	Outside of appetite (Capital, Estates & Infrastructure)

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

Initial risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
20	20	15	31/03/2028	Change to target date to reflect Target Operating Model timelines.	Outside of appetite (Digital, data and cyber security)

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

Initial risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
20	**20**	**10**	30/09/29	No change	Outside of appetite (Capital, Estates & Infrastructure)

Strategic Risk	**PATIENT ADMINISTRATION ISSUES (MFT/009518)**	**Description**	If there are insufficient systems, processes, controls and assurance to manage the use of the patient record then key clinical information, including diagnostics, results and follow-up actions, may not be consistently recorded, reviewed or acted upon in a timely manner resulting in patients being lost to follow-up (including following DNAs), delays to diagnosis and treatment, increased risk of patient harm, deterioration in clinical outcomes, and adverse impacts on quality, performance and patient experience.
Lead Executive director	Chief Digital and Information Officer	**Management Committee**	Digital Management Committee

Initial risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
20	**20**	**8**	31/12/27	Target date now identified	Outside appetite (Digital, data and cyber security)

CORPORATE RISKS ALIGNED TO STRATEGIC AIM

Linked Corporate Risks	Current Risk Score	Target Risk Score	Target date
Risk of insufficient cash resources to fund Trust operational and strategic requirements in 2026/27 and beyond. (MFT/008655)	16	2	31/03/27
Commissioner Affordability Constraints for MFT Activity Related Income delivery (MFT/008897)	20	10	31/03/27
MFT/008419: Management of asbestos	16	8	31/12/26
MFT/005527: Failure of Reinforced Autoclaved Aerated Concrete	15	5	31/03/27
MFT/008818: Security Management	20	4	31/03/27
MFT/007067: Fire safety management and building compliance	15	5	30/12/27

STRATEGIC AIM 5: DELIVER WORLD-CLASS RESEARCH AND INNOVATION THAT IMPROVES PEOPLE'S LIVES

STRATEGIC AIM 5	**DELIVER WORLD-CLASS RESEARCH AND INNOVATION THAT IMPROVES PEOPLE'S LIVES**	**GM mission**	Improve quality and safety and addressing inequalities	**Date of update**	May 2026	**Integrated Performance Report reference**	Page 33 (Alert) Page 51 (Advise) Pages 60 – 64 (Assure)

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

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

ANNUAL PLAN DELIVERY

2026/27 priorities	Key result	Update
Make it easier for people to take part in research and innovation, growing the volume and value of our R&I activity	Increase number of research studies hitting 150-day target by 50% by August 2026.	Clinical trial set up and first recruitment time is now part of the National Oversight Framework (NOF). The metric is 90-day set-up time. Q1 baseline performance was 32.3% compliance and Q2 performance is 60.0% compliance with the 90 day target, this exceeds the Q2 target (48.4%).
Develop our digital infrastructure and embrace technology, including AI and wearables, to drive new models of care, improve quality and productivity across the organisation	By Q1 we will have undertaken an AVT (Ambient Voice Technology) pilot and Evaluation across 2 platforms for up to 600 users.	A pilot has been completed with over 400 users. Investment case drafted and progressing through governance approvals.
	Using MyMFT, we will increase remote hypertension monitoring and other telehealth services in maternity by 5% by the end of Q3.	There has been a 24% increase in number of patients enrolled in MyMFT for hypertension from 680 patients in March to 845 in September.
Improve the strategic alignment between MFT and our academic and industry partners	Finalise a partnership agreement and programme of work with the University of Manchester by the end of Quarter 2	Work with the University of Manchester continues with a partnership agreement drafted ahead of formal agreement.

STRATEGIC RISKS

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

Initial Risk score	Current Risk Score	Target Risk Score	Target date	Change since last presented	Risk appetite status
12	12	8 (previously 12)	01/06/2027	Target risk score reduced from 12 to 8	Approaching appetite (Partnerships and integrated care delivery)

APPENDIX: RISK APPETITE STATEMENT

Key Risk Areas	Risk Appetite	Risk Appetite Statement	What This Means in Practice	Indicative Scoring Thresholds
Capital, Estates & Infrastructure	**Measured**	MFT accepts prioritisation risk where capital decisions deliver safer environments, improved compliance, better patient experience, and more resilient infrastructure. Risk is acceptable when investment leads to clear improvements in estate safety, clinical environments, and operational reliability. Exposure that compromises statutory compliance or patient safety is outside of appetite.	Capital resources will be prioritised across Estates, Medical Devices and Digital to manage the Trust's most significant safety, compliance, operational resilience and transformation risks. Investment decisions must be evidence based, transparent and aligned to organisational priorities. Mitigation plans must be clear for backlog maintenance, autoclaved aerated concrete (RAAC), fire safety and ventilation issues. Where critical estates, equipment or digital risks cannot be mitigated within available resources, these must be subject to explicit Board oversight, agreed mitigation and define recovery trajectory.	Within appetite: 9 or below Approaching appetite: 10 Outside appetite: 12+
Culture, Behaviour & Inclusion	**Averse**	MFT has no appetite for cultural or behavioural risk that undermines safety, experience, dignity, or compassion, for our patients and colleagues, or impacts to psychological safety. Risk is acceptable only when cultural change leads to clear improvements in safety culture, leadership behaviours, inclusion, and team reliability. Cultural risk is outside appetite when it results in: • Compromised patient safety or experience • Psychological safety failures or fear of speaking up • Discriminatory or exclusionary behaviours • Leadership behaviours that destabilise teams • Cultural deterioration that impacts care quality or reliability	Zero tolerance for behaviours that compromise safety, dignity, respect, or inclusion. Speaking-up concerns must be acted on quickly. Leadership behaviours must model values consistently. Cultural deterioration that impacts care quality triggers immediate intervention.	Within appetite: less than 6 Approaching appetite: 6-8 Outside of appetite: 8+

Key Risk Areas	Risk Appetite	Risk Appetite Statement	What This Means in Practice	Indicative Scoring Thresholds
Digital, Data & Cyber Security	**Progressive (Innovation)** **Averse (Cyber & Data)**	MFT supports progressive digital risk where innovation delivers better decision-making, improved flow, stronger productivity, and enhanced clinical outcomes. Cyber and data risk is outside appetite unless controls ensure system reliability, data integrity, and uninterrupted clinical care. Exposure that threatens patient safety, system availability, or data accuracy is not tolerated.	Innovation (AI, automation, digital redesign) is encouraged with strong governance. Cyber controls must meet DSPT, NCSC, and NHS England standards. System outages or data loss require immediate escalation.	Innovation risk (Progressive): Within appetite: 10 or below Approaching appetite: 12 Outside of appetite: 15 or above Cyber/Data risk (Averse): Within appetite: less than 6 Approaching appetite: 6-8 Outside of appetite: 8+
Financial Sustainability & Cash	**Measured (with targeted progressive exposure)**	MFT accepts measured financial risk with targeted progressive exposure where investment delivers clear value, stronger productivity, improved sustainability, and long-term resilience. Risk is acceptable when decisions are commercially grounded, costed, and supported by credible return-on-investment. Financial risk is outside appetite when it threatens liquidity, solvency, regulatory confidence, or recurrent sustainability.	Investment decisions must be costed, commercial, and evidence-based. Non-recurrent savings must have a credible exit plan. Cash deterioration or liquidity risk is outside appetite.	Within appetite: 9 or below Approaching appetite: 10 Outside appetite: 12+
Governance, Assurance & Risk Management	**Limited**	MFT has low tolerance for governance risk that weakens visibility, escalation, accountability, or informed decision-making. Risk is acceptable only when governance reform leads to better assurance, clearer accountability, and stronger delivery confidence. Assurance gaps that obscure outcome risk are outside appetite.	Risks must be clearly articulated through the BAF with defined trajectories. Escalation must be timely and evidence-based. Assurance gaps require immediate action. Committees must provide triangulated insight, not data volume.	Within appetite: 8 or below Approaching appetite: 9 Outside of appetite: 10+

Key Risk Areas	Risk Appetite	Risk Appetite Statement	What This Means in Practice	Indicative Scoring Thresholds
Medical Equipment/ Devices	**Limited**	MFT has a limited appetite for risks relating to the availability, reliability and management of medical equipment and medical devices. We are willing to accept carefully managed risk where it supports innovation, replacement programmes, technological advancement improvements to patient safety and patient outcomes. However, we have a low tolerance for risks that could cause patient harm, or impact regulatory compliance, service continuity and ability of colleagues to deliver safe care.	Medical equipment must be maintained, tested, calibrated and serviced in accordance with statutory requirements, manufacturer guidance and local maintenance schedules. Equipment operating beyond recommended lifecycle, particularly critical equipment, must be subject to enhanced oversight, with clear understanding of reliability, maintenance requirements, availability of spare parts, manufacturer support arrangements and business continuity plans. Decisions regarding allocation of capital & revenue annual funding for decommissioning & replacement equipment & business cases for new equipment must be risk based and clinically informed to ensure safe prioritisation.	Within appetite: 8 or below Approaching appetite: 9 Outside of appetite: 10+
Operational Performance & Access (including Flow, RTT, UEC)	**Limited (with targeted, time-bound measured exposure)**	MFT accepts only targeted, time-bound measured exposure where doing so will deliver clear improvements in flow, reduced overcrowding, shorter waits, and more reliable access. Risk is acceptable only when recovery plans are credible, costed, time-limited, and actively governed. Performance risk is outside appetite when deterioration is persistent, unfunded, harms patients, or lacks a deliverable recovery trajectory.	Recovery plans must be credible, costed, and time-limited. Flow deterioration or RTT harm must trigger rapid intervention. Performance outside appetite requires explicit Board acceptance.	Within appetite: 8 or below Approaching appetite: 9 Outside of appetite: 10+
Partnerships & Integrated Care Delivery	**Progressive**	MFT supports ambitious partnership risk where collaboration demonstrably improves flow, strengthens community capacity, reduces avoidable admissions, and narrows health inequalities. Risk is acceptable when partners commit to shared accountability for outcomes, with	Partnerships must have shared accountability for outcomes and deliver measurable improvement. MFT will work with long term partners to understand shared risk and agree their joint ownership and mitigation. MFT will withdraw or redesign partnerships that do not deliver outcomes. Governance must be clear, effective, and jointly owned.	Within appetite: 10 or below Approaching appetite: 12 Outside of appetite: 15 or above

Key Risk Areas	Risk Appetite	Risk Appetite Statement	What This Means in Practice	Indicative Scoring Thresholds
		clear objectives, measurable impact, and joint ownership of delivery. Partnerships are outside appetite when: • MFT cannot influence or shape outcomes • Accountability is diffuse or contested • Governance is unclear or ineffective • Measurable improvement cannot be demonstrated • Partners do not share responsibility for delivery or consequences		
Quality of Care & Patient Safety	**Limited (Low tolerance for harm)**	MFT accepts time-limited variation only where there are clear benefit, strong evidence, and robust controls. There is very low tolerance for avoidable harm, including deterioration, infection, delays, or reliability failures. Risk is acceptable only when it enables safer care, earlier intervention, improved reliability, and better outcomes. Normalisation of harm or unmanaged deterioration is outside appetite.	Safety risks must be identified early and mitigated quickly. Never Events, deterioration, or infection control failures require immediate action. Data and learning systems must support early detection and intervention.	Within appetite: 8 or below Approaching appetite: 9 Outside of appetite: 10+
Strategic Transformation & Major Programmes	**Transformational**	MFT accepts significant delivery risk where transformation programmes deliver material improvement in patient outcomes, workforce experience, productivity, and long-term sustainability. Risk is acceptable when transformation is realistically resourced, governed through strong assurance, and delivers clear, evidenced benefits.	Transformation must be realistically resourced and governed through SPMO. Benefits must be evidenced, tracked, and reported. Programmes must pause or reset when care standards decline. Transformation must strengthen not destabilise everyday care.	Within appetite: 12 or below Approaching appetite: 15 Outside of appetite: 16 or above

Key Risk Areas	Risk Appetite	Risk Appetite Statement	What This Means in Practice	Indicative Scoring Thresholds
		Stop Rules: Transformation must pause, reset, or escalate when: • Care standards deteriorate • Operational performance declines without credible recovery • Workforce wellbeing or leadership resilience is harmed • Benefits cannot be evidenced or tracked • Governance weakens or milestones repeatedly slip • Financial exposure increases without clear return • System dependencies cannot be secured Transformation must strengthen not destabilise everyday care.		
System Working, Policy & External Change	**Progressive**	MFT accepts higher levels of strategic risk where system collaboration and policy change deliver better access, improved population health, reduced inequality, and a more sustainable care model. Risk is acceptable when decisions are evidence-led, system-aligned, and outcome-driven, with clear ownership and strong governance. Uncoordinated change, unmanaged system instability, or policy shifts that do not improve outcomes are outside appetite.	Decisions must be evidence-led and system-aligned. MFT will lead and shape system change where outcomes improve. Uncoordinated or weakly governed system change is outside appetite.	Within appetite: 10 or below Approaching appetite: 12 Outside of appetite: 15 or above
Workforce, Capacity & Wellbeing	**Measured**	MFT accepts moderate, time-limited workforce risk where doing so will improve recruitment, strengthen retention, stabilise staffing, and enhance wellbeing. Risk is	Workforce redesign must deliver clear improvements in stability and safety. Agency reliance must reduce with a credible exit plan. Burnout, unsafe staffing, or leadership fragility are outside appetite. Investment must	Within appetite: 9 or below Approaching appetite: 10 Outside appetite: 12+

Key Risk Areas	Risk Appetite	Risk Appetite Statement	What This Means in Practice	Indicative Scoring Thresholds
		acceptable when it enables better rostering, improved leadership capability, reduced agency reliance, and clear improvements in team stability and safety. Workforce risk is outside appetite when it results in unsafe staffing, burnout, leadership fragility, or deterioration in care quality.	strengthen leadership capability, wellbeing, and retention.	

Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday, 25 November 2026

Paper Title:	Integrated Performance Report (IPR)	**Agenda Item 9.2**
Presented by:	Interim Chief Delivery Officer / Chief Digital Information Officer Deputy Trust Chief Executive / Chief Nursing Officer Deputy Trust Chief Executive Joint Chief Medical Officers Chief Finance Officer Chief People Officer	
Prepared by:	Deputy Chief Nursing Officer Director of Performance and Planning (performance) Deputy Chief People Officer (workforce) Deputy Director of Financial Reporting & Planning (finance) Managing Director, R&I Deputy Digital Information Officer Consultant in Public Health	

Meetings where content has been discussed previously	Board Committees	
Purpose of the paper Please check **one** box only:	☐ For approval ☒ For discussion	☐ For support ☐ For noting

Executive summary / key messages for the meeting to consider

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

Of note is inclusion of information regarding the National Oversight Framework where for quarter 1 MFT has been rated as segment 2. The average metric score for Q1 is 2.24, with a national ranking of 29 out of 134 providers.

Strategic Doman: Quality and Safety

NOF Domain: Experience of Care
The overall patient experience outcome score from MFT Patient Experience Survey continues to perform above standard (95.3% against a standard of 95%). The SHMI mortality indicator is stable and continues to perform in line or better than Shelford peers.

Category 3 caesarean sections not performed within 24 hours is above target (47 against a plan of less than 10 per month) due to increasing demand. Mitigations are in place, with interim

Oxford Road Campus (ORC) Sunday lists agreed, and a paper proposing increase in elective caesarean capacity to be presented to commissioners in Q4.

NOF Domain: Patient Safety
One MRSA bacteraemia was reported at MRI in-month, bringing the year-to-date total to 3 against a standard of 0. C. difficile remained above trajectory, with 26 cases against a threshold of 22.2. E. coli remains within required threshold. Collaboratives remain in place to support focused improvement.
Never Events: 0 Never Events were reported in-month; however, Never Event prevention remains a Trust-wide patient safety priority given the cumulative position supported by Executive and Clinical Group Chief Executive oversight.

Strategic Domain: Operational Performance

NOF Domain: Access to Services
Sustained demand above plan continues to affect access and flow. September ED attendances were 6.3% above plan and four-hour performance was 6.6 percentage points below trajectory; RTT was 0.61 percentage points below plan, with demand growth contributing to a waiting list 8,497 above plan. However, 52-week waits continued to reduce in line with plan, the Faster Diagnosis and 31-day cancer standards were achieved, and 62-day cancer performance was broadly on trajectory. Delivery is being managed through strengthened Clinical Group oversight, the Winter Plan, Care on Time and targeted tumour-site recovery plans, with a Trust-wide cancer improvement programme supporting sustainable pathway redesign.

Strategic Domain: Workforce

NOF Domain: People
R12M sickness absence has increased slightly, moving performance away from the 5.4% target by March 2027, and requiring continued focus to restore the improvement trajectory. AfC appraisal compliance remains below target but has seen slight improvement compared to previous month. Substantive WTE numbers are 238 WTE higher than the Workforce Plan.

Strategic Domain: Finance

NOF Domain: Finance, Productivity and Innovation
The organisation is reporting a year-to-date position of breakeven to plan, primarily due to inclusion of YTD adjustments for PFI penalties, owed hours on e-roster and prior year VAT reclaims offset by under-delivery of cost improvements through the VfP programme and unmitigated, unfunded costs of Resident Doctor's industrial action taken in April 2026. NOF score remains at 1 based on submission of a compliant breakeven plan and a breakeven forecast outturn.

Strategic Domain: Research and Innovation

NOF Domain: Effectiveness of Care and Population Health

Decline in weighted (and overall) recruitment has slowed, within a national context of decrease recruitment. Action plan in place to increase recruitment overseen by R&I Management Committee, including strengthened performance management, specialty specific recovery, improved participant identification, and workforce capacity and focus review.

MFT is 4th and 6th nationally for recruitment into commercial and non-commercial studies and 90 day target for set up and first patient recruitment (NOF metric) is up from 34.4% in Q1 to 62.5% in Q2.

The Trust maintained 917 active studies and 92% of MFT-sponsored NIHR portfolio studies were on track (against 80% target).

Strategic Domain: Digital

NOF Domain: N/A
Overall strong performance against Digital key performance metrics, with cyber risks requiring continued capital prioritisation.

Recommendation(s)
The Board of Directors is asked to: • Note the performance assurance provided.

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

Relationship to the strategic objectives	
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)	
☐ LHL Objective 1	☐ LHL Objective 2
☐ HQSC Objective 1	☐ HQSC Objective 2
☐ HQSC Objective 3	☐ PEW Objective 1
☐ PEW Objective 2	☐ VfP Objective 1
☐ VfP Objective 2	☐ R&I Objective 1
☐ R&I Objective 2	☒ Good Governance

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

NHS
Manchester University
NHS Foundation Trust

MFT Integrated Performance Report

September 2026

Measuring our performance

Manchester University NHS Foundation Trust

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

Variation



Common cause – no significant change



Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values



Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

Assurance



Variation indicates Inconsistently passing and falling short of the target



Variation indicates consistently (P)assing the target



Variation indicates Consistently (F)alling short of the target

Compliance against plan



Target (MFT plan for the month) being met



Target (MFT plan for the month) not met



For information, no target set or target not due

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

Executive Summary

Executive Summary:

Strategic Domain	NOF Domain	Summary
Quality and Safety	Experience of Care	The overall patient experience outcome score from MFT Patient Experience Survey continues to perform above standard (95.3% against a standard of 95%). The SHMI mortality indicator is stable and continues to perform in line or better than Shelford peers. Category 3 caesarean sections not performed within 24 hours is above target (47 against a plan of less than 10 per month) due to increasing demand. Mitigations are in place, with interim Oxford Road Campus (ORC) Sunday lists agreed, and a paper proposing increase in elective caesarean capacity to be presented to Commissioners in Q4.
	Patient Safety	One MRSA bacteraemia was reported at MRI in-month, bringing the year-to-date total to 3 against a standard of 0. C. difficile remained above trajectory, with 26 cases against a threshold of 22.2. E. coli remains within required threshold. Collaboratives remain in place to support focused improvement. Never Events: 0 Never Events were reported in-month; however, Never Event prevention remains a Trust-wide patient safety priority given the cumulative position supported by Executive and Clinical Group Chief Executive oversight.
Operational Performance	Access to services	Sustained demand above plan continues to affect access and flow. September ED attendances were 6.3% above plan and four-hour performance was 6.6 percentage points below trajectory; RTT was 0.61 percentage points below plan, with demand growth contributing to a waiting list 8,497 above plan. However, 52-week waits continued to reduce in line with plan, the Faster Diagnosis and 31-day cancer standards were achieved, and 62-day cancer performance was broadly on trajectory. Delivery is being managed through strengthened Clinical Group oversight, the Winter Plan, Care on Time and targeted tumour-site recovery plans, with a Trust-wide cancer improvement programme supporting sustainable pathway redesign.
Workforce	People	R12M sickness absence has increased slightly, moving performance away from the 5.4% target by March 2027, and requiring continued focus to restore the improvement trajectory. AfC appraisal compliance remains below target but has seen slight improvement compared to previous month. Substantive WTE numbers are 238 WTE higher than the Workforce Plan.
Finance	Finance, Productivity & Innovation	The organisation is reporting a year-to-date position of breakeven to plan, primarily due to inclusion of YTD adjustments for PFI penalties, owed hours on e-roster and prior year VAT reclaims offset by under-delivery of cost improvements through the VfP programme and unmitigated, unfunded costs of Resident Doctor's industrial action taken in April 2026. NOF score remains at 1 based on submission of a compliant breakeven plan and a breakeven forecast outturn.
Research & Innovation	Effectiveness of Care and Population Health	Decline in weighted (and overall) recruitment has slowed, within a national context of decrease recruitment. Action plan in place to increase recruitment overseen by R&I Management Committee, including strengthened performance management, specialty specific recovery, improved participant identification, and workforce capacity and focus review. MFT is 4th and 6th nationally for recruitment into commercial and non-commercial studies and 90 day target for set up and first patient recruitment (NOF metric) is up from 34.4% in Q1 to 62.5% in Q2. The Trust maintained 917 active studies and 92% of MFT-sponsored NIHR portfolio studies were on track (against 80% target).
Digital	N/A	Overall strong performance against Digital key performance metrics, with cyber risks requiring continued capital prioritisation.

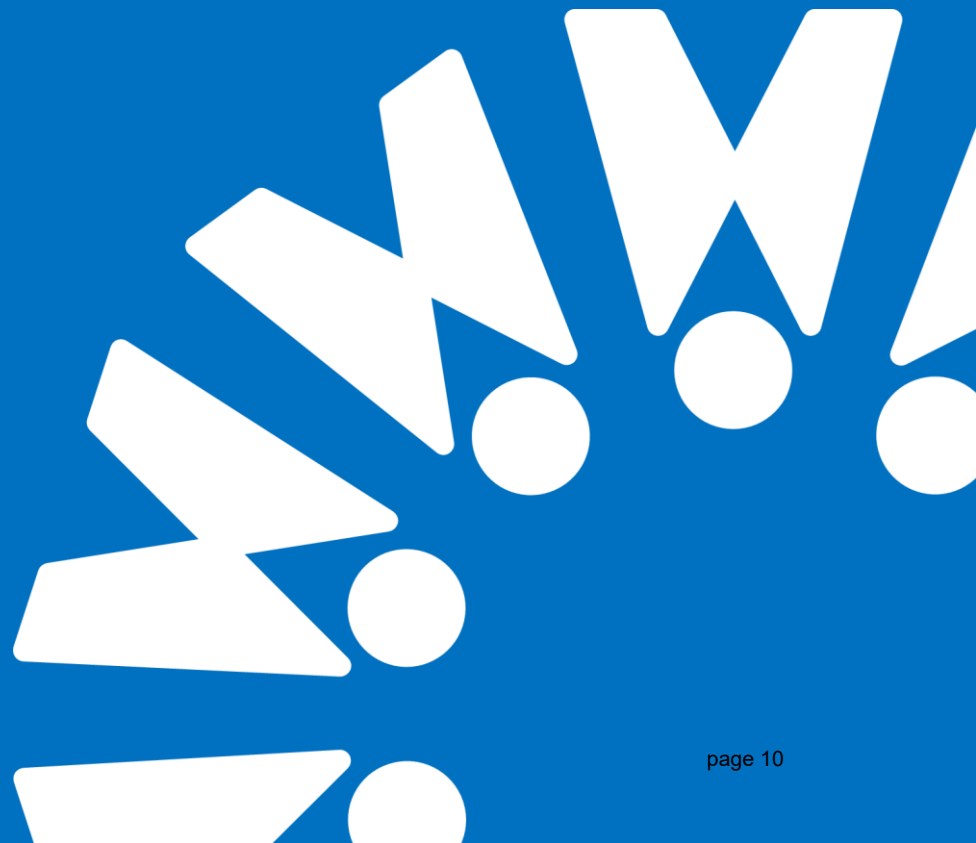
Q1 NOF segmentation

Manchester University NHS Foundation Trust

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

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

Measures for Board attention



Never Events

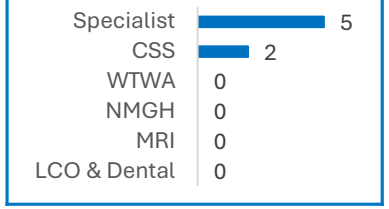
Manchester University NHS Foundation Trust

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

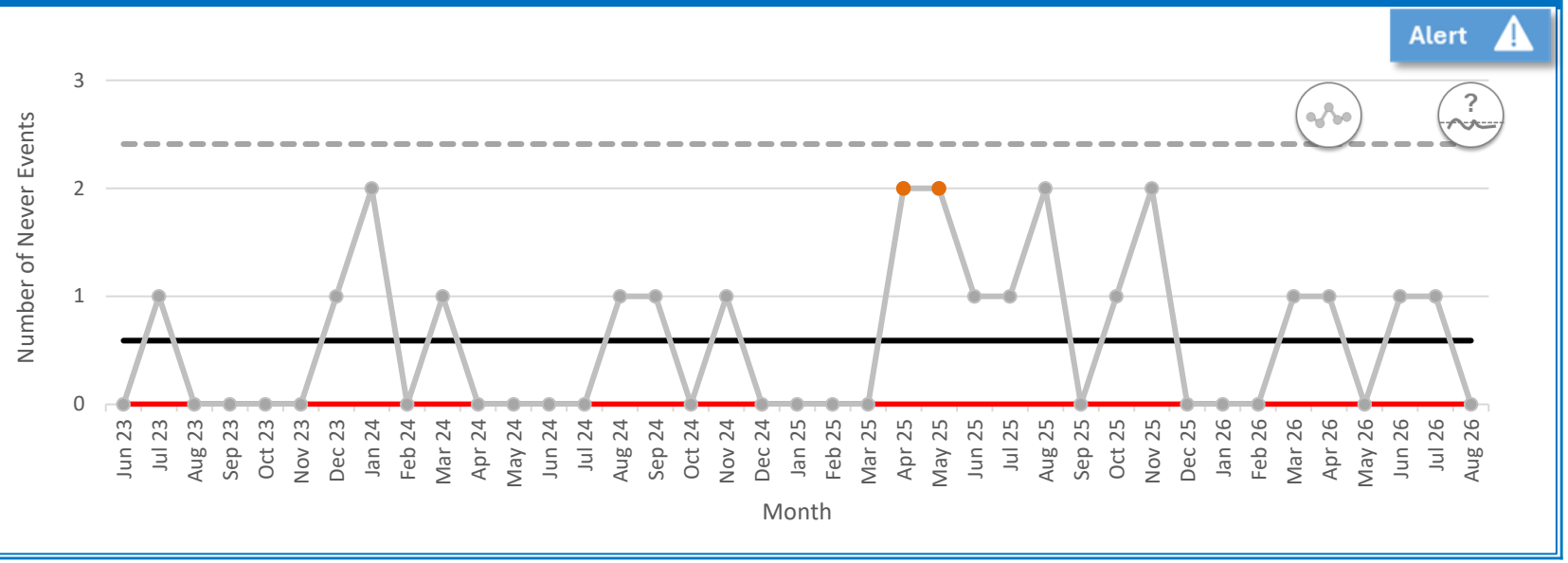
Actual	Standard / Plan	Variance
0	**0**	0

Compliance	Variance	Assurance	Actions
✓	~	?	👁

Clinical Group breakdown (12 months)



Never Events



Understanding the performance

0 Never Events were reported in August 2026. Alert status remains in place due to the cumulative number of Never Events reported over the preceding 12-month period.

Risks and controls

Monthly review of themes, trends and near misses led by Clinical Group Medical Directors and Directors of Nursing.
Executive oversight through the Interventional Procedures Safety Group to address recurrent themes, strengthen safety controls and reduce recurrence.
Enhanced monitoring of action delivery and impact to support sustained improvement and safer practice.

Actions and timescales

Implementation of the Patient Safety Network by Q3 2026/27.Ongoing Never Event improvement programmes throughout 2026/27 in Ophthalmology, Maternity and Specialist Hospital Theatres .
DoN and MD review meeting scheduled for 7 October 2026 to review Never Event themes, assess the effectiveness of current improvement plans, and agree any additional actions required.

Trust attributable MRSA Bacteraemia

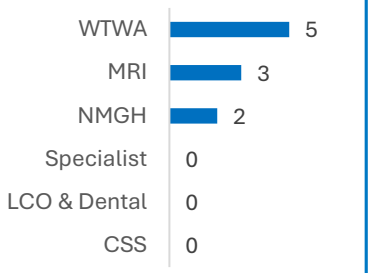
Manchester University NHS Foundation Trust

- **Accountable Executive: Kimberley Salmon-Jamieson| Accountable Group: Quality, Safety and Performance Board Committee**
  NOF: 3.96 | Rates of Healthcare Associated Infection (MRSA, C-Difficile and E-Coli)

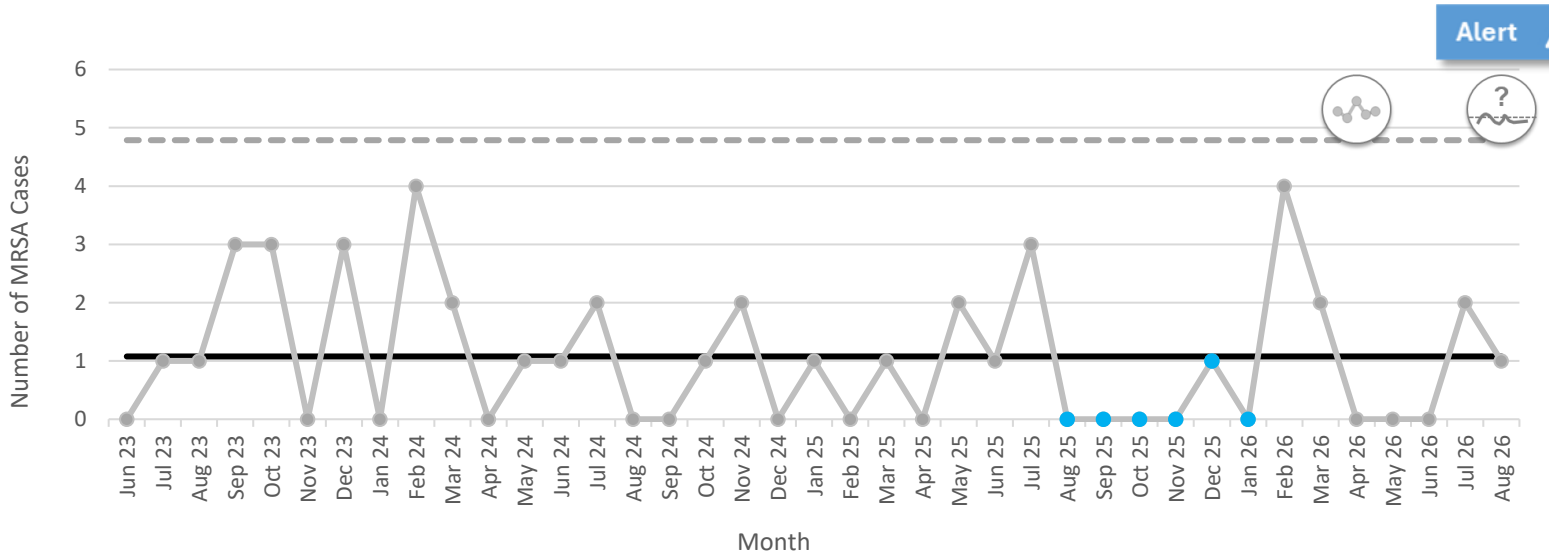
Actual	Standard / Plan	Variance
1	0	+1

Compliance	Variance	Assurance	Actions
✗	~	?	✗

Clinical Group overview (12 rolling months)



MRSA Bacteraemia



Understanding the performance

Cases increased by one compared with the previous month (2 to 3). The in-month case at MRI relates to an ongoing deep-seated infection that was previously classified as a community-onset healthcare-associated case.

Risks and controls

Senior Nurse and IPC nursing team review all MRSA colonised patients to ensure compliance with decolonisation and invasive devices.
Clinical Group action plans in place overseen by Clinical Group Q&S and TICC.
Ongoing IPC audit, surveillance and assurance activity, including hand hygiene and compliance with infection prevention standards.

Actions and timescales

ANTT and MRSA policy updates ratified at TICC in September 2026.
MRSA compliance audit within Hive to be completed by November 2026.
CG action plans in place.
All cases reviewed using PSIRF to identify additional learning, action plans developed and shared across CG to support wider learning.
ANTT compliance monitored via CG and reported to TICC via escalation report.

Trust attributable *Clostridioides difficile* infection

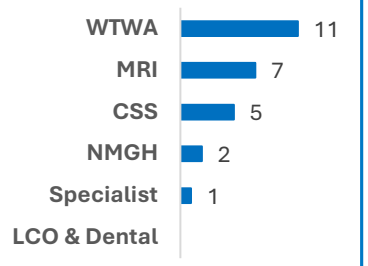
Manchester University NHS Foundation Trust

- **Accountable Executive: Kimberley Salmon-Jamieson| Accountable Group: Quality, Safety and Performance Board Committee**
  NOF: 1.00 | Rates of Healthcare Associated Infection (MRSA, C-Difficile and E-Coli)

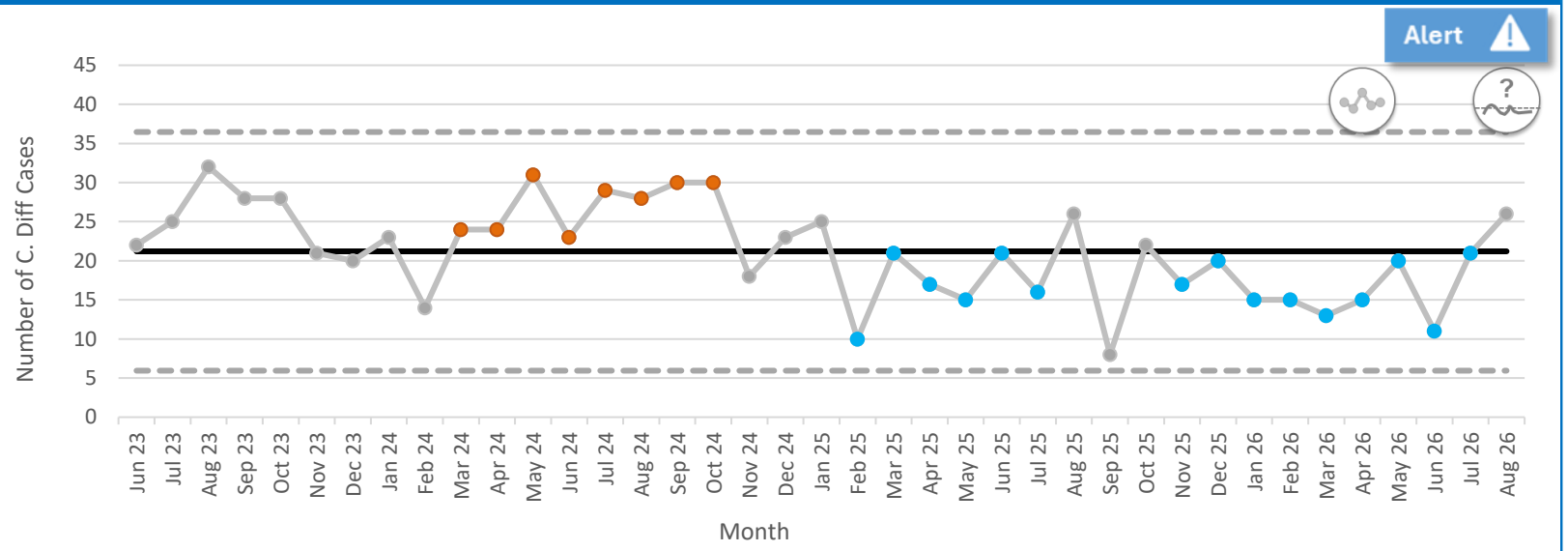
Actual	Standard / Plan	Variance
26	**<22.2**	+3.8

Compliance	Variance	Assurance	Actions
✗	~	?	✗

Clinical Group breakdown



Clostridioides difficile infection



Understanding the performance

Cases increased by five compared with the previous month (21 to 26). Increases were observed in WTWA (3 to 11) and CSS (2 to 5), whilst cases reduced in MRI (10 to 7) and SHCG (4 to 1). NMGH remained unchanged.

Risks and controls

Hive Antimicrobial Stewardship (AMS) dashboards support clinical review of antimicrobial therapy/ prescribing practices. AMS workplan overseen by the Trust Antimicrobial Management Group (AMG).
Learning identified via CDI tracker oversight and assurance to CG IPC committee.

Actions and timescales

Improvement Pioneers project focusing on duration of antimicrobial therapy commenced June 2026 – overseen by AMG and expected completion date of February 2027.
CDI tracker implemented within WTWA and MRI, with rollout to Specialist Hospitals and NMGH by November 2026 to support identification of prescribing, isolation and sampling trends, shared learning across Clinical Groups, and oversight through Clinical Group IPC Committees - escalation to TICC as required.

Gram negative infection – *Klebsiella sp.*

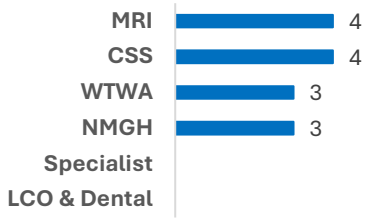
Manchester University NHS Foundation Trust

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

Actual	Standard / Plan	Variance
14	<10.9	+3.1

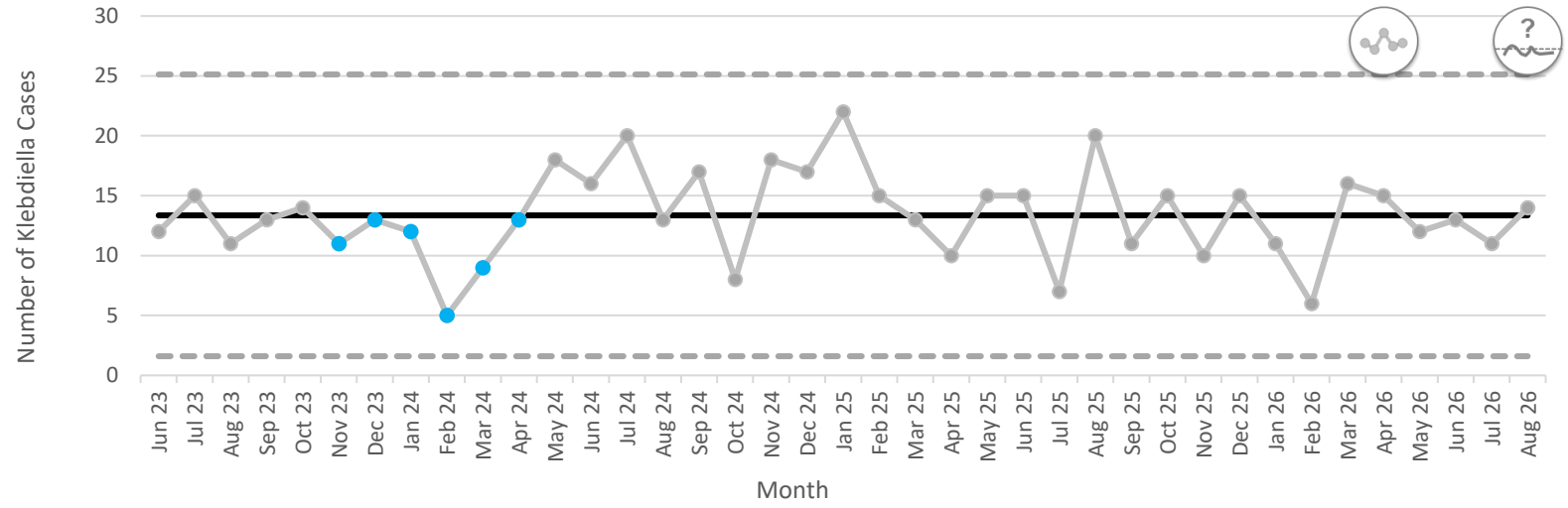
Compliance	Variance	Assurance	Actions
✗	~	?	◉

Clinical Group breakdown



Gram negative infection – Klebsiella

Alert



Understanding the performance

Cases increased overall by 3 compared to the previous month (11) and by 1 each in CSS, NMGH, and WTWA. Cases remained unchanged in MRI.

Risks and controls

All cases are incident reported and reviewed with risk factor data included in the report.
Hive antimicrobial dashboard to support antimicrobial therapy review.
CAUTI audit (power BI) launched to support CG in identifying areas of focus.

Actions and timescales

Risk factor data to be reviewed to identify areas of improvement focus – by end of September 2026.
Clinical Group improvement plans for Vascular Access Devices (VAD) and Catheter-Associated UTIs (CAUTI) in place - overseen by Clinical Group IPC Committees.
ANTT compliance oversight via CG and assurance to TICC
Real time CAUTI audit implemented Sept 2026

Gram negative infection – *Pseudomonas sp.*

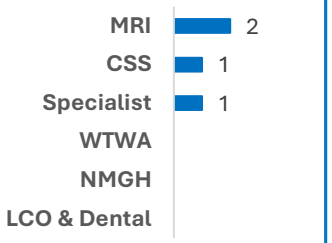
Manchester University NHS Foundation Trust

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

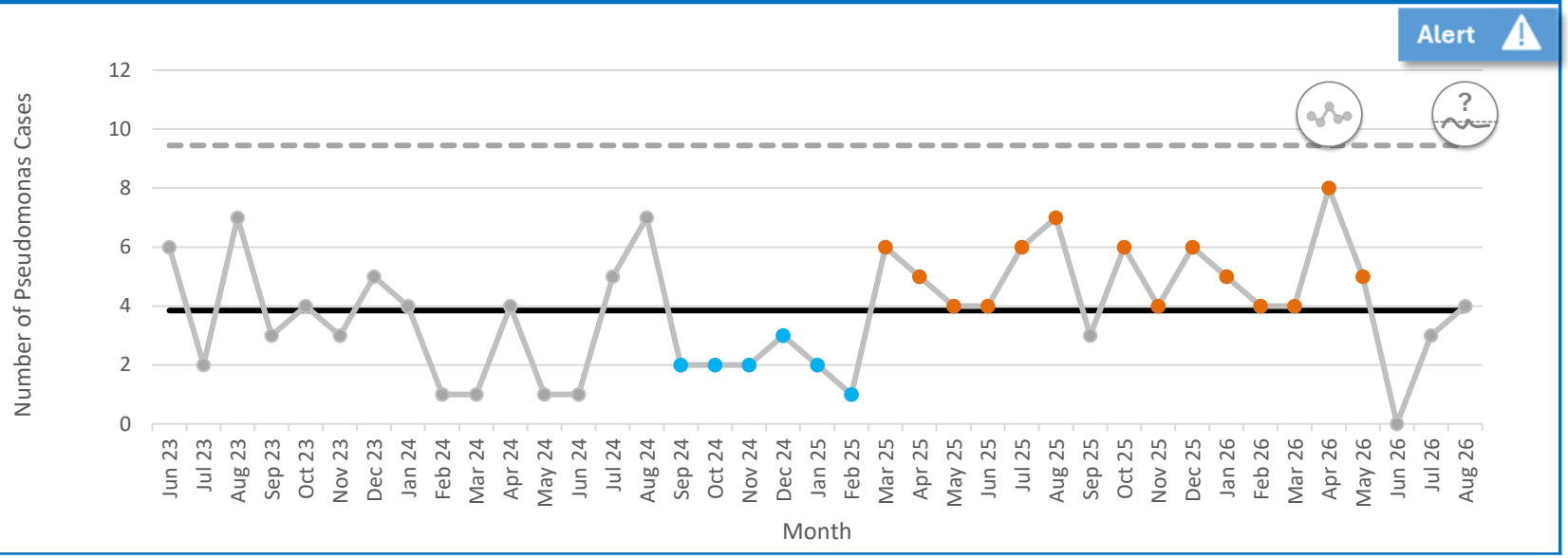
Actual	Standard / Plan	Variance
4	<2.4	+1.6

Compliance	Variance	Assurance	Actions
✗	~	?	◉

Clinical Group breakdown



Gram negative infection – Pseudomonas



Understanding the performance

Cases increased overall by 1 compared to the previous month (3) and by 2 in MRI (0). Cases decreased by 1 in CSS (2) and remained the same for Specialist.

Risks and controls

All cases are incident reported and reviewed with risk factor data included in the report.
Hive antimicrobial dashboard to support antimicrobial therapy review.
CAUTI audit (power BI) launched to support CG in identifying areas of focus.
Augmented care water testing across MFT with processes in place for any positive outlets.

Actions and timescales

Risk factor data to be reviewed to identify areas of improvement focus – by end of September 2026.
Clinical Group improvement plans for Vascular Access Devices (VAD) and Catheter-Associated UTIs (CAUTI) in place - overseen by Clinical Group IPC Committees.
ANTT compliance oversight via CG and assurance to TICC
Real time CAUTI audit implemented Sept 2026.
Deep dive into increased cases throughout 2025 underway will be presented to TICC in Nov 26.

Category 3 Caesarean sections not performed within 24 hours

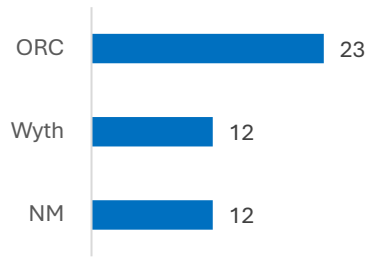
Manchester University NHS Foundation Trust

- **Accountable Executive: Kimberley Salmon-Jamieson| Accountable Group: Quality, Safety and Performance Board Committee**
  NOF: N/A | Internal Measure

Actual	Standard / Plan	Variance
47	<10	+37

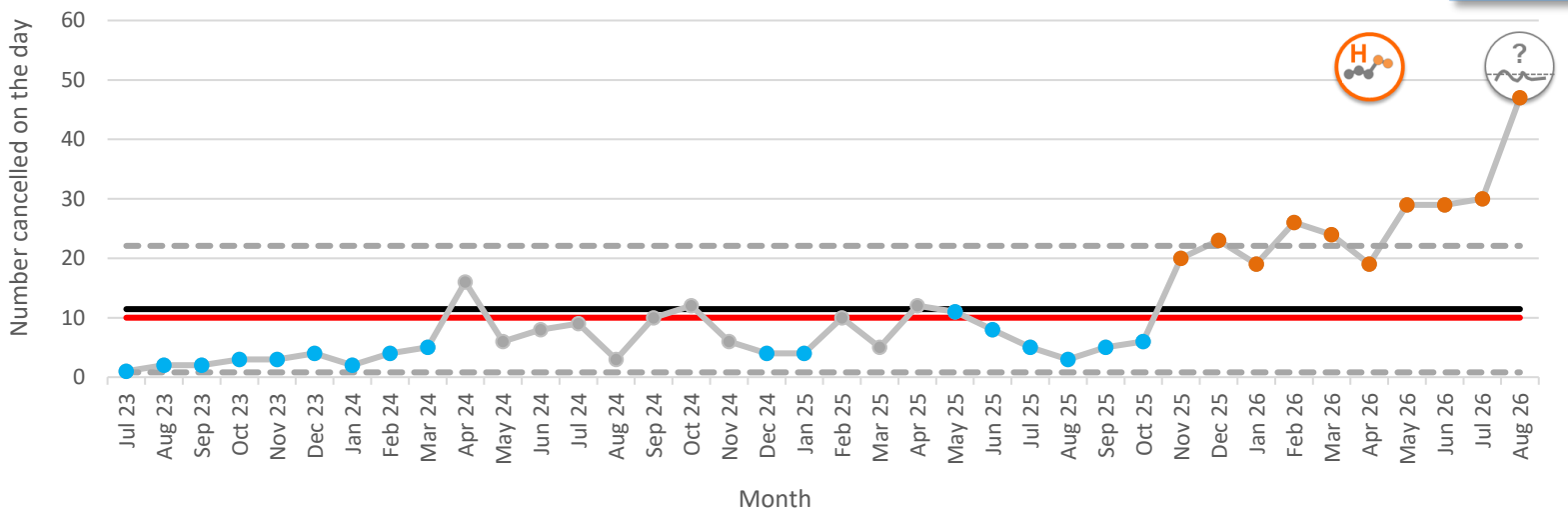
Compliance	Variance	Assurance	Actions
✗	H	?	✗

Clinical Group breakdown



Category 3 Caesarean sections not performed within 24 hours

Alert



Understanding the performance

Increase of 17 cases overall compared to the previous month (30) and at all three sites: 7 more cases at ORC (16) and Wythenshawe (5) and 3 more cases at NMGH (9). No poor outcomes identified from delays.

Use of Propess impacts IOL delays - in turn leads to increases in requests for Category 3 C-sections.

Risks and controls

Increasing demand for non-emergency caesarean sections.

Activity monitored at the twice daily flow meetings and actions taken. Twice weekly forward planning meeting in place. Additional weekly ORC Sunday list.

Actions and timescales

Additional 6 lists carried out in August to support demand. Manual data validation process - awaiting digital solution (no timescale identified due to challenges with digital team capacity). Director of Strategy supporting a paper proposing an increase in elective caesarean capacity (additional 3 theatre lists per week) - to be presented to Commissioners in Q4.

Initial assessment time (Maternity Triage)

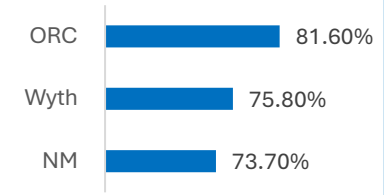
Manchester University NHS Foundation Trust

- **Accountable Executive: Kimberley Salmon-Jamieson | Accountable Group: Quality, Safety and Performance Board Committee**
  NOF: N/A | Internal Measure

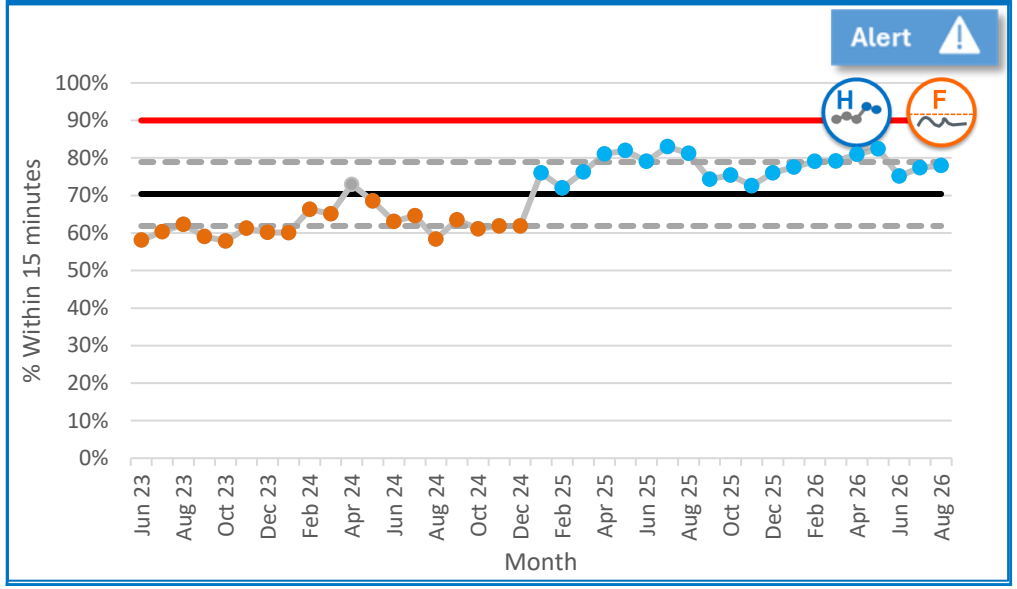
Actual	Standard / Plan	Variance
78.00% 94.40%	>90%	-12.0% +4.40%

Compliance	Variance	Assurance	Actions
✗	H	F	✗

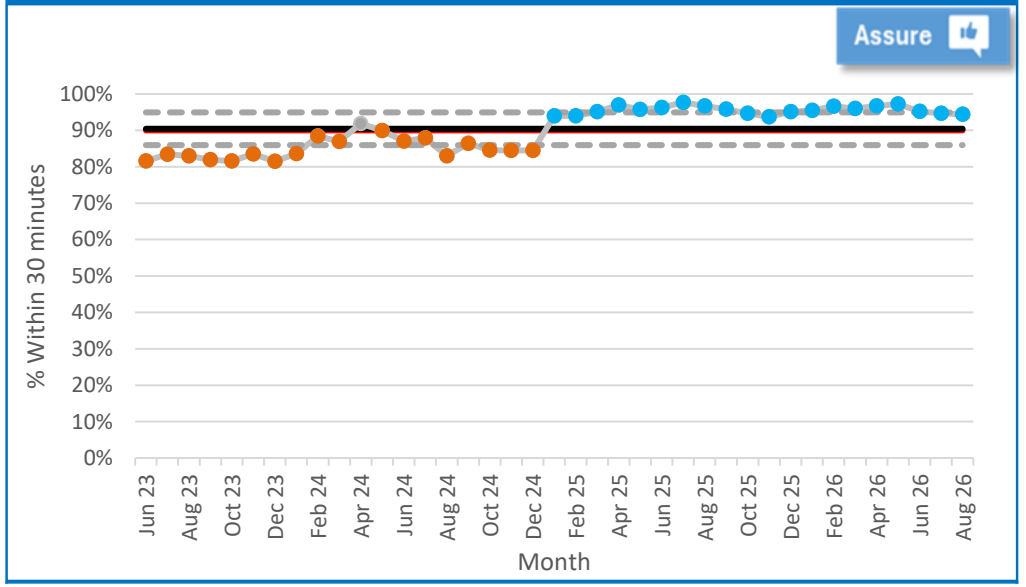
Clinical Group breakdown



Initial assessment time (Maternity Triage -15 mins)



Initial assessment time (Maternity Triage -30 mins)



Understanding the performance

Overall performance for triage within 15 minutes improved by 0.6% compared with the previous month (77.4%) and by 2.4% at NMGH (71.30%) and 3.1% at Wythenshawe (72.70%). Performance decreased by 2% at ORC (83.6%)

No poor outcomes identified due to delayed initial assessment.

Risks and controls

Increased activity continues - 4725 attended in August 2026 compared to 4015 in August 2024 - 17.7% increase.

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

Actions and timescales

Director of Strategy supporting a paper proposing an increase in triage staffing and to expand the Wythenshawe Triage footprint - to be presented to Commissioners in Q4.

Benchmarking against the national Maternity Triage service specification published July 2026 – to be completed by end of September 2026.

Induction pathway - transfer to intrapartum area within 24 hours

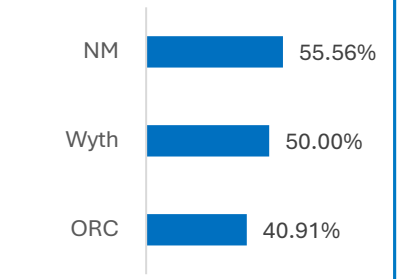
Manchester University NHS Foundation Trust

- **Accountable Executive: Kimberley Salmon-Jamieson| Accountable Group: Quality, Safety and Performance Board Committee**
  NOF: N/A | Internal Measure

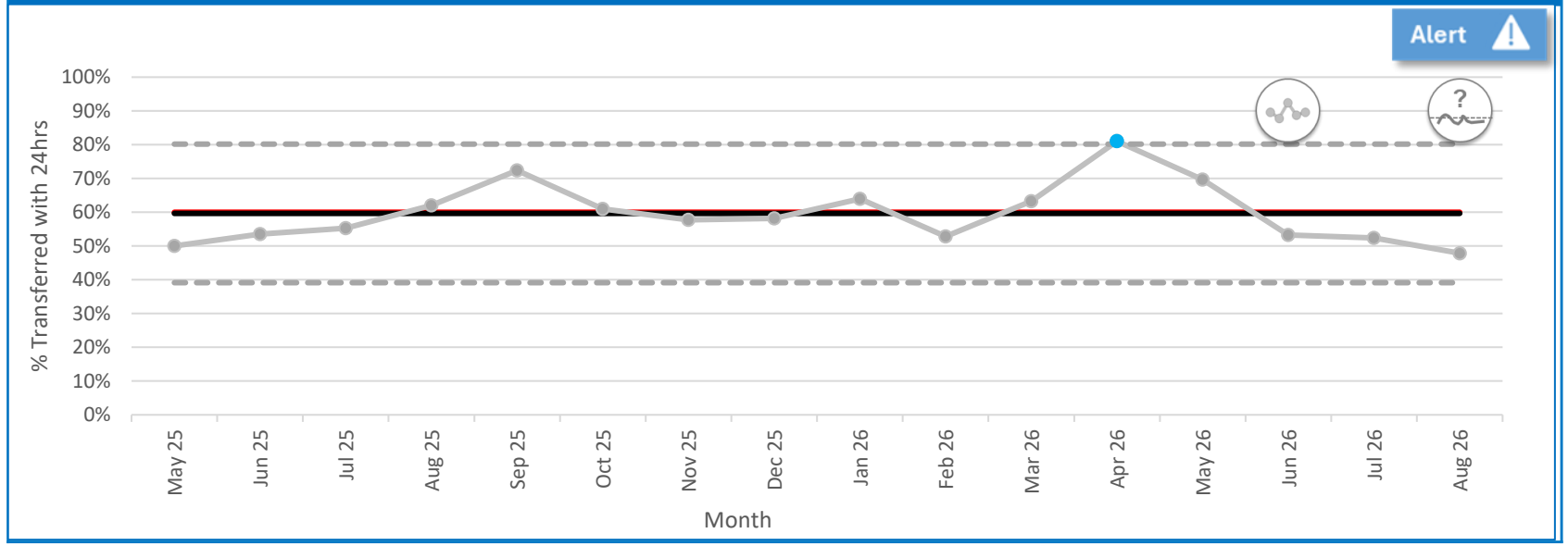
Actual	Standard / Plan	Variance
47.87%	60%	-12.13%

Compliance	Variance	Assurance	Actions
✗	~	?	✗

Clinical Group breakdown



Induction pathway delays



Understanding the performance

Performance declined overall by 4.55% compared to the previous month (52.42%) and at ORC by 14.65% (55.56%). Performance improved by 3.48% at NMGH (52.08%) and by 2.11% at Wythenshawe (14.89%).

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

Risks and controls

Increased acuity impacts on patient flow on all three sites. Women may decline transfer for care at an alternative site, or it may not be appropriate to offer transfer due to level of clinical care required.

Twice daily flow and twice weekly IOL capacity meetings.

Actions and timescales

Director of Strategy supporting a paper proposing improvements identified in the May 2026 demand and capacity review - to be presented to Commissioners in Q4.

Births outside of intrapartum birth setting

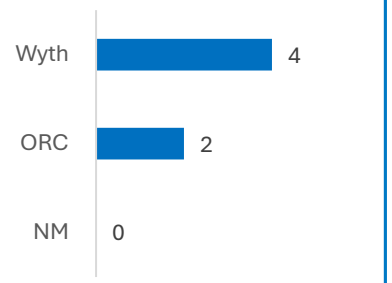
Manchester University NHS Foundation Trust

- **Accountable Executive: Kimberley Salmon-Jamieson| Accountable Group: Quality, Safety and Performance Board Committee**
  NOF: N/A | Internal Measure

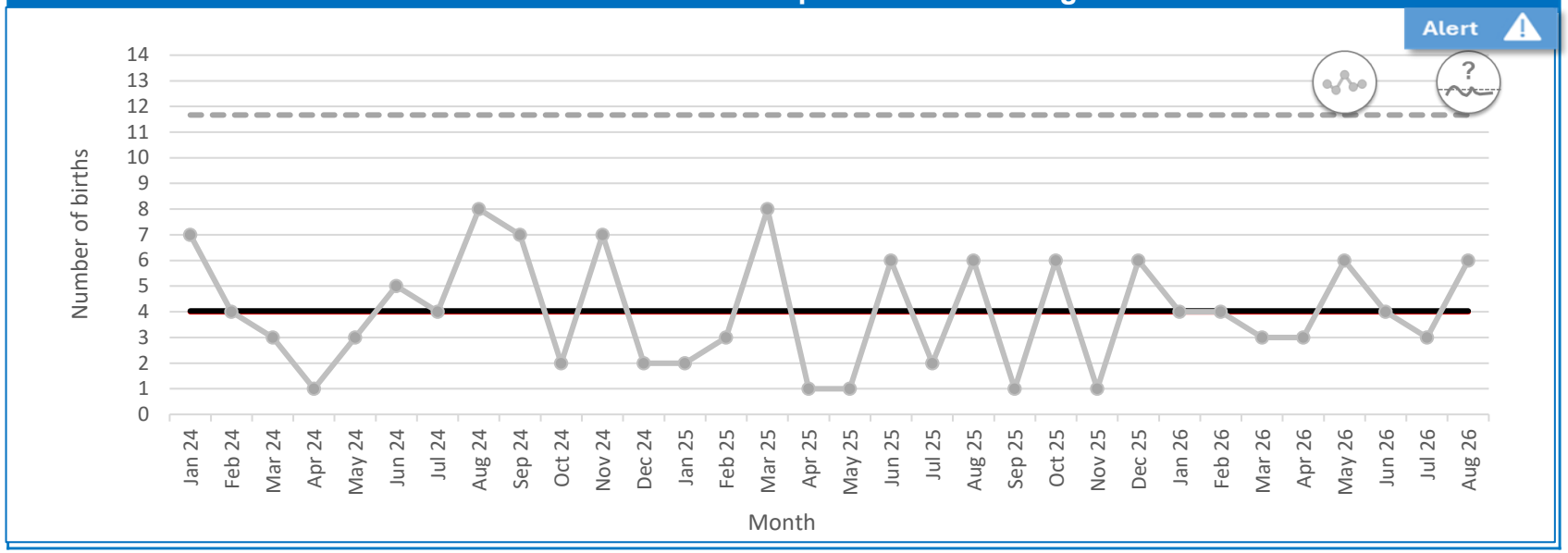
Actual	Standard / Plan	Variance
6	<4	+2

Compliance	Variance	Assurance	Actions
✗	~	?	👁

Clinical Group breakdown



Births outside of intrapartum birth setting



Understanding the performance

Cases increased by 3 compared to the previous month (3) and by 4 at Wythenshawe (0) and1 at ORC (1). Cases decreased by 2 at NMGH.

All 6 cases in-month were considered unavoidable precipitate births. No modifiable care issues identified.

Risks and controls

All births reviewed by cross-site team to identify and share learning.

Actions and timescales

Nil to report.

Number of babies with suspected Hypoxic–ischaemic Encephalopathy (HIE) Grade 2/3 per 1000 births

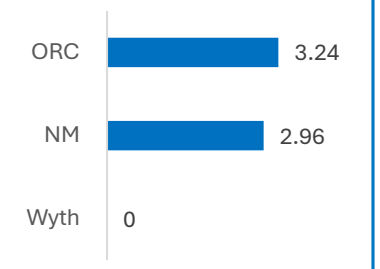
Manchester University NHS Foundation Trust

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

Actual	Standard / Plan	Variance
2.2	<0.75/1000	+1.45

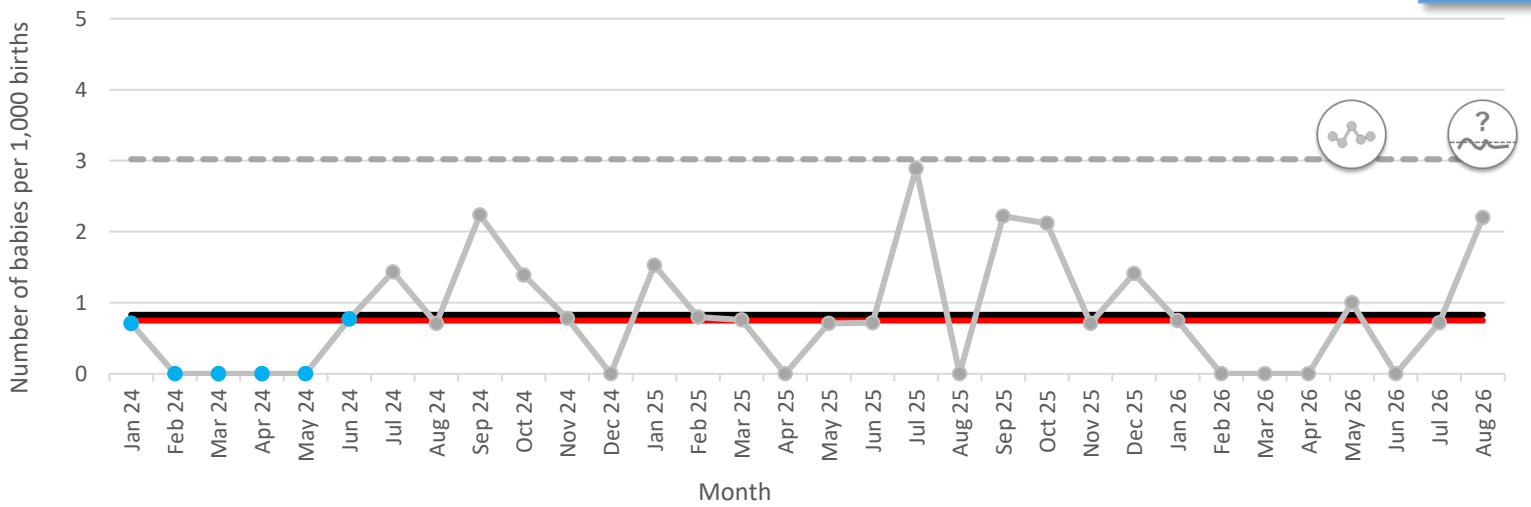
Compliance	Variance	Assurance	Actions
✕	~	?	👁

Clinical Group breakdown



Number of babies with suspected HIE Grade 2/3

Alert ⚠



Understanding the performance

Number of cases increased by 1 compared to the previous month (2).
3 cases referred to MNSI under the category "potential severe brain injury": 2 ORC, 1 NMGH.

Duty of candour completed for all cases.

Risks and controls

Robust governance processes in place to identify cases of HIE and review care provided. Shared learning via multiple routes – LMNS Safety SIG, Quality, Safety and Performance meetings and governance monthly newsletter.
MNSI submission where criteria met.

Actions and timescales

- Case 1: Improving situational awareness in a theatre environment with a focus on instrumental births (January 2027).
- Case 2: Quality improvement work to improve SBAR handovers during labour care.(January 2027).
- Case 3: Enhancing counselling regarding NICU cot availability and the potential impact on induction timing (December 2026).

Post Partum Haemorrhage ≥2 litres

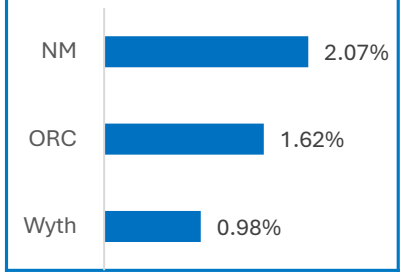
Manchester University NHS Foundation Trust

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

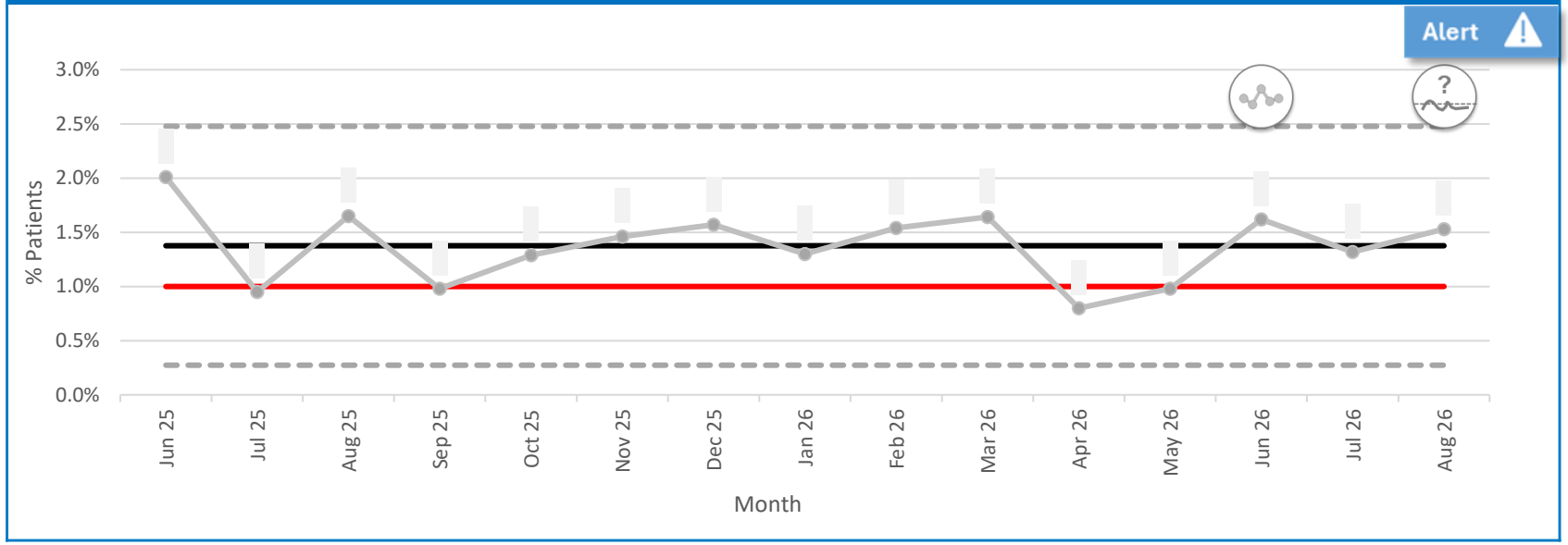
Actual	Standard / Plan	Variance
1.53%	<1%	+0.53%

Compliance	Variance	Assurance	Actions
✗	~	?	👁

Clinical Group breakdown



Post Partum Haemorrhage ≥2 litres



Understanding the performance

Overall performance declined by 0.21% compared to the previous month (1.32%) and by 0.51% at NMGH (1.56%), 0.18% at ORC (1.44%), and 0.01% at Wythenshawe (0.97%).

No care issues identified and no site-based themes.

Risks and controls

High risk cohort of women at ORC due to regional placenta accreta spectrum service.

Actions and timescales

Local guideline being updated in line with revised regional guideline (October 2026). Additional MDT resources required - MDT Working Group established to develop and track action and monitor rates - 6 monthly audit of PPH 1-2 litres underway (November 2026).

Single Sex Compliance Breaches

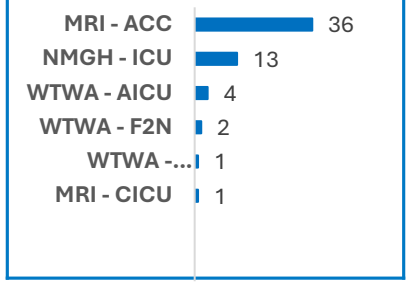
Manchester University NHS Foundation Trust

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

Actual	Standard / Plan	Variance
57	0	+57

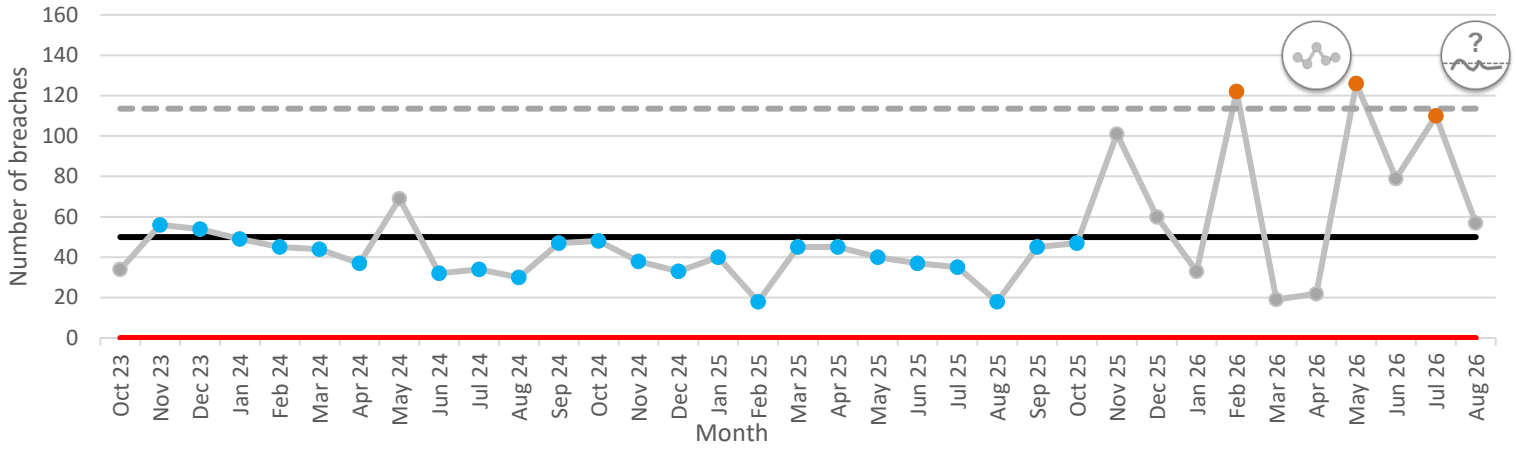
Compliance	Variance	Assurance	Actions
✗	~	F	✗

Clinical Group breakdown



Single Sex Compliance Breaches

Alert



Understanding the performance

Overall decrease of 22 breaches across MFT and decrease in breaches in all Clinical Groups.

Risks and controls

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

Actions and timescales

Nil to report.

Complaints and PALS

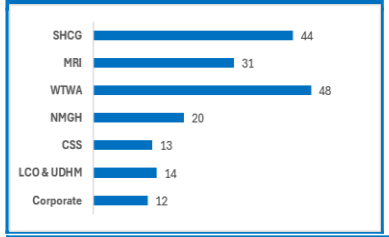
- **Accountable Executive: Kimberley Salmon-Jamieson | Accountable Group: Quality, Safety and Performance Board Committee**
  NOF: N/A | NHS England Reportable

Manchester University NHS Foundation Trust

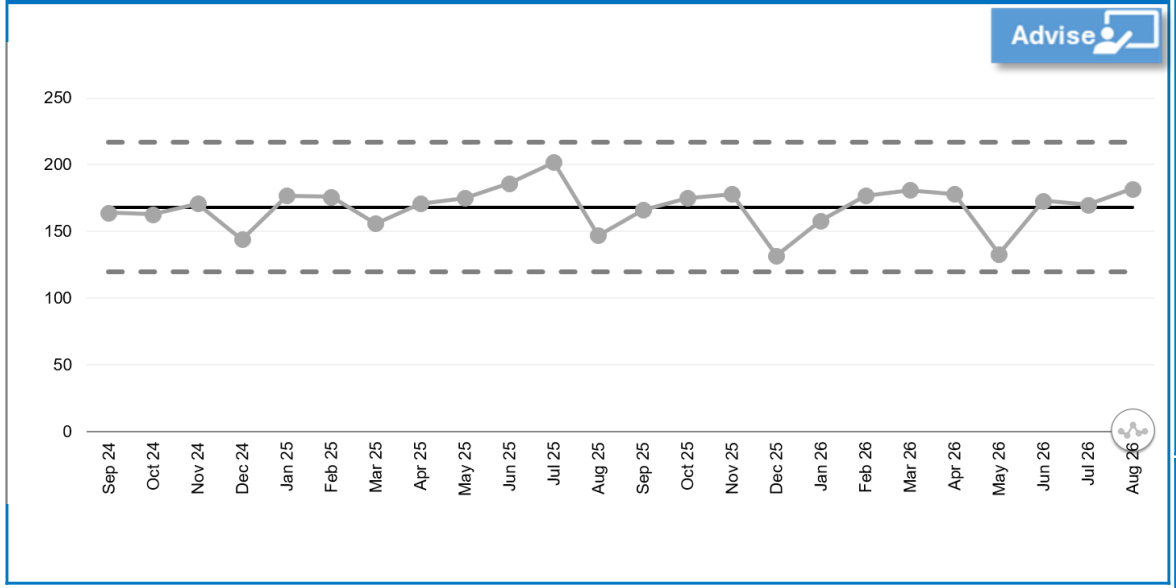
Actual	Standard / Plan	Variance
182	N/A	N/A

Compliance | Variance | Assurance | Actions

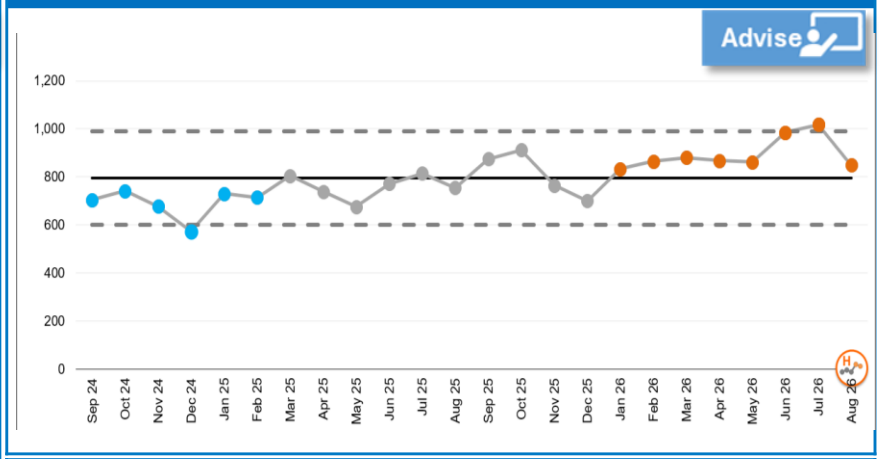
Clinical Group breakdown



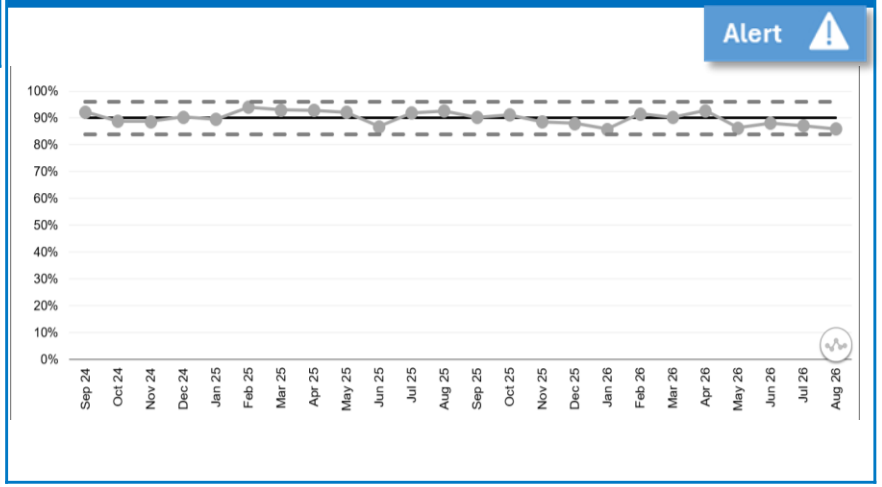
Number of Formal Complaints opened



Patient Advice & Liaison Service Contacts



% Complaints closed in agreed timescale



Understanding the performance

Overall increase of 12 complaints compared to the previous month (170) - Themes identified alongside PALS include communication access namely telephony.

86% of complaints were responded to within the agreed timescale against a standard of 90%, with lowest performance at MRI (73.9%) and NMGH (80.8%).

Risks and controls

Complaints oversight through established governance arrangements.

Themes and trends reviewed and triangulated with incidents to support organisational learning and identify emerging risks across portfolios.

Actions and timescales

Strengthened approval process implemented at MRI. Deep-dive on complaint themes shared with Clinical Group SLTs in September 2026. AI guidance tools for complaints team to be developed by January 2027.

Corridor care in Emergency Departments

Manchester University NHS Foundation Trust

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

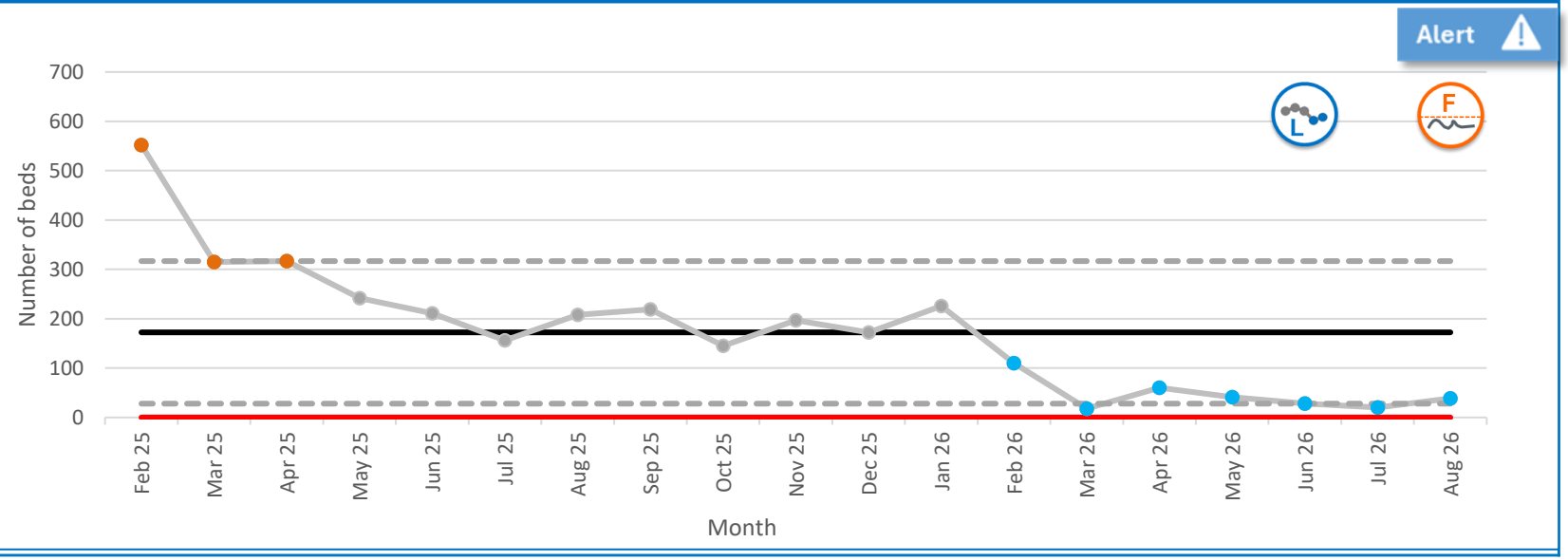
Actual	Standard / Plan	Variance
39	0	+39

Compliance	Variance	Assurance	Actions
✗	L	F	✗

Clinical Group breakdown

WTWA	31
MRI	8
NMGH	0
LCO & Dental	0
CSS	0
Specialist	0
Corporate	0

Corridor care in Emergency Departments (+45 minutes)



Understanding the performance

Overall increase of 19 occurrences compared to the previous month (20). Occurrences decreased in MRI (20) and increased at WTWA with no occurrences at WTWA in the previous month.

Risks and controls

Site capacity monitoring, OPEL status and site escalation. SOP in place with real-time breach review, senior oversight, and regular observations, medicines, hydration and privacy checks.

Actions and timescales

Occurrences result from capacity issues – nil actions to report.

Clinical Group Directors of Nursing providing senior leadership support directly into ED during Q3.

Urgent & Emergency Care (UEC)

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

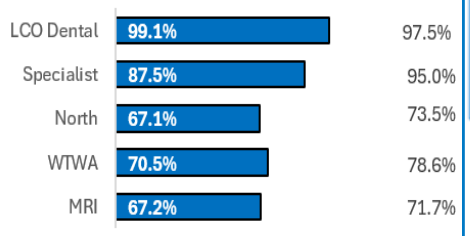
NHS Manchester University NHS Foundation Trust

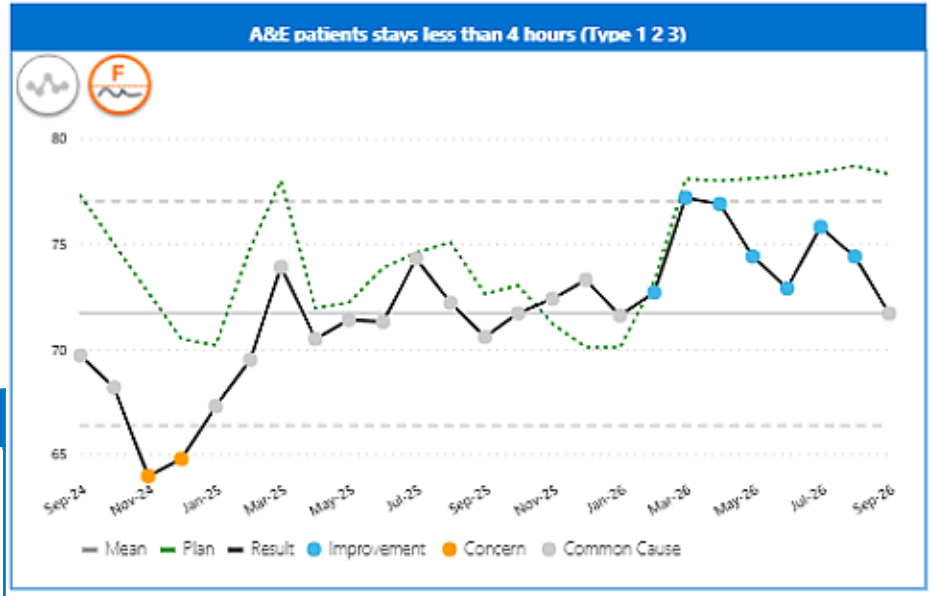
Alert

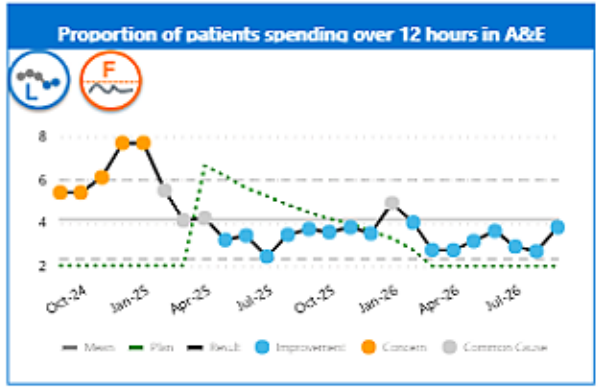
Sep-26		
Actual	Plan	Variance
71.7%	78.3%	-6.6%

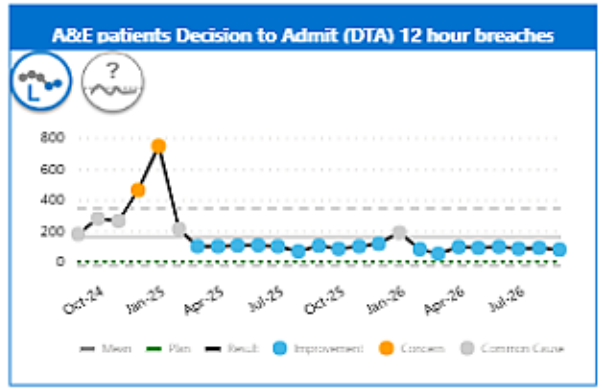
Compliance	Variance	Assurance
✖	~	F

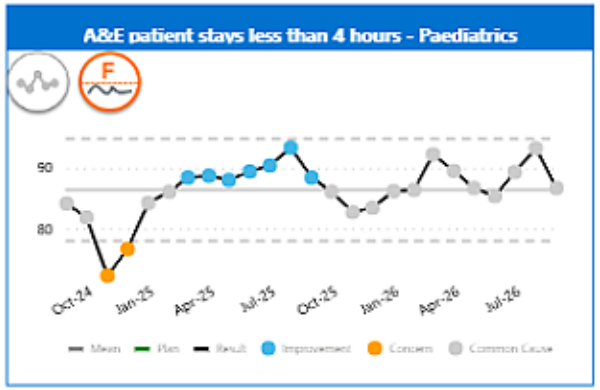
Clinical Group Overview











Understanding the performance

High levels of ED attendances continued in September with 47,512 patient attendances, 2,809 patients (6.3%) above plan and 8.2% higher than September 2025.
71.7% of patients were seen within the 4 hour standard, 6.6 percentage points below the planned trajectory of 78.3%. Patients discharged without admission was higher at 82.7% within 4 hours.
Despite the increase in attendances, A&E admissions remained broadly stable and were slightly lower than September 2025.
There were 87 patients experiencing 12-hour waits during September 26, compared with 97 in August 26.

Risks and controls

Sustained levels of ED demand above plan continue to present a risk to delivery of the four-hour standard and patient flow.

Controls are included in our Winter Plan and include continued delivery of Care Closer to Home, Model ED and Hospital at Home, alongside oversight of flow and discharge through the Delivery Oversight Framework.

Further improvement is planned as the Model ED approach continues to be embedded across MRI, North Manchester and Wythenshawe.

Actions and timescales

Clinical Group action plans are in place and monitored through the UEC Improvement Group and Delivery Oversight Management Committee, with escalation through the Quality, Safety and Performance Board Committee.

Priority improvement programmes focus on patient safety, experience and flow through delivery of the Model Emergency Department, First 72 Hours in Hospital standards and expansion of Care Closer to Home across WTWA and NMGH.

The four-hour improvement trajectory is based on the August 2026 baseline, with performance planned to improve to 82% by March 2027.

Elective Referral to Treatment (RTT) standards

Alert

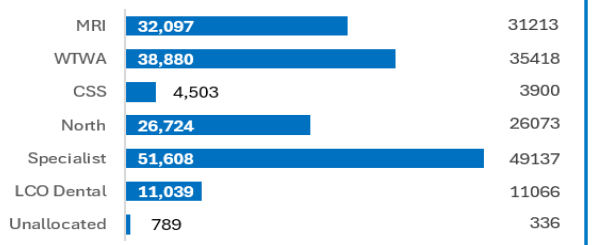
Accountable Executive: David Walliker | Accountable Group: Quality, Safety and Performance Board Committee

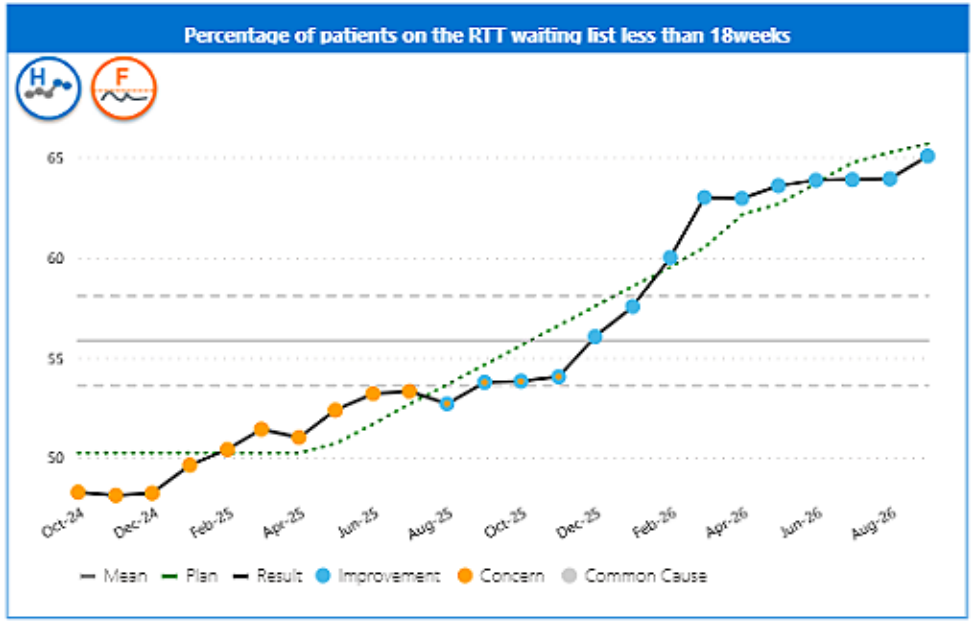
NHS Manchester University NHS Foundation Trust

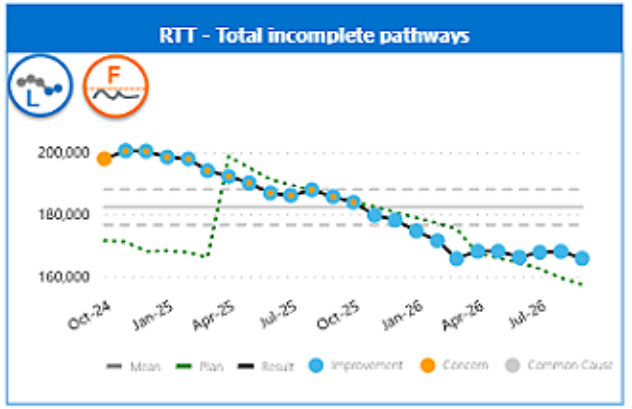
Sep-26		
Actual	Plan	Variance
65.06%	65.67%	-0.61%

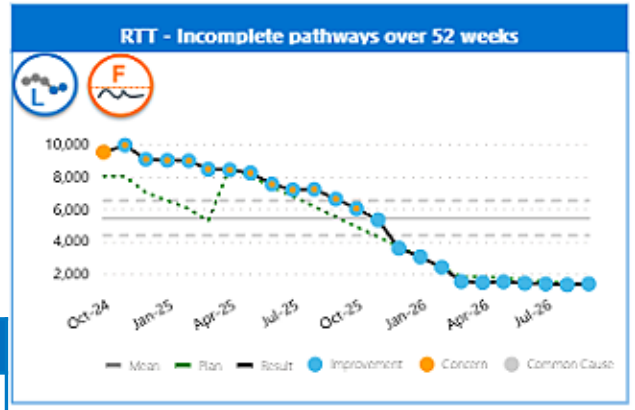
Compliance	Variance	Assurance
✖	H	F

Clinical Group Overview









Understanding the performance

65.06% of patients were seen within 18 weeks in September; 0.61pp below plan. Patients waiting over 52-weeks continue to reduce in line with plan.

The overall waiting list size remains off plan in September, with 8,497 patients more than planned. This is due to the demand increase of 2%. Interventions to manage these increases are agreed with the ICB, Additional activity is taking place to respond where appropriate.

Risks and controls

Continued increases is in demand above plan will create a risk to delivery but monthly meetings are in place the ICB to track demand and agree to mitigation actions.

Improvement at the required pace is a risk and therefore focused planning has taken place to ensure the trajectory can be re-joined in October.

Actions and timescales

Clinical Group action plans are in place for September and October with further plans wihtin the Half 2 plan.

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

National outpatient first appointment scheme is currently being scoped for delivery.

Staff WTE: Substantive, Bank and Agency

Manchester University NHS Foundation Trust

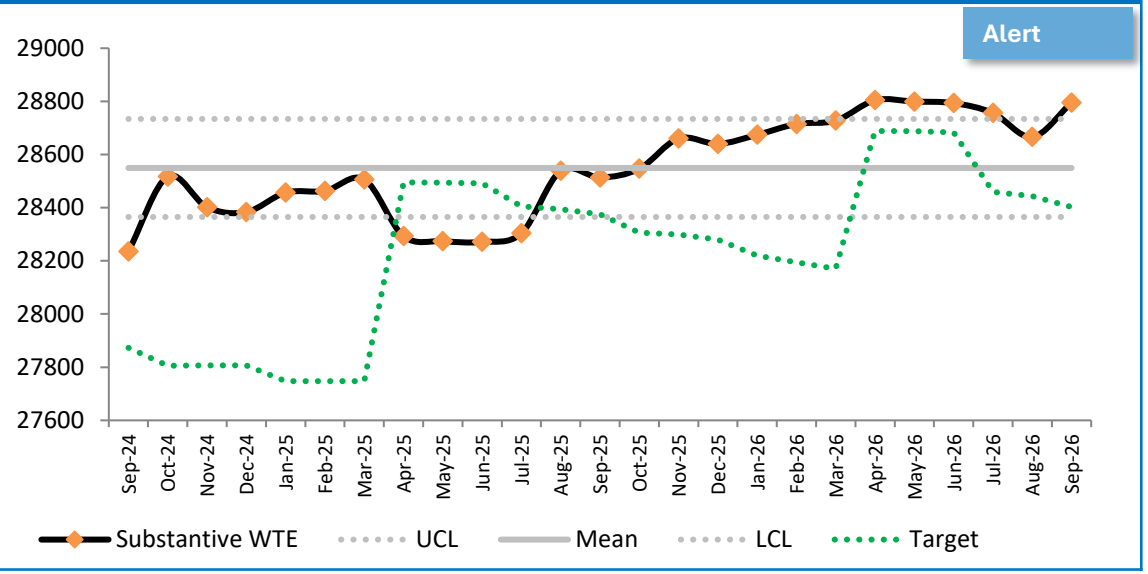
Accountable Executive: Meera Nair| Accountable Group: People Board Committee

Sep-26	Target
30,049.1	29,810.8

Compliance	Variance	Assurance	Actions
✗	~	F	✗

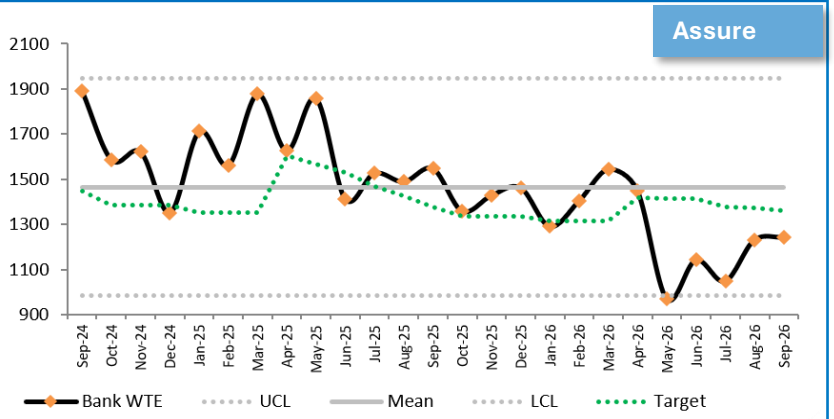
Substantive WTE

Alert



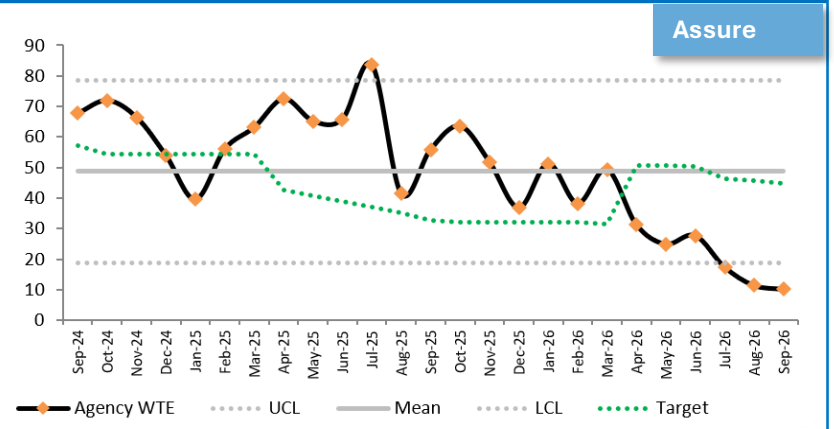
Bank WTE

Assure



Agency WTE

Assure



Understanding the performance

Total staffing WTE is 238 worse than the Annual plan for September 2026. This variance is predominantly driven by;

- Substantive WTE which is 392 worse than plan.
- Temporary Staffing is better than plan by 119 WTE in bank usage for September and 35 WTE for Agency usage.

Percentage Pay bill for M06 Agency 2026/27 is now 0.31% and 4.49% for Bank. MFT is pressing forwards with its ambition to reduce Bank and Agency which currently are within the NHSE targets. MFT % Paybill targets are set at 5.5% and 0.5%).

Risks and controls

The VFP programme was planned to deliver a reduction of 1,188 WTE throughout the course of the year; which is offset by some growth through approved bysiness cases to meet the demands of clinical activity of 284 WTEs.

In 2026/27 a total NET reduction of 904 WTEs is anticipated. Most of the Month 6 shortfall relates to VFP underachievement (183 WTE). Further action is needed to map WTE against WAVE.

Actions and timescales

1. Targeted Agency reduction continues across all staff groups with exit plans and migration to bank or substantive staffing to achieve MFTs ambition of zero Agency by the end of this financial year.
2. Clinical Groups to upload WTE values against all WAVE schemes.
3. Further VfP schemes required on WAVE for substantive WTE

Rolling 12 month (R12m) Sickness Absence

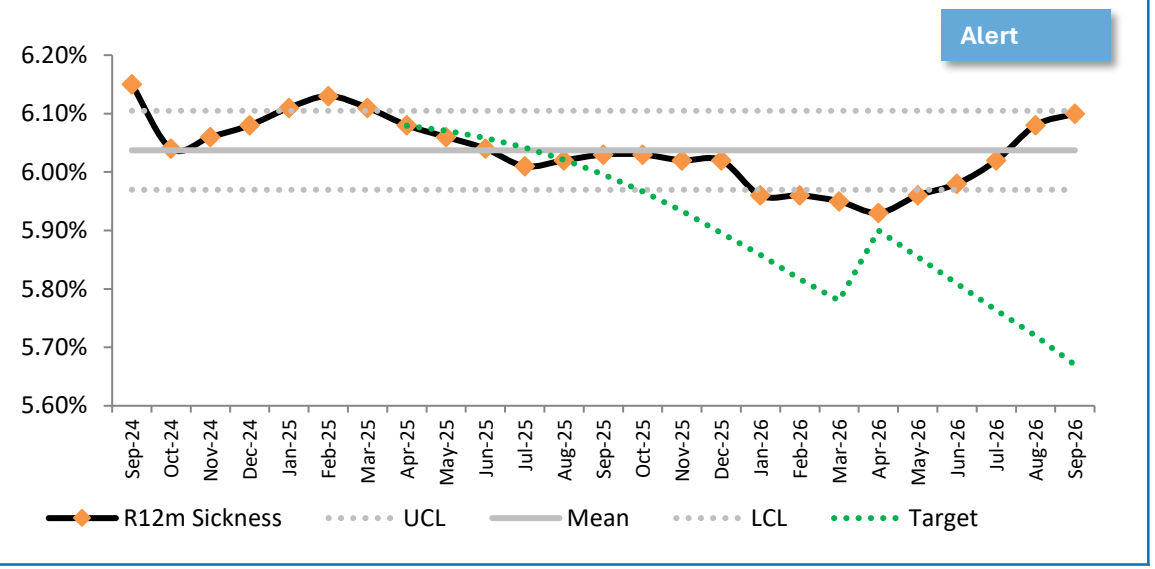
NHS Manchester University NHS Foundation Trust

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

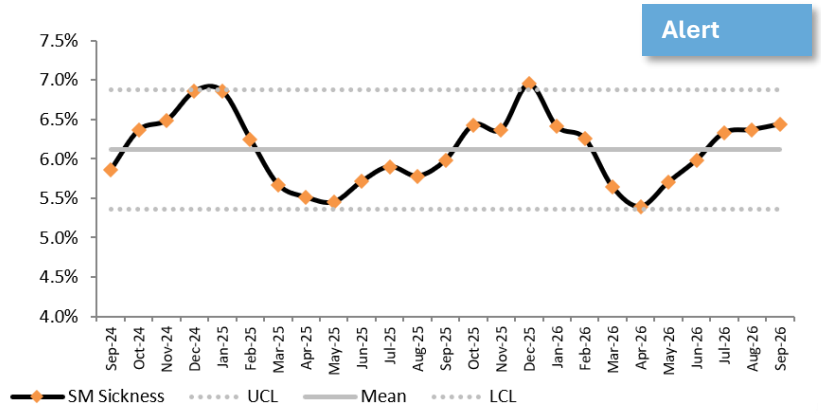
Sep-26	Target
SM 6.4%	5.9%
R12M 6.1%	5.7%

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

R12M Sickness Absence %



Single Month Sickness Absence %



Understanding the performance

MFT's rolling 12-month sickness absence rate was 6.1% in September 2026, remaining above the Trust target of 5.7%. Long-term sickness accounted for 3.7% and short-term sickness 2.4%. Anxiety/Stress/Depression remained the leading cause of absence at 1.8% on a rolling 12-month basis. In the single-month position, Cold/Cough/Flu increased notably between August and September, from 0.37% to 0.67%, with occurrences more than doubling from 700 to 1,480. Gastrointestinal absence also remained a significant contributor, while Anxiety/Stress/Depression continued to account for the highest overall level of absence.

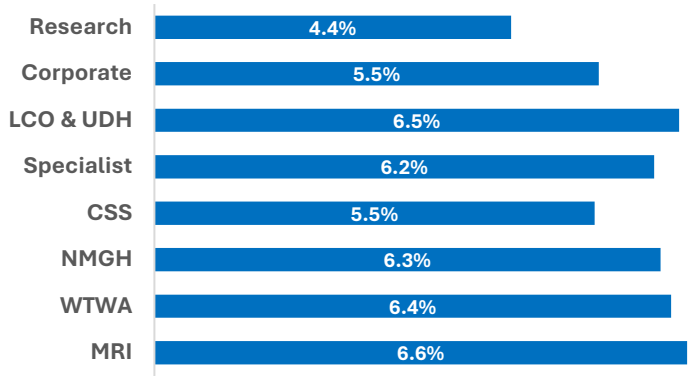
Risks and controls

Weekly targeted review of sickness absence at Clinical Group and Corporate Function level led by the Directors of Workforce and OD. Focus on long term sickness and escalation of cases.
Relaunch of Oversight group with focus on wellbeing and attendance including a review of historical workstreams.

Actions and timescales

1. The Trust has developed an outline proposal focusing upon preventative measures to support staff wellbeing. A final proposal will be delivered to TLTC in November.
2. Policy review and consultation with staff side continues.
3. Empatctis Review completed awaiting final recommendations and feedback

Clinical Group breakdown (R12m)



Appraisal: AfC and Medical

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

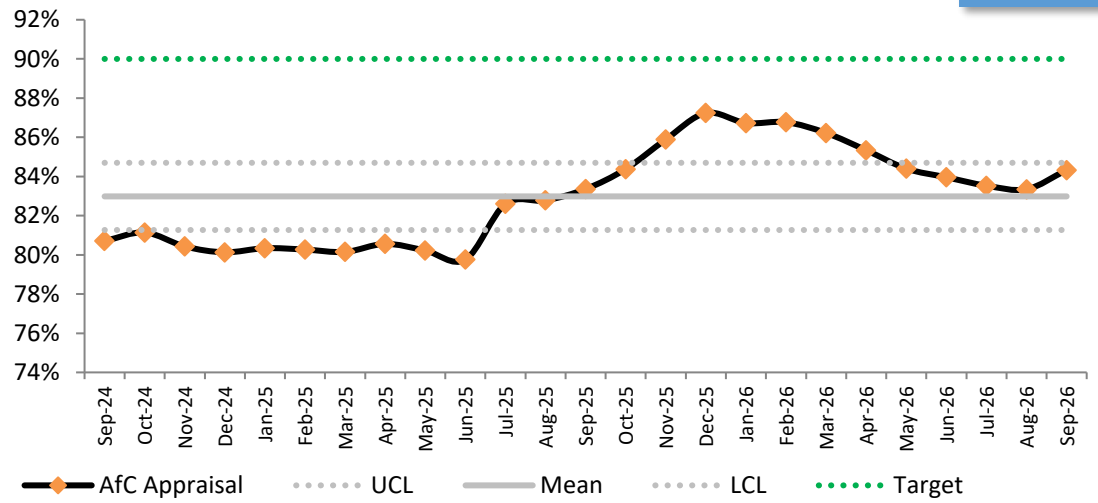
Manchester University NHS Foundation Trust

Sep-26	Target
AfC 84.3%	90.0%
Med 92.9%	90.0%

	Compliance	Variance	Assurance	Actions
AFC	✗	H	F	✓
MED	✓	~	P	⇄

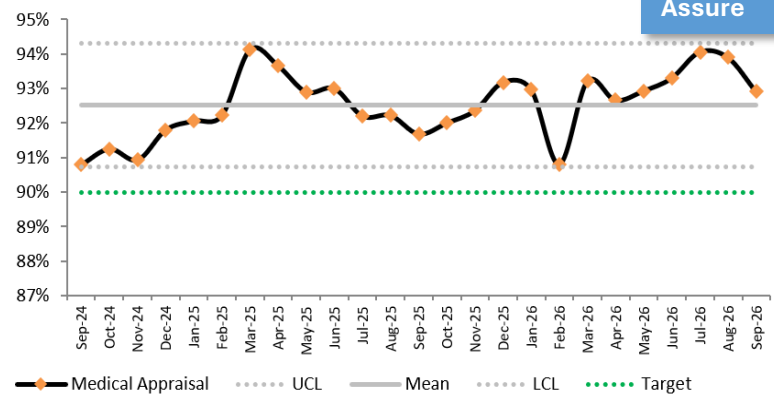
AfC Appraisal

Alert



Medical Appraisal

Assure



Understanding the performance

In September 2026, AfC appraisal compliance was 84.3%, against a Trust target of 90%, while Medical Appraisal compliance was 92.9%, exceeding the target. Although Medical Appraisal performance remains strong, AfC appraisal compliance had been showing consecutive falls in compliance until this reporting month.

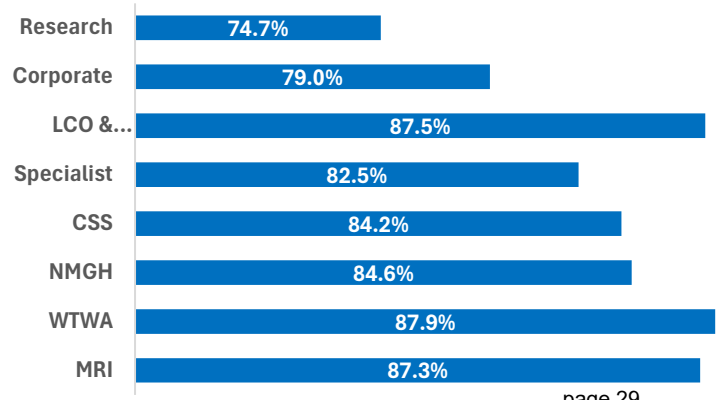
Risks and controls

Not having timely appraisal discussions reduces the ability to demonstrate that staff are receiving regular performance, development and wellbeing conversations, creating a risk that development needs and support requirements are not identified or addressed. Controls in place include monthly performance monitoring through WEMC, Divisional Performance Reviews, targeted support for low performing areas and regular reporting to SLTs.

Actions and timescales

1. November Culture and Staff Experience Forum focussed topic will be in relation to appraisals, from both a managers and staff members perspective, and how we can make the process as meaningful as possible – complete by 30th November 26.
2. New Digital Appraisal System – complete by 31st December 2026.
3. Continued increased scrutiny via WEMC and Divisional Performance Reviews – ongoing.

Clinical Group breakdown (AfC)



Liquidity – Operating Expenditure Days

Manchester University NHS Foundation Trust

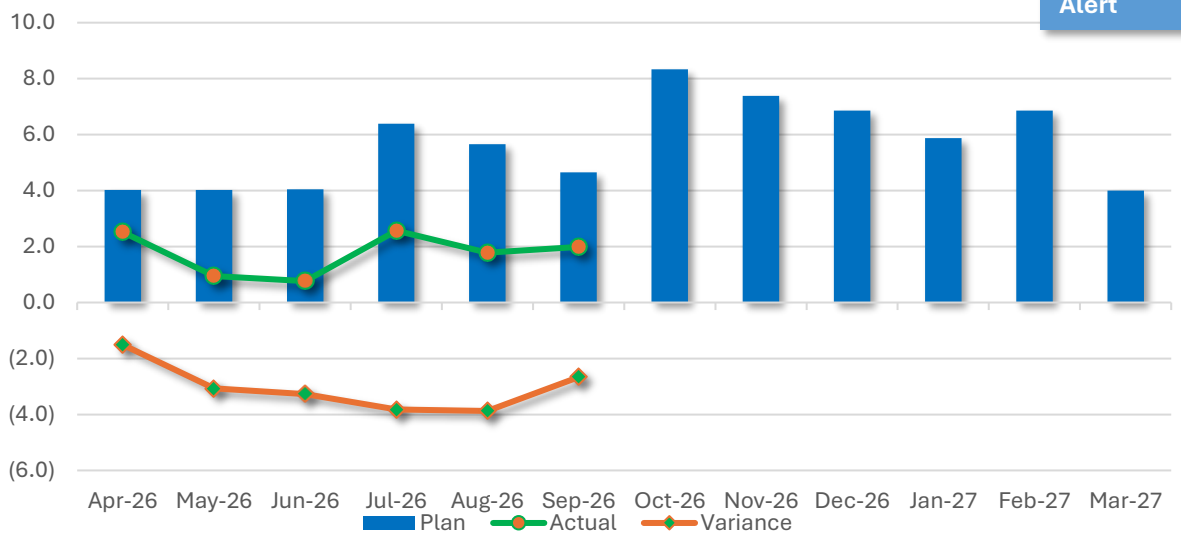
Accountable Executive: Claire Wilson | Accountable Group: Finance Board Committee

Sep-26		
Actual	Plan	Variance
Days	Days	Days
2.0	4.7	(2.7)

Compliance	Variance	Assurance	Actions
✗	L	F	✗

Liquidity – year to date operating expenditure days

Alert



Understanding the performance

The Trust cash balance at the end of September reflects 2.0 days of revenue operating cash days and equates to £16.8m – an increase of £2.2m from the balance at the end of August. This balance is £21.9m below plan but £1.4m above forecast due to YTD I&E delivery being based on assumptions on PFI penalties and other non-cash items.

Risks and controls

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

Actions and timescales

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

Agency expenditure as a proportion of total pay expenditure YTD

Manchester University NHS Foundation Trust

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

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

Compliance	Variance	Assurance	Actions
✗	~	F	✗

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



Clinical Group breakdown

Rank	Clinical Group	YTD Value %
1	SHCG	0.0%
2	LCO & Dental	0.0%
3	WTWA	0.3%
4	NMGH	0.6%
5	MRI	0.6%
6	CSS	0.7%

Understanding the performance

YTD expenditure on agency staffing is £3.3m against an internally set target of £0. This equates to just 0.3% of total pay expenditure.

The externally set annual cap for MFT is £6.4m. Pro-rata to month 6 this would be £3.2m, so the Trust is adverse to this by £0.1m.

Risks and controls

Key risks around clinical scientists in CSS and Consultants in paediatric services where recruitment to substantive positions is extremely difficult and there is no bank staff available. Exit plans are in place and tracked through workforce governance processes.

Actions and timescales

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

Target delivery date - March 2027.

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

Manchester University NHS Foundation Trust

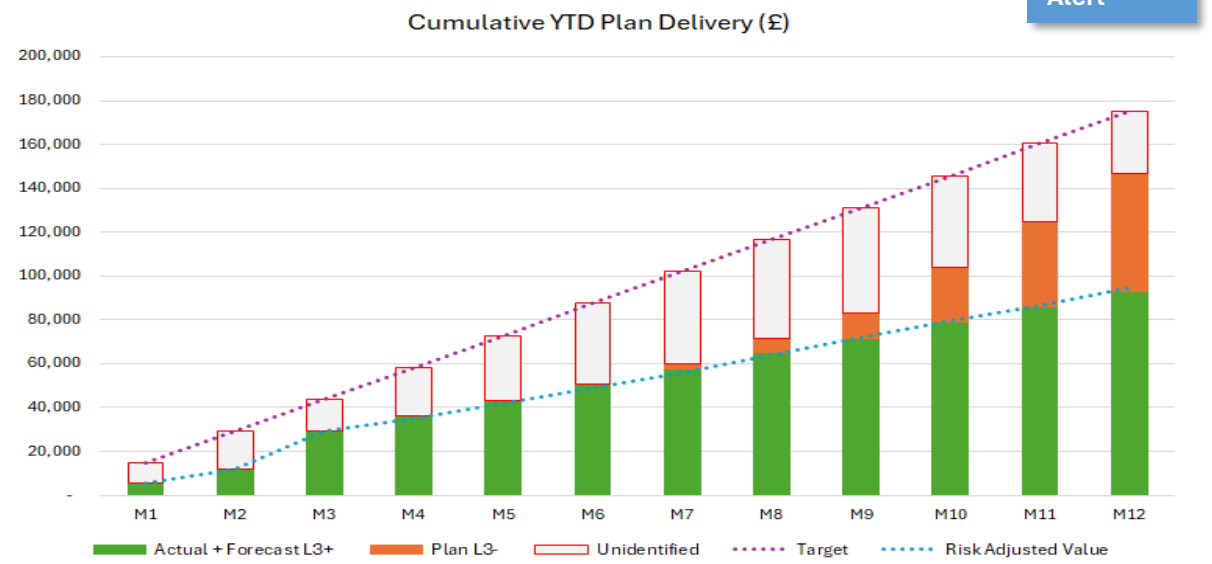
Accountable Executive: Darren Banks| Accountable Group: Finance Board Committee

Sep-26		
Actual	Plan	Variance
£m	£m	£m
50.7	87.6	(36.9)

Compliance	Variance	Assurance	Actions
✗	L	F	✗

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

Alert



Group breakdown

Estates & Facilities	125%
NMGH	94%
CSS	36%
SHCG	46%
WTWA	40%
LCO & UDHM	42%
MRI	29%
Corporate	64%
Digital Services	79%

Understanding the performance

- 26/27 programme has identified £146.9m against a target of £175m (£94.7m risk adjusted).
- Financial planning continues, although minimum £28.1m additional is required to reach the £175m target.
- YTD actual delivery £50.7m against a target of £87.6m (variance to target £36.9m)

(Note: the target phasing in Wave (YTD £87.6m) is different to the phasing as per the PFR (YTD £75.0m). Full year target reported is the same.)

Risks and controls

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

Actions and timescales

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

National Overview – 2026/27 so far

Manchester University NHS Foundation Trust

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

90-day set-up performance per financial year quarter for NHS boards (NOF)

Trust Name	No of studies with FPFV in Q1 2026/27 within 90 days	No of studies with FPFV in Q1 2026/27	Q1 Metric	No of studies with FPFV in Q2 2026/27 within 90 days	No of studies with FPFV in Q2 2026/27	Q2 Metric
Totals	-	-	-	-	-	-
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	11	32	34.4%	10	16	62.5%

For studies included in the 90-day metric with MFT selected as a site from February 2026 we hit the 90-day target in 95% of studies (n=23). We also set-up and recruited into 21 studies in 2026/27 which were excluded from the 90-day metric showing the breadth of the studies we are delivering on.

60-day metric – Median days = 57.5 - hitting target in 58% of studies (n=104).

30-day metric – Median days = 35 – hitting target in 48% of studies (n=48).

MFT is 4th and 6th nationally for recruitment into commercial and non-commercial studies.

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

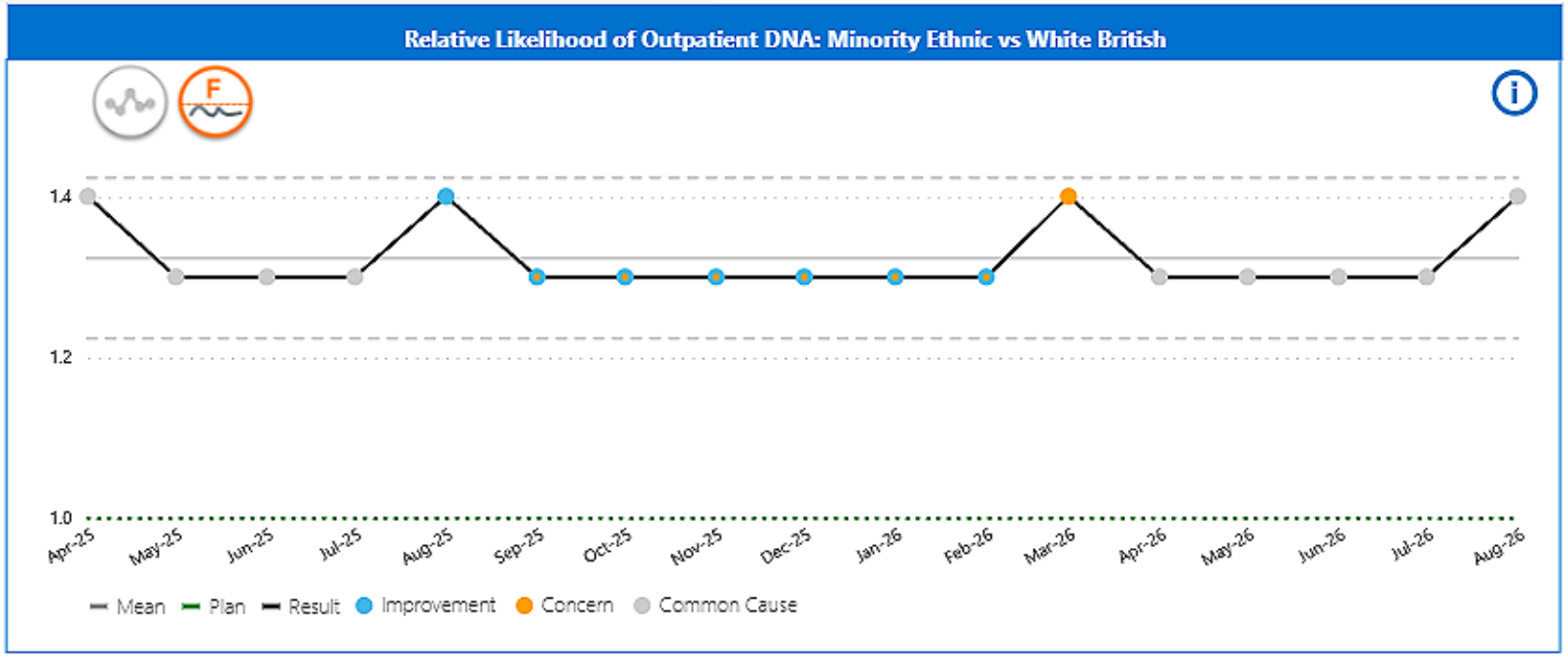
Alert

Manchester University NHS Foundation Trust

Accountable Executive: David Walliker | Accountable Group: Population Health Committee

Aug-26		
Actual	Plan	Variance
1.4	1.0	0.4

Compliance	Variance	Assurance
✖	~	F



Metric Definition

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

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

Understanding the performance	Risks and controls	Actions and timescales
12-month average 1.4; slight increase (0.1) on previous month, but within previous range.	Persistent ethnicity gap showing that those from global majority backgrounds are more likely to miss appointments; data-quality measures for ethnicity recording not yet in the dashboard.	Track data-quality and actively improve ethnicity recording. Continue to keep tracking the gap. Narrow the gap though DNA predict, communications work and other initiatives

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

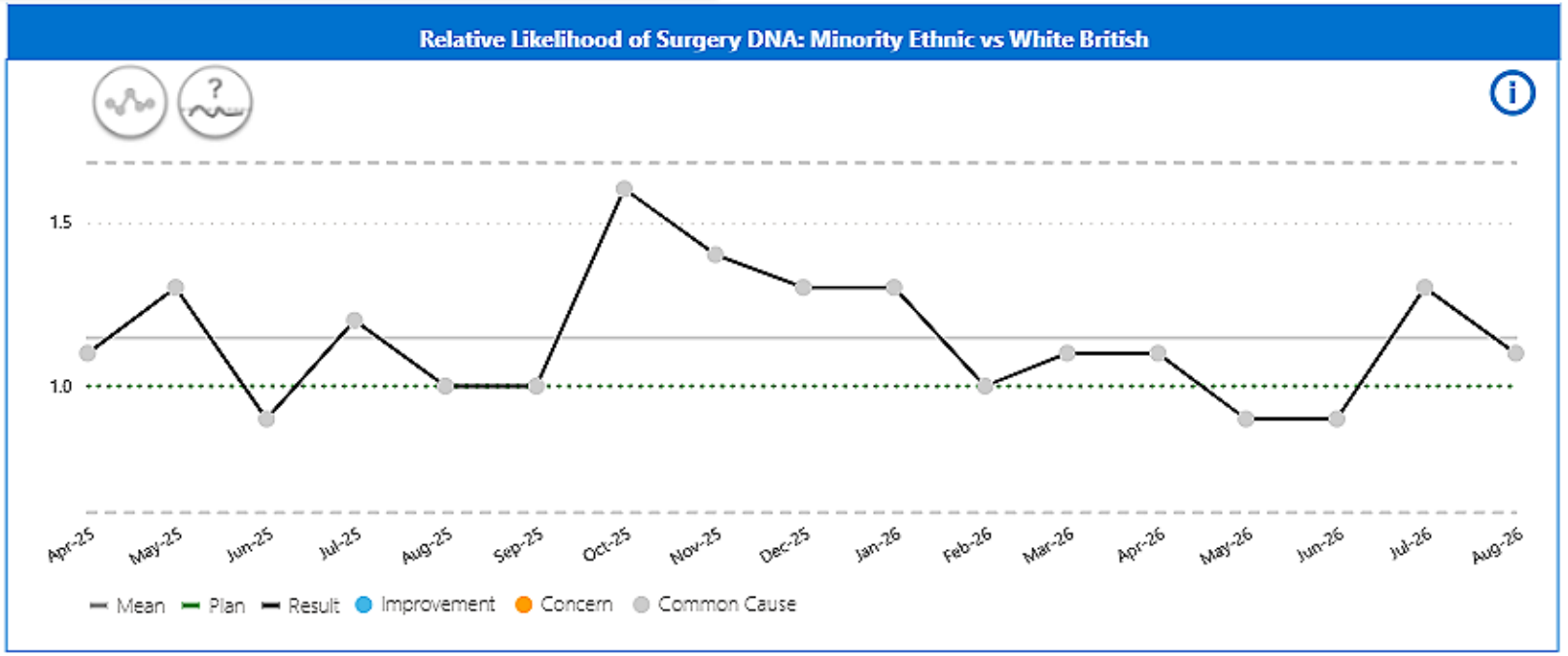
Alert

Manchester University NHS Foundation Trust

Accountable Executive: David Walliker | Accountable Group: Population Health Committee

Aug-26		
Actual	Plan	Variance
1.1	1.0	0.1

Compliance	Variance	Assurance
✖	~	?



Metric Definition

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

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

Understanding the performance	Risks and controls	Actions and timescales
Decrease from 1.2 to 1.1; last 6 months averaged 1.0 which is indicative of parity; ie no difference in DNA rate by ethnicity for surgery.	Monthly variation remains despite the recent average reaching parity.	Track data-quality measures. Continue to keep tracking and see if it stays close to 1.0.

Relative Likelihood of Outpatient DNA: Most vs Least Deprived Quintile

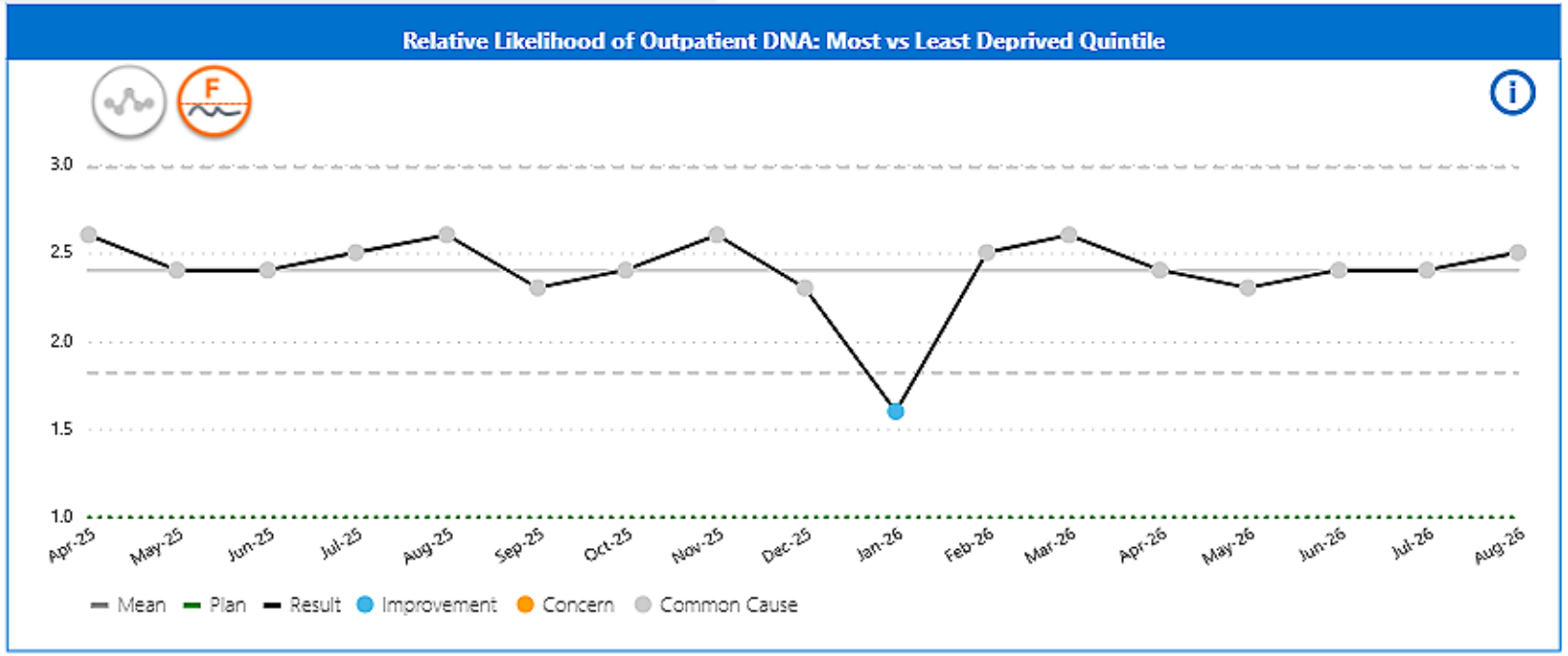
Alert

NHS Manchester University NHS Foundation Trust

Accountable Executive: David Walliker | Accountable Group: Population Health Committee

Aug-26		
Actual	Plan	Variance
2.5	1.0	1.5

Compliance	Variance	Assurance
✖	~	F



Metric Definition

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

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

Understanding the performance	Risks and controls	Actions and timescales
Slight increase (0.1) but remains at the level broadly observed for the last year; 12-month average 2.4.	Persistent 2.4× inequality despite a stable Trust DNA rate shows a stark gap between low and high income groups in terms of their ability to attend appointments. Those living in more deprived areas 2.4 times less likely to attend than those from affluent areas.	Continue monthly monitoring. Address and attempt to narrow the gap through DNA predict, communication improvement work and other targeted work such as planned free travel pilot with TFGM.

Relative Likelihood of Surgery DNA: Most vs Least Deprived Quintile

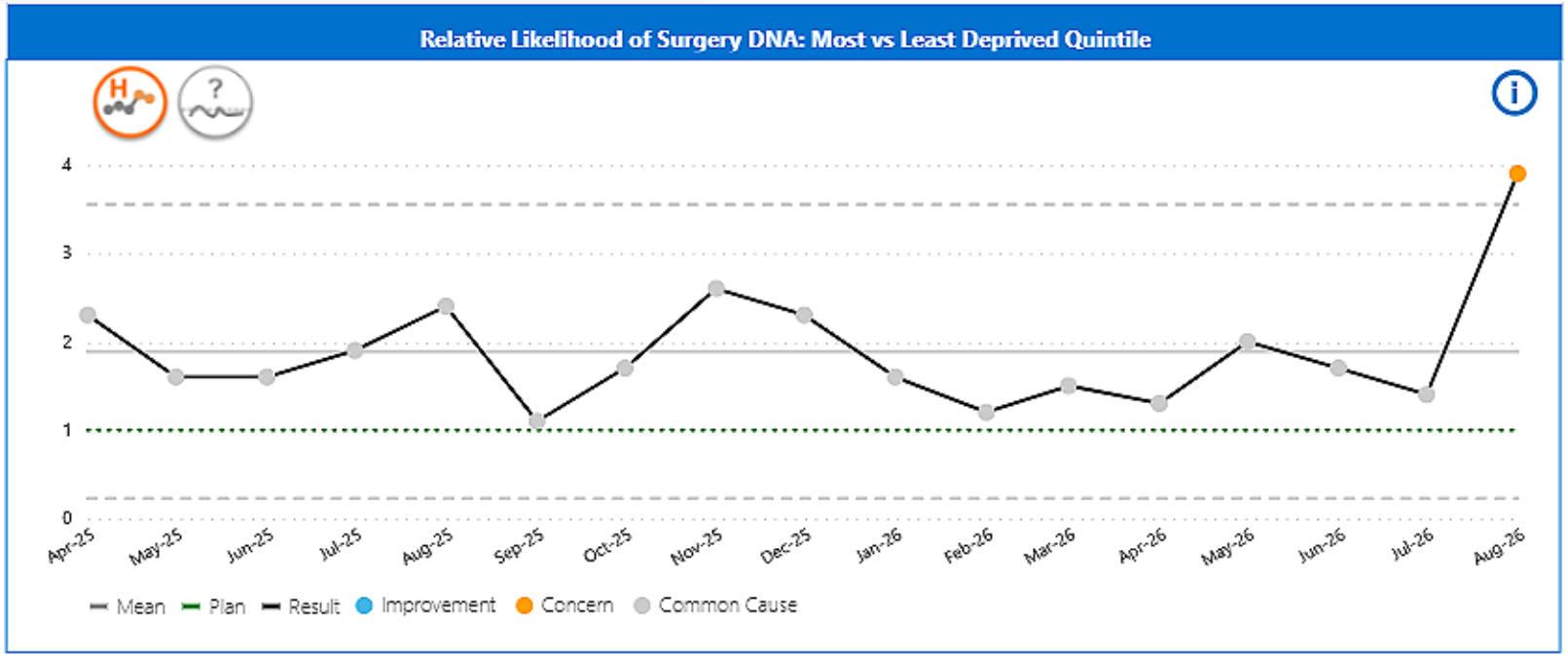
Alert

Manchester University NHS Foundation Trust

Accountable Executive: David Walliker | Accountable Group: Population Health Committee

Aug-26		
Actual	Plan	Variance
3.9	1.0	2.9

Compliance	Variance	Assurance
✖	H	?



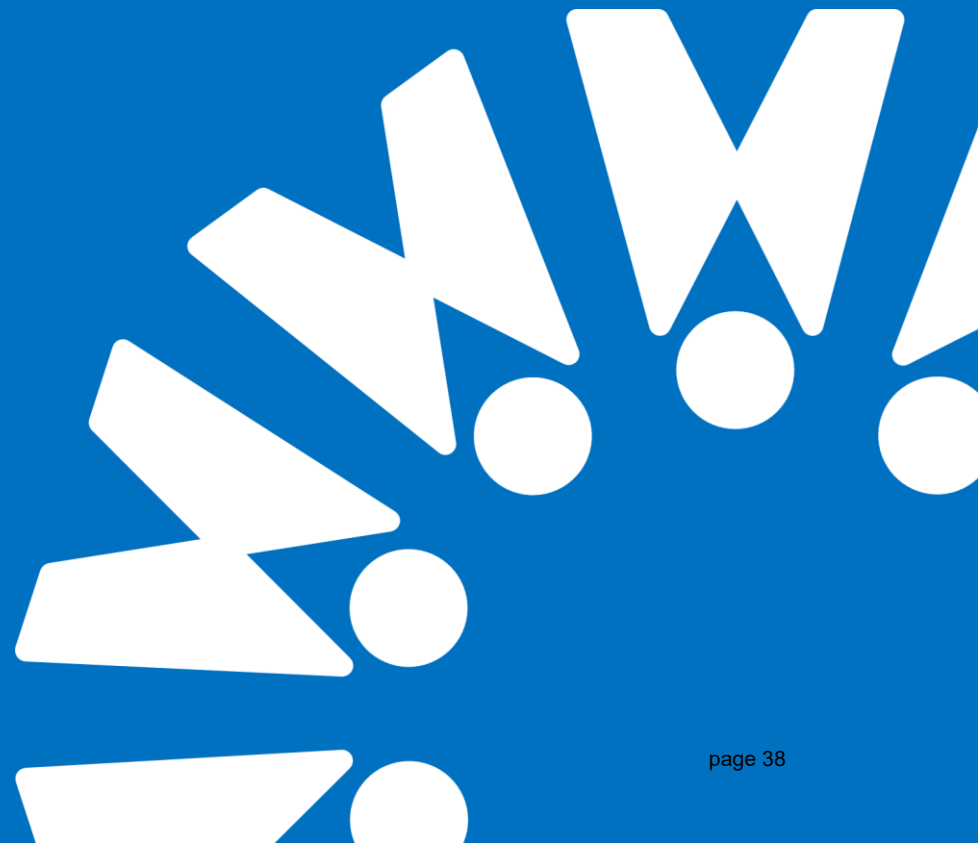
Metric Definition

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

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

Understanding the performance	Risks and controls	Actions and timescales
Steep increase since last month and deviation from the previous 12-month average of 1.7.	Significant increase; don't fully understand why at point of publish; investigation ongoing. Persistent 12 month average 1.7× inequality despite a stable Trust DNA rate shows a stark gap between low and high income groups in terms of their ability to attend appointments.	Continue monthly monitoring and see if gap increase returns to average in following month. Address and attempt to narrow the gap through DNA predict, communication improvement work and other targeted work.

Measures to note



Measures to note

Manchester University NHS Foundation Trust

Key Oversight Performance Metrics							
Focus	Compliance	Variation	Assurance	Action status	Performance	Plan / standard	Indicator
Maternity			N/A		0	N/A	Number of maternal deaths
			N/A		3	N/A	Number of incidents accepted for MNSI investigation
Complaints			N/A		182	N/A	Number of formal complaints opened
			N/A		2	N/A	Number of PHSO complaints
Learning from Deaths			N/A		79.85	N/A	Hospital Standardised Mortality Ratio (HSMR)
			N/A		3.15%	N/A	Crude mortality (rolling 12 month)
			N/A		100	N/A	Summary Hospital-level Mortality Indicator (SHMI)

Measures to note

Maternity: 0 maternal deaths reported,3 cases accepted for Maternity and Newborn Safety Investigations (MNSI), all required therapeutic cooling.

Complaints: 2 PHSO complaints received relating to historic complaints from 2024 for T&O and WTWA. Complaint numbers increased compared to the previous month.

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

Cancer Standards

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

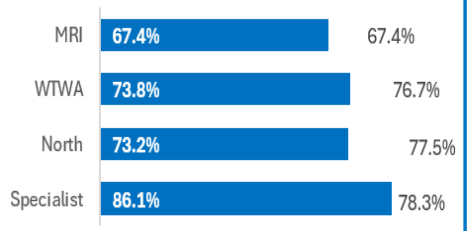
Advise

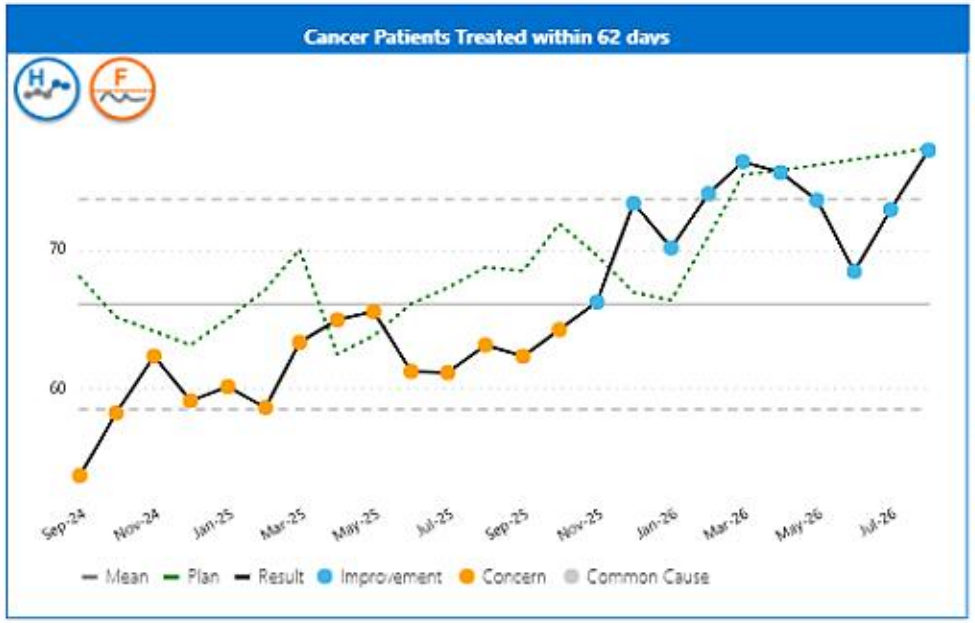
NHS Manchester University NHS Foundation Trust

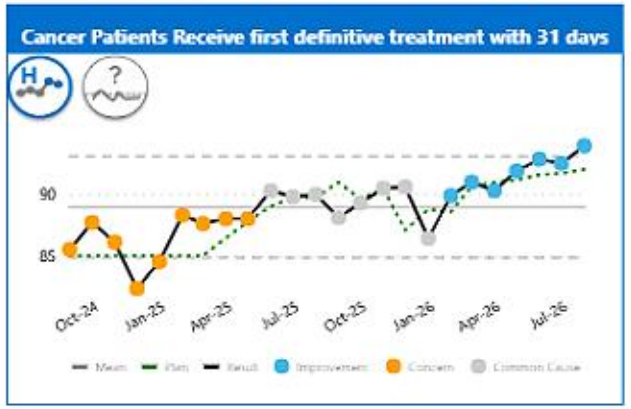
Aug-26		
Actual	Plan	Variance
77.1%	77.3%	-0.2%

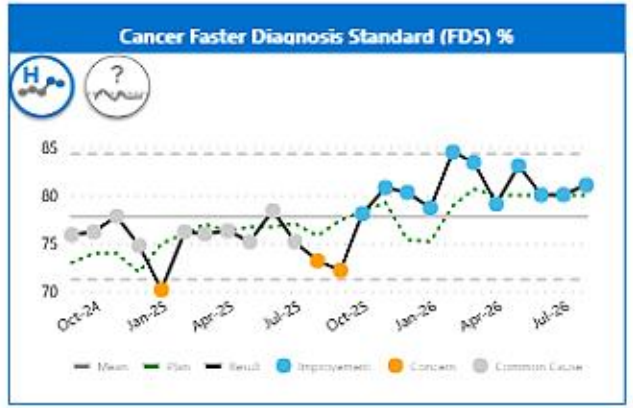
Compliance	Variance	Assurance
✖	H	F

Clinical Group Overview









Understanding the performance

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

Delivery of the 62-day standard was broadly on plan (-0.17%) variance, with 77.1% of patients having their treatment delivered within 62 days against the plan of 77.3% - a combination of complex patients, diagnostic delays and specialist workforce availability were the key pathway challenges.

62 day standard delivery is continuing to improve but is not yet sustained with monthly fluctuations.

Risks and controls

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

High volume of patients in the backlog is being controlled through daily management of pathway compliance with lead indicators in place.

Actions and timescales

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

Daily huddles in place with higher risk tumour groups.

A Trust-wide improvement programme has commenced o deliver significant pathway redesign leading to sustainable change and delivery of the longer term performance ambitions.

Ambulance Handover

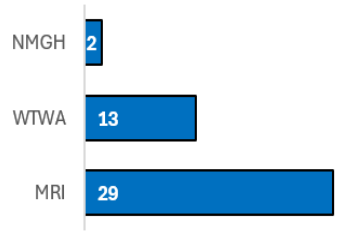
Accountable Executive: David Walliker | Accountable Group: Quality, Safety and Performance Board Committee

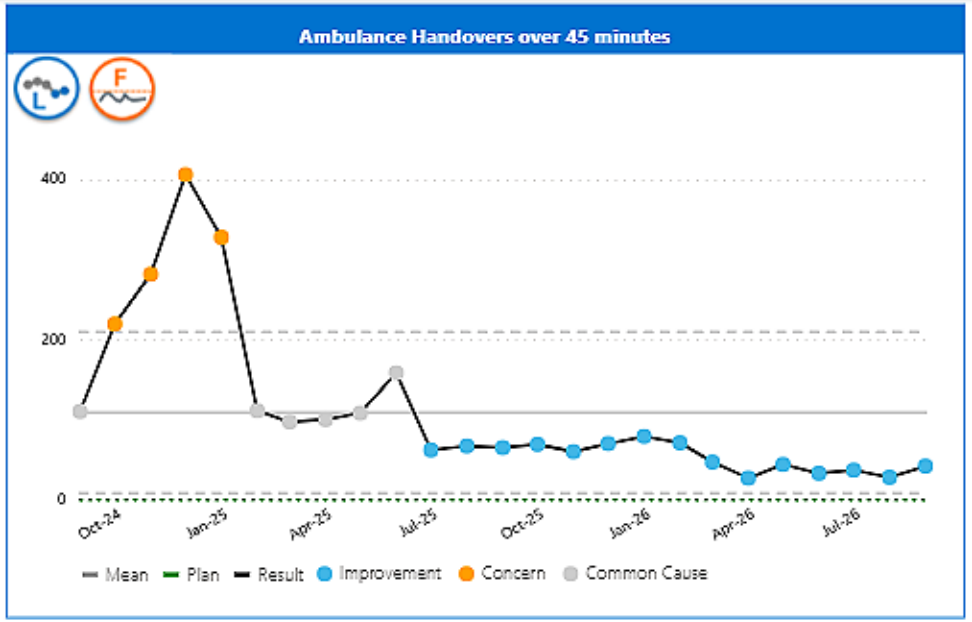
Advise

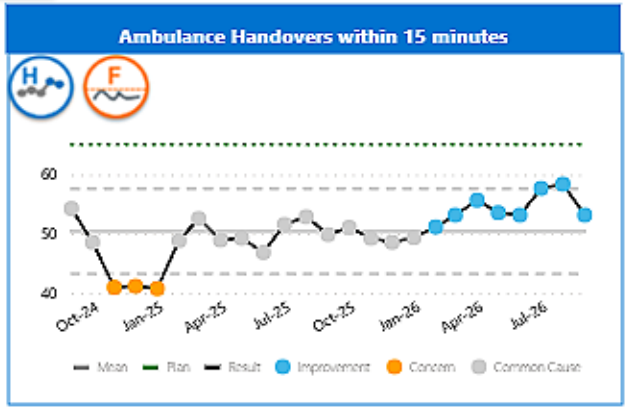
Sep-26		
Actual	Plan	Variance
42	0	42

Compliance	Variance	Assurance
✖	L	F

Clinical Group Overview







Understanding the performance

In September 26, there were 42 patients handed over beyond 45 minutes. This compares to 28 in August 26. Delivery against <15 min handovers remains below standard (65%) at 53.1%. Average turnaround is stable at 25m 18s and average handover time at 16m 2s.

Patient handovers over 45 min equates to 0.67% of ambulance attends during September. Work continues in collaboration with the North West Ambulance Service (NWAS) to ensure handover time of patients when taken to catheter labs is reduced.

Risks and controls

Recording accuracy for pin-out data remains a key area of focus, with data quality issues continuing. Sustained operational pressures, particularly within catheter lab pathways, also present a risk.

A programme of regular validation, assurance and shared learning with NWAS is supporting improvements in data quality and operational processes is in place. Site-specific improvement plans are being delivered under the oversight of the UEC Improvement Group, with progress tracked through the weekly performance framework and Delivery Oversight Framework to support the elimination of remaining handover delays.

Actions and timescales

A coordinated programme of work with NWAS and Clinical Groups remains in place to improve timely pin-outs, with particular focus on PCI patient handovers and ambulance handover performance in October with further specific actions being agreed NWAS leadership.

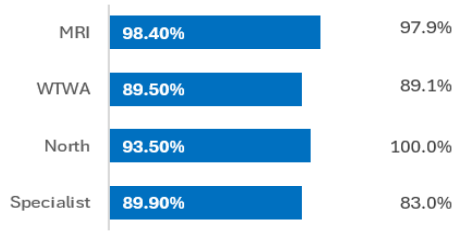
Patient Flow

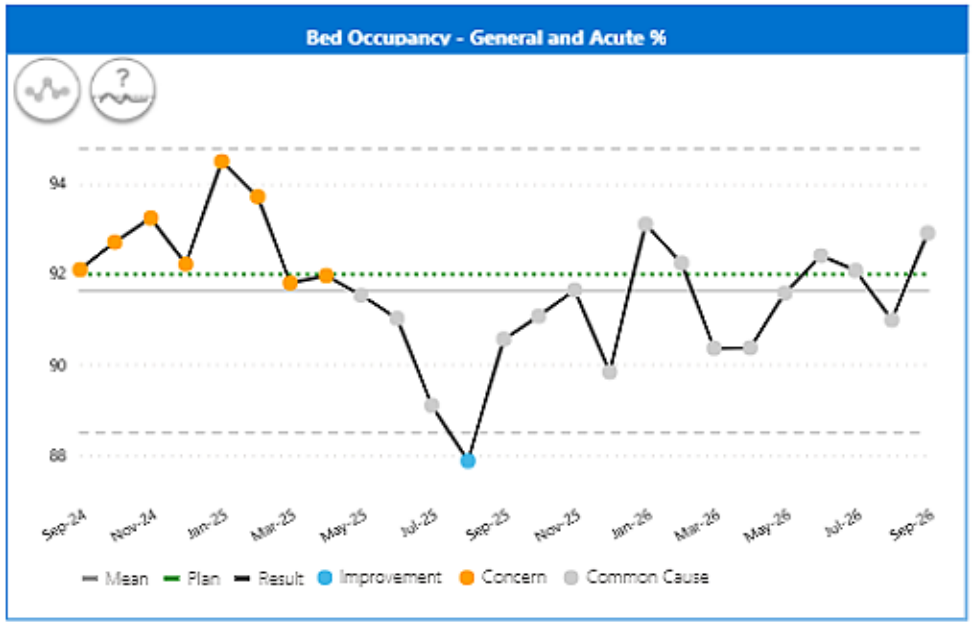
Accountable Executive: David Walliker | Accountable Group: Quality, Safety and Performance Board Committee

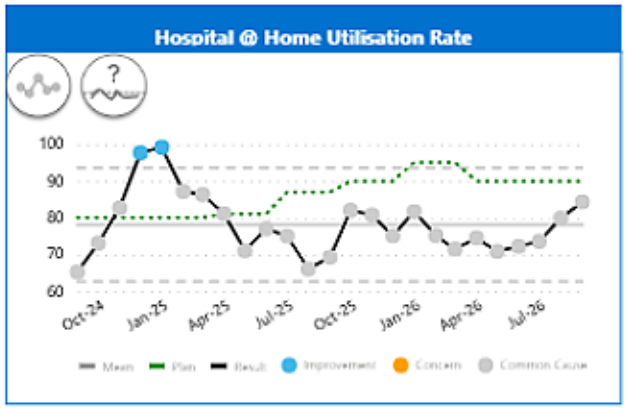
Sep-26		
Actual	Plan	Variance
92.9%	92.0%	0.9%

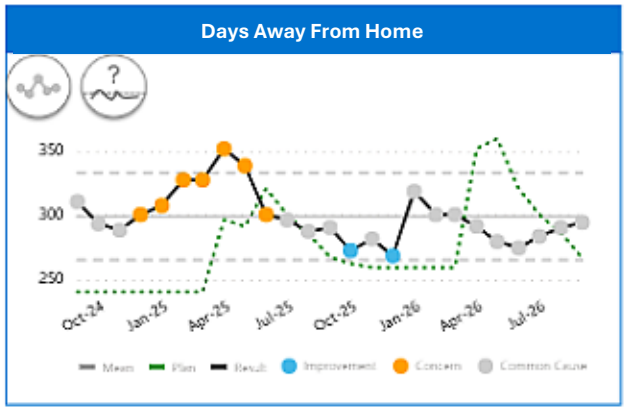
Compliance	Variance	Assurance
✖	~	?

Clinical Group Overview









Understanding the performance

G&A occupancy was above plan across MFT in September at 92.9%, 0.9pp above plan, with variation across Clinical Groups. Days Away From Home averaged 294 patients with No Criteria To Reside per day in September, with ongoing reablement and community improvement plans in place.

Combined Adult Acute & Community Hospital at Home utilisation was 84.3% in September, increasing by 4.4% on the previous month, above the national ambition however 5.7% below the MFT plan.

Risks and controls

Discharge flow remains challenged, with increased P1 and P3 delays at WTWA and MRI. Care Closer to Home Silver and Gold cycles provide strengthened oversight across acute, community and Adult Social Care leads, with a focus on a consistent reablement offer and reducing Integrated Discharge Team delays.

Hospital at Home capacity is being actively flexed across acute site teams, alongside review of HIVE pending lists and delayed transfers.

Actions and timescales

Additional community support continues across all sites through winter readiness, supporting discharge navigation. SLT-to-SLT review with Adult Social Care is underway, alongside continued Care Closer to Home oversight of reablement and IDT delays.

Hospital at Home has expanded by 10 acute medicine beds from 5th October, with 5 additional beds in Central and 5 in South. Acute telemedicine is due to launch shortly, alongside strengthened communications for Hospital at Home & SPoA.

Diagnostic Waiting Times

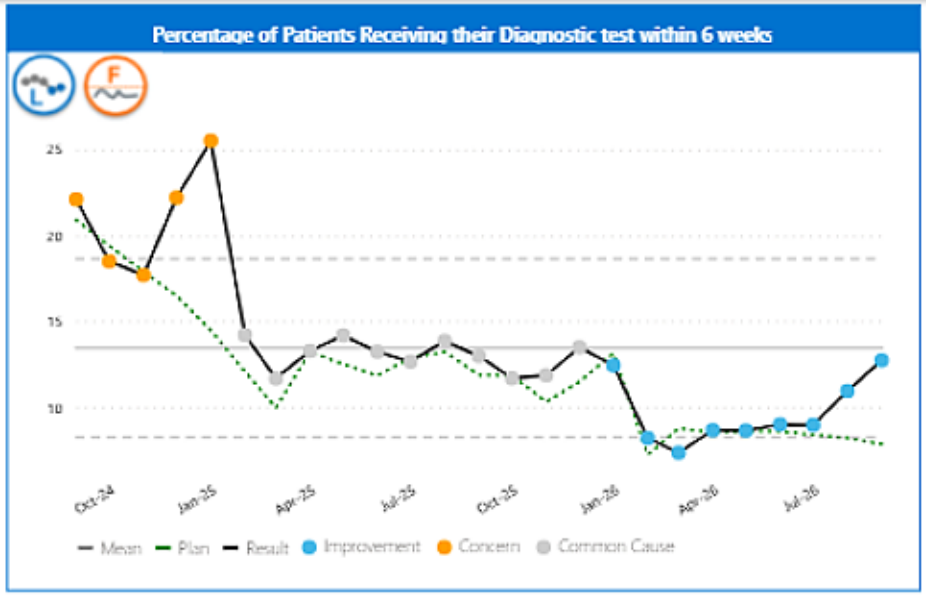
Accountable Executive: David Walliker | Accountable Group: Quality, Safety and Performance Board Committee

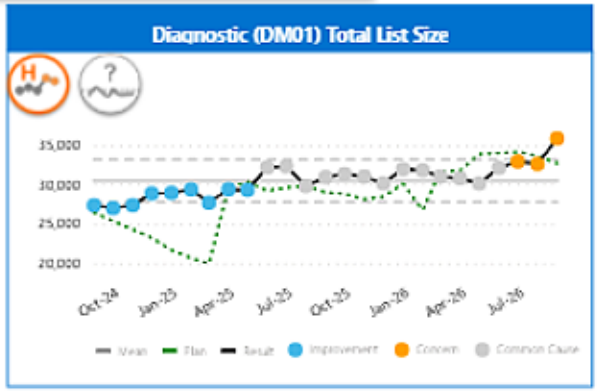
NHS Manchester University NHS Foundation Trust

Advise

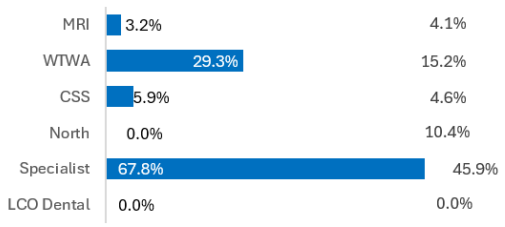
Sep-26		
Actual	Plan	Variance
12.75%	7.89%	4.86%

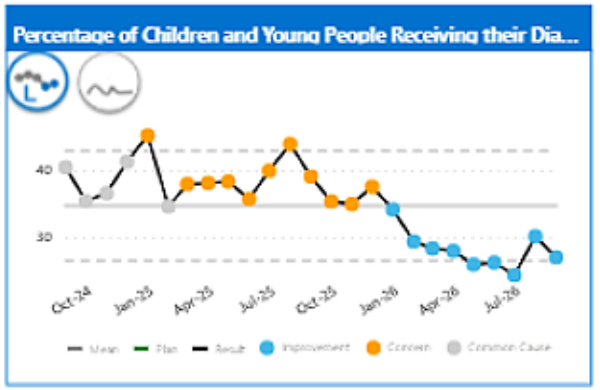
Compliance	Variance	Assurance
✖	L	F





Clinical Group Overview





Understanding the performance

In September, there were 2,222 more patients on the diagnostic waiting list than plan at 35,748 patients (plan 33,526) and 12.75% of patients waited over 6 weeks (4.86pp more than plan).

The key drivers are endoscopy within RMCH and sleep service and cardiac MRI/CT within WTWA, which reported 72.90% and 29.25% respectively, with Sleep Studies modality is at 51.77% against a 15.91% plan. MRI also deteriorated to 17.67% against 12.28% plan until new CDC capacity comes on line.

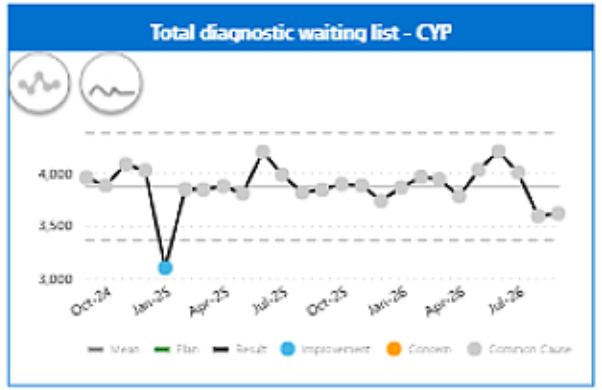
Risks and controls

The waiting list size, particularly in children and young people (CYP) is increasing and therefore additional diagnostic tests will be required to be undertaken. CYP capacity remains constrained for MR sedation lists and theatre access for sedated endoscopy, affecting gastroscopy performance and limited equipment impacting CYP respiratory physiology. Sleep demand increased by 24% in Q1 26/27 compared to Q1 25/26 additional capacity agreed to manage demand

Actions and timescales

Increase endoscopy insourcing Oct 2026–Mar 2027. Additional sleep equipment is expected from October, outsourcing of 1,700 sleep tests from December and use CDC capacity results in delivery by end January.

Plans in place to increase Cardiac CT/MR activity from October. CSS forecasts return to plan from October with new CDC MR capacity and substantive staff.



Elective Waiting Times in the Community

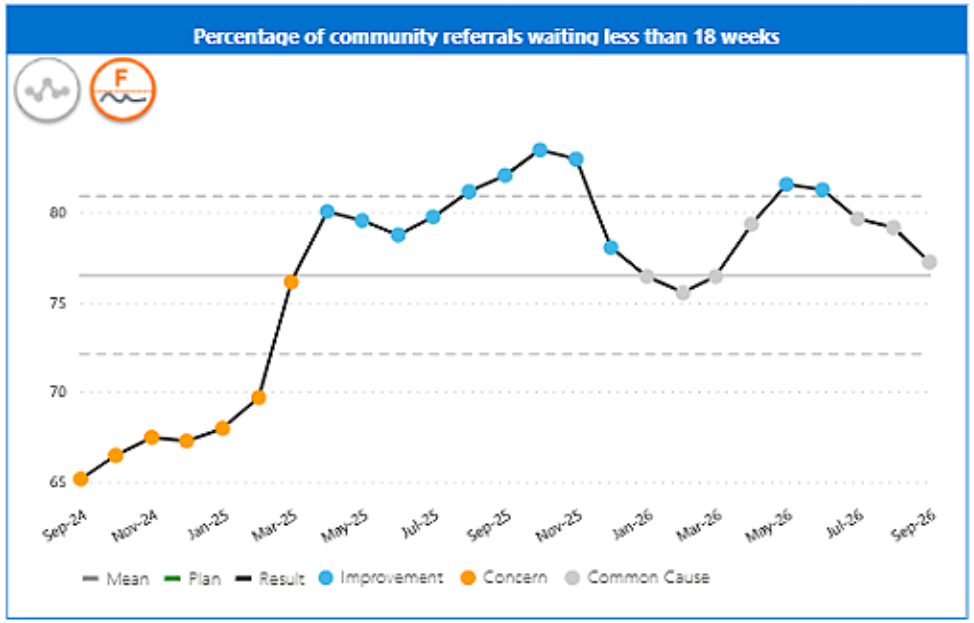
Accountable Executive: David Walliker | Accountable Group: Quality, Safety and Performance Board Committee
NOF: Access to Services | 'Percentage of patients waiting over 52 weeks for community services'

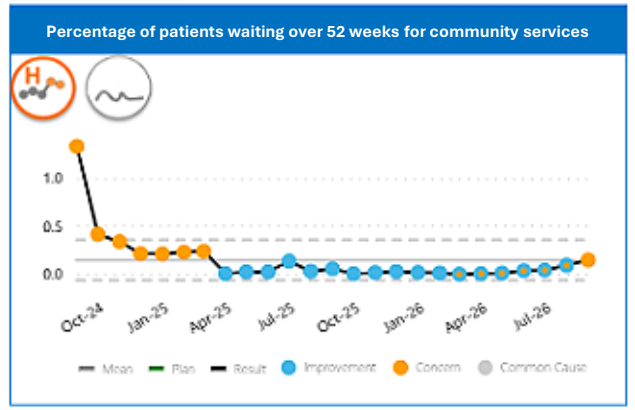
NHS Manchester University NHS Foundation Trust

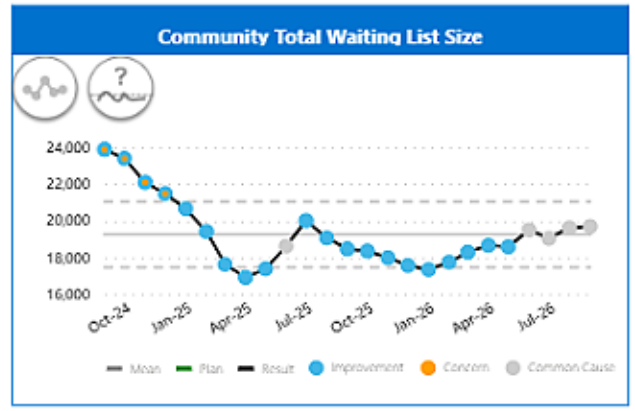
Advise

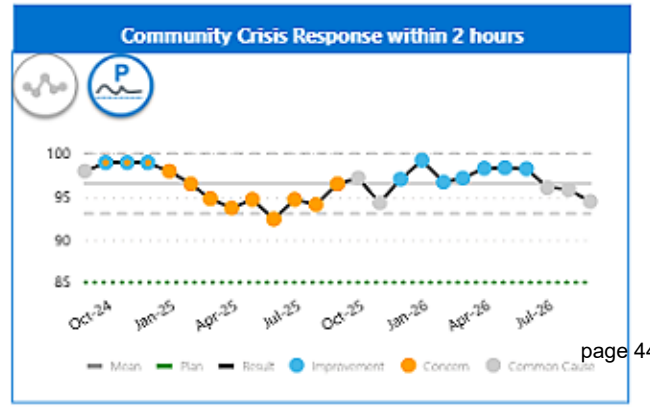
Sep-26		
Actual	Plan	Variance
77.2%	83.0%	-5.8%

Compliance	Variance	Assurance
✖	~	F









Understanding the performance

The Community 18-week performance is below the national 26/27 ambition of 78%, September delivery has fallen by 1.9% to 77.2% compared to the previous month. The total community waiting list increased by 77 patients (0.4%) from 19,593 in August to 19,670 in September. There were 29 (0.15%) patients who waited over 52-weeks in September with work underway to manage 52-week risk. Crisis service continues to meet plan and be above the national average.

Risks and controls

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

Podiatry capacity remains constrained, particularly in Trafford, due to vacancies, maternity leave and concerns from practices regarding prescribing and assessment activity, impacting timely access.

Actions and timescales

Mobilisation of £525k non-recurrent funding is now agreed to support addressing the longest waiting patients and priority children and young people cohorts, alongside work to identify a sustainable GM solution.

Podiatry actions include engagement with Trafford practices, recruitment, short-term staffing support and divisional mutual aid, with regular progress updates to SLT.

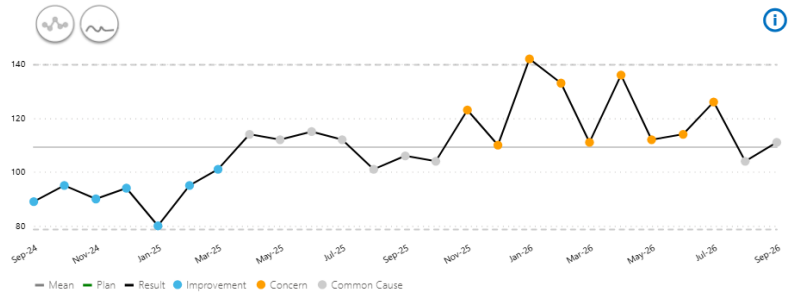
Neurodiversity waiting times (CAMHS)

Manchester University NHS Foundation Trust

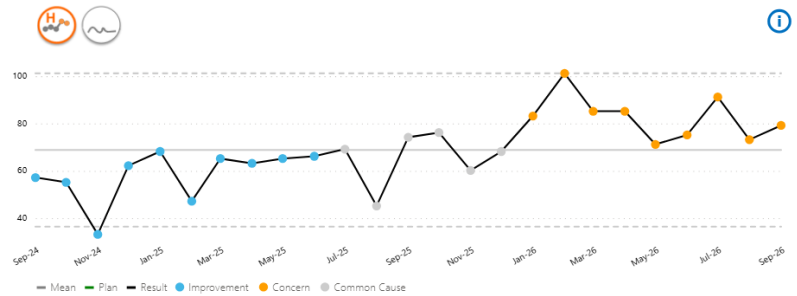
	September - 26	Plan
Autism	111	-
ADHD	79	-

	Compliance	Variance	Assurance
Autism			
ADHD			

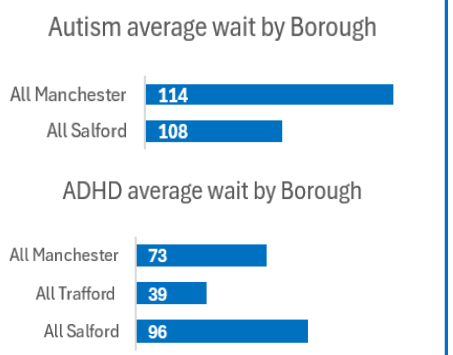
Autism Waiting Times for First Assessment (weeks)



ADHD Waiting Times for First Assessment (weeks)



Overview - September 26



Understanding the performance

Patients are waiting an average of 111 weeks for their autism assessment, an increase from August (104). The longest waits were in Manchester (114 weeks).

ADHD assessment waits show variation, averaging 79 weeks for patient first appointments an increase from August (73), with the longest waits in Salford at 106 weeks.

Demand for neurodevelopmental assessments (Autism and ADHD) continues to exceed CAMHS capacity and funding.

Risks and controls

There is growing demand for neurodevelopmental assessments across both ADHD and autism pathways; however, CAMHS is not structured or funded to meet this demand. This is resulting in long waiting times, increased pressure on resources, and poor patient experience, with challenges evident across both pathways but impacting ADHD and autism services separately. Monitoring in place.

From Jan 2026, CAMHS only accept referrals for ADHD or Autism with co-occurring mental health needs. Although, all Greater Manchester CAMHS services have been asked by the ICB to remain flexible as the new system-wide care model continues to evolve and be implemented. As part of this, CAMHS will be required to adhere with the co-occurring mental health and neurodevelopmental conditions pathway from April 2027.

Actions and timescales

A full business case has been finalised and submitted to GM ICB, outlining c.£3m recurrent investment requirements to support implementation of the new GM needs-led ND pathway across Manchester and Trafford.

This includes investment to deliver the MDT needs-led triage (£1.1m) and additional capacity to address the gap between demand and commissioned activity for new referrals (£1.9m). In the interim,

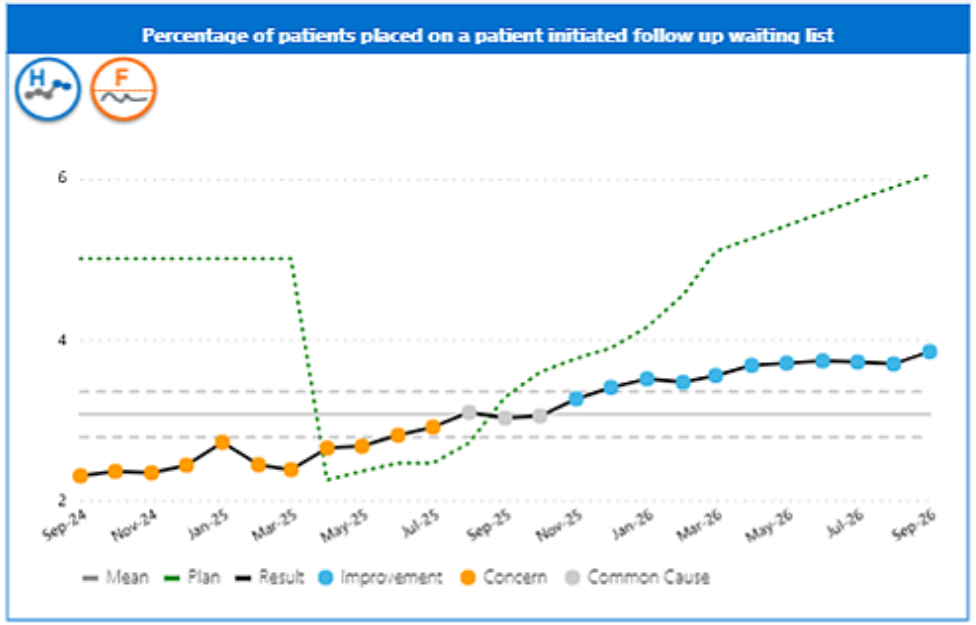
MFT has received £525k non-recurrent funding to support delivery of longest waits and priority cohorts, with mobilisation underway across LCO and CAMHS services. A Needs Led Model being mobilised with the new triage model official launched16th July at North Star (Manchester). Engagement events continue with young people and parent/ carers.

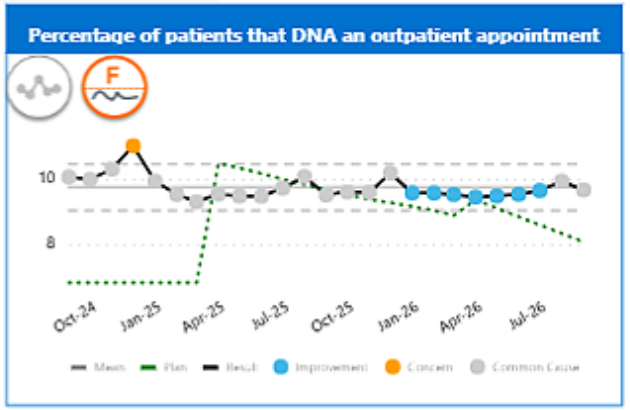
Outpatient Productivity

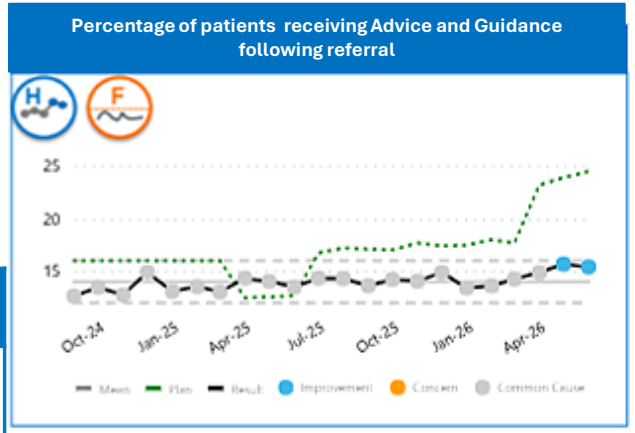
Accountable Executive: David Walliker | Accountable Group: Quality, Safety and Performance Board Committee

Sep-26		
Actual	Plan	Variance
3.8%	6.0%	-2.2%

Compliance	Variance	Assurance
✖	H	F







Understanding the performance

PIFU performance continues to show improving variation although remains below plan at 4.04% in September against the 6.0% plan (-2pp) but specialty performance varies. The denominator also contains activity that may not be eligible for PIFU. DNA rate remains static indicating that existing approaches are not materially shifting the position. Advice & Guidance has seen an improving variation with the establishment of consultant led triage in a number of specialties. There remains opportunities when assessed against national benchmarks.

Risks and controls

There is continued risk to under delivery and as a result additional follow up demand created and service transformation needed.

Clinical group level productivity targets and delivery plans have been reviewed for the second half of the year.

Actions and timescales

PIFU framework in development to increase uptake, strengthened tracking/reporting of PIFU cohorts, and consistent pathway management to convert demand. However, this should not be viewed in isolation and specialty level assessment has been undertaken to triangulate with N:F ratio and discharge at first appointment to identify areas of focus. These are being built into the H2 plan. Adoption of GIRFT further faster follow up pathways and optimisation of clinic templates. Focus on First plans and learning from MRI approach to deliver an increase in new outpatient slots.

Theatre Productivity

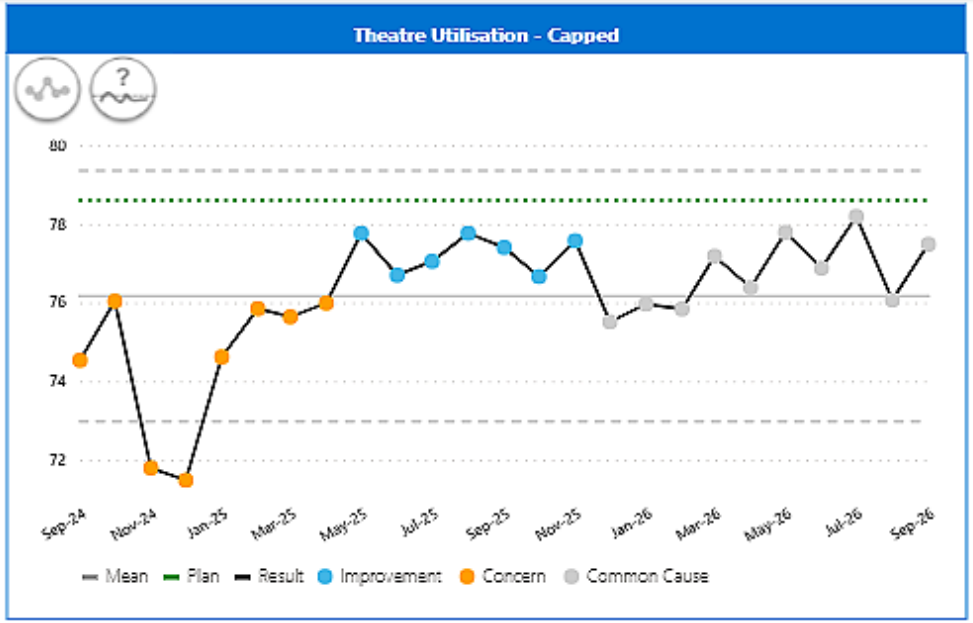
Accountable Executive: David Walliker | Accountable Group: Quality, Safety and Performance Board Committee

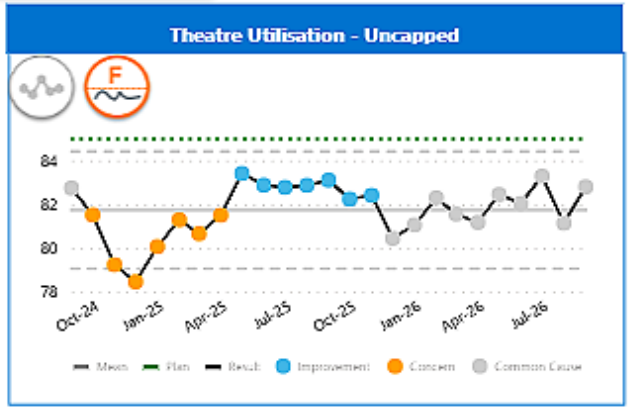
Advise

NHS Manchester University NHS Foundation Trust

Sep-26		
Actual	Plan	Variance
77.5%	78.6%	-1.1%

Compliance	Variance	Assurance
✖	~	?





Understanding the performance

Theatre utilisation remains statistically stable, with August delivery at 77.5% against a 78.6% plan (-1.1pp). Performance is above the current mean (~76%) and consistent with recent months, but not yet reliably delivering.

Trafford Elective Hub
achieved 85.2% utilisation in September, the only site to reach >80% in September.

Risks and controls

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

Improving theatre productivity is a key focus of the Care on Time Programme's Theatre Improvement workstream. The plan for the second half of the year focuses on best-practice scheduling and daily operational oversight, supported by strong governance and quarterly sprints to test and embed improvements.

Actions and timescales

A new theatre productivity and utilisation group will begin work in October, focusing on theatre session uptake and utilisation to drive average cases per list during the second half of the year. Site Clinical Leaders and senior operational managers will be responsible for delivering improvements in line with annual plan assumptions and implementing improvement actions.

The group will complement the existing theatre productivity workstream, which focuses on detailed operational improvements and alignment with national gold standards for theatre management.

Financial performance against budget YTD (£m)

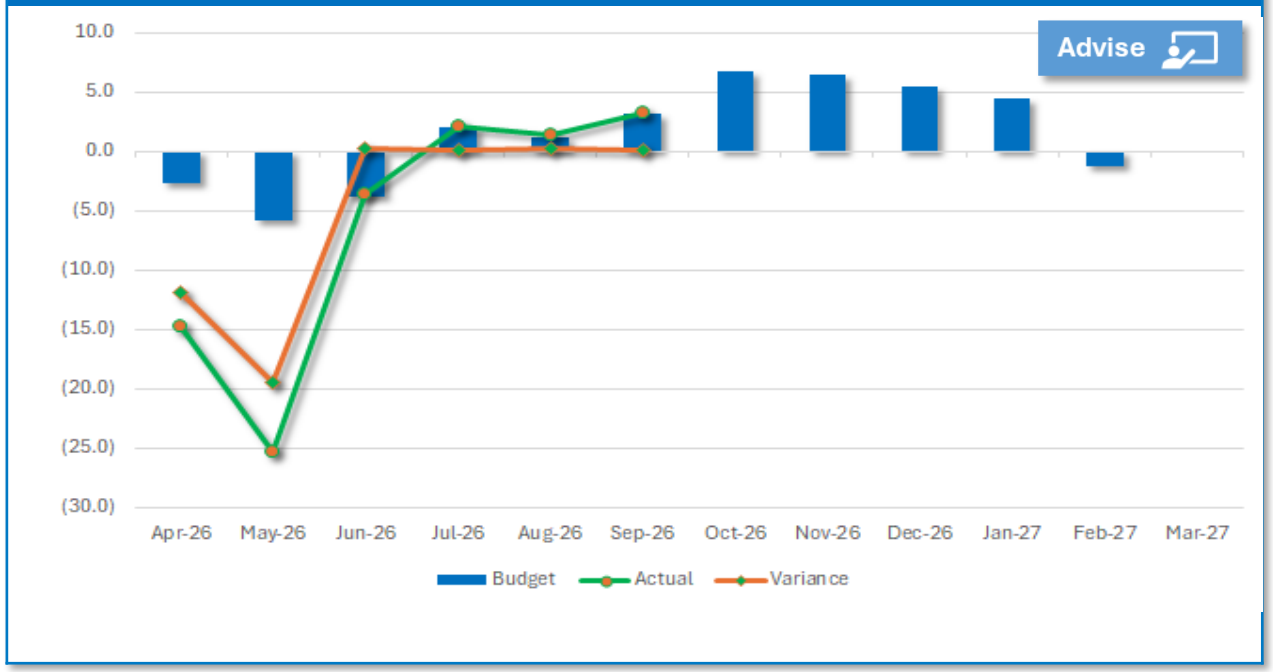
Accountable Executive: Claire Wilson | Accountable Group: Finance Board Committee

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

Sep-26		
Actual	Plan	Variance
£m	£m	£m
3.2	3.2	0.0

Compliance	Variance	Assurance	Actions
✓	~	?	👁

Financial performance against budget YTD (£m)



Clinical Group breakdown

Rank	Clinical Group	YTD Value £m
1	LCO & Dental	(2.33)
2	NMGH	(2.42)
3	WTWA	(10.19)
4	MRI	(13.06)
5	CSS	(14.12)
6	SHCG	(18.67)

Understanding the performance

Month 6 delivered in line with plan but only after material non-recurrent and technical adjustments. NOF score remains at 1 although this is not representative of YTD performance but based on breakeven plan and forecast outturn.

Risks and controls

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

Actions and timescales

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

Measures to note

Advise

Accountable Executive: David Walliker| Digital & Estates Board Committee

Key Oversight Performance Metrics: August 2026						
Compliance	Variation	Assurance	Action status	Performance	Plan	Indicator
!	H	?		84.17%	90.00%	Freedom of Information Requests (FOIs)

Measures to note

FOI: FOI compliance fell to 84.17% in August, below the 90% target and 3.15 percentage points lower than July, while YTD performance was 88.64%; improvement opportunities remain under review. Close engagement with ICO continues to ensure MFT performance satisfies expectations.

Recruitment

Manchester University NHS Foundation Trust

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

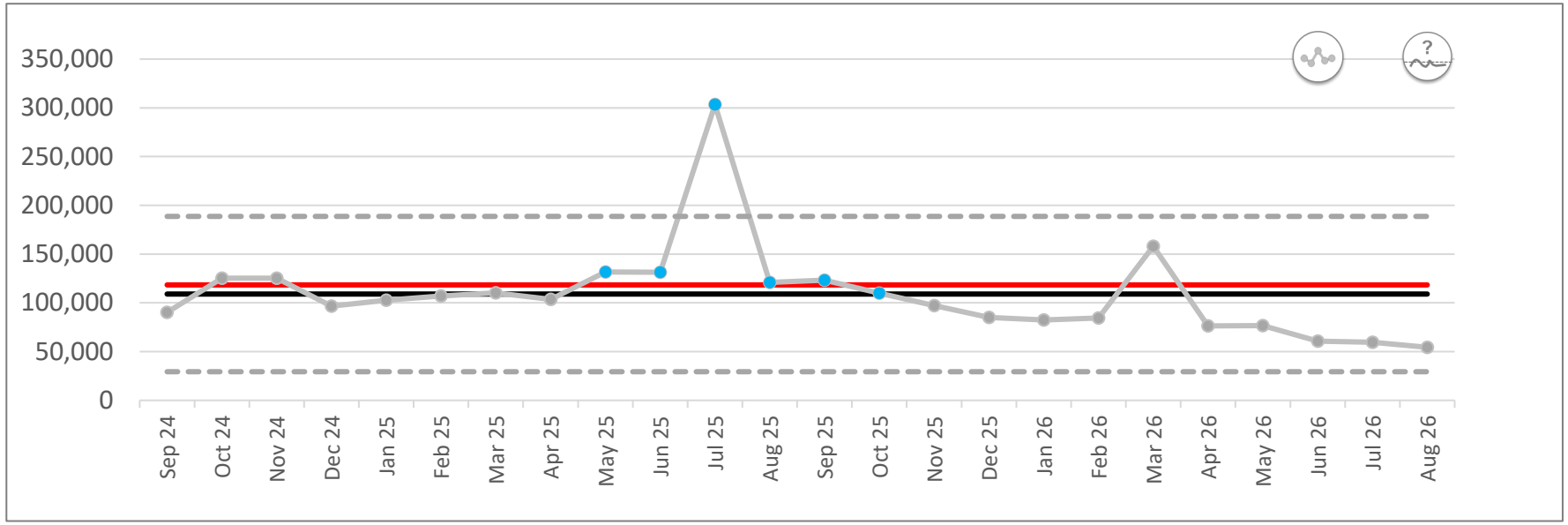
Aug-26	Target
54425	118375

Compliance	Variance	Assurance	Actions

Status

Advise

Weighted (by type) total monthly recruitment



2025				2026							
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
1676	1609	1412	1210	1114	1125	2028	1045	1007	865	858	857

Non weighted recruitment

Updates since previous month

Lower recruitment across the last few months. Status is Advise due to decreases in successive months. Nationally, currently 4th and 6th respectively for recruitment into commercial and non-commercial portfolio adopted studies.

Current issues

Balancing capacity to recruit with follow-up of patients already on trials. Focus on 150 days for getting 1st patient within 30 days of green light or prior to end of August ahead of BRC application.

Key dependencies

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

Future actions

Focus on recruiting to time and target across our portfolio to maximise patient benefit. Workshop across clinical and operational team in early October to focus on RTT.

Commercial Study Initiation – Set-up

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

Manchester University NHS Foundation Trust

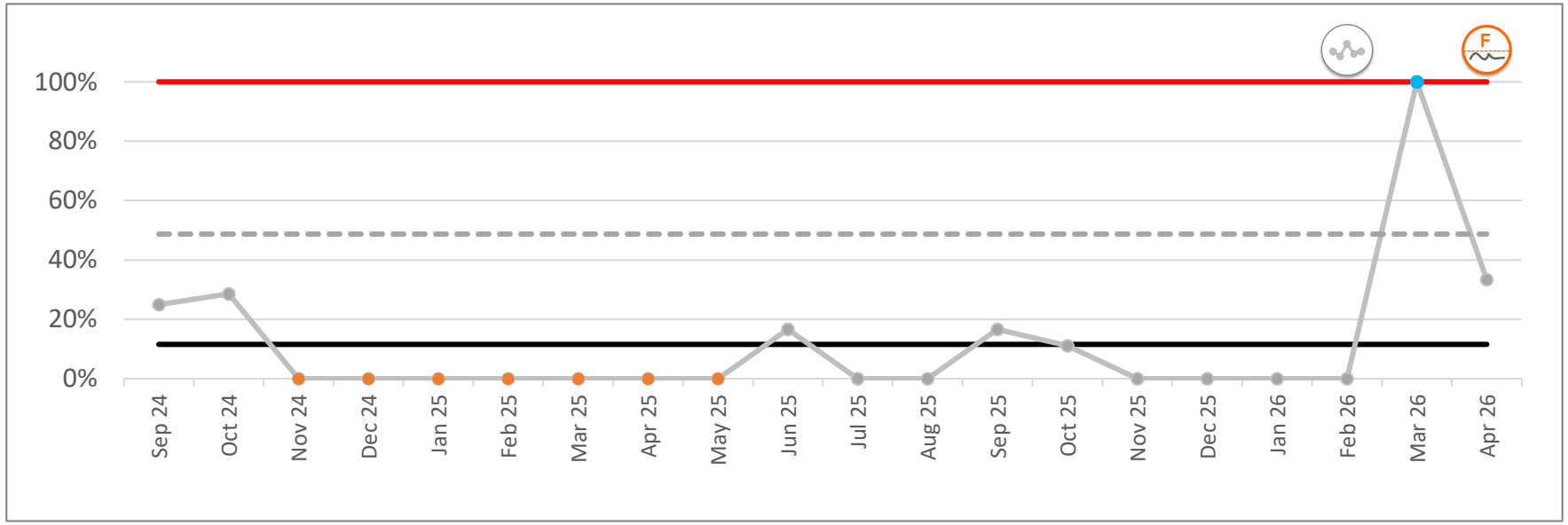
Apr-26	Target
33%	100%

Compliance	Variance	Assurance	Actions
✗	~	F	✓

Status

Advise

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



Month	Total studies	% HRA appr to start 60d
Mar-26	1	100%
Apr-26	3	33%
May-26	0	N/A
Jun-26	0	N/A
Jul-26	0	N/A
Aug-26	0	N/A

Updates since previous month

Fluctuation in those hitting the 60 day target across March and April. Monthly data in terms of number of days is showing average number of days is below 60 days, however remaining as advise due to impact on BRC application.

Current issues

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

Key dependencies

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

Future actions

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

Measures for assurance

Measures for assurance

Key Oversight Performance Metrics							
Focus	Compliance	Variation	Assurance	Action status	Performance	Plan / standard	Indicator
Infection Prevention and Control					21	<24.8	Gram negative infection – *E. coli*
Maternity					3.67	<4/1000	Neonatal deaths per 1000 live births
					2.93	<6/1000	Stillbirths per 1000 live births (excluding termination of pregnancy)
					3	<4	Number of maternity incidents with moderate harm and above
					5.22%	<6	Term admissions to the Neonatal Unit
					94.40%	>90%	Initial assessment time in maternity triage – 30 minutes
					3.85%	<20%	Augmentation of labour pathway delays
					0	0	Maternity related concern (MNSI/ NHSR/ CQC/ Coroner Reg 28)
Patient Experience					95.3%	95%	Patient Experience Survey (Overall Performance Score)
Learning from Deaths					0	0	Prevention of Future Deaths reports impacting the Trust

Activity

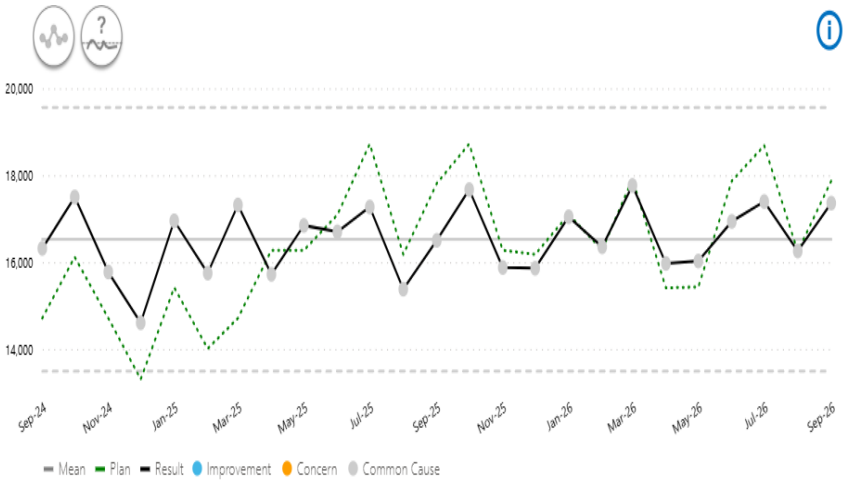
Accountable Executive: David Walliker | Accountable Group: Quality, Safety and Performance Board Committee

Assure NHS
Manchester University
NHS Foundation Trust

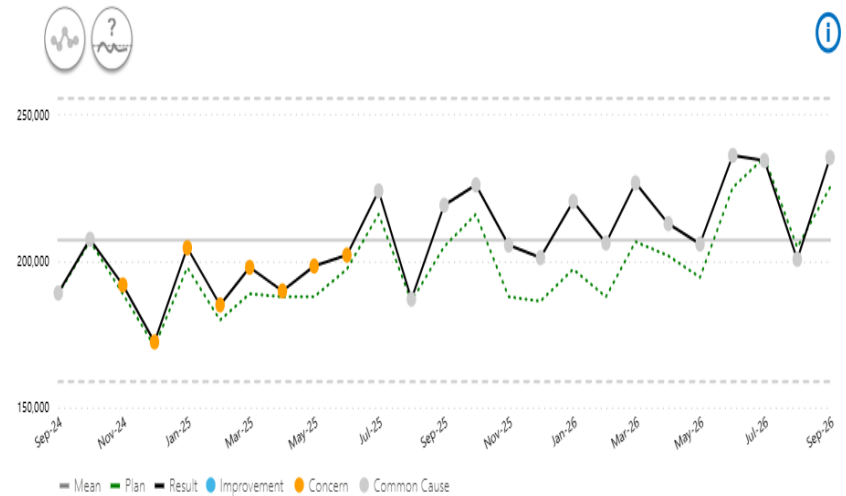
Sept - 26	Actual	Plan	Variance
Inpatient	17,366	17,875	-509
Outpatient	235,260	225,073	10,187

	Compliance	Variance	Assurance
IP	✖	~	?
OP	✔	~	?

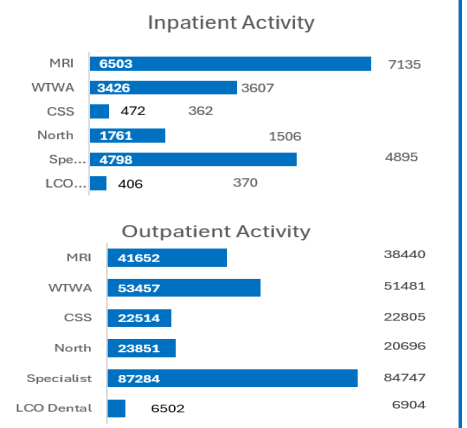
Elective Inpatient and Daycase Activity



Elective Outpatient Activity



Overview – September 26



Understanding the performance

Inpatient activity shows common cause variation for delivered activity in inpatients and daycase elective treatment. September performance reported below plan by 509 patients.

Outpatient activity also shows common cause variation for delivered activity in outpatients. September performance returned above plan reporting +10,187.

Risks and controls

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

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

CG activity plans refreshed for the second half of the year and monitoring in place.

Actions and timescales

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

Sexual Assault Referral Centre waiting times

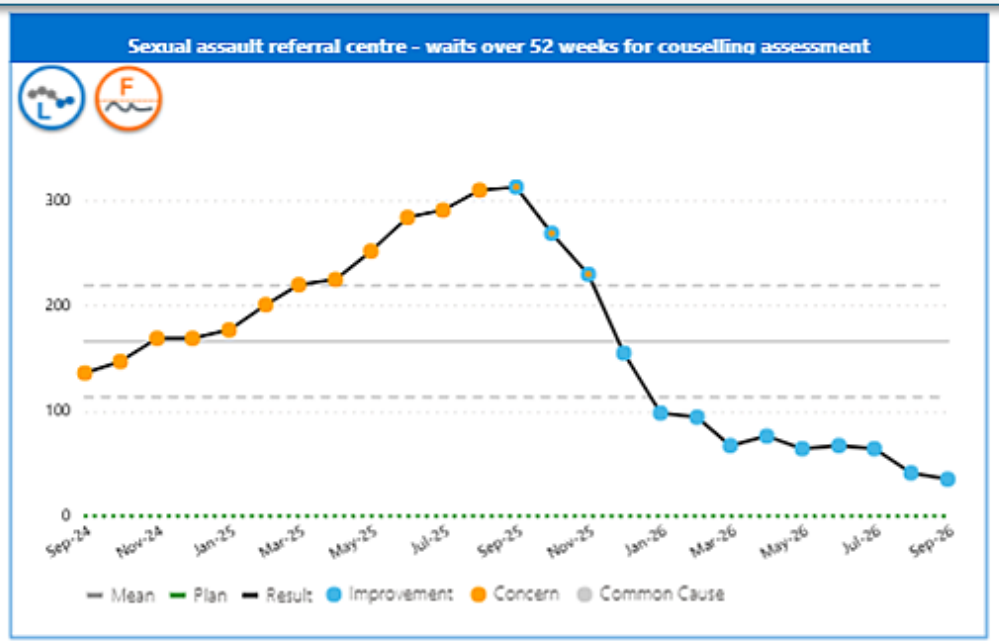
Accountable Executive: David Walliker | Accountable Group: Quality, Safety and Performance Board Committee

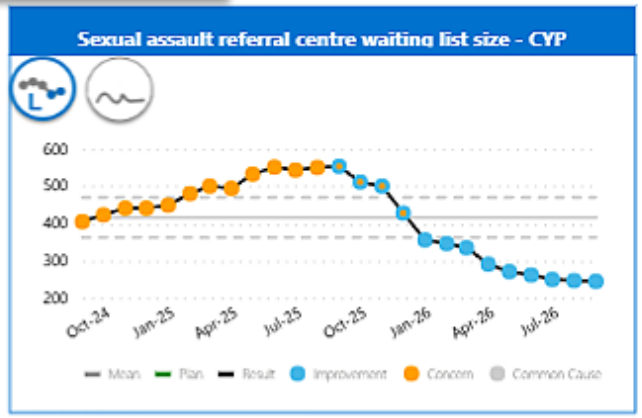
Assure

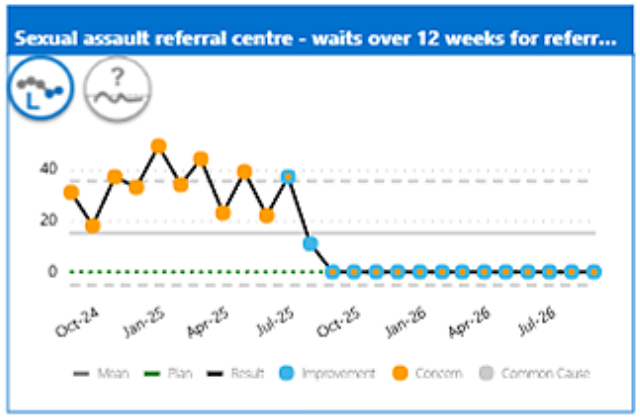
NHS Manchester University NHS Foundation Trust

Sep-26		
Actual	Plan	Variance
35	0	35

Compliance	Variance	Assurance
✖	L	F







Understanding the performance

September reported 35 patients waiting over 52 weeks for counselling assessment, down from 41 in August, with improving variation but remaining above the plan of zero.

Longest and average waits increased to 73 and 57 weeks respectively, reflecting reduced workforce capacity.

Referral volumes remain consistent following criteria changes, while assessment waits exceed 30 days, mitigated by adult team support for 16/17-year-olds.

Risks and controls

The key risk remains workforce, where resignations and sickness have temporarily reduced the workforce by 75%.

Recruitment is underway, but with lengthy recruitment timescales and induction, it will take several months to increase the workforce, which is a significant concern and will impact upon the waiting list.

Actions and timescales

Workflow review currently taking place.

All current vacancies are within the recruitment process.

Mandatory Training: Level 1 and Level 2 & 3

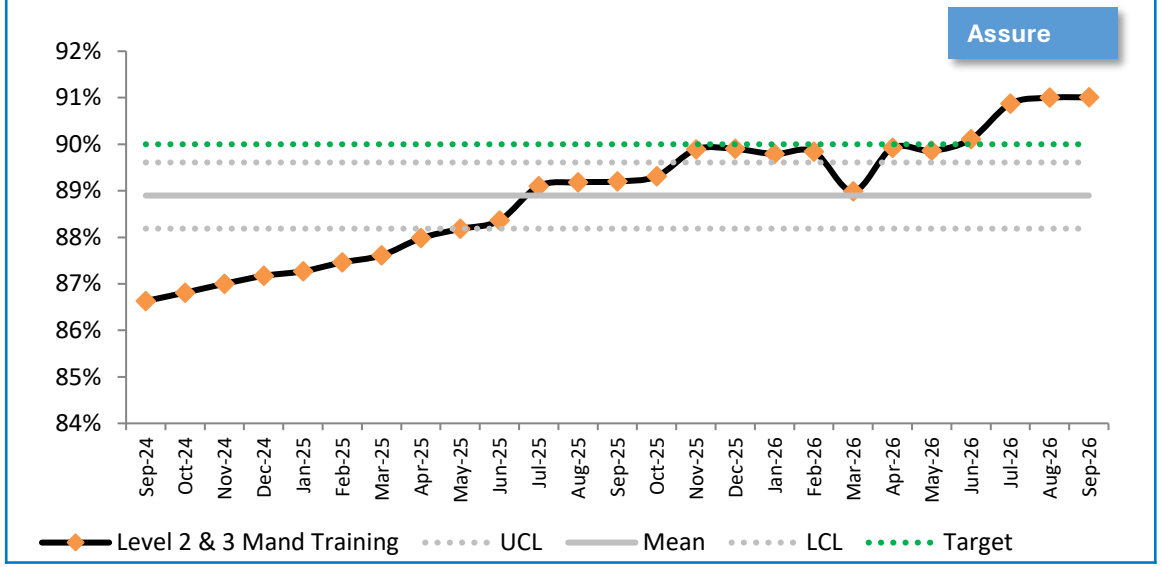
Accountable Executive: Meera Nair | Accountable Group: People Board Committee

Manchester University NHS Foundation Trust

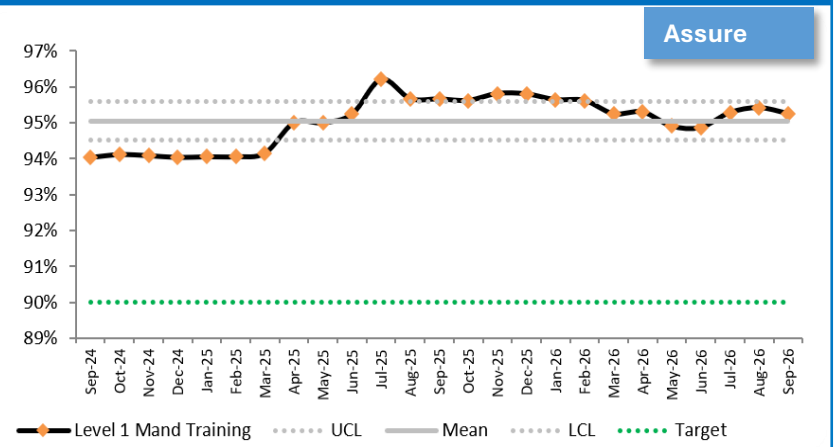
Sep-26	Target
Lvl 1 95.3%	90.0%
Lvl2&3 91.0%	90.0%

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

Level 2 & 3 Mandatory Training



Level 1 Mandatory Training



Understanding the performance

In September 2026, MFT reported compliance of 95.3% for Level 1 mandatory training and 91.0% for Level 2 and 3 mandatory training, both exceeding the Trust target of 90%. Level 2 and 3 compliance has now remained above target for four consecutive months, reflecting the sustained focus on mandatory training across the organisation and continued improvement in compliance performance.

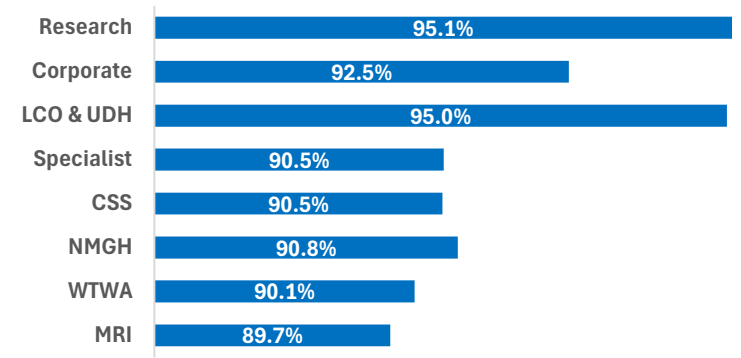
Risks and controls

Mandatory training compliance remains a key control in ensuring staff have the knowledge and skills in core areas to meet regulatory and statutory requirements. Controls include monthly reporting through WEMC and Divisional Performance Reviews.

Actions and timescales

1. Reporting has been refined to ensure that granular detail on each subject is known and not one single accumulated figure – COMPLETE
2. TLTC oversight provided through a deep dive review of hot spot areas on Mandatory Training – COMPLETE
3. All staff behind compliance have been written to support increase in completion rates - COMPLETE

Clinical Group breakdown (Level 2 & 3)



Turnover

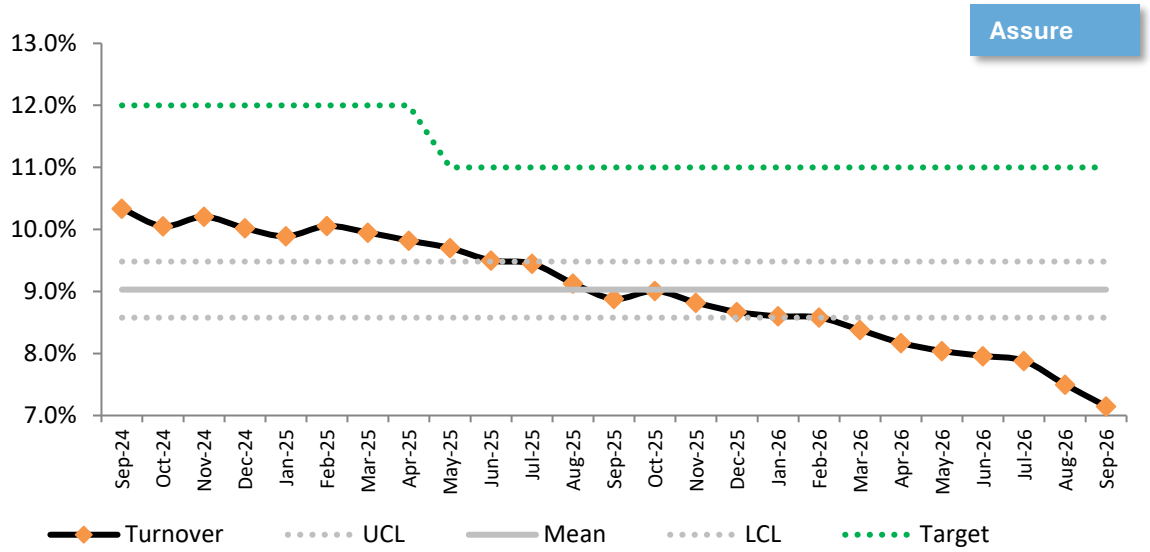
Accountable Executive: Meera Nair| Accountable Group: People Board Committee

Manchester University NHS Foundation Trust

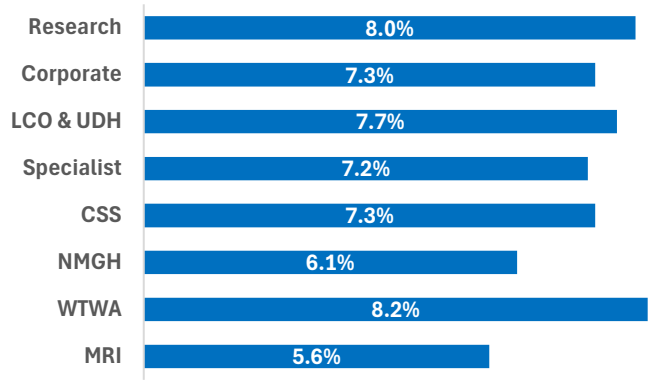
Sep-26	Target
7.2%	11.0%

Compliance	Variance	Assurance	Actions
✓	L	P	⇄

Turnover



Clinical Group breakdown



Understanding the performance

Turnover for September 2026 is 7.2%, continuing the sustained downward trend observed over the past two years and remaining well below the 11.0% target. Performance has steadily improved from 10.3% in September 2024 to the current level, with particularly consistent reductions throughout 2025 and into 2026.

Risks and controls

Turnover remains at a historically low level and exceeding target. Continued monitoring is in place to identify any emerging workforce risks, including areas where very low turnover may impact workforce flexibility, career progression or skill mix.

Actions and timescales

1. Maintain routine monitoring of turnover at Trust and Clinical Group level, with any emerging areas of concern reviewed through established workforce governance arrangements. No additional Trust-wide action is required at this time.

Measures for assurance

Key Oversight Performance Metrics							
Focus	Compliance	Variation	Assurance	Action Status	Performance	Plan	Indicator
Finance and Commercial					8.34	0.0	Income including Elective - variance to income in finance plan (£m)

Measures for assurance

Manchester University NHS Foundation Trust

Accountable Executive: David Walliker| Digital & Estates Board Committee

Key Oversight Performance Metrics: August 2026						
Compliance	Variation	Assurance	Action status	Performance	Plan	Indicator
✓				99.49%	90.00%	Subject Access Requests (SARs)
✓				7Hrs 18mins	<= 15Hrs	Clinical and Operational Unplanned Downtime

Commentary

SAR: August performance improved to 99.49%, with 970 of 975 requests completed on time and only five complex cases breaching, while lower demand helped reduce the backlog from 473 to 267 cases.

Clinical and Operational Downtime: Performance represents an aggregate of all types of downtime at individual service level across the Trust. It equates to two incidents, both were unforeseen issues caused by planned improvement changes.

Active studies

Manchester University NHS Foundation Trust

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

Aug-26	Target
917	

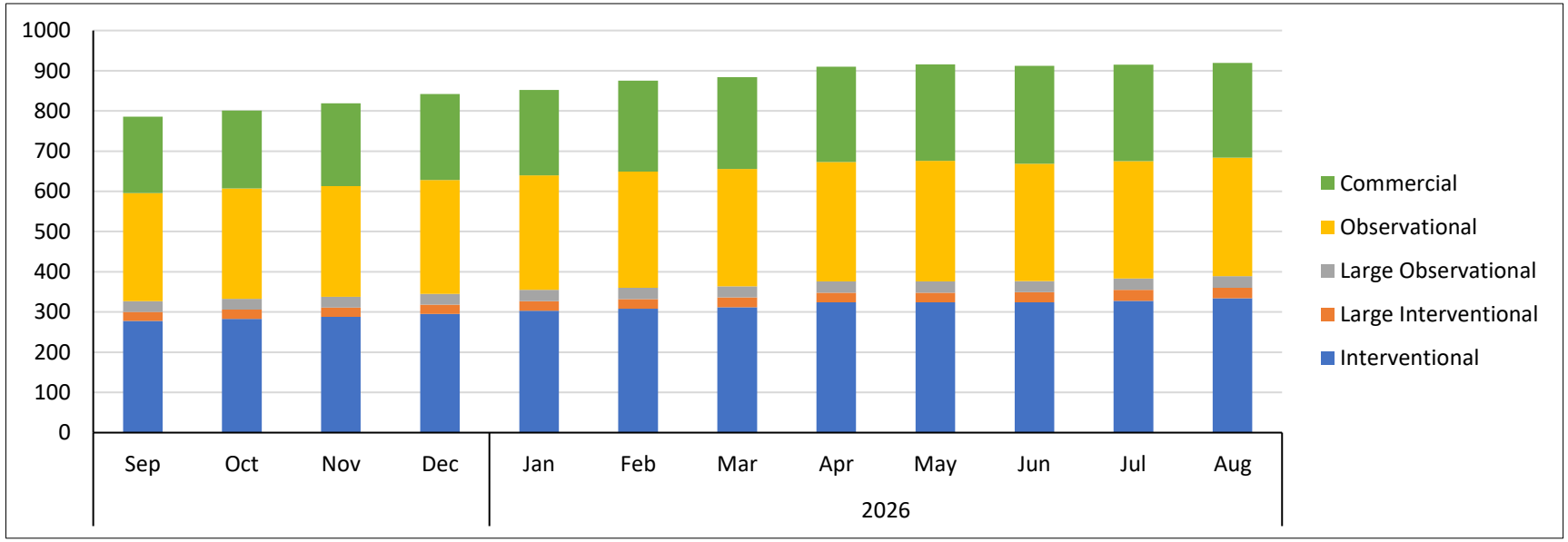
Status

Assure

	2025				2026							
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Comm	206	214	212	226	228	237	240	243	240	235	229	232
Interv	278	283	288	295	303	308	312	324	324	324	328	334
Large Int	23	23	24	24	24	24	24	25	27	26	26	26
Large Obs	28	28	28	28	28	28	28	29	29	30	30	30
Obs	269	274	275	283	285	289	292	297	300	292	292	295

Total number of studies (open and in follow up)

Number of studies by study types which inform RRDN funding



Updates since previous month

Increase by 3 commercial studies, 6 interventional and 3 observational with large observational and large interventional remaining stable.

Current issues

Staff turnover. Balancing capacity to open new studies alongside supporting studies open and in follow-up and closing out studies.

Key dependencies

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

Future actions

Focus on opening highly weighted studies to support increasing our weighted recruitment to maximise patient benefit and sustainability of our workforce through RDN funding.

Study Delivery

Manchester University NHS Foundation Trust

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

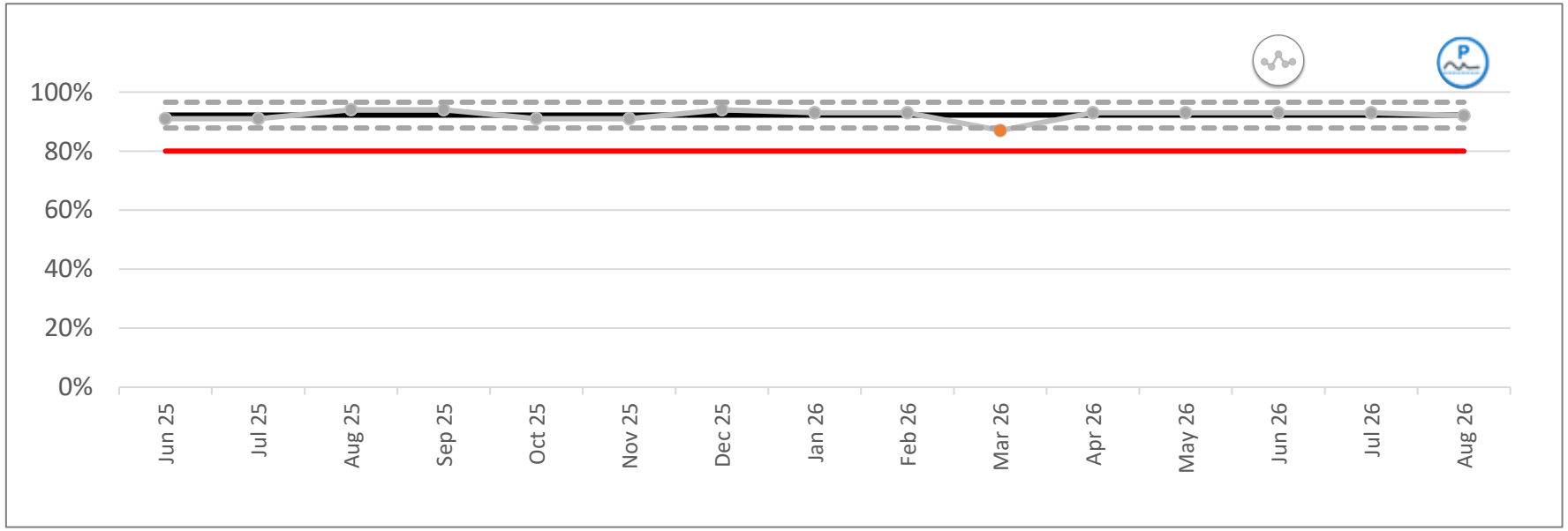
Aug-26	Target
92%	80%

Compliance	Variance	Assurance	Actions
✓	~	P	👁

Status

Assure

MFT-sponsored, NIHR Portfolio-adopted research studies on track for recruitment to time and target



Updates since previous month

No change.

Current issues

No current issues.

Key dependencies

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

Future actions

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

All Clinical Trial Study Initiation – Set-up

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

Manchester University NHS Foundation Trust

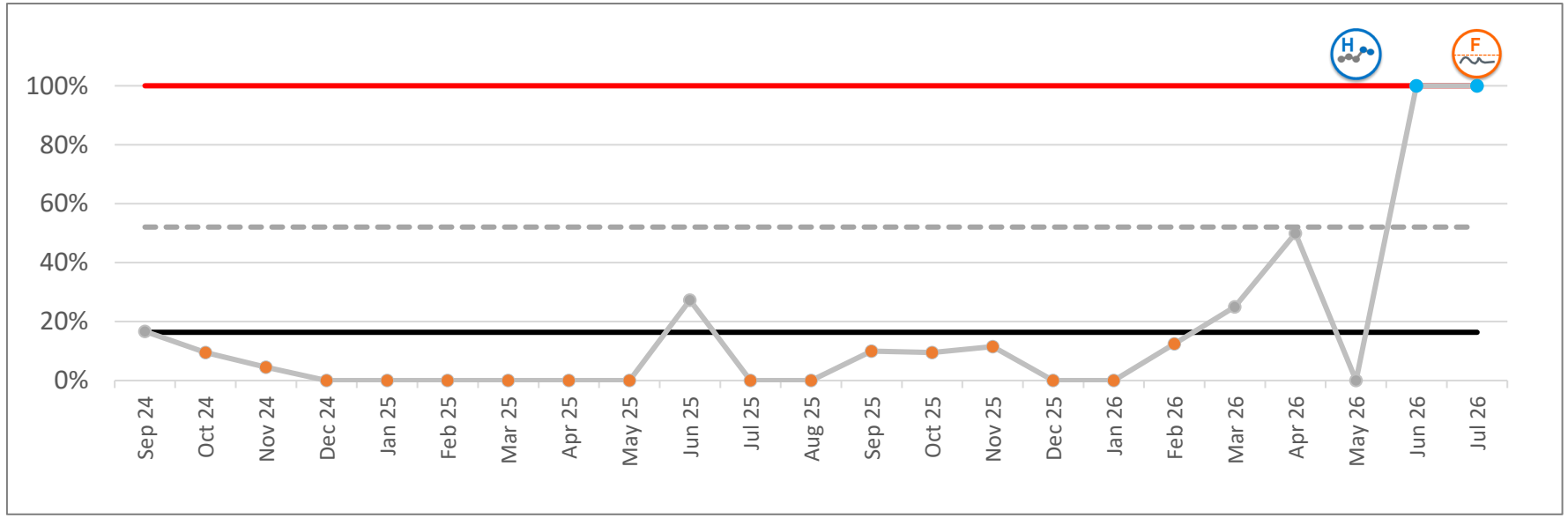
Jul-26	Target
100%	100%

Compliance	Variance	Assurance	Actions
✗	H	F	✓

Status

Assure

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



Month	Total studies	% HRA appr to start 60d
Feb-26	8	13%
Mar-26	4	25%
Apr-26	6	50%
May-26	3	0%
Jun-26	4	100%
Jul-26	1	100%
Aug-26	0	N/A

Updates since previous month

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

Key dependencies

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

Current issues

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

Future actions

Maintain full staffing of research operational and research office staff to enable efficient set-up of studies. Implementation of EDGE and streamlined set-up process. Weekly meetings.

Commercial Study Initiation - Recruitment

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

Manchester University NHS Foundation Trust

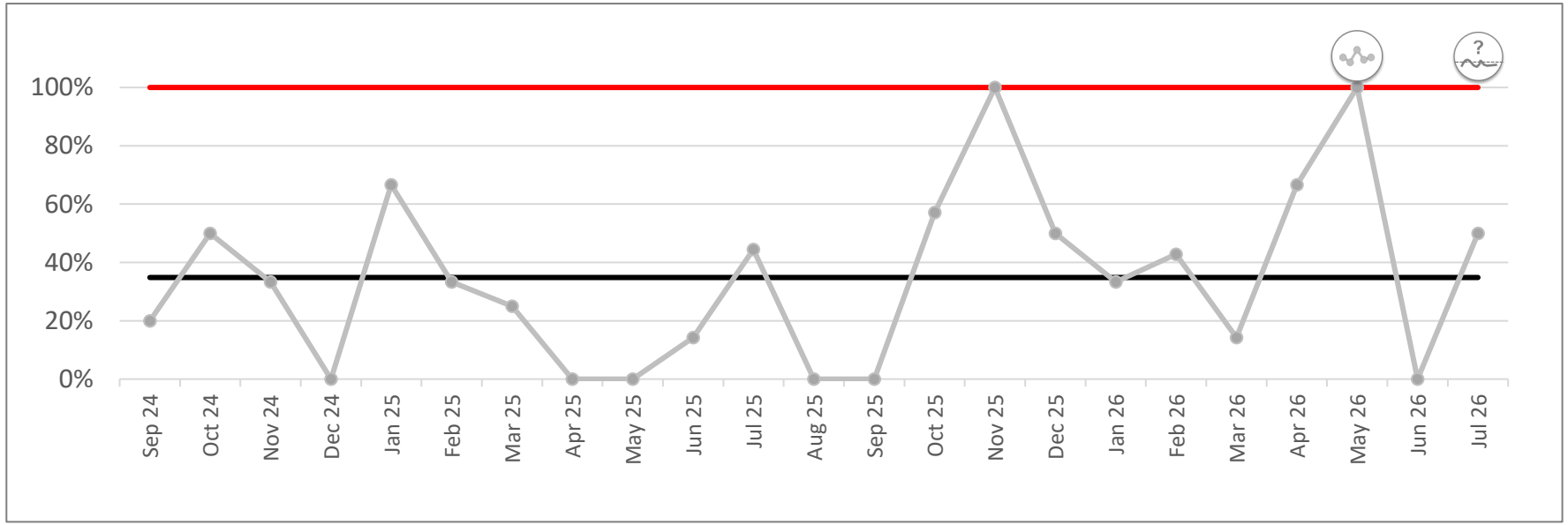
Jul-26	Target
50%	100%

Compliance	Variance	Assurance	Actions

Status

Advise

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



Month	Total studies	% Start to FP 30d
Feb-26	7	43%
Mar-26	7	14%
Apr-26	3	67%
May-26	3	100%
Jun-26	1	0%
Jul-26	4	50%
Aug-26	0	N/A

Updates since previous month

Fluctuation due to small numbers of studies. Data in terms of number of days is showing average number of days is below 30 days, however remaining as advise due to impact on BRC application.

Key dependencies

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

Current issues

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

Future actions

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

All Clinical Trial Study Initiation – Recruitment

Manchester University NHS Foundation Trust

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

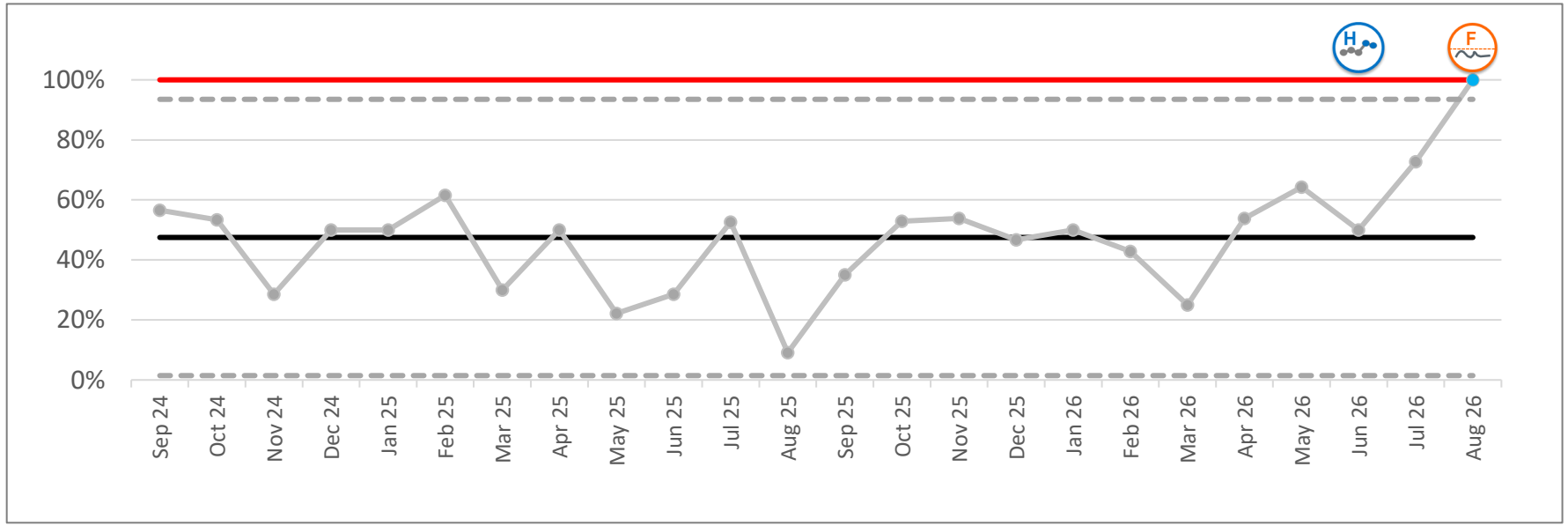
Aug-26	Target
100%	100%

Compliance	Variance	Assurance	Actions
✗	H	F	✓

Status

Assure

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



Month	Total studies	% Start to FP 30d
Feb-26	14	43%
Mar-26	16	25%
Apr-26	13	54%
May-26	14	64%
Jun-26	14	50%
Jul-26	11	73%
Aug-26	7	100%

Updates since previous month

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

Current issues

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

Key dependencies

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

Future actions

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

Population Health Assurance Summary

Metric	Actual	Plan	Variance	Change	Variation	Assurance	Sparkline
M0426 - ACSC Cardiology Quarterly Admissions	821			821			
M0427 - ACSC Endocrine Quarterly Admissions	311			311			
M0428 - ACSC Respiratory Quarterly Admissions	1,104			1,104			
M0429 - ACSC Quarterly Admissions	2,460			2,460			
M0413 - Relative Likelihood of Surgery DNA: Minority Ethnic vs White British	1.1	1.0	0.1	(0.2)			
M0412 - Relative Likelihood of Outpatient DNA: Minority Ethnic vs White British	1.4	1.0	0.4	0.1			
M0416 - Relative Likelihood of Surgery DNA: Most vs Least Deprived Quintile	3.9	1.0	2.9	2.5			
M0414 - Relative Likelihood of Community DNA: Minority Ethnic vs White British	1.7	1.0	0.7	(0.1)			
M0417 - Relative Likelihood of Community DNA: Most vs Least Deprived Quintile	2.1	1.0	1.1	0.0			
M0415 - Relative Likelihood of Outpatient DNA: Most vs Least Deprived Quintile	2.5	1.0	1.5	0.1			

**ACSC:* ambulatory care sensitive conditions; conditions that if managed well should not generally result in hospital admission. Tracking our admissions for total and specialty specific conditions where MFTs left shift work should lead to a positive change in admissions for these conditions.
ACSC data have not been updated since Dec-25 and so remain the same as the last report

NHS
Manchester University
NHS Foundation Trust

Escalation and Assurance Report
North Manchester Board Committee

Report to: Board of Directors
Report from: Mark Gifford, Non-Executive Director and Chair of ODBC
Date of meeting: 12/10/26

Key escalation and discussion points from the meeting
Alert:
The Committee remains assured that the programme is progressing and that the principal risks are visible and actively managed. The key escalation is the increasing breadth and interdependence of risks across affordability, transformation, digital infrastructure, masterplanning and organisational capacity. As these mature, further consideration is required of whether the current MFT risk architecture and governance arrangements provide sufficient oversight across the whole programme.
Advise:
The Committee noted continued progress with the **New Hospital Project**, including approval of RIBA Stage 1 and commencement of RIBA Stage 2. Affordability remains the principal programme risk**.** NHP supports the agreed scope and schedule of accommodation but available funding remains insufficient at present. Earlier main contractor involvement in discussions should reduce programme risk and support delivery. The Committee emphasised that resolution of affordability must not compromise clinical quality, outcomes or programme benefits. The Committee discussed the **project plan for the New Hospital Project** which remains broadly aligned with published delivery milestones despite some movement within individual activities. Current outpatient milestones include OBC submission by the end of February 2027, advanced works from July 2027, main works completion in January 2029 and first patients in April 2029. The Committee reviewed the conditions associated with progression from **RIBA Stage 1 into Stage 2.** Members specifically sought assurance that commencing Stage 2 before all outstanding conditions had been discharged did not expose MFT to additional financial, operational or reputational risk. Assurance was provided that the remaining conditions represented normal programme activity, technical matters and requirements appropriately addressed during the next stage, with progress already being made in closing them. The Committee highlighted the significant clinical capacity required to support RIBA Stage 2 design activity alongside operational pressures. Assurance was provided that appropriate clinical representation and protected engagement are being actively managed. The Committee was therefore reassured that progression to RIBA Stage 2 was appropriate and did not create material additional exposure for MFT. The Committee noted progress with the **Transformation project** in converting business-case assumptions into a transformation roadmap, with transformation needing to keep pace with hospital design and construction. Particular focus is being placed on outpatient transformation, including one-stop clinics, direct access to diagnostics and advice and guidance. Members emphasised the importance of metrics demonstrating that transformation assumptions and external dependencies are translating into deliverable change. The Committee noted that a partnership group has been established to support system engagement and business-case development.

The Committee discussed site phasing for the **Masterplan project**, with a study expected to conclude in February 2027. Emerging options could defer elements of the Healthy Neighbourhood development until after completion of the new hospital, with implications particularly for housing ambitions and external stakeholder expectations. Members also emphasised the complexity of constructing the new hospital while maintaining safe services from the existing estate. Reassurance was provided that site-logistics governance is being established to coordinate construction, operational, access and safety requirements. The Committee requested continuing visibility of the phasing risk as options develop.

The Committee welcomed the consolidated redevelopment **programme dashboard** covering the principal North Manchester workstreams. The longer-term intention is to develop this into an integrated programme view showing milestones, dependencies, risks and relationships between the new hospital, transformation and masterplan activity. Members welcomed the transparency provided, including visibility of emerging risks such as site coordination, and supported continued development of the dashboard as a key Committee assurance tool.

Assure

The Committee welcomed continued transparency from the underlying programme governance arrangements. Members considered it valuable to have early visibility of developing issues and risks before they necessarily reach the threshold for formal escalation. This supports the Committee in understanding the wider programme risk environment and identifying emerging interdependencies. The Committee supported continuation of this approach.

Risks discussed at the meeting

The Committee reviewed the overarching **North Manchester strategic risk**, currently scored 20 against a target of 15 and outside risk appetite. Members supported reconsidering whether a single risk remains appropriate given the increasingly distinct risks relating to hospital delivery, affordability, transformation, digital infrastructure and the masterplan. These have different controls, mitigations and risk appetites.

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

Agenda:

Manchester University
NHS Foundation Trust

North Manchester Board Committee

Date: Monday 12th October 2026
Time: 2:00pm – 3:30pm
Location: MS Teams

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	2:00pm
2.	**Declaration of interest** (verbal)	Meeting admin	Chair	2:00pm
3.	**Minutes of the previous meeting** *(18th August 2026)*	Meeting admin	Chair	2:00pm
4.	**Action Log**	Discussion	Chair	2:05pm
5.	**Matters Arising**		Chair	2.05pm
6.	**Assurance Reporting**			
6.1	Strategic and Corporate Risks	Discussion	CW	2:10pm
7. Strategic Aim 4: Ensure value for our patients and communities by making best use of resources				
7.1	**NMGH Programme Summary & Strategic Project Reports:** ▪ 7.1a NMGH New Hospital Project Update ▪ 7.1b NMGH Transformation Project Update ▪ 7.1c NMGH Masterplan Project Update ▪ 7.1d NMGH Redevelopment Programme Dashboard	Discussion	CW VG TR CW	2:15pm
7.2	**New Hospital Project:** NHP RIBA Stage 1 Commencement Conditions	Discussion	CW	2.35pm
7.3	**New Hospital Project:** Programme Plan Update (Acute & OPD) & Stage 2 Engagement Overview	Discussion	CW	2.50pm
Committee Business				
8.	**Minutes of the Following Meetings (for information):** **8.1** *NMGH Strategic Programme Committee*: 8.1a – 7 September 2026 (Approved) **8.2** *NMGH New Hospital Project Board*: 8.2a – 11 August 2026 (Approved)	Information		
9.	**Escalation report**	Discussion	Chair	3.05pm
10.	**Workplan Review**	Meeting admin	Chair	3:10pm
11.	**Any Other Business** (verbal)	Discussion	Chair	3.15pm

12.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	3.20pm
Date of next meeting: Thursday 17th December 2026 at 1:00pm – 3:00pm, MS Teams				
Committee Supporting Information: A1: NMGH New Hospital Project - Staff Newsletter August 2026 A2: NMGH New Hospital Project - Staff Newsletter September 2026				

Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday, 25 November 2026

Paper Title:	Strategic Development Update	**Agenda Item 10.2**
Presented by:	Tom Rafferty, Chief Strategy Officer	
Prepared by:	Caroline Davidson, Director of Strategy	

Meetings where content has been discussed previously	Service Strategy and Planning Management Committee	
Purpose of the paper Please check **one** box only:	☐ For approval ☒ For discussion	☐ For support ☐ For noting

Executive summary / key messages for the meeting to consider

This paper provides an update to the Board of Directors on national, regional and local strategic developments relevant to MFT. Below is a summary of the key developments covered:

National Developments

- **NHS Bill changes:** Subject to legislation, NHS England will become part of DHSC from April 2027, with an NHS Group established within the Department to oversee operational delivery and regional teams retained through a transitional Special Health Authority. The changes are intended to strengthen clinical and patient input and support greater devolution and alignment between the NHS, social care, local government and mayoral authorities.

Regional and Local Developments

- **Manchester Brain Health Programme:** The two-year Brain Health Clinic pilot is progressing alongside development of the longer-term vision for a permanent Manchester Brain Health Centre, bringing together clinical care, research and earlier diagnosis and treatment of dementia. An Outline Business Case is targeted for December 2026, alongside work on the future model, estate, governance, funding and wider Greater Manchester opportunities.
- **Vascular and Cardiac Service Change Assurance Process:** Public consultation on the proposed changes concluded in September, with feedback from nearly 1,000 contributors and 28 engagement meetings highlighting travel, access and workforce impacts as key issues. The feedback will inform the final proposals and Decision-Making Business Cases, including further development of the proposed single arterial vascular centre at Manchester Royal Infirmary.
- **Major Trauma:** Greater Manchester partners are developing a single Major Trauma Service operating across Manchester Royal Infirmary and Salford Royal, with common clinical pathways, governance, workforce planning and learning. Pathways are expected

to be developed by March 2027 ahead of implementation from April, with work continuing on patient flows, financial arrangements and key clinical dependencies.

- **GM Pathology:** The Greater Manchester Trust Provider Collaborative has supported, in principle, a move towards a lead-provider model for pathology, with a longer-term ambition for a hub-and-spoke arrangement. Potential lead providers are being considered, with a decision expected in the new year.

- **Manchester Lung Institute:** MFT and the University of Manchester are developing a Manchester Lung Institute to bring together the city's strengths in respiratory clinical care, research, innovation and education. The Institute would support earlier diagnosis and prevention, improve access to research and new treatments, tackle health inequalities and strengthen Manchester's position in respiratory medicine.

MFT Developments

- **Community Diagnostics Centres:** MFT's strategic delivery plan aims to develop Community Diagnostic Centres as integrated local hubs, expanding access to high-quality diagnostics closer to home through redesigned pathways, GP direct access, straight-to-test referrals and coordinated testing. Planned developments include expansion of Gorton CDC and a Women's Health Hub at Manchester & Trafford CDC.

- **Left Shift Programme Update:** The programme is progressing plans to provide more proactive and integrated care closer to home, with current priorities including palliative and end-of-life care, ENT, gynaecology, paediatrics and diabetes. MFT is also developing its potential role as an accountable pathway integrator, coordinating end-to-end pathways with partners while retaining existing commissioner and organisational accountabilities.

- **LCO Integrated Neighbourhood Teams:** A stocktake of Integrated Neighbourhood Teams across Manchester and Trafford has demonstrated measurable impact, including more than 3,100 additional bowel-screening records, improvements of up to 10% among groups experiencing greater health inequalities, and an 18.1% reduction in ED attendances in the six months following first proactive case-management contact. A strategic case is now being developed with GPs, councils, VCFSE organisations and wider partners to standardise the INT core offer, align it more closely with PCNs, strengthen GP led neighbourhood MDTs and use hospital admission, long term-condition and frailty data to focus proactive care on residents with the greatest modifiable risk.

Recommendation(s)

The Board of Directors is asked to:

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

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

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

Main report

1. Introduction

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

2. National Developments

NHS Bill

The Secretary of State has set out plans for the future organisation of the NHS as part of the DHSC.

On 1 April 2027, subject to the passage of the Health Bill, NHSE will become part of the DHSC. The new DHSC will be a streamlined and agile organisation executing a core set of national functions. The centre will provide a single vision, clarity on the future strategy, and a set of national priorities and minimum standards. There will be a clear rules-based system that rewards success, coordinates an overall improvement offer and intervenes where there is failure.

The model will draw on that past experience of what works at a national level, in the interests of patients and communities. The role of NHS CEO will be retained and an NHS Group will be established within DHSC, focused on NHS operational delivery and working alongside other departmental business and priorities including policy development, social care, and public health.

The vast majority of the current NHSE national delivery functions will transfer into the NHS Group. In other areas, combined policy teams will be created bringing together current NHSE and DHSC expertise including on areas like neighbourhood health that rely heavily on the interface between the NHS and social care and other partners from across government.

The SoS wants to see greater devolution to local organisations and communities, and greater alignment between the NHS, social care, mayoral strategic authorities and local councils. NHS regional teams will support further work around boundaries, partnerships and alignment of powers, across regions and local areas.

A transitional Special Health Authority (SpHa) will be established to host the NHS regions that is accountable to the SoS through the NHS Group within the Department. The SpHa will provide legal underpinning for the existing regional teams so that they remain close to the frontline who they support day-to-day, rather than being centralised within the DHSC.

The SoS also outlined measures to ensure that decisions about care are informed by the experience of patients and the public. Healthwatch will now be retained and strengthened. A new patient experience director will be appointed and a new dedicated team will be established within DHSC to support patients and families who have experienced harm and injustice. Clinical leadership across the health and care system will be strengthened through the establishment of a clinical council. This will bring together a small group of senior clinicians to strengthen leadership to the system and advise ministers on the NHS's major clinical priorities.

3. Regional and Local Developments

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

- Brain Health Programme

Details of further regional and local developments are set out below:

3.2. Vascular and Cardiac Service Change Assurance Process

The Vascular and Cardiac pre-consultation business case was well received earlier this year and approved to proceed to public consultation. The public consultation ran from July to the end

of September with good engagement across many patient groups and service stakeholders. The consultation report was published in late October. Feedback was received from nearly 1000 contributors directly through submission of survey and from 28 patient/public engagement meetings. Key issues raised included travel and access, particularly for vascular patients, and the potential impact on staff. The consultation feedback will inform the final proposals and Decision-Making Business Cases.

For vascular services, the proposed model would establish a single arterial centre at Manchester Royal Infirmary, with Royal Oldham continuing as a spoke site. MFT and the Northern Care Alliance continue to work together on the detailed service, workforce and financial arrangements, with plans to implement the changes – subject to NHS England and GM ICB approval, from April 2027.

3.3 Major Trauma

Work continues across Greater Manchester to establish a single Major Trauma Service operating across the two existing Major Trauma Centres at Manchester Royal Infirmary and Salford Royal, following the decision to retain both centres. The ambition is to establish a more integrated service with common clinical pathways, governance, workforce planning and learning across the two sites. A clinical lead has been appointed and pathway workstreams involving MFT, the Northern Care Alliance and wider system partners are underway.

The programme timetable has been revised, with clinical pathways now expected to be developed by the end of March 2027 and implementation beginning from April 2027. Work is particularly focused on ensuring appropriate patient flows between the two centres and establishing effective clinical networks and transfer arrangements. Important issues still requiring resolution include the commissioner financial framework, alignment between providers and the sustainability of clinical dependencies including spinal, pelvic and cardiac services.

3.4 GM Pathology

In September the GM Trust Provider Collaborative (TPC) supported, in principle, a lead provider model for the delivery of pathology in GM. The aim is to work towards a hub-and-spoke arrangement over time, with a hosted integrated model possible in the longer term. A process is underway to assess lead provider nominations against agreed criteria and work through how the arrangement will operate, which is expected to conclude in the new year.

3.5 Manchester Lung Institute

MFT and the University of Manchester are developing proposals for a Manchester Lung Institute, bringing together Manchester's significant strengths in respiratory clinical care, research, innovation and education.

MFT has the largest respiratory clinical service in the UK, hosting the most specialist services in the field. There is strength in respiratory clinical academia with eleven professors and eight honorary professors. The vision for a Lung Institute is as a vehicle for integrating and aligning the work of MFT and UoM on respiratory biology, health, disease, diagnosis and care to be '*Shaping a future where lung disease no longer defines lives'.*

The Institute would focus on three areas: discovery, translating research and innovation into clinical practice, and developing clinical and academic talent. It aims to support earlier diagnosis and prevention, improve access to research and new treatments, reduce health inequalities and

further strengthen Manchester's national and international position in respiratory medicine. A business case to support the establishment of the Institute is in development.

4. MFT Strategic Developments

4.2 Left Shift Programme Update

The Left Shift Programme continues to develop as MFT's strategic approach to providing more proactive, integrated care closer to people's homes, supporting earlier intervention and reducing avoidable reliance on acute hospital services. Current priorities include palliative and end-of-life care, community ENT, gynaecology, general paediatrics and diabetes, alongside wider opportunities to deliver care through neighbourhood and community settings. Recent progress includes development of a neighbourhood-based ENT model; an all-age palliative and end-of-life care strategy; and proposals to pilot a general paediatric multidisciplinary model across four Primary Care Network localities. The programme is also working with partners to make better use of community infrastructure, including Community Diagnostic Centres, neighbourhood health centres, GP premises and family hubs.

In parallel, MFT is developing its proposed role as a pathway integrator, working with partners to coordinate end-to-end pathways. The emerging scope includes gynaecology, ENT, cardiology. Implementation would be phased according to specialty readiness.

These plans are feeding into the MFT annual planning process and discussions with commissioners for 27/28.

4.3 LCO Integrated Neighbourhood Teams

A stocktake across Manchester and Trafford Integrated Neighbourhood Teams has demonstrated the impact and delivery of national NHS planning requirements. Over the last 18 months, targeted neighbourhood interventions have increased access to prevention, including more than 3,100 additional bowel screening records and an increase of up to 10% in key groups with a greater health inequality in 2023. Proactive case management also demonstrates an 18.1% reduction in ED attendances in the six months following first contact. These findings indicate that locally targeted interventions and personalised, multidisciplinary support can improve prevention and reduce urgent-care use. The findings also highlight the potential to standardise further in each neighbourhood, increasing focus on residents with the greatest modifiable risk using hospital admission, long term condition and frailty Trust data alongside the GP led MDT referrals.

A strategic case is being developed with partners including GPs, councils and VCSFE to establish the next steps for proactive population health, neighbourhood care and community unplanned care as an alternative to hospital. The INT core offer will further align with PCNs, use the learnings to focus population health activity on a smaller number of measurable priorities, and strengthen GP led neighbourhood MDTs and proactive care cohort identification. These

plans are feeding into the MFT annual planning process and discussions with commissioners for 27/28.

3. Recommendations

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

Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday, 25 November 2026

Paper Title:	Annual Planning 2027/28	**Agenda Item 10.3**
Presented by:	Tom Raffery, Chief Strategy Officer	
Prepared by:	Caroline Davidson, Director of Strategy	
Meetings where content has been discussed previously	n/a	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☐ For discussion ☒ For noting	

Executive summary / key messages for the meeting to consider

The annual planning process brings together the development of activity, workforce, finance and delivery plans that will enable us to implement the Trust strategy, meet forecast demand and waiting time standards, and improve productivity. Lessons from the previous year have informed a revised approach for 27/28. Key changes are greater detail in capacity and demand planning, particularly for non-elective activity and diagnostics, use of benchmarking data to help identify improvement opportunities and potential savings and splitting the planning process into two phases. During phase 1, which runs from September to December 2026, the activity, finance and workforce submissions are developed. During phase 2, from December 2026 to March 2027, we will focus on delivery planning, assurance and readiness for implementation from 1 April 2027. Key programmes and expected results will be identified earlier to guide Clinical Group and Corporate Team plans, informed by engagement with Governors.

Governance arrangements, guidance and templates are in place. Oversight is provided through the Annual Planning Oversight Group, supported by a working group and risk register. The Board's Annual Planning Sub-committee and dedicated Board sessions will scrutinise assumptions and deliverability and support the required NHS England assurance statements.

GM ICB's commissioning intentions are informing our plans, with discussions underway to ensure that our demand assumptions are aligned and clarify ICB service change proposals.

In line with the timetable, Clinical Groups submitted their first cut activity, finance and workforce plans on 2 November. This was followed by a peer review to test consistency, productivity assumptions and support requirements. The second submission is due on 1 December.

Submission to GM ICB is scheduled for 13 December and NHS England for 16 December. The ICB submission will remain subject to final Board approval. National guidance, including

potentially significant tariff and funding changes, remains awaited, creating a risk of limited time to adjust plans before submission.

Recommendation(s)

The Board of Directors is asked to:

- Note the annual planning process for 27/28
- Note the timetable of key dates, in particular the external submissions and that our GM submissions will be subject to Board approval
- Note that further regular updates will be brought to the Board

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

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

Main report

1. Introduction

Each year we develop a plan that describes how we are going to implement our Trust strategy in the coming years. The annual planning process encompasses a number of related activities including:

- Developing an activity plan that meets forecast demand and waiting time standards
- Developing a workforce plan that supports delivery
- Developing a financial plan that balances income with expenditure and delivers productivity improvements
- Developing action plans that describe how all of this is going to be delivered
- Agreeing contracts and funding with commissioners for the required level of activity

2. Planning Process 2027/28

At the end of each year's planning process, we review what worked well and what could be improved. We use the findings to refine the following year's process and improve the quality of the plans produced.

The planning process for 27/28 is based on submitting a final version of the numerical annual plan templates (covering activity, finance and workforce) to NHSE in December 26. It also assumes that there will be an agreed position with the ICB at this point. The preparations, including developing the templates and guidance and setting up the governance arrangements were undertaken over the summer.

Planning is being undertaken over 2 phases. Phase 1 focuses on activity, finance and workforce planning and the completion of the NHSE numerical templates. This is taking place from September to December 26. Phase 2 will focus on the narrative and actions required to deliver the plans and will take place from December 26 to March 27. This two phase approach is designed to provide dedicated time for action planning, assurance and readiness planning so that we develop better quality plans that are ready to be implemented from 1 April 27.

There are to be two cuts (submissions) of the activity, finance and workforce plans; the first at the start of November and the second submission at the start of December. Capacity and demand planning will be undertaken at sub-specialty level and planning for non-elective activity and diagnostics will be more detailed than in previous years. There will be a peer review process after cut 1 to compare plans across Clinical Groups and a wash-up following cut 2.

We will use the annual planning process to focus on areas that have the greatest opportunity for improvement and areas where there appears to be surplus capacity and therefore potential to make savings. This will be informed by the use of benchmarking data.

3. Governance

The process is being overseen by the Annual Planning Oversight Group (APOG). APOG is responsible for overseeing the process to develop Clinical Group and Corporate Team plans and reviewing and signing off the key products such as the templates and guidance. It formally reports to SSPMC and TLTC; the timescales and the pace of work means that regular update reports are provided directly to TLTC.

The Annual Planning Working Group sits below APOG and develops the products for APOG to review and sign-off and pulls together the MFT submissions.

The Board of Directors Annual Planning Sub-committee is being reconvened. A number of dedicated sessions have been planned with the Board so that they are able to test and challenge the plans and the underlying assumptions as they are iterated and will be in a position to sign-off the NHS England Board Assurance Statements confirming that they are satisfied that our plans are robust and deliverable.

We have created a risk register that identifies the key risks to the process.

4. ICB commissioning intentions

GM ICB has issued their commissioning intentions for 27/28. They provide a framework for aligning our activity, workforce and financial plans with those of the ICB. They are structured into four categories:

- ***Strategic commissioning signals*** which describe broader commissioning direction and organisational intent (e.g. neighbourhood health)
- ***Material commissioning intentions*** which set out the specific commissioning decisions that will be implemented during 2027/28 (e.g. Tier 2 service expansion in Gynaecology, ENT)
- ***Provider planning assumptions*** which set out known or forecast changes which should be incorporated into plans (e.g. net non-elective growth of 2%)
- ***Programmes and strategic finance****,* including local finance assumptions and new models (e.g. lead provider models)

We have met with ICB colleagues to discuss their proposals and to compare the outputs of our respective demand models to ensure that we are all planning on a similar basis. We have also prepared a list of service-specific questions which the ICB will respond to in writing.

5. Timeline and Submissions

Timeline

The table below sets out the key dates in the process.

Key Dates	From	To
Issue guidance (1), templates and benchmarking data	07/09/2026	07/09/2026
Cross check modelling assumptions with ICB	15/09/2026	15/09/2026
Cut 1 submission	02/11/2026	02/11/2026
Cut 1 peer review	13/11/2026	13/11/2026
Cut 2 submission	01/12/2026	01/12/2026
Cut 2 wash-up	11/12/2026	11/12/2026
Phase 2 guidance launch	12/12/2026	12/12/2026
Submit plan to GM ICB	13/12/2026	13/12/2026
Submit plan to NHSE	16/12/2026	16/12/2026
BoD seminar /sign off submission	16/12/2026	16/12/2026
Submit plan to NHSE	16/12/2026	16/12/2026
BoD Annual Planning sub group meeting to sign off submission	08/02/2027	08/02/2027
Submit plan to GM ICB	08/02/2027	08/02/2027
Submit plan to NHSE	11/02/2027	11/02/2027
Peer Review of plans for delivering productivity improvements & savings	12/02/2027	12/02/2027
Management Committee review of plans for delivering MFT strategy	01/03/2027	26/04/2027
Plans signed off through March DoF meetings	10/03/2027	11/03/2027
BoD meeting - sign off IDP	24/03/2027	24/03/2027

Submissions

Provider submissions are expected by NHS Greater Manchester three working days before the national submission deadline. Providers and the ICB are expected to submit to region one working day before the national deadline, leaving NHS GM two working days to aggregate the GM position. Our timeline is set out below:

Action	Timeline
BoD Annual Planning sub-group meeting	07/12/2026
Submit plan to GM ICB	13/12/2026
BoD seminar / sign off submission	16/12/2026
Submit plan to NHSE	16/12/2026

As last year, the position that we submit to the ICB will not be the position signed off by the Board, it will therefore be submitted with the caveat that it is subject to final approval by the Board and may change.

6. Preparation for phase 2 planning

We are beginning to prepare for Phase 2 planning. This year, we plan to identify the key programmes of work and expected results (OKRs) for 2027/28 earlier in the process and include them in the phase 2 planning guidance so that Clinical Groups and Corporate Teams understand the priorities that should shape their plans from the outset.

A meeting with the Council of Governors was held on 20 October to seek their views on our forward plans and specifically on what Governors think we need to prioritise in 27/28 and the metrics (OKRs) that we should use to measure progress. A further session is to be held on 15 December to review performance against our 26/27 plan and discuss in more detail our priorities for 27/28.

7. Current Position

The foundations including developing and putting in place the governance arrangements and developing the timeline and the planning guidance took place over the summer.

Clinical Groups updated their capacity plans over the summer. The demand data, productivity opportunities and assumed impact of key transformation programmes were issued and are now being used to support Clinical Groups in developing their activity, finance and workforce plans. Cut 1 plans were submitted on 2 November and a peer review was undertaken with Clinical Groups key SLT members and executive directors. The review aimed to share the key messages from cut 1, check that Clinical Groups had taken a consistent approach to planning and productivity improvements, and build a shared understanding of the plans, their impact and any support needed.

National guidance is awaited, with some potentially significant changes to the national tariff and funding flows. Further detail is not expected until mid-November which could leave little time for plan to be adjusted ahead of final submission.

8. Actions/Recommendations

The Board of Directors is asked to:

- Note the annual planning process for 27/28
- Note the timetable of key dates, in particular the external submissions and that our GM submissions will be subject to Board approval
- Note that further regular updates will be brought to the Board.

Manchester University
NHS Foundation Trust

Escalation and Assurance Report
Quality, Safety and Performance Board Committee

Report to: Board of Directors
Report of: Jackie Hanson, Non-Executive Director and Chair of QSP Board Committee
Date of meeting: 27 October 2026

Key escalation and discussion points from the meeting
Alert
The Committee received the **operational performance Integrated Performance Report** which described an overall mixed position. Higher than planned demand had impacted delivery of improvement trajectories. Urgent and emergency care (UEC) demand also remained high and whilst MFT's performance of 71.7% remained comparatively strong across Greater Manchester, it was a 6.6% behind MFT's own improvement trajectory. RTT performance was also behind plan, though had improved on the previous months' performance and further work was required to sustain progress. The waiting list for diagnostics had increased above plan, will key drivers including endoscopy, sleep service and cardiac MRI/CT. Actions in place to support improvement were confirmed, though it was noted that full recovery was not expected until March 2027. The **quality and safety Integrated Performance Report** was presented to the Committee, which detailed that a number of metrics remained below the required standards, with specific updates provided on never events, pressure ulcers and MRSA bacteraemia. The Committee was informed that whilst no Never Events had been reported during the period, the cumulative in-year position remained escalated, with a programme of work continuing to address recurring themes. Work to support pressure ulcer performance, including the joint work across neighbourhood, integrated and district nursing teams, was outlined, and confirmation provided that all incidents reported in the LCO within the reporting period had been reviewed and learning identified. One case of MRSA bacteraemia was reported, with improvement work continuing around decolonisation, invasive device management, on-going surveillance of practice and environmental standards. Clarity was also requested on the increase in incidents involving detained patients absent from care and received confirmation provided that immediate actions and strengthened controls had been implemented. The Committee considered progress of the **Patient Administration** programme of work and noted the framework in place to delivery of the improvement plan, currently planned for completion by 31 March 2027. Delivery remained dependent on sustained capacity, completion of audit and validation processes and management of new in-flow. Additional resource had been identified to support the programme and a time-limited NED-chaired task and finish group established to provide further oversight. The Committee received assurance on the controls in place to support safe delivery of the programme, including the prioritisation of records requiring individual validation according to clinical risk and pathway status, with established clinical governance processes in place where further review was required. The importance of maintaining oversight of delivery, patient safety and the sustainability of improvements was emphasised. The Committee was assured by the approach and would continue to monitor progress. The Committee considered the patient safety and operational risks associated with **digital capital** constraints. The strategic risk remains rated at 20. Assurance was provided that no patient harm has occurred that is directly attributed to this risk. The Committee supported development of a clinically

informed, risk-based approach to prioritising investment and requested further assurance on how this would be applied across digital, medical equipment and estates.

The **Safeguarding Annual Report** confirmed that statutory and regulatory responsibilities had been met, against a backdrop of continuing high demand and complexity. Remaining actions from the independent safeguarding review were progressing, with structural changes expected to be completed by December 2026. Further focus is required on the timeliness of initial health assessments for looked-after children, as performance against the 20-working-day standard remained below target across Manchester and Trafford impacted by local authority response times. Work with local authorities and GMICB was underway to consider system dependencies and mitigating actions. The report is presented to the Board of Directors.

The **Maternity and Neonatal Thematic Learning Report** provided triangulated learning from perinatal mortality reviews, investigations, complaints, audit and patient feedback. Recurring themes included recognition and escalation of clinical deterioration, communication, personalised care and multidisciplinary working, with established governance arrangements overseeing delivery of associated actions. Future reports will include learning from relevant coronial reviews.

An update on MFT's response to the national **Thirlwall Inquiry** recommendations was provided which outlined the governance arrangements established to oversee the 17 recommendations and consider their wider organisational implications. Further national direction was awaited in relation to CCTV and monitoring, with MFT continuing to progress actions that could appropriately be taken locally.

Advise:

The **quality and safety Integrated Performance Report** detailed 16 metrics that demonstrated improvement with the following seeing consistent improvement: number of maternal deaths, Hospital Standardised Mortality Ratio (HSMR), Crude Mortality (rolling 12 month) and Summary Hospital level Mortality Indicator (SHMI)

The **operational performance Integrated Performance Report** detailed 8 measures to note, where performance was improving and the associated risk was being actively managed. These included cancer standards, ambulance handover, patient flow, diagnostic waiting times, elective waiting times in the community, neurodiversity waiting times (CAMHS); outpatient productivity and theatre productivity. The Committee highlighted the continued importance of improving patient flow and discharge, including maximising Hospital at Home. The Committee also requested that communication arrangements for patients and their families experiencing longer waits on the CAMHS pathway.

The Committee received the **Maternity Safety and Assurance Report**, which reported that most maternity and neonatal safety commitments remained on track, with no immediate safety matters requiring escalation. Maternity triage remained the principal residual risk, with full compliance with the national specification constrained by estate and facilities requirements. Progress against the national 10-point plan, Maternity Incentive Scheme and actions arising from ICB assurance visits remained positive. Confirmation was provided that governance arrangements for managing periods of increased clinical activity and acuity had also been strengthened, with revised oversight and escalation guidance providing greater clarity around the deployment of resources and introducing additional safeguards where staff with non-clinically facing roles may be redeployed to direct clinical care. This included a requirement for risk assessment to ensure staff work within their skills and competence. The wider work to assess maternity capacity and demand was also progressing and will inform future elective capacity requirements.

The Committee considered the outcomes of the **National Maternity Survey**, which are embargoed until later in the year. Once published, a further report will be presented to the Committee, with actions to address improvement opportunities progressed immediately.

The Committee was updated on progress against the **Paediatric ENT Improvement Plan**, including strengthened governance and professional oversight, patient safety and Freedom to Speak Up arrangements, and improvements to supporting clinical processes. The Committee sought assurance regarding a small number of delayed actions, including the establishment of formal multidisciplinary team arrangements. Confirmation was provided that recruitment had progressed and enhanced oversight through the Task and Finish Group was in place to support completion. The Committee also emphasised the wider organisational learning from the review, particularly the importance of creating an environment in which colleagues feel supported and able to raise and escalate concerns.

The **Mortuary Assurance Report** confirmed that all major findings from the 2025 Human Tissue Authority inspection had been formally closed, with two Fuller Inquiry actions relating to security infrastructure remaining outstanding and interim mitigations in place. The retrospective review, undertaken in response to the HTA regulatory alert issued to all Trusts, identified nine cases for reporting to the HTA, with no additional risks identified beyond those already being managed through existing actions. Ongoing compliance will be monitored through the formal audit programme and established quality governance arrangements, with annual assurance to the Committee and reporting by exception as required.

The Committee received assurance on the implementation of **Martha's Rule**, with Trust-wide rollout substantially complete and neonatal implementation on track. Early learning from use of the service had identified themes relating to communication, coordination, clinical review and discharge planning, with these being addressed locally. Work is progressing to extend Martha's Rule to Emergency Departments, with implementation planned for March 2027, ahead of the national requirement, supported by additional funding.

The Committee received the **Annual Report on Medicines Incident Themes**, noting a strong incident-reporting culture and the continued programme of improvement across key medicines safety themes, including injectable medicines, medicines at discharge and insulin safety.

The **Controlled Drugs Accountable Officer's Annual Report** demonstrated good overall compliance in the management of controlled drugs, with arrangements strengthened to support safer prescribing and discharge practices. Improvement work arising from the Internal Auditor review was underway, including establishment of a multidisciplinary Task and Finish Group to oversee delivery, with audit actions expected to be completed within six months. The Committee emphasised the importance of detailed monitoring to ensure that high-level compliance does not mask variation in practice and requested a further update in six months.

The Committee received the **Medicines Optimisation Annual Report**, noting positive progress across patient care, digital capability, antimicrobial stewardship, research and delivery of value and efficiencies. Continuing risks relating to medicines reconciliation, aseptic and automation infrastructure and national medicines supply remained subject to established oversight.

The Committee received the **Biannual Legal Services Activity Report** which highlighted treatment and follow-up delays as recurring themes arising from claims. The work underway to strengthen how learning from claims, inquests and Prevention of Future Deaths matters is triangulated with wider patient safety and improvement activity was noted.

The **Clinical Accreditation Programme** continued to progress following its relaunch, with 89 of 147 accreditations completed. The revised approach provides greater emphasis on safety, compassion, collaboration and early identification of risk, with no areas requiring additional support at the time of reporting.

Assure

The **operational performance Integrated Performance Report** detailed two 'assure' measures in respect of elective activity and sexual assault referral centre waiting times.

The quality and safety **Integrated Performance Report** detailed 13 'assure' metrics which are on target with the standard set. The Committee was informed that of these metrics, those related to duty of candour, Initial assessment time in maternity triage within 30 minutes, augmentation of labour pathway delays, overall patient experience survey performance score and critical medication omissions due to medicines unavailable reported continued improvement.

The **National Cancer Patient Experience Survey** provided positive assurance, with an overall score of 9.1 compared with a national average of 8.9 and performance at or above the national average in 56 of 65 questions. Improvement activity will focus on information about recurrence or progression, emotional wellbeing, financial support and variation in experience between different patient groups.

The **National Adult Inpatient Survey** provided positive overall assurance, with a score of 8.3 compared with the national average of 8.2. Areas of strong performance included dignity and respect, kindness and compassion and ward cleanliness, with improvement activity focused on personalised care, virtual wards and medicines information at discharge.

Risks discussed at the meeting

The Committee reviewed the **Board Assurance Framework** and noted that three strategic risks within its remit remained outside the Board's agreed risk appetite: mental health service capacity and demand; harm whilst waiting for treatment; and under-delivery against annual plans. The Committee challenged the pace and clarity of mitigating actions and requested that the risk narratives better distinguish those matters within the Trust's direct control from those dependent upon system partners, and more clearly reflect the developing assurance and governance arrangements. A discussion also progressed in relation to the relationship between target risk scores and the Board's agreed risk appetite, particularly where a risk is already within appetite, but further action is being pursued to reach a lower target score. This will be considered further.

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

Manchester University
NHS Foundation Trust

Quality, Safety and Performance Board Committee

Date: 27th October 2026
Time: 10:00 – 13:00
Location: Held Virtually via MS Teams

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	10.00
2.	**Declaration of interest** (verbal)	Meeting admin	Chair	
3.	**Minutes of the previous meeting**	Meeting admin	Chair	
4.	**Action Log**	Discussion	Chair	
5.	**Matters Arising / Hot Topics**	Discussion	Chair	10.05
6.	**Assurance**			
6.1	Board Assurance Framework	Discussion	Trust Board Secretary	10.10
6.1.1	Patient Administration Issues Update	Discussion	Deputy CDIO	10.20
6.1.2	Digital Capital Constraints: Patient Safety, Risk and Assurance	Discussion	Deputy CDIO	10.30
6.2.	**Integrated Performance Reports**			
6.2.1	Operational Performance IPR	Discussion	Director of Performance	10.40
6.2.2	Quality and Safety IPR	Discussion	Executive Directors	10.45
6.3.	**Maternity and Neonatal Service Assurance**			
6.3.1	Maternity Safety and Assurance Report (Quarter 1 2026/27) including 10-point plan progress report	Discussion	Director of Nursing and Midwifery Clinical Head of Division, Maternity	10.55
6.3.2	Maternity Thematic Learning Report (Quarter 1 2026/27)			
6.3.3	Maternity Survey (embargoed results)			
6.3.4	Thirlwall Inquiry Report Briefing			

	Item	Purpose	Lead	Time
	Break – 5 mins			11.25
7.	**Strategic aim 2: Provide high quality, safe care with excellent outcomes and experience**			
7.1	Paediatric ENT Action Plan Update	Discussion	DoN SHCG	11.30
7.2	Mortuary Update	Discussion	DCNO	11.40
7.3	Martha's Rule Update including Emergency Department implementation	Discussion	DCNO	11.50
7.4	Annual Report on Medicine Incident Themes	Discussion	Chief Pharmacist	12.00
7.5	Controlled Drug Accountable Officer's Annual Report	Discussion	Chief Pharmacist	12.05
7.6	Medicine Optimisation Report	Discussion	Chief Pharmacist	12.10
7.7	Safeguarding Annual Report 2025-26	Discussion	DCNO	12.15
7.8	Cancer Survey Report	Support	DCNO	12.20
7.9	National Adult Inpatient Survey Benchmark Report	Support	DCNO	12.30
8.	**Items for Information**			
8.1	MFT Update on National Quality Strategy for NHS Funded Care	For Information	DCNO	-
8.2	Service developments (strategic objectives 4 and 5)	For Information	CSO	-
8.3	Common Health Games	For Information	DCNO	-
8.4	Quality and Safety Management Committee Escalation Report (September 2026)	For Information	-	-
Good Governance				
9.	Legal Services Activity Report	Discussion	DCNO	12.40
Committee business				
10.	**Escalation report** (verbal)	Approval	Chair	12.50
11.	**Workplan Review**	Meeting admin	Chair	12.55
12.	**Any Other Business** (verbal)	Discussion	Chair	
13.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	
Date of next meeting: 22 December 2026				

NHS
Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday, 25 November 2026

Paper Title:	NHS Adult Inpatient Survey 2025 Benchmark Report	**Agenda Item 11.2**
Presented by:	Kimberley Salmon-Jamieson, Deputy Trust Chief Executive & Chief Nursing Officer	
Prepared by:	Jemma Haines, Interim Director of Patient Experience Claire Horsefield, Patient Experience and Engagement Lead	
Meetings where content has been discussed previously	Trust Leadership Team Committee (30.09.26) Quality and Safety Management Committee (13.10.26) Quality, Safety and Performance Board Committee (27.10.26)	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion ☐ For noting	

Executive summary / key messages for the meeting to consider

The 2025 NHS Adult Inpatient Survey provides positive assurance that patient experience at MFT remains aligned with national benchmarks. **MFT achieved an overall experience score of 8.3, above the national average of 8.2 and improved from 8.2 in 2024**. All 12 survey sections were rated "about the same" as other Trusts, with 50 of 51 questions within the expected range; one discharge question, relating to discussion of further health or social care needs after leaving hospital, was rated somewhat better than expected.

Relational care remains a key strength. The highest section scores were respect and dignity (9.3), kindness and compassion (9.2), doctors (8.9), nurses (8.5), and care and treatment (8.4). Core fundamentals were also positive, including privacy when examined or treated (9.5), enough to drink (9.5), confidence and trust in doctors (9.3), confidence and trust in nurses (9.0), and cleanliness (9.0).

The most improved priorities are individual needs (7.2), virtual wards (7.0), leaving hospital (7.2), medicines information at discharge (4.1), carer involvement in discharge discussions (6.1), mental health needs (5.5), and site-level variation, particularly for NMGH. Over recent survey years, the results show a positive direction of travel, with overall experience improving and most comparable questions showing numerical improvement in 2025, including statistically significant gains in ward-bed waits, access to staff help and cleanliness.

Recommendation(s)

The Board of Directors is asked to:

- Note the request via TLTC to discuss survey and results at Clinical Group Management Boards and share with professional leaders via Clinical Groups, Directors of Nursing,

Midwifery and Allied Health Professionals, Clinical Heads of Divisions for awareness, understanding of connection with programmes of work in train and further patient experience work streams.

- Endorse that Clinical Group improvement plans are developed and monitored using the results of the survey, progressed at Clinical Group Patient Experience meetings and have Clinical Group Management Boards oversight.
- Note that survey improvement plans will be monitored via the Trust Patient Experience Oversight Group, that will be reported through to Quality Safety Performance Board Committee via Quality and Safety Management Committee.

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

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

Main Report

1. Background

The Care Quality Commission published the 2025 Adult Inpatient Survey results on 26 August 2026.

A total of 160,829 patients were invited to participate across 130 acute and specialist NHS Trusts. Completed responses were received from 58,139 respondents; patients were eligible to participate if they were aged 16 years or over, had spent at least one night in hospital, and were not admitted to maternity or psychiatric units during November 2025. Fieldwork took place between January and April 2026.

The survey assesses patient experience across 12 sections of the inpatient journey, from admission to discharge and overall experience. Section scores are based on 51 evaluative questions and reported on a 0–10 scale, where 10 is the best possible result. The national average is the weighted arithmetic mean of all trusts' scores. Scores are not reported where fewer than 30 respondents answered a question or contributed to a section. There were minor questionnaire changes in the 2025 survey, including three new questions and wording updates.

2. Respondent Profile

A total of 380 patients responded (**62%** from urgent/emergency admission and **38%** from planned admissions) with a survey response rate of **33%**, compared with the national average response rate of 38% and 38% for MFT in 2024, lower than the national average and the previous year. Early insight from the embargoed results in May identified a reduction in survey response rates, prompting immediate action to influence this year's survey response. A Trust-wide Task and Finish Group, with representation from all Clinical Groups, was established and developed a coordinated improvement plan to increase participation across future surveys. Actions have focused on raising awareness of the survey, increasing promotion through volunteers, local champions and Trust communications.

Respondents were predominantly older adults, with over half aged 66 or above. A high proportion also reported living with a long-term health condition, disability or illness (83%). Gender profile was broadly balanced, with responses received from females (52%) and males (48%). Most respondents identified as White (84%) and Christian (63%), while 26% reported no religion. When considered alongside Manchester's wider demographic profile, the survey respondent group was older and less ethnically and religiously diverse than the local population. The age profile reflects the expected profile of an inpatient cohort; however, it also highlights the importance of triangulating survey findings with wider patient experience intelligence, to ensure the experiences of under-represented groups are better understood and inform targeted action for the Task and Finish Group to improve demographic representation.

3. Overview of headline results

Overall, MFT performed well in the 2025 Adult Inpatient Survey, achieving an overall score of **8.3**, above the 8.2 national average and an improvement from 8.2 in 2024, giving stable benchmark assurance for patient experience. Across all survey sections MFT performed about the same as other Trusts (Table 1). Respect and dignity (9.3) and kindness and compassion (9.2) were the strongest section scores with the clearest improvement opportunities in virtual wards (7.0), individual needs (7.2) and leaving hospital (7.2) sections.
Compared with 2024 results, all comparable questions had numerical positive change accept doctors and virtual ward sections.
Table 1: Overall section performance

Expected range analysis compares a Trust's results with the national average, considering the number of responses and statistical variation. Results are rated as either "better than", "about the same as", or "worse than" most Trusts.

Section	MFT score 2024	MFT score 2025	Change	Expected range analysis
1. Admission to hospital	6.9	7.4	+0.5	About the same
2. The hospital and ward	7.4	7.6	+0.2	About the same
3. Basic needs	7.7	8.1	+0.4	About the same
4. Doctors	9.1	8.9	-0.2	About the same
5. Nurses	8.3	8.5	+0.2	About the same
6. Your care and treatment	8.3	8.4	+0.1	About the same
7. Individual needs	-	7.2	-	About the same
8. Virtual wards	7.8	7.0	-0.8	About the same
9. Leaving hospital	7.1	7.2	+0.1	About the same
10. Kindness and compassion	9.0	9.2	+0.2	About the same
11. Respect and dignity	9.1	9.3	+0.2	About the same
12. Overall experience	8.2	8.3	+0.1	About the same

3.1 Question level summary

Appendix 1 shows question- level scores across MFT sites, showing performance over time and in comparison, with peer Trusts; 50 of 51 questions were 'about the same' as most trusts, with 'Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital' scoring **'somewhat better than expected'** in comparison with other Trusts. The improvement reflects the Trusts' continued focus on strengthening discharge planning to ensure patients have timely discussions about ongoing health or social care support they may require following discharge, helping them feel better prepared for their recovery and ongoing care needs.

Areas of strongest question performance included:

- During your time in hospital, did you get enough to drink? **(9.5)**
- Were you given enough privacy when being examined or treated? **(9.5)**
- Did you have confidence and trust in the doctors treating you? **(9.3)**
- Overall, did you feel you were treated with respect and dignity while you were in the hospital? **(9.3)**
- Overall, did you feel you were treated with kindness and compassion while you were in the hospital? **(9.2)**
- To what extent did you understand the information you were given about what you should or should not do after leaving hospital? **(9.1)**
- Did you have confidence and trust in the nurses treating you? **(9.0)**
- How clean was the hospital room or ward that you were in? **(9.0)**

Questions with improvement opportunity were:

- Were you ever prevented from sleeping at night by any of the following? I was not prevented from sleeping **(4.0)**

- Were you ever prevented from sleeping at night by room temperature? **(9.1)** (all peer Trusts scored highly on this question)
- Thinking about any medicine you were to take at home, were you given any of the following [list in question]? **(4.1)**
- Thinking about your care and treatment, did hospital staff take into account the following individual needs? Mental health needs (e.g. a quiet space, emotional support) **(5.5)**

3.2 Comparison over time

The 2025 results are comparable with data from the Adult Inpatient 2020, 2021, 2022, 2023 and 2024 surveys, unless a question has changed or been introduced. For questions across survey years, there were three statistically significant improvements (waiting for a bed on arrival at hospital; ability to get a member of staff to help when attention was needed; and cleanliness of the hospital room or ward) and no areas of significant deterioration. Twenty-two showed numerical improvement, indicating positive movement even where the change did not meet the threshold for statistical significance (Table 2). Most numerical decreases were less than 0.6 points, with the exception of the larger reduction in virtual ward risks and benefits information (-1.0); reduced scores included medicines information at discharge, noise from other patients at night, and aspects of communication and involvement with doctors.

Table 2: Numerical score comparison 2024 vs 2025

Increased numerical scores compared with 2024	**Decreased numerical scores compared with 2024**
• Waiting for a bed on a ward after arriving at hospital: 6.4 to 6.9 **(+0.5)** • Noise from staff at night: 8.4 to 8.5 **(+0.1)** • Room temperature at night: 9.0 to 9.1 **(+0.1)** • Cleanliness of hospital room or ward: 8.7 to 9.0 **(+0.3)** • Help to wash or keep clean: 7.9 to 8.0 **(+0.1)** • Taking own medication when needed: 7.6 to 8.3 **(+0.7)** • Help to eat meals: 7.9 to 8.4 **(+0.5)** • Food outside set mealtimes: 5.7 to 6.4 **(+0.7)** • Enough to drink: 9.3 to 9.5 **(+0.2)** • Confidence and trust in nurses: 8.8 to 9.0 **(+0.2)** • Enough nurses on duty: 7.3 to 7.7 **(+0.4)** • Able to talk to staff about worries and fears: 7.7 to 7.9 **(+0.2)** • Pain control: 8.7 to 8.8 **(+0.1)**	• Length of time on waiting list before admission: 7.5 to 7.3 **(-0.2)** • Noise from other patients at night: 6.9 to 6.6 **(-0.3)** • Doctors answered questions clearly: 9.1 to 8.8 **(-0.3)** • Confidence and trust in doctors: 9.4 to 9.3 **(-0.1)** • Included when doctors spoke about care: 9.0 to 8.7 **(-0.3)** • Involvement in decisions about care and treatment: 7.3 to 7.2 **(-0.1)** • Information about condition or treatment: 9.0 to 8.9 **(-0.1)** • Virtual ward risks and benefits information: 7.5 to 6.5 **(-1.0)** • Information about virtual ward care and treatment: 8.2 to 7.6 **(-0.6)** • Information about what to do after leaving hospital: 8.1 to 8.0 **(-0.1)** • Understanding discharge information: 9.2 to 9.1 **(-0.1)** • Medicines information at discharge: 4.5 to 4.1 **(-0.4)**

• Able to get staff help when attention was needed: 7.9 to 8.3 **(+0.4)** • Involvement in decisions about leaving hospital: 6.8 to 7.0 **(+0.2)** • Equipment or home changes discussed: 7.9 to 8.7 **(+0.8)** • Who to contact after leaving hospital: 7.6 to 7.9 **(+0.3)** • Further health or social care needs discussed: 7.9 to 8.6 **(+0.7)** • Post-discharge support to recover or manage condition: 6.6 to 6.7 **(+0.1)** • Kindness and compassion: 9.0 to 9.2 **(+0.2)** • Respect and dignity: 9.1 to 9.3 **(+0.2)** • Overall experience: 8.2 to 8.3 **(+0.1)**	

3.3 ***Best and worst performance relative to the national average***

Strongest relative performance (five highest scoring questions compared to national average) was in questions relating to discharge planning and transition home, particularly discussions about equipment or home adaptations needed after leaving hospital (Chart 1). This indicates positive assurance that patients generally felt well supported with practical arrangements for returning home.

The lowest relative scores (five lowest scoring questions compared to national average; Chart 2) were concentrated in the Individual Needs domain, particularly mental health needs (5.5). All these questions were new to the 2025 survey and therefore comparison trend data for the specific question domains are unavailable. Despite scores in this domain being MFT's lowest scoring area overall, it rated 'about the same' in comparison to other Trusts.

Chart 1: Best performance relative to the national average

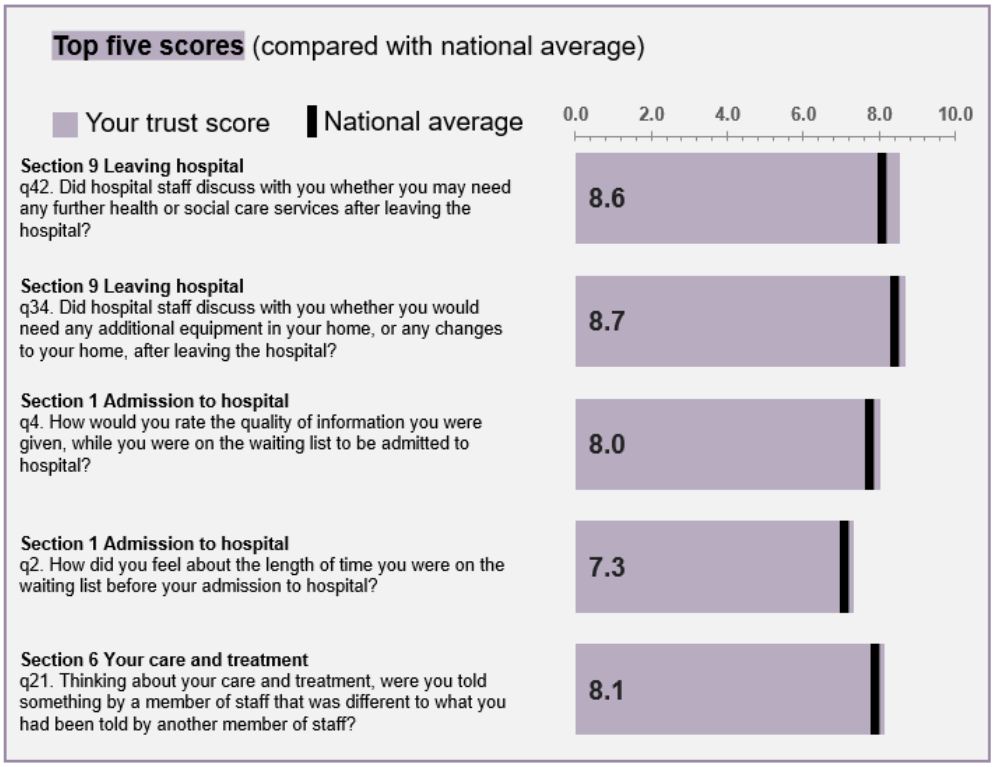
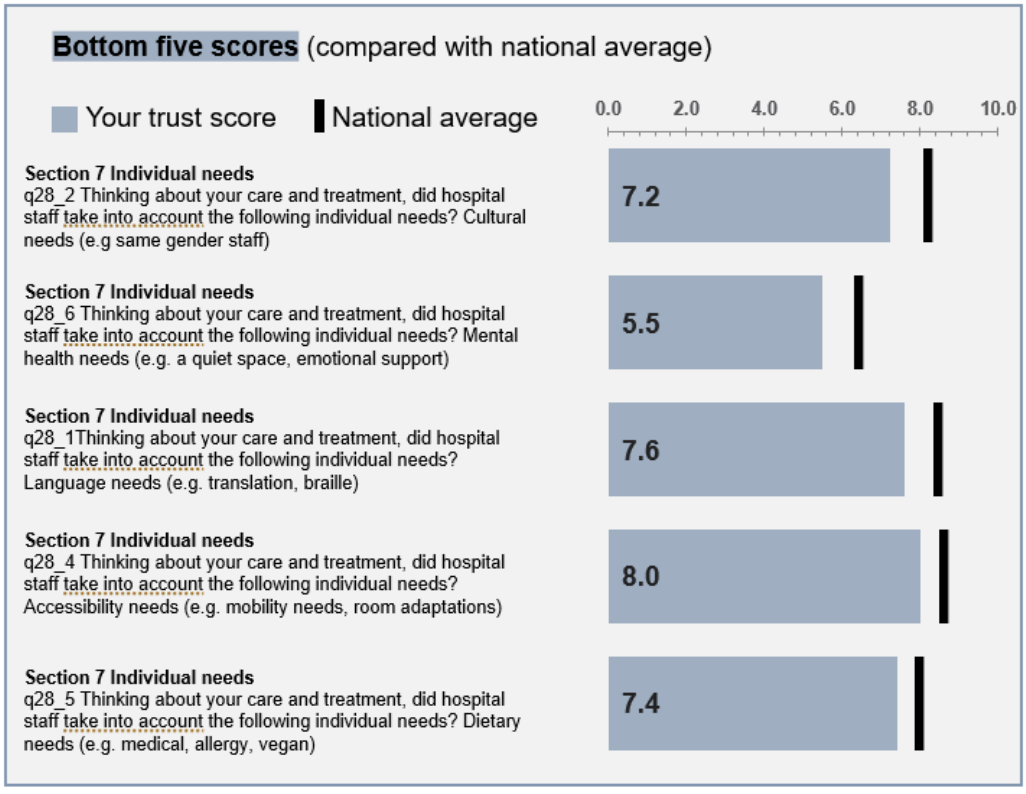


Chart 2: Worst performance relative to the national average



3.4 MFT site level comparison

Core standards remained strong across all sites (Appendix 1), with overall experience highest at Wythenshawe Hospital (8.4), followed by Manchester Royal Infirmary (MRI) (8.3) and North Manchester General Hospital (NMGH) (7.6). Wythenshawe showed the strongest overall site profile, with higher scores across a number of domains including waiting-list information (8.6), accessibility needs (8.3), dietary needs (7.8), post-discharge support (7.3), and discussion of further health or social care services after discharge (8.7). MRI generally performed close to, or slightly above, the Trust average, with stronger results for waiting to access a ward bed after arrival (7.1), cleanliness (9.0), nurses answering questions clearly (8.7), and patients feeling able to talk to staff about worries and fears (8.3). NMGH showed greater variation; lower scores were seen for patients being prevented to sleep at night (2.5), help to wash or keep clean (6.1), involvement in care and treatment decisions (5.9), information before leaving hospital (6.5), medicines information at discharge (3.1), and overall experience (7.6).

Further details of site level comparisons are reported in Appendix 2 survey section results analysis.

4. Survey section result analysis

Appendix 2 presents detailed survey section results for each of the 12 survey sections, covering overview and results, trend data over time, MFT site-level comparison and comparison with other Trusts.

5. Shelford Group peers comparison

Compared with Shelford Group peers (Appendix 3), MFT demonstrated a broadly mid-range performance across the 12 Adult Inpatient Survey sections. MFT's strongest comparative position was ranking joint third for kindness and compassion with a score of 9.2, and joint third for respect and dignity with a score of 9.3. MFT also performed in the middle of the Shelford distribution for nurses, care and treatment, leaving hospital and overall experience, indicating that patients' reported experience at MFT is broadly comparable with other large teaching hospitals.

The main comparative opportunity relates to individual needs, where MFT recorded the lowest Shelford Group score at 7.2. Virtual wards, one of MFT's lower-scoring areas (7.0), was close to the available Shelford range (6.9-7.3) and above one comparator trust. For Doctors, MFT scored the third lowest (8.9) and aligned to four Shelford peers who scored equally. Overall, the Shelford comparison provides assurance that MFT is performing within the expected range for most domains.

6. Key priority improvement themes based on thematic analysis of results

Thematic review of survey results, trend data, site-level variation and triangulation of additional data insights (section 5) identifies seven key priority improvement actions (Table 3).

Table 3: Priority improvement themes

Priority theme	Triangulated evidence
1. Discharge reliability and transition home	Lower survey scores for medicines information (4.1), carer involvement (6.1), carer information (6.3), knowing what happens next (6.8) and post-discharge support (6.7), triangulated with incidents relating to access, admission, transfer or discharge.

2. Communication and shared decision-making	Communication is a recurrent complaints theme and aligns with survey opportunities in involvement in care decisions (7.2), involvement in leaving hospital (7.0), doctors including patients in conversations (8.7) and information before discharge (8.0).
3. Individual needs and reasonable adjustments	Individual needs was one of the lowest-scoring sections (7.2), with all individual-needs questions below national average and mental health needs the lowest result (5.5).
4. Virtual ward information and consent	Virtual wards was the lowest-scoring section (7.0) and declined from 2024, with risks and benefits information reducing from 7.5 to 6.5 and care information reducing from 8.2 to 7.6.
5. Ward environment, rest and sleep	Sleep remained the lowest ward-environment question (4.0).
6. Site-level variation and learning spread	Wythenshawe showed the strongest overall site profile, MRI was generally close to the Trust average, and NMGH showed greater variation across sleep, personal care, involvement, discharge information and medicines information.
7. Sustain relational care strengths	High scores for respect and dignity (9.3), kindness and compassion (9.2), privacy (9.5), hydration (9.5), confidence in doctors (9.3) and confidence in nurses (9.0) provide strong assurance.

7. Next steps

Clinical Group SLT, led by the Directors of Nursing, are requested to review the content of this paper and prepare responsive improvement action plans based on the presented results, to be progressed via local Patient Experience governance with Clinical Management Board oversight. The Patient Experience Oversight Group will monitor action plans as part of assurance measures that will be reported through to Quality Safety Performance Board Committee via Quality and Safety Management Committee.

8. Conclusion

The 2025 Adult Inpatient Survey provides positive assurance that patients continue to report strong overall experience at MFT, with high scores for respect and dignity (9.3), kindness and compassion (9.2) and core fundamentals such as privacy and hydration (both 9.5). Overall experience improved to 8.3 and remained above the national average, with 50 of 51 questions rated about the same as other Trusts and one discharge question rated somewhat better than expected. The key priorities are to sustain relational care strengths while accelerating improvement in individual needs, virtual ward communication, discharge reliability, medicines information and site-level variation through Clinical Group action plans and Patient Experience Oversight Group monitoring.

Appendix 1: Trust and Site Results



Figure key:

- Green = Increase in score compared with the previous year
- Red = Decrease in score compared with the previous year
- Blue = No change in score compared with the previous year

		MRI	NMGH	WYTH	NA	MFT 2023	MFT 2024	MFT 2025
Section 1: Admission to hospital (Section score = 7.4 – About the same)								
Q2	How did you feel about the length of time you were on the waiting list before your admission to hospital?	7.3	-	7.7	6.9	6.9	7.5	7.3
Q4.	How would you rate the quality of information you were given, while you were on the waiting list to be admitted to hospital?	7.8	-	8.6	7.6	7.7	8.0	8.0
Q5.	How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	7.1	6.5	6.8	6.8	6.7	6.4	6.9
Section 2: The hospital and ward (Section score = 7.6 – About the same)								
Q7_1.	Were you ever prevented from sleeping at night by noise from other patients?	6.9	5.4	6.5	6.6	6.6	6.9	6.6
Q7_2.	Were you ever prevented from sleeping at night by noise from staff?	8.8	7.9	8.6	8.4	8.1	8.4	8.5
Q7_4.	Were you ever prevented from sleeping at night by hospital lighting?	8.7	8.0	8.6	8.4	8.4	8.6	8.6
Q7_6.	Were you ever prevented from sleeping at night by the room temperature?	8.7	9.1	9.2	9.1	9.0	9.0	9.1
Q7_8.	Were you ever prevented from sleeping at night by any of the following? I was not prevented from sleeping	4.3	2.5	3.9	3.9	3.9	4.0	4.0
Q8.	How clean was the hospital room or ward that you were in?	9.0	9.0	9.0	8.9	8.6	8.7	9.0
Section 3: Basic needs (Section score = 8.1 – About the same)								
Q9.	Did you get enough help from staff to wash or keep yourself clean?	7.8	6.1	8.2	8.2	6.4	7.9	8.0
Q10.	If you brought medication with you to hospital, were you able to take it when you needed to?	8.0	8.0	8.2	8.2	7.6	7.6	8.3
Q11.	Did you get enough help from staff to eat your meals?	7.8	-	8.4	8.1	6.5	7.9	8.4
Q12.	Were you able to get hospital food outside of set mealtimes?	6.4	-	6.6	6.5	4.9	5.7	6.4
Q13.	During your time in hospital, did you get enough to drink?	9.4	9.4	9.6	9.4	9.1	9.3	9.5
Section 4: Doctors (Section score = 8.9 – About the same)								
Q14.	When you asked doctors questions, did you get answers you could understand?	8.8	8.3	8.9	8.7	8.6	9.1	8.8
Q15.	Did you have confidence and trust in the doctors treating you?	9.2	8.9	9.5	9.1	8.9	9.4	9.3

Q16.	When doctors spoke about your care in front of you, were you included in the conversation?	8.5	8.7	8.9	8.8	8.7	9.0	8.7
Section 5: Nurses (Section score = 8.5 – About the same)								
Q17.	When you asked nurses questions, did you get answers you could understand?	8.7	8.5	8.5	8.7	8.3	8.5	8.5
Q18.	Did you have confidence and trust in the nurses treating you?	8.9	8.2	9.3	9.0	8.5	8.8	9.0
Q19.	When nurses spoke about your care in front of you, were you included in the conversation?	8.8	7.6	8.7	8.8	8.5	8.7	8.7
Q20.	In your opinion, were there enough nurses on duty to care for you in hospital?	7.7	7.6	7.5	7.6	7.1	7.3	7.7
Section 6: Your care and treatment (Section score = 8.4 – About the same)								
Q21.	Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?	8.3	6.8	8.3	7.8	7.4	8.1	8.1
Q22.	To what extent did staff looking after you involve you in decisions about your care and treatment?	7.3	5.9	7.4	7.3	6.9	7.3	7.2
Q23.	How much information about your condition or treatment was given to you?	8.9	8.5	8.9	8.9	8.6	9.0	8.9
Q24.	Did you feel able to talk to members of hospital staff about your worries and fears?	8.3	8.0	7.2	7.8	7.4	7.7	7.9
Q25.	Were you given enough privacy when being examined or treated?	9.4	9.6	9.5	9.5	9.5	9.5	9.5
Q26.	Do you think the hospital staff did everything they could to help control your pain?	8.7	8.4	8.8	8.8	8.5	8.7	8.8
Q27.	Were you able to get a member of staff to help you when you needed attention?	8.3	7.7	8.4	8.3	7.9	7.9	8.3
Section 7: Individual needs (Section score = 7.2 – About the same)								
Q28_1.	Thinking about your care and treatment, did hospital staff take into account the following individual needs? Language needs (e.g. translation, braille)	-	-	-	8.3	-	-	7.6
Q28_2.	Thinking about your care and treatment, did hospital staff take into account the following individual needs? Cultural needs (e.g. same gender staff)	-	-	-	8.1	-	-	7.2
Q28_3.	Thinking about your care and treatment, did hospital staff take into account the following individual needs? Religious needs (e.g. space to pray / meditate)	-	-	-	7.9	-	-	7.6
Q28_4.	Thinking about your care and treatment, did hospital staff take into account the following individual needs? Accessibility needs (e.g. mobility needs, room adaptations)	7.5	-	8.3	8.5	-	8.0	8.0
Q28_5.	Thinking about your care and treatment, did hospital staff take into account the following individual needs? Dietary needs (e.g. medical, allergy, vegan)	7.2	-	7.8	7.9	-	7.1	7.4

Q28_6.	Thinking about your care and treatment, did hospital staff take into account the following individual needs? Mental health needs (e.g. a quiet space, emotional support)	5.8	-	5.5	6.3	-	-	5.5
Section 8: Virtual wards (Section score = 7.0 – About the same)								
Q30.	Before being admitted onto a virtual ward, did hospital staff give you information about the risks and benefits of continuing your treatment on a virtual ward?	-	-	-	6.8	-	7.5	6.5
Q31.	Were you given enough information about the care and treatment you would receive while on a virtual ward?	-	-	-	7.3	7.6	8.2	7.6
Section 9: Leaving Hospital (Section score = 7.2 – About the same)								
Q32.	To what extent did staff involve you in decisions about leaving the hospital?	7.3	6.0	6.9	6.7	6.5	6.8	7.0
Q33.	To what extent did hospital staff involve your family or carers in discussions about you leaving the hospital?	6.1	5.6	6.2	5.8	5.6	5.6	6.1
Q34.	Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	7.9	8.0	8.9	8.3	7.9	7.9	8.7
Q35.	Were you given enough notice about when you were going to leave hospital?	7.1	6.9	7.1	6.9	6.8	7.1	7.1
Q36.	Before you left the hospital, were you given any information about what you should or should not do after leaving the hospital?	8.2	6.5	8.3	7.9	7.5	8.1	8.0
Q37.	To what extent did you understand the information you were given about what you should or should not do after leaving the hospital?	9.1	9.0	9.2	9.0	8.8	9.2	9.1
Q38.	Before you left the hospital, were your family or carers given the information they needed to care for you at home?	6.7	5.0	6.4	6.3	-	-	6.3
Q39.	Thinking about any medicine you were to take at home, were you given any of the following?	4.2	3.1	4.3	4.5	4.2	4.6	4.1
Q40.	Before you left the hospital, did you know what would happen next with your care?	7.0	6.0	6.9	6.7	6.5	6.8	6.8
Q41.	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.6	6.7	8.3	7.7	7.1	7.6	7.9
Q42.	Did hospital staff discuss with you whether you may need any further health or social care services after leaving the hospital?	8.6	7.5	8.7	8.0	6.5	6.6	8.6
Q43.	After leaving the hospital, did you get enough support from health or social care services to help you recover or manage your condition?	6.5	6.1	7.3	6.3	-	-	6.7
Section 10: Kindness and compassion (Section score 9.2 – About the same)								
Q44.	Overall, did you feel you were treated with kindness and compassion while you were in the hospital?	9.2	8.3	9.2	9.0	8.8	9.0	9.2

Section 11: Respect & Dignity (Section score 9.3 – About the same)								
Q45.	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.4	8.7	9.2	9.1	9.0	9.1	9.3
Section 12: Overall experience (Section score 8.3 – About the same)								
Q46.	Overall, how was your experience while you were in the hospital?	8.3	7.6	8.4	8.2	8.0	8.2	8.3

Appendix 2: Section results analysis

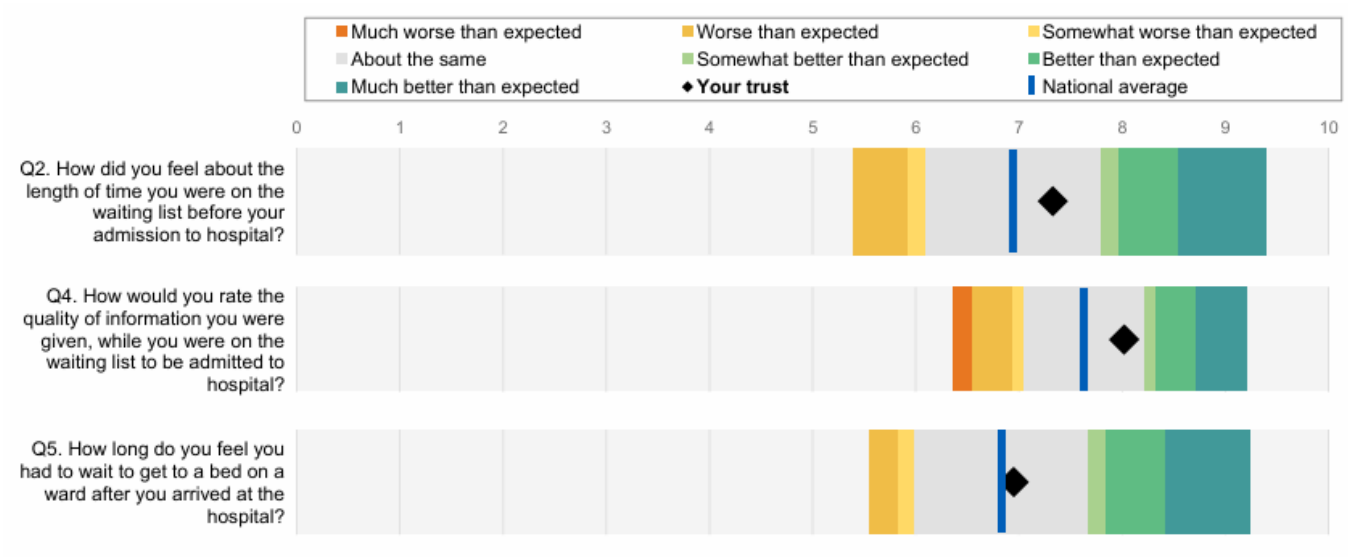
1. Section 1: Admission to hospital

1.1 Section overview and results

Section 1 focuses on patients' experience of being admitted to hospital, including the time spent on the waiting list before admission, the quality of information provided while waiting, and the length of time patients waited to get to a bed on a ward after arriving at hospital. MFT achieved an **overall section score of 7.4**, which was rated as about the same as other NHS Trusts nationally. This indicates stable performance, with patient experience broadly aligned to the national benchmark.

MFT scored above the national average for all three questions in this section (Chart A), providing positive assurance that admission-related experience is comparatively strong, while also highlighting that waiting to access a ward bed remains the lowest-scoring element within the section.

Chart A: Question scores for Admission to hospital



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same: 131	7.3	6.9	5.4	9.4
About the same: 136	8.0	7.6	6.4	9.2
About the same: 362	6.9	6.8	5.5	9.2

1.2 Trend data: comparisons over time

Section 1 showed an improvement compared with 2024, increasing from 6.9 to 7.4, representing a positive year-on-year change of +0.5. This is one of the more notable section-level improvements in the 2025 survey results. The improvement was driven primarily by better scores for waiting to get to a bed on a ward after arrival at hospital, which increased from 6.4 in 2024 to 6.9 in 2025. The score for quality of information

while on the waiting list remained stable at 8.0, while the rating for length of time on the waiting list reduced slightly from 7.5 in 2024 to 7.3 in 2025.

Overall, trend data suggests that patients reported a more positive experience of admission in 2025. However, the slight reduction in patients' views about waiting list length should continue to be monitored alongside operational indicators and local patient feedback, as this remains an important determinant of pre-admission experience.

1.3 MFT site-level comparison

Appendix 1 details Section 1 scores across MFT sites. Site-level analysis shows variation across sites. Wythenshawe Hospital performed most strongly for the quality of information provided while patients were on the waiting list, scoring 8.6, and also achieved the highest score for views about waiting list length at 7.7. MRI also performed above the national average for these waiting-list measures, scoring 7.3 for waiting list length and 7.8 for waiting list information. Site-level data for NMGH was not available for the two waiting-list questions due to suppressed data (sample size responses ≤ 30).

For waiting to get to a bed on a ward after arrival at hospital, MRI achieved the highest site score at 7.1, followed by Wythenshawe at 6.8 and NMGH at 6.5.

1.4 Comparison to other Trusts

In comparison with other Trusts nationally, MFT's Section 1 score of 7.4 was rated as about the same, indicating performance within the expected range. Regionally, MFT performed better than several North West Trusts, including Bolton NHS Foundation Trust (6.2), East Cheshire NHS Trust (6.6), North Cheshire and Mersey NHS Foundation Trust (6.7), Mid Cheshire Hospitals NHS Foundation Trust (6.7) and Northern Care Alliance NHS Foundation Trust (6.7). Specialist providers recorded the highest regional scores for this section, including The Christie NHS Foundation Trust (8.9), The Clatterbridge Cancer Centre NHS Foundation Trust (8.9) and Liverpool Heart and Chest Hospital NHS Foundation Trust (8.8).

Overall, the comparative data provides assurance that MFT's admission experience is broadly in line with peer performance and above a number of regional acute Trusts. The continued opportunity is to build on the improvement in ward-bed access following arrival, maintain the comparatively positive position for waiting-list information, and use site-level learning from stronger-performing areas to reduce variation across MFT.

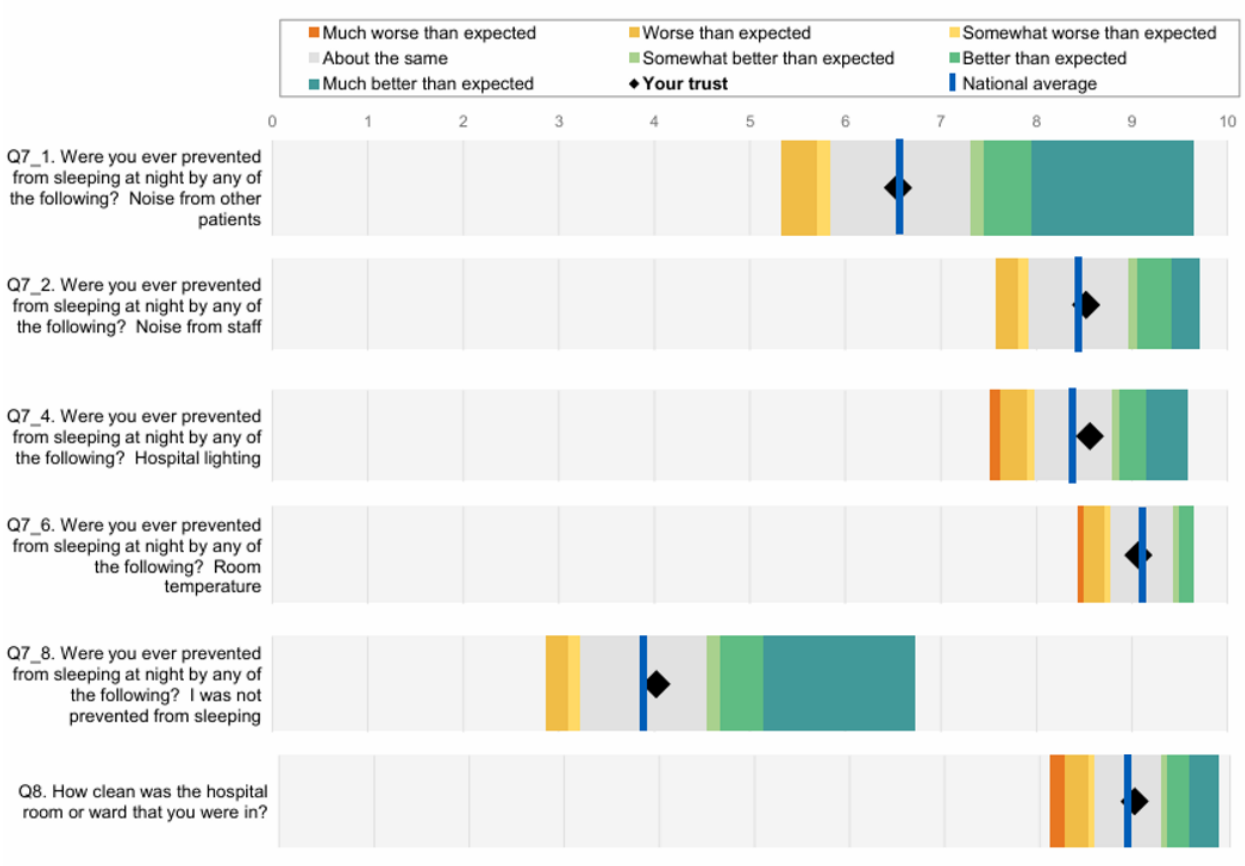
2. Section 2: The hospital and ward

2.1 Section overview and results

Section 2 focuses on patients' experience of the hospital and ward environment, including factors that affect rest, comfort and cleanliness during an inpatient stay. MFT achieved an **overall section score of 7.6**, which was rated as about the same as other NHS Trusts nationally. This indicates that the overall ward environment experience remains broadly aligned with national expectations.

MFT scored at or above the national average for most questions in this section (Chart B). Patients rated cleanliness highly at 9.0, above the national average of 8.9, and reported positive experiences of night-time lighting, room temperature and noise from staff. The lowest score related to whether patients were prevented from sleeping at night, where MFT scored 4.0 compared with a national average of 3.9. Although this was broadly in line with national performance, it remains the clearest opportunity for improvement within the section.

Chart B: Question scores for The hospital and ward



			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	370	6.6	6.6	5.3	9.6
About the same	370	8.5	8.4	7.6	9.7
About the same	370	8.6	8.4	7.5	9.6
About the same	370	9.1	9.1	8.4	9.7
About the same	370	4.0	3.9	2.9	6.7
About the same	376	9.0	8.9	8.1	9.9

2.2 Trend data: comparisons over time

Section 2 improved from 7.4 in 2024 to 7.6 in 2025, representing a positive year-on-year change of +0.2. The most notable improvement was cleanliness, which increased from 8.7 in 2024 to 9.0 in 2025 and was one of the three statistically significant improvements across the survey.

The main reduction within this section related to noise from other patients at night, which decreased from 6.9 in 2024 to 6.6 in 2025. Although this remains rated as about the same as other Trusts nationally, it highlights an area where ward-based improvement activity could support better rest and recovery. Overall, the trend data suggests a positive direction of travel for the ward environment, with continued opportunities to reduce avoidable sleep disruption.

2.3 MFT site-level comparison

Appendix 1 details Section 2 scores across MFT sites. Site-level results show broadly consistent performance across MRI, NMGH and Wythenshawe for cleanliness, with all three sites scoring 9.0. MRI performed most strongly for noise from other patients at night, scoring 6.9, compared with 6.5 at Wythenshawe and 5.4 at NMGH. For noise from staff at night, MRI scored 8.8, Wythenshawe 8.6 and NMGH 7.9. Room temperature at night was rated highly (negative) across sites, with Wythenshawe scoring 9.2, NMGH 9.1 and MRI 8.7. The lowest site-level score in this section related to patients not being prevented from sleeping, where NMGH scored 2.5 compared with MRI at 4.3 and Wythenshawe at 3.9. These findings suggest that while the overall ward environment is broadly positive, reducing sleep disruption should remain a focus.

2.4 Comparison to other Trusts

In comparison with other Trusts nationally, MFT's Section 2 score of 7.6 was rated as about the same, indicating performance within the expected range. Regionally, MFT performed better than several North West Trusts, including Lancashire Teaching Hospitals NHS Foundation Trust (7.1), East Cheshire NHS Trust (7.2), Tameside and Glossop Integrated Care NHS Foundation Trust (7.3), East Lancashire Hospitals NHS Trust (7.3) and Mid Cheshire Hospitals NHS Foundation Trust (7.4).

Specialist providers recorded the highest regional scores for this section, including The Clatterbridge Cancer Centre NHS Foundation Trust (9.1), Liverpool Heart and Chest Hospital NHS Foundation Trust (8.4), Liverpool Women's NHS Foundation Trust (8.3) and The Christie NHS Foundation Trust (8.1). Overall, the comparative data provides assurance that MFT's hospital and ward environment is broadly in line with national and regional peers, with improvement opportunities focused on sleep disruption, particularly noise from other patients and local site variation.

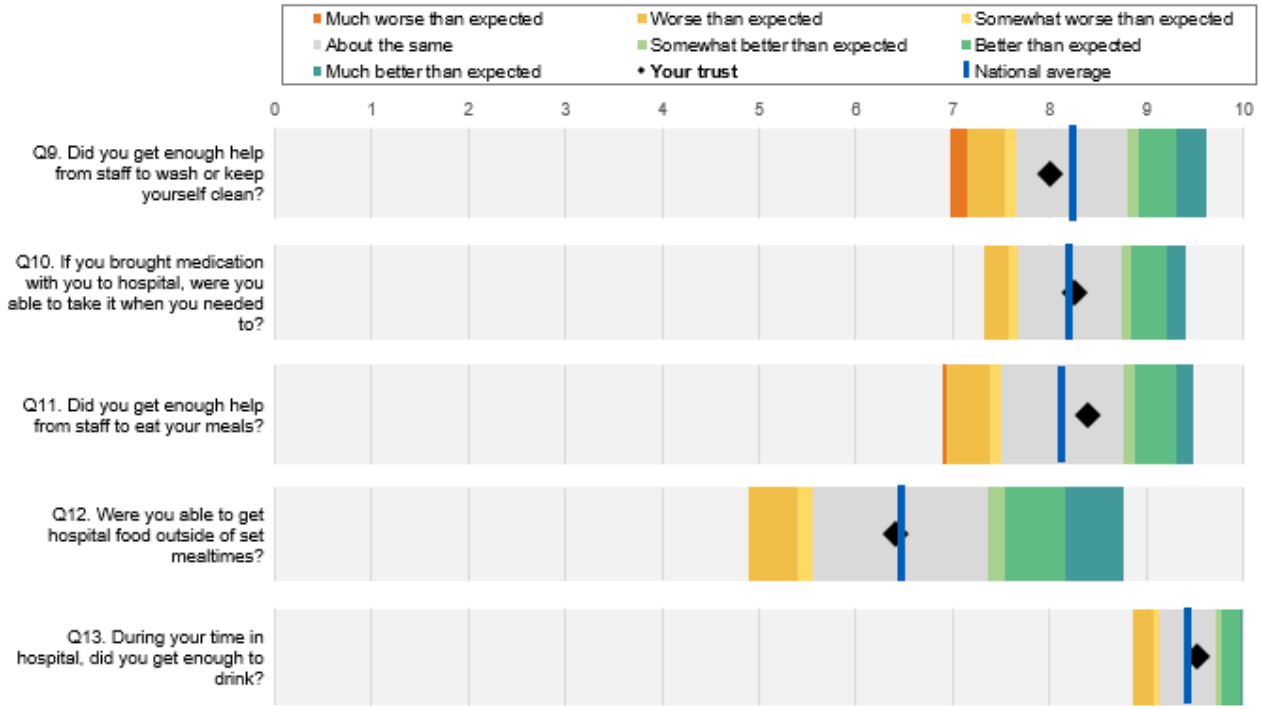
3. Section 3: Basic needs

3.1 Section overview and results

Section 3 focuses on patients' basic needs during their inpatient stay, including support with washing, eating, access to food and drink, and the ability to take their own medication when needed. MFT achieved an **overall section score of 8.1**, which was rated as about the same as other NHS Trusts nationally. This provides assurance that performance in relation to basic care needs remains broadly in line with national expectations.

MFT scored above the national average for support with eating meals and access to drinks during the hospital stay (Chart C). The highest-scoring question in this section was whether patients had enough to drink, where MFT scored 9.5 compared with a national average of 9.4. Patients also reported improved support to eat meals, with MFT scoring 8.4 compared with a national average of 8.1. The lowest score related to access to food outside set mealtimes, where MFT scored 6.4 compared with a national average of 6.5. Although this was rated as about the same nationally, it remains the clearest opportunity for improvement within this section.

Chart C: Question scores for Basic needs



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same				
258	8.0	8.2	7.0	9.6
About the same				
186	8.3	8.2	7.3	9.4
About the same				
126	8.4	8.1	6.9	9.5
About the same				
159	6.4	6.5	4.9	8.8
About the same				
354	9.5	9.4	8.9	10.0

3.2 Trend data: comparisons over time

Section 3 improved from 7.7 in 2024 to 8.1 in 2025, representing a positive year-on-year change of +0.4. Improvements were seen across all comparable questions in this section, including help to wash or keep clean, taking own medication when needed, help to eat meals, food outside set mealtimes and enough to drink. This represents a positive direction of travel for a core aspect of inpatient care.

The most notable improvements were for taking own medication when needed and access to food outside set mealtimes, both increasing by +0.7 compared with 2024. Help from staff to eat meals also increased by +0.5. These findings suggest that Trust improvement activity focused on nutrition, hydration and personalised support is reflected in more positive patient-reported experience.

3.3 MFT site-level comparison

Appendix 1 details Section 3 scores across MFT sites. Site-level results show Wythenshawe performing most strongly for several basic needs measures, including help to wash or keep clean, help to eat meals and enough to drink. MRI and Wythenshawe both scored positively for patients being able to take their own medication when needed, while NMGH showed greater variation across the available measures.

The lowest site-level score in this section related to help from staff to wash or keep clean at NMGH, which scored 6.1 compared with 7.8 at MRI and 8.2 at Wythenshawe. For food outside set mealtimes, available site-level scores were 6.4 at MRI and 6.6 at Wythenshawe, with NMGH suppressed due to low response numbers. These results indicate that while basic needs performance has improved overall, there remains scope to reduce variation and strengthen consistency of support across sites.

3.4 Comparison to other Trusts

In comparison with other Trusts nationally, MFT's Section 3 score of 8.1 was rated as about the same, indicating performance within the expected range. Regionally, MFT performed better than several North West Trusts, including Tameside and Glossop Integrated Care NHS Foundation Trust (7.6), East Lancashire Hospitals NHS Trust (7.7), Liverpool University Hospitals NHS Foundation Trust (7.7), Lancashire Teaching Hospitals NHS Foundation Trust (7.8) and Mid Cheshire Hospitals NHS Foundation Trust (7.8).

Similar to other section results, specialist providers recorded the highest regional, including The Christie NHS Foundation Trust (9.1), The Clatterbridge Cancer Centre NHS Foundation Trust (9.0), Liverpool Heart and Chest Hospital NHS Foundation Trust (9.0), The Walton Centre NHS Foundation Trust (8.6) and Liverpool Women's NHS Foundation Trust (8.5).

4. Section 4: Doctors

4.1 Section overview and results

Section 4 focuses on patients' experience of doctors during their inpatient stay, including whether doctors answered questions clearly, whether patients had confidence and trust in the doctors treating them, and whether patients felt included when doctors spoke about their care. MFT achieved an **overall section score of 8.9**, which was rated as about the same as other NHS Trusts nationally. This indicates that patients' experience of medical communication and confidence in doctors remains broadly aligned with national expectations.

MFT scored above the national average for patients having confidence and trust in doctors, achieving 9.3 compared with a national average of 9.1 (Chart D). The Trust also scored slightly above the national average for doctors answering questions clearly, with a score of 8.8 compared with 8.7 nationally. The lowest question score in this section related to patients being included when doctors spoke about their care, where MFT scored 8.7 compared with a national average of 8.8. Although all three questions were rated as about the same nationally, the results highlight an opportunity to strengthen consistency of patient involvement during medical discussions.

Chart D: Question scores for Doctors



	All trusts in England				
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	346	8.8	8.7	8.0	9.5
About the same	373	9.3	9.1	8.6	9.8
About the same	371	8.7	8.8	8.1	9.7

4.2 Trend data: comparisons over time

Section 4 reduced from 9.1 in 2024 to 8.9 in 2025, representing a year-on-year change of -0.2. This was driven by small reductions across all three questions in the section. Doctors answering questions clearly reduced from 9.1 to 8.8, confidence and trust in doctors reduced from 9.4 to 9.3, and patients being included when doctors spoke about their care reduced from 9.0 to 8.7. Despite these reductions, all question scores remained high and continued to be rated as about the same as other Trusts nationally. The results indicate that patient confidence in doctors remains a relative strength, while continued focus is needed on clear communication, active involvement and ensuring that patients feel included in conversations about their care.

4.3 MFT site-level comparison

Appendix 1 details Section 4 scores across MFT sites. Site-level results show Wythenshawe performing most strongly overall for doctors, including a score of 9.5 for confidence and trust in doctors and 8.9 for doctors answering questions clearly. MRI also scored highly for confidence and trust in doctors at 9.2, while NMGH scored 8.9. For patients being included when doctors spoke about their care, Wythenshawe scored 8.9, NMGH 8.7 and MRI 8.5. These site-level results indicate generally positive and consistent experience across sites.

4.4 Comparison to other Trusts

In comparison with other Trusts nationally, MFT's Section 4 score of 8.9 was rated as about the same, indicating performance within the expected range. Regionally, MFT performed better than several North West Trusts, including Tameside and Glossop Integrated Care NHS Foundation Trust (8.5), North Cheshire and Mersey NHS Foundation Trust (8.6), Lancashire Teaching Hospitals NHS Foundation Trust (8.6), East Lancashire Hospitals NHS Trust (8.7) and Mid Cheshire Hospitals NHS Foundation Trust (8.7). Specialist providers recorded the highest regional scores for this section, including The Christie NHS Foundation Trust (9.6), The Clatterbridge Cancer Centre NHS Foundation Trust (9.6), Liverpool Heart and Chest Hospital NHS Foundation Trust (9.5), The Walton Centre NHS Foundation Trust (9.1) and Liverpool Women's NHS Foundation Trust (9.1). Overall, the comparative data provides assurance that MFT's experience of doctors is broadly in line with national and regional peers, with improvement opportunities focused on maintaining high levels of trust while strengthening patient inclusion in conversations about care.

5. Section 5: Nurses

5.1 Section overview and results

Section 5 focuses on patients' experience of nursing care during their inpatient stay. MFT achieved an **overall section score of 8.5**, which was rated as about the same as other NHS Trusts nationally. This indicates that patients' experience of nursing care remains broadly aligned with national expectations. MFT scored at or above the national average for confidence and trust in nurses and perceptions of nurse staffing (Chart E). Patients rated confidence and trust in nurses at 9.0, in line with the national average, and rated enough nurses on duty at 7.7 compared with a national average of 7.6. The lowest score in this section related to nurses answering questions clearly, where MFT scored 8.5 compared with a national average of 8.7.

Chart E: Question scores for Nurses



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same: 355	8.5	8.7	8.0	9.6
About the same: 376	9.0	9.0	8.3	9.7
About the same: 370	8.7	8.8	7.9	9.7
About the same: 373	7.7	7.6	6.7	9.3

5.2 Trend data: comparisons over time

Section 5 improved from 8.3 in 2024 to 8.5 in 2025, representing a positive year-on-year change of +0.2. Improvements were seen in confidence and trust in nurses, which increased from 8.8 to 9.0, and perceptions of there being enough nurses on duty, which increased from 7.3 to 7.7. Nurses answering questions clearly remained stable at 8.5. Overall, the trend data suggests a positive direction of travel for nursing care and provides assurance that patients continue to report high levels of confidence in nursing colleagues. The improvement in perceptions of staffing is particularly important, as this is likely to influence patients' experience of timely support, communication and responsiveness during their stay.

5.3 MFT site-level comparison

Appendix 1 details Section 5 scores across MFT sites. Site-level results show Wythenshawe performing most strongly for confidence and trust in nurses, scoring 9.3 compared with 8.9 at MRI and 8.2 at NMGH. MRI achieved the highest score for nurses answering questions clearly at 8.7, compared with 8.5 at both NMGH and Wythenshawe. For patients being included when nurses spoke about their care, MRI scored 8.8, Wythenshawe 8.7 and NMGH 7.6. Perceptions of having enough nurses on duty were broadly consistent across sites, with MRI scoring 7.7, NMGH 7.6 and Wythenshawe 7.5. These results indicate generally positive nursing experience across sites, with an opportunity to reduce variation in patients feeling included in conversations about their care, particularly where site-level scores are lower.

5.4 Comparison to other Trusts

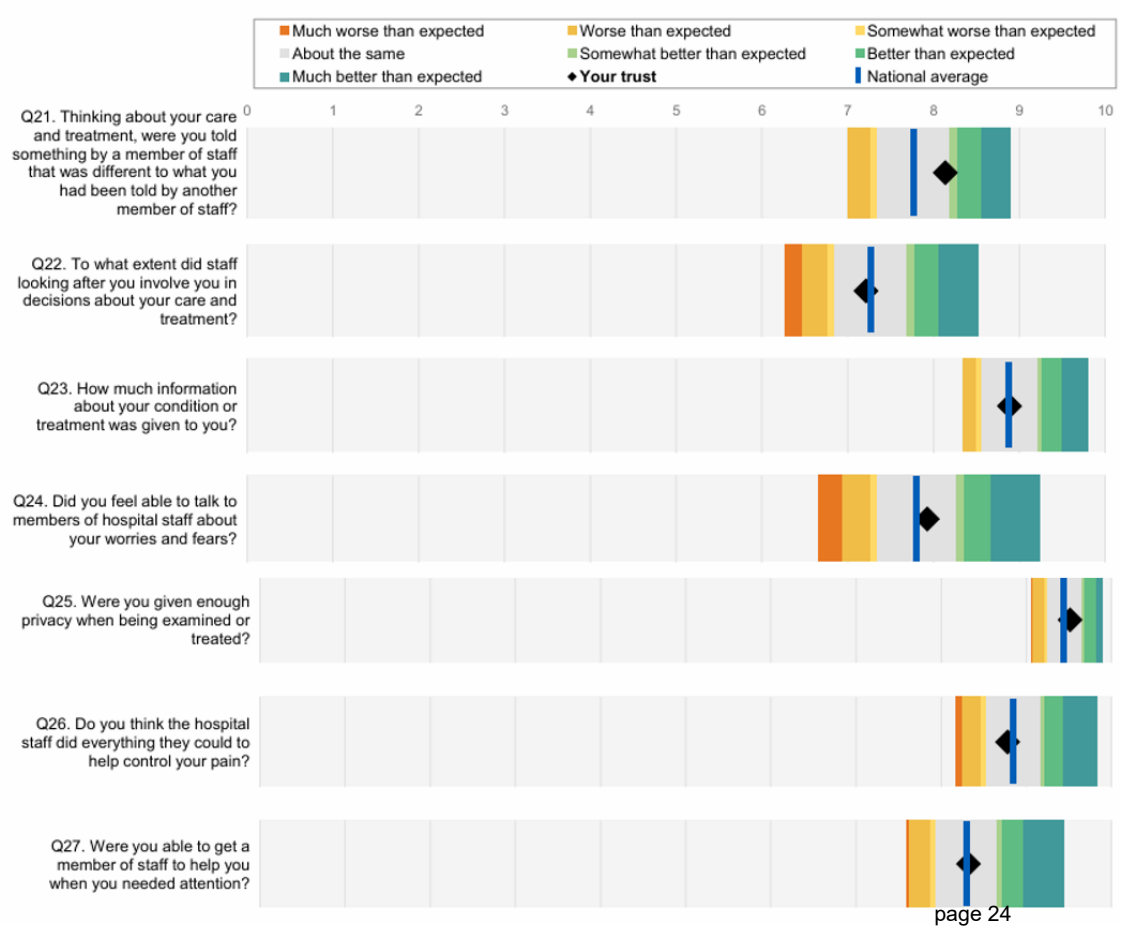
In comparison with other Trusts nationally, MFT's Section 5 score of 8.5 was rated as about the same, indicating performance within the expected range. Regionally, MFT performed better than several North West Trusts, including Lancashire Teaching Hospitals NHS Foundation Trust (8.3), Tameside and Glossop Integrated Care NHS Foundation Trust (8.3), Mid Cheshire Hospitals NHS Foundation Trust (8.3), Bolton NHS Foundation Trust (8.3) and Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (8.3). Specialist providers recorded the highest regional scores for this section, including The Clatterbridge Cancer Centre NHS Foundation Trust (9.3), Liverpool Heart and Chest Hospital NHS Foundation Trust (9.3), The Christie NHS Foundation Trust (9.2), Liverpool Women's NHS Foundation Trust (8.8) and University Hospitals of Morecambe Bay NHS Foundation Trust (8.8). Overall, the comparative data provides assurance that MFT's nursing care is broadly in line with national and regional peers, with improvement opportunities focused on communication, inclusion in care conversations and continued attention to staffing-related experience.

6. Section 6: Your care and treatment

6.1 Section overview and results

Section 6 focuses on patients' experience of care and treatment during their inpatient stay, including communication, involvement in decisions, information about condition or treatment, privacy, pain control and the ability to access staff help when needed (Chart F). MFT achieved an **overall section score of 8.4**, which was rated as about the same as other NHS Trusts nationally. The highest question scores related to privacy when examined or treated, where MFT scored 9.5, and information about condition or treatment and pain control, both of which were in line with national averages. The lowest score related to involvement in decisions about care and treatment, where MFT scored 7.2 compared with a national average of 7.3. Although all questions in this section were rated as about the same nationally, the results highlight opportunities to further strengthen shared decision-making, consistency of information and responsiveness to patient concerns.

Chart F: Question scores for Your care and treatment



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	344	8.1	7.8	7.0	8.9
About the same	367	7.2	7.3	6.3	8.5
About the same	371	8.9	8.9	8.3	9.8
About the same	322	7.9	7.8	6.7	9.2
About the same	366	9.5	9.5	9.1	9.9
About the same	317	8.8	8.8	8.2	9.8
About the same	334	8.3	8.3	7.6	9.4

6.2 Trend data: comparisons over time

Section 6 improved from 8.3 in 2024 to 8.4 in 2025, representing a positive year-on-year change of +0.1. Improvements were reported for patients being able to talk to staff about worries and fears, pain control, and being able to get staff help when attention was needed. The improvement in access to staff help was statistically significant, increasing from 7.9 in 2024 to 8.3 in 2025.

Small reductions were seen for involvement in decisions about care and treatment and information about condition or treatment. Overall, the trend data suggests stable and slightly improved performance, with the clearest improvement opportunity focused on ensuring that patients are consistently involved in decisions and receive clear, joined-up information throughout their care.

6.3 MFT site-level comparison

Appendix 1 details Section 6 scores across MFT sites. Site-level results show generally positive performance across MRI, NMGH and Wythenshawe, with particularly strong scores for privacy when examined or treated and pain control. Wythenshawe achieved the highest score for being able to get staff help when needed at 8.4, followed by MRI at 8.3 and NMGH at 7.7. MRI scored most strongly for being able to talk to staff about worries and fears, at 8.3, compared with 8.0 at NMGH and 7.2 at Wythenshawe. The lowest site-level score in this section related to involvement in decisions about care and treatment at NMGH, which scored 5.9 compared with 7.3 at MRI and 7.4 at Wythenshawe. These results suggest that whilst the overall care and treatment experience is positive, there is scope to reduce site-level variation in involvement, communication and responsiveness.

6.4 Comparison to other Trusts

In comparison with other Trusts nationally, MFT's Section 6 score of 8.4 was rated as about the same, indicating performance within the expected range. Regionally, MFT performed better than several North West Trusts, including Lancashire Teaching Hospitals NHS Foundation Trust (8.1), Tameside and Glossop Integrated Care NHS Foundation Trust (8.1), East Lancashire Hospitals NHS Trust (8.2), North Cheshire and Mersey NHS Foundation Trust (8.2) and Liverpool University Hospitals NHS Foundation Trust (8.2). Specialist providers recorded the highest regional scores for this section, including Liverpool Heart and Chest Hospital NHS Foundation Trust (9.2), The Clatterbridge Cancer Centre NHS Foundation Trust (9.1), The Christie NHS Foundation Trust (9.0), Liverpool Women's NHS Foundation Trust (8.7) and The Walton Centre NHS Foundation Trust (8.6). Overall, the comparative data provides assurance that MFT's care and treatment performance is broadly in line with national and regional peers, with improvement opportunities focused on involvement in decisions, consistency of communication and reducing site-level variation.

7. Section 7: Individual needs

7.1 Section overview and results

Section 7 focuses on whether patients felt that hospital staff took account of their individual needs during their care and treatment, including language, cultural, religious, accessibility, dietary and mental health needs (Chart G). MFT achieved an **overall section score of 7.2**, which was rated as about the same as other NHS Trusts nationally. This was one of the Trust's lower-scoring sections and highlights an important opportunity to strengthen personalised care, reasonable adjustments and the consistent identification of individual needs. MFT scored below the national average across each of the individual needs questions. The highest score related to accessibility needs, where MFT scored 8.0 compared with a national average of 8.5. Language needs and religious needs both scored 7.6, while dietary needs scored 7.4 and cultural needs scored 7.2. The lowest score related to mental health needs, where MFT scored 5.5 compared with a national average of 6.3. Although all questions were rated as about the same nationally, the results indicate that patients did not always feel their individual needs were identified, understood or supported consistently.

7.2 Trend data: comparisons over time

Section 7 individual needs questions were introduced in the 2025 Adult Inpatient Survey and therefore direct comparison with previous survey years is not available for most questions. The absence of trend data means that 2025 should be treated as a baseline position for monitoring personalised care, reasonable adjustments and support for specific individual needs in future survey cycles.

7.3 MFT site-level comparison

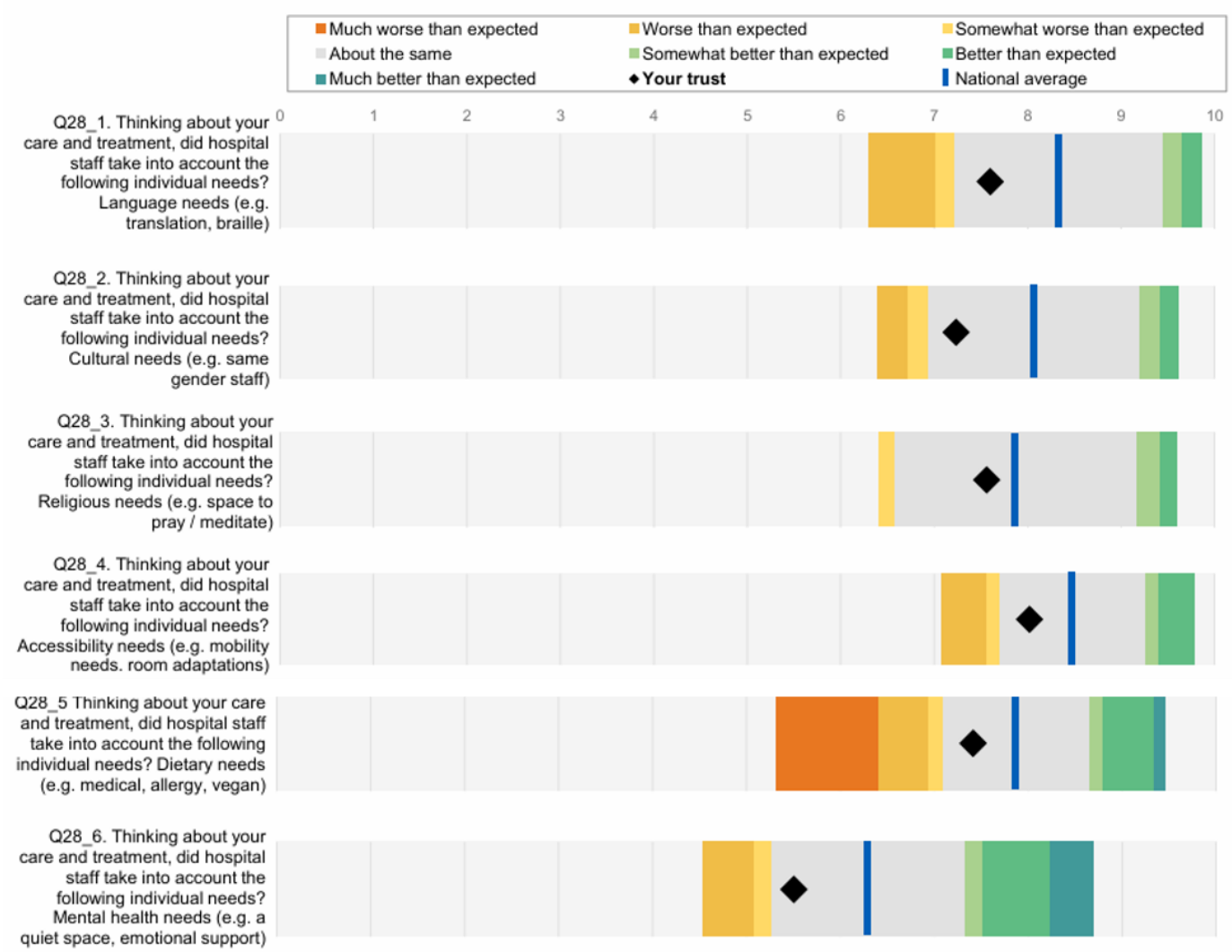
Appendix 1 details Section 7 scores across MFT sites. Site-level results are limited for some questions due to suppressed data where response numbers were low. Where site-level data is available, there is variation in reported experience, with Wythenshawe showing stronger results for accessibility and dietary needs, while MRI reported the highest score for language needs. Mental health needs remained the lowest-scoring individual needs measure, with available site-level data indicating this as an area requiring further exploration and targeted improvement.

7.4 Comparison to other Trusts

In comparison with other Trusts nationally, MFT's Section 7 score of 7.2 was rated as about the same, indicating performance within the expected range, despite all question scores being below the national average. Regionally, MFT's score was similar to Tameside and Glossop Integrated Care NHS Foundation Trust (7.2) and Liverpool University Hospitals NHS Foundation Trust (7.2), and below a number of other

North West Trusts. Specialist providers recorded the highest regional scores for this section, including Liverpool Heart and Chest Hospital NHS Foundation Trust (9.1), The Christie NHS Foundation Trust (8.9) and The Walton Centre NHS Foundation Trust (8.6). Overall, the comparative data highlights individual needs as a priority improvement area for MFT, particularly in relation to mental health needs, cultural needs and ensuring that reasonable adjustments are consistently identified, communicated and acted upon.

Chart G: Question scores for Individual needs



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same				
54	7.6	8.3	6.3	9.9
About the same				
59	7.2	8.1	6.4	9.6
About the same				
55	7.6	7.9	6.4	9.6
About the same				
100	8.0	8.5	7.1	9.8
About the same				
106	7.4	7.9	5.3	9.5
About the same				
86	5.5	6.3	4.5	8.7

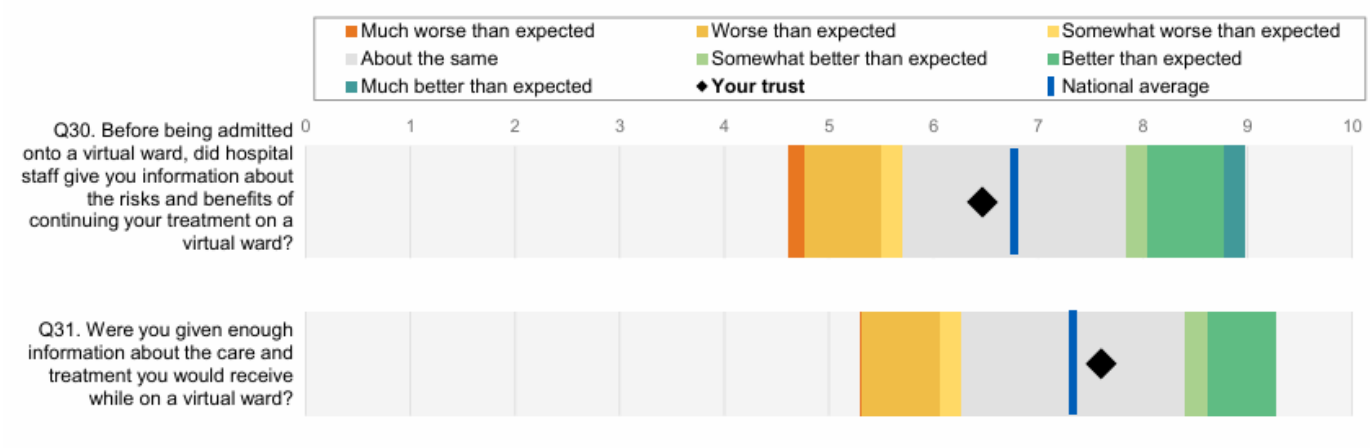
8. Section 8: Virtual wards

8.1 Section overview and results

Section 8 focuses on patients' experience of virtual wards, including whether patients received information about the risks and benefits of continuing treatment on a virtual ward and whether they were given enough information about the care and treatment they would receive (Chart H). MFT achieved an **overall section score of 7.0**, which was rated as about the same as other NHS Trusts nationally. This was the lowest-scoring section in the survey and therefore represents a clear priority area for further review and improvement.

MFT scored 6.5 for information about the risks and benefits of continuing treatment on a virtual ward, compared with a national average of 6.8. The Trust scored 7.6 for whether patients were given enough information about the care and treatment they would receive while on a virtual ward, compared with a national average of 7.3.

Chart H: Question scores for Virtual wards



	All trusts in England				
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	35	6.5	6.8	4.6	9.0
About the same	33	7.6	7.3	5.3	9.3

8.2 Trend data: comparisons over time

Section 8 reduced from 7.8 in 2024 to 7.0 in 2025, representing a year-on-year change of -0.8. Both virtual ward questions declined compared with the previous year. Information about the risks and benefits of continuing treatment on a virtual ward reduced from 7.5 to 6.5, while information about the care and treatment patients would receive on a virtual ward reduced from 8.2 to 7.6.

Although both questions remained rated as about the same as other Trusts nationally, the direction of travel indicates the need for focused review. Improvement work should consider how virtual ward discussions are introduced, how risks and benefits are explained, and whether patients and carers receive clear, consistent information before transfer onto a virtual ward.

8.3 MFT site-level comparison

Appendix 1 details Section 8 virtual ward scores. Site-level comparison is limited because response numbers were small and some site-level values were suppressed. Given the lower score and downward movement from 2024, site and service-level review should focus on the quality and consistency of patient preparation, consent discussions, information leaflets, escalation advice and follow-up arrangements. Particular attention should be given to ensuring that patients and carers understand what virtual ward care involves and who to contact if their condition changes.

8.4 Comparison to other Trusts

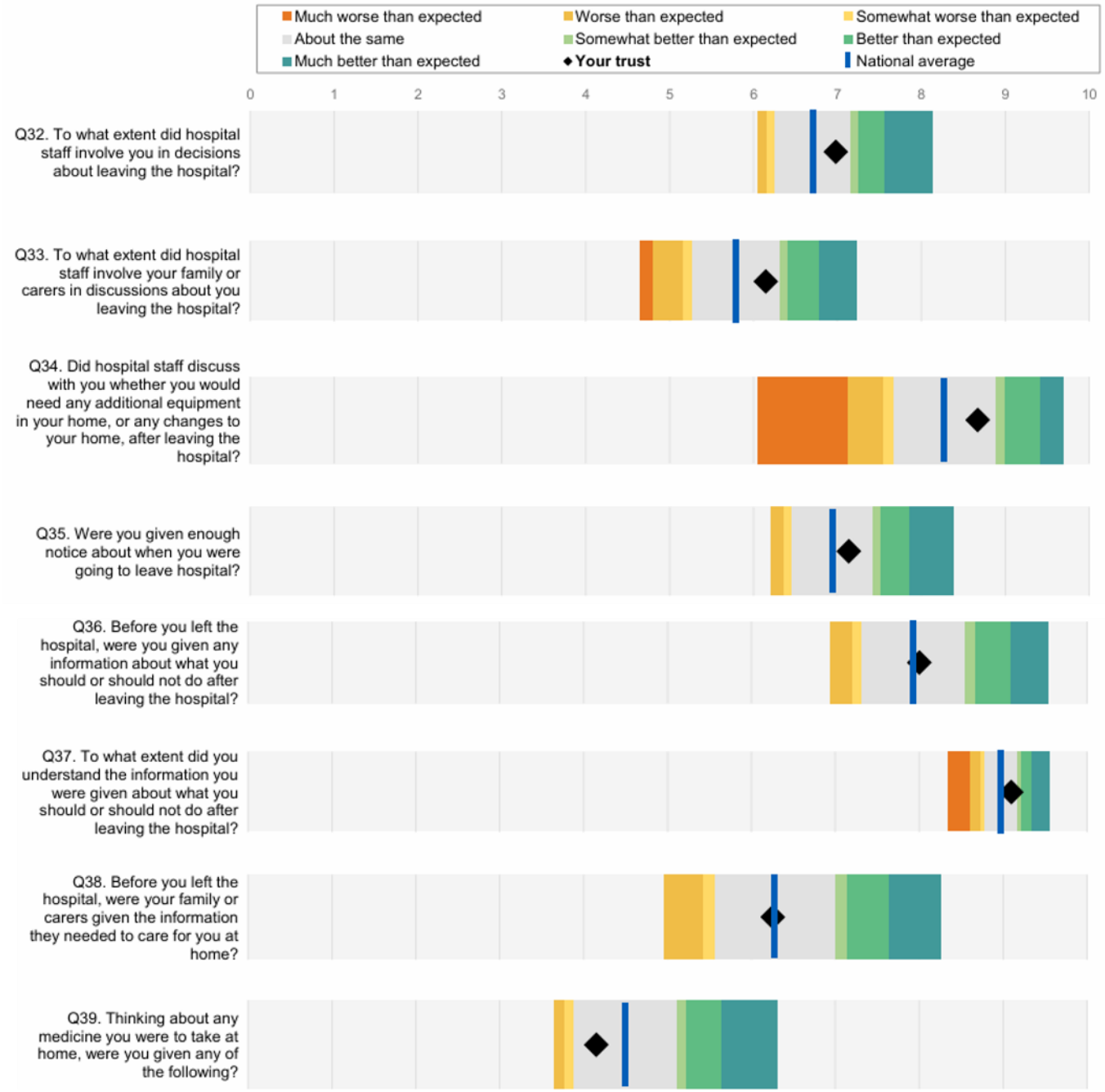
In comparison with other Trusts nationally, MFT's Section 8 score of 7.0 was rated as **about the same**, indicating performance within the expected range. Regionally, MFT performed above several North West Trusts, including Stockport NHS Foundation Trust (6.3), Lancashire Teaching Hospitals NHS Foundation Trust (6.4), North Cheshire and Mersey NHS Foundation Trust (6.6), Countess of Chester Hospital NHS Foundation Trust (6.6) and Northern Care Alliance NHS Foundation Trust (6.9).The highest regional scores for this section were recorded by Liverpool Heart and Chest Hospital NHS Foundation Trust (8.1), East Cheshire NHS Trust (7.8), East Lancashire Hospitals NHS Trust (7.7), Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (7.6) and Liverpool University Hospitals NHS Foundation Trust (7.3). Overall, the comparative data provides some assurance that MFT's virtual ward score remains within expected national variation, but the section remains MFT's lowest-scoring domain and has declined compared with 2024. This reinforces the need for targeted improvement in virtual ward communication, patient preparation, risk and benefit discussions, and support for patients receiving care outside the traditional ward environment.

9. Section 9: Leaving hospital

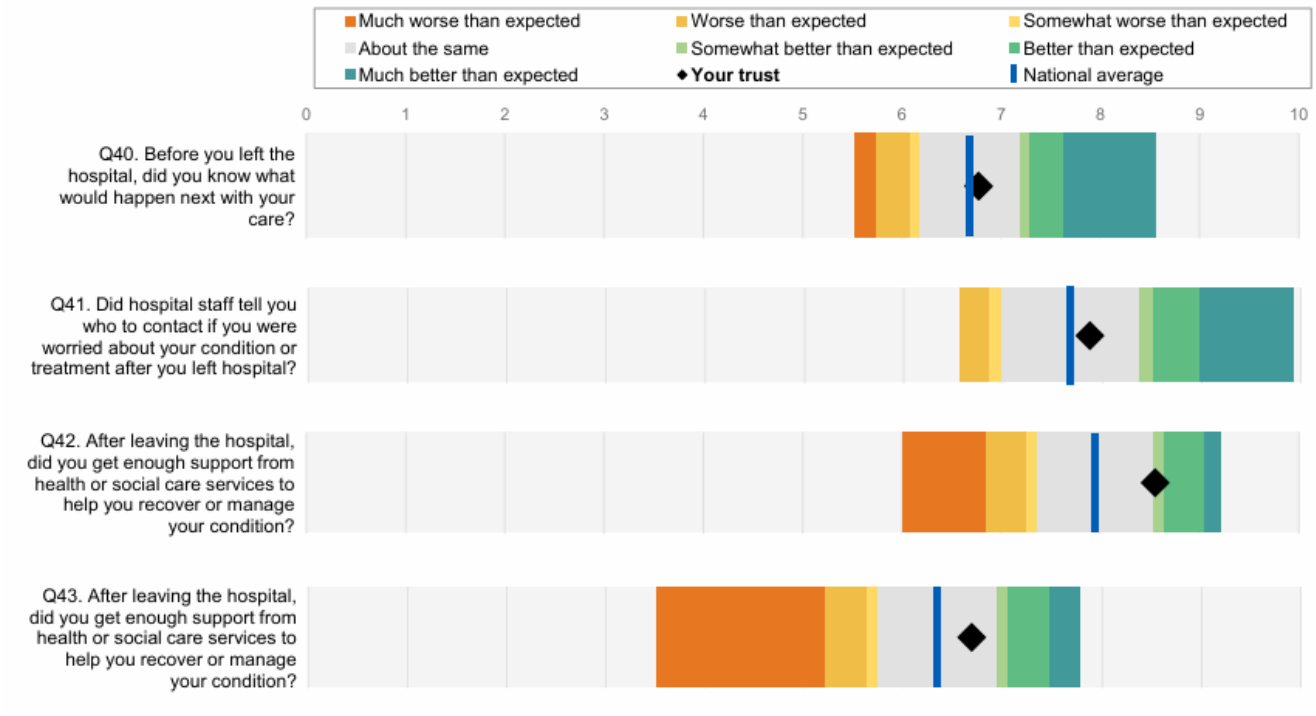
9.1 Section overview and results

Section 9 questions focuses on patients' experience of leaving hospital (Chart I). MFT achieved an **overall section score of 7.2**, which was rated as about the same as other NHS Trusts nationally. Although this section remains one of the Trust's lower-scoring domains, several discharge-related questions showed positive numerical movement compared with 2024 and one question was benchmarked somewhat better than expected. MFT's strongest result in this section related to patients understanding the information they were given about what they should or should not do after leaving hospital, which scored 9.1. MFT also scored 8.7 for whether equipment or home adaptations were discussed before discharge, and 8.6 for whether staff discussed the need for further health or social care services after discharge; this latter question was rated somewhat better than expected compared with other Trusts. The lowest score related to medicines information at discharge, at 4.1, followed by family or carer involvement and information, scoring 6.1 and 6.3 respectively. These findings indicate that whilst practical discharge planning and onward care discussions are areas of relative strength, further improvement is required in medicines communication, carer involvement and consistency of information for patients and families at the point of discharge.

Chart I: Question scores for Leaving hospital



		All trusts in England			
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	369	7.0	6.7	6.1	8.1
About the same	244	6.1	5.8	4.6	7.2
About the same	129	8.7	8.3	6.1	9.7
About the same	372	7.1	6.9	6.2	8.4
About the same	358	8.0	7.9	6.9	9.5
About the same	289	9.1	9.0	8.3	9.6
About the same	214	6.3	6.3	5.0	8.3
About the same	303	4.1	4.5	3.7	6.3



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	348	6.8	6.7	5.5	8.6
About the same	349	7.9	7.7	6.6	9.9
Somewhat better than expected	197	8.6	8.0	6.0	9.2
About the same	224	6.7	6.3	3.5	7.8

9.2 Trend data: comparisons over time

Section 9 improved from 7.1 in 2024 to 7.2 in 2025, representing a positive year-on-year change of +0.1. Several discharge-related questions showed numerical improvement, including involvement in decisions about leaving hospital, equipment or home changes being discussed, being told who to contact after leaving hospital, further health or social care services being discussed, and post-discharge support to recover or manage their condition. The most notable positive movement was in whether staff discussed additional equipment or changes needed at home, which increased from 7.9 to 8.7, and whether further health or social care services were discussed, which increased from 7.9 to 8.6 and was rated somewhat better than expected compared with other Trusts. However, medicines information at discharge reduced from 4.5 to 4.1 and remained the lowest-scoring question in the section. These findings indicate improving discharge planning overall, while reinforcing the need to strengthen medicines communication, family or carer involvement and consistency of information at the point of discharge.

9.3 MFT site-level comparison

Appendix 1 details Section 9 scores across MFT sites. Site-level results show variation across discharge-related measures, with Wythenshawe generally performing most strongly for practical discharge planning and onward care discussions. Wythenshawe scored 8.9 for equipment or home changes being discussed and 8.7 for further health or social care services being discussed after discharge. MRI also performed well for several discharge measures, including information about what to do after leaving hospital and understanding discharge information.

NMGH showed greater variation across discharge measures, with lower scores for involvement in discharge decisions, information provided before leaving hospital and medicines information at discharge. Medicines information remained the lowest-scoring discharge question at Trust level and also showed site-level variation, indicating a need for targeted improvement in medicines communication, patient understanding and carer involvement prior to discharge.

9.4 Comparison to other Trusts

In comparison with other Trusts nationally, MFT's Section 9 score of 7.2 was rated as about the same, indicating performance within the expected range. Within this section, the question on whether staff discussed further health or social care services after discharge was rated somewhat better than expected, providing positive assurance in relation to onward care planning. Regionally, MFT performed better than several North West Trusts, including Tameside and Glossop Integrated Care NHS Foundation Trust (6.7), North Cheshire and Mersey NHS Foundation Trust (6.8), Liverpool University Hospitals NHS Foundation Trust (6.9), Lancashire Teaching Hospitals NHS Foundation Trust (7.0) and East Lancashire Hospitals NHS Trust (7.1). Specialist providers recorded the highest regional scores for this section, including Liverpool Heart and Chest Hospital NHS Foundation Trust (8.3), The Christie NHS Foundation Trust (8.1), The Clatterbridge Cancer Centre NHS Foundation Trust (8.0), The Walton Centre NHS Foundation Trust (7.8) and Liverpool Women's NHS Foundation Trust (7.6). Overall, the comparative data provides assurance that MFT's discharge experience is broadly in line with national and peer performance, with specific strengths in onward care discussions and practical discharge planning. However, the lower scores for medicines information, family or carer involvement and family or carer information indicate clear opportunities to improve the consistency, safety and person-centredness of the discharge process.

10. Section 10: Kindness and compassion

10.1 Section overview and results

Section 10 focuses on whether patients felt they were treated with kindness and compassion while in hospital (Chart J). MFT achieved a section score of **9.2**, which was rated as **about the same** as other NHS Trusts nationally. This was one of MFT's strongest performing domains and provides positive assurance that compassionate care remains a clear strength within the Trust's inpatient experience.

MFT scored 9.2 for patients feeling treated with kindness and compassion, compared with a national average of 9.1 and a 2024 score of 9.0. This indicates both a positive position against the national average and year-on-year improvement. The result reinforces the importance of sustaining compassionate behaviours and ensuring that kindness and compassion remain embedded across all clinical areas, especially where other sections identify opportunities to improve communication, discharge and personalised care.

Chart J: Question scores for Kindness and compassion



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
375	9.2	9.0	8.4	9.8

10.2 Trend data: comparisons over time

Section 10 improved from 9.0 in 2024 to 9.2 in 2025, representing a positive year-on-year change of +0.2. This improvement indicates that patients reported a more positive experience of kindness and compassion and that relational aspects of care continue to strengthen. The score is also above the national average, providing assurance that compassionate care remains a core strength for MFT.

10.3 MFT site-level comparison

Appendix 1 details Section 10 scores across MFT sites. Site-level results show consistently high scores for kindness and compassion across MRI (9.2), NMGH (8.3) and Wythenshawe (9.2), indicating that patients generally experienced compassionate care across the Trust.

10.4 Comparison to other Trusts

In comparison with other Trusts nationally, MFT's Section 10 score of 9.2 was rated as about the same, indicating performance within the expected range. Regionally, MFT performed better than several North West Trusts, including Bolton NHS Foundation Trust (8.8), Liverpool University Hospitals NHS Foundation Trust (8.8), Tameside and Glossop Integrated Care NHS Foundation Trust (8.8), Lancashire Teaching Hospitals NHS Foundation Trust (8.8) and Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (8.9). The highest regional scores were recorded by Liverpool Heart and Chest Hospital NHS Foundation Trust (9.7), The Clatterbridge Cancer Centre NHS Foundation Trust (9.6), The Christie NHS Foundation Trust (9.6), The Walton Centre NHS Foundation Trust (9.4) and Wirral University Teaching Hospital NHS Foundation Trust (9.2). Overall, the comparative data provides assurance that kindness and compassion remain a strong area of performance for MFT, with the Trust scoring above the national average for this question (9.2 compared with 9.0) and maintaining a position within the expected national range.

11. Section 11: Respect and dignity

11.1 Section overview and results

Section 11 focuses on whether patients felt they were treated with respect and dignity (chart K) while in hospital. MFT achieved a section score of **9.3**, which was rated as about the same as other NHS Trusts nationally. This was MFT's highest-scoring section and provides strong assurance that respectful, dignified care remains a clear strength within the Trust's inpatient experience.

MFT scored 9.3 for patients feeling treated with respect and dignity, compared with a national average of 9.1 and a 2024 score of 9.1. This demonstrates both a positive position against the national average and year-on-year improvement. The result reinforces the importance of sustaining respectful communication, privacy, dignity and person-centred behaviours across all clinical areas.

Chart K: Question scores for Respect and dignity



	All trusts in England			
Number of respondents	Your trust	National average	Lowest score	Highest score
371	9.3	9.1	8.4	9.8

11.2 Trend data: comparisons over time

Section 11 improved from 9.1 in 2024 to 9.3 in 2025, representing a positive year-on-year change of +0.2. This improvement indicates that patients reported a more positive experience of being treated with respect and dignity and confirms that relational and person-centred aspects of care remain strong.

11.3 MFT site-level comparison

Appendix 1 details Section 11 scores across MFT sites. Site-level results show consistently high scores for respect and dignity across MFT (MRI, 9.4; Wythenshawe 9.2; NMGH 8.7) indicating that patients generally experienced dignified and respectful care across the Trust.

11.4 Comparison to other Trusts

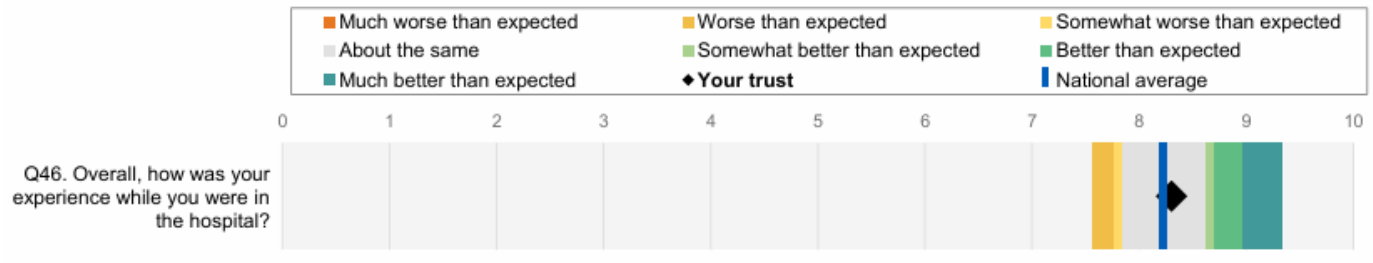
In comparison with other Trusts nationally, MFT's Section 11 score of 9.3 was rated as about the same, indicating performance within the expected range. Regionally, MFT performed better than several North West Trusts, including Bolton NHS Foundation Trust (8.8), Liverpool University Hospitals NHS Foundation Trust (8.9), North Cheshire and Mersey NHS Foundation Trust (8.9), Tameside and Glossop Integrated Care NHS Foundation Trust (8.9) and Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (8.9). The highest regional scores were recorded by The Clatterbridge Cancer Centre NHS Foundation Trust (9.7), Liverpool Heart and Chest Hospital NHS Foundation Trust (9.6), The Christie NHS Foundation Trust (9.6), Liverpool Women's NHS Foundation Trust (9.3) and Wirral University Teaching Hospital NHS Foundation Trust (9.3). Overall, the comparative data provides assurance that respect and dignity remain a strong area of performance for MFT, with the Trust scoring above the national average for this question (9.3 compared with 9.1) and maintaining a position within the expected national range.

12. Section 12: Overall experience

12.1 Section overview and results

Section 12 summarises patients' overall experience while in hospital (Chart L). MFT achieved an **overall experience score of 8.3**, which was rated as about the same as other NHS Trusts nationally. This score was above the national average of 8.2 and provides positive assurance that patients' overall experience of inpatient care at MFT remains strong. MFT's overall experience score improved from 8.2 in 2024 to 8.3 in 2025. These results provide assurance that the overall inpatient experience remains positive.

Chart L: Question scores for Overall experience



About the same

		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
374	8.3	8.2	7.6	9.3

12.2 Trend data: comparisons over time

Section 12 improved from 8.2 in 2024 to 8.3 in 2025, representing a positive year-on-year change of +0.1. Although this is a modest numerical non-significant improvement, in 2025 vs 2003 there was a significant improvement and all results indicate positive movement for patients' overall assessment of their hospital stay.

12.3 MFT site-level comparison

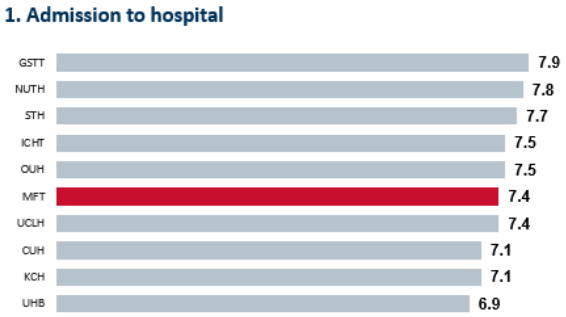
Appendix 1 details Section 12 scores across MFT sites. Overall experience was highest at Wythenshawe Hospital (8.4), followed by MRI (8.3) and NMGH (7.6), with the Trust overall score at 8.3. This reflects the wider site-level pattern in the report, where Wythenshawe generally achieved stronger scores across several domains, MRI was broadly aligned with the Trust average, and NMGH showed greater variation across measures such as sleep disruption, involvement in decisions, discharge information and medicines information.

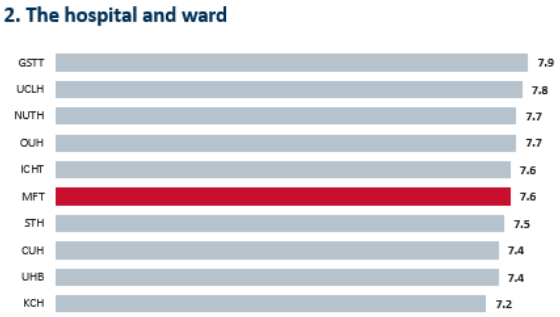
12.4 Comparison to other Trusts

In comparison with other Trusts nationally, MFT's Section 12 score of 8.3 was rated as about the same, indicating performance within the expected range. The Trust scored slightly above the national average for overall experience (8.3 compared with 8.2) and improved from 2024 (8.2 to 8.3; +0.1). Regionally, MFT performed above several North West Trusts, including Lancashire Teaching Hospitals NHS Foundation Trust (7.7), Bolton NHS Foundation Trust (7.8), East Cheshire NHS Trust (7.8), North Cheshire and Mersey NHS Foundation Trust (7.9) and East Lancashire Hospitals NHS Trust (7.9). The highest regional scores were recorded by The Clatterbridge Cancer Centre NHS Foundation Trust (9.3), Liverpool Heart and Chest Hospital NHS Foundation Trust (9.2), The Christie NHS Foundation Trust (9.2), The Walton Centre NHS Foundation Trust (8.9) and Liverpool Women's NHS Foundation Trust (8.9). Overall, the comparative data provides assurance that MFT's inpatient experience is positive and broadly aligned with national and peer benchmarks.

Appendix 3: Shelford Group peer comparison of section question scores

Key: *CUH: Cambridge University Hospitals NHS FT; GSTT: Guy's and St Thomas' NHS FT; ICHT: Imperial College Healthcare NHS Trust; KCH: King's College Hospital NHS FT; MFT: Manchester University NHS FT; NUTH: Newcastle upon Tyne Hospitals NHS FT; OUH: Oxford University Hospitals NHS FT; STH: Sheffield Teaching Hospitals NHS FT; UCLH: University College London Hospitals NHS FT; UHB: University Hospitals Birmingham NHS FT.*

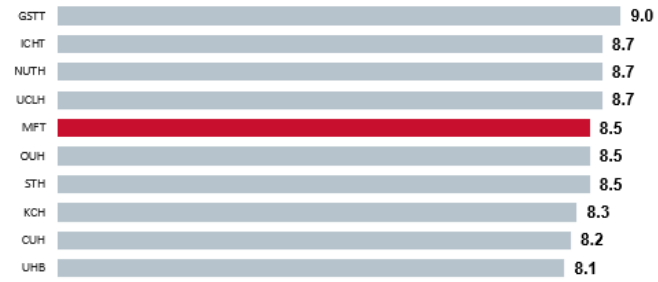




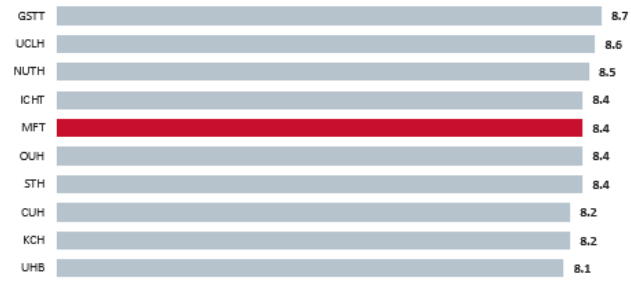




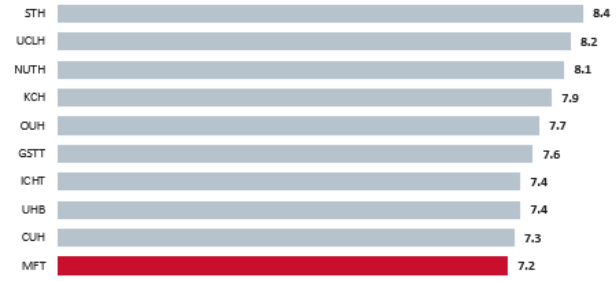
5. Nurses



6. Care and treatment

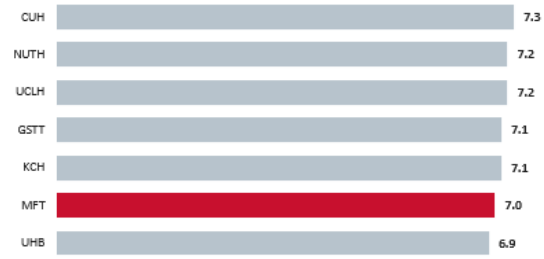


7. Individual needs

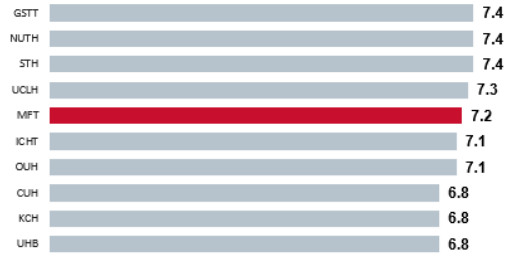


8. Virtual wards

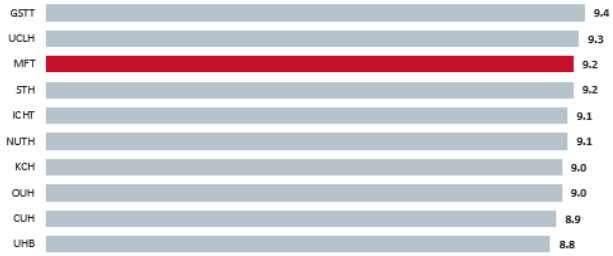
Data unavailable: ICHT, OUH, STH



9. Leaving hospital



10. Kindness and compassion



11. Respect and dignity



12. Overall experience



NHS
Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday, 25 November 2026

Paper Title:	National Cancer Patient Experience Survey 2025 Results	**Agenda Item 11.3**
Presented by:	Kimberley Salmon-Jamieson, Deputy Trust Chief Executive and Chief Nursing Officer	
Prepared by:	Layla Alani, Deputy Chief Nursing Officer Emma Dodd, Head of Nursing Cancer	
Meetings where content has been discussed previously	Quality, Safety and performance Board Committee, October 2026	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion ☐ For noting	

Executive summary / key messages for the meeting to consider

The National Cancer Patient Experience Survey (NCPES) 2025 is the fifteenth national survey since its inception in 2010. It provides an important measure of patients' experiences of cancer care and supports both national benchmarking and local quality improvement. The survey included patients aged 16 years and over with a confirmed cancer diagnosis who were discharged following an inpatient or day-case attendance at an NHS Trust between 1 April and 30 June 2025. Participants were invited to provide feedback across 61 questions using a mixed-methodology approach.

Key Points:

• MFT achieved an overall cancer care rating of 9.1, above the national average of 8.9, demonstrating consistently positive patient experience and sustained high-quality cancer care.

• MFT achieved the national average or better in 56 of 65 questions (86%), including 23 questions scoring above the national average, up from 15 in 2024.

• No questions scored below the expected range, maintaining the positive position achieved since 2023.

• Two areas scored marginally below the national average: information provided before diagnostic tests (92% vs 93%) and clinic waiting times (78% vs 80%). Targeted improvement actions will be progressed through Clinical Group cancer governance arrangements.

• Benchmarking demonstrates strengthened comparative performance, with MFT ranking joint first within the Shelford Group and joint second across GM Cancer, representing an improvement on the previous year.

• Performance was particularly strong across key categories, with all five questions within 'finding out you had cancer' and all four questions within 'deciding on the best treatment' scoring above the national average, alongside demonstrable improvement compared with the previous year.

The 2025 survey notes significant improvements from 2024 in:
• Patients reported waiting the right length of time for diagnostic tests (↑5%)
• Patients were able to discuss worries and fears with hospital staff (↑8%)
• Patient was given enough information about signs of cancer returning (↑5%)
• Cancer research opportunities were discussed (↑6%)
• Patient had confidence and trust in the team looking after them (↑4%)

Areas for improvement
While performance was above the national average in several key areas, opportunities remain to improve support for patients beyond their direct clinical care.

• Information about financial support scored 74% (3% above the national average), although this represents a slight deterioration from 2024. Work is underway to strengthen links between Macmillan Centres, wellbeing hubs and clinical teams.

• Information about recurrence or progression scored 67% (9% above the national average); however, significant variation exists across tumour groups (54% to 75%). Targeted review and improvement work will focus on pathways demonstrating lower performance.

• Support for emotional wellbeing at home and within the community scored 40% (7% above the national average), with marked variation across tumour groups (18% to 51%). Further work will be undertaken with community and voluntary sector partners to improve access and consistency of support.

• A focused programme will be established to increase survey participation from under-represented groups, including ethnic minority communities, people living in areas of deprivation, patients with learning disabilities and those with mental health support needs, to better inform future service improvements and reduce health inequalities.

Conclusion
Cancer patient experience at MFT continues to improve, with strong performance across overall care, communication and patient involvement.

Targeted improvement work will focus on information provision, emotional support, reducing variation between tumour groups and improving feedback from under-represented communities.

Action plans will be delivered through tumour groups and Clinical Group cancer governance arrangements to support further improvements in patient experience and outcomes.

The Clinical Groups will

• Lead improvement plans, with Clinical Group Chief Executives ensuring tumour-specific actions are developed, implemented and monitored through established cancer governance arrangements.

• Support the priority improvement areas identified within the survey.

• Support actions to reduce health inequalities and improve outcomes for underserved populations through a population health approach.

Recommendation(s)
The Board of Directors is asked to: • Note the continued improvement in cancer patient experience and monitoring arrangements.

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

Relationship to the strategic objectives	
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)	
☒ LHL Objective 1	☐ LHL Objective 2
☒ HQSC Objective 1	☐ HQSC Objective 2
☐ HQSC Objective 3	☒ PEW Objective 1
☒ PEW Objective 2	☒ VfP Objective 1
☒ VfP Objective 2	☐ R&I Objective 1
☐ R&I Objective 2	☒ Good Governance
Links to Trust Risks	The work contained within this report links to the following strategic, corporate, or operational risks: •
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Caring ☒ Effective ☒ Well-Led ☒ Responsive

Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the report: • CQC Regulation 17 – Quality and Safety - requirement for providers to have systems and processes to assess, monitor, and improve the quality and safety of services.

Main report

1 Introduction

1.1 The National Cancer Patient Experience Survey (NCPES) is an annual survey that assesses the quality of cancer care and identifies opportunities for service improvement. The 2025 survey included patients aged 16 years and over with a confirmed cancer diagnosis who were discharged following an inpatient or day-case attendance between 1 April and 30 June 2025. Participants were asked to respond to 61 questions and provide qualitative feedback on their experiences of care.

1.2 Responses are grouped into key thematic areas across the cancer pathway, enabling a structured assessment of patient experience and identification of areas for improvement, as summarised in **Table 1.** In cases where a result is based on fewer than 10 responses, the result has been suppressed, this is to ensure unreliable results based on small numbers of respondents are not released, and to prevent individuals being identifiable in the data.

Table 1

GP support	Treatment
Diagnostic tests	Side Effects
Cancer diagnosis	Support at home
Support from main contact	GP support post discharge
Decisions on treatment	Living with and beyond cancer
Care planning	Hospital Care
Support from hospital staff	Overall NHS Care

Table 1: NCPES theme categories

2.0 Results - Response Rate

2.1 MFT's response rate was 46% (735 respondents), representing a slight improvement on the previous year and remaining marginally below the national average of 48%.

2.2 MFT met or exceeded the national average in 56 of 65 questions. Twenty-three questions scored above the national average, compared with 15 in the previous year, demonstrating continued improvement in patient experience. Table 2 summarises the areas that scored above the national average.

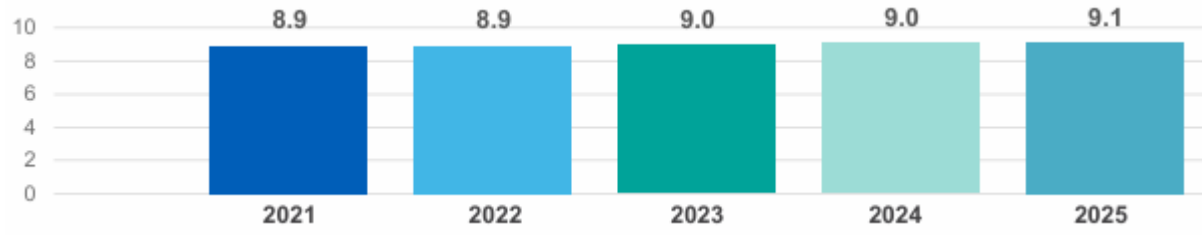
Executive summary

Questions above expected range

	Case mix adjusted scores			National score
	2025 score	Lower expected range	Upper expected range	
Q07. Patient felt the length of time waiting for diagnostic test results was about right	84%	73%	83%	**78%**
Q08. Diagnostic test results were explained in a way the patient could completely understand	83%	75%	82%	**79%**
Q12. Patient was told they could have a family member, carer or friend with them when told diagnosis	88%	80%	86%	**83%**
Q13. Patient was definitely told sensitively that they had cancer	81%	72%	78%	**75%**
Q14. Cancer diagnosis explained in a way the patient could completely understand	84%	75%	81%	**78%**
Q15. Patient was definitely told about their diagnosis in an appropriate place	89%	84%	89%	**86%**
Q16. Patient was told they could go back later for more information about their diagnosis	90%	82%	89%	**85%**
Q19. Patient found advice from main contact person was very or quite helpful	98%	94%	97%	**96%**
Q20. Treatment options were explained in a way the patient could completely understand	86%	80%	86%	**83%**
Q21. Patient was definitely involved as much as they wanted to be in decisions about their treatment	84%	77%	83%	**80%**
Q22. Family and/or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	88%	82%	88%	**85%**
Q23. Patient could get further advice from a different healthcare professional before making decisions about their treatment options	67%	53%	63%	**58%**
Q24. Patient was definitely able to have a discussion about their needs or concerns prior to treatment	79%	69%	76%	**73%**
Q31. Patient had confidence and trust in all of the team looking after them during their stay in hospital	83%	74%	82%	**78%**
Q35. Patient was always able to discuss worries and fears with hospital staff	74%	61%	71%	**66%**
Q39. Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	84%	76%	84%	**80%**
Q47. Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment	65%	57%	64%	**61%**
Q48. Patient was definitely able to discuss options for managing the impact of any long-term side effects	62%	51%	60%	**56%**
Q52. Patient has had a cancer care review with someone from their GP practice (excluding patients who have not had a review but were diagnosed less than or around 12 months ago)	54%	30%	53%	**41%**
Q53. After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	40%	27%	39%	**33%**
Q55. Patient was given enough information about the possibility and signs of cancer coming back or spreading	70%	61%	69%	**65%**
Q57. Administration of care was very good or good	91%	84%	90%	**87%**
Q58. Cancer research opportunities were discussed with patient	59%	36%	55%	**45%**

Table 2 – Questions achieving above the national average

2.3 MFT's overall cancer care rating scored 9.1, exceeding the national average of 8.9 and demonstrating growth progression and an improved patient experience.



Graph 1: Overall cancer care results 2021-2025

2.4 98% of patients found advice from the main contact was helpful or very helpful, 2% above the national average and marginal 1% increase from the previous year.

2.5 Patient confidence and trust in the team providing care during hospital admission improved to 83%, representing a 4% increase on the previous year and 5% above the national average. Patients' ability to discuss worries and fears with hospital staff also improved to 74%, 8% above the national average and 8% higher than the previous year. These results demonstrate continued progress in delivering person-centred care, improving communication, and strengthening support for patients and families throughout the cancer pathway.

2.6 Discussion of cancer research opportunities with patients increased to 62%, a 6% improvement on the previous year and 17% above the national average. This reflects the impact of targeted training and enhanced communication approaches introduced in response to lower scores in the 2023 and 2024 surveys, supporting more consistent integration of research conversations into routine clinical practice.

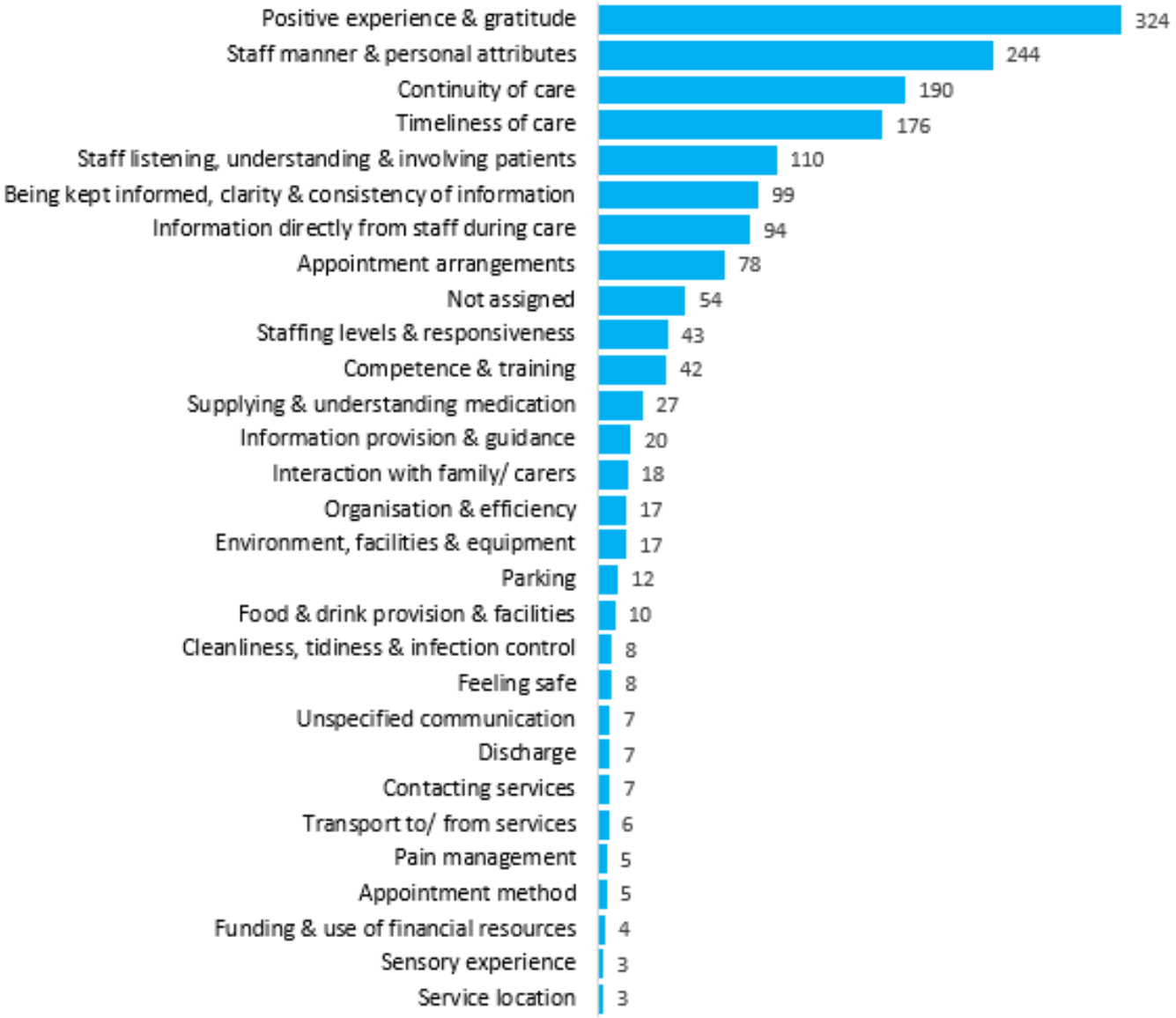
2.7 Although MFT met or exceeded the national average overall, two question scores declined compared with the previous survey. These related to patients receiving sufficient information about hormone therapy (-7%) and understanding that information (-10%). The reduction is attributable to the Breast service and will be addressed through a targeted action plan within the Breast Cancer Improvement Collaborative.

2.8 Variation remains in relation to patients receiving sufficient information about the possibility and signs of cancer recurrence or progression. MFT's overall score was 67%, 9% above the national average; however, tumour group performance ranged from 54% to 75%, with Colorectal scoring 66% and Breast 55%. Both pathways have Personalised Stratified Follow Up (PSFU) in place, where recurrence information is a core component. A focused review will be undertaken by 30th November 2026 to understand the causes of variation and agree targeted improvement actions. This will be supported by the GM Cancer Alliance workstream on patient education around recurrence, with co-designed infographics to be incorporated into MFT end of treatment summaries.

2.9 Emotional support at home, in the community and through voluntary sector services remains an area for improvement. Although MFT scored 40%, which is 7% above the national average, performance varied significantly across tumour groups (18% to 51%). A detailed review will be completed by 1st December 2026 to understand this variation and identify opportunities to strengthen emotional and community-based support through partnership working with the LCO Clinical Group and VCSE organisations.

3. Qualitative Feedback

3.1 MFT received 908 free-text comments, of which 70% were positive. The most common themes were staff compassion and kindness, pathway efficiency, and confidence in clinical care. A further 24% identified opportunities for improvement, primarily relating to communication between services, discharge support and follow-up communication. The remaining 6% were either not related to the survey or provided service-specific feedback. **Graph 2** summarises the themes identified from free-text comments.



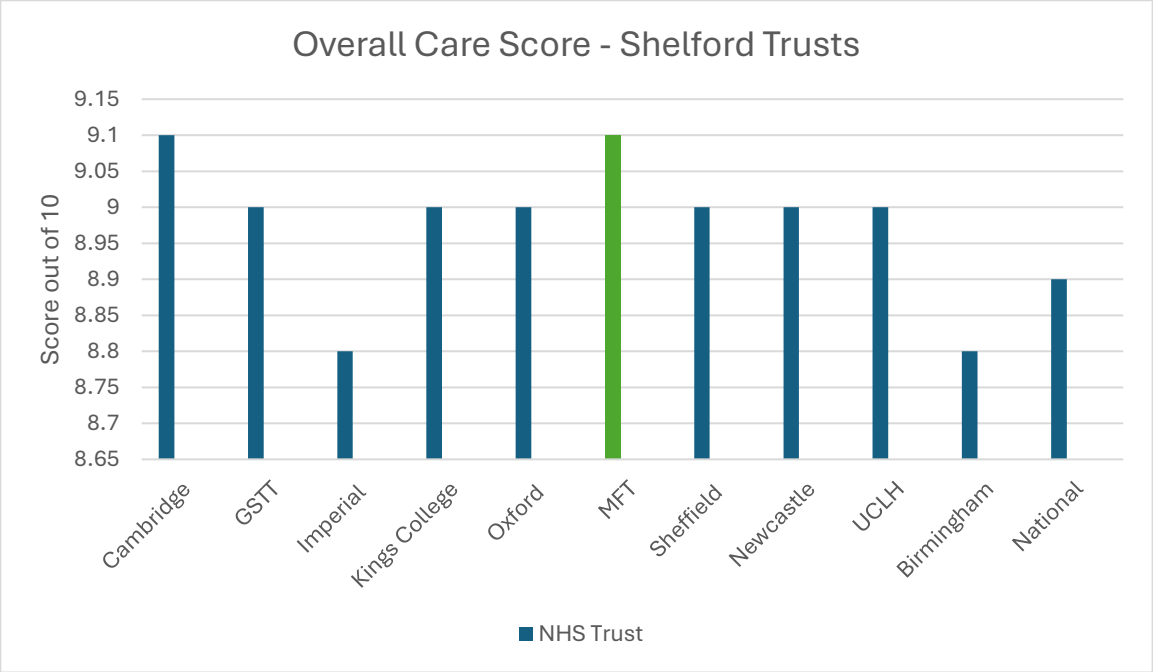
Graph 2: Subcategories of free text comments

3.2 Patients being offered information about financial help and benefits scored 74% which is 3% above the national average but a decrease of 1% from last year's results and noted to be feedback in the overall comments. The cancer leadership team will develop a plan by 21st October 2026, to improve communication between the Macmillan centres, MFT wellbeing hubs and clinical teams.

Improvements for all areas outlined will be monitored and reported to Trust Cancer Group.

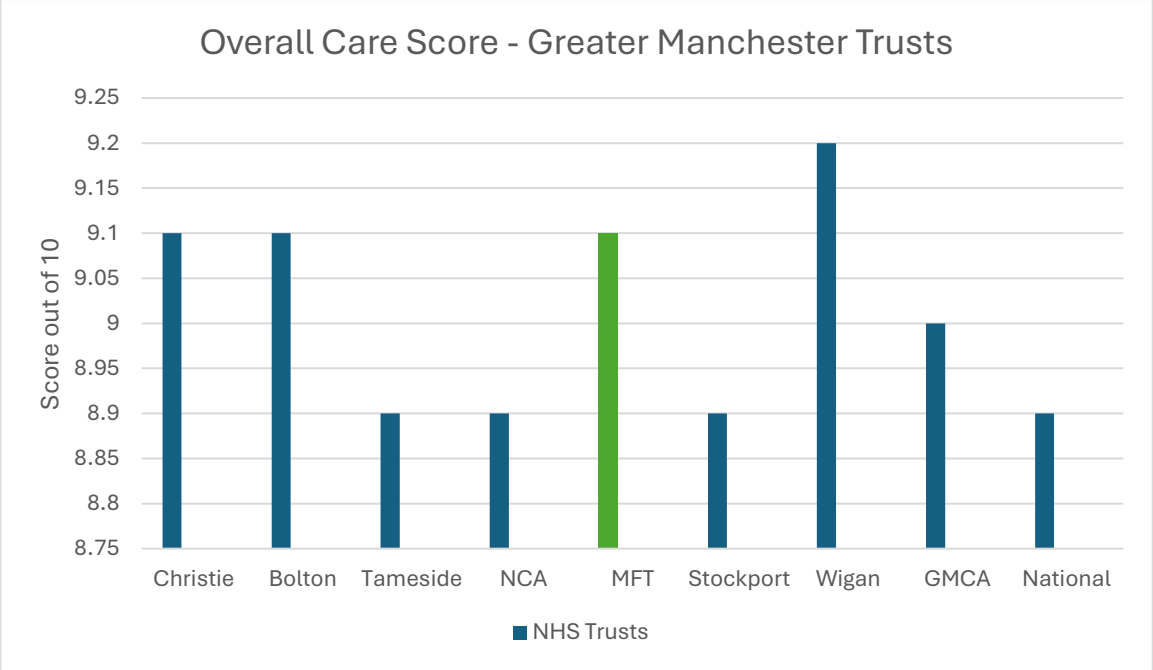
4. Benchmarking

4.1 Benchmarking demonstrates strengthened comparative performance, with MFT ranking joint first within the Shelford Group and joint second with Bolton and the Christie, across GM Cancer, representing an improvement on the previous year.



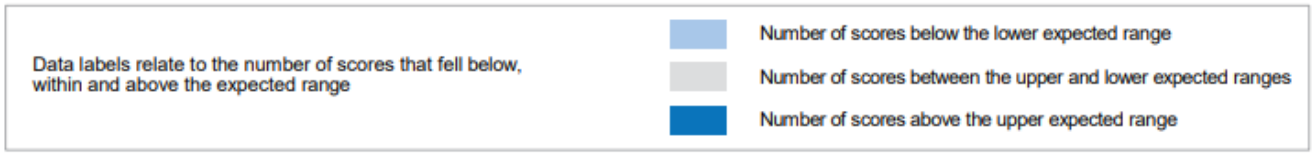
Graph 3: Shelford Trust comparison

4.2 **Graph 4** demonstrates MFT's benchmarking for overall care against other GM Trusts, scoring 9.1 for overall care in line with The Christie and Bolton and marginally lower than Wigan who score 9.2.



Graph 4: GM Trusts comparison

4.3 While MFT was not the highest-scoring Trust in Greater Manchester for overall cancer care, **Graph 5** demonstrates a continued strengthening of MFT's comparative position, particularly when considered in the context of the Trust's size, scale and complexity. The results show marked improvement in the number of measures scoring above the expected range and national average, indicating positive progress relative to other Greater Manchester Trusts.



Trust		Expected range classification
R0A	Manchester University NHS Foundation Trust	0 38 23
RRF	Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust	0 44 17
RBV	The Christie NHS Foundation Trust	0 54 7
RMC	Bolton NHS Foundation Trust	1 53 7
RWJ	Stockport NHS Foundation Trust	1 55
RMP	Tameside and Glossop Integrated Care NHS Foundation Trust	2 50
RM3	Northern Care Alliance NHS Foundation Trust	4 56

Graph 5: Greater Manchester Cancer Alliance expected range summary

5. Tumour Group breakdown

5.1 MFT received survey responses across 12 tumour sites which are demonstrated in table 3. Due to the small sample sizes for brain, prostate, and sarcoma, these tumour groups have been excluded from the comparison data by the national team, as results are not statistically significant.

Table 3

	Number of respondents
Brain / CNS	1
Breast	145
Colorectal / LGT	48
Gynaecological	13
Haematological	136
Head and neck	28
Lung	211
Prostate	8
Sarcoma	5
Skin	13
Upper gastro	36
Urological	31
Other	60
Total	**735**

Table 3: Respondents by tumour group

5.2 The results are reported at tumour group level rather than by individual Clinical Group. While this provides a valuable overview of pathway-level patient experience, it limits the ability to make direct comparisons between services with different roles, case mix, and models of care within the same tumour group. This is particularly relevant for lung cancer services. Wythenshawe operates as both a diagnostic provider and tertiary centre, functioning as the regional surgical hub and receiving referrals from across Greater Manchester. In contrast, lung services at NMGH and MRI primarily provide diagnostic pathways for their local populations. Future interpretation of Wythenshawe's lung cancer results should therefore include benchmarking against comparable large national thoracic surgical centres, rather than relying solely on comparison with other MFT sites.

5.3 The three tumour groups with the highest response volumes have remained consistent over the last five years and reflect the largest cancer services provided by MFT: Breast (211 responses, 28%), Colorectal (145 responses, 20%) and Haematology (136 responses, 19%).

5.4 The overall care scores improved from the previous year in 8 of the tumour groups, 1 (breast) maintained the score and decrease in score in the urology team. Of the 10 tumour groups that received a score, 8 achieved an overall care score of 9.0 or above, demonstrating a strong overall patient experience across the majority of tumour groups.

5.5 All tumour groups scored highly in relation to patients finding advice from their main contact helpful or very helpful, with scores ranging from 95% to 100%. This represents an improvement compared with the previous year and contributes to MFT's overall score of 98%, which is above the national average.

5.6 The scores improved across all tumour groups in relation to family and/or carers being involved in treatment decisions to the extent patients wanted. In addition, seven of the eight tumour groups assessed achieved 100% for patients reporting that their care plans were reviewed and updated.
5.7 Responses relating to hospital care were positive, with all tumour groups scoring above the national average. Of note, the Gynaecology service achieved 100% for five of the nine questions within this section, indicating consistently strong patient experience in this area.

6. Demographic Insights and Equity Considerations in Patient Experience
6.1 The 2025 survey captured demographic information from respondents, providing valuable insight into patient experience. The findings highlight inequalities across age, deprivation, and ethnicity, offering clear opportunities to target improvements and ensure more equitable cancer care. A Freephone helpline and email was available for respondents to opt out, ask questions about the survey, enable them to complete their questionnaire over the phone and provide access to a translation and interpreting facility for those whose first language was not English.

6.2 The respondent profile was weighted towards older age groups, with the highest number of responses received from patients aged 65–74, followed closely by those aged 75–84. The lowest response levels were from patients aged 16–34; due to small numbers, these data were suppressed, limiting the ability to undertake meaningful interpretation for this cohort. This is an important equity consideration given the nationally recognised increase in cancer diagnoses among people under 50. Recent evidence shows that, following a plateau in 2020, cancer diagnoses among younger adults increased over the subsequent three years, with reported rises of 11.7% in those aged 18–29, 7.2% in those aged 30–39, and 7.5% in those aged 40–49[1].The most common cancer types identified within this younger cohort include colorectal cancer, which is increasing by approximately 3% annually, and breast cancer.

The current survey approach is primarily paper based, with the survey issued by post and an online completion route made available through a web link. For younger patients, who are more likely to be digitally enabled, this model may reduce engagement and contribute to lower participation. NHS England recognises this challenge, and the 2026 survey approach will include text messaging with an online link. MFT will also explore use of the MyMFT app to promote survey participation, improve accessibility, and support more representative feedback from younger patients and other under-represented groups.

[1] The rising tides of cancers among young adults - PMC

6.3 The results highlight variation in patient experience by deprivation level (quintiles 1 most deprived–5 least deprived). The largest gaps between patients in the most and least deprived areas were in three key areas: being told sensitively about their diagnosis, receiving information on treatment and potential side effects, and overall care and team coordination. These findings are consistent with national results and underline the need for more targeted support for patients from the most deprived communities. A total of 223 free-text comments were received from patients in IMD quintile 1. The majority were positive, with 42% (95) expressing a positive experience, with 36.7% (82) recognising staff professionalism and 29.15% (65) praising the quality of care. Negative feedback mainly focused on appointments, transport, and hospital food.

6.4 Analysis of respondents by ethnicity shows that 602 respondents (82%) identified as White British. Smaller numbers of respondents identified as Indian (8), Pakistani (12), Chinese (10), another Asian background (8), and African or other Caribbean background (14). A further 39 respondents chose not to disclose their ethnicity. The respondent profile does not fully reflect the ethnic diversity of Greater Manchester, limiting the relevant feedback for some communities.

6.5 Further analysis identified variation in reported experience across ethnic groups. Asian respondents reported lower understanding of treatment options, with 76% positive responses compared with 87% among White British respondents and 82% among Black respondents. Black respondents reported lower understanding of diagnostic test results, with 53% positive responses compared with 83% among White British respondents and 79% among Asian respondents. Overall care was rated 9.1 by both White British and Black respondents, compared with 8.3 by Asian respondents. To support participation, the survey was promoted through posters in outpatient areas, cancer ward areas and Macmillan Information Centres, with translated materials provided in the five most commonly spoken languages following consultation with Interpretation and Translation Services: Cantonese, Polish, English, Urdu and Arabic. The survey was also promoted on MFTV in waiting areas.

6.6 To address these disparities and improve representation, the Cancer Leadership Team will work with community and faith groups to better understand the drivers of variation and ensure cancer services are culturally sensitive, accessible and responsive to the needs of local communities. For the 2026/27 survey, the focus will be on strengthening targeted engagement and increasing participation from a broader range of ethnic groups, supporting more representative feedback and enabling focused improvement action across cancer pathways.

6.7 The NCPES does not include specific questions on mental health support or access for patients with a learning disability. Within the free-text responses, 64 patients identified themselves as having a mental health condition and seven patients identified as having a learning disability. Feedback from patients with a learning disability was predominantly positive, particularly in relation to reasonable adjustments and support provided by the Cancer Team; however, some negative experiences were identified, including difficulties accessing translation support, which contributed to increased anxiety. Patients with learning disabilities experience recognised inequalities across the cancer pathway, including later diagnosis, lower rates of urgent symptom referral, reduced access to screening, and poorer outcomes for some treatable cancers. In response, the Cancer Leadership Team will undertake a focused review to understand the number of patients with a learning disability diagnosed with cancer at MFT and to assess their experience across diagnostic, treatment, follow-up, and personalised care pathways. This review will be completed by 7th December 2026 to identify opportunities for learning and improvement, including earlier identification of reasonable adjustments, improved

communication, better access to accessible information, and stronger coordination with carers, learning disability services, primary care and community partners. This aligns with the Trust Strategy and NHS Cancer plan objectives to reduce health inequalities, provide high-quality, safe care with excellent outcomes and experience, deliver responsive services and reduce unwarranted variation for people who may be at greater risk of poorer cancer outcomes.

6.8 Feedback from patients identifying as having a mental health condition was predominantly positive, with comments highlighting the quality of care received, effective communication from specialist cancer teams, and the provision of reasonable adjustments. Of the 64 free-text comments received from this group, 12 identified negative experiences, primarily relating to communication between clinical teams and primary care. These issues were reported to contribute to additional worry, anxiety, and stress for patients. The findings highlight the importance of strengthening communication and coordination across organisational boundaries to support more personalised, inclusive, and psychologically informed cancer care.

7.Next Steps

7.1 Clinical Group senior leadership teams are asked to review the results pertaining to the cancer care delivered ensuring their teams actively develop, implement, and monitor detailed tumour-specific action plans with progress reported through the established cancer governance structures.

7.2 The MFT Cancer Strategic Delivery Plan was launched last year, with a key action focused on improving patient experience and reducing health inequalities. As part of this effort, the Trust is working closely with community and faith groups to better understand the needs of minority populations and ensure services are culturally responsive and accessible.

7.3 The cancer leadership team will collaborate with local VCSE sector and local community groups to improve uptake from underrepresented communities to support focused quality improvement for these patients, this will be led through the MFT Macmillan Information centres.

7.4 To support improvements in the response rate to the survey, a new toolkit has been developed by Picker. This was distributed to each tumour group to implement appropriate measures aimed at improving participation rates.

7.5 To sustain the improvement in patient experience relating to discussions about cancer research opportunities, the Cancer Leadership Team will continue to strengthen targeted communication, awareness, and staff engagement. This will support consistent promotion of research opportunities for patients and align with the ambitions of the NHS Cancer Plan.

7.6 The Cancer Leadership Team will review opportunities to utilise digital technologies to improve cancer patient experience and increase participation in future NCPES surveys. This will include exploring digital approaches to strengthen communication, improve access to timely information, support personalised care, and enable more inclusive patient feedback. This approach aligns with MFT's strategic objectives to improve experience, outcomes and equity, and with national ambitions to use digital transformation to support more personalised, accessible and coordinated care.

7.7 The implementation of the National Aspirant Cancer Career and Education Framework

(ACCEND) will standardise education for staff working in cancer services, improve the quality of care provided to patients, and create opportunities for staff development and career progression.

8. Conclusion

8.1 MFT's 2025 NCPES outcomes reflect a sustained commitment to delivering patient-centred cancer care. Improvements in care coordination, communication, and involvement in decision-making demonstrate positive progress, supported by staff professionalism and strong clinical engagement. Gaps remain in participation and experience among underserved groups, and further work is being undertaken to address variability in access to information and continuity of care.

NHS
Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday, 25 November 2026

Paper Title:	Safeguarding Annual Report 25/26	**Agenda Item 11.4**
Presented by:	Kimberley Salmon-Jamieson, Deputy Trust Chief Executive and Chief Nursing Officer	
Prepared by:	Layla Alani, Deputy Chief Nursing Officer Ruth Speight, Associate Chief Nurse Safeguarding	
Meetings where content has been discussed previously	Safeguarding Committee, September 2026 QSPBC, October 2026	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion ☐ For noting	

Executive summary / key messages for the meeting to consider

The Safeguarding Annual Report 2025-2026 provides assurance that Manchester University NHS Foundation Trust (MFT) continues to meet statutory and regulatory safeguarding responsibilities, supported by established governance arrangements and effective partnership working across Manchester, Trafford and Greater Manchester. During a period of sustained safeguarding demand, increasing complexity and significant national reform, MFT has demonstrated robust governance, effective partnership working and a continued commitment to protecting children, young people and adults at risk.

During the reporting period MFT achieved full compliance with the Provider Safeguarding Commissioning Assurance Toolkit (P-SCAT) and Prevent standards, providing strong external assurance on the effectiveness of the Trust's safeguarding arrangements. Compliance with Greater Manchester contractual requirements remained high, with 82 out of 85 standards achieved and no areas of non-compliance identified. Three areas were identified as partially compliant relating to policy completion, (which has been progressed in Q1 2026), training compliance and timely completion of Initial Health Assessments (IHA) for Looked After Children (LAC) in Trafford and Manchester. This is an area of particular challenge due to fluctuating numbers of children entering care and is impacted by Trafford and Manchester Local Authorities compliance in alerting MFT that the child is LAC and providing consent for treatment for which plans are in place with system partners

Safeguarding activity across MFT remains high in volume, with 40,311 referrals received during 2025-2026. While overall referrals reduced by 9% compared with 2024-2025**,** this reflects strengthened scrutiny, pathway redesign and revised reporting. Children's safeguarding referrals increased by 10% (+1,758 referrals)**,** demonstrating continued vigilance by frontline colleagues and sustained demand across services. Reductions in adult and maternity referrals reflect strengthened scrutiny, improved application of referral thresholds and pathway redesign, providing assurance that referrals are more appropriate and targeted rather than indicating a reduction in underlying safeguarding need.

During 2025/26, 267 serious safeguarding incidents were escalated to the executive lead for safeguarding (Deputy Chief Executive and Chief Nursing Officer), with 68 incidents meeting the criteria for formal multi-agency safeguarding partnership reviews (Safeguarding Adult Review, Child Safeguarding Practice Review or Domestic Abuse Death Review). Learning from safeguarding reviews continues to be systematically translated into service improvement, strengthening policy, workforce capability, training,

supervision, audit processes, targeted communications and organisational learning across the Trust and wider partnerships.

Key safeguarding themes remain aligned with system priorities, including neglect, domestic violence and abuse (DVA), and mental ill health. During 2025-2026, 968 individuals were identified at high risk of domestic abuse homicide, with MFT contributing actively to Multi Agency Risk Assessment Conference (MARAC) processes, sustaining identification rates above national averages for health providers.

Safeguarding training Levels 1 and 2 remain consistently above 90%, while Level 3 compliance has improved to 89%, 1% below the Trust standard. Completion of Oliver McGowan mandatory training is 87.89% for e-learning, with Tier 2 completion at 23.71% meeting the agreed regional threshold for the financial year.

Care for patients with Learning Disabilities and Autism (LD&A) has been strengthened, with revised policy guidance, improved digital reporting on the Hive electronic patient record (EPR), quality assurance and training. During 2025-2026, 91% of LD&A patients utilised a Hospital Passport and 90% of patients received appropriate reasonable adjustments. Digital delivery continues to progress, with the Child Protection Information System (CPIS) fully embedded across unscheduled care settings, demonstrating high compliance across Emergency Departments. Implementation of CPIS Phase 2 is progressing in line with mandated timelines; however, full end-to-end digital integration remains constrained and under ongoing review.

The MFT Independent Safeguarding Review reported in July 2025 identified 7 high level recommendations and a 40-point improvement plan to be delivered by 30th September 2026. To date, 27 actions have been completed, with the plan progressing as expected. Key improvements include enhanced leadership visibility, strengthened organisational culture and the co-design and pilot of a Trust-wide Safeguarding Triage model (March–May 2026).

Risks Identified

There are 9 Safeguarding Risks and 6 Mental Health Risks on the Risk Register (1 strategic, 6 corporate and 8 operational risks), including:

- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) processes remain on the corporate safeguarding risk register (score 12) with 2,854 DoLS applications and 73 authorisations (3.5%) completed due to Local Authority capacity constraints. Significant improvement work has been completed in strengthening policy guidance, training, digital systems, partnership working including enhanced tracking, challenge and escalation with Local Authority Best Interest Teams (LA BIA).
- 6 mental health risks being addressed in the mental health joint action plan (with Greater Manchester Mental Health Foundation Trust (GMMH) in response to increased volume and complexity of patients with a mental health condition admitted to MFT hospitals due to constraints in system wide availability of mental health inpatient facilities. Alongside risks to address suicide prevention, restraint reduction and consistent application of the Mental Health Act (MHA).
- 3 operational risks in the safeguarding children team in relation to capacity to deliver safeguarding response in complex safeguarding team, safeguarding supervision in the CAMHS and staffing challenges due to vacancies and sickness. A review of the safeguarding team structure and operating model is in progress following recommendations from the Chief Nursing Officer's commissioned Safeguarding Review recommendations and concerns raised by colleagues in the freedom to speak up process.
- Timeliness of LAC IHAs remains on the safeguarding operational risk register (score 12) - improvement work is underway with Manchester and Trafford Children's Social Care to address delays in information sharing and consent.
- National challenge in the delivery of the Oliver McGowan training model, led through the Chief People Officer directorate with continued support through external facilitation.

Priorities for 2026/27

- Completing the remaining 13/40 actions following 7 recommendations of the Safeguarding Review, this includes standardising safeguarding triage and duty response.
- Completion of timely IHAs with support of system partners.
- Review of DoLS authorisations process alongside system partners in line with recent Supreme Court Judgement which means that the previous criteria for DoLS (acid test) has been replaced by a multi factorial holistic assessment. This is likely to result in a reduced number of DoLS with patients continuing to be cared for in line with the MCA framework.
- Delivery of CPIS Phase 2.
- Deliver the nationally mandated Families First Programme by April 2027, working with Manchester and Trafford Councils to support whole-family safeguarding approaches and align with Special Education Needs and/or Disabilities (SEND) and Giving Every Child the Best Start in Life reforms.
- Implement safeguarding messages from Crime and Policing Act (2026)- duty to report child sexual abuse and strengthened legal framework to tackling exploitation.

Recommendation(s)

The Board of Directors is asked to:

- Discuss and note the Safeguarding Annual Report with particular focus on the assurance provided relating to the delivery of statutory and regulatory standards and the risks outlined.
- Discuss and note the delivery priorities for 2026/27.

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

Relationship to the strategic objectives

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

☒	LHL Objective 1	☐	LHL Objective 2
☒	HQSC Objective 1	☐	HQSC Objective 2
☐	HQSC Objective 3	☒	PEW Objective 1
☒	PEW Objective 2	☒	VfP Objective 1
☒	VfP Objective 2	☐	R&I Objective 1
☐	R&I Objective 2	☒	Good Governance
Links to Trust Risks		The work contained within this report links to the following strategic, corporate, or operational risks:	

	There are **15** risks actively managed by the safeguarding team on the Trust Safeguarding and Mental Health Risk Register, 9 focus on safeguarding, and 6 focus on Mental Health. • 1 Strategic Mental Health risk Score 16 • 6 Corporate risks Score 12 or below {application of MCA and MHA, DoLS, Restraint Reduction, Suicide Prevention and Level 3 Mandatory Safeguarding training compliance}. • 8 operational risks Score 12 or below {LAC Performance (2), CPIS compliance (1) delivery of safeguarding supervision to CAMHS, workforce capacity in safeguarding children's teams (2), expiry of mental health act section and delivery of MHA Section 136 in emergency departments (2)}. All risks, controls, mitigations and actions are reviewed monthly by the Assistant Chief Nurse Safeguarding and are reported quarterly in the safeguarding quarterly report to TSG and bi-monthly to the Mental Health subgroup.
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Caring ☒ Effective ☒ Well-Led ☒ Responsive
Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the report: • The Trust is required to meet the following legislative and regulatory requirements. Adult Safeguarding: Roles and Competencies for Health Care Staff CQC registration standards, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 The Children Act (1989) The Children Act (2004) Children's Wellbeing and Schools Act 2026 Children and Social Work Act (2017) Crime and Policing Act 2026 Domestic Abuse Act (2021) Female Genital Mutilation Act (2003) Health and Care Act 2008 and 2022

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
The Sexual Offences Act (2003)
The Serious Crime Act (2015)
The Care Act (2014)
Mental Capacity Act (2005)
Mental Capacity Amendment Act (2019)
Mental Health Act (1983 updated 2007)
Prevent Duty Guidance (2023)
Safeguarding children and young people & children and young people in care
Serious Violence Duty 2022
Working Together to Safeguard Children (2026)

Main report

1. Introduction

This Annual Report provides assurance that Manchester University NHS Foundation Trust (MFT) is meeting its statutory and regulatory safeguarding responsibilities, summarising governance, activity, key risks and improvement priorities for 2025/26. It reinforces MFT's commitment to high-quality care, a culture where *safeguarding is everyone's responsibility*, and continuous improvement.

Assurance is provided in relation to compliance with statutory and regulatory requirements, including:

i. Section 11 of the Children Act, the Care Act 2004
ii. The Care Act 2014
iii. NHS England Safeguarding Accountability and Assurance Framework
iv. Care Quality Commission (CQC) Regulation 13: Safeguarding Service Users from Abuse and Improper Treatment[1].

The report also provides assurance on the promotion of health and wellbeing for Looked After Children (LAC), and the delivery of high-quality, safe, person-centred care for people with a mental health condition, learning disability and/or autism, in line with Trust policy and national guidance.

2. Population Demographic

MFT provides safeguarding support to Greater Manchester (GM) and regional tertiary paediatric service through the Specialist Hospital Clinical Group, as well as the GM and Cheshire and Mersey Sexual Assault Referral Centres services, alongside local safeguarding provision for Manchester and Trafford residents.

[1] The Children Act (2004)
[1] The Care Act (2014)
[1] **Safeguarding children, young people and adults at risk in the NHS**
NHS England (2022). Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework (Version 3). Publication reference: PAR818. NHS England, London. Available at: NHS England official publication.
[1] Regulation 13 Safeguarding service users from abuse and improper treatment

Trafford has a smaller and increasingly ethnically diverse population and safeguarding profile, of around 67,000 children and young people (25% of the population) and 198,065 adults in 2024. Key safeguarding concerns are neglect and acts of omission in adults, and emotional abuse and neglect in children, with 2,665 Deprivation of Liberty Safeguards (DoLS) applications recorded in 2023/24.
Manchester serves a larger increasing and more complex ethnically diverse population, with around 153,000 children and 452,575 adults. Neglect remains the leading concern for children; for adults, the predominant concerns are neglect and acts of omission, physical abuse and self-neglect. This is reflected in higher levels (than national average) of mental ill health (1 in 5 people over 16 years), domestic abuse, Female Genital Mutilation (FGM) prevalence, and 4,420 DoLS applications per annum[2].

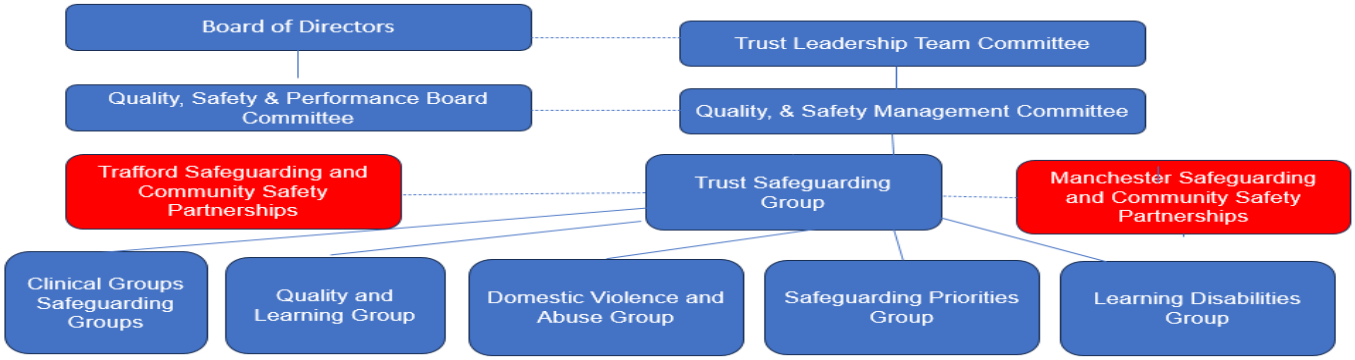
Greater Manchester data identifies the increasing prevalence of child exploitation with criminal exploitation including forced begging, cuckooing of properties, labour exploitation and county lines drug distribution[3] Knife crime remains an area of safeguarding concern, whilst noting that police recorded knife crime has reduced by 15% in Greater Manchester[4].

3. Governance

Figure 1 outlines the MFT safeguarding governance arrangements, demonstrating clear oversight, escalation and risk management processes, with defined reporting from service level through to the Board of Directors (BoD).

Board level leadership is provided through the Trust Deputy Chief Executive & Chief Nursing Officer (executive lead) and the safeguarding Non-Executive Director (NED) lead. There is a defined senior safeguarding leadership and operational structure in place.

Figure 1: MFT Safeguarding Governance Arrangements



Safeguarding governance arrangements are aligned to the eight priorities of the Manchester and Trafford Safeguarding and Community Safety Partnerships (MSP, TSP and CSP), with Trust Safeguarding Group (TSG) providing strategic oversight provided through partnership boards and operational delivery supported through the Trust's four thematic and Clinical Group safeguarding subgroups. This demonstrates clear accountability, coordinated delivery and robust governance across both partnership and organisational structures.

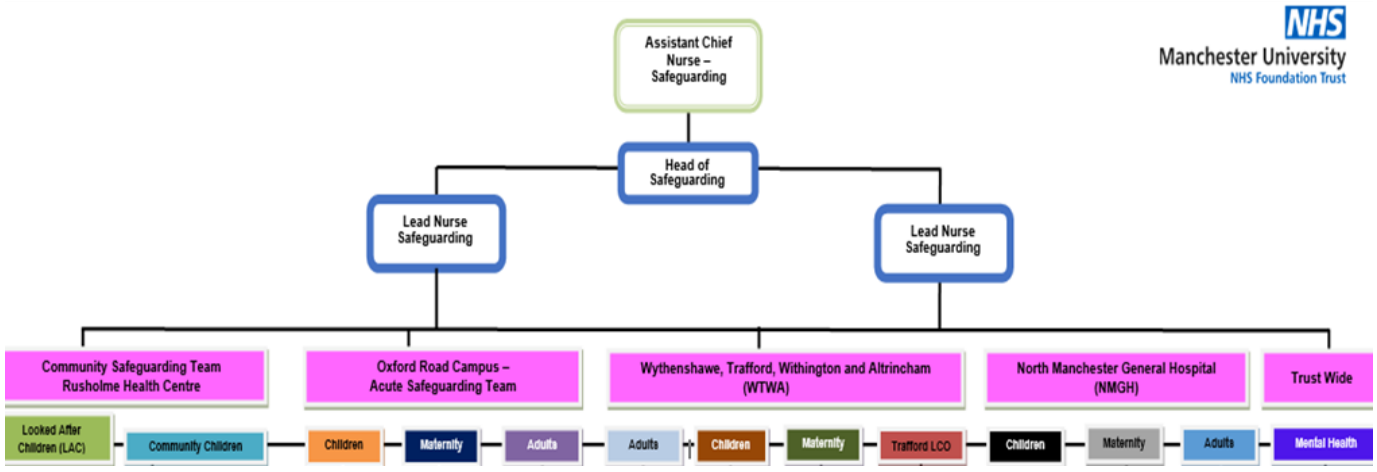
There are several mechanisms in place across MFT to provide assurance, monitor performance, identify and act upon risk and drive improvement. These are outlined in section 5 of the report.

[2] Census 2021 Overview, Tackling Exploitation in Greater Manchester, Joint Strategic Needs Assessment Children and Young People, FGM England and Wales, English indices of deprivation, Children in need statistics.
[3] MSP Complex Safeguarding Strategy accessed at https://www.manchestersafeguardingpartnership.co.uk/wp-content/uploads/2024/04/MSP-Tackling-Exploitation-in-Manchester-24-27-Strategy_FINAL.pdf
[4] Greater Manchester Combined Authority Knife crime falls, and homicide rate drop to historic low in Greater Manchester accessed at https://www.greatermanchester-ca.gov.uk/news/knife-crime-falls-and-homicide-rate-drop-to-historic-low-in-greater-manchester/

4. Workforce Structure

The Safeguarding Team structure is outlined below, with leadership provided by the Assistant Chief Nurse for Safeguarding, supported by the Head of Safeguarding, Lead Nurses, Named and Specialist Safeguarding Leads, Looked After Children (LAC), Mental Health and Learning Disability practitioners. The team holds delegated responsibility to promote and deliver safe safeguarding systems and practice, in line with Royal College Intercollegiate competencies and relevant regulatory and legislative standards.

Figure 2; MFT Safeguarding Team Structure



5. Safeguarding Assurance

MFT is required to meet national and local regulatory safeguarding standards. As noted in section 3 of this report, a range of governance and assurance mechanisms are in place across MFT as follows;

5.1 MFT Safeguarding Review

The Trust Deputy Chief Executive and Chief Nursing Officer commissioned a Safeguarding Review which was reported to Trust Leadership Team in July 2025. The review identified 7 high-level recommendations and informed a 40-point improvement plan (12 high, 26 medium, 2 low) with completion scheduled for 30th September 2026. To date, 27 actions are complete (including 10/12 high-risk actions) with the 13 remaining actions (2 high risk actions review of safeguarding model), training and digital improvement, progressing as planned (Appendix 1).

The review highlighted some specific areas of focus including:

- Leadership visibility and culture – ongoing programme of work over the next 12 months including enhanced engagement, Freedom to Speak Up walk rounds and civility training.
- Design and pilot a duty triage model to improve timeliness, equity and standardisation of MFT safeguarding duty response - evaluation completed May 2026.
- Digital capability informing a 2026 improvement plan to streamline safeguarding activity through Hive systems.
- Training access is expanding through digital/flexible delivery with Levels 1–2 compliance >90% and Level 3 improving to 89% compliance still slightly below MFT standard (90%).
- Cross-boundary partnership work is progressing to reduce duplication (notably for out-of-area maternity patients across 10 GM LAs).
- Importantly, the review recognised a safeguarding service that was highly regarded, professionally committed and trusted by operational teams, while also identifying opportunities to further strengthen consistency, visibility and organisational effectiveness.

5.2 Clinical Group Annual Regulation 13 Self-Assessment 2025-2026

Clinical Groups complete an annual safeguarding self-assessment aligned to CQC Regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment**)**, the Children Act (1989 and 2004) and Care Act (2014). The self-assessment is informed by *Working Together to Safeguard Children*, *Care and Support Statutory Guidance* and the NHS England Safeguarding Accountability and Assurance Framework.

Areas for improvement identified are incorporated into the MFT Safeguarding Risk Register (safeguarding level 3 training compliance risk and 3 operational risks in providing equitable safeguarding services), Safeguarding Workplan and Audit Calendar. Figure 3 summarises the headline findings of the self-assessment.

Figure 3: Self-assessment Headline Findings

Regulation 13 Self Assessments completed in all Clinical Groups Outcome		
What's Working Well	**Areas of Development**	**Areas Requiring Safeguarding Support**
Safeguarding governance framework in all Clinical Groups (CG), provide assurance and oversight of mechanisms of safeguarding activity	Continued improvements through Safeguarding Training Strategy Group to meet 90% level 3 training compliance standards	Visible and available safeguarding team delivered through safeguarding review improvement plan
Assurance that Trust wide safeguarding work programmes were evidenced being delivered at the frontline.	Mental Health subgroup improvement plan to address system and Trust wide response to increasing volume and complexity of safeguarding and mental health concerns	Frontline colleagues 'accessibility to safeguarding champion network and specialist safeguarding supervision reviewed through Quality and Learning Group reporting.
Detailed self-assessments evidence CG were. • Responsive to safeguarding concerns. • Working collaboratively with our patients and partners to safeguard people.	Safeguarding Quality and Learning group completed thematic review and action plan into safeguarding learning from discharges	Safeguarding bespoke training to continue to be delivered at the frontline line (2003 trained in 2025/26).

5.3 Safeguarding Audit

A total of 25 safeguarding audits were completed during the reporting period providing substantial assurance regarding compliance with safeguarding standards, quality of practice and the effectiveness of improvement activity across the Trust. (20 single agency and 5 multi agency audits), with the internal MFT audits summarised in Figure 4. In all audits an action plan was implemented if significant assurance standards were not met.

Figure 4: Safeguarding Audits

Audits Completed	**Children and Unborn**		**Looked after children (LAC)**	**Safeguarding Adult**	**Learning Disability and Autism (LD&A)**	**Mental Health**
Number	6		2	3	2	7
Assurance	Assurance in delivery of safeguarding standards in • 3 audits in child protection		Focussed assurance provided on LAC at home health needs being met.	Assurance in application of • Mental Capacity Act (MCA)	Focused improvement work required in flagging and documentation LD&A patients reasonable	Assurance in delivery of Mental Health Improvement Plan in relation to application of

	medicals aligned to Royal College of Paediatrics standards (inconsistent assurance), • Midwifery safeguarding (assurance provided) • Application of Child Protection Information Sharing (significant assurance) • Communication through safeguarding newsletter (significant assurance)		assurance that children who have additional/ complex needs/ disabilities have their needs met when placed within GM (limited assurance)	(significant assurance) • Deprivation of Liberty Safeguards (DoLS) (significant assurance) • Domestic abuse risk assessment good assurance)	adjustment care plan on Hive EPR (limited assurance)	Mental Health Act, provision of safe environment and least restrictive care. (significant assurance in response to environmental ligature risk assessment, knowledge and application of restrictive interventions). 87% compliance in application of MJHA and 86% compliance in application of missing from care guidance).
Priority Actions	Targeted training and information sharing programme for paediatricians		GMICB LAC strategic plan including local action plan	Revised DOLS process implemented	Delivery of Oliver McGowan Training programme	Continuous programme of quality assurance

In 2026, 29 audits are planned to evidence the Trust's response to legislative, regulatory and contractual safeguarding standards, learning from incidents and safeguarding partnership reviews.

5.4 Unannounced Assurance Visits

15 unannounced safeguarding assurance visits were undertaken across 6 Clinical Groups and in Research and Innovation to review safeguarding practice at the frontline. A report was submitted to each Clinical Group Safeguarding Group and an action plan implemented. The visits concluded that frontline colleagues understood the Think Family Safeguarding approach and were confident regarding the safeguarding referral processes. Thematic areas of improvement were addressed in a deep dive into improvements and actions required to recognise and respond to domestic violence and abuse (DVA) and amendments to policy guidance and Hive EPR to facilitate safer discharges.

5.5 Safeguarding Policies

The Trust has a suite of **24** safeguarding policies that evidence compliance against the NHSE Safeguarding Commissioning Assurance Toolkit (SCAT) standards. In 2025/26 **12** policies were reviewed in line with the MFT Safeguarding Review, changes to national guidance (Working Together to Safeguard Children [2026], David Fuller Enquiry 2026[5] Royal College of Emergency Medicine Guidance[6]), safeguarding partnership

[5] David Fuller Enquiry
[6] RCEM Position Statement on Spiking

priorities (Complex Safeguarding) and local learning (DoLS). The remaining policies are in date and aligned to current regulatory and legislative standards.

5.6 External Assurance Mechanisms

National Safeguarding Steering Group NHS Safeguarding Integrated Data Dashboard

From September 2024 the National Safeguarding Steering Group mandated NHS provider Trusts to complete the NHS Safeguarding Integrated Data Dashboard Data Quality Improvement dashboard**7** as part of the NHS Safeguarding accountability and assurance framework**8** (SAAF). This has been updated quarterly by the safeguarding team following reports to TSG, which inform on how MFT has been compliant in meeting the Provider Safeguarding Commissioning Assurance Toolkit (P-SCAT) and Prevent standards. To be fully compliance MFT was required to provide evidence for.

- **7** standards on MFT Prevent training compliance. **Assurance: MFT met expected standards.**
- **28** P-SCAT standards relating to 7 thematic areas, safeguarding leadership, training, recruitment and human resources, interagency working, implementation of Shared Learning, patient engagement and supervision. **Assurance: MFT met expected standards.**

Schedule 2.K NHS Greater Manchester Safeguarding Children, Young People and Adults at Risk Contractual Standards 2025-2026.

As part of the NHSE SAAF, MFT is required to complete an annual self-assessment of the Greater Manchester Safeguarding Children, Young People and Adults at Risk Contractual Standards and update this quarterly at contractual standards compliance meetings with the Manchester and Trafford's ICB designated safeguarding team.

- MFT was fully compliant in **82** of 85 standards,
- There were **0** standards rated as non-compliant.
- There are 3 areas of partial compliance, these are indicated in **Figure 5** with progress to meet the standard articulated in within this report.

Figure 5: Areas of Partial Compliance requiring an Improvement Plan

A1.3 Staff have access to a suite of safeguarding policies and procedures. MFT is fully compliant with 12/13 policies required. Trust's Social Media policy is under 3 yearly review was reported o TSG for approval; in May 2026.

A2.4 Staff training compliance must reach 90% standard at all levels. At end of Q4 2025/26 compliance has increased to 89% -1% below expected standard

At end of Q1 Level 3 safeguarding adult compliance improved marginally during Q1, increasing to **89.59%** from 89.19%. Level 3 safeguarding children training compliance remained stable at **88.54%** during Q1.

A8.4 Promoting wellbeing of looked after children, including the timeliness of initial health assessments. At the end of Q4, **24% in Manchester)** and **45.7% in Trafford)** of Initial Health Assessments for children entering care were completed within the **20-day statutory timeframe**. System-wide improvement activity at both local and Greater Manchester levels is underway, with support from Director and Assistant Directors of Children Social Care and Director of Safeguarding GMICB, an improvement plan has focused on improving communication, timeliness of Local Authority (LA) consent, and sustaining paediatric capacity to meet fluctuating demand. Performance has also been impacted by the fluctuating and increased number of children entering care including increased numbers of unaccompanied asylum-seeking children (UASC) requiring a culturally sensitive physical and mental health response. At end of Q1 **42% in Manchester)** and **53**% **in Trafford)** of Initial Health Assessments for children entering care were completed within the **20-day statutory timeframe**.

[7] National Safeguarding Steering Group NHS Safeguarding Integrated Data Dashboard Data Quality Improvement Plan (draft)
[8] Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework

6. MFT Strategic Aim Provide high quality, safe care with excellent outcomes and experience

6.1 Safeguarding Referrals

40,311 referrals to the safeguarding team were completed in 2025-26, a **9%** decrease from 42,702 in 2024-25. This activity is reflected in Figures 6 and 7 below:

Figure 6: Referrals to Safeguarding Team 2025-26

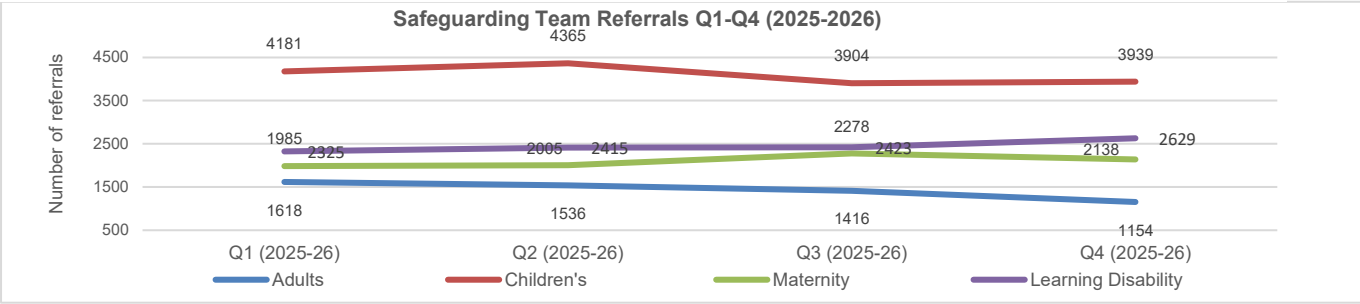
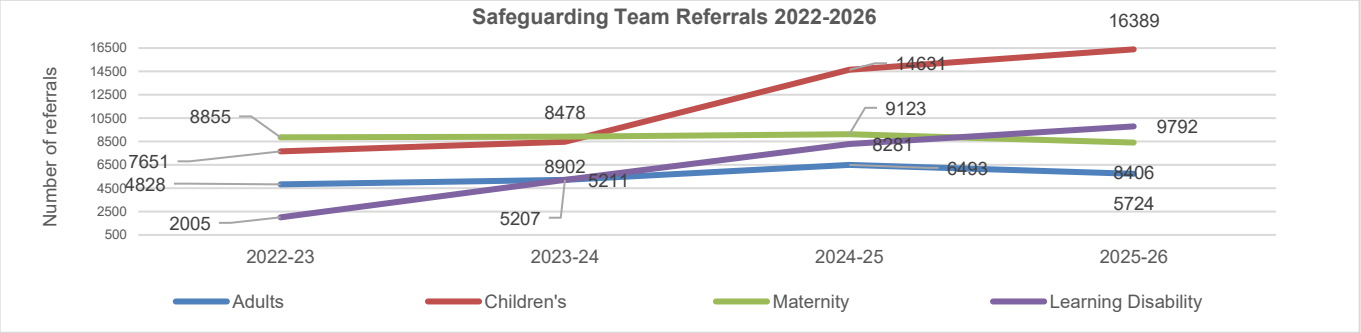


Figure 7: Referrals to Safeguarding Team 2022-26



Safeguarding children referrals continue to increase (↑1,758, 10%), at a higher rate than national reporting (in England there was a 1.8% increase in children's referrals to LA by healthcare providers). This is reflected in the recent Trafford Inspection of Local Authority Children's Services (ILACS) Report[9] (August 2026), that identified a year-on-year increased demand, with the contacts and referrals not always responded to in a timely, proportionate or risk-based way. MFT colleagues in Q1 2026/27 have worked with the multi-agency safeguarding partnership to review the Supporting and Protecting Babies Children and Families in Trafford threshold levels in need guidance that will be implemented in August and September 2026. In Manchester the ILACS found contacts and referrals to children's services are responded to in a timely way, with thresholds for services well applied[10].

The MFT decrease in adult and maternity safeguarding referrals is not reflective of the national reporting of a 4% increase in safeguarding adult referrals.
The MFT decrease is attributed to:

- A streamlining of safeguarding maternity referrals to redirect requests for early help and support with mental health needs to specialists' midwives.
- Reporting of referrals to the safeguarding mental health team (2,135).

[9] Trafford Inspection of Local Authority Children's Services Report accessed at Trafford Metropolitan Borough Council - Open - Find an Inspection Report - Ofsted
[10] Manchester ILACS accessed 50290914

- Scrutiny of adult safeguarding referrals and targeted support to redirect requests for adult help and support.

The volume of safeguarding activity remains high, with sustained levels of referrals to the MFT Safeguarding Team. This reflects increasing workforce awareness and recognition of safeguarding concerns; alongside growing support needs to implement reasonable adjustments for people with a learning disability and/or autism. It is also reflective of the high levels of deprivation across the population, particularly in Manchester, which is among the most deprived areas nationally. All referrals to the safeguarding teams are risk assessed, with safeguarding plans reviewed and support implemented by the Trust safeguarding team in collaboration with Trust colleagues and multi-agency partners as required.

6.2 Severity of Safeguarding Risk

In 2025-26. **267** (**282** 2024/25**)** serious safeguarding incidents with MFT and/or system wide learning were escalated to the Trust Deputy Chief Executive and Chief Nursing Officer, Clinical Group Directors of Nursing and the ICB Designated Safeguarding Team. MFT responded to **68 (42** 2024/25) safeguarding concerns that met the criteria for safeguarding adult, child or domestic homicide reviews, representing a marginal increase variance of 25.

6.3 Safeguarding Activity in line with Manchester and Trafford Safeguarding Partnership and MFT Priorities

Figures 8 to 11 identify the number of safeguarding referrals to the safeguarding adult and children Trust safeguarding teams with categories of safeguarding concern that align to MFT and safeguarding partnership priorities. Detail relating to these graphs is provided within the subsequent sections, namely themes and trends identified.

Figure 8: Adult Safeguarding Referrals Categories of Safeguarding Concern 2024-26

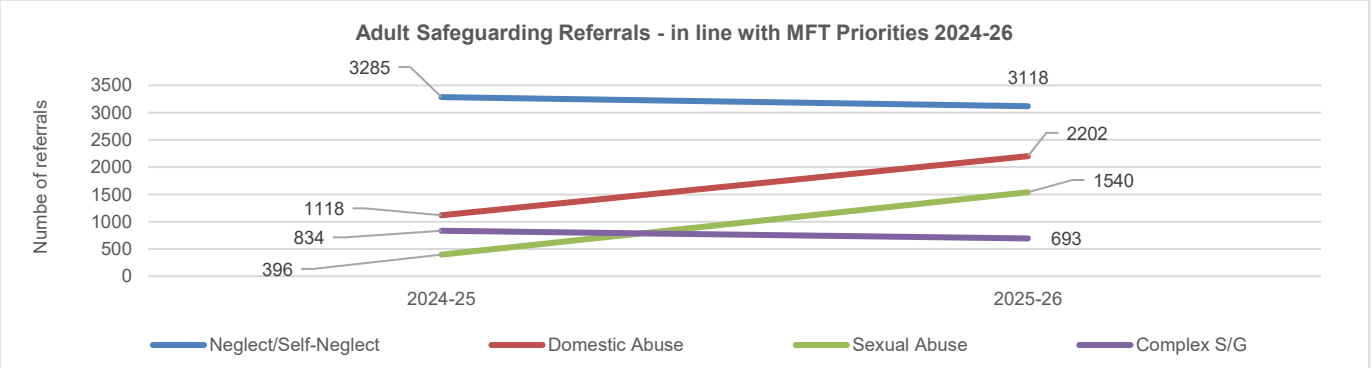


Figure 9: Adult Safeguarding Referral Categories of Safeguarding Concern 2025-26

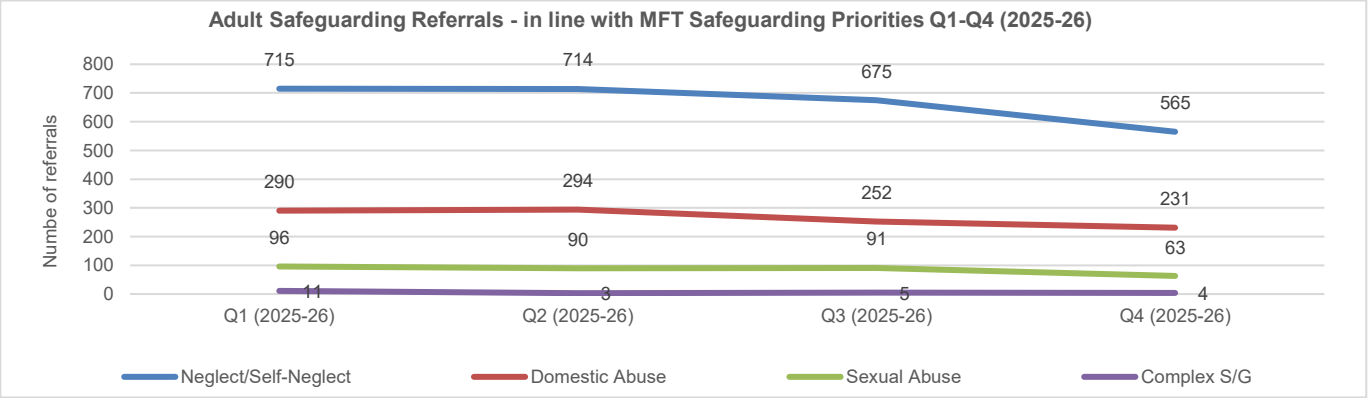


Figure 10: Safeguarding Children and the Unborn Referrals in line with MFT Safeguarding Priorities 2025-26

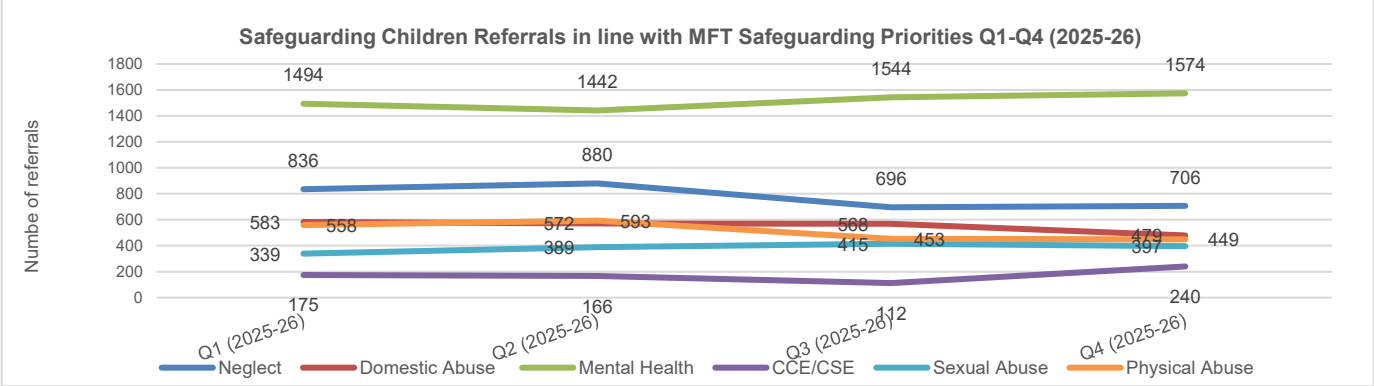
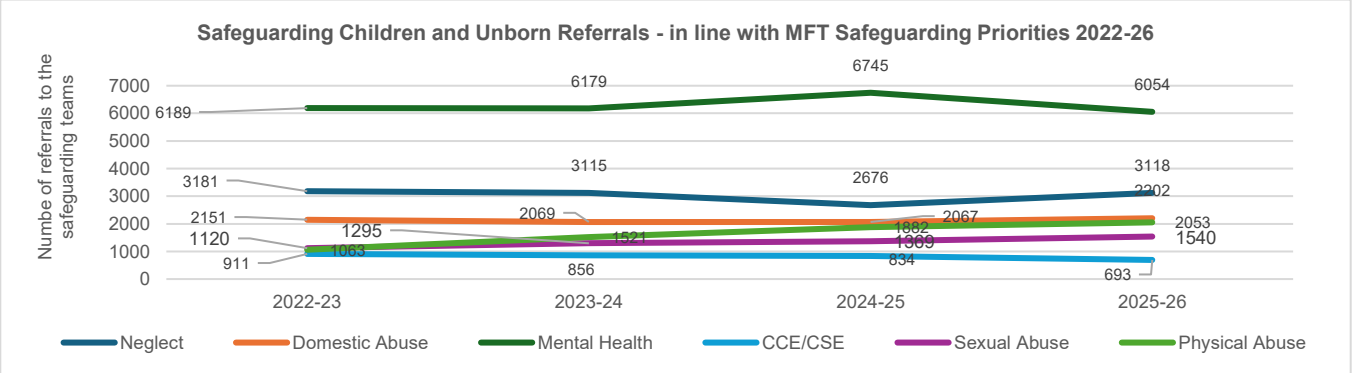


Figure 11: Safeguarding Children and the Unborn Referrals in line with MFT Safeguarding Priorities 2022-26



Neglect, domestic violence and abuse, and safeguarding people in the context of mental ill health have remained the most frequent categories of safeguarding concern reported.

6.4 Recognition and Response to Neglect and Self Neglect in Adults

Figures 8 to 11 identify neglect (in adult and child safeguarding), and self-neglect (in adult safeguarding) as the most frequent category of safeguarding concern in safeguarding adults and the second most frequent category in safeguarding the unborn and children in MFT.

MFT Response to Findings:

- Working with MSP to develop "Responding to Neglect – Enabling Children to Thrive 2026–2029", strategy and implement the All-Age Neglect Screening Tool (2026/27).
- Fifteen neglect champions have been identified to promote implementation and support dissemination of the new strategy.

- Training:
  - 9 colleagues are licensed NSPCC Graded Care Profile 2 (GCP2) trainers and will co-deliver multi-agency GCP2 neglect training in 2026, with additional sessions planned for MFT colleagues.
  - An adult neglect/self-neglect and child neglect e learning module has been launched (completed by 160 colleagues (Q4)).
- A digital solution to record GCP2 completion in Hive and EMIS EPR is in development, enabling evaluation of training impact in 2026/27.

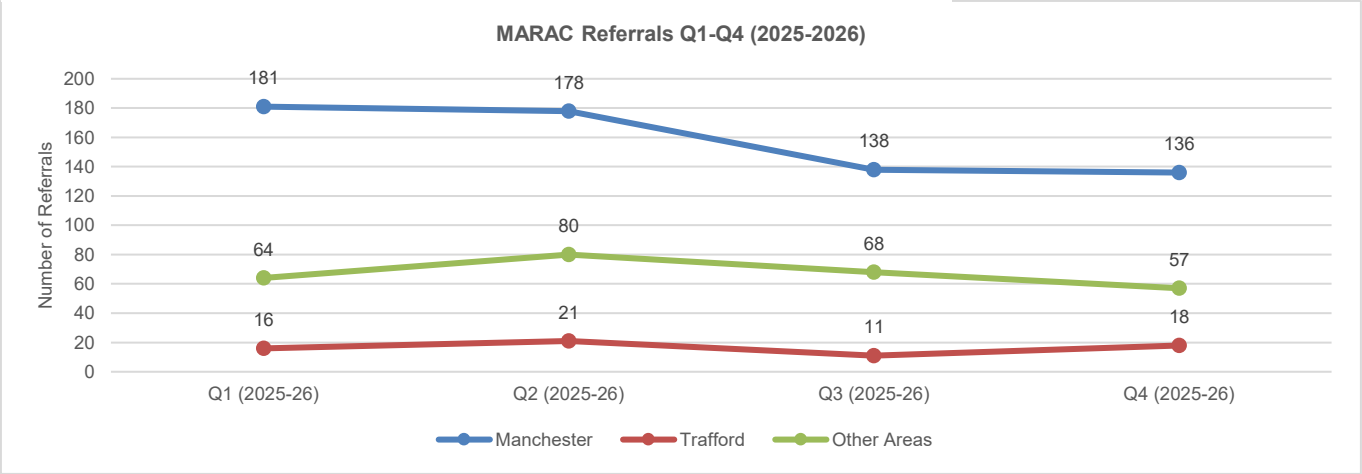
6.5 Domestic Violence and Abuse and Female Genital Mutilation

National data identifies approximately 1 in 13 people experienced domestic abuse in year ending March 2025[11].

Figures 8 to 11 identify domestic violence and abuse (DVA) as the 2nd most frequently reported category of concern for safeguarding adults and 3rd most frequently reported category in safeguarding children and the unborn. There were **3089** safeguarding referrals with DVA being the category of concern in 2025-26, compared to 3185 in 2024-25.

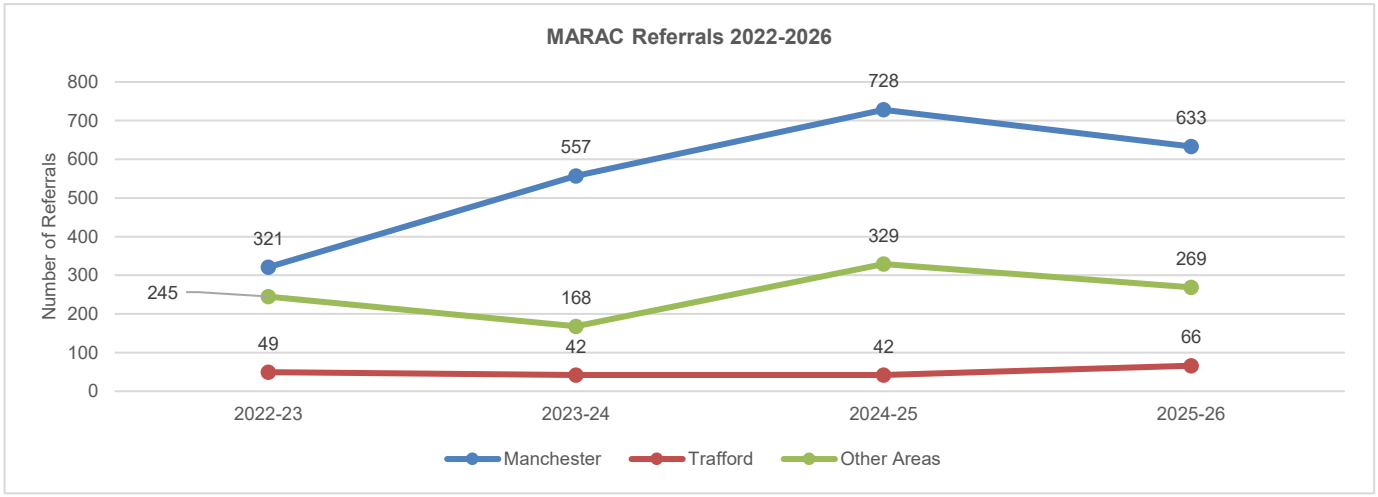
Figures 12 and 13 identify **968** people experiencing high-risk domestic violence and abuse were identified by Trust colleagues and referred to the Multi Agency Risk Assessment Conference (MARAC).

Figure 12: MARAC Referrals Q1-Q4 (2025-2026)



[11] Domestic abuse prevalence and trends, England and Wales: year ending March 2025

Figure 13: MARAC Referrals 2022-26



MFT completed 23% of referrals to Manchester MARAC and 4% to Trafford MARAC, exceeding the national average for acute and secondary care providers (2.8%). This demonstrates a mature safeguarding system, strong workforce awareness and effective identification of individuals at high risk of serious harm from domestic abuse cases.

In 2025/26, safeguarding teams contributed to multi-agency risk assessment and safety planning in 2,777 referrals to Manchester MARAC and 1,635 to Trafford MARAC, reflecting sustained high demand and an increase in high-risk cases requiring multi-agency intervention.

Nationally 6,980 females in England were identified to have had FGM in 16,300 attendances. MFT reported 510 (7%) of the total FGM cases reported nationally demonstrating positive trends identification and action, being the 5th highest reporter of FGM outside of London.

Figures 14 and 15 identify **510** mandatory reports were completed to the NHS national FGM dataset[12] when FGM was observed in clinical practice (all reports were for women over 18 years).

Figure 14: Women identified to have experienced FGM reported to the National Database – Q1-Q4 (2025-26)

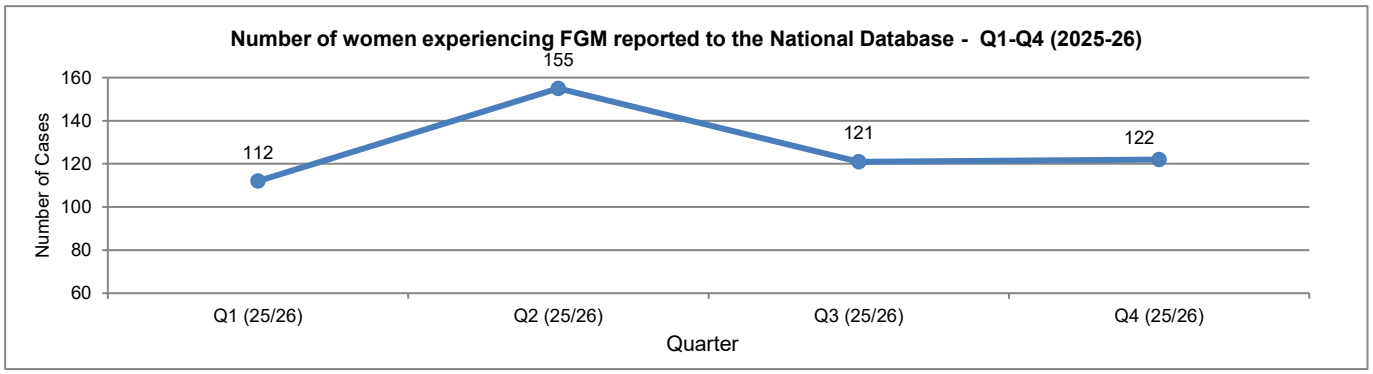
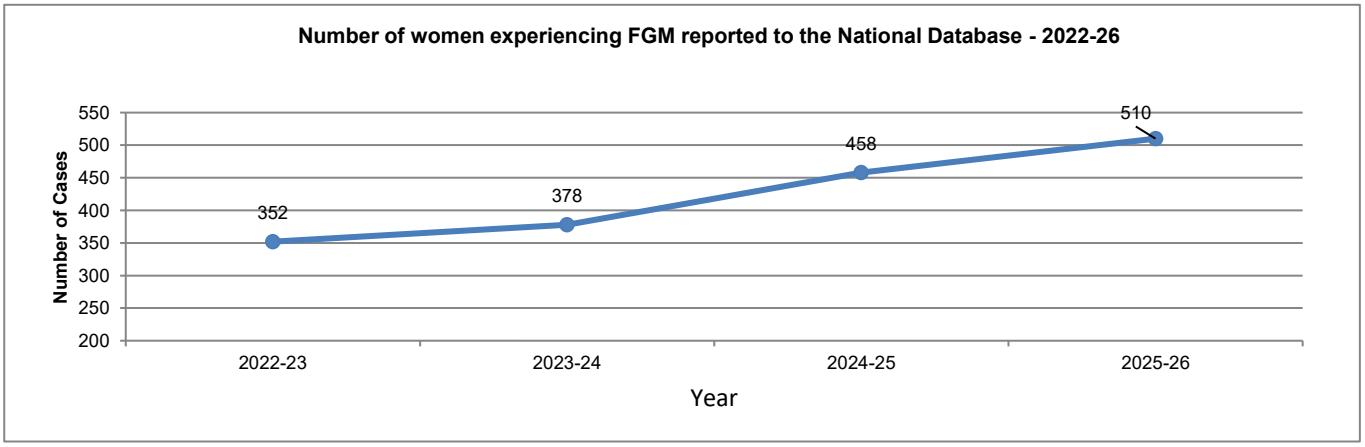


Figure 15: Women identified to have experienced FGM reported to the National Database – 2022-26

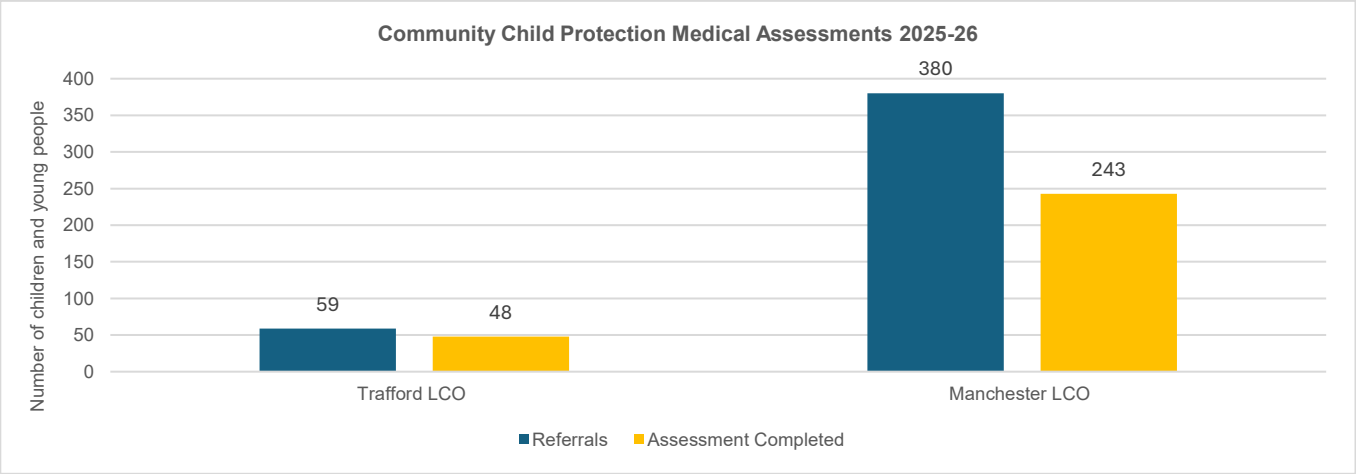


6.6 Child Protection Medicals Service

Figure 16 reports on the completion of child protection medical examinations as part of the Children Act (1989) Section 47 child protection enquiries. Local Care Organisation (LCO) children's community services (CCS) complete this process with the exception of children aged less than 18 months of age, or for children who need to be seen in hospital.

[12] Female Genital Mutilation, Quarterly Report: July to September 2025

Figure 16: Community Child Protection Medicals Assessments 2025-26



In Wythenshawe, Trafford, Withington and Altrincham (WTWA) **35,** RMCH ORC **87,** NMGH **20** medicals were completed over the last year.

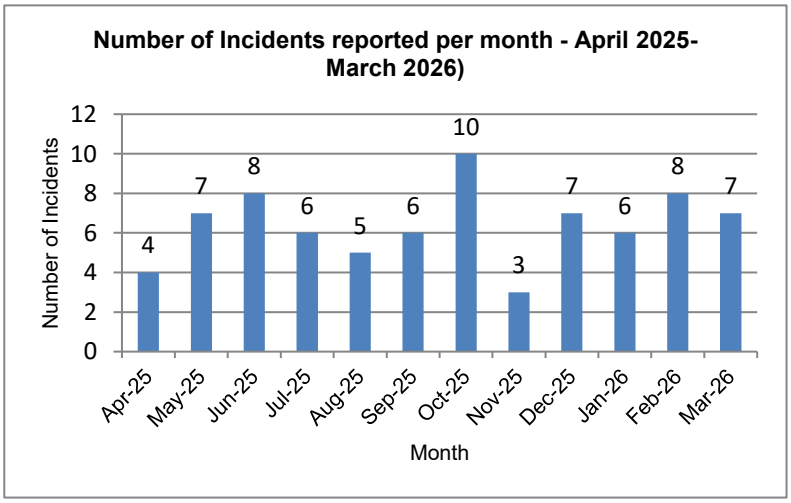
6.7 Managing Safeguarding Allegations against MFT Colleagues

The managing allegations process is triggered when a colleague is accused of harming a child or vulnerable person.

Figures 17 and 18 indicate **77** managing allegations referrals in 2025-2026, an increase of 14 compared with 2024-25, resulting in 42 referrals to LA Person in Position of Trust (PiPoT) and 20 to LA Designated Officer (LADO). Triangulation meetings with patient safety incidents and regulatory referrals continued to ensure incidents were identified and responded to. A deep dive into referrals has been reported to TSG (August 2026). The Deputy Chief Executive and Chief Nursing Officer has emailed all clinical group directors of nursing and human resources, as well as medical directors to clarify the escalation requirements for all serious safeguarding incidents which would involve the Managing allegations for all MFT colleagues who work with children and adults at risk policy (August 2026).

Figure 17: Managing Allegations Referrals to PiPoT and LADO Q1 – Q4 (2025-26)

Managing Allegations Activity by Month (April 2025 to March 2026)



Managing Allegations Referrals by Adult and Child Safeguarding Category

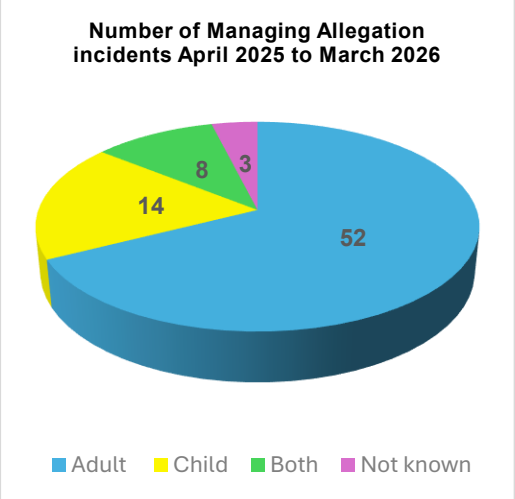
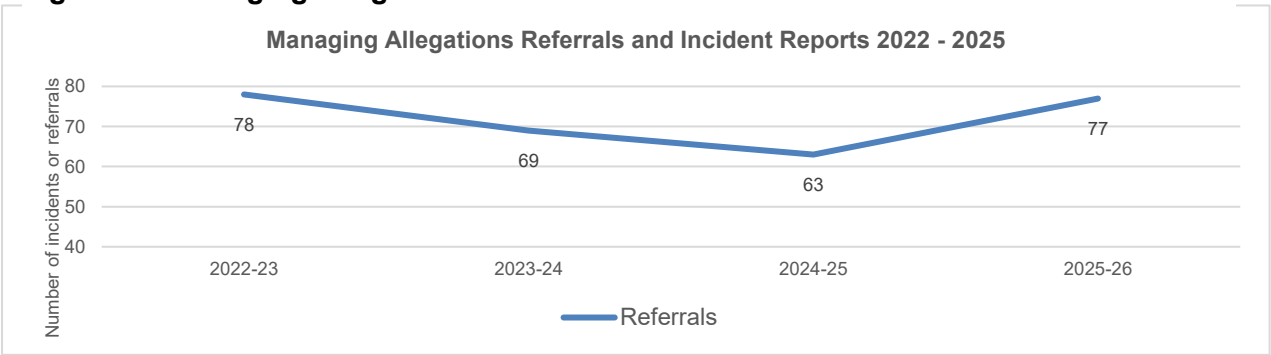


Figure 18: Managing Allegations Referrals



The delivery, assurance and oversight of the response to Trust Policy Managing Allegations against MFT colleagues who work with children, young people and adults at risk has been strengthened through the following activities.

- A review and implementation of revised Trust policy designed to be more accessible to colleagues.
- Development of an e-learning training package and bespoke training provision to 145 management colleagues.
- A deep dive of the managing allegations process reported to TSG (August 2026) provided assurance that arrangements for managing allegations were operating effectively with continuous improvement actions to strengthen quarterly reporting metrics to TSG.

7. Patient Experience

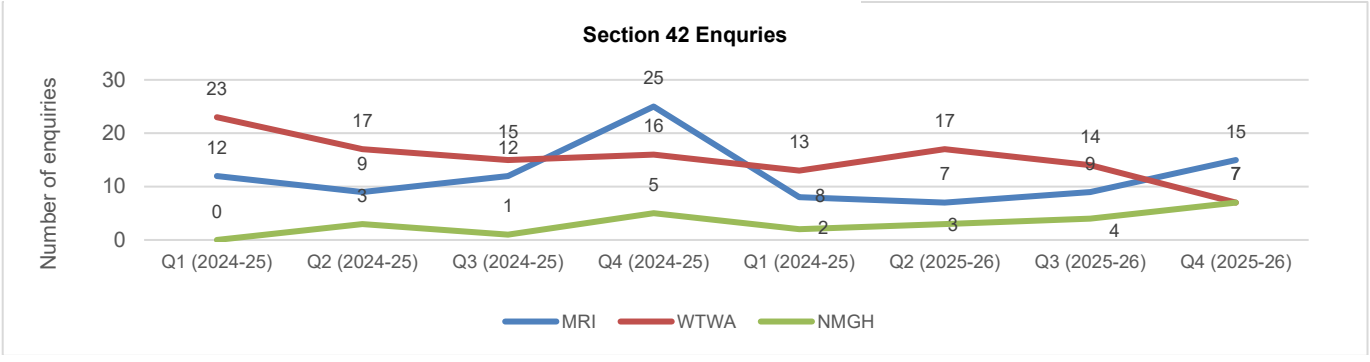
7.1 Advocacy

In RMCH, the risk was identified that there was no local authority-commissioned Independent Mental Health Advocate (IMHA) service for children under 16 years, in line with the Mental Health Act (MHA) Code of Practice, impacting 14 children and young people (Dec 2024–Mar 2026). From April 2026, Manchester LA Commissioned Real Advocacy to provide this service which has been promoted through Trust wide communication coordinated by the Mental Health subgroup. The impact of the new service provision will be presented to the Mental Health subgroup in October 2026.

7.2 Section 42 Enquiries

Figures 19 and 20 identify that in 2025-26 **106** (138 2024-25) Care Act Adult Safeguarding Section 42 (s.42) enquiries were completed by the LA where there were safeguarding concerns about care and treatment provided in MFT. The themes of the s.42 enquiries were unsafe discharge (35), skin damage (24), falls (23), neglect 8) other 16.

Figure 19: Section 42 Enquiries Q1-Q4 (2024-26)

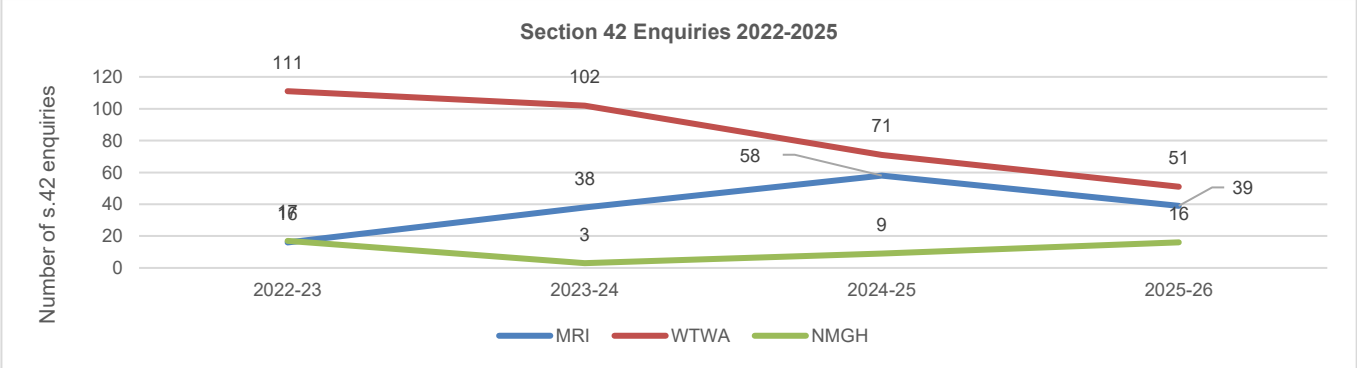


The statutory timescale of response to the LA is 20 working days, **87%** (**92**) of MFT s.42 enquiries were responded to within this timescale, with all LA receiving a response from the Trust to all s.42 enquiries in 2025/26. A joint Clinical Group, governance and safeguarding team response is reported monthly to Assistant Chief Nurse Safeguarding with targeted tracking to improve response time to all enquiries within mandated timescales.

A thematic review of 56 discharge cases (Jan–Sep 2025), identified through complaints and safeguarding processes, highlighted issues with medicines on discharge, communication and documentation, and discharge planning (including equipment and care packages), and wound care concerns challenges.

Actions were implemented and learning shared through governance forums, alongside Hive EPR improvements to strengthen discharge documentation via the Discharge Navigator. Learning from the enquiries is informing the Trust Home First Discharge Policy review and will contribute to the patient experience workstream on discharge in (Q1 and 2 2026/27).

Figure 20: Section 42 Enquiries Q1-Q4 (2022-26)



7.3 Safeguarding Complaints

Figures 21 and 22 indicate that there were **189** complaints identified to involve a safeguarding concern.

Figure 21: Safeguarding Concerns/Complaints by Clinical Group 2025-26

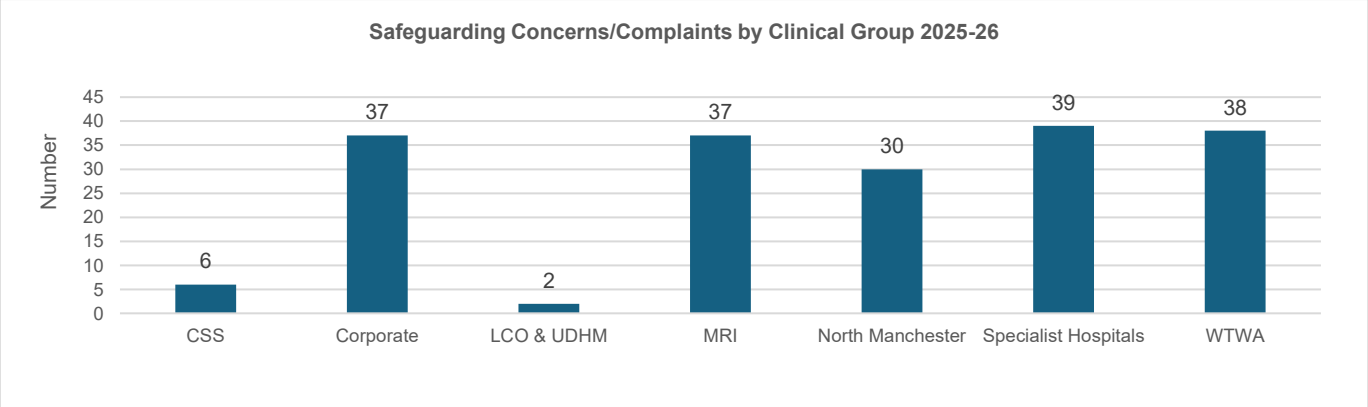
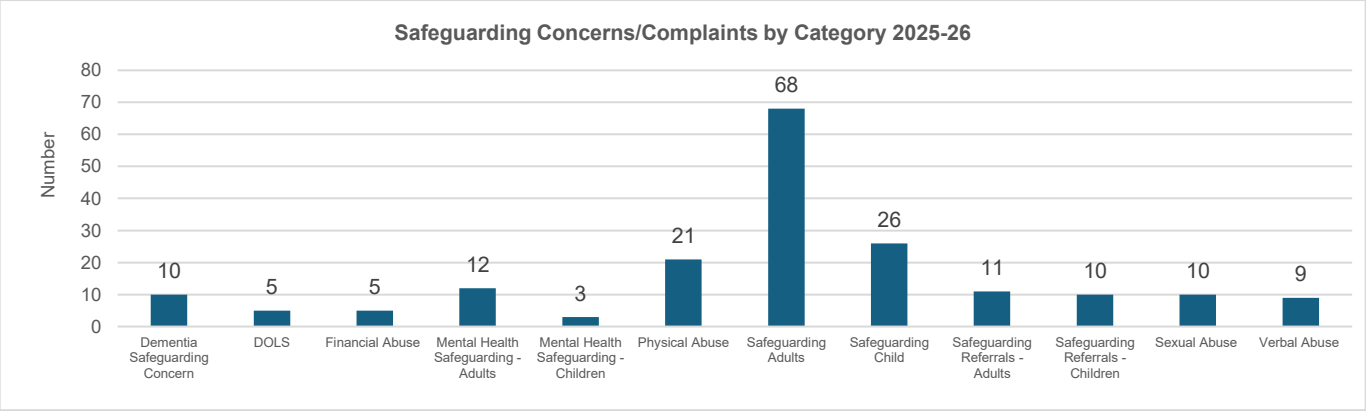


Figure 22: Safeguarding Concerns/Complaints by Category Q1-Q4 (2025-26)



- Specialist Hospitals, WTWA, MRI and Corporate Services received the most PALS and Complaints in relation to safeguarding, whilst CSS and LCO and UDHM contributed very low volume (this reflects volume of safeguarding activity and complexity being high at WTWA MRI and SHS compared to CSS).

- Overall patterns indicate concentration and episodic spikes, with most volume sitting in a few services/themes (safeguarding adults, safeguarding children and physical abuse) and month-to-month surges likely driven by specific safeguarding incidents rather than systemic thematic issues. Immediate safeguarding concerns identified in complaints are responded to in line with statutory safeguarding processes. The most frequently reported learning is the need to improve communication and transparency with families in application of statutory and regulatory responsibilities.

7.4 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

Application of the MCA and DoLS ensures lawful restriction of liberty, protects patient rights, supports best-interest decision-making, and mitigates risk of unlawful detention, particularly in urgent care.

In partnership with LA Best Interest Assessment (BIA) teams and legal teams, MFT has strengthened its DoLS process through a revised policy, improved Hive EPR workflows, enhanced training, and strengthened quality assurance aligned to Association of Directors of Adult Social Services (ADASS) prioritisation. Audit findings provide strong assurance of staff understanding and application of MCA principles, with **89%** of the mapped workforce trained (85% 2024/25) and **333** staff completing additional bespoke training in 2025/26. Despite this, **2,854** applications resulted in only **73** authorisations reported to the Care Quality Commission in line with regulatory guidance, highlighting a significant ongoing risk for the LA BIA team (Supervisory body) who are not completing DoLS applications within mandated timescales resulting in patients deprived of their liberty in the Trust without an authorised legal framework (MFT Corporate Risk Score 12). (Figures 23 and 24).

Figure 23: DoLS Applications and Authorisations Q1 – Q4 (2025-26)

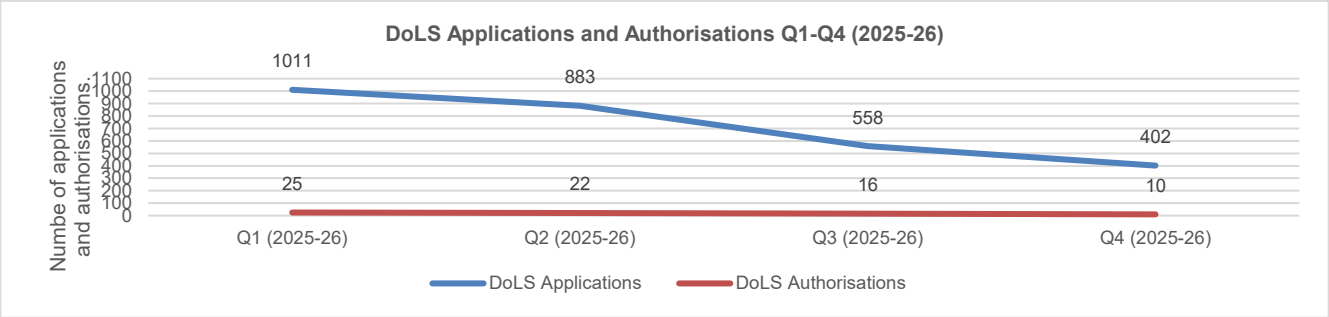
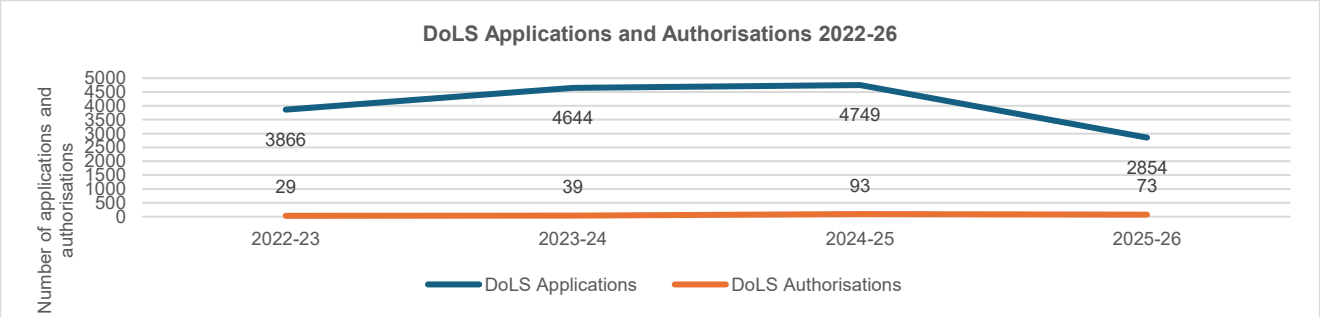


Figure 24: DoLS Applications and Authorisations 2022-26



Nationally, **4%** of acute hospital DoLS applications were fully completed and assessed by the Local Authority[13]. In MFT **3.5%** of DoLS applications were completed and authorised.

Progress to address this risk is reported monthly in the Integrated Performance Report (IPR) to the QSPBC and quarterly to TSG. Actions to improve the rate of DoLS authorisations included:

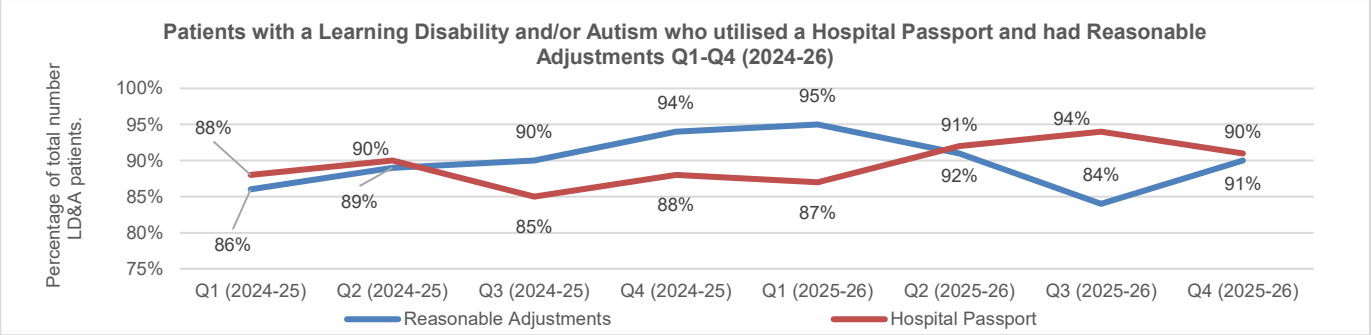
- The MCA 2019 Amendment Act aims to address this national issue through implementation of Liberty Protection Safeguards, with the MCA code of practice expected to be consulted upon in 2026. In addition, in response to Supreme Court Judgement (June 2026), revised DoLS application processes will be implemented.
- Escalation and deep dive into the barriers impacting on DoLS authorisations escalated to Manchester LA Head of Safeguarding resulting in a deep dive of LA processes reporting to TSG (August 2025) which informed Trust policy review. A further escalation April 2026 has been completed resulting in a further deep dive Q1, 2026/27

8. Providing high-quality reasonable adjustment care to people with a learning disability and autism. Our plan for people with learning disabilities and/or autism, their families, and carers.

The progress to the strategic aims of the MFT strategy "Our plan for people with learning disabilities and/or autism, their families, and carers 2022–2025" has been reported to the MFT Learning Disability Steering Group. A revised strategic delivery plan has been developed and approved by Quality Safety Management Committee in July 2026.

All patients admitted with a diagnosis of learning disability and autism (LD&A) are flagged with an equality monitoring LD&A flag on their Hive EPR, and within 48 hours of admission receive a Quality Care Check (QCC) completed by the specialist LD&A nursing team. The outcome of the QCC is reported in **Figure 25**. During the reporting period,**1,767** Quality Care Checks were completed, with **91%** of patients supported through the use of Hospital Passports and **90%** compliance that patients received appropriate reasonable adjustments (standard is 100%). These outcomes demonstrate continued progress towards reducing health inequalities and improving the experience of people with learning disabilities and autism.

Figure 25: Patients with a Learning Disability and/or Autism who utilised a Hospital Passport and had Reasonable Adjustments Q1-Q4 (2024-26)



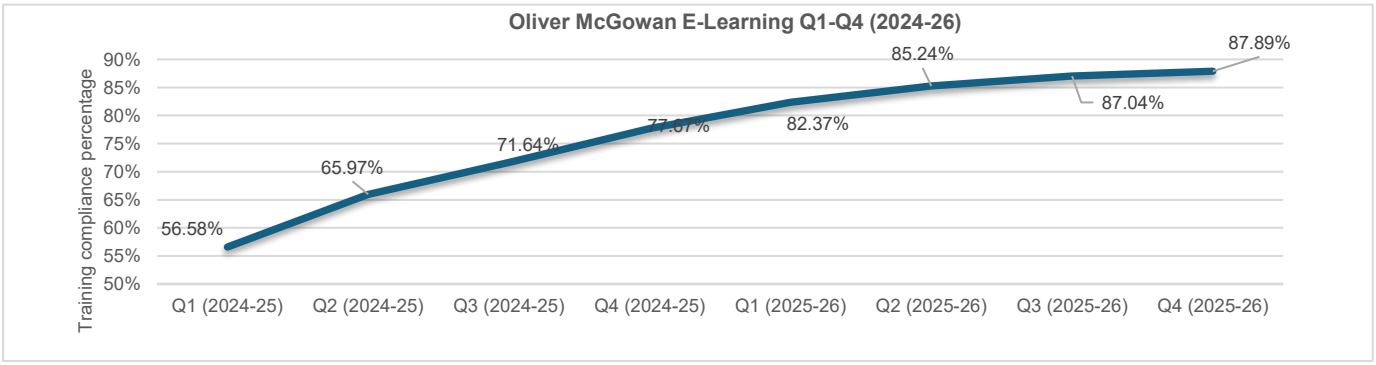
8.1 Reasonable Adjustment Digital Flag (RADF)

NHS England has introduced an information standard for the Reasonable Adjustment Digital Flag (RADF), requiring organisations to implement the RADF recorded on the NHS Summary Care Record into local NHS provider systems by September 2026 and progress to full digital integration. MFT is engaging with NHS England and Epic to ensure compliance and is currently mapping the clinical and operational process for identifying, recording and actioning reasonable adjustment, aligning the MFT Hive EPR For Your Information (FYI) and Accessible Information Standard (AIS) flags to the national standard, (reporting to TSG within mandated timescales September 2026).

8.2 Oliver McGowan Training

Oliver McGowan learning disability and autism training is mandatory for NHS Trusts[14]

Figure 26: Oliver McGowan E-Learning Q1-Q4 (2024-2026)



- **87.89%** of colleagues had completed Oliver McGowan e-learning, not meeting the Trust standard of 90%. Training trajectories are in place across Clinical Groups to meet the expected trajectory. This is reported to the LD&A steering group and TSG.
- MFT have procured the services of two providers (BeWell and MENCAP) to deliver Oliver McGowan Tier 2 training for clinical staff. 196 full day sessions delivered, with a cap of 30 learners per session. Attendance is 100%, and the current level of completion for Tier 2 for MFT is **23.71%.** This is compliant with the regional requirement.
- MFT has committed further funding to deliver Part 2 Tier 1 and Tier 2 for the next 12-month period.
- This further funding will also see a programme for the delivery of Tier 1 training for non-clinical staff, with **33%** of non-clinical staff trained during the next 12 months.

8.3 Learning from Lives and Deaths – People with a Learning Disability and Autistic People)

In 2025/26, 47 patients with a learning disability and/or autism died while admitted at MFT; 44 reviews are complete and 7 are being finalised.

[13] Deprivation of Liberty Safeguards, England: 2024 to 2025
[14] Oliver McGowan Code of Practice.

Reviews identified strengths in family/carer communication, use of hospital passports, reasonable adjustments and timely specialist input. Key learning includes improved clarity of DNACPR/ReSPECT rationale and discussions this is a key focus for 26/27.

9. Mental Health

Mental health remains a strategic risk; however, this has been reviewed and the risk is supported by 12 clear mitigations/control measures, with 5 completed actions and 7 open actions to manage the current position. The residual risk reflects system-wide pressures rather than internal control gaps and is currently rated at score of 16.

The risk states if system-wide mental health demand and capacity pressures continue then, medically optimised patients will remain in emergency departments (ED) and inpatient settings that are not designed to meet their needs, resulting in increasing risks to safety, absconsion, poor experience, delayed flow and reduced capacity, higher costs, and regulatory escalation.

In May 2026 an Executive Level MFT/ Greater Manchester Mental Health Foundation Trust workshop was held resulting in a joint 18 point action plan to be delivered in 120 days

9.1 Volume and Complexity of Mental Health Patients

There have been sustained high volume of patients detained under the MHA (**Figure 27 to 29**) in general and acute wards, and on average 33 patients attending emergency departments monthly subject to MHA Section 136.

Figure 27: MHA Detentions

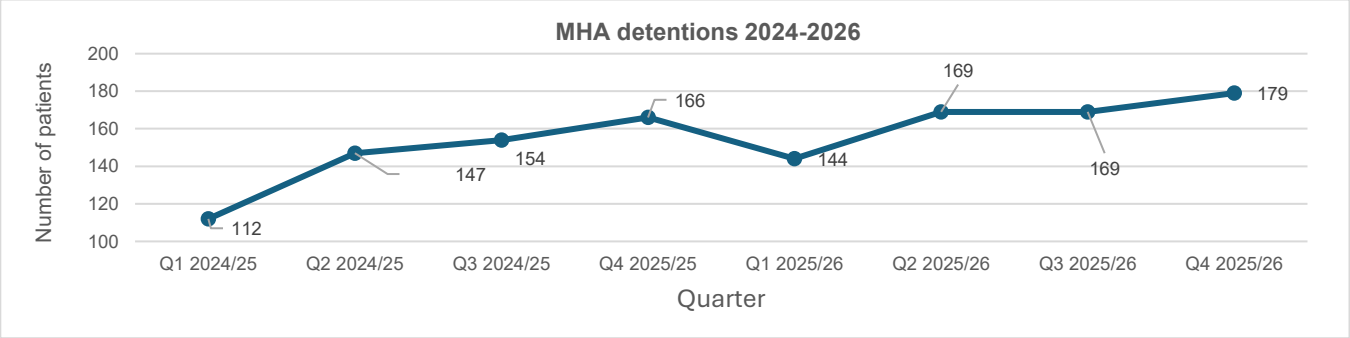


Figure 28: MHA Detained Patients

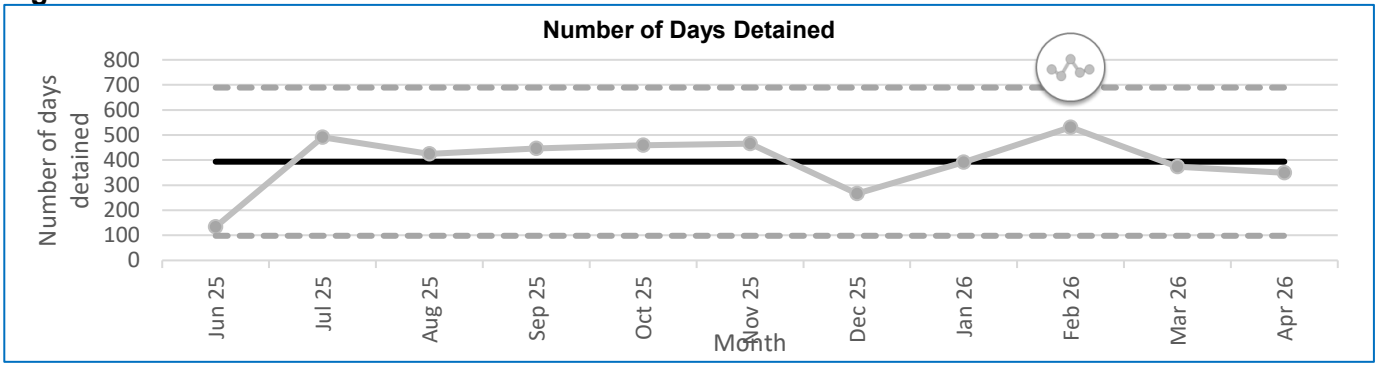
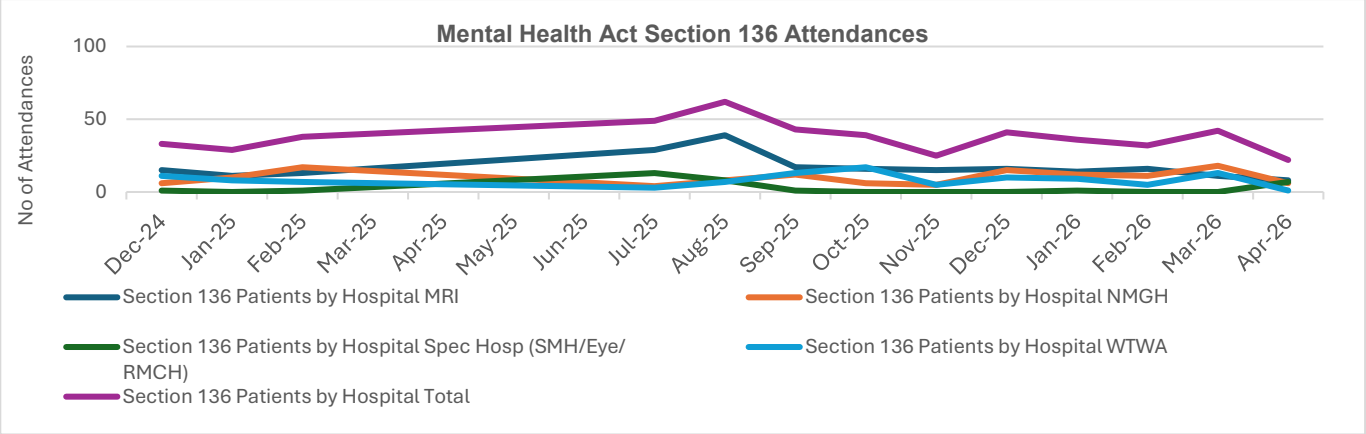


Figure 29: MHA Section 136 Attendances 16th March to 3rd May.



The Mersey Care Mental Health Peer Review (completed January 2024) identified 62 recommendations, 49 of the recommendations are complete, 12 are in progress for delivery by 30th October 2026 and 1 remains on hold pending national direction regarding Liberty Protection Safeguards. The implementation of the recommendations has resulted in a strengthened and more consistent approach to mental health care across MFT, with improvements in governance, operational processes, workforce capability and partnership working, thus providing greater assurance that care is delivered safely, lawfully and effectively

The action plan will be closed at Mental Health subgroup October 2026 with all further actions through the revised Mental Health strategic risk (July 2026) and the Joint Action Plan

Figure 30: Governance Arrangements Supporting Delivery of Mental Health Improvement Plan

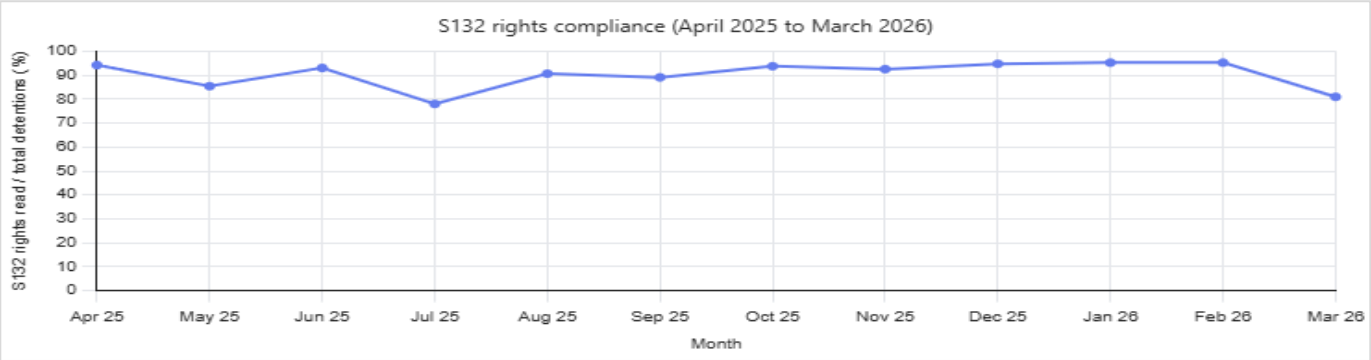
Governance	Actions Progressed
Bi-monthly Mental Health subgroup reporting to QSMC	Clinical Groups Mental Health Delivery Groups bi-monthly reporting of progress against Mental Health 5 strategic aims
Policies	8 policies reviewed 2024-2026. New guidance developed in escalation, environmental standards and application of MHA Section 136
Audit	7 mental health audits delivered. • Least Restrictive Interventions and Restraint • ELRAT audit of all inpatient clinical areas • Audit of data from security teams in relation to least restrictive interventions and physical restraint • Section 132 review of application of Patient's rights being applied according to MHA. • MHA audit – review of documentation • Right Care Right Person (RCRP) – review implementation of Prevention and Management of Missing Patients, including Adults, Children and Young People Policy • Right Care Right Person – review of implementation and embedding into practice of Mental Health Act Section 136 SOP.
Mental Health Act Training	578 colleagues trained
Mental Health Training Level 1	96% colleagues compliant with training
Mental Health Training Level 1	86% compliance 3/6 Clinical Groups meeting standard improvement plan in place to meet trajectories where 90% standard not met (June 2026).
Additional CPD Mental Health training	583 (ligature incident management, altered behaviour training)
Mental Health Risks	6 risks, 1 strategic, 3 corporate and 2 operational risks overseen by Mental Health Subgroup (strategic mental health risk, corporate suicide prevention, application of mental health act and restraint reduction risks and operational right care right person and mental health act expiry risks.
Reporting arrangements	Daily, weekly and quarterly mental health reporting to Clinical Group Senior Leadership Teams

Compliance with the Metal Health Code of Practice has been supported by:

- MHA training programme training (578 colleagues trained including Clinical Group Senior Leadership teams and 178 senior operational managers).
- MHA scheme of delegation, policy guidance and robust quality assurance oversight of all MHA detentions.

Figure 31 indicates sustained high-level compliance in a provision of patient rights from October to February with immediate escalation actions taken if compliance standards not met within 1 working day.

Figure 31: Provision of patients' rights April 2025-March 2026



9.2 Restraint Reduction Programme

MFT restraint reduction risk score 12 on corporate risk register with 6 actions completed, 5 open and on track for completion by March 2027 including:

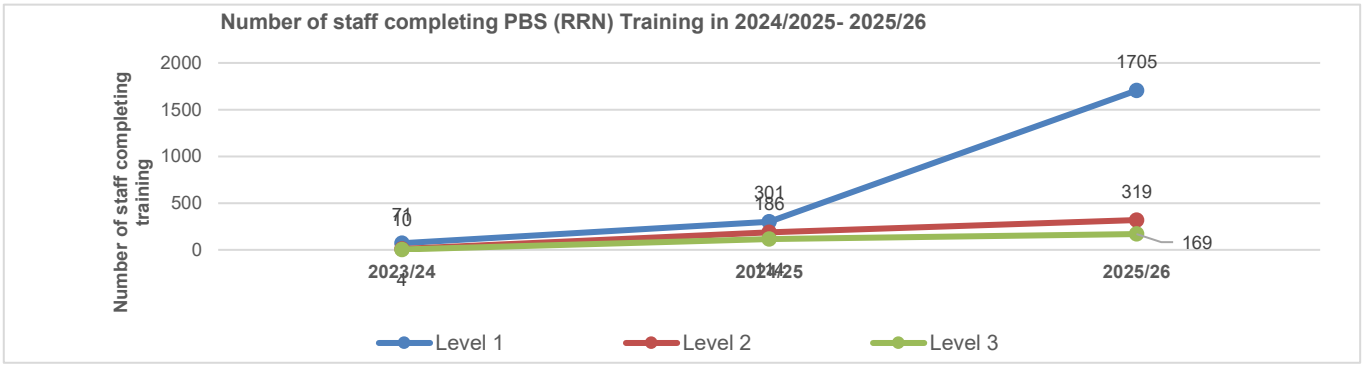
- Policy guidance (for physical, mechanical and chemical restraint).
- Training in line with restraint reduction network standards (Positive Behaviour Support (PBS) training.
- Audit (2 audits indicating significant assurance in application of Trust standards).
- Reporting arrangements in place to record all restraint incidents (Figure 32).
- Progress to ensure enhanced therapeutic observations of care are delivered by the nursing workforce with reduction in reliance on enhanced security supervision and observations (ESSO), **from Q1: 25,024 to Q4 12 314 hours.**

Figures 32 and 33 indicate the number of restraint incidents and training delivered.

Figure 32: Restrictive Practice 2025/26

Number of Incidents	Application of Policy	Outcome
1,639 de-escalation events	De-escalation is used more frequently than restraint, indicating that staff are: • Applying non-restrictive approaches in practice • Prioritising least restrictive interventions in line with training principles	The majority of incidents result in no harm. • A smaller proportion result in low harm • Very few escalate to moderate or serious harm
1,133 restraint events		

Figure 32: PBS Training 2024-2026



The RRN-aligned training programme has been delivered across a wide range of frontline roles, including nurses, healthcare assistants, and ward-based teams.

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

10.1 Safeguarding Training

Figures 34 to 37 report on compliance of the Trust's workforce to meeting expected mandatory safeguarding training standards in line with, NHSE SCAT standards and CQC regulatory guidance (90% compliance). Focussed improvement work is progressing to support medical and dental colleagues improve compliance standards in level 3 (protected time for training, senior oversight, bespoke and targeted support).

Figure 33: Mandatory Safeguarding Training Compliance Level 1 to 3 Q1-Q4 (2024-26)

	Q1 (24/25)	Q2 (24/25)	Q3 (24/25)	Q4 (24/25)	Q1 (25/26)	Q2 (25/26)	Q3 (25/26)	Q4 (25/26)
Level 1 Adults	95%	95%	95%	95%	96%	96%	97%	96%
Level 1 Children	95%	95%	95%	95%	96%	96%	96%	95%
Level 2 Adults	93%	92%	93%	94%	95%	96%	96%	95%
Level 2 Children	93%	93%	93%	94%	95%	96%	96%	95%
Level 3 Adults	80%	80%	82%	85%	86%	88%	90%	89%
Level 3 Children	82%	83%	83%	83%	85%	87%	89%	89%

Figure 34: Mandatory Safeguarding Training Compliance Levels 1 to 3 2022-26

	2022-23	2023-24	2024-25	2025-26
Level 1 Adults	91%	94%	95%	96%
Level 1 Children	91%	93%	95%	95%
Level 2 Adults	89%	92%	94%	95%
Level 2 Children	87%	92%	94%	95%
Level 3 Adults	70%	80%	85%	89%
Level 3 Children	72%	80%	83%	89%

Figure 35: Safeguarding Adults Level 3 Training Compliance – AHPs, Medical and Dental, Nursing and Midwifery Q1-Q4 (2024-26)

	Q1 24-25	Q2 24-25	Q3 24-25	Q4 24-25	Q1 25-26	Q2 25-26	Q3 25-26	Q4 25-26
Allied Health Professionals	87.76%	87.56%	89.62%	89.61%	90.13%	90.42%	92.84%	92.24%
Medical and Dental	58.51%	57.14%	58.20%	65.39%	68.34%	67.46%	74.25%	74.02%
Nursing and Midwifery	84.01%	85.47%	86.54%	89.23%	90.41%	92.87%	93.81%	93.00%
Total	**79.73%**	**80.42%**	**81.59%**	**84.80%**	**86.19%**	**87.64%**	**89.85%**	**89.15%**

Figure 36: Safeguarding Children Level 3 Training Compliance – AHPs, Medical and Dental, Nursing and Midwifery Q1-Q4 (2024-26)

	Q1 24-25	Q2 24-25	Q3 24-25	Q4 24-25	Q1 25-26	Q2 25-26	Q3 25-26	Q4 25-26
Allied Health	86.93%	88.37%	90.25%	88.39%	88.30%	88.62%	92.57%	92.99%
Medical and Dental	62.75%	63.17%	63.92%	66.64%	70.15%	70.79%	74.63%	74.50%
Nursing and Midwifery	86.17%	87.05%	87.09%	86.00%	88.46%	91.36%	91.34%	92.25%
Total	**81.87%**	**82.83%**	**83.25%**	**82.91%**	**85.30%**	**87.41%**	**88.47%**	**88.91%**

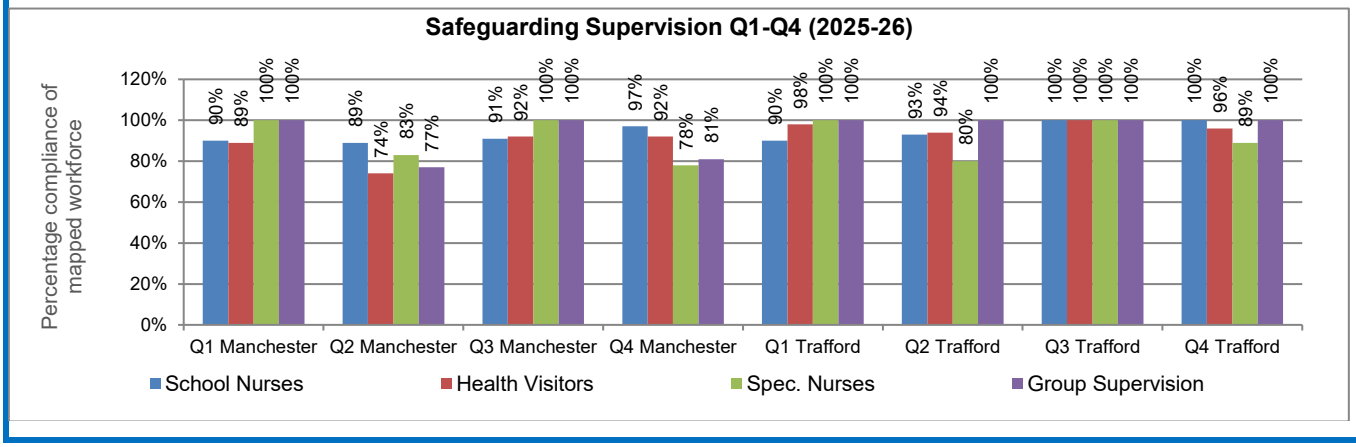
An executive level safeguarding training event is being arranged for the Deputy Chief Executive and Chief Nursing Officer (CNO). Deputy CNO, Directors of Nursing and their deputies by October 2026 in time for the 3 year review (last completed October 2023)

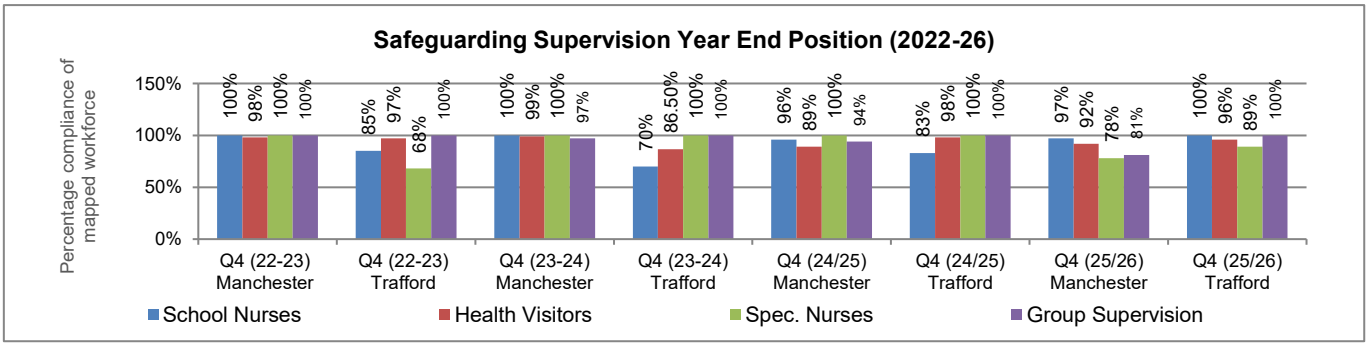
10.2 Supervision is provided and attended by the workforce in areas of high safeguarding risk and need

Mandatory safeguarding supervision is delivered in line with NHSE SCAT, GMICB contractual and Royal College Intercollegiate standards. **2510** colleagues have received safeguarding supervision across acute and community services, in line with the Trust's Think Family Approach to Safeguarding Supervision Policy. **Figures 38 and 39** indicate consistent high levels of compliance in children's community services.

Figure 37: Safeguarding Supervision Q1-Q4 (2025-26)

Figure 38: Safeguarding Supervision 2022-26





11. Work with partners to help people live longer, healthier lives (LHL)

MFT has worked closely with multi-agency partners to strategically and operationally deliver safeguarding priority workstreams across Greater Manchester, Manchester, and Trafford. Key areas of contribution include.

- **Active Participation in Governance Structures:**
  MFT has engaged in all safeguarding boards, executive groups, sub-boards, and working groups across Manchester (11 groups) and in Trafford (11 of 13 groups) with agreement made that MFT will contribute to Trafford Safeguarding Adult Board Executive through Deputy Chief Nursing Officer representation from Q1 2026/27.
- **Delivery of Partnership Priorities:**
  The Trust has supported the implementation of two MSP and six TSSP priorities, both across the partnership and internally coordinated through the Safeguarding Priorities Group
- **Contribution and delivery of Children's Social Care Reforms in the Families First Programme**[15] through representation in GM and Manchester and Trafford workstreams implementing in MFT through a local improvement plan. Application for Manchester Department of Education funding has been successful and will support the transformation programme 2026/28.
- **Provision of complex safeguarding and Multi Agency Safeguarding Front Door resource.** MFT has provided (1.6 wte), specialist nurses supporting **128** young people open to the complex safeguarding teams (end Q4), and specialist nurses (2 wte) completing enquiries into 2,565 referrals to Manchester Children's Social Care and contribution to review in 7240 referrals in Trafford.

11.1 Prevent

The Deputy Chief Executive and the Chief Nursing Officer is the Executive lead for the Prevent responsibilities with the Prevent duty allocated to Assistant Chief Nurse Safeguarding.

Figures 40 and 41 identify that compliance with Prevent e-learning by Trust colleagues is achieving the expected 90% Trust compliance and NHSE Prevent reporting standards.

Figure 39: Prevent Training Q1-Q4 (2024-26)

[15] Families First Programme

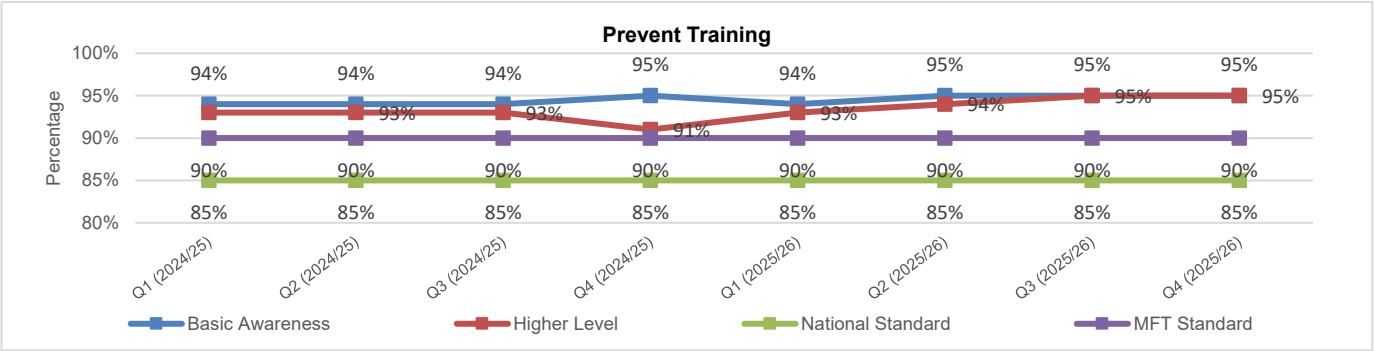
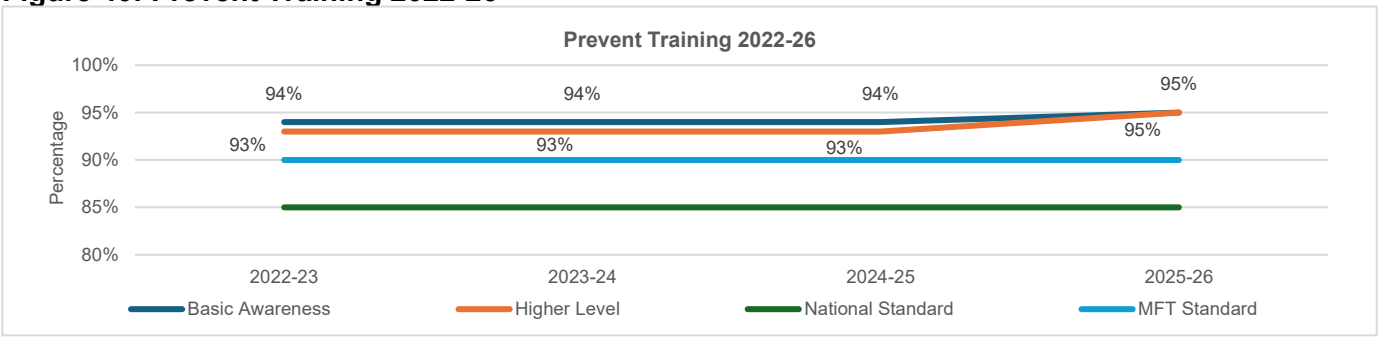


Figure 40: Prevent Training 2022-26



The Trust has reported quarterly to the National Safeguarding Steering Group (NSSG)[16] that the Trust is compliant in expected standards of Prevent training.

- The Trust has continued to contribute to Manchester and Trafford Channel Panels completing **23** information sharing requests and has completed **4** Prevent referrals.
- The Trust's Prevent policy has been reviewed and ratified at TSG.

11.2 Implementation of the Child Protection Information System (CPIS)

CPIS is an NHS England–mandated digital service supporting real-time identification of vulnerable children. It is fully implemented across urgent and emergency care, with Q4 audit and AAA reporting providing strong assurance of compliance across sites (100% at MRI, NMGH and Wythenshawe ED; 90% at TGH).

CPIS Phase 2 implementation is progressing in line with national requirements, with delivery on track across community and specialist services. Of 31 actions for 2026, 12 are complete and 19 on track, including improved NHS Spine access and training delivered to 641 staff. Full digital integration remains under review and is planned for 2027/28.

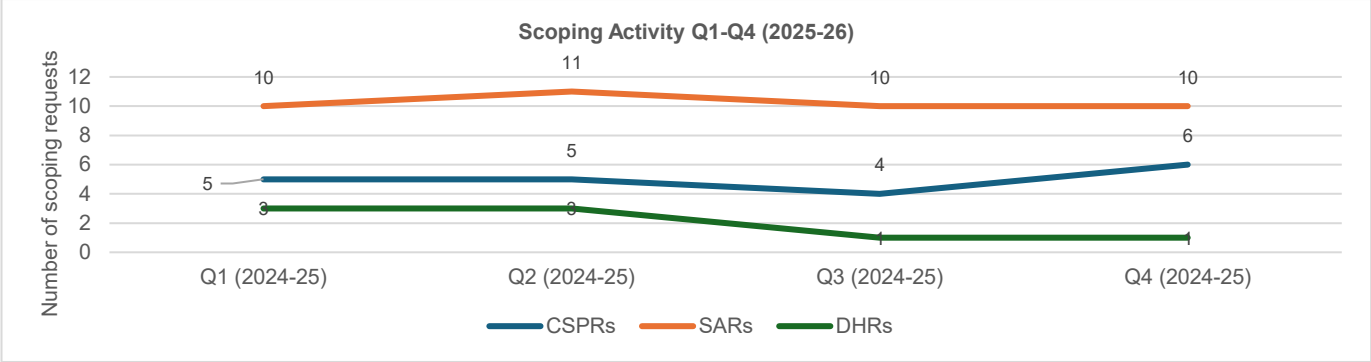
11.3 Multi Agency Safeguarding Reviews

A safeguarding review is commissioned when a person dies or is seriously harmed through neglect or abuse in situations where agencies have not worked together effectively.

Figure 42 indicated that MFT has contributed to **69** scoping reviews, for child safeguarding practice reviews (CSPR), safeguarding adult reviews (SAR) and domestic homicide reviews (DHR) where MFT provided care and treatment to the person involved or their family.

Figure 41: Scoping Activity Q1-Q4 (2025-26)

[16] National Safeguarding Steering Group (NSSG) NHS Safeguarding Integrated Dashboard



Learning from SARs, CSPRs and DHRs has been themed around improving recognition of risk (including domestic abuse and contextual safeguarding), strengthening information sharing and multi-agency risk management, and improving responses to neglect/self-neglect, professional curiosity and MCA application. In response, MFT has delivered targeted workforce development (including domestic abuse awareness training and complex safeguarding training).

7 reviews have been published by MSP, TSAB and TSCP this year. Learning and action plans from each review is implemented within the Trust and partnership and reported to the Safeguarding Quality and Learning subgroup, Clinical Groups and in the Trust newsletter with a thematic report provided annually to TSG. MFT learning focused on safer child safeguarding practice (including use of neglect identification tools, escalation and giving children opportunities to be heard) and recurring adult themes (self-neglect, consideration of mental capacity, engagement and multi-agency risk management).

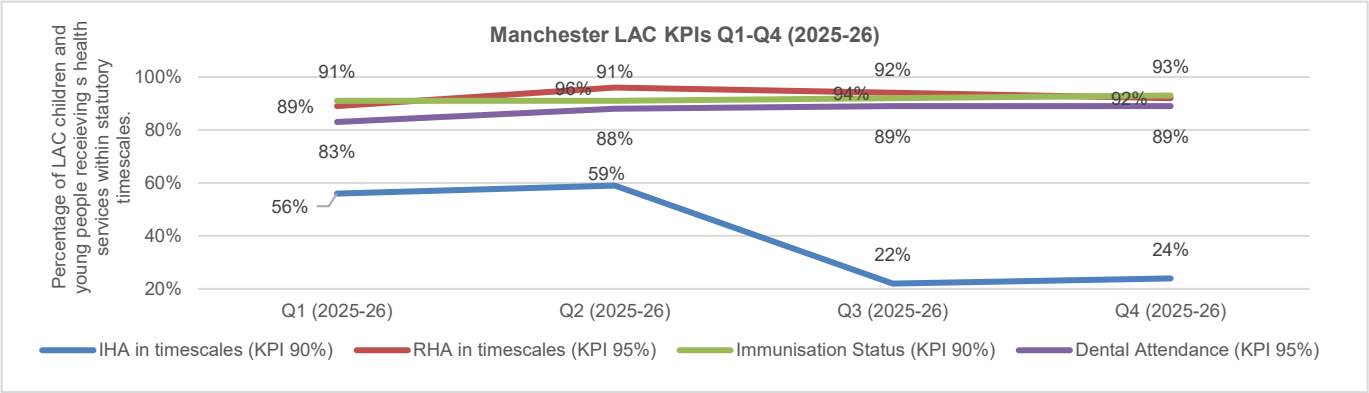
11.4 Looked After Children (LAC)

Under the Children Act 2004 and in line with Statutory Guidance on Promoting the Health and Well-Being of Looked after Children[17], health professionals have a legal responsibility to promote the health and wellbeing of children and young people.

In Manchester at the end of Q4 there were **1294** LAC and **317** in Trafford.

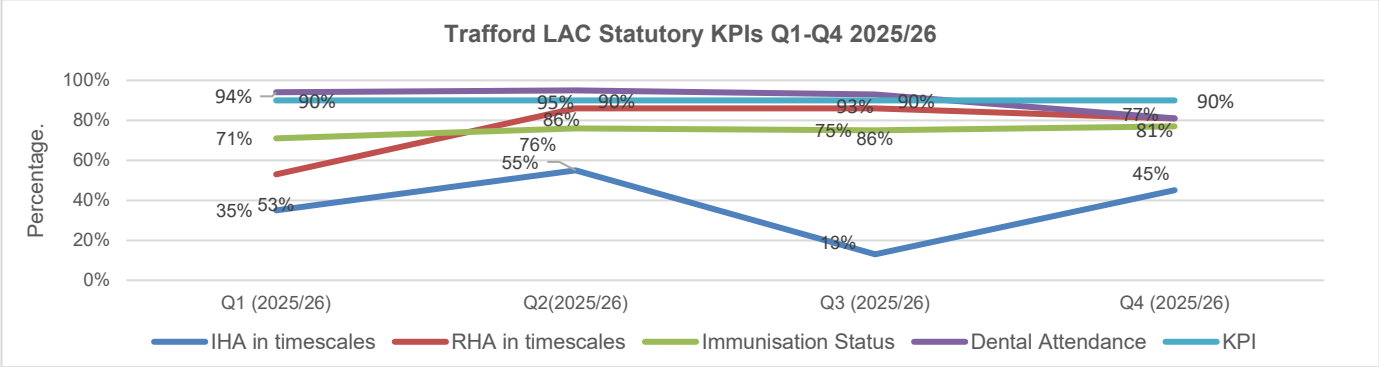
Figures 43-44, identify the performance of the MFT looked after children's services and Local Care Organisation community children's services in meeting statutory looked after children's health requirements in partnership with the local authority CSC, noting a significant decline in timeliness of LAC health assessments.

Figure 41: Manchester LAC Statutory Health KPIs Q1 – Q4 (2025-26)



[17] Statutory Guidance on Promoting the Health and Well-Being of Looked after Children 2015 accessed at https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2.

Figure 42: Trafford LAC Statutory KPIs Q1-Q4 (2025/26)



Performance in Manchester against meeting statutory health requirements is currently over 90% in all areas apart from IHAs, whilst in Trafford continued improvement is required in the partnership performance of LAC receiving dental checks and immunisations (not provided by MFT) under oversight from ICB, children's social care (CSC) and MFT as corporate parents in a joint improvement plan.

TSG has overseen the MFT LAC improvement plan to increase the number of IHA completed within statutory timescales; this has involved extensive partnership working and escalation with CSC in Manchester and Trafford to overcome the primary barrier of achieving information and consent for the IHAs from CSC in time to complete the IHA in 20 working days. This risk is included on the safeguarding operational risk register. The trajectory of improvement is inconsistent in both Trafford and Manchester due to fluctuating numbers of children entering LA care and inconsistent timely information sharing from CSC. However, the LCO children's community services have made improvements to ensure there is capacity for paediatric consultants to complete IHAs within the 20-day timescales of notification to MFT.

12. Safeguarding Team Achievements and Impact in 2025-2026

During 2025-2026, the safeguarding service has delivered significant improvements in safeguarding practice, workforce development, partnership working, digital innovation and patient experience. Key achievements include:

12.1 Named Doctors Safeguarding Children

- MFT hosted our 3rd annual child protection study day which had valuable contributions from colleagues across MFT, receiving excellent feedback.
- In March 2026, RMCH hosted the Northern Heads national peer review supporting practitioners working in Abusive Head Trauma. On completion of a pilot scheme in Abusive Head Trauma, the tertiary safeguarding team at RMCH has continued to work alongside the radiology team to support practitioners across GM in the assessment of Abusive Head Trauma and complex skeletal injury via a weekly MDT.
- Contributed to 'My Voice Matters' – a nationwide quality improvement project aiming to improve the quality and quantity of the voice of the child captured in child protection medical assessments by introducing a visual communication toolkit.
- In 2026/27 a review of the arrangements for named doctor safeguarding adults will be completed and a proposal presented to TSG in November 2026.

12.2 Safeguarding Team

- Assistant Chief Nurse Safeguarding led the Nursing Midwifery and Allied Health Professionals Bee Brilliant Quality Improvement project July and August 2025 resulting in over 150 projects trust wide in Think Family Safeguarding. Subsequent Trust wide ward accreditation visits noted improved responses to safeguarding lines of enquiry.



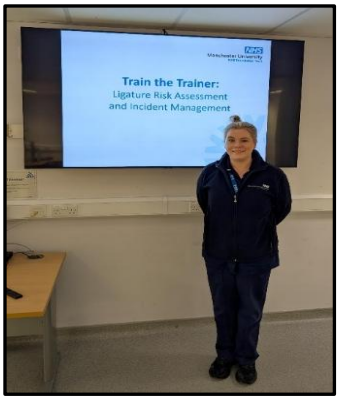


Safeguarding Team Development Day December established team commitments and work programme for 2026 in line with Safeguarding Review Findings



- A Safeguarding Newsletter was cascaded monthly across the Trust to share key safeguarding messages; the content and presentation have been revised to focus on delivery of key safeguarding messages with an audit identifying the newsletter was of high quality and provided useful content for colleagues.
- Safeguarding midwives supported delivery of Hope boxes, a compassionate care package designed to reduce trauma to mothers and babies legally separated postnatally due to childcare law proceedings.
- The Trafford Children in Care team took part in a public health film led by care-experienced young people. Filmed at Gorse Hill Studios, the project focused on smoking cessation and the support available to Children in Care.
- Bespoke safeguarding training delivered to 2003 colleagues as well as mental health training to 578 colleagues.







- MSP True for Us Joint Targeted Area Inspection (JTAI) Domestic Abuse self-assessment; indicating MFT is well aligned to the JTAI standards (strong practice, systems, and leadership),
- 2 Safeguarding conferences in Safeguarding Adults week (November) highlighting Safeguarding is Everyone's Responsibility



Head of Nursing for Safeguarding Mak Inayat talking at the North Manchester Adults Safeguarding Conference 2025.



North Manchester Adults Safeguarding team at the North Manchester Adults Safeguarding



MFT Cared for Children's team at the North Manchester Adults Safeguarding Conference

- MFT completed 15 actions arising from Manchester Joint Targeted Inspection (JTAI) Multi-agency responses to serious youth violence: working together to support and protect children GOV.UK[18] in youth participation, stratification of CAMHS waiting lists for at risk children in youth justice service, CAMHS waiting well offer and strengthening use of Education Health Care Plans including using the All About Me person centred profile.
- National Care Leavers week in November included bespoke training packages on Rising **as Me: Overcoming challenges, transforming, and finding your identity.**

[18] Multi-agency responses to serious youth violence: working together to support and protect children - GOV.UK

- Safeguarding team contributed to Joint multi agency complex safeguarding weeks of action
- Working in partnership with Manchester Children's services who have become the first in the Northwest of England to be rated as 'outstanding' by Ofsted.
- The MFT Learning Disability and Autism patient Carer Forum have MFT contributed to modification of hospital passports.
- Digital improvements in HIVE electronic patient records (child protection proforma, DoLS process, mental health navigator.
- A Families First Implementation Plan is responding to the system wide children services reforms mandated by the Children's Wellbeing and Schools Act in the Department for Education Families First Programme.

13. Conclusion

This annual report provides strong assurance that MFT continues to meet its statutory safeguarding duties and responsibilities and maintains effective arrangements to protect children, young people and adults at risk. Despite increasing complexity, sustained demand and continuing system pressures, safeguarding performance remains strong, governance arrangements are robust, and there is clear evidence of continuous improvement.

The Trust has demonstrated significant progress during 2025/26 through delivery of the safeguarding review improvement programme, strengthened safeguarding leadership, enhanced workforce capability, improved digital systems, and sustained partnership engagement across Greater Manchester. Independent assurance, regulatory compliance, audit activity and safeguarding review outcomes collectively demonstrate a safeguarding system that is responsive, effective and focused on learning.

- Whilst challenges remain in relation to Looked After Children IHA timeliness, achieving Level 3 training compliance above 90%, system constraints impacting DoLS authorisations and delivery of CPIS Phase 2, clear improvement plans are in place and these risks are being managed and actively monitored through the Trust Safeguarding and Mental Health Risk Register and. through established governance structures.

The priorities identified for 2026/27 position MFT well to respond to forthcoming national reforms, strengthen consistency of safeguarding practice, and further improve outcomes, experiences and protections for the populations it serves. The Trust can therefore take assurance that safeguarding remains a strategic priority and that substantial progress continues to be delivered across all areas of safeguarding practice.

Appendix 1

No.	Safeguarding Review Recommendation	Action	Priority	Status
1.1	Leadership & Team Culture: Strengthen senior leadership visibility and engagement, promoting a respectful, inclusive, and collaborative culture within safeguarding teams.	Communications and Engagement Plan	High	Complete
1.2		Organisational Development Programme, including development day and output plan	High	Complete
1.3		Freedom to Speak Drops in, training and champions identified	High	On Track
1.4		Leadership Presence at frontline sites Frontline visit programme	High	Complete
1.5		PSIRF training programme	Medium	On Track
2.1 to 2.4	Safeguarding Model review	Map safeguarding structure to NHSE SAAF and Intercollegiate Guidance, comparable Trusts, workforce demand	Medium	Complete
2.5		Revisit communication plan	Medium	Completed
2.6 to 2.13		Review team structure and resource	Medium	5/7 actions completed, 2 On Track
2.14		Review out of area response to maternity patients	High	On Track
2.15 to 2.16		Revised Team Structure	High	1 /2 actions completed 1 On Track
2.17		Digital Immersive visit and improvement plan	High	Completed
3.1	Safeguarding Practice & Processes Standardise development opportunities across team	Review workstream mapping	Medium	Completed
3.2		Review training needs analysis aligned to competency framework	Medium	Completed
3.3		Colleague Wellbeing plan, flexible working opportunities	Medium	Completed
4.1 to 4.7	Duty Based Operating Model	Design and deliver Duty Based Operating Model to manage demand in team.	5 High 2 medium	5/7 completed 2 On Track

No.	Safeguarding Review Recommendation	Action	Priority	Status
5.1	Governance, Compliance and Oversight Governance & Information Sharing: Streamline internal governance and information-sharing processes to support more responsive, transparent, and accountable decision-making	Review Digital reporting and escalation arrangements	2 Medium	1 completed 1 on Track
		Review 10 of 23 safeguarding policies	Medium	On Track
6	Training and Awareness	90% of mapped workforce has completed safeguarding training. Review Safeguarding Training Strategy	3 Medium	1 completed 2 on Track
7.1		To share annual quality assurance plans with safeguarding partnerships	low	Completed
7.2		Review of Pathway to response to Safeguarding Adult Review (SAR), Child Safeguarding Practice Review (CSPR) and Domestic Homicide (DHR) Scoping including	Low	On Track

Appendix 2 Acronyms

Abbreviation	Meaning of Abbreviation
AIS	Accessible Information Standard (AIS) flags
ADVISE	Assessing for Domestic Violence in Sexual Health Environments
AAA	Alert Advise and Assurance
BIA	Local Authority Best Interest Assessment Teams BIAs
CPIS	Child Protection Information Sharing
CSP	Community Safety Partnerships
CSPR	Child Safeguarding Practice Review
DoLS	Deprivation of Liberty Safeguards
DARDR	Domestic Abuse Related Death Reviews
DASH/RIC	Audit Domestic Abuse Stalking and Honour Based Violence Risk Indicator Checklists
DHR	Domestic Homicide Review
DVA	Domestic Violence and Abuse
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation

Abbreviation	Meaning of Abbreviation
FYI	For Your Information
GM	Greater Manchester
GMP	Greater Manchester Police
IHA	Initial Health Assessment
ICB	Integrated Care Board
ISVA	Independent Sexual Violence Advisors
IDVA	Independent Domestic Violence Advisors
JTAI	Joint Targeted Area Inspection
KPI	Key Performance Indicators
LAC	Looked after Child
MFT	Manchester University NHS Foundation Trust
MSP	Manchester Safeguarding Partnership
MCA	Mental Capacity Act
MHA	Mental Health Act
MIDASS	Midwifery and Domestic Abuse Support Service

Abbreviation	Meaning of Abbreviation
MARAC	Multi Agency Risk Assessment Conferences (High Risk Domestic Abuse Victims Multi Agency Risk Assessment Conferences (High Risk Domestic Abuse Victims)
MATAC	multi-agency tasking and coordination (MATAC) (to identify the most harmful and serial abusers of domestic abuse (DA) and provide multi-agency interventions to prevent re-offending Steering Group
NHSE	NHS England
QSMC	Quality and Safety Management Committee
QSPBC	Quality and Safety Performance Board Committee
RHA	Review Health Assessment
SCAT	Safeguarding Commissioning Assurance Framework Toolkit

Manchester University NHS Foundation Trust

Escalation and Assurance Report
People Board Committee (PBC)

Report to: Board of Directors
Report from: Angela Adimora, Trust Non-Executive Director and Chair of PBC
Date of meeting: 27/10/26

Key escalation and discussion points from the meeting
Alert
Sickness absence remains an alert, with the September 2026 Integrated Performance Report noting a 6.1% rolling 12-month position and a 6.4% single-month position against target rates of 5.9% and 5.7% respectively. Absence rates increased between August and September 2026 with work continuing through the Attendance Improvement Programme, focused on grip and control, prevention and broader wellbeing with supporting discussions/proposals being progressed through TLTC. **Substantive WTE workforce reduction performance** remains an alert. The September 2026 Integrated Performance Report outlines that the Trust is 238 WTE worse than plan overall driven by substantive WTE being 392 WTE worse than plan, while bank and agency usage remained better than plan. The Committee noted the forecast year-end WTE gap, the need for further VfP scheme maturity and the requirement to bring key workforce transformation schemes more clearly into future reporting. **Agenda for Change appraisal compliance** remains an alert, with September 2026 compliance at 84.3% against the 90% Trust standard. The Committee noted that improvement activity will continue through robust oversight, the forthcoming Culture and Staff Experience Forum focus on appraisals and implementation of the new Learning Management System. **Mandatory Training Compliance:** Whilst the Committee noted sustained positive performance in Core Level 1 subjects, this item has been escalated to an alert, as several (seven out of 13) Core Level 2 and 3 courses remain below the Trust's compliance threshold (90%) in relation to practical moving and handling, adult and paediatric resuscitation, and Level 3 safeguarding children training. Oversight continues through Workforce and Education Management Committee, TLTC and the Quality Compliance Oversight Group to support continued improvement and achievement of compliance for the safety-critical courses.
Advise:
GM Collaborative Recruitment Hub Business Case: The Committee supported the business case recommendations for MFT to be the host organisation in the GM NHS Recruitment Hub, with onward consideration through the Trust's governance processes and the Board of Directors' Meeting scheduled for November 2026. The Committee noted the planned 1st April 2027 go-live date, the 50-day time-to-hire ambition, expected financial and operational benefits, and implementation risks. The Committee received the **Board Assurance Framework** section within its remit and noted that both strategic risks, absence and engagement, and headcount reduction, are currently outside the Board's risk appetite. Further narrative and RAG rating will be added to the full BAF for presentation to the Board of Directors in November 2026. The Committee received the **Integrated Performance Report** and discussed sickness absence, WTE performance and appraisal compliance. The Committee noted the need to understand the relationship

between reduced bank and agency usage, sickness absence and workforce pressures, particularly within nursing and midwifery, with mitigations continuing through quality impact assessment, circuit breaker arrangements and senior workforce governance routes.

Chief People Officer's report: The Committee noted updates on the NHS Staff Survey, the new Learning Management System, flu vaccination campaign, Empactis system user feedback, security contract and First Steps Day Nursery Ofsted outcome. The Committee noted that the staff survey response rate was around 29% at the time of discussion and that the flu campaign was progressing well, with targeted work required to improve uptake among underrepresented staff groups.

Medical and Agenda for Change staff appraisals: The Committee noted the continued gap in AfC appraisal compliance with improvements being progressed via and the planned refresh of the appraisal model, supported by the new Learning Management System and Culture and Staff Experience Forum discussion.

Pathways into Employment: The Committee noted positive external assurance on apprenticeship quality and the Trust's position in the top 100 apprenticeship providers nationally. The need to increase apprenticeship activity, strengthen internal delivery capacity and make better use of the apprenticeship levy, supported by the appointment of the Director of Strategic Learning was outlined.

Workforce Performance reports: The Committee noted several reports including 'Performance (WTE) to Plan', 'Time to Hire' update, 'Payroll Performance' and Job Evaluation update. Time to hire performance remains below target, with internal recruitment streamlining, dashboard reporting and process controls being progressed. Payroll efficiency benchmarks strongly, with further work focused on reducing overpayments and underpayments. The Committee noted the Nursing and Midwifery Job Profiles and Band 5 review programme, including the need for further detail on delivery timescales and potential financial impact. As previously described, the Performance (WTE) to Plan is below target mainly driven by VfP schemes being behind plan with reduction monitoring continuing to be supported.

Sexual Safety: The Committee noted progress against the NHS Sexual Safety Charter, including the consolidated delivery and assurance plan, revised policy, awareness activity and strengthened governance. Future reporting will include opportunities for learning with partners and how the Trust is complying with the preventative duty in relation to sexual harassment.

Freedom to Speak Up: The Committee received the Quarter 2 report with 128 concerns received with worker safety and wellbeing remaining the most frequently reported theme. The Committee noted strong user feedback, continued growth of the Champion network and the importance of civility, kindness and follow-up when concerns are raised.

Guardian of Safe Working: The Committee received the annual report and noted 1,146 valid exception reports submitted by 244 resident doctors, representing a 30% increase compared with the previous year. The Committee noted the increase in Guardian of Safe Working fines, the majority relating to shifts exceeding 13 hours, and the positive use of fine income to improve resident doctor facilities.

Improving Resident Doctors' Working Lives: The Committee noted progress against the NHSE 10-point plan, with MFT fully compliant with six of the eight areas and partially compliant with the remaining two. Continued focus is required on rota communication and payroll accuracy.

Assure:

Bi-monthly safer staffing report – Nursing and Allied Health Professionals: The Committee received assurance that nursing services across the Trust remains compliant with national safer staffing guidance (NQB 2016; DWS 2018). The reduced nursing bank spend, reduced nursing assistant turnover, continued Enhanced Therapeutic Observation and Care improvement work, and ongoing AHP workforce review activity was noted. The Committee supported presentation of the report to the Board of Directors in November 2026.

Perinatal Integrated Bi-annual Workforce Report: The Committee received assurance that safe staffing arrangements across maternity and newborn services remained robust and in line with national safer staffing guidance and Maternity Incentive Scheme Year 8. 100% compliance has been achieved with one-to-one care in labour, maintained medical and obstetric staffing resilience across all sites, and newborn services remaining compliant with cot-side staffing. The Committee noted progress towards neonatal Qualification in Specialty (QIS) compliance, particularly at Oxford Road Campus, and the actions being taken to improve sickness absence performance. The Committee supported submission of the report to the Board of Directors in November 2026, subject to amendment of the midwifery establishment table prior to submission.

Risks discussed at the meeting

Board Assurance Framework strategic risks: The Committee reviewed the BAF section within its remit and noted that the two strategic risks, absence and engagement, and headcount reduction, are both currently outside the Board's risk appetite. The need for continued strengthening of controls, assurance and actions ahead of presentation of the full BAF to Board in November 2026 was noted.

Sickness absence and workforce wellbeing: Sickness absence remains an area of ongoing risk as described earlier. The Committee noted the increase in absences and the continued requirement for prevention, wellbeing and management grip through the Attendance Improvement Programme.

Workforce headcount reduction and substantive WTE delivery: The Committee noted that total staffing (WTE) was worse than plan. Bank and agency reductions remains better than plan with the Committee noting the risk in reliance on temporary staffing reductions alone will not deliver the required workforce reduction. Further VfP scheme maturity and clearer reporting of key workforce transformation schemes are required going forward.

GM Collaborative Recruitment Hub: The Committee noted the implementation risks associated with MFT hosting the GM NHS Recruitment Hub, including partner organisations not approving participation, stranded costs, TUPE and workforce transition, staffing of the hub, collaboration agreement terms and digital readiness.

Job Evaluation and Band 5 review: The Committee noted the potential financial risk associated with the Nursing and Midwifery Job Profiles and Band 5 review programme, pending job evaluation outcomes and national funding arrangements. Further detail on the review timeline and financial impact will be provided to a future People Board Committee.

Mandatory training compliance: The Committee noted residual compliance risk in Core Mandatory Levels 2 & 3 and MFT Mandatory Training, particularly practical, site-based and safety-critical competencies, with continued oversight through established workforce and quality governance routes.

Perinatal workforce and maternity triage: The Committee noted prolonged waits in maternity triage and requested further review of whether current waits would support a broader review of midwifery staffing and capacity levels.

Report approved by: Angela Adimora, Trust Non-Executive Director and Chair of PBC

Agenda

NHS
Manchester University
NHS Foundation Trust

Date: Tuesday, 27th October 2026
Time: 2:00pm – 4:00pm
Location: MS Teams

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	2:00pm
2.	**Declaration of interest** (verbal)	Meeting admin	Chair	
3.	**Minutes of the previous meeting** (25th August 2026)	Meeting admin	Chair	
4.	**Action Log**	Discussion	Chair	
5.	**Matters Arising**	Discussion	Chair	
6.	Staff story (film)	Discussion	Chief People Officer	2:05pm
7.	**Assurance Reporting:**			
7.1	Board Assurance Framework	Discussion	Chief People Officer	2:10pm
7.2	Integrated Performance Report	Discussion	Deputy Chief People Officer	2:15pm
Strategic aim 3: Be the place where people enjoy working, learning and building a career				
8.	Chief People Officer report	Discussion	Chief People Officer	2:20pm

9.	Medical and AFC Staff Appraisals	Discussion	Chief People Officer	2:30pm
10.	Pathways into Employment (Including OFSTED Self-Assessment Rating)	Discussion	Deputy Chief People Officer	2.40pm
11.	Workforce Performance: 11.1 GM Recruitment Hub Business Case 11.2 Performance (WTE) to Plan 11.3 Time to Hire Performance 11.4 Payroll Performance 11.5 Job Evaluation Update	Discussion	Deputy Chief People Officer	2:50pm
12.	Sexual Safety	Discussion	Deputy Chief People Officer	3:05pm
13.	Freedom to Speak Up Quarterly Report (Q2)	Discussion	Freedom to Speak Up Guardian	3:10pm
14.	Guardian of Safe Working: Annual Report	Discussion	Guardian of Safe Working	3:20pm
15.	Mandatory Training Compliance L1 L2 L3 • Compliance Assurance • Non-compliance Considerations	Discussion	Deputy Chief People Officer	3:25pm
16.	Improving Residential Doctors' working lives - 10-point plan	Discussion	Associate Director of Medical Education	3:30pm
17.	Bi-monthly safer staffing report (Nursing and AHP)	Discussion	Deputy Chief Nursing Officer	3:35pm
18.	Perinatal Integrated Bi-annual Workforce Report (Midwifery and Newborn Services) including a review of anxiety, stress and depression related sickness absence levels in maternity services	Discussion	Deputy Chief Nursing Officer	3:40pm
Committee business				
19.	**Workplan review**	Meeting admin	Chair	3:45pm
20.	**Escalation report**	Approval	Chair	3:50pm
21.	**Any Other Business** (verbal)	Discussion	All	3:50pm
22.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	3:50pm

Date of next meeting: Tuesday, 22nd December 2026 at 2.00pm in the Main Boardroom, near Cobbett House

Papers for Information:

- **Workforce Education and Management Committee Escalation Report**

Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday, 25 November 2026

Paper Title:	Safer Staffing Report (Nursing and AHP)	**Agenda Item 12.2**
Presented by:	Kimberley Salmon-Jamieson, Deputy Trust Chief Executive / Chief Nursing Officer	
Prepared by:	Mark Keegan, Corporate Director of Nursing – Workforce and Education; Marie Mathew, NMAHP Workforce Lead Nurse; Darren Dunleavy, NMAHP Workforce Programme Lead	
Meetings where content has been discussed previously	People Board Committee, 27th October 2026	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion ☐ For noting	

Executive summary / key messages for the meeting to consider

This bi-monthly report provides assurance that MFT remained compliant with national safer staffing guidance for nursing and Allied Health Professionals during July and August 2026.

Workforce productivity measures are delivering significant reductions in variable pay. Nursing bank spend was £6.6m (26.5%) lower year to date than 2025/26, AHP agency spend reduced by £426k (33.0%), and premium overtime remained low. The ETOC improvement programme reduced average monthly bank use from 178 WTE to 82 WTE, generating estimated savings of £320,917 per month.

Registered nursing vacancies were 235.7 WTE (2.6%), below the national rate, although sickness increased to 6.9%. Nursing assistant vacancies reduced to 388.3 WTE, with sickness remaining above the national average.

Nursing fill rates were sustained at 94–95%, with all 114 wards and departments reporting fill rates above 85% in August, and CHPPD reduced to 9.2 in July and August, compared with a 12-month MFT and Shelford Group average of 9.5, reflecting lower temporary staffing use.

The Nursing and Midwifery Support Worker Development Programme supports progression from Band 2 to Band 3 within nine months. Progression can be delayed because of operational pressures, rota demands, training gaps and colleagues requiring a longer period to attain competencies, with 281 of 3,500 support workers currently remaining at Band 2 beyond the 9-month period. Additional controls have been implemented to eliminate such delays by the end of January 2027, including automatic uplift to Band 3 at nine months. This will be monitored through Clinical Group Workforce and Education Groups and overseen by the NMAHP Workforce and Education Forum.

AHP vacancies reduced overall to 21.4 WTE, and targeted risks remain in radiography, occupational therapy, dietetics, critical care, stroke, burns and specialist breast therapy services; these are being managed through established escalation, redeployment and recruitment arrangements.

The SafeCare e-roster tool for matching inpatient staffing to patient acuity and dependency is being implemented across all in-patient areas after the 90% target needed to maintain reliable daily data was achieved. The system supports early identification and management of staffing risks by providing a live view of ward staffing and changes and highlighting site-wide pressures and hotspot areas for senior review. MRI completed the first full SafeCare rollout in July and August 2026. Lessons and final system improvements will inform implementation across NMGH and WTWA.

All staffing-related incidents were recorded as no harm (82%) or low harm (18%), and reviews of reported pressure ulcers did not identify safe staffing as a contributory factor.

A workshop in August 2026 brought together Deputy Trust Chief Executive / Chief Nursing Officer, Deputy Chief Nursing Officer and Directors of Nursing / Midwifery to review the current nursing and midwifery workforce to inform development of a strategic delivery plan, with further detail to be included in the next Safer Staffing report.

Recommendation(s)

The Board of Directors is asked to:

- Receive this report and note that Nursing and AHP services across MFT remain compliant with the national guidance (NQB 2026; DWS 2018) in relation to safer staffing.
- Note the report was received and discussed at the People Board Committee on 27th October 2026.
- Receive assurance of safe staffing as described in sections 5, 6, 7, 8 and 9.
- Note that at end August 2026 nursing bank spend was £6.6m (26.5%) lower year to date than 2025/26 against the NHSE target of 10% and AHP agency spend reduced by £426k (33.0%).

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

Relationship to the strategic objectives

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

☐ LHL Objective 1	☐ LHL Objective 2
☒ HQSC Objective 1	☐ HQSC Objective 2

Relationship to the strategic objectives	
☐ HQSC Objective 3	☐ PEW Objective 1
☐ PEW Objective 2	☒ VfP Objective 1
☐ VfP Objective 2	☐ R&I Objective 1
☐ R&I Objective 2	☒ Good Governance
Links to Trust Risks	The work contained within this report links to the following strategic, corporate, or operational risks: •
Care Quality Commission domains Please check **all** that apply	☒ Safe ☐ Caring ☐ Effective ☒ Well-Led ☐ Responsive
Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the report: • National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016) • CQC's fundamental standards – staffing; safety; good governance • Developing workforce safeguards - Supporting providers to deliver high-quality care through safe and effective staffing; NHSE; 2018

Main report

1. Introduction

This bi-monthly Safe Staffing report provides assurance that MFT remains compliant with the national guidance in relation to safer staffing for nursing and Allied Health Professionals (AHP) for the period of July and August 2026. A midwifery safe staffing report is provided separately.

2. Background

The National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016), states 3 expectations of the Trust Board of Directors. These are endorsed by the NHS Improvement (NHSI) Developing Workforce Safeguards (DWS) Guidance (2018) (Appendix B).

There is no nationally validated framework for AHP safe staffing, and this report utilises advisory benchmark standards.

A report of the comprehensive establishment and skill mix review for nursing and AHPs is presented twice a year.

In between these reports, the bi-monthly safe staffing report provides assurance that the Trust remains compliant with the national guidance in relation to safer staffing for nursing and AHPs.

3. NMAHP Workforce Productivity

The Deputy Trust Chief Executive / Chief Nursing Officer is accountable for the NMAHP Workforce VfP programme. The Director of Nursing (Workforce and Education) leads the programme and provides regular updates through the NMAHP Professional Advisory Forum and Workforce VfP Steering Group.

At the end of August 2026, nursing and midwifery bank spend was 26.5% (£6.6m) lower than 2025/26 YTD, against the NHSE target of 10% (appendix A), mainly due to increased scrutiny and additional controls implemented by each Clinical Group from May 2026 overseen by the Deputy Chief Nursing Officer.

The financial position demonstrates that workforce controls are contributing significantly to the Trust's financial recovery programme whilst supporting national expectations to reduce temporary staffing reliance.

A Quality Impact Assessment (QiA) review has been undertaken to assess any unintended consequences arising from the controls. Whilst no significant deterioration has been identified in core quality or rostering indicators, several workforce-related pressures have emerged. These include increased sickness absence, growing pressure on staff wellbeing, reduced availability of development time, declining appraisal compliance and reduced capacity for managerial and non-clinical activities.

Mitigating actions are in place and ongoing monitoring will continue through existing workforce, quality and operational governance arrangements to ensure financial improvements are delivered without compromising patient safety, workforce sustainability or regulatory compliance.

It is proposed that bank reduction measures are maintained, with regular “circuit breaker” periods during time of predicted increased bank usage during which non-ward based colleagues undertake clinical shift cover to support the ongoing Trust financial recovery program and importantly resume business as usual role responsibility outside this time, as a response to the unintended impact of the actions taken in the first half of 2026/27. Clinical Group Directors of Nursing will determine and implement arrangements for circuit-breaker periods, taking account of local operational pressures, workforce availability, and the skills and competencies required to maintain safe and effective patient care.

This would provide a balance to support the Trust financial recovery program whilst maintaining the functions of these integral professional roles, with a projected end of year savings of £10.69m compared to previous years spend, equivalent to 19.2% which is above the 10% NHSE target.

Nursing and midwifery premium overtime remains at a very low level, averaging 5k in July and August 2026 (appendix A). This equates to an approximated 0.001% of the monthly nursing and midwifery budget of c£50m is mainly due to supporting overruns in Theatre units.

Demand for AHP premium overtime spend is decreasing, at the end of August 2026 (£69k) lower YTD compared to 2025/26, mainly attributed to increased controls implemented in CSS imaging services division (appendix A). 99.9% is utilised in Clinical Scientific Services (imaging services 80.5% and AHP services 19.4%). NMAHP corporate team are supporting CSS CG with a programme of work to migrate imaging staff to NHSP bank contracts. LCOD AHP Therapy services have stopped all premium overtime spend.

AHP agency spend has decreased by 33.0% YTD compared to previous financial year, equivalent to £426k, attributed to successful migration of colleagues to NHSP bank (appendix a). AHP agency colleagues are provided by framework agencies sourced via NHS Professionals Bank, and those sourced through outsourcing arrangements directly managed by CSS Clinical Group. A review of outsourcing arrangements has been identified as the priority for the VfP AHP programme in 2026/27.

A nursing and midwifery workforce workshop was held in August 2026, which brought together the Deputy Trust Chief Executive / Chief Nursing Officer, Deputy Chief Nursing Officer and Directors of Nursing / Midwifery from all Clinical Groups. The session was facilitated by the Director of Nursing – Workforce and Education.

The group reviewed a wide range of workforce data and intelligence in the context of the 10-Year Health Plan for England and specifically the shift from hospital to community. This included the current workforce profile, attraction / recruitment / retention activity, workforce stressors, and career and professional development. The outcomes from the workshop will form the basis for the NMAHP Workforce Strategic Delivery Plan.

4. Nursing and Midwifery National Job Profiles

The N&M Job Profiles Programme will ensure all 11,400 nursing and midwifery colleagues across band 4 to 9 have a job description aligned to the new national job profiles.

NHS England has instructed that all Band 5 job descriptions should be completed by October 2028. NHS Employers and NHS Staff Council Job Evaluation Group have asked organisations to prioritise the review of Health Visitors (HV) job descriptions alongside the band 5 phase due to the withdrawal of the band 6 profile meaning there is a single band 7 national job profile for HVs.

A standardised process has been agreed with Staff-Side colleagues by which job descriptions will be created through to job evaluation and publication. It is supported by a framework for the creation of job descriptions and the first series of focus groups with colleagues working at band 5 level took place during August 2026.

5. Achieving the set establishment

Registered Nursing

The registered nursing establishment for all roles band 5 and above in August 2026 is 9,146.1WTE with a reduction of 17.7WTE noted since June 2026 due to continued adjustments made by financial account teams to correct inaccuracies in financial budgets.

Continued improvement has been noted in registered nursing turnover rates, which have decreased month on month since April 2025. The current MFT rate is down to 6.2% compared to the national turnover rate currently reported at 6.3%.

Registered nursing vacancies are at 2.6% or 235.7WTE in August 2026, this remains significantly less than the current national vacancy rate at 5.3% and is attributed to posts being held for planned recruitment activity for band 5 graduates in quarter 3 2026/27. Further detailed breakdown of current registered nursing vacancies by Clinical Group and speciality can be found in Appendix C.

Clinical Groups are progressing internal recruitment to promote band 5 colleagues into band 6 vacancies to create a larger pool of band 5 vacancies for student nurses and student nursing associates graduating in September 2026, with an estimated 81 graduates proceeding through onboarding checks and being placed into vacancies across all Clinical Groups.

Sickness rates have increased for the fourth consecutive month, up to 6.9% in August 2026 which is above the national sickness rate of 5.8% with the primary reported reason for sickness absence being anxiety/stress related illnesses. This is thought to be associated with the workforce-related pressures identified in the quality impact assessment of the temporary staffing control measures, described in section 3, and sickness rates are anticipated to reduce as a result of the associated mitigating actions.

Nursing assistant

The current nursing assistant establishment in August 2026 was 3509.8WTE. Establishment has reduced by a total of -33.8WTE since June 2026 primarily due to closure of Opal Unit at Wythenshawe Hospital (-29.5WTE) with colleagues being redeployed to other clinical areas.

There has been a reduction in nursing assistant vacancies in August 2026 down to 388.3WTE (11.1%) from an average of 469.8WTE during 2025/26. This is due to a combination of the overall reduction in establishment due to bed closures, recruitment activity and the continued reduction in turnover from a high of 12% in May 2025 to 9.7% in August 2026.

Detailed breakdown of current nursing assistant vacancies by Clinical Group can be found in Appendix C. The recruitment pipeline for Quarter 2 remains positive, with 21 confirmed starters and a further 102 candidates at various stages of the recruitment process projected to commence employment during October 2026.

Clinical Groups have established recruitment trajectories and are actively progressing local recruitment plans to attract and appoint nursing assistants. This work is supported by the Talent Attraction Team through a range of targeted approaches, including social media promotion, short videos featuring nursing assistants describing their roles, and engagement with community groups and colleagues.

The rolling average sickness rate has reduced from of 10.2% in May 2025 to 9.4% in August 2026, compared to a national average of 7.9%.

The Nursing and Midwifery Support Worker Development Programme was introduced in April 2022 to provide a structured development pathway that equips colleagues with the knowledge, skills and competencies required to progress from Band 2 to Band 3 within 9 months from commencing employment.

Nursing Support Worker colleagues are experiencing delays in progressing from band 2 to band 3 due to a range of factors, including those outside their control such as not being able to attend development sessions due to operational pressures, rota demands, and gaps in provision of training.

281 colleagues from total of 3500 Nursing Support Workers are currently enrolled on the development programme and have remained at band 2 for more than nine months following date of employment.

The current development programme will remain with several additional controls to prevent delays in progression, including introduction of an automatic uplift to band 3 at 9 months following commencement in post. This will be monitored through Clinical Group Workforce and Education Groups, with oversight through the NMAHP Workforce and Education Forum

Daily staffing reviews

Nurse staffing levels within the Clinical Groups are reviewed daily in real time and monitored through the safer ‘staffing huddles’ to ensure they are adequate to meet patient acuity and nursing needs on each ward and department.

SafeCare is part of the established e-roster system used across MFT that facilitates the measurement of acuity and dependency needs of patients within inpatient areas and uses the same acuity tools as those used during the bi-annual safer staffing reviews models, including the Safer Nursing Care Tool (SNCT).

A programme to replace the use of manual spreadsheets to capture daily staffing information with the more efficient and productive use of live information from the SafeCare system is in progress across all Clinical Groups. The system offers live visibility of staffing levels aligned to patient requirements and will support real-time staff deployment.

It helps teams to proactively highlight and address risks through early identification and management of staffing pressures and effective workforce deployment by:

- Providing a live status view of wards and changes as they happen.
- Providing oversight of site-wide staffing levels, highlighting hotspot areas and any potential issues.

Enable colleagues to highlight risks that can be viewed by senior nurses responsible for overseeing safe staffing. Following a period of education and support for ward teams the overall compliance with use of the system has improved from 50% in 2024 to 89% in August 2026 against a target is 90%. NHS trusts generally set a target threshold of 90% compliance for daily data entry as falling below this threshold limits the validity of the data.

MRI Clinical Group has implemented the first full roll out of SafeCare to support their daily nurse staffing oversight processes during July / August 2026, with final system improvements identified and logged with the system provider. Learning from the implementation is being reviewed to inform the next phase of implementation across NMGH and WTWA Clinical Groups.

Temporary Staffing

Temporary staffing resource is provided to the Trust by NHS Professionals (NHSP) to cover shortfalls in the nursing workforce. The NHSP Bank is well established with 90% of shifts requested being filled. A further detailed overview of nursing NHSP bank fill can be found in Appendix D.

Enhanced Therapeutic Observations and Care.

The Enhanced Therapeutic Observation and Care (ETOC) Improvement Programme continues aligned with the NHS England National ETOC Improvement Collaborative. The programme includes development of a validated screening tool in collaboration with University of Manchester, development of education resources (clinical induction; face-to-face training; an e-learning module) and development of Hive workflows including the new Ward Assurance Dashboard, which provides real-time visibility patients requiring ETOC.

Between the start of improvement programme from April 2025 to June 2026 the average number of patients receiving ETOC per month reduced by 313 from 1382 to 1069 per month.

During the 2024/2025 financial year, the average NHSP filled WTE to support ETOC requirements was 178WTE per month. Since the introduction of the ETOC improvement programme, there has been an average monthly reduction from 178WTE to 82WTE per month. This equates to a cost saving of £320,917 per month.

6. Fill rate

MFT is required to submit a monthly Safe Staffing Unify Report to NHS England detailing actual registered nurse staffing levels as a percentage against those that were planned. The fill rates are based on the budgeted bed base of each area and do not take account of any additional beds that are open and are inclusive of additional staff sourced through NHSP bank or additional substantive hours.

On average the MFT level fill rate has been maintained between 94% and 95% for the last 6 months (figure 9). 100% (114) of wards / departments reported fill rates above 85% in August 2026. This metric features in the workforce IPR.

Daily staffing levels are reviewed through the safer ‘staffing huddles’ alongside reported outcome measures to provide safe and effective patient care. Professional judgment is applied to respond to staffing gaps caused by unplanned absences or increased demand, with colleagues transferred between clinical areas to ensure the correct staffing levels and skill mix.

7. Care Hours Per Patient Bed Days (CHPPD)

Care Hours Per Patient Day (CHPPD) is the national metric used by NHS England to measure workforce deployment and safe staffing levels on inpatient wards since April 2016 and is calculated by taking all the shift hours worked over the 24 hours period by registered nurses and nursing assistants and dividing this by the number of patients occupying a bed at midnight.

The MFT wide 12-month average CHPPD is 9.5 against a Shelford Group average of 9.5 hours. The reduction in CHPPD to 9.2 in July and August is associated with the reduction in temporary staffing usage (Shelford average for July and August not available due to the lag in provision of Model Hospital data).

NHSE model hospital data shows CHPPD at MFT has remained in the middle of the range over the last 12 months when compared to the Shelford Group of NHS Trusts. CHPPD varies significantly across NHS trusts due to differences in trust type, patient acuity, specialty mix, ward architecture, and local workforce availability.

Table 1: NHSE Model Hospital CHPPD Overview for Shelford Group Trusts (Latest available - June 2026)

Trust name	Total Nursing and Midwifery CHPPD
Guy's and St Thomas' NHS Foundation Trust	11.6
University College London Hospitals NHS Foundation Trust	11.3
Imperial College Healthcare NHS Trust	10.5
King's College Hospital NHS Foundation Trust	10.5
Oxford University Hospitals NHS Foundation Trust	9.8
Manchester University NHS Foundation Trust	9.3
Cambridge University Hospitals NHS Foundation Trust	9.1
Newcastle Upon Tyne Hospitals NHS Foundation Trust	9.1
University Hospitals Birmingham NHS Foundation Trust	8.5
Sheffield Teaching Hospitals NHS Foundation Trust	8.0

CHPPD also varies across the Clinical Groups (table 2) due to the differences in specialty mix and ward architecture, with critical care areas and paediatric areas having a higher CHPPD due to the higher ratio of staff per patient. NMGH has a higher CHPPD when compared to WTWA and MRI due to additional staffing requirements associated with the fire evacuation risk and a significant number of wards with smaller bed bases.

Table 2: CHPPD by Clinical Group

Clinical Group	CHPPD
CSS	35.2
SH – RMCH	15.1
NMGH	10.3
SH – SMH Nursing	10.3
SH - REH	9
MRI	7.4
WTWA	7.2

8. AHP Staffing at MFT

The NQB Safer Staffing Guidance (2016) and NHSI Developing Workforce Safeguards (2018) apply to all professional groups, including AHPs. Unlike nursing, there is no nationally validated tool to determine AHP staffing requirements and NHS England commissioned work, led by the University of Worcester, to develop AHP-specific safer staffing guidance, publication of a national framework remains outstanding.

A Trust wide AHP Safer Staffing Task and Finish Group has undertaken a review of available national guidance, professional standards and specialty specific workforce recommendations applicable across AHP services. This work identified considerable variation in the availability, scope and maturity of workforce standards across AHP professions and clinical services, with no single framework applicable across all AHP services.

The Task and Finish Group aims to develop a pragmatic assurance methodology that aligns local arrangements while continuing to monitor and respond to national developments. This approach is supported by the MFT AHPs Deliver Programme, where work to strengthen professional leadership, career development and job planning is expected to enhance workforce intelligence, improve visibility of workforce capacity and capability, and support more consistent workforce planning across AHP services.

AHP Workforce Integrated Performance Report (IPR)

The AHP workforce dashboard is now established within the Workforce IPR and is routinely reviewed through the AHP Forum. The IPR provides visibility of workforce indicators including establishment, vacancies, turnover, sickness absence and workforce trends across AHP services. Ongoing work continues to improve data quality and refine workforce reporting.

Registered AHP Establishment

The current registered AHP establishment WTE for roles band 5 and above in August 2026 is 1845.8WTE. There has been an increase of 7WTE from June 2026, specifically in the paediatric physio/OT team (3WTE) and paediatric speech and language team (4WTE) across LCOD Clinical Group.

The current registered AHP contracted WTE for roles band 5 and above in August 2026 was 1824.4WTE. There has been an increase of 13.2WTE in the last two months.

Increases in establishment offset by an increase in contracted WTE have reduced the vacancy position in the last two months. In August 2026 there were 21.4WTE AHP trust-wide vacancies. Within AHP services there are several professions with higher levels of vacancies most notably in radiography (29.96WTE) and occupational therapy (11.87WTE), and CSS Clinical Group divisional teams are monitoring the vacancy position and associated variable pay pressure.

There are currently 11.0WTE radiographers and 4.0 occupational therapists in the recruitment pipeline with agreed or provisional start date. In contrast some roles are currently over established, a full breakdown by profession for August 2026 in table 3. Further details and breakdown of registered AHP vacancies by Clinical Group can be found in Appendix G.

Table 2: AHP Vacancies by Profession – All MFT – August 2026

AHP Profession	Establishment WTE	Contracted WTE	Vacancies WTE
AHP General	33.33	38.75	-5.42
Chiropody / Podiatry	66.96	61.48	5.48
Dietetics	141.15	147.67	-6.52
Occupational Therapy	310.25	298.38	11.87
Orthoptics	31.36	30.33	1.03
Physiotherapy	611.64	626.31	-14.67
Radiography	477.29	447.33	29.96
SALT	173.77	174.13	-0.36

AHP assistants

The current AHP assistant establishment in August 2026 was 273.8WTE. Establishment has remained within standard variation since April 2026.

The current AHP assistant contracted WTE in August 2026 was 258.4WT. There has been an increase of 7.4WTE in the last two months.

Recruitment into the increase in establishment from the end of last financial year has not been completed resulting in an increase in the vacancy position, this has improved in August 2026 down to 15.4WT. A breakdown by AHP service is provided in table 4 and by Clinical Group can be found in Appendix G.

Table 3: AHP assistant Vacancies by Profession Type – All MFT – August 2026

AHP Profession	Establishment WTE	Contracted WTE	Vacancies WTE
Chiropody / Podiatry	5.17	2.37	2.80
Dietetics	17.99	18.35	-0.36
Occupational Therapy	31.21	31.93	-0.72
Orthoptics	1.00	1.00	0.00
Physiotherapy	103.11	103.06	0.05
Radiography	92.88	78.66	14.22
SALT	22.45	23.05	-0.60

AHP Staffing Escalation and Managing Shortfalls against Current Establishment

AHP staffing levels are actively monitored across Clinical Groups, with risks identified in key services including adult and paediatric dietetics (particularly acute dietetics at WTWA), critical care (below Guidelines for the Provision of Intensive Care Services (GPICS) standards), stroke services (below Sentinel Stroke National Audit Programme (SSNAP) recommendations), burns and paediatric burns therapy (below recommended levels), and the Manchester breast cancer service (no specialist breast therapist). These risks, and their mitigations, are recorded on divisional and AHP risk registers and reviewed through established workforce governance forums.

Daily shortfalls are discussed at therapy department lunchtime huddles to identify immediate mitigations and seek cross-team support. Weekly escalations are managed through workforce and Clinical Group management boards, with issues added to risk registers as required. Longer term shortages are raised at divisional risk meetings and AHP vacancy control meetings with HR and Finance, with business cases developed where guidelines or standards cannot be met.

Managing shortfalls includes redeployment, use of cross-cover arrangements, and prioritisation of urgent services. Patient caseloads may be adjusted, clinics rescheduled, or waiting times extended where unavoidable. Risk registers are updated to capture ongoing issues, and bank and agency staff continue to be used where necessary, though reliance varies across professions. Retention and staff wellbeing remain a focus to reduce attrition and strengthen workforce resilience.

Workforce risks and responses are tracked through the AHP Workforce Efficiency Committees, divisional workforce efficiency meetings, and commissioned service reviews (e.g. weekend service models and safer staffing in medical wards). This escalation and review process provides assurance that AHP staffing risks are identified, tracked, and mitigated in real time, with governance aligned to the nursing escalation framework to ensure safe, effective, and sustainable care delivery.

9. Safe Staffing Incidents

During the period July and August 2026, the majority of incidents related to staffing were recorded as no harm (82%), and the appropriate actions were taken at the time following local investigation (Table 4).

Table 4 – Safe Staffing Incidents

Incident Actual Impact	Jul 2026	Aug 2026
Level 1 – No harm	275	314
Level 2 – Low Harm	57	72
Overall	332	389

Pressure Ulcers

There were 14 attributable Category 3 and 4 pressure ulcers reported in July 2026 with the majority (12) reported in the Community. Review of the pressure ulcers identified at NMGH (1) and WTWA (1) did not identify safe staffing as a contributory factor.

There has been a reduction in reported incidents within LCO compared with the previous month (down from 21). A revised Standard Operating Procedure (SOP) has been implemented to improve the accuracy and consistency of pressure ulcer categorisation and reporting. The LCO continues to work towards its improvement trajectory of achieving a 50% reduction in incidents by Quarter 3, supported by ongoing collaboration with the Patient Safety Team.

Falls

The overall falls data demonstrates a pattern of normal variation close to the average of 4.7 falls per 1000 beds days over the last 9 months with the rate of falls resulting in serious harm

following a similar pattern with an average of 0.1. The falls strategy is currently being reviewed and will be aligned to Clinical Group falls prevention improvement work, which currently includes trials of a range of technological solutions such as falls sensors.

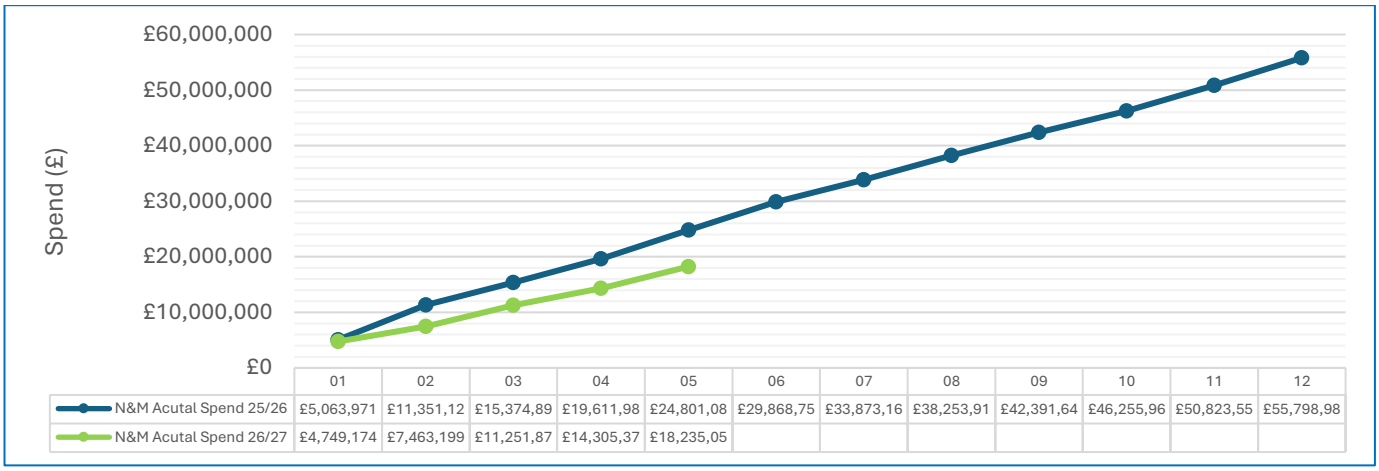
10. Recommendations

The Board of Directors is asked to:

- Receive this report and note that Nursing and AHP services across MFT remain compliant with the national guidance (NQB 2026; DWS 2018) in relation to safer staffing.
- Note the report was received and discussed at the People Board Committee on 27th October 2026.
- Receive assurance of safe staffing as described in sections 5, 6, 7, 8 and 9.
- Note that at end August 2026 nursing bank spend was £6.6m (26.5%) lower year to date than 2025/26 against the NHSE target of 10% and AHP agency spend reduced by £426k (33.0%).

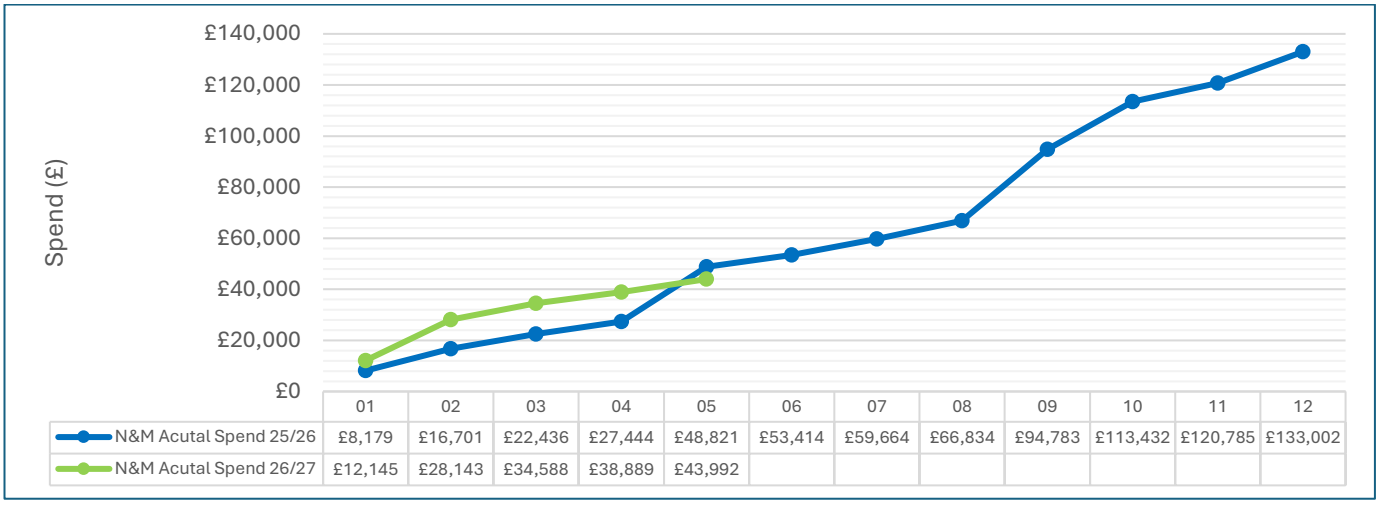
Appendix A

Nursing and Midwifery bank reduction 26/27 compared to 25/26 (£ spend)



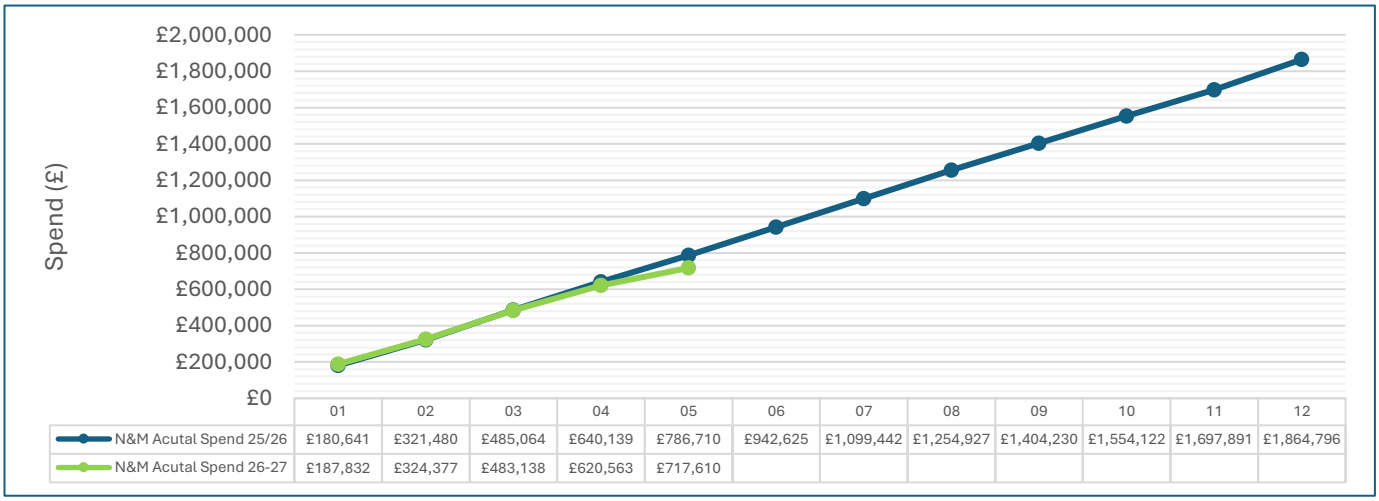
	01	02	03	04	05	06	07	08	09	10	11	12
N&M Acutal Spend 25/26	£5,063,971	£11,351,12	£15,374,89	£19,611,98	£24,801,08	£29,868,75	£33,873,16	£38,253,91	£42,391,64	£46,255,96	£50,823,55	£55,798,98
N&M Acutal Spend 26/27	£4,749,174	£7,463,199	£11,251,87	£14,305,37	£18,235,05							

Nursing and Midwifery Premium Overtime spend (£ spend) All MFT



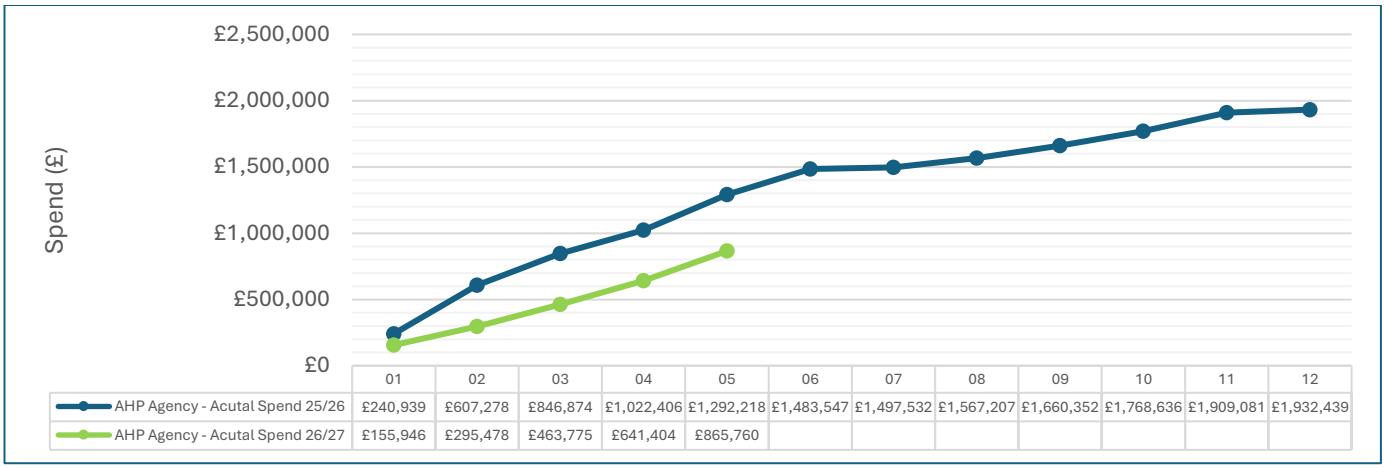
	01	02	03	04	05	06	07	08	09	10	11	12
N&M Acutal Spend 25/26	£8,179	£16,701	£22,436	£27,444	£48,821	£53,414	£59,664	£66,834	£94,783	£113,432	£120,785	£133,002
N&M Acutal Spend 26/27	£12,145	£28,143	£34,588	£38,889	£43,992							

AHP Premium Overtime Spend (£ spend) All MFT



	01	02	03	04	05	06	07	08	09	10	11	12
N&M Acutal Spend 25/26	£180,641	£321,480	£485,064	£640,139	£786,710	£942,625	£1,099,442	£1,254,927	£1,404,230	£1,554,122	£1,697,891	£1,864,796
N&M Acutal Spend 26-27	£187,832	£324,377	£483,138	£620,563	£717,610							

AHP Agency Spend reduction 26/27 compared to 25/26 (£ spend)



	01	02	03	04	05	06	07	08	09	10	11	12
AHP Agency - Acutal Spend 25/26	£240,939	£607,278	£846,874	£1,022,406	£1,292,218	£1,483,547	£1,497,532	£1,567,207	£1,660,352	£1,768,636	£1,909,081	£1,932,439
AHP Agency - Acutal Spend 26/27	£155,946	£295,478	£463,775	£641,404	£865,760							

Appendix B

The National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016), states 3 expectations of the Trust Board of Directors. These are endorsed by the NHS Improvement (NHSI) Developing Workforce Safeguards (DWS) Guidance (2018).

Expectation 1: Right staff
Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations.

Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.

Expectation 2: Right skills
Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services.

Expectation 3: Right place and time
Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise.

Appendix C

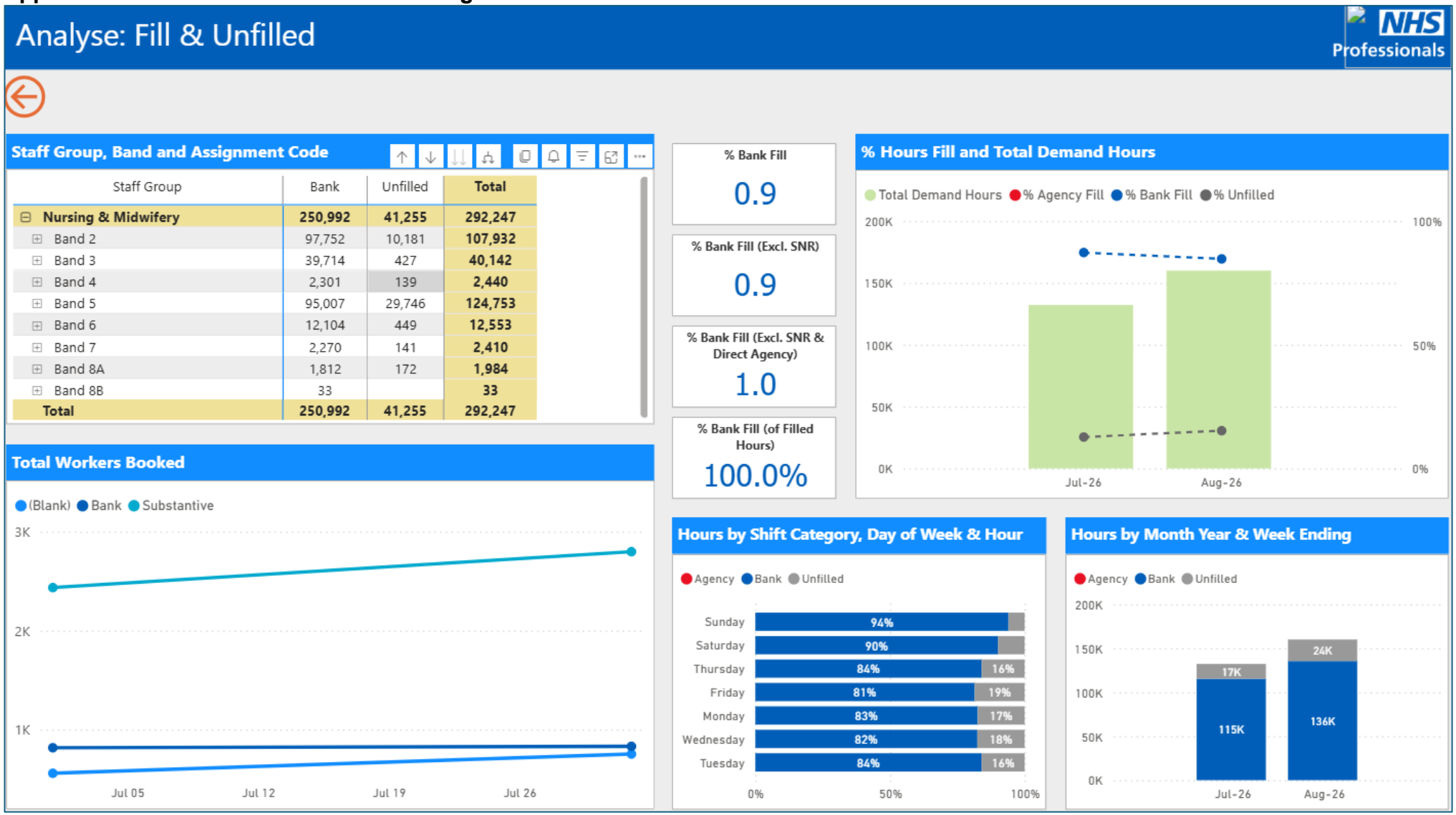
Registered Nursing - Workforce Metrics by Clinical Group (August 2026)

Clinical Group	Establishment (WTE)	Contracted (WTE)	Vacancies (WTE)	Vacancy Rate %	Turnover %	Maternity Leave %	Sickness %
CSS	1010.44	1002.69	7.75	0.8%	6.1%	4.1%	7.2%
LCOD	1144.27	1072.69	71.58	6.3%	7.5%	3.3%	8.0%
MRI	1741.12	1671.27	69.85	4.0%	4.6%	5.4%	6.8%
NMGH	861.10	846.80	14.30	1.7%	4.7%	5.3%	6.4%
SPEC	1982.93	1927.54	55.39	2.8%	6.9%	5.1%	7.5%
WTWA	1861.95	1876.51	0.00	0.0%	6.0%	4.6%	6.2%

Nursing assistant - Workforce Metrics by Clinical Group (August 2026)

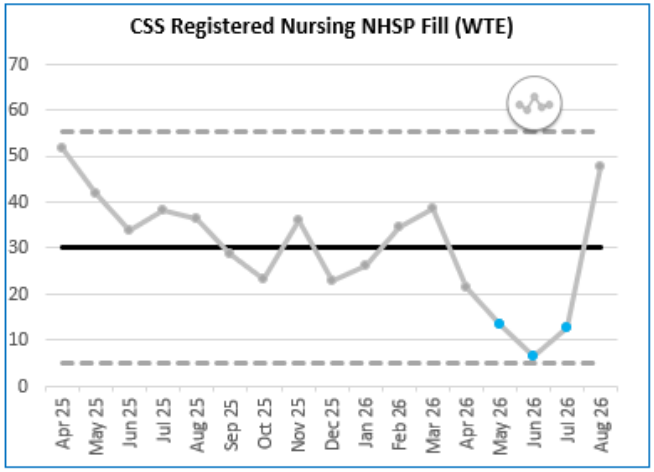
Clinical Group	Establishment (WTE)	Contracted (WTE)	Vacancies (WTE)	Vacancy Rate %	Turnover %	Maternity Leave %	Sickness %
CSS	86.26	79.40	6.86	8.0%			
LCOD	498.29	383.06	115.23	23.1%			
MRI	844.67	765.78	78.89	9.3%			
NMGH	574.55	543.48	31.07	5.4%			
SPE	526.12	450.36	75.76	14.4%			
WTWA	900.28	822.87	77.41	8.6%			

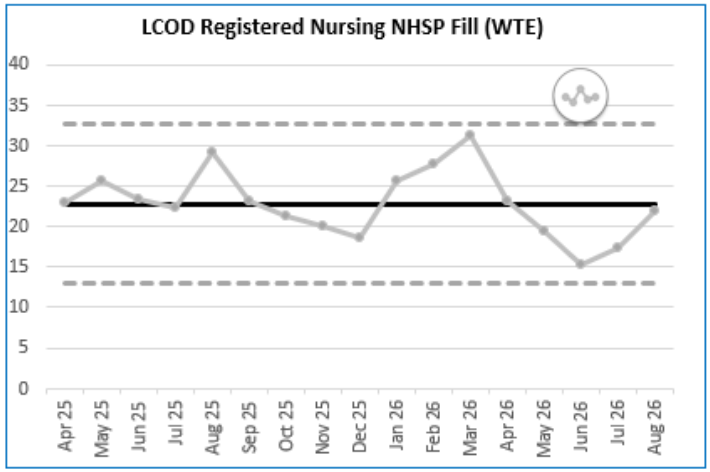
Appendix D - NHSP Fill Overview – Nursing

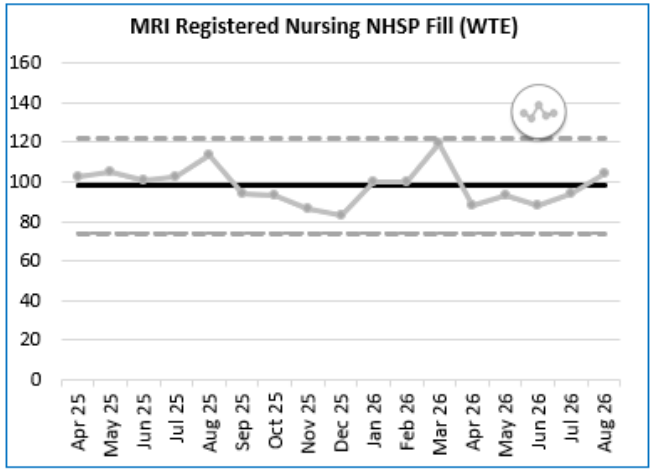


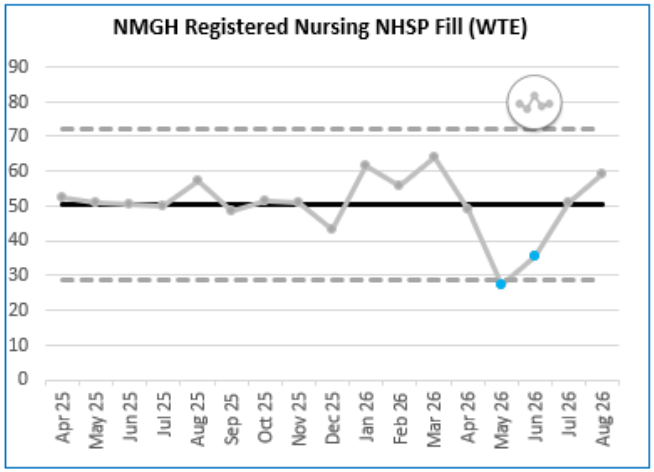
Appendix E

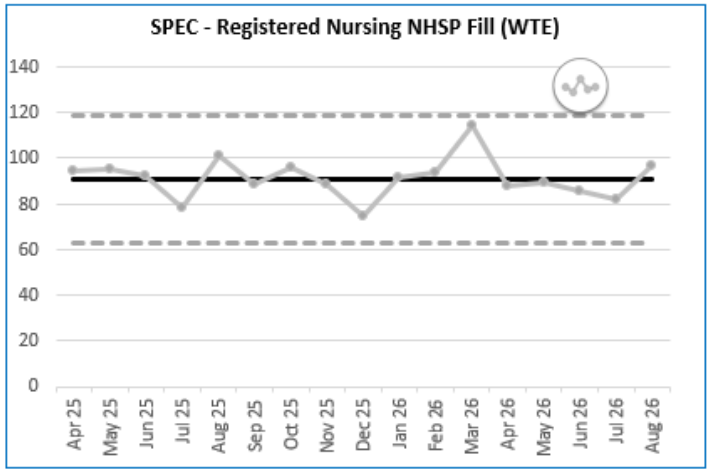
NHSP registered nursing fill rate by clinical group

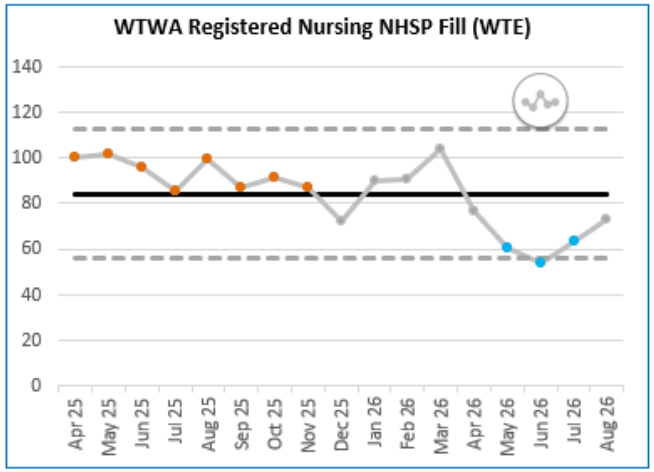






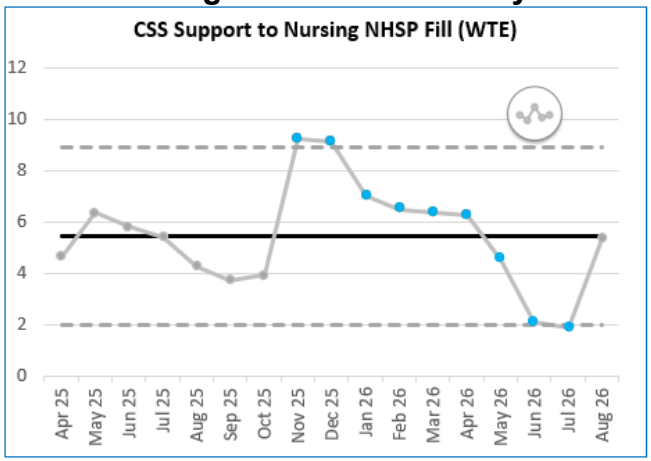


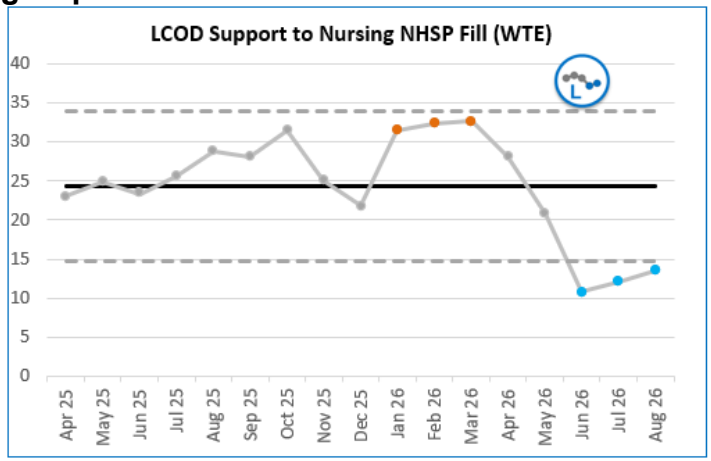


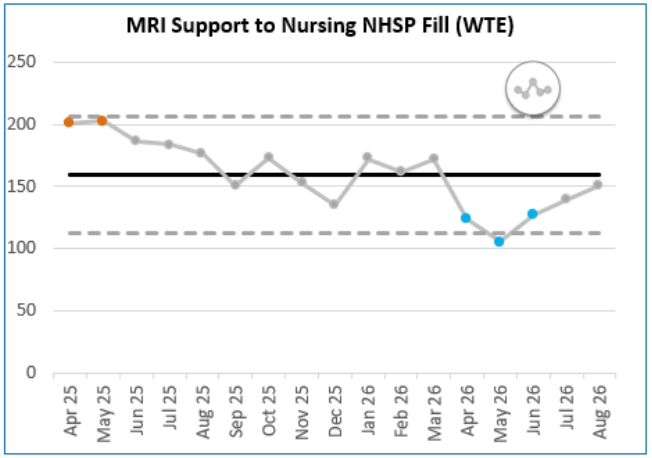


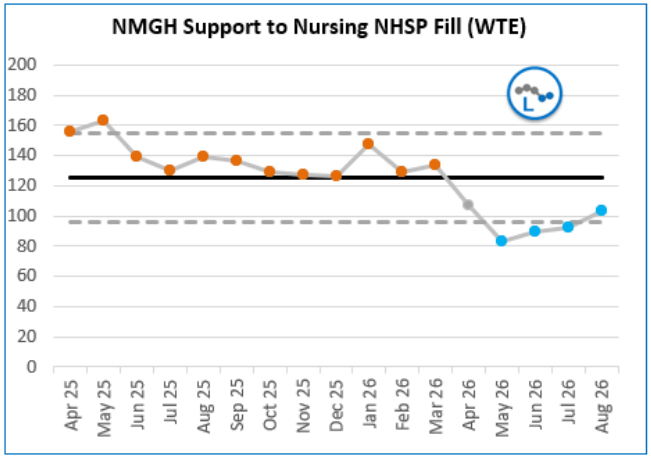
Appendix F

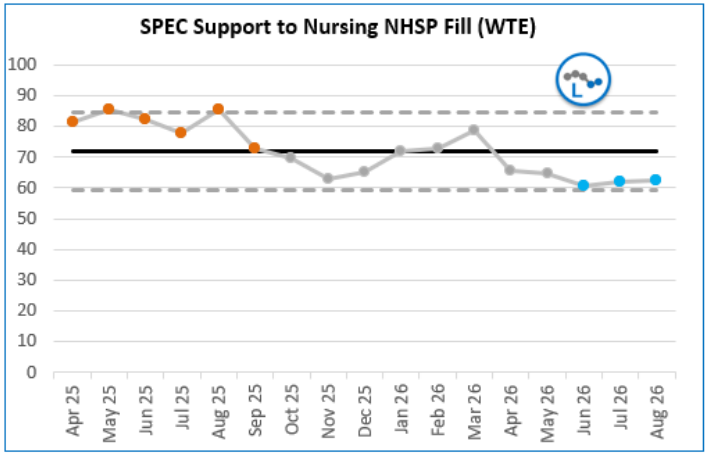
NHSP Nursing assistant fill rate by clinical group

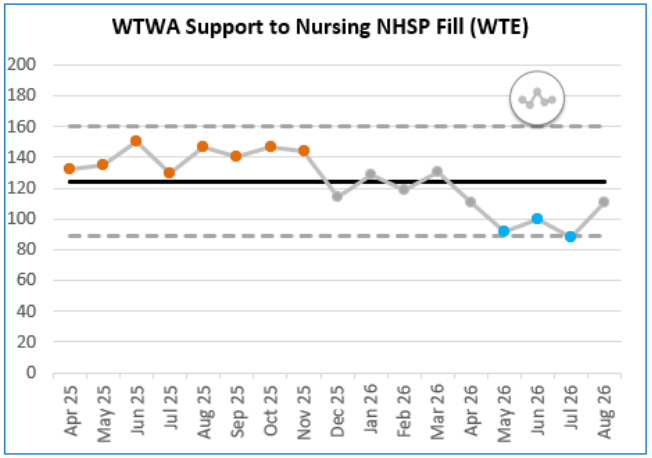












Appendix G

AHP Registered - Workforce Metrics by Clinical Group (August 2026)

Clinical Group	Establishment (WTE)	Contracted (WTE)	Vacancies (WTE)	Vacancy Rate %	Turnover %	Maternity Leave %	Sickness %
CSS	1133.46	1114.56	18.90	1.7%	8.1%	4.0%	4.3%
CSS AHP	657.47	668.33	0.00	0.0%	8.4%	4.3%	4.3%
CSS Imaging	468.00	444.23	23.77	5.1%	7.6%	3.5%	5.3%
LCOD	566.01	561.59	4.42	0.8%	6.0%	3.7%	4.8%
MRI	13.33	15.33	0.00	0.0%	5.8%	1.3%	6.4%
NMGH	4.95	4.10	0.85	17.2%	2.9%	0.0%	8.7%
SPEC	54.19	56.52	0.00	0.0%	6.0%	2.8%	5.2%
WTWA	58.70	56.30	2.40	4.1%	4.5%	3.2%	4.3%

AHP assistant - Workforce Metrics by Clinical Group (August 2026)

Clinical Group	Establishment (WTE)	Contracted (WTE)	Vacancies (WTE)	Vacancy Rate %	Turnover %	Maternity Leave %	Sickness %
CSS	185.88	171.40	14.48	7.8%			
CSS AHP	93.00	92.74	0.26	0.3%			
CSS Imaging	92.88	78.66	14.22	15.3%			
LCOD	79.32	75.66	3.66	4.6%			
MRI	0.00	0.00	0.00	0.0%			
NMGH	4.00	3.60	0.40	10.0%			
SPE	1.00	4.60	0.00	0.0%			
WTWA	3.61	3.16	0.45	12.5%			

Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday, 25 November 2026

Paper Title:	Bi-annual Safer Staffing (workforce) Report (midwifery and newborn services)	**Agenda Item 12.3**
Presented by:	Kathy Murphy, Director of Nursing and Midwifery, SHCG Kim MacLeod, Clinical Head of Division Maternity Services Susan Kamupira, Clinical Head of Division Newborn Services Kimberley Salmon-Jamieson, Deputy Trust Chief Executive & Chief Nursing Officer	
Prepared by:	Kathy Murphy, Director of Nursing and Midwifery, Specialist Hospitals Clinical Group (SHCG) Jen Sager, Deputy Director of Nursing and Midwifery Saint Mary's Managed Clinical Service (SM MCS)	
Meetings where content has been discussed previously	SM MCS Quality, Safety and Performance October 2026 SHCG Quality, Safety and Performance October 2026 People Board Committee, October 2026	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion ☐ For noting	

Executive summary / key messages for the meeting to consider

This six-month report provides assurance on the midwifery, neonatal nursing and medical workforce across Saint Mary's Managed Clinical Services for the period January to June 2026. It supports compliance with the Maternity Incentive Scheme Year 8, Safer Staffing requirements and Board of Directors oversight. This is the first report bringing together the multidisciplinary workforce for maternity and neonatal services in line with Safety Action A of Maternity Incentive Scheme Year 8.

The March 2026 Birthrate Plus assessment supported by professional judgment recommends a qualified midwifery establishment of 812.56 WTE, which includes provision for Maternity Triage at Oxford Road Campus. Recruitment and retention were positive, supported by strong Band 5 and Band 6 recruitment pipelines.

Safe staffing across all staffing disciplines remain robust. Staffing and patient flow are reviewed twice daily, supported by unit status reporting, NHSP scrutiny, Director-level approval of temporary staffing and workforce monitoring tools. These arrangements enable staffing gaps to be identified, escalated and mitigated promptly.

Quality and safety indicators demonstrate that workforce pressures were managed effectively in several areas. There were no escalations in midwife-to-birth ratios or one to one care provided, there were no occasions when the supernumerary Delivery Unit Coordinator was required to provide clinical care, and no incidents of moderate harm or above associated with diverts or deflects.

Maternity workforce pressures, alongside acuity and capacity constraints, have contributed to longer triage stays and delays in transferring women to intrapartum care for artificial rupture of membranes (ARM). Key safety indicators remained stable, with no harm identified. The impact on timely care is continually monitored and addressed through twice-daily flow meetings, which review acuity and delays. Where possible, women are offered transfer to another maternity site for ARM to avoid extended delays. When triage acuity is high, women where clinically appropriate are deflected to alternative sites in the MCS to reduce waiting times and ensure care within recommended timeframes.

Newborn Services met cot-side staffing and supernumerary coordinator standards across all three neonatal units. Nursing vacancies improved in June 2026, although they remained concentrated at Oxford Road Campus. Qualification in Specialty remains the principal neonatal workforce risk. Oxford Road improved from 60% to 65% and remained below the 70% BAPM standard, while North Manchester and Wythenshawe met or exceeded the standard by June 2026.

Sickness absence remained above the Trust NMAHP trajectory of 5% at 6.6% in June 2026 and improved from the January peak at 7.56%. Mental health-related conditions remained the leading cause of absence. Attendance plans, stress risk assessments, workplace adjustments, Occupational Health support and divisional oversight continue to support workforce resilience.

Medical workforce audits confirmed that safe staffing was maintained across all three sites. Consultant, anaesthetic and Operating Department Practitioner fill rates remained strong. Key pressures related to resident doctor gaps, neonatal night cover at Oxford Road, implementation of the revised North Manchester obstetric rota and Maternity Triage registrar cover at Wythenshawe.

The principal ongoing risk is the sustainability and equity of senior registrar cover in Wythenshawe Maternity Triage, which remains reliant on locum uptake differing from Oxford Road and North Manchester – Risk MFT/007790 - Obstetric Trainees Wythenshawe (score 12). The risk is monitored via Divisional Management Board and the SHCG Risk Committee

The Maternity Right-Sizing Business Case provides the route to establishing substantive registrar provision which is expected to be completed by the end of Q3 26/27.

Recommendation(s)

The Board of Directors is asked to:

- **Receive** the SM MCS Integrated Maternity and Neonatal Workforce report in line with national guidance on safer staffing and Maternity Incentive Scheme Year 8
- **Recognise** progress towards Neonatal QIS compliance, particularly on the Oxford Road Campus site
- **Note** the actions being taken to improve sickness and absence performance

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

Relationship to the strategic objectives	
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)	
☐ LHL Objective 1	☐ LHL Objective 2
☒ HQSC Objective 1	☐ HQSC Objective 2
☐ HQSC Objective 3	☒ PEW Objective 1
☒ PEW Objective 2	☒ VfP Objective 1
☐ VfP Objective 2	☒ R&I Objective 1
☐ R&I Objective 2	☒ Good Governance
Links to Trust Risks	The work contained within this report links to the following strategic, corporate, or operational risks: • MFT/007789 - Obstetric Trainees North Manchester (15) • MFT/005897- North Manchester- Consultant Obstetricians to provide sustainable rota (12) • MFT/007790 - Obstetric Trainees Wythenshawe (12) • MFT/008615 Community Midwifery Staffing (12) • MFT/007608 - Lack of second ODP out of hours on Wythenshawe Delivery Suite (9) • MFT/008478 - Implementation of a new homebirth staffing model (9) • MFT/005896 - Midwifery Staffing (8)
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Caring ☒ Effective ☒ Well-Led ☒ Responsive
Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the report: • Maternity Incentive Scheme Year 8 • CQC

Main report

Background

The Maternity Incentive Scheme[1] (MIS), in its eighth year, supports safety improvement across NHS maternity and neonatal services. This report supports Safety Action A, focusing on workforce and capacity to confirm that Saint Mary's Managed Clinical Service (SM MCS) is safely staffed, resilient and subject to robust Board oversight.

This six-monthly report provides the Trust Board of Directors with an assessment of staffing, rota stability and capacity across the perinatal MDT, using midwifery, obstetric, neonatal and anaesthetic workforce metrics to identify risks, monitor compliance and support mitigation.

The report assesses MIS Year 8 compliance in relation to:

- **Establishment vs. Actual Staffing:** Assessing the variance between funded staffing models and actual rostered hours.
- **Rota Gaps and Mitigation:** Quantifying vacancy rates and identifying SM MCS reliance on agency, bank, or locum staff to fill critical gaps.
- **Capacity and Escalation:** Reviewing operational pressures, including unit closures, escalation activations, and the impact of elective activity on safe care delivery.
- **Multidisciplinary (MDT) Alignment:** Demonstrating unified oversight from Trust Board and SM MCS Leadership Teams to foster a collaborative culture of safety.

These metrics are key indicators of safe, sustainable care. The report provides formal assurance that staffing and capacity risks are monitored and managed to support high-quality, personalised care for women, babies and families. The principal maternity workforce risk relates to community and Homebirth team vacancy.

Further oversight is maintained through the workforce Integrated Workforce Report (IPR) (Appendix 1).

Midwifery Workforce

NICE NG4[2] sets expectations for safe midwifery staffing, and MIS Year 8 Safety Action A4 requires Trusts to have a fully funded midwifery establishment aligned to a Birthrate Plus (BR+) review completed within the last three years.
The SM MCS BR+ review for all three maternity sites was completed in March 2026 using 2024/25 activity data.

The model applied the current MFT 22% uplift for leave, sickness, and training.

The BR+ reviews identified increased outpatient and intrapartum activity since 2023, reflecting greater complexity, acuity and associated administrative workload.

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

[2] https://www.nice.org.uk/guidance/ng4

Although recruitment has improved, gaps remain in specialist midwifery roles. BR+ recommends redistributing capacity into roles such as safeguarding, perinatal mental health, fetal monitoring, safety and enhanced care pathways, recognising their contribution to safety, flow and quality.

Table 1: Total midwifery establishment

	2025/26 Total establishment (WTE)	BR+ assessment March 2026 Total establishment 22% uplift
ORC	385.2	377.59*
Wythenshawe	231.68	234.52
North Manchester	190.42	196.81
Total	**807.3**	**808.92***

***This does not include the 3.64 WTE Band 7 for Maternity Triage at SM ORC.**

Birth Rate+ reports identified and overall, 1.62 WTE gap between the existing establishment (807.3 WTE) and recommended establishment (808.92 WTE). In addition, as the reports did not take into account the additional triage coordinator roles at SM ORC, a further 3.64 WTE has been included as professional judgement.

As such, in addition to the 807.3 WTE funded establishment, 5.26 WTE increase is required, giving a new total midwifery funded establishment of 812.56 WTE.

The revised BR+ establishments have been agreed by the SHCG Senior Leadership Team and will be transacted to ledgers by November 2026. Table 2 sets out the clinical and non-clinical split.

Table 2: BR+ establishments demonstrating clinical and non-clinical split

	Clinical Workforce	Non-Clinical Workforce	Total
ORC	341.16	39.70	380.85
Wythenshawe	212.18	23.07	235.25
North Manchester	176.11	20.35	196.46
Total BR Plus	**729.45**	**83.12**	**812.56**

Recruitment and Retention January 2026-June 2026

Summary position

Recruitment and retention remained positive between January and June 2026. The Band 5/6 pipeline was strong at the start of the period, with 25.72 WTE in active recruitment, six additional Community Band 5 Hybrid Midwives appointed, and future cohorts from Bolton University and the University of Manchester factored into workforce planning.

Recruitment activity reduced the projected vacancy position from 0.58 WTE by March to an over-established position during spring 2026, supported by temporary NHSE Band 3–5 uplift funding allowing the service to operate 10 WTE above establishment until September 2026.

By March, recruitment had converted much of the pipeline into post, with 7.57 WTE Band 5, 0.4 WTE Band 6 and a further 4.92 WTE Band 5/6 starters. The active pipeline reduced to 8.67 WTE, reflecting successful appointment activity.

In April and May, recruitment continued with 4.21 WTE and 3.63 WTE Band 5 starters respectively. The remaining pipeline reduced to 2.4 WTE by May, although candidate withdrawals increased, reflecting wider workforce competition.

June 2026 represented a shift in the workforce position, with the highest turnover of the period at 9.31 WTE, no new starters and emerging vacancy pressure across all three sites. As such total midwifery vacancies were 13.88 WTE, comprising ORC 6.7 WTE, North Manchester 4.84 WTE and Wythenshawe 2.34 WTE. Overall staffing remained safe and positive, and the trend indicated the need to maintain active recruitment trajectories ahead of BR+ ledger changes.

Midwifery Turnover

The Midwifery turnover for the reporting period is detailed below in table 3. For the months of May and June the turnover rate increased. All staff members are offered exit interviews and local data suggests that the majority of leavers are due to relocation.

Table 3: Midwifery turnover between January to June 2026

Month 2026	Maternity Services Average Monthly Turnover (WTE)
January	0.64 WTE
February	2.01 WTE
March	2.24 WTE
April	1.48 WTE
May	6.23 WTE
June	9.31 WTE

6 monthly average turnover	3.65 WTE

The trend in midwifery vacancies is set against the adjusted budget setting in M01 26/27. Please note that when BR+ adjustments are implemented into the ledger this will increase the vacancy rate and therefore recruitment trajectories have been supported accordingly.

Planned Verses Actual Midwifery Staffing and Managing Staffing Gaps

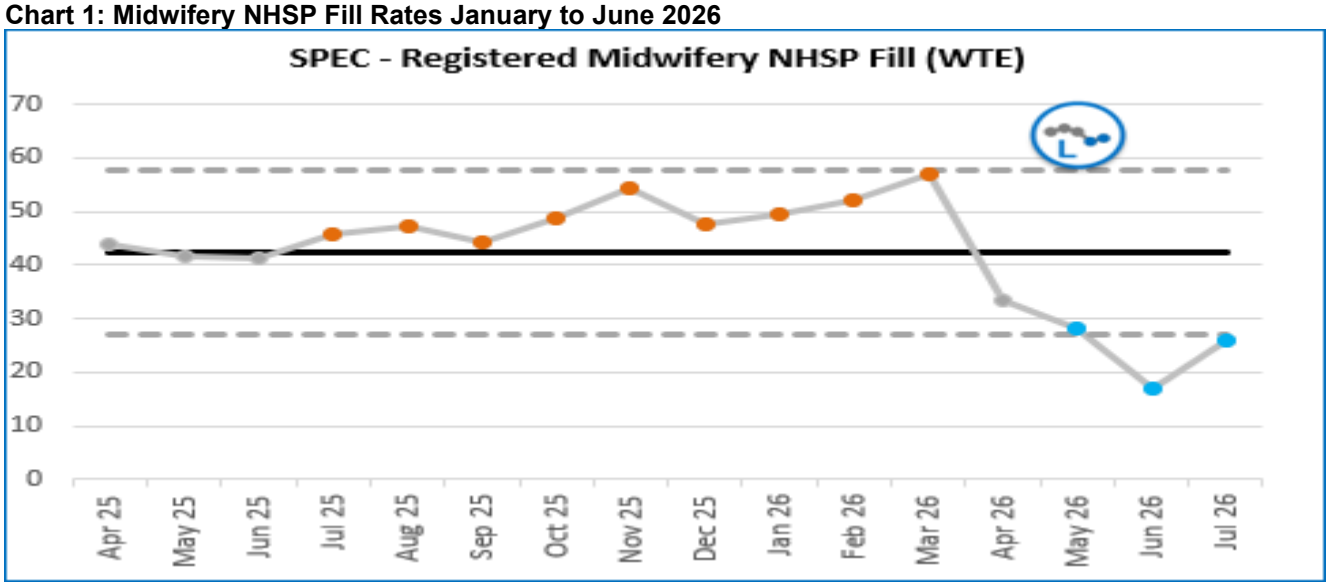
Maternity Services review staffing and flow twice daily with Newborn Services, chaired by Heads or Deputy Heads of Midwifery to oversee clinical area cover and facilitate redeployment where required.

A maternity unit status report is circulated three times daily to senior divisional, nursing and on-call leadership teams.

Temporary staffing supports safe staffing, with monthly NHSP huddles reviewing fill rates, incidents and workforce applications.

Heads of Midwifery (HOMs) monitor NHSP fill rates weekly using the Workforce Establishment Review Model (WERM) Tool. Rates reduced after March 2026, with some increase as summer leave commenced; trends are shown in Graph 1.

Chart 1: Midwifery NHSP Fill Rates January to June 2026



Maternity Services use a staffing tool to prospectively monitor NHSP spend against vacancies, supernumerary staffing, sickness and training uplift, supporting managers to use NHSP efficiently within budget.

Areas of focus January to June 2026:
Additional hours worked by part-time staff, alongside NHSP shift requests, are reviewed weekly through SM MCS staffing meetings and scrutinised by Heads of Midwifery.

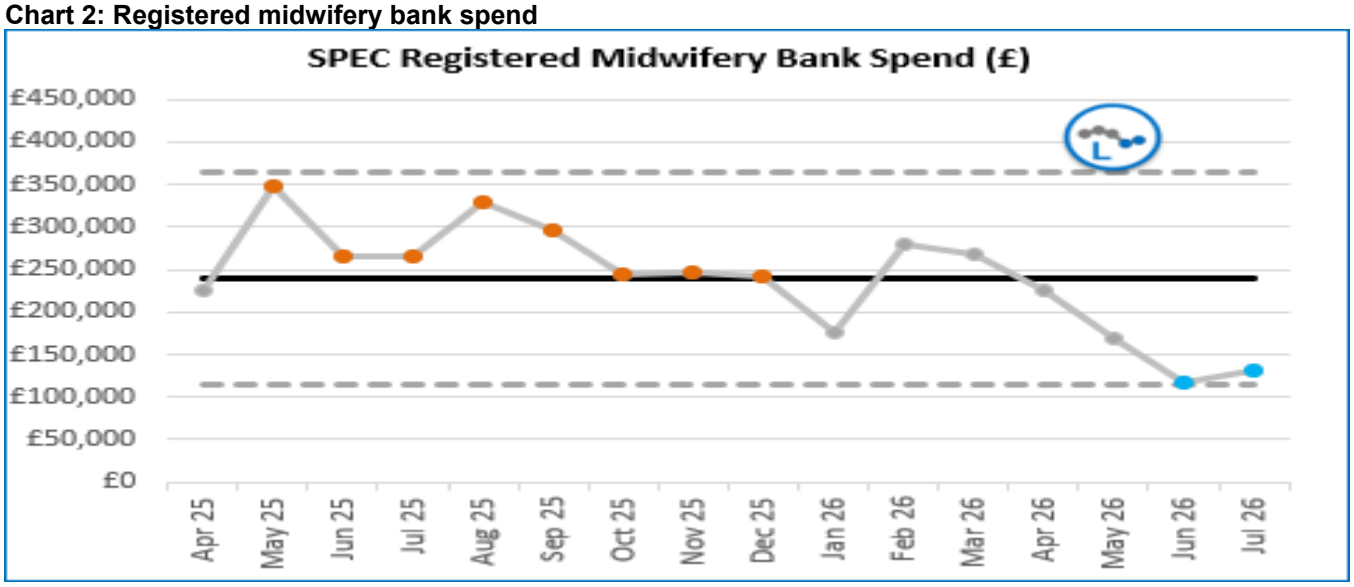
Hours owed, time owing and annual leave are reviewed weekly by roster oversight Matrons, supported by twice-weekly corporate workforce reports. Roster cleansing has reduced excess

balances, with only four staff now exceeding 50 hours; remaining issues relate to sickness calculations or split roles and are being addressed with IT support.

Since May 2026, all NHSP shifts have required Director of Nursing and Midwifery authorisation to strengthen oversight and appropriate use.

Tighter controls and reduced temporary staffing fill rates have contributed to a downward trend in maternity bank spend, shown in Graph 2.

Chart 2: Registered midwifery bank spend



Midwife to Birth Ratio

Ratios of births to midwives are dependent on demographics, case mix, models of care, total number of community cases and the differing needs of women thus are different from provider to provider and month to month. The BR+ review ratios are calculated based on individual unit need and acuity. Maternity Services monitor birth to midwife ratios monthly and submit this to the Greater Manchester Local Maternity and Neonatal System (GM LMNS) maternity dashboard.

The birth to midwife ratio is also monitored via the MFT maternity dashboard and People Board Committee bi-monthly meeting in line with the Perinatal Quality Oversight Model (PQOM). There have been no escalations between January and June 2026. Ratios for birth to midwife are demonstrated in table 4 below.

Table 4: Midwife to birth ratio January to June 2026

	January 2026	February 2026	March 2026	April 2026	May 2026	June 2026
ORC	22	21.5	23	25	21	22
Wythenshawe	24.3	24.19	25.6	22	24	23.9
North Manchester	23	22	22	22	24	24.8

Red Flag Staffing Events January 2026 – June 2026

Red flag events are signs that incidents may relate to inadequate midwifery staffing. Red-flag reporting supports compliance with the PQOM, providing a mechanism for the identification, escalation and oversight of emerging maternity safety risks.

It was identified that there was an overreporting of midwifery Red Flag incidents, as on review not all related to delays caused by midwifery staffing. The reporting process has recently been reviewed, with new categories added to the Ulysses incident reporting system. This supports the reporting of delays unrelated midwifery staffing, whilst not conflating Red Flag events.

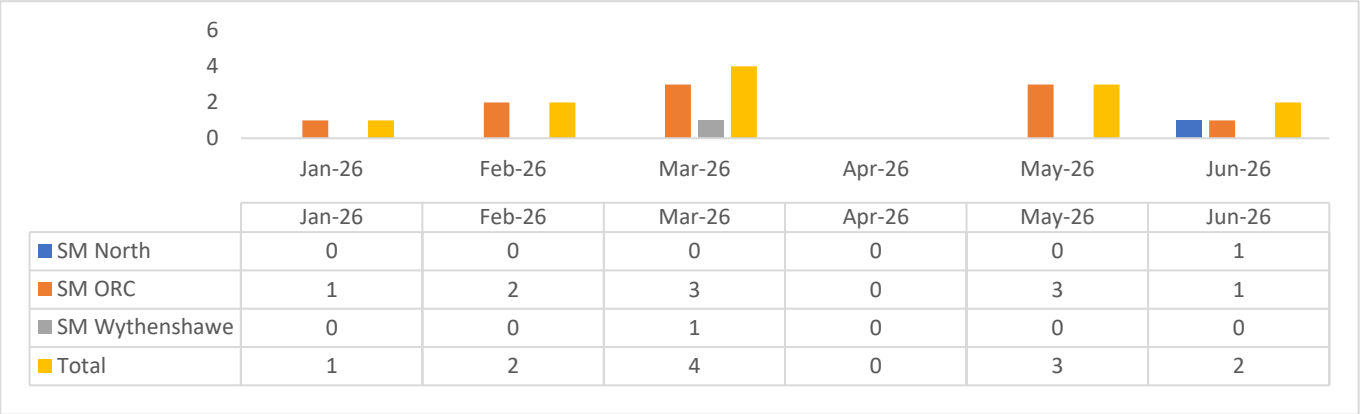
Red flag incidents reported between January-June 2026 related to redeployment of midwifery staff from mandatory training. In all cases, escalation pathways were followed, and redeployment of staff did not impact training compliance.

There were no red flag incidents reported in relation to midwifery staffing within Maternity Triage. Over the six-month reporting period, on average 79% of women had an initial midwifery triage assessment within 15 minutes of arrival. Whilst this has varied between 75-82%, improvement has been noted on the Oxford Road site, following the introduction of a Band 7 Triage Coordinator.

No red flag incidents were reported relating to transfer delays for women continuing induction of labour. Over the six-month reporting period, an average of 35% of women waited more than 24 hours for transfer for ARM, meeting the target of less than 40%. However, monthly variation was evident, with 46% waiting more than 24 hours in June 2026. Increased turnover, vacancies and limited recruitment options in June, along with a change to a less effective induction agent and increased acuity all contributed to these delays.

Real time monitoring in place for both metrics with twice daily flow meetings, alongside monthly reporting to the Trust Quality and Safety IPR and bimonthly reporting to Quality, Safety and Performance Board Committee in line with PQOM.

Chart 3: Red Flag Events January to June 2026



	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
SM North	0	0	0	0	0	1
SM ORC	1	2	3	0	3	1
SM Wythenshawe	0	0	1	0	0	0
Total	1	2	4	0	3	2

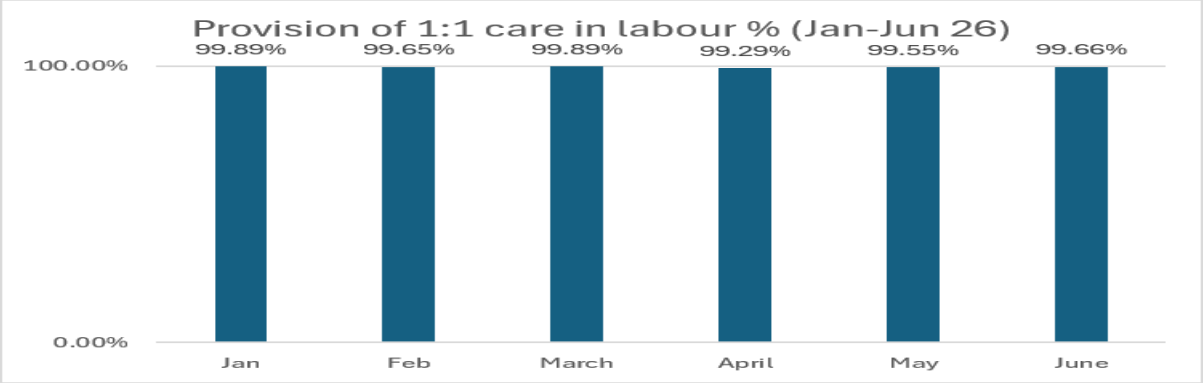
Supernumerary Midwifery Coordinator

The midwifery coordinator on all three delivery units across SM MCS has supernumerary status to ensure that they can maintain oversight of all birth activity within the service. There has been

100% compliance with having a supernumerary coordinator throughout January to June 2026 (Appendix 1). In addition, the midwifery coordinator is supported on most clinical shifts by a second Band 7 Midwife.
There were no incidents due to the supernumerary coordinator needing to provide clinical care.

One-to-one care in labour
Cases where one-to-one care has not been provided are reviewed and actions developed to drive improvement. A monthly report is presented to the Maternity Operational Delivery Group (MDOG) chaired by the Director of Nursing and Midwifery and into SHCG Governance forums. A quarterly report and action plan in developed to the Maternity Services Quality, Safety and Performance Committee.

Chart 4: One-to-one care in labour January to June 2026



Diverts and Deflects

Routine review of daily acuity, medical and midwifery staffing and planned elective work occurs twice per day during the morning and evening daily flow meetings. This enables elective work to be transferred between sites to support reduction in waiting times specifically for women awaiting artificial rupture of membranes (ARM) or category 3 caesarean section.

Deflects are temporary transfers of maternity activity between MFT internal maternity sites in response to local capacity, acuity, staffing, operational pressures or Maternity Triage escalation points. Each site has a specific number of triage attendees which triggers an escalation to support initial clinical assessment being completed within the appropriate timeframe. A deflect will be considered where triage acuity cannot be safely managed despite all available measures, including staff redeployment and the use of additional triage rooms.

Diverts represent a higher level of escalation whereby a unit temporarily redirects admissions after local escalation measures have been exhausted and safe service provision requires additional measures and must be approved and supported by Directors and NWAS. Monitoring of deflects and diverts provides an indicator of workforce, demand, and capacity pressures within maternity services.

All diverts and deflects are incident reported and monitored through divisional governance processes, with outcomes for all women reviewed locally. There were two diverts and 51 deflects between January and June 2026 (Graphs 5 and 6). The deflects were predominantly associated with periods of increased clinical acuity, activity and capacity pressure, with midwifery staffing

constraints (3) also contributing. Specific operational factors included medical staffing gaps (2), theatre pressures (4), a malfunctioning alarm (1) and an IT outage (1).

Actions taken in response to monitoring of diverts and deflects includes a right-sizing review of capacity and demand to support future-proofing services.

No incidents have been identified graded moderate harm or above related to a divert or deflect.

Chart 5: Diverts January to June 2026

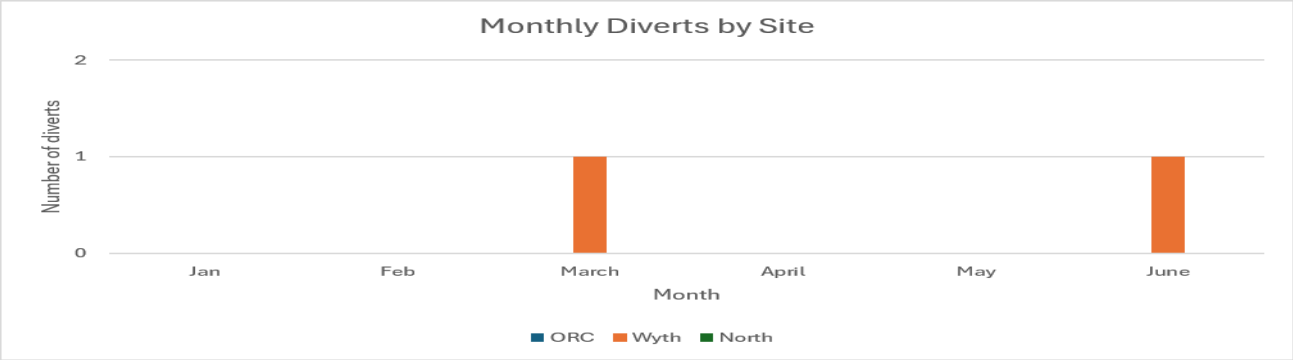
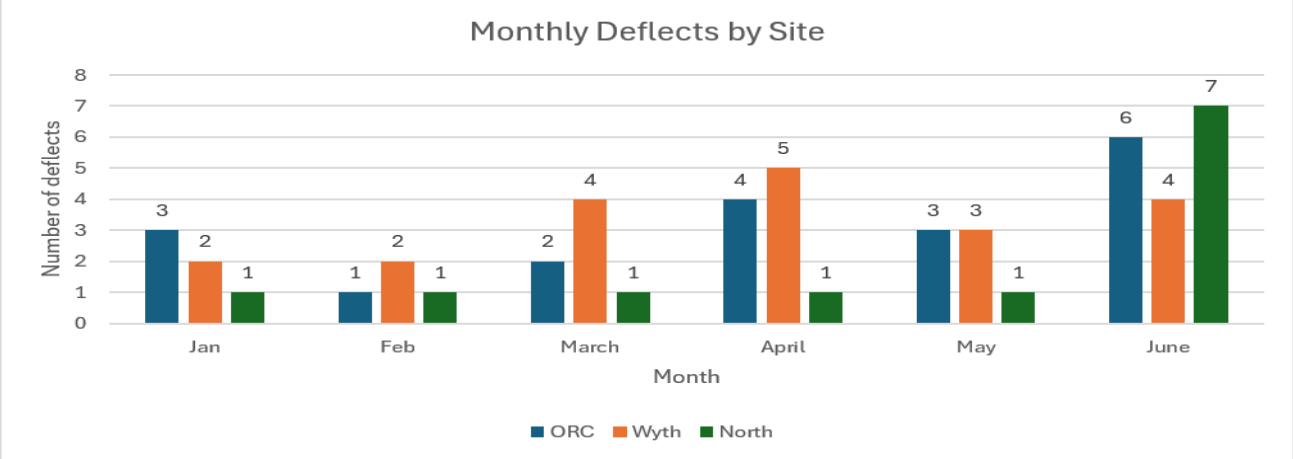


Chart 6: Deflects January to June 2026



Community and Homebirth Team Midwifery Staffing

The community midwifery teams across the MCS remain challenged in respect of recruiting to vacancies. The recruitment and retention team are supporting targeted recruitment to address the current vacancy including options of hybrid working The team continue to be supported by Community Team Leaders, Managers and Matrons to ensure the delivery of a safe and effective service.

The Homebirth team has a budgeted establishment of 8 WTE. Due to turnover within the team with reasons including relocation and wishing to return to the traditional community setting

alongside maternity leave, the team currently has a vacancy of 2.1WTE. To ensure the service is maintained several community midwives, and two consultant midwives are currently supporting the on-call provision. The vacancy has been externally advertised and there is currently 0.64 WTE in active recruitment. To provide resilience within the team, midwives from alternate teams are being supported to complete the Homebirth team training in line with the TNA, to increase the number of midwives available to support the team. The model and establishment will be considered as part of the planned annual review of the Homebirth Service due to report Trust Quality, Safety and Performance Board Committee in December 2026

Neonatal Nursing Workforce

This section of the report provides an overview of the Newborn Services' nursing workforce position across Oxford Road Campus (ORC) Neonatal Intensive Care Unit (NICU), and the Local Neonatal Units (LNUs) at Wythenshawe and North Manchester for the period January to June 2026. The paper provides assurance regarding workforce establishment, recruitment and retention, temporary staffing, sickness absence, Qualification in Specialty (QiS) compliance and compliance with recognised national staffing standards.

During the reporting period, Newborn Services remained compliant with cot-side staffing requirements and supernumerary shift coordinator standards across all three neonatal units. The principal workforce risk continues to relate to QiS compliance at ORC; however, significant progress has been made across all sites through focused recruitment, retention and workforce development initiatives.

Workforce Establishment

Newborn Services maintained a funded nursing establishment of **336.04 WTE** throughout the reporting period (Table 5).

Table 5: Neonatal nursing workforce establishment

Site	Establishment (WTE)
Oxford Road Campus	247.17
Wythenshawe	48.28
North Manchester	40.59
Total	336.04

All three units continued to meet the funded establishment required to support cot-side care and remained compliant with the British Association of Perinatal Medicine (BAPM[3] requirements for supernumerary shift coordinators.

Recruitment and Retention

[3] https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/3581/BAPM_Service_Quality_Standards_FINAL.pdf

The registered neonatal nursing vacancy position improved steadily during the first six months of 2026.

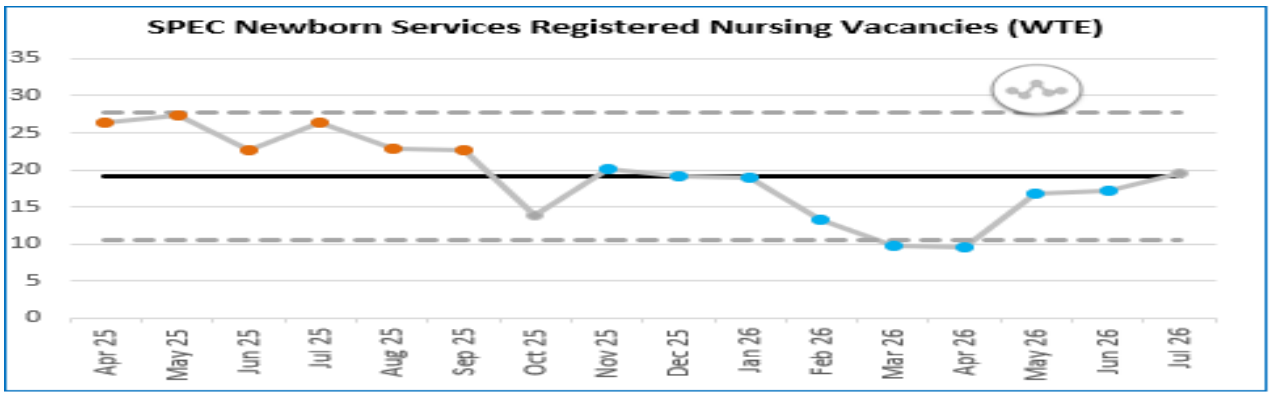
At the end of February 2026, Newborn Services reported 15.35 WTE vacancies across Bands 5 to 7. Nine Band 5 nurses were in recruitment pipelines and expected to commence employment between March and April 2026. In addition, two guaranteed job interview Nurse Associates were progressing through appointment processes.

By April 2026, vacancies had increased slightly to 16.75 WTE across Bands 4 to 7, although four Band 4 and Band 5 staff were already recruited and due to start in May 2026.

By June 2026, vacancies had reduced again to 14.28 WTE, representing an improvement in the overall vacancy position. Four additional Band 4 staff remained in the recruitment pipeline awaiting start dates. Vacancies remained concentrated predominantly within the ORC workforce.

Across the six-month period, Newborn Services has continued to utilise internal rotation opportunities between ORC, Wythenshawe and North Manchester to support staff retention and reduce workforce attrition.

Chart 7: Newborn Services Registered Nursing Vacancies (WTE)



Turnover

Turnover remained relatively stable across the reporting period 0.8 WTE per month, demonstrating workforce stability.:

- January-February 2026: 2.0 WTE leavers per month.
- March-April 2026: 0.6 WTE leavers per month.
- May-June 2026: 2.3 WTE leavers per month**.**

Whilst turnover increased during May and June, vacancy reduction indicates recruitment activity continued to offset workforce losses.

Qualification in Speciality

Compliance with the BAPM[4] recommendation that a minimum of 70% of neonatal nurses hold the QiS remained the most significant workforce challenge within Newborn Services during the reporting period. Neonatal Services remained formally non-compliant overall because ORC had

[4] https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk

not yet achieved the 70% standard; however, sustained improvement continued throughout the reporting period. Risk MFT/004452 remained on the risk register with a score of 12.

QiS compliance improved across all Newborn Services sites from January to June 2026. ORC increased from 60% to 65% but remained below the 70% BAPM standard; North Manchester reached 70% from March, and Wythenshawe exceeded the standard from March, reaching 72% in June. This reflects continued investment in QiS training, recruitment and retention. Subject to retaining QiS-qualified staff and programme completion, all sites are forecast to exceed 70% during 2026.

Table 6: QIS Compliance January –June 2026

Site	Jan 2026	Feb 2026	Mar 2026*	Apr 2026*	May 2026	Jun 2026	Change Jan-Jun
Oxford Road Campus (NICU)	60%	61%	61%	61%	63%	65%	**+5%**
North Manchester (LNU)	63%	70%	70%	70%	70%	70%	**+7%**
Wythenshawe (LNU)	65%	71%	71%	71%	73%	72%	**+7%**

Temporary Staffing and NHSP

Newborn Services continued to utilise temporary staffing appropriately to support safe staffing levels and maintain neonatal service delivery. Reduced NHSP bank rates were introduced in Maternity Services on 1st November 2025 and in January 2026 within Newborn Services.

During January and February 2026, following implementation of revised NHSP bank rates, NHSP expenditure reduced to:

- January 2026: £102,342
- February 2026: £114,085

The reduction was attributed to improved recruitment, reduced maternity leave backfill requirements and fewer training-related workforce pressures.

During March and April 2026, NHSP usage was driven predominantly by backfill requirements associated with QiS and Foundation in Neonates training programmes, alongside periods of supernumerary study leave. The service maintained close scrutiny through daily staffing reviews and utilised mutual aid and redeployment where possible.

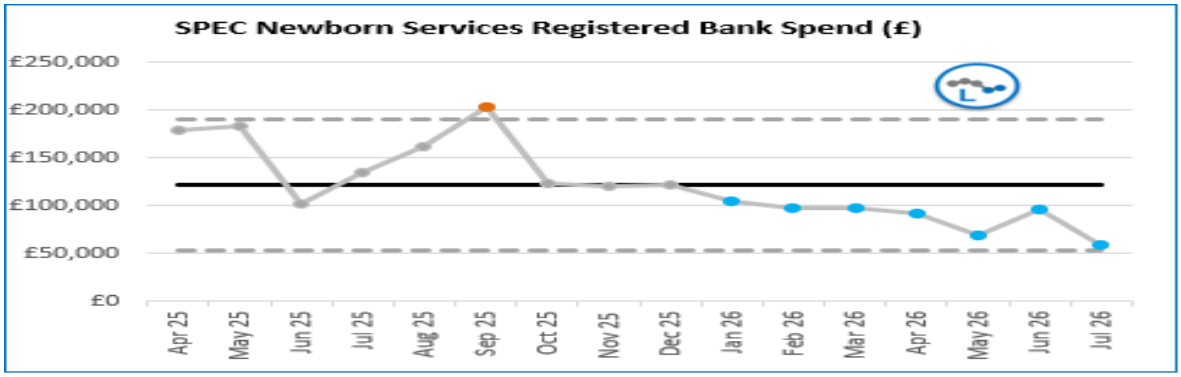
Throughout the reporting period, NHSP utilisation was predominantly driven by:

- Increased patient acuity and activity.
- Unit configuration and room layout requirements.
- Infection prevention and control requirements.

- Maintaining safe staffing levels whilst recruitment and workforce development initiatives progressed.

Additional Senior Leadership Team and Divisional Leadership Team check-and-challenge processes have been introduced prior to shifts being advertised, providing greater scrutiny and senior oversight of NHSP bookings. All requests are reviewed against acuity, activity, staffing establishment and associated risk.

Chart 7: Newborn Services registered nursing bank spend

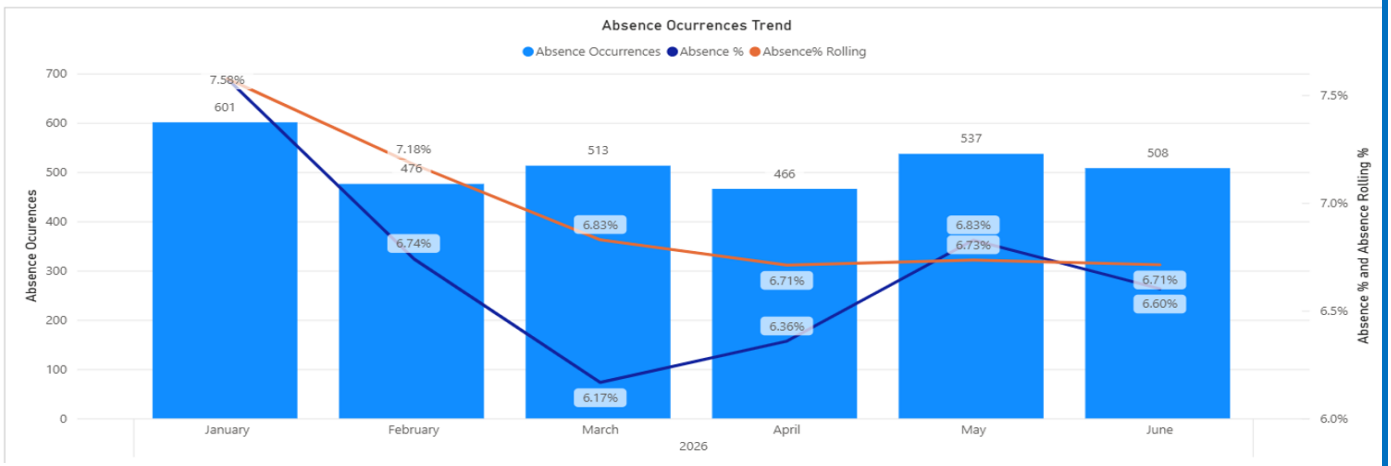


Sickness Absence – Nursing and Midwifery

Sickness absence across Maternity and Newborn Services was closely monitored from January to June 2026. Although above the Trust NMAHP trajectory of 5%, rates improved overall, indicating that attendance improvement actions are having a positive impact.

Absence peaked at 7.58% in January, reflecting seasonal pressures, then fell to 6.17% in March before fluctuating slightly and improving again by June. Overall, rates were more stable later in the period and improved compared with the start of the year.

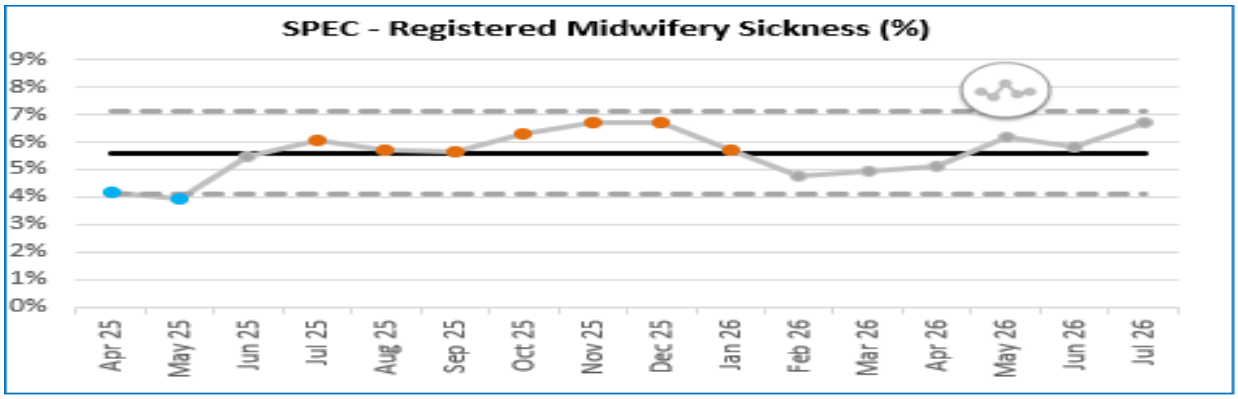
Chart 8: Maternity and Newborn Services Care Division Absence January to June 2026.



Between January and June 2026, registered midwifery sickness absence was consistently lower than registered nursing sickness absence (Charts 9 and 10).

Registered midwifery sickness absence fell from approximately 5.6% in January to 4.7% in February, before gradually increasing to around 5.8% in June 2026. Although the rate rose during the latter part of the period, it remained within the expected control limits and showed relatively limited variation.

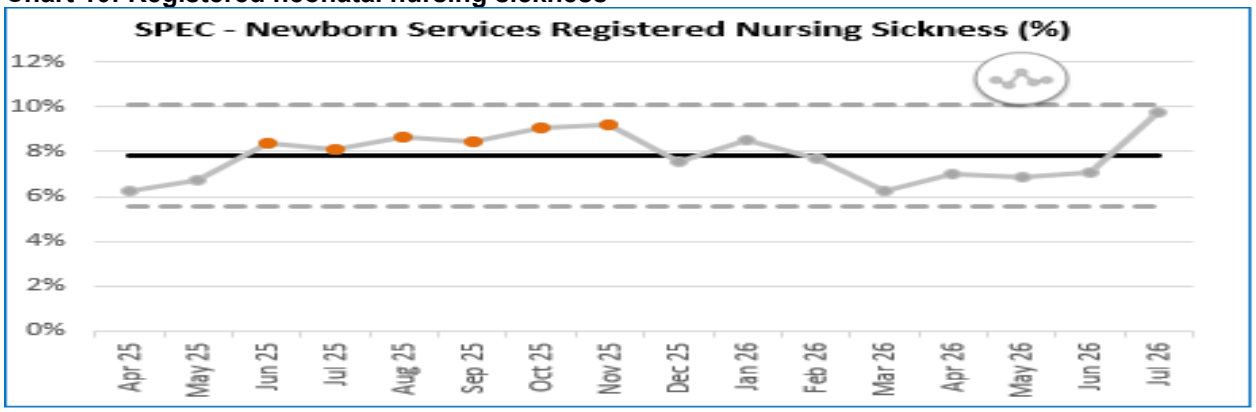
Chart 9: registered midwifery sickness absence



Newborn Services registered nursing sickness absence was higher throughout the period. It increased from approximately 8.5% in January to around 7.7% in February, before falling to approximately 6.2% in March. It then rose to around 7% in April and remained broadly stable through May and June 2026.

Within Newborn Services it is recognised that sustained operational pressures associated with increasing activity and patient acuity, alongside the redeployment of staff from quality-enhancing roles into direct patient care and limited access to dedicated psychological support, can impact workforce resilience, staff wellbeing and capacity for service improvement; however, a range of measures remain in place to support staff, promote wellbeing and maintain safe service delivery.

Chart 10: Registered neonatal nursing sickness



Within Midwifery, the predominant reasons for sickness absence remained consistent throughout the reporting period. Anxiety, stress, depression and other psychiatric illnesses continued to be

the most common causes of absence and were largely associated with long-term health conditions, personal circumstances, family-related health issues and bereavement. This is consistent across all 3 sites with 1.74% at ORC, 2.14% at North Manchester and 2.27% at Wythenshawe.

For comparison, in July 2026 MFT were at 2.3%, other Shelford Group Trusts were 2.1%, and the national rate was 2.4% for the reported absence % of Registered Midwifery staff absent due to anxiety, stress and depression.

Anxiety, stress depression and other psychiatric illnesses within midwifery are made up of 39.5% long term sickness absences and 60.5% short term sickness absences. Managers are engaging with staff as early as possible during their absence to understand the factors affecting their health and wellbeing and identify appropriate support.

This includes completing stress risk assessments and exploring potential workplace adjustments to facilitate a safe and timely return to work. Adjustments may include changes to working hours or shift patterns, greater flexibility, and identifying and reducing workplace triggers that may be contributing to stress or anxiety. These discussions support an individualised approach to staff wellbeing, with the aim of reducing the impact of work-related factors and supporting sustainable returns to work. Staff are encouraged to access the range of health and wellbeing support available through the Trust, including Employee Health and Wellbeing Services and the Employee Assistance Programme. This support aims to ensure staff are aware of the help available to them and can access appropriate advice and resources to support their mental health and wellbeing.

Gastrointestinal illness and coughs, colds and flu also featured consistently amongst the most common reasons for absence. Colds, coughs and flu remain similar across the 3 sites (ORC 0.43%. Wythenshawe 0.69% and North Manchester 0.48%) however there is variation across the sites for absences related to gastrointestinal problems with no reported cases on the North Manchester site and 0.45% at Wythenshawe and 0.41% at ORC. The highest reported absence rates are within smaller teams, where the absence of even a small number of staff can have a significant impact on the overall figures. This is evident in areas such as AAU and ANC at North Manchester, and ERP and the Birth Centre at Wythenshawe.

Chart 11. Absence Reason

Absence Category	Absence Reason	All Maternity	WTWA	NMGH	ORC
Sickness	**Total**	**5.41%**	**5.55%**	**6.20%**	**4.94%**
	S10 Anxiety/stress/depression/other psychiatric illnesses	1.99%	2.27%	2.14%	1.74%
	S13 Cold, Cough, Flu - Influenza	0.51%	0.69%	0.48%	0.43%
	S25 Gastrointestinal problems	0.45%	0.45%	0.00%	0.41%
	S98 Other known causes - not elsewhere classified	0.39%	0.42%	0.36%	0.39%
	S30 Pregnancy related disorders	0.33%	0.49%	0.18%	0.30%
	S16 Headache / migraine	0.29%	0.26%	0.00%	0.21%
	S28 Injury, fracture	0.25%	0.10%	0.17%	0.37%
	S26 Genitourinary & gynaecological disorders	0.18%	0.17%	0.23%	0.16%
	S15 Chest & respiratory problems	0.15%	0.02%	0.00%	0.05%
	S12 Other musculoskeletal problems	0.15%	0.20%	0.20%	0.04%
	S21 Ear, nose, throat (ENT)	0.13%	0.23%	0.13%	0.07%
	S18 Blood disorders	0.12%	0.00%	0.00%	0.26%
	S11 Back Problems	0.11%	0.09%	0.09%	0.13%
	S31 Skin disorders	0.10%	0.00%	0.00%	0.02%
	S29 Nervous system disorders	0.06%	0.00%	0.00%	0.13%
	S24 Endocrine / glandular problems	0.05%	0.00%	0.00%	0.11%
	S19 Heart, cardiac & circulatory problems	0.05%	0.01%	0.00%	0.06%
	S17 Benign and malignant tumours, cancers	0.03%	0.12%	0.12%	0.00%
	S23 Eye problems	0.02%	0.01%	0.01%	0.01%
	S22 Dental and oral problems	0.02%	0.01%	0.01%	0.01%
	S27 Infectious diseases	0.01%	0.00%	0.00%	0.02%
	S20 Burns, poisoning, frostbite, hypothermia	0.01%	0.01%	0.01%	0.01%
	S99 Unknown causes / Not specified	0.00%	0.00%	0.00%	0.00%

Chart 12. Long term V Short term sickness

Long term is defined as episodes >28 days

Absence Reason	Long Term	Short Term
S10 Anxiety/stress/depression/other psychiatric illnesses	39.54%	60.46%
S11 Back Problems	14.93%	85.07%
S12 Other musculoskeletal problems	17.73%	82.27%
S13 Cold, Cough, Flu - Influenza	1.04%	98.96%
S14 Asthma	4.58%	95.42%
S15 Chest & respiratory problems	8.13%	91.87%
S16 Headache / migraine	2.58%	97.42%
S17 Benign and malignant tumours, cancers	65.50%	34.50%
S18 Blood disorders	18.71%	81.29%
S19 Heart, cardiac & circulatory problems	23.81%	76.19%
S20 Burns, poisoning, frostbite, hypothermia	14.04%	85.96%
S21 Ear, nose, throat (ENT)	4.12%	95.88%
S22 Dental and oral problems	1.31%	98.69%
S23 Eye problems	8.56%	91.44%
S24 Endocrine / glandular problems	18.90%	81.10%
S25 Gastrointestinal problems	2.53%	97.47%
S26 Genitourinary & gynaecological disorders	11.82%	88.18%
S27 Infectious diseases	7.41%	92.59%
S28 Injury, fracture	28.06%	71.94%
S29 Nervous system disorders	26.82%	73.18%
S30 Pregnancy related disorders	20.24%	79.76%
S31 Skin disorders	8.04%	91.96%
S32 Substance abuse	100.00%	0.00%
S98 Other known causes - not elsewhere classified	44.09%	55.91%
S99 Unknown causes / Not specified	6.64%	93.36%

Managers continue to support wellbeing and earlier return to work through stress risk assessments, workplace adjustments, signposting to Employee Assistance Programme (EAP), Occupational Health and Wellbeing services, and regular return-to-work and risk assessment reviews. Long-term sickness duration has reduced since January 2026, with only three cases now exceeding twelve months.

Absence patterns adjusted from 56% short-term and 44% long-term in March/April to 40% short-term and 60% long-term in May/June, indicating more complex cases requiring sustained support and case management. Progress is monitored through the attendance improvement programme, divisional safer staffing meetings and monthly Delivery Oversight Framework reporting, where sickness levels, absence reasons, actions, call-backs and return-to-work compliance are reviewed and reported to the Specialist Hospitals Clinical Group (SHCG) Senior Leadership Team.

Further oversight is provided through the bi-weekly Safer Staffing Workstream, supported by Human Resources (HR), with regular review of action plans and monthly HR-chaired attendance assurance meetings.

Safer Medical Workforce Review Summary
This section summarises the six-month workforce audit across obstetrics, neonatology, anaesthetics and Operating Department Practitioners (ODPs).

Audits for ORC, North Manchester and Wythenshawe covered January to June 2026 and assessed vacancies, acute shift fill, triage registrar cover, sickness absence, and anaesthetic/ODP fill rates.

The analysis summarises workforce performance, operational context, mitigation and assurance arrangements used to maintain safe staffing during workforce pressures.

Overall, medical staffing resilience was maintained across all three sites, with full obstetric anaesthetic and ODP shift fill throughout.

Key pressures related to resident doctor vacancies and variable shift fill, particularly ORC neonatal night cover, North Manchester obstetric night cover following rota changes, and Wythenshawe triage registrar cover. Wythenshawe remains reliant on locum uptake, creating an ongoing sustainability and equity risk across the MCS.

Across SM MCS, maternity triage stays exceeding five hours have increased (see table below). All women received midwifery and medical reviews, with no incidents of harm or increase in concerns raised by women about waiting times. Review findings indicate that longer stays mainly reflect waits for investigation results, further review and confirmation of ongoing care plans, affected by medical staffing availability and increase in triage attendances.

	January	February	March	April	May	June
Prolonged waits in triage (over 5 hours)	16%	17.9%	17.7%	15.8%	16.7%	20.6%

The right-sizing business case provides an opportunity to address this by adding a substantive Wythenshawe Maternity Triage registrar shift, aligning the site with ORC and North Manchester.

ORC Analysis – Workforce Audit (Appendix 3)

Obstetrics
There were no obstetric consultant vacancies. Resident doctor vacancies were two from January to May, increasing to four in June, with improvement expected after the August 2026 rotation. Consultant shifts were fully filled, and resident day/night fill remained high. Maternity Triage registrar fill was strong until March but reduced from April due to redeployment to support Delivery Unit pressures and maintain safe cover in higher-risk areas.

Neonatology
The neonatal medical workforce is fully funded in line with BAPM standards (Appendix 2).
The neonatal consultant vacancy linked to long-term sickness resolved when the substantive consultant returned in May 2026. Acute commitments were maintained through consultant extra-contractual lists, providing assurance of safe cover.

Resident doctor vacancies were broadly stable, rising from two to three in April/May before returning to two in June. Consultant night cover was fully staffed and day fill ranged from 93.0% to 100%.

Resident day fill ranged from 92.5% to 96.5%, while night fill remained below threshold at 82.8% to 91.4%, reflecting ongoing neonatal recruitment challenges. Mitigations remained in place to maintain safe staffing and oversight.

Mitigations and Assurance.

Neonatal rota gaps are reviewed proactively, with mitigations including shift swaps, staff bank advertising and escalated rates for short-notice gaps.

The service has 24-hour consultant cover, with non-resident consultant support available. Staffing is reviewed against acuity and activity, with capacity adjusted where required to maintain safety.

Recruitment is actively managed, with prospective vacancies advertised early. Appointment delays are monitored by the senior leadership team, and no patient safety concerns attributable to staffing gaps were identified.

North Manchester Analysis – Workforce Audit (Appendix 4)

Obstetrics
Consultant vacancies ranged from one to three between January and June 2026. Two locums were recruited, one substantive post was advertised, and interviews were scheduled for September 2026, resulting in the appointment of six substantive obstetricians. Two will be based at North Manchester to support the rota expansion from 1-in-8 to 1-in-12, following approval of the business case. Resident doctor vacancies remained at one from January to April before rising to five in May and June, when the rota was reconfigured from a 1-in-12 arrangement to two 1-in-9 rotas. This required the recruitment of six senior clinical fellows or specialty doctors; following recruitment, only one vacancy remains.

Consultant acute shift fill remained at 98.4% or above, with other shifts fully covered. Unfilled shifts were mitigated through non-resident consultant support or a Specialty Doctor acting up with consultant oversight. Resident day fill ranged from 95.4% to 100%, with gaps risk-assessed and activity prioritised to maintain safety.

The May 2026 rota introduced two senior registrar tiers overnight, a resident Tier 1 doctor and an on-call obstetrics and gynaecology consultant. Due to vacancies, the obstetric consultant remained resident until September 2026. Although night fill reduced to 90.3% in May and 78.9% in June, required senior cover remained on site.

Maternity Triage registrar fill rates ranged from 90.0% to 96.7%. Before May 2026, triage shifts depended on locum cover. Following the May rota redesign, a dedicated triage registrar shift was incorporated into the baseline rota, improving sustainability, fill rates and senior clinical presence.

Consultant sickness remained low at 1.7% to 2.8%. Resident doctor sickness peaked at 5.2% in March and April, possibly linked to rota change, prompting listening sessions led by the Clinical Head of Division and Head of Midwifery. By June, sickness was 4.7%, with no recurring themes identified and support mechanisms in place.

Neonatology
The neonatal medical workforce is fully funded in line with BAPM standards (Appendix 2). There were no neonatal consultant vacancies, and recorded consultant and resident day/night shifts were consistently filled. Retrospective resident vacancy data were unavailable, limiting trend analysis; a monthly workforce data process is now in place and will inform future biannual audits.

Wythenshawe Analysis – Workforce Audit (Appendix 5)

Obstetrics
There were no consultant vacancies. Resident doctor vacancies improved from three in January to zero by June 2026 following successful recruitment.

Consultant day and night shifts were fully filled throughout. Resident day fill ranged from 94.6% to 99.2%, and night fill from 85.8% to 98.4%, with the April low mainly due to vacancies and less than full time (LTFT) working.

Unfilled shifts were escalated and advertised through the staff bank, with enhanced rates considered for short-notice gaps. An additional registrar mitigated estate-related risks from split maternity theatre locations, and non-resident consultant support remained available when required.

Dedicated Maternity Triage registrar fill remained low at 35.5% to 64.3%. Unlike the other two MCS sites, Wythenshawe does not have this role embedded in the substantive rota and remains reliant on locum uptake, creating a significant workforce resilience risk.

The absence of a substantive Maternity Triage workforce model affects sustainability, equity, patient flow and timely senior decision-making. A dedicated triage registrar shift is included in the Maternity Right-Sizing Business Case to strengthen compliance, resilience and equity while reducing reliance on temporary staffing.

Consultant sickness remained low at 0% to 0.3%. Resident doctor sickness was variable, peaking at 7.4% in January and 5.2% in April before reducing to 2.0% by June. No recurring themes were identified, and sickness absence management processes remain in place.

Neonatology
The neonatal medical workforce is fully funded in line with BAPM standards (Appendix 2). Neonatal consultant vacancies reduced from one between January and March to zero from April. Consultant shifts were fully filled throughout, providing assurance on senior cover.

Retrospective neonatal resident vacancy and fill-rate data were unavailable because no routine reporting process existed for Wythenshawe. A monthly data process has now been established to support routine monitoring and future biannual audits.

In the absence of retrospective data, local operational intelligence and Ulysses reporting identified no patient safety compromise linked to resident doctor staffing gaps.

Anaesthetic and ODP Analysis across the MCS

Across ORC, North Manchester and Wythenshawe, Consultant Obstetric Anaesthetists and resident anaesthetist day and night shifts were recorded as fully filled throughout January to June 2026 in line with the Anaesthesia Clinical Services Accreditation (ACSA) Standards[5]. ODP day and night shifts were also fully filled on all three sites, in line with the ACSA Standards. This provides a positive level of assurance regarding the availability of the theatre workforce.

Short term locum

No new short-term Tier 2 locums have been engaged since April 2026. Current locums are established workers, supporting continuity and familiarity with local maternity services.
A live locum register was introduced in April 2026 to support ongoing assurance, including annual review of competence progression (ARCP) or certificate of eligibility (short-term locums) (CEL) documentation where applicable.

Agency locum reliance continues to be minimised to strengthen continuity, governance and patient safety.

A standard operating procedure ensures temporary medical staff are familiarised with unit processes. For agency locums, ARCP or CEL eligibility is confirmed by the Temporary Workforce Team before consultant or clinical lead review.

All locums must complete an induction form confirming local induction.

Locum use, including Trust-employed doctors, is audited and reviewed. Rota gaps are reviewed three times weekly by the General Manager, with any new locum use scrutinised. These controls provide assurance that short-term locum use is certified, inducted and governed appropriately.

[5] https://www.rcoa.ac.uk/safety-standards-quality/anaesthesia-clinical-services-accreditation/acsa-standards

Consultant Attendance in Defined Acute Care Situations

The Royal College of Obstetricians and Gynaecologists (RCOG) *Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology*[6] describes the recommended consultant attendance in certain acute care situations. In line with the MIS Year 8 requirements for a minimum compliance of 80%, Maternity Services has completed an audit against the RCOG standards.

Maternity Services can confirm that a consultant was present in ≥80% of the applicable acute care situations on all three sites.

Acute care situations and availability of data

The RCOG guidance was not designed as a performance management tool and as a result not all specific situations highlighted are amenable to audit due to varying recording in clinical notes. Some metrics are currently recorded using our Hive electronic patient records (EPR) data and these are listed below in Table 7.

Table 7: Auditable data available in Hive EPR

Acute care situation requiring consultant presence	Data available
Any return to theatre	Yes
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU/ITU care is likely to become necessary	Protocol available, data not available in Hive EPR
Caesarean birth for placenta praevia/ abnormally invasive placenta	Yes
Caesarean birth for women with BMI >50	Yes
Caesarean birth < 28 weeks	Yes
Premature births, 30 weeks	Yes
4th degree perineal tear repair	Yes
Unexpected intrapartum stillbirth	Yes
Eclampsia	Yes
Maternal collapse e.g. septic shock, massive abruption	Guideline in place for consultant attendance at serious clinical indications, including maternal collapse and placental abruption.
PPH> 2L where the haemorrhage is continuing and the massive obstetric haemorrhage protocol has been instigated	Yes

Audit of compliance with RCOG Roles and responsibilities of the consultant

Maternity Services completed an audit of the RCOG prescribed acute care situations for May and June 2026 (Table 7).

For ORC, there was one case of postpartum haemorrhage (PPH) >2 L where the haemorrhage was ongoing and the massive obstetric haemorrhage (MOH) protocol had been instigated, and the Consultant Obstetrician was not present. The consultant was aware of the ongoing

[6] https://www.rcog.org.uk/media/1e0jwloo/roles-and-responsibilities-of-the-consultant-workforce-report-may-2022-update.pdf

haemorrhage when blood loss reached 1.9 L but did not attend theatre. For this case the ST6 resident doctor was present in theatre.

At Wythenshawe there was also one instance where the Consultant Obstetrician was not present at PPH> 2L where the haemorrhage was continuing and the MOH protocol had been instigated. The Consultant Obstetrician was in handover and was informed of the situation. A Senior Clinical Fellow was present in this instance.

North Manchester demonstrated 100% compliance with all acute care situations.

Table 8: Audit of RCOG prescribed acute care situations May and June 2026.

Situation mandating consultant attendance	ORC Compliance (n)	Wythenshawe Compliance (n)	North Manchester Compliance (n)
Return to theatre	N/A	N/A	N/A
PPH> 2L where the haemorrhage is continuing and MOH protocol instigated	925 (12/13)	80% (5/5)	100% (5/5)
Caesarean birth for major placenta praevia / abnormally invasive placenta	N/A	N/A	N/A
Caesarean birth for women with a BMI >50	1005 (3/3)	100% (1/1)	100% (3/3)
Caesarean birth <28/40	100% (5/5)	100% (1/1)	N/A
Premature twins <30/40	1005 (2/2)	100%	N/A
Intrapartum stillbirth	N/A	N/A	N/A
Eclampsia	N/A	100% (1/1)	N/A
4th Degree tears	100% (1/1)	N/A	N/A

Note: N/A where zero reported cases

This audit provides overall assurance that SM MCS is compliant with the RCOG requirements for consultant attendance in specified high-risk obstetric situations, meeting or exceeding the 80% compliance threshold for all cases. Maternity Services has a continued focus on documentation standards, escalation processes and review of non-attendance cases to strengthen ongoing assurance.

To support ongoing oversight and feedback Maternity Services will be completing the audit monthly with findings collated into a six-monthly summary included in future reports.

Conclusion

This six-month integrated workforce report provides assurance on the maternity, neonatal nursing and medical workforce position across Maternity and Newborn Services Care Division for January to June 2026, aligned to MIS Year 8, safer staffing requirements and Board oversight expectations.

Recruitment and retention remained broadly positive, with strong Band 5/6 pipelines and active management of workforce pressures.

Quality and safety indicators confirm active management of workforce risks, with no midwife-to-birth ratio escalations, no supernumerary coordinator breaches and no moderate harm or above incidents related to diverts or deflects.

Newborn Services remained compliant with cot-side staffing and supernumerary coordinator standards. Nursing vacancies improved by June, although ORC remained the main vacancy area. QiS compliance remains the key risk: ORC improved from 60% to 65% but remained below the 70% BAPM standard, while North Manchester and Wythenshawe achieved or exceeded compliance.

Sickness absence remained above the 5% Trust NMAHP trajectory but improved from the January peak. Attendance improvement plans, wellbeing support, Occupational Health input and divisional oversight continue to support resilience.

Medical workforce audits confirmed safe staffing across all sites, with strong consultant, anaesthetic and ODP fill rates. Main pressures related to resident doctor gaps, ORC neonatal night cover, North Manchester rota transition and Wythenshawe Maternity Triage registrar cover. The key ongoing risk is the sustainability and equity of senior registrar cover in Wythenshawe Maternity Triage, where reliance on locums differs from ORC and North Manchester. The Maternity Right-Sizing Business Case provides the route to substantive provision.

The Care Division has met the minimum staffing requirements for MIS Year 8 Safety Action A:

1. Consultant presence audit confirms ≥80% compliance in defined acute care situations.
2. Locum certification, live short-term locum register and annual review are in place.
3. Neonatal funded establishments for nursing and medical meet BAPM requirements for cot side care.
4. The midwifery workforce is aligned to the March 2026 BR+ assessment, with ledgers due to be updated by November 2026.
5. Each site has 24/7 duty anaesthetist and trained assistant cover in line with ACSA standards.

Appendix 1: Workforce IPR
Appendix 2: Fully funded neonatal medical workforce
Appendix 3: ORC Obstetric Workforce Audit
Appendix 4: North Manchester Obstetric Workforce Audit
Appendix 5: Wythenshawe Obstetric Workforce Audit

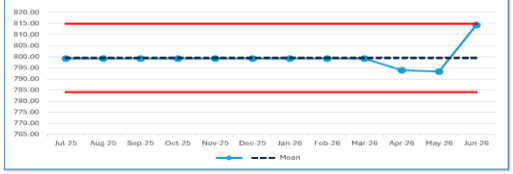
Appendix 1: Workforce IPR

Establishment WTE – Registered Midwifery

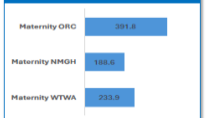
NHS Manchester University NHS Foundation Trust

Advise	W1 metric
Jun-26	Target
814.3	-

Compliance | Variance | Assurance | Actions



Site Overview



Updates since previous month
Increases in establishment in ORC Maternity Services and WYTH.

Current issues
External funded posts, inclusion in establishments as WTE.

Key dependencies
Ongoing ESR / Ledger accuracy

For information, all vacancy factors and CIP/VFP unidentified schemes are excluded form this data

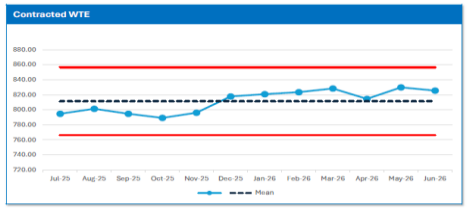
Future actions
Monitor establishment in ledger, impact from birth rate plus review. Review if externally funded posts are accurately recorded in ledger system.

Contracted WTE – Registered Midwifery

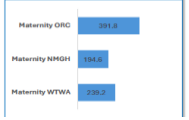
NHS Manchester University NHS Foundation Trust

Advise	W2 metric
Jun-26	Target
825.5	-

Compliance | Variance | Assurance | Actions



Site Overview



Updates since previous month
Contracted wte remains above 12 month average, no significant variation noted in month.

Current issues
None.

Key dependencies
Accurate ledger housekeeping.

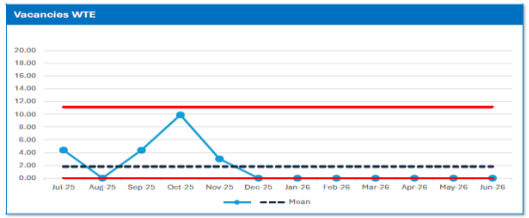
Future actions
Monitor contracted wte in ledger.

Vacancies WTE – Registered Midwifery

NHS Manchester University NHS Foundation Trust

Advise	W3 metric
Jun-26	Target
0.0	-

Compliance | Variance | Assurance | Actions



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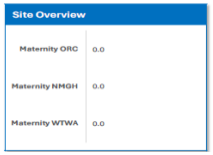


Updates since previous month
Minimal vacancy position maintained since early 2025.

Current issues
NMGH and WYTH currently with minor over establishment.

Key dependencies
For information, all vacancy factors and CIP/VFP unidentified schemes are excluded form the establishment data in reported vacancy position.

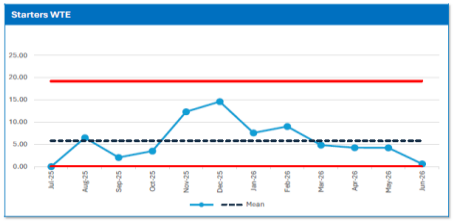
Future actions

Starters WTE – Registered Midwifery

NHS Manchester University NHS Foundation Trust

Advise	W4 metric
Jun-26	Target
0.6	-

Compliance | Variance | Assurance | Actions



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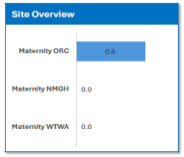


Updates since previous month
Minimal starters each month, reflective of vacancy position

Current issues
None

Key dependencies
Proactive recruitment where required

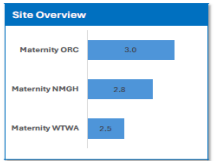
Future actions
No specific actions.

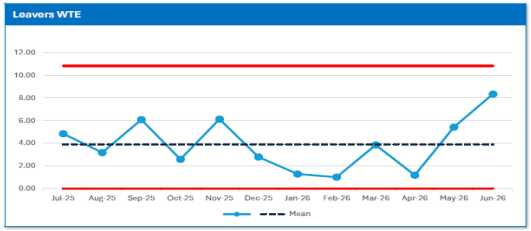
Leavers WTE – Registered Midwifery

Manchester University NHS Foundation Trust

Advise	W5 metric
Jun-26	Target
8.4	-

Compliance | Variance | Assurance | Actions





Updates since previous month
Leavers back down to lower level from April 2025. Ad hoc increase in month.

Current issues
None

Key dependencies
Retention strategy

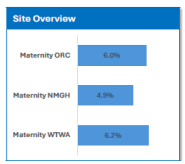
Future actions
Monitor future months ensure Jun-26 is one off and not reflective of increased turnover rate.

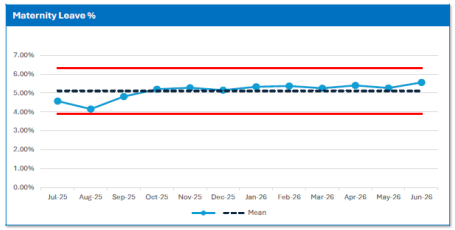
Maternity Leave % - Registered Midwifery

Manchester University NHS Foundation Trust

Advise	W6 metric
Jun-26	Target
5.6%	-

Compliance | Variance | Assurance | Actions





Updates since previous month
Maternity leave remains at higher level 5.6%.

Current issues
Current unfunded workforce pressure of 44.9wte due to maternity leave,

Key dependencies
Forward planning on receipt of individual maternity plans from staff members.

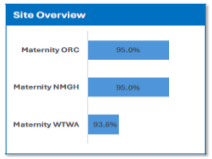
Future actions
No specific actions, continue to monitor.

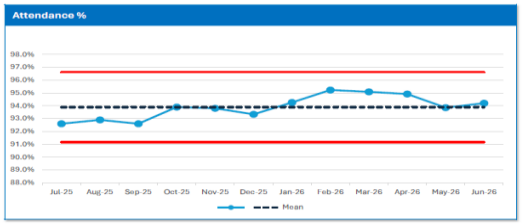
Attendance % - Registered Midwifery

Manchester University NHS Foundation Trust

Advise	W7 metric
Jun-26	Target
94.2%	95.0%

Compliance | Variance | Assurance | Actions





Updates since previous month
Improved attendance figure in last six months following increase in sickness absence during winter period.

Current issues
Two sites achieving attendance target, WTWA attendance lowest rate at 93.8%.

Key dependencies
Proactive management of sickness.

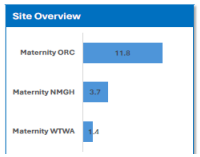
Future actions

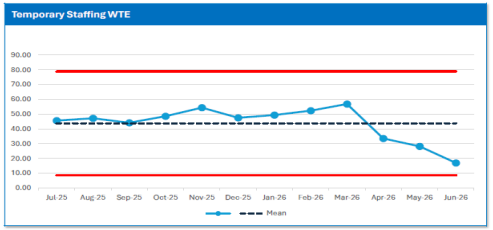
Temporary Staffing WTE – Registered Midwifery

Manchester University NHS Foundation Trust

Alert	W9 metric
Jun-26	Target
16.9	-

Compliance | Variance | Assurance | Actions





Updates since previous month
Focussed efforts to reduce temporary staffing from April 2026. Currently far below 12 month mean average.

Current issues
None

Key dependencies
Staffing unavailability, Roster Efficiencies and proactive recruitment activity.

Future actions
Continue to monitor and scrutinise all temporary staffing usage.

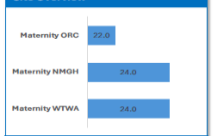
Midwife to Birth Ratio

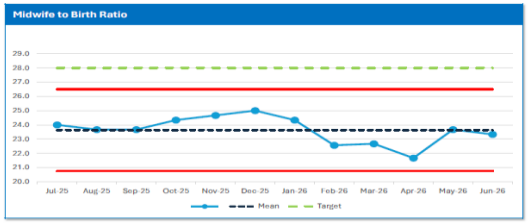
NHS Manchester University NHS Foundation Trust

Assure	M1 metric
Jun-26	Target
23.3	≤28.0

Compliance | Variance | Assurance | Actions

Site Overview





Updates since previous month
Birth Rate Plus report approved at SHCG SLT. Following professional judgement there is a 6 WTE deficit across SM MCS

Current issues
Nil

Key dependencies
Recruitment to Turnover
Retention
Absence management

Future actions
Submission to NHS E for NQM funding, to support increase to BR plus establishment.

Occasions of no Supernumerary LW Co-Ordinator

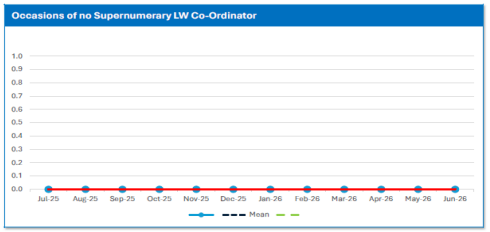
NHS Manchester University NHS Foundation Trust

Assure	M1 metric
Jun-26	Target
0	0

Compliance | Variance | Assurance | Actions

Site Overview





Updates since previous month
SM MCS consistently meeting 100% compliance with having 1 supernumerary LW coordinator on every shift

Current issues
Nil

Key dependencies
Absence management

Future actions

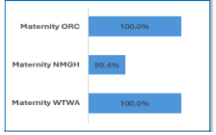
1:1 care in labour

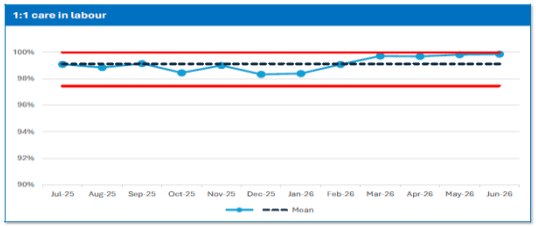
NHS Manchester University NHS Foundation Trust

Assure	M1 metric
Jun-26	Target
99.8%	99.5%

Compliance | Variance | Assurance | Actions

Site Overview





Updates since previous month
Action plan in place to address learning from 1 occasion when 1:1 care in labour not achieved. No adverse clinical outcomes for those where 1:1 care was not achieved.

Current issues
1 opportunity missed to transfer care to delivery unit to support 1:1 care

Key dependencies

Future actions
Monitor themes from occasions when 1:1 care not provided

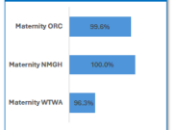
% of obstetrics shifts with appropriate medical cover

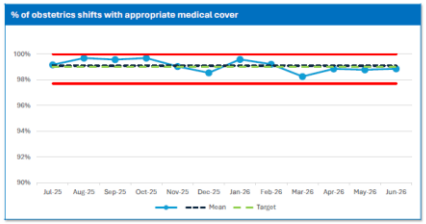
NHS Manchester University NHS Foundation Trust

Assure	M1 metric
Jun-26	Target
98.9%	≥99%

Compliance | Variance | Assurance | Actions

Site Overview





Updates since previous month
Transferred from score card to Workforce IPR.

Current issues
nil

Key dependencies
Absence management

Future actions
Continue to support timely escalation and resolution of shift gaps.

Appendix 2: Neonatal Medical Workforce

Table 1: Oxford Road Neonatal Intensive Care Unit

Standard	Description	Compliant	More information
Consultant staff qualifications	Consultant staff should be on the GMC register for neonatal medicine or equivalent	Yes	All substantive consultants meet this requirement
All tiers separate rota compliance	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should always have separate cover at each level of staff	Yes	
Tier 1 sperate rota compliance 24/7	Tier 1 staff (ANNP or junior doctor ST1-3) should be available 24/7 and have no responsibilities outside of neonatal care	Yes	Tier 1 rota cover is provided by a multidisciplinary workforce with speciality trainees, locally employed (non-trainee) doctors (ST2 equivalent), advanced neonatal nurse practitioners, enhanced nurse practitioners and physician's assistants. They are only responsible for neonatal care.
Tier 2 separate rota compliance 24/7	Tier 2 staff (ANNP or junior doctor ST4 and above) should be available 24/7 and have no responsibilities outside of neonatal care (including neonatal transport)	Yes	They are only responsible for neonatal care.
Tier 3 presence on the unit	Tier 3 (consultant) presence on the unit for at least 12 hours per day (generally expected to include two ward rounds/handovers)	Yes	
Activity based standards			
Tier 1 compliance more than 7000 deliveries per year	Two dedicated Tier 1 (ANNP or junior doctor ST1-3) 24/7 to support emergency care	Yes	The tier 1 rota cover is provided by a multidisciplinary workforce with speciality trainee and non-trainee doctors (ST2 equivalent), advanced neonatal nurse practitioners, enhanced nurse practitioners and physician assistants. They are only responsible for neonatal care
Tier 2 compliance if more than 2500 IC (XA01Z) days per year	Two dedicated Tier 2 (or resident consultant presence in addition to tier 3 requirements) available 24/7 with duties only on the neonatal unit.	Yes	Saint Mary's Oxford Road has over 5000 ICU days and has a rota with two tier 2 doctors.
Tier 3 compliance if more than 2500 IC days per year	Presence of at least two consultant led teams during normal daytime hours	Yes	Five consultant led teams are present during normal working hours. There are two teams during weekend daytime hours and overnight there is one resident

			consultant and one-off site consultant available 'on call'
Tier 3 compliance if more than 4000 IC days per year	Consultant presence 24/7 in addition to Tier 2 staffing requirements	Yes	Consultant presence on the unit is 24/7 with full Tier 2 rota in place.
Tier 3 compliance if more than 4000 IC days per year (daytime hours)	Three consultant led teams during normal daytime hours	Yes	There are five consultant led teams for the whole unit during normal working hours, however there are over 5000 ICU days, there are two Consultant led teams for ICU. Therefore, two Consultant teams cover >5000 ICU days.

Table 2: Saint Mary's North Manchester and Wythenshawe Local Neonatal Units

Standard	Description	Compliance		More information
		North Manchester	Wythenshawe	
Tier 1 separate rota compliance 24/7	Tier 1 staff (ANNP or junior doctor ST1-3) should be available 24/7 and have no responsibilities outside of neonatal care	Yes	Yes	Tier 1 rota cover is provided by a multidisciplinary workforce with speciality trainee, GP trainees and non-trainee doctors (ST2 equivalent), advanced neonatal nurse practitioners. Postnatal ward cover is provided by additional Tier 1 doctor on weekdays. All are responsible for neonatal care only.
Tier 2 separate rota compliance 24/7	Tier 2 staff (ANNP or junior doctor ST4 and above) should be available 24/7 and have no responsibilities outside of neonatal care	Yes	Yes	Both units have dedicated Tier 2 staff available with no responsibilities outside of neonatal care
Tier 3 separate rota compliance 24/7	All consultants take part in the "consultant of the week" system and do at least 4 weeks in a year	Yes	Yes	Both sites have consultant of the week system on the neonatal unit.
Tier 3 on call rota	On-call rota should not be more onerous for more than 1 in 6 on-calls	Yes	Yes	Both sites are compliant

Appendix 3: ORC Obstetric Workforce Audit

	Local Threshold								
ORC - Safe Medical Workforce	G	A	R	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Obstetric Consultant vacancy rate	≤1		≥3	0	0	0	0	0	0
Obstetric Resident vacancy rate	≤2		≥5	2	2	2	2	2	4
Obstetric Consultant Shift Fill rate - Acute Services - day %	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Obstetric Consultant Shift Fill rate - Acute Services - Night %	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Obstetric Resident Shift Fill rate - Acute Services - day %	≤97.5%		≥92.5%	98.38%	100.00%	98.79%	99%	97.98%	95.41%
Obstetric Resident Shift Fill rate - Acute Services - Night %	≤97.5%		≥92.5%	100%	100%	99.19%	98.33%	100%	100%
Triage Registrar Fill rate %	≤97.5%		≥92.5%	98%	100%	98%	85.00%	87.09%	86.66%
Sickness % Consultants	≤3.9%		≥5.9%	0.40%	0.12%	0%	0.05%	0.30%	0.39%
Sickness % Residents	≤3.9%		≥5.9%	2.08%	2.12%	1.02%	0.87%	2.51%	3.33%
Neonatal Consultant vacancy rate	≤1		≥3	1	1	1	1	0	0
Neonatal Resident vacancy rate	≤2		≥5	2	2	2	3	3	2
Neonatal Consultant Shift Fill rate - Acute Services - day %	100%		≥97.5%	100%	100%	93.90%	92.96%	97.13%	100%
Neonatal Consultant Shift Fill rate - Acute Services - Night %	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Neonatal Resident Shift Fill rate - Acute Services - day %	≤97.5%		≥92.5%	92.55%	94.78%	92.92%	92.69%	92.55%	96.53%
Neonatal Resident Shift Fill rate - Acute Services - Night %	≤97.5%		≥92.5%	91.39%	87.5%%	82.79%	83.33%	85.48%	85.00%
Anaesthetic Consultant (Obstetric) Shift fill rate - Acute services - day	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Anaesthetic Consultant (Obstetric) Shift fill rate - Acute services - Night	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Anaesthetic Resident (Obstetric) Shift fill rate - Acute services - day	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Anaesthetic Resident (Obstetric) Shift fill rate - Acute services - Night	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Operating Department Practitioner (ODP) (Obstetric) Shift fill rate - Acute services - day	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Operating Department Practitioner (ODP) (Obstetric) Shift fill rate - Acute services - nigh	100%		≥97.5%	100%	100%	100%	100%	100%	100%

Appendix 4: North Manchester Obstetric Workforce Audit

	Local Threshold								
NMG - Safe Medical Workforce	G	A	R	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Obstetric Consultant vacancy rate	≤1		≥3	2	2	2	1	2	3
Obstetric Resident vacancy rate	≤2		≥5	1	1	1	1	5	5
Obstetric Consultant Shift Fill rate - Acute Services - day %	100%		≥97.5%	100%	100%	98.90%	100%	100%	100%
Obstetric Consultant Shift Fill rate - Acute Services - Night %	100%		≥97.5%	100%	100%	98.40%	100%	100%	100%
Obstetric Resident Shift Fill rate - Acute Services - day %	≤97.5%		≥92.5%	98.8%%	97.3%%	98%%	95.4%%	100%	100%
Obstetric Resident Shift Fill rate - Acute Services - Night %	≤97.5%		≥92.5%	100%	100%	100%	100%	90.30%	78.90%
Triage Registrar Fill rate %	≤97.5%		≥92.5%	90.32%	90.32%	93.50%	90%	93.55%	96.67%
Sickness % Consultants	≤3.9%		≥5.9%	2.62%	2.02%	1.69%	2.19%	2.84%	2.03%
Sickness % Residents	≤3.9%		≥5.9%	2.57%	1.39%	5.17%	5.16%	1.68%	4.70%
Neonatal Consultant vacancy rate	≤1		≥3	0	0	0	0	0	0
Neonatal Resident vacancy rate	≤2		≥5						
Neonatal Consultant Shift Fill rate - Acute Services - day %	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Neonatal Consultant Shift Fill rate - Acute Services - Night %	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Neonatal Resident Shift Fill rate - Acute Services - day %	≤97.5%		≥92.5%	100%	100%	100%	100%	100%	100%
Neonatal Resident Shift Fill rate - Acute Services - Night %	≤97.5%		≥92.5%	100%	100%	100%	100%	100%	100%
Anaesthetic Consultant (Obsteric) Shift fill rate - Acute services - day	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Anaesthetic Consultant (Obsteric) Shift fill rate - Acute services - Night	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Anaesthetic Resident (Obsteric) Shift fill rate - Acute services - day	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Anaesthetic Resident (Obsteric) Shift fill rate - Acute services - Night	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Operating Department Practitioner (ODP) (Obstetric) Shift fill rate - Acute services - day	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Operating Department Practitioner (ODP) (Obstetric) Shift fill rate - Acute services - nigh	100%		≥97.5%	100%	100%	100%	100%	100%	100%

Appendix 5: Wythenshawe Obstetric Workforce Audit

	Local Threshold								
WYTH - Safe Medical Workforce	G	A	R	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Obstetric Consultant vacancy rate	≤1		≥3	0	0	0	0	0	0
Obstetric Resident vacancy rate	≤2		≥5	3	2	3	2	1	0
Obstetric Consultant Shift Fill rate - Acute Services - day %	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Obstetric Consultant Shift Fill rate - Acute Services - Night %	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Obstetric Resident Shift Fill rate - Acute Services - day %	≤97.5%		≥92.5%	99.2%	97.3%	96.0%	96.7%	97.6%	94.6%
Obstetric Resident Shift Fill rate - Acute Services - Night %	≤97.5%		≥92.5%	98.4%	98.2%	96.0%	85.8%	97.6%	95.0%
Triage Registrar Fill rate %	≤97.5%		≥92.5%	35.5%	64.3%	35.5%	43.3%	41.9%	43.3%
Sickness % Consultants	≤3.9%		≥5.9%	0	0.14%	0.3%	0.3%	0	0
Sickness % Residents	≤3.9%		≥5.9%	7.4%	1.23%	1.8%	5.2%	1.8%	2%
Neonatal Consultant vacancy rate	≤1		≥3	1	1	1	0	0	0
Neonatal Resident vacancy rate	≤2		≥5						
Neonatal Consultant Shift Fill rate - Acute Services - day %	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Neonatal Consultant Shift Fill rate - Acute Services - Night %	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Neonatal Resident Shift Fill rate - Acute Services - day %	≤97.5%		≥92.5%						
Neonatal Resident Shift Fill rate - Acute Services - Night %	≤97.5%		≥92.5%						
Anaesthetic Consultant (Obstetric) Shift fill rate - Acute services - day	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Anaesthetic Consultant (Obstetric) Shift fill rate - Acute services - Night	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Anaesthetic Resident (Obstetric) Shift fill rate - Acute services - day	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Anaesthetic Resident (Obstetric) Shift fill rate - Acute services - Night	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Operating Department Practitioner (ODP) (Obsteric) Shift fill rate - Acute services - day	100%		≥97.5%	100%	100%	100%	100%	100%	100%
Operating Department Practitioner (ODP) (Obsteric) Shift fill rate - Acute services - night	100%		≥97.5%	100%	100%	100%	100%	100%	100%

Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday, 25 November 2026

Paper Title:	Annual Provider Self-Assessment submission to NHS England	**Agenda Item 12.4**
Presented by:	Professor Sohail Munshi, Joint Chief Medical Officer	
Prepared by:	Tracey Lakin, Trust Associate Director of Medical Education	
Meetings where content has been discussed previously	Joint Chief Medical Officers' Workforce Group	
Purpose of the paper Please check **one** box only:	☒ For approval ☐ For support ☐ For discussion ☐ For noting	

Executive summary / key messages for the meeting to consider

NHS England requires all Trusts to submit an annual self-assessment of their education-related achievements and challenges, as well as updates on a range of services, including library services, governance, financial position and ED&I work, relating to all learners in their organisation.

Colleagues from Medical and Non-medical Education, Pharmacy, Workforce, Finance and Clinical Governance have contributed to this submission.

MFT, in its submission on 18 November 2026, confirmed compliance with all required educational standards, as per previous submissions and reported the following key themes this year:

Achievements

- Work in postgraduate and undergraduate medical education to support learners and make improvements in their working and learning environments (e.g. through the Improving Resident Doctors' Working Lives programme of work)
- Increased support for pre-registration NMAHPS and Pharmacy learners
- Achievements in the Apprenticeship scheme in educational impact
- Course developments in Surgical Simulation and Robotic Assisted Surgery for undergraduate and postgraduate learners
- Expansion of NMAHP Supporting Learners in Practice programme

Challenges

- Limitations on further expansion due to current funding challenges
- Rising medical student numbers which place a challenge on finding suitable placements
- Pre-registration placement capacity and increased cohorts of Pharmacy learners

- Physician Associate low morale due to the Leng Review and associated outcomes

The Board is asked to receive and note this year's submission to NHS England. Workstreams arising from the submission will be coordinated with NHSE via existing structures e.g. via the patch Associate Dean in Medical Education.

Recommendation(s)
The Board of Directors is asked to: • receive the annual Provider Self-Assessment 2026, as submitted to NHS England on 18 November 2026, noting compliance with all required education standards.

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

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

Main report

Please see Appendix 1, which is a hard copy of the online Provider Self-Assessment submission to NHS England for 2026.

The submission relates to all learners at the Trust, with a new section added this year relating to Improving Resident Doctors' Working Lives. Colleagues from across the Trust have been involved in this submission, including medical and non-medical education, clinical governance, ED&I, medical workforce and finance.

As in previous years, any queries arising from NHS England regarding the submission will be coordinated via Medical Education.

Education and Training Annual Provider Self Assessment

The NHS England Self-Assessment for Placement Providers supports organisations to review and carry out their own quality evaluation against the required education and training standards, including compliance with relevant Education Funding Agreement obligations. The survey should be completed on behalf of the whole organisation, with input from the colleagues responsible for each section. All sections of the Self-Assessment must be completed before final submission. Please refer to the accompanying guidance document and the technical guidance for full details on completing, saving, printing and submitting the survey.

How to complete this workbook

1. Only the pale yellow cells can be edited; everything else is locked.
2. Each numbered tab is one section of the self-assessment. Different colleagues can own different tabs; if the file is stored on SharePoint or Teams, up to 15 people can work in it at the same time.
3. Use the dropdown arrows for standard responses, and choose the tick mark for multi-select lists. To remove a tick mark press delete.
4. Type narrative or evidence into the larger boxes; character counts appear alongside where limits apply.
5. Each section ends with a completion declaration for the responsible colleague.
6. Before submitting, open the Checks tab (the last worksheet) and resolve anything marked ACTION NEEDED.
7. Save the file as PSA2026_<ODS code>_<Provider name>.xlsx and return to england.wte.quality@nhs.net.
8. Please do not copy and paste blocks of cells into the workbook, and do not attempt to add or remove rows, columns or tabs; this file is machine-read on return.

A note on colours: pale yellow cells are for your answers. If a cell turns amber it means an answer is needed there because of something you selected earlier; it turns back to yellow once you have filled it in.

Your Region, Organisation and Named Lead

Region	North West	
Provider	Manchester University NHS Foundation Trust	*Choose your Region first, then select your organisation from this list.*
ODS code	NA	*Optional. Your organisation's ODS code, which can be found on the ODS website. Enter NA if you do not have an ODS code.*
Named Lead for the Provider Self Assessment	Tracey Lakin, Associate Director of Medical Education	
Email address of Named Lead for the Provider Self Assessment	tracey.lakin@mft.nhs.uk	

Please select from the list, the professional groups which your organisation currently trains.

Tick all that apply:

Advanced Practice	✓
Allied Health Professionals	✓
Dental Undergraduate	✓
Dental Postgraduate	✓
Healthcare Science	✓
Medicine Undergraduate	✓
Medicine Postgraduate	✓
Midwifery	✓
Nursing	✓
Paramedicine	✓
Pharmacy	✓
Physician Assistant	✓
Physician Assistant in Anaesthesia	✓
Psychological Professions	✓

Social Workers	
Surgical Care Practitioner	✓
Other (please specify)	

Section progress		
1. Achievements	100%	Complete
1. Challenges	100%	Complete
2. EFA KPIs	100%	Complete
3. Financial	100%	Complete
3a. UGM-UGD Finance	100%	Complete
4. Quality Performance	100%	Complete
5. Library & TEL	100%	Complete
6. Educators	100%	Complete
7. Resident Doctors	104%	Complete
8. EDI	100%	Complete
9. Declaration	100%	Complete

Overall (core questions answered) **101%**

Section 1 - Achievements

Answered: 3 of 3

Provide details of up to 3 achievements within education and training. Select the category, tick affected professional groups, and provide a brief narrative of up to 1000 characters.

No.	Question / field	Your response	Guidance
1	Achievement category:	Learner / trainee support or wellbeing	
	Professional groups affected:		
	Advanced Practice		
	Allied Health Professionals		
	Dental Undergraduate		
	Dental Postgraduate		
	Healthcare Science		
	Medicine Undergraduate	✓	
	Medicine Postgraduate	✓	
	Midwifery		
	Nursing		
	Paramedicine		
	Pharmacy		
	Physician Assistant		
	Physician Assistant in Anaesthesia		
	Psychological Professions		
	Social Workers		
	Surgical Care Practitioner		
	Other (please specify)		
	Brief narrative, up to 1000 characters	The Improving Resident Doctors Working Lives agenda is ensuring doctors have supportive, working and learning environments. UGME Student Experience Leads provide informal drop-ins, monthly wellbeing activities and safe spaces that promote peer support. Surgical education has also expanded: all incoming Year 3 students undertake the Surgical Skills 101 course at the Manchester Surgical Skills and Simulation Centre, with positive feedback supporting their transition into surgical environments. Surgical skills sessions are embedded within the Year 5 surgical block, and all Year 3, 4 and 5 medical students now have access to virtual reality simulation.	*656 character(s) of 1000 maximum*
2	Achievement category:	Apprenticeships	
	Professional groups affected:		
	Advanced Practice		
	Allied Health Professionals		
	Dental Undergraduate		
	Dental Postgraduate		
	Healthcare Science		
	Medicine Undergraduate		
	Medicine Postgraduate	✓	

Midwifery	
Nursing	✓
Paramedicine	
Pharmacy	
Physician Assistant	
Physician Assistant in Anaesthesia	
Psychological Professions	
Social Workers	
Surgical Care Practitioner	
Other (please specify)	Appenticships

Brief narrative, up to 1000 characters

PGME's quality framework has improved resident doctor feedback, monitoring and ISF scores in specialties under NHSE/GMC review. Following NETS and learner feedback, Pre-Registration NMAHP strengthened support for raising concerns, signposting and champion awareness, and established a learner voice forum led by the Director of Nursing for Workforce and Education. The Level 4 Mammography Associate Apprenticeship was a Greater Manchester Cancer Awards finalist for educational impact. Pharmacy Tutors received fully funded PGCert and prescribing qualification support, strengthening teaching and mentoring. Placement evidence supported the University of Manchester's successful GPhC reaccreditation, with no conditions or recommendations in February 2026.

756 character(s) of 1000 maximum

3 Achievement category: Innovative training / course development

Professional groups affected:

Advanced Practice	
Allied Health Professionals	
Dental Undergraduate	
Dental Postgraduate	
Healthcare Science	
Medicine Undergraduate	
Medicine Postgraduate	✓
Midwifery	
Nursing	✓
Paramedicine	
Pharmacy	✓
Physician Assistant	
Physician Assistant in Anaesthesia	
Psychological Professions	
Social Workers	
Surgical Care Practitioner	
Other (please specify)	

Brief narrative, up to 1000 characters

MSSSC was one of four national centres selected to pilot the Shelford Surgical Training in Advanced Robotic Technology programme, with a successful pilot leading to a second year. Pre-Registration NMAHP has expanded community placement capacity by using hospital-based practice assessors as long-arm assessors for smaller teams. Its multiprofessional Supporting Learners in Practice programme equips registered and non-registered staff to support learners; regular review and feedback show increased participant confidence. Assessment continues to improve through greater use of verbal feedback in Year 4 and a revised Year 3 oral case presentation mark scheme, informed by Pharmacy Tutors' PGCert work. Pharmacy Tutors have supported placement research, evaluation and dissemination through local and external conferences.

823 character(s) of 1000 maximum

Section 1 - Challenges

Answered: 3 of 3

Provide details of up to 3 challenges within education and training. Select the category, tick affected professional groups, and provide a brief narrative of up to 1000 characters.

No.	Question / field	Your response	Guidance
1	Challenge category:	Placement management / capacity	
	Professional groups affected:		
	Advanced Practice		
	Allied Health Professionals		
	Dental Undergraduate		
	Dental Postgraduate		
	Healthcare Science		
	Medicine Undergraduate	✓	
	Medicine Postgraduate	✓	
	Midwifery		
	Nursing	✓	
	Paramedicine		
	Pharmacy	✓	
	Physician Assistant		
	Physician Assistant in Anaesthesia		
	Psychological Professions		
	Social Workers		
	Surgical Care Practitioner		
	Other (please specify)	Apprenticehsips	
	Brief narrative, up to 1000 characters	Limited NHSE funding makes it difficult to identify medical specialty training expansion posts. National resident doctor contract reform further restrict opportunities to convert LED roles into training posts. Rising medical student numbers present a challenge to current placement resources. Clinical pressures, job planning and current vacancy controls hinder recruitment of supervisors, examiners and core staff, affecting service delivery. Wi-Fi capacity and estate issues create further pressures. Pre-Registration placement capacity is under pressure from expanding HEI programmes, ward reconfiguration and peaks in placement demand. Large cohorts and staff sickness continue to challenge pharmacy tutors. Support from ward pharmacists is limited because of wider service pressures.	*790 character(s) of 1000 maximum*
2	Challenge category:	Burnout / wellbeing	
	Professional groups affected:		
	Advanced Practice		
	Allied Health Professionals		
	Dental Undergraduate		
	Dental Postgraduate		
	Healthcare Science		

Medicine Undergraduate	
Medicine Postgraduate	✓
Midwifery	
Nursing	✓
Paramedicine	
Pharmacy	
Physician Assistant	✓
Physician Assistant in Anaesthesia	
Psychological Professions	
Social Workers	
Surgical Care Practitioner	
Other (please specify)	

Brief narrative, up to 1000 characters

Ongoing uncertainty about the 2025 Leng Review and implementation delays have adversely affected Physician Associate morale and wellbeing across the Trust. The Lead Employer model and related systems and processes can hinder the Trust's ability to improve sickness absence support and mandatory training compliance for Lead Employer employed resident doctors, due to multiple systems and the lack of connection between them. Increasing numbers of pre-registration learners require increasingly complex reasonable adjustments. Delayed communication from learners or HEIs makes timely planning and support difficult.

614 character(s) of 1000 maximum

3 Challenge category: Funding requirements / unpredictability / timeliness

Professional groups affected:

Advanced Practice	✓
Allied Health Professionals	✓
Dental Undergraduate	✓
Dental Postgraduate	✓
Healthcare Science	✓
Medicine Undergraduate	✓
Medicine Postgraduate	✓
Midwifery	✓
Nursing	✓
Paramedicine	✓
Pharmacy	✓
Physician Assistant	✓
Physician Assistant in Anaesthesia	✓
Psychological Professions	✓
Social Workers	✓
Surgical Care Practitioner	
Other (please specify)	

Brief narrative, up to 1000 characters

The Library and Knowledge Service should receive 2.4% of placement tariff income and currently receives £850,000 against an expected £1.24 million, limiting delivery of the commissioned service specification. Pharmacy training equipment and system issues. Key issues include expired student logins, unreliable access to the intranet and hospital policies, and no replacement plan for ageing or damaged university laptops. These problems increase tutor workload and restrict case-based learning. Teaching space for pharmacy undergraduates remains a major challenge. Changes to opening hours and the closure of the North Manchester Education Centre has affected provision and will continue to do so next academic year. Pre-Registration NMAHP data identified a need to help educators complete learner paperwork promptly. The team is introducing initiatives to support timely completion and data sharing.

901 character(s) of 1000 maximum

Section 2 - NHS Education Funding Agreement (EFA) - Schedule 3 KPIs

Answered: 12 of 12

Complete the response field for each question. Dropdown fields are used for single-select answers.

No.	Question / field	Your response	Guidance
Q1	**Does the organisation have formal board oversight of education and training?**		
	Response	Yes	
	If No, please provide further detail.		
Q2	**Please provide the name and email address of the board named individual responsible for education and training.**		
	Name:	Meera Nair, Chief People Officer	*Enter NA if there is no formal named person.*
	Email address:	meera.nair@mft.nhs.uk	
Q3	**Did the organisation, or any third party delivering EFA-funded activity on its behalf, have any material breaches of the NHS Education Funding Agreement requirements in the last 12 months?**		
	Response	No breaches	
	If Yes, please provide further detail.		
Q4	**Have there been any actual or suspected data protection breaches in the last 12 months relating to education and training activity or learner information?**		
	Actual data protection breaches:	No	
	Suspected data protection breaches:	No	
	Please provide further detail:		
Q5	**Did the organisation have any material health and safety incidents or breaches in the last 12 months affecting learners or the learning environment which required investigation, reporting or corrective action?**		
	Response	No	
	Please provide further detail where relevant.		
Q6	**Does the organisation have effective arrangements for cross-system collaboration with ICS, education providers and other relevant stakeholders to support safe, high-quality delivery of education and training?**		
	ICS arrangements:	Fully in place and evidenced	
	Education provider arrangements:	Fully in place and evidenced	
	Other relevant stakeholder arrangements:	Fully in place and evidenced	
	Narrative on arrangements, impact or variation:		
Q7	**Have any material education quality concerns, learner safety issues or contractual breaches relating to EFA-funded activity been escalated to NHS England through the appropriate route and timescale?**		
	Response	No concerns identified	
	Please provide further detail where relevant.		
Q8	**Has the organisation been subject to any education and training-related regulatory referral, review, condition, concern or escalation in the last 12 months, including by GMC, GDC, HCPC, NMC, CQC, GPhC or another relevant regulator? Do not include referrals relating only to an individual learner.**		
	Response	Yes	
	If Yes, provide regulator, profession or learner group, nature of concern, conditions and current status.	O&G at North Manchester General Hospital remains under enhanced GMC monitoring.	*79 character(s)*
Q9	**Is the organisation actively implementing and embedding the Safe Learning Environment Charter across all relevant professions and learner groups?**		
	Response	Partially embedded	
	If partial or no, describe barriers, affected groups, planned actions and support required.	SLEC is embedded across all NMAHP pre-reg learning environments PGME and UGME raising awareness of SLEC via Directors of Medical Education and Associate Directors of Medical Education across all hospitals/services.	*218 character(s)*
Q10	**Does the organisation have a Freedom to Speak Up Guardian and actively promote the process for raising concerns through them to their learners?**		
	Response	Yes, and actively promoted	
	Please provide further detail where relevant.		
Q11	**Has the organisation reviewed NETS findings at board governance level and taken action to address the findings?**		
	Response	Yes	
	If Yes, provide a brief description of the action taken. If No, provide plans to use NETS data for future quality improvement activity.	NETs Executive Summary produced and presented at Board level (People Board) along with results from the GMC surveys and MFT Trust learner surveys. All survey outcomes reviewed in detail at Hospital level education committees, with action plans produced and monitored by e.g. the Hospital Director of Medical Education. Committees have educators and learner representatives in attendance.	*391 character(s)*
Q12	**How will your organisation ensure you continue to improve your year-on-year response rate/number for the NETS and GMC NTS? Please provide examples or evidence.**		
	Response	Pre-Reg NMAHP - Yes we review responses year on year and have a comprehensive implementation plan for actions to improved response rates and indicators each year. Medical Education - all responses are reviewed each year and the teams encourage responses via reminders on a weekly basis once the surveys are open. Results are discussed at the Improving Resident Doctors Working Lives group, where Resident Doctors can see the impact of the survey results and outcomes.	*470 character(s)*
	Section completion declaration		
	I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	I confirm	*Choose 'I confirm' from the dropdown.*
	Name:	Tracey Lakin, Associate Director of Medical Education	
	Email address:	tracey.lakin@mft.nhs.uk	

Section 3 - Financial Accountability

Answered: 8 of 8

Complete the response field for each question. Dropdown fields are used for single-select answers.

No.	Question / field	Your response	Guidance
Q1	**How assured is the organisation that EFA funding is used for its intended education and training purposes?**		
	Response	Highly assured	
	Describe the evidence informing the assessment, such as financial oversight, internal audit, budget mapping or governance review.	A review of the EFA funding and its allocation across the Trust took place in February 2026, giving assurance that funds were appropriately allocated.	*151 character(s)*
Q2	**Is there formal board-level oversight of EFA funding, with regular review of expenditure and performance?**		
	Response	Yes	
	Please provide further detail.	EFA funding forms part of Hospital and corporate budgets and these are monitored and reviewed at Hospital finance committee in addition to Trust finance board on a montly basis	*177 character(s)*
Q3	**Does the organisation deliver any EFA-funded activity through a third party, sub-contractor or external provider? Please include apprenticeship providers where they deliver EFA-funded activity, unless national guidance states otherwise.**		
	Response	No	
	Please provide further detail.	Apprenticeship funding comes from DfE not EFA. Other courses externally commissioned have come from alternative sources of funding, e.g. King's Fund/internal provision.	*173 character(s)*
Q4	**If response is Yes to the above question, do you have effective financial oversight and assurance arrangements in place?**		
	Response	Yes	
	Please provide further detail.		
Q5	**Does the organisation have arrangements to identify, investigate, correct and where necessary report any misallocation or financial irregularity relating to EFA funding?**		
	Response	Yes	
	Please provide further detail.	This is managed by the budget holders and corporate accounts income team.	*73 character(s)*
Q6	**Can the organisation evidence how EFA funding has been allocated, monitored and used for education and training activity during the reporting period?**		
	Response	Yes	
	Describe actions to improve transparency.	Funding is received centrally and managed locally via Directors of Finance and Operations, for the delivery of the education and training for all learner, reported via each Hospital's Board, which meets monthly and includes finance reports.	*241 character(s)*
Q7	**Does the organisation reconcile EFA funding with actual delivery of education and training activity, such as learner numbers, placements or other agreed activity measures?**		
	Response	No	
	Please provide further detail.	Medical Education continues to progress the correct allocation of PAs for e.g. Educational Supervision, based on learner numbers, via job planning and disccussions with the relevant Medical and Clinical Directors.	*214 character(s)*
Q8	**Can the organisation evidence how EFA funding supports educator/supervisor time, senior educator roles and required training extensions where applicable?**		
	Response	Yes	
	Provide summary evidence or explain limitations.	Educator sessions for e.g. Educational Supervision/Trust Specialty Training lead roles are factored into job plans and reviewed as part of the Trust's annual job planning process. NHSE funded roles, e.g. Training Programme Directors/Foundation educator roles based at the Trust are clearly identified in the education contract and resources allocated to the relevant department.	*382 character(s)*
	Section completion declaration		
	I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	I confirm	*Choose 'I confirm' from the dropdown.*
	Name:	Tracey Lakin	
	Email address:	tracey.lakin@mft.nhs.uk	

Section 3a - Undergraduate Medical/Dental Financial Accountability

Answered: 7 of 7

Complete the response field for each question. Dropdown fields are used for single-select answers.

No.	Question / field	Your response	Guidance
	If you do not train Undergraduate Medical/Undergraduate Dental trainees, please confirm here	We do train and have completed the section below	
Q1	**Will any of the Undergraduate Medical/Undergraduate Dental Tariff be used to cross-subsidise other learner groups in 2026/27? If Yes, please provide the amount and learner groups.**		
	Cross-subsidy response:	No	
	Amount:		
	Learner groups:		
	Advanced Practice		
	Allied Health Professionals		
	Dental Undergraduate		
	Dental Postgraduate		
	Healthcare Science		
	Medicine Undergraduate		
	Medicine Postgraduate		
	Midwifery		
	Nursing		
	Paramedicine		
	Pharmacy		
	Physician Assistant		
	Physician Assistant in Anaesthesia		
	Psychological Professions		
	Social Workers		
	Surgical Care Practitioner		
	Other (please specify)		
	Please provide further detail where relevant		
Q2	**How assured is the organisation that Undergraduate Medical/Undergraduate Dental Tariff funding within the Trust flows down to the individual clinical directorate level?**		
	Response	Highly assured	
	Please provide further detail	A review of the EFA funding and its allocation across the Trust took place in February 2026, giving assurance that funds were appropriately allocated.	*151 character(s) of 1000 maximum*
Q3	**Please confirm the percentage of Undergraduate Medical/Undergraduate Dental Tariff funding allocated to the following areas: administration, delivery of education and training, and clinical supervision salaries.**		
	Administration percentage:	0	*Numbers only, 0 to 100.*

	Delivery of education and training percentage:	0	
	Clinical supervision salaries percentage:	0	
	Please provide further detail	Further information required from NHSE on definitions to inform response	*73 character(s) of 1000 maximum*
Q4	**How frequently do you meet the Medical School(s) and/or Dental School(s) each financial year to discuss the quality and delivery of education?**		
	Medical/Dental School 1:	University of Manchester	
	Frequency:	Monthly	
	Medical/Dental School 2:	University of Manchester	
	Frequency:	Other - please specify	
	Medical/Dental School 3:		
	Frequency:		
	Medical/Dental School 4:		
	Frequency:		
	Add additional details here for multiple Medical/Dental Schools where required.	Meet with Dental School Bi-weekly and attend UoM meeings monthly.	*65 character(s) of 1000 maximum*
Q5	**Does the Trust provide clinical placements for additional international medical students from overseas Medical Schools?**		
	Response	No	
	If Yes, identify the names of the overseas Medical Schools.		
Q6	**Please briefly describe how Undergraduate Medical/Undergraduate Dental Tariff funding will be used to improve the quality of healthcare for patients in 2026/27. Please describe the impact on education and patient care.**		
	Response (up to 150 words)	By providing high quality medical and dental education to the future workforce of the NHS. The UoM programme encourages inclusive, patient focused, compassionate care with an emphasis on communication skills and patient safety	*226 character(s) of 1500 maximum*
Q7	**Please provide the name of the person responsible for Undergraduate Medical/Undergraduate Dental financial governance at Board level.**		
	Name	Claire Wilson	
	Section completion declaration		
	I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	I confirm	*Choose 'I confirm' from the dropdown.*
	Name:	David Pearson	
	Email address:	david.pearson@mft.nhs.uk	

Section 4 - NHS Education Funding Agreement - Schedule 3 Quality Performance

Answered: 17 of 17

Complete the response field for each question. Dropdown fields are used for single-select answers. If exceptions are reported, complete the areas of exception and narrative below.

No.	Question / field	Your response	Guidance
Std 1	Organisations must ensure the physical and psychological safety and wellbeing of all learners and educators at all times. Systems should not only exist but also foster an environment where learners feel safe and empowered to use them without fear of negative repercussions.		
	Do systems and culture enable learners and educators to raise concerns without fear of negative consequences?		
	Response	We meet the standard for all professions / learner groups we train	
Std 2	Induction programmes must be tailored to meet the specific needs of learners and are essential for both quality and service user safety. Inductions should be regularly reviewed to ensure they remain relevant and effective.		
	Are induction programmes tailored to learner needs, regularly reviewed and effective in supporting education quality?		
	Response	We meet the standard for all professions / learner groups we train	
Std 3	Continuous supervision must be provided for all learners, aligned with the requirements of the relevant professional bodies and the Educator Workforce Strategy.		
	Is appropriate supervision available for all learners, aligned to learner need, professional requirements and placement setting?		
	Response	We meet the standard for all professions / learner groups we train	
Std 4	Providers should actively promote quality improvement throughout education and training. Leadership skills development should also be embedded within the learning environments.		
	Are learners supported to participate in education quality improvement relevant to their programme or profession?		
	Response	We meet the standard for all professions / learner groups we train	
Std 5	The learning environment must support and encourage multi-professional education and collaboration.		
	Does the learning environment support and encourage multi-professional education and collaboration?		
	Response	We meet the standard for all professions / learner groups we train	
Std 6	Organisations must promote equality, diversity, and inclusion in all aspects of the learning environment.		
	Are equality, diversity and inclusion promoted in all aspects of the learning environment, with detailed assurance captured in Section 8?		
	Response	We meet the standard for all professions / learner groups we train	
Std 7	Organisations must facilitate cross-system and collaborative approaches to quality, working with partners to drive improvement.		
	Does the organisation work with NHS England and relevant partners to identify and improve education quality issues?		
	Response	We meet the standard for all professions / learner groups we train	
Std 8	Organisations must ensure there are accessible systems and processes at all levels for raising concerns. These systems must be actively promoted, and learners should feel confident and safe to use them.		
	Are accessible processes in place for learners and educators to raise education quality or safety concerns, and are these actively promoted?		
	Response	We meet the standard for all professions / learner groups we train	
Std 9	Organisations must have robust systems and processes in place to ensure patient safety and provide appropriate training for all healthcare learners and educators.		
	Are robust systems in place to ensure patient-safety-related training and supervision for healthcare learners and educators?		
	Response	We meet the standard for all professions / learner groups we train	
Std 10	The systems used for online and virtual learning must be suitable and accessible for all learners and educators participating in these modes of education.		
	Are online and virtual learning systems suitable and accessible for all learners and educators using them?		
	Response	We meet the standard for all professions / learner groups we train	
Std 11	Where there are specific quality issues or concerns identified, the organisation must actively engage and cooperate with NHS England in remedial and quality improvement activities.		
	Where education quality issues are identified, does the organisation engage with NHS England Education Quality teams and implement remedial or quality improvement actions?		
	Response	We meet the standard for all professions / learner groups we train	
Std 12	Organisations must support learners to complete their courses and enter the workplace confidently, within expected timeframes.		
	Are learners provided with suitable learning opportunities to acquire required skills, meet curriculum/course requirements and progress within expected timeframes?		
	Response	We meet the standard for all professions / learner groups we train	

Std 13	Ensure all regulatory conditions are met and is actively engaging and co-operating with system and professional regulators.		
	Is the organisation meeting relevant education and training regulatory standards and actively engaging with system and professional regulators where required?		
	Response	We meet the standard for all professions / learner groups we train	
Std 14	Ensure that regular communication is taking place between the provider and NHS England and any other stakeholders as are necessary to deliver the required services safely and effectively.		
	Are communication routes with NHS England and relevant education/placement partners sufficient to deliver education and training safely and effectively?		
	Response	We meet the standard for all professions / learner groups we train	
Std 15	Ensure that issues or concerns must be reported to NHS England in line with the education concerns process.		
	Are education quality issues or concerns reported to NHS England Education Quality teams in line with agreed regional or national processes?		
	Response	We meet the standard for all professions / learner groups we train	
Q16	**Areas of exception: From the professional groups you train, please select which professional group(s) are impacted. Where you have multiple sites, if the issue is site specific, select Site specific and enter the site name in the comments box. If required, add sub-professions or specific specialties in the comments box.**		
	Select all that apply:		
	All professions	✓	
	Site specific		
	Advanced Practice		
	Allied Health Professionals		
	Dental Undergraduate		
	Dental Postgraduate		
	Healthcare Science		
	Medicine Undergraduate		
	Medicine Postgraduate		
	Midwifery		
	Nursing		
	Paramedicine		
	Pharmacy		
	Physician Assistant		
	Physician Assistant in Anaesthesia		
	Psychological Professions		
	Social Workers		
	Surgical Care Practitioner		
	Other (please specify)		
	Comments:	N/A	*3 character(s)*
Q17	**For the exceptions listed above, please provide further details including a brief summary of the issues and challenges impacting your ability to meet the standard, any barriers you are facing, and what support you need from WT&E.**		
	Please provide detail	N/A	*3 character(s)*
	Section completion declaration		
	I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	I confirm	*Choose 'I confirm' from the dropdown.*
	Name:	Tracey Lakin, Associate Director of Medical Education	
	Email address:	tracey.lakin@mft.nhs.uk	

Section 5 - Library and Knowledge Services and Technology Enhanced Learning

Answered: 6 of 6

Complete the response field for each question. Dropdown fields are used for single-select answers.

No.	Question / field	Your response	Guidance
Q1	**Has the organisation developed and implemented a service improvement plan for NHS-funded Knowledge and Library Services where applicable?**		
	Response	Yes	*Clinical decision support tool reference: https://access.bmjgroup.com/nhse/*
	Please provide further detail.	The Quality and Improvement Outcomes Framework (QIOF) review for the Library and Knowledge Service has been completed in the current cycle. The outcomes of the review have been considered by the service management team and incorporated into the service improvement planning process. Actions arising from the review are being actively progressed, with work underway to address identified development areas, build on existing strengths, and support continued progression against the QIOF outcomes. This ongoing programme of improvement will ensure that the service continues to align with organisational priorities, supports evidence-informed decision making, and demonstrates its impact on patient care, education, research, and workforce development.	*750 character(s)*
Q2	**Is the organisation promoting the national clinical decision support tool funded by NHS England to learners?**		
	Response	Actively promoted and evidenced	
Q3	**How is the tool promoted and what outcome is expected from this promotion?**		
	Describe target learners, promotion route, intended education and training outcome, and usage evidence if available.	The Library and Knowledge Service actively promotes BMJ Best Practice, the nationally funded clinical decision support resource, to all staff and learners across the organisation. Promotion is embedded within corporate and departmental induction programmes, study days, and the library's formal teaching and training curriculum. Additional awareness-raising activities are undertaken through library displays, targeted communications, and direct engagement with clinical and professional groups. These activities support the organisation's commitment to evidence-based practice by increasing awareness, access, and utilisation of BMJ Best Practice at the point of need. The impact of this work is evidenced through ongoing engagement with the resource, incorporation into learning and development activities, and its use in supporting clinical decision-making, continuing professional development, and the delivery of safe, effective, evidence-informed patient care.	*966 character(s)*
Q4	**Do learners have access to appropriate technology, digital learning tools and virtual learning support required for their education and training activity?**		
	Response	Partial access	

	Please provide further detail.	The Library and Knowledge Service provides learners and staff with partial on site access in daytime working hours (Monday - Friday) to computers to support research, education and completion of mandatory online learning and assessments. The service also provides 24/7 access to a comprehensive range of high-quality, evidence-based digital resources, including bibliographic databases, electronic journals and eBooks, supporting learning, professional development, research and evidence-informed practice	*505 character(s)*
Q5	**To what extent is the organisation aware of the appropriate evidence-based principles for modernising healthcare education effectively?**		
	Response	Aware but not consistently applying them	
	Please provide further detail.	Principles of the hierarchy of effectiveness, as well as using data to inform areas of improvement influence decisions over training priorities. We have adopted all NHSE provided training which offers assessment-first, and are working towards implementing Situation Judgement Tests for statutory and mandatory learning in line with NHS England guidance and advice. These will be incorporated as soon as the new NHSE framework content is shared and will be trialled with locally-mandated content as well.	*503 character(s)*
Q6	**My organisation actively addresses barriers to modernising healthcare education, for example technological, cultural or structural barriers.**		
	Response	Agree	
	Please provide further detail.	The Trust uses an intuitive, bespoke LMS. All training is either already provided with the recommended range of accessibility features, or in process of being transferred to this format. Training which is designed in-house goes through an EQI assessment and is designed and written with EAL users and breadth of representation in mind.	*336 character(s)*
	Section completion declaration		
	I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	I confirm	*Choose 'I confirm' from the dropdown.*
	Name:	Tracey Lakin	
	Email address:	tracey.lakin@mft.nhs.uk	

Section 6 - Educators

Answered: 5 of 5

Complete the response field for each question. Dropdown fields are used for single-select answers.

No.	Question / field	Your response	Guidance
Q1	*Organisations should demonstrate that learners receive training and supervised opportunities to identify patients who may be approaching the end of life and to initiate Advance Care Planning (ACP) conversations, including documentation of preferred place of death. Please describe how this is embedded in clinical placements and provide evidence of trainee competency in this domain.* **Are training and supervised opportunities in end-of-life care and advance care planning embedded in the organisation?**		
	Response	Embedded	
	Identify professions or learner groups, placement settings, evidence of competency or learning opportunity, and any gaps.	There two end of life modules, which are MFT Mandatory training. End of life care - Childrens - 3 year - 88.89% compliant Pallaitve and end of life care - Adults - 3 years - 91.04% compliant	*191 character(s)*
Q2	**To what extent are educators and supervisors across the professions appropriately supported and given the time or capacity required to undertake their education roles?**		
	Response	Fully supported across professions	
	Provide evidence by profession, including time or capacity arrangements, development support, gaps and actions.	Provides a comprehensive annual postgraduate educator development programme, including sessions, conferences and workshops that enable educational and clinical supervisors to maintain GMC accreditation and support appraisal and professional development. All named ES receive 0.25 x PA per trainee in their job plan. Pre-registration learners receive appropriate training and support from departments, the pre-registration team and Learning Environment Education Links. Although there is no mandatory protected time, supporting learners is embedded across all NMAHP roles Trust-wide. The University of Manchester provides tailored supervisor and educator training through PRiME (https://sites.manchester.ac.uk/prime/). The UG team calculates and shares each consultant's annual teaching contribution to support job-planning discussions.	*839 character(s)*
Q3	**What approaches are used to ensure educators across all professions consistently use protected time set aside for their educational duties?**		
	Response	We have a formal scheduling system and leadership to support and prioritise protected educator time	
Q4	**Does the organisation maintain a register or other reliable record of educators across the professions it trains?**		
	Response	Yes, across all professions	

	Please provide further detail.	The pre-registration education team maintains a register of qualified practice supervisors, practice assessors and AHP educators across all professions. The Trust maintains a GMC accreditation database for all educational and clinical supervisors of resident doctors. The Associate DME has overall responsibility for the database and related processes. The University of Manchester cannot currently share training records because of information governance restrictions, although work is underway to resolve this. UG teams maintain local records but rely on trained individuals to self-report.	*593 character(s)*
Q5	**Please provide the name and e-mail address(es) of Senior Educator(s) or Educator Leaders responsible or accountable for education and training for all groups.**		
	Advanced Practice	Kimberley Salmon Jamieson, Chief Nursing Officer and Interim Deputy Chief Executive. Kimberley.salmon-jamieson@mft.nhs.uk	*Please enter details for all responsible colleagues. If not relevant enter NA*
	Allied Health Professionals	Kimberley Salmon Jamieson, Chief Nursing Officer and Interim Deputy Chief Executive. Kimberley.salmon-jamieson@mft.nhs.uk	
	Dental		
	Healthcare science	Kimberley Salmon Jamieson, Chief Nursing Officer and Interim Deputy Chief Executive. Kimberley.salmon-jamieson@mft.nhs.uk	
	Medical	Professor Matthew Makin, Interim Joint Chief Medical Officer, matthew.makin@mft.nhs.uk	
	Non-clinical roles	Kimberley Salmon Jamieson, Chief Nursing Officer and Interim Deputy Chief Executive. Kimberley.salmon-jamieson@mft.nhs.uk	
	Nursing and Midwifery	Kimberley Salmon Jamieson, Chief Nursing Officer and Interim Deputy Chief Executive. Kimberley.salmon-jamieson@mft.nhs.uk	
	Pharmacy	Charlotte Skitterall, Chief Pharmacist, charlotte.skitteral@mft.nhs.uk	
	Psychological Professions		
	Other		
	Section completion declaration		
	I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	I confirm	*Choose 'I confirm' from the dropdown.*
	Name:	Tracey Lakin, Associate Director of Medical Education	
	Email address:	tracey.lakin@mft.nhs.uk	

Section 7 - Improving the Working Lives of Resident Doctors

Answered: 29 of 28

Complete the response field for each question. Dropdown fields are used for single-select answers.

No.	Question / field	Your response	Guidance
Q1	**Please provide the name and e-mail addresses of the Non-Executive Director, Executive Lead for Resident Doctors and Resident Doctor Peer Lead who have responsibility for**		
	Non-Executive Director:	Sam Liscio, samantha.liscio@mft.nhs.uk	
	Executive Lead:	Professor Matt Makin, matthew.makin@mft.nhs.uk	
	Resident Doctor Peer Lead(s), up to 4:	Dr Rachel Ferguson, rachel.ferguson@mft.nhs.uk	
Q2	**What support have you put in place to ensure that the next Resident Doctor Peer Leads are inducted and supported when their roles rotate?**		
	Select all that apply:		
	Dedicated local induction programme		
	Meeting with Executive Lead for Resident Doctors in first week	✓	
	Leadership Training		
	Handover meeting with outgoing Resident Doctor Peer Lead(s)	✓	
	Other - please specify	Meeting with CEO	
Q3	**How frequently does the Executive Lead for Resident Doctors experience report to the board on Resident Doctor experience and the 10 Point Plan progress, risks or opportunities?**		
	Response	Quarterly	
	If Other, please specify:		
Q4	**What forums do you have to facilitate regular engagement and feedback to identify and act on Resident Doctors concerns in a timely and effective way?**		
	Select all that apply:		
	Meet regularly with local representative body	✓	
	Meet regularly with British Medical Association representatives	✓	
	Resident Doctor Forum	✓	
	Resident Doctor Survey	✓	
	Direct engagement with the Resident Doctor Peer Lead, such as walk arounds, drop-ins or meetings	✓	
	Other - please specify	Specific fortnightly working group set up for IRDWL with key stakeholders including medical education, medical workforce, recruitment, payroll, facilities and resident doctor leads - open invitation to attend to all resident doctors.	
Q5	**Do you currently have a clear action plan for improving the working lives of Resident Doctors?**		
	Response	Yes	
Q6	**If yes, is this shared with the Trust Board as part of the governance for this programme?**		
	Response	Yes	
Q7	**If yes, what are your top 3 priority areas from your local action plan?**		
	Response	Two main focus areas of less than full compliance are receiving rotas 6 weeks in advance and under and over payment issues. Additional focus is on maintaining momentum and engagement with the RD cohort.	*203 character(s)*
Q8	**We are keen to hear about initiatives and good practice relating to improving the working lives of Resident Doctors within your organisation. If you would like to share any examples,**		

	Response (up to 1000 words)	Implementation of the Too Tired to Drive Policy •Guidance sets out support for resident doctors who feel too exhausted to drive home after a shift, including on-site accommodation where available, hotel accommodation or alternative transport. •Doctors can claim eligible travel and accommodation expenses through Easy Expenses. •Posters and online guidance explain the arrangements and provide access to hospital-specific information. Infant feeding •Policy updates are underway to clarify responsibilities, improve information about feeding facilities and milk storage, and strengthen support for staff returning to work. •Trafford's infant feeding room is expected to open in the new year, while a request for space at Wythenshawe remains under consideration. •Planned awareness improvements include updated website and SharePoint information, induction guidance and proactive contact with returning doctors through PGME and SuppoRTT. Improvement of rest areas •Support has reached 25 areas across six hospital sites, covering doctors' messes, on-call rooms and other rest, work and wellbeing spaces. •Eight improvement plans are active, with a further visit planned. •Currently installed 321 lockers across 20 areas Engagement with resident doctors •Named executive, non-executive and resident doctor peer leads provide leadership for the Trust's 10 Point Plan. •A dedicated SharePoint hub brings together progress updates, support information and opportunities for resident doctors to get involved or request help. •Active engagement with mess committees, the Medical Leadership Fellows, Resident doctor representatives and Chief registrars.	*1662 character(s) of 7000 maximum*
Q9	**Which of the following facilities and amenities are available to all resident doctors? Please select all that apply.**		
	Select all that apply:		
	Beds or sleeping pods, free of charge for those who feel too tired to drive home	✓	
	The ability to take a rest break when rostered for 5 hours or more	✓	
	Facilities which allow Resident Doctors to safely park and reach or leave the hospital building when on call, such as dedicated on-call parking	✓	
	Resident Doctors can typically complete self-directed learning from a flexible location	✓	
	Mess Facilities	✓	
Q10	**If any of the above are not or only partially available, please outline briefly below the rationale for different local practice or alternative arrangements.**		
	Response	n/a	*3 character(s)*
Q11	**Are hot and cold food facilities accessible 24/7, for example either canteen or vending machine and microwave?**		
	Response	Yes - All learners (including Resident Doctors)	
Q12	**If Yes, what is provided?**		

	Response	Depending on site either 24/7 canteen or hot food vending machine	*65 character(s)*
Q13	**If No, please explain why hot and cold food is not available 24/7 and what actions are being taken to address this**		
	Response	n/a	*3 character(s)*
Q14	**Does the organisation have a Guardian of Safe Working, if postgraduate doctors in training are being trained, and actively promote the process for raising concerns through them to**		
	Response	Yes, in place and actively promoted	
	If no, please provide further details.		
Q15	**Are you compliant with the Minimum standards in Annual Leave for Resident Doctors?**		
	Response	Yes	
	If no, please provide detail of what you are planning to do to close any gaps or provide further rationale.		
Q16	**Please provide the number of breaches in the last 12 months for this standard**		
	Response	Not known	*Enter a number, or 'Not Known'.*
Q17	**Are there clear mechanisms in place to identify and correct payroll errors for Resident Doctors in a timely manner?**		
	Response	Yes	
Q18	**Are payroll errors for Resident Doctors reported to your board on a regular ongoing basis?**		
	Response	Yes	
Q19	**Are you compliant with the National Payroll Improvement Programme Data Request?**		
	Response	Yes	
Q20	**What actions are in place to further reduce payroll errors for Resident Doctors?**		
	Response	A number of initiatives have been implemented to reduce pay-affecting errors for Resident Doctors, including the monthly publication of an overpayment dashboard for all Clinical Groups, providing visibility of trends, causes, and affected departments to support targeted action. Other improvements include enhanced work schedule and rota communication processes, a new Medical and Dental Standard Operating Procedure (SOP), full HealthRoster attendance rollout, and automation of change-of-hours processing. Further developments include the expansion of overpayment reporting to key contacts within Clinical Groups, the development of an underpayment dashboard, implementation of an employee-led termination form, and the publication of a Resident Doctor Guide to Pay to improve understanding of pay and reduce pay-affecting errors.	*833 character(s)*
Q21	**Please confirm the number of payroll errors in the last 12 months**		
	Response	131	*Enter a number.*
Q22	**Are Resident Doctors now able to claim reimbursement of course fees at the point of incurring the expense?**		
	Response	Yes	
Q23	**Please confirm the percentage of course fee reimbursement paid within six weeks**		
	Response	100	*Numbers only, 0 to 100.*
Q24	**Does your Trust comply with the May 2025 Statutory and Mandatory Staff Movement Memorandum of Understanding (MoU) to accept prior mandatory training?**		
	Response	Yes	
Q25	**Have you fully implemented the new exception reporting process for Resident Doctors?**		
	Response	Yes	

Q26	**What actions are you taking locally to follow up on areas highlighted by the revised exception reporting processes?**		
	Response	We have improved our monthly reporting to departments so that trends and areas of concern are highlighted more clearly. We RAG-rate rotas according to identified risks, drawing on feedback and exception reports received from resident doctors during the month. This enables us to identify recurring themes and prioritise areas requiring further attention. We then follow up with the relevant departments to ensure that the issues raised are reviewed and appropriate action is being taken. Where concerns remain or themes recur, we continue to monitor progress and escalate them as appropriate.	*593 character(s)*
Q27	**What actions are you putting in place to improve compliance with the Rota and Scheduling standards for resident doctors, providing work schedules at least 8 weeks before the**		
	Response	Consistently 100% compliant with 8 week deadline. Primary block to 6 weeks is LTFT and getting work schedules that are agreed by both the department and the doctor; processes are being placed to understand their requirements ahead of time.	*239 character(s)*
Q28	**What is your organisation's current percentage compliance to provide work schedules 8 weeks before the rotation commences?**		
	Response	100	*Numbers only, 0 to 100.*
Q29	**What is your organisation's current percentage compliance to provide detailed rotas 6 weeks in advance?**		
	Response	79	*Numbers only, 0 to 100.*
	Section completion declaration		
	I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	I confirm	*Choose 'I confirm' from the dropdown.*
	Name:	Tracey Lakin	
	Email address:	tracey.lakin@mft.nhs.uk	

Section 8 - Equality, Diversity and Inclusion (EDI)

Answered: 6 of 6

Complete the response field for each question. Dropdown fields are used for single-select answers. Square tick boxes are used for multi-select answers.

No.	Question / field	Your response	Guidance
Q1	**Does your organisation have an Equality, Diversity and Inclusion Lead, or equivalent, with responsibility for or a clear link to education and training? Please provide the name, role and contact details of that lead, and briefly describe the governance arrangements and how education and training teams liaise with them.**		
	Response:	Yes	
	Name:	Juliette Tait	
	Role:	Trust Head of Edquality, Diversity and Inclusion	
	Email address:	juliette.tait@mft.nhs.uk	
	Governance arrangements and liaison with education and training:	Equality, Diversity and Human Rights group is Chaired by the Chief People Officer and includes representation from every Hospital, with medical and non-medical workforce representatives. The Trust Associate Director for Medical Workforce and the Trust Director of Nursing for Workforce and Education are members of the group, ensuring education and training is a key consideration in this workstream.	*401 character(s)*
Q2	**How assured are you that learners from protected groups experience education and training equitably?**		
	Response	Highly assured	
	What evidence informs this assessment?	PGME's Associate DME for LTFT, Support and Wellbeing, supported by the wider team, ensures LTFT applications are handled fairly and equitably. The Trust DME oversees all resident doctors in training who require additional support, including training extensions and reasonable adjustments. UGME has an Associate Head of Division for Student Experience at both campuses, supported by campus-based pastoral support teams. DASS plans are incorporated for students moving from Year 2 to Year 3, with appropriate adjustments made for examinations and clinical placements. Neurodiversity training is included in the University of Manchester's PRIME educator training.	*661 character(s)*
Q3	**Please confirm whether your organisation has arrangements in place for the following in relation to education and training. Please tick all that apply.**		
	Tick all that apply:		
	Learner-inclusive reporting and data collection	✓	
	Reasonable adjustments for learners with a disability	✓	
	Review of policies and procedures to avoid negative impact on learners with protected characteristics	✓	
	A specific induction for international graduates, including International Medical Graduates	✓	
	Managing discriminatory behaviour from patients	✓	
	A policy to manage sexual harassment in the workplace	✓	
	Initiatives to support reporting of sexual harassment	✓	
	Sign-up to the NHS England Sexual Safety in Healthcare Organisational Charter	✓	
	A designated sexual safety lead	✓	
	Appropriate processes for managing reports	✓	
Q4	**Please provide additional comments where arrangements are not in place.**		

	Response	N/A	*3 character(s)*
Q5	**Please describe any equality, diversity and inclusion initiatives that are specific to, or have a positive impact on, education and training in your organisation. Please also provide the email address of a contact who can discuss these initiatives further.**		
	EDI initiatives narrative:	The postgraduate Associate DME for EDI is part of the clinical education leadership team and oversees specific EDI initiatives. Current work includes a differential attainment project and an audit of sexual safety data for resident doctors in training across MFT. A pre-registration EDI implementation plan is in place to improve signposting, support learners to raise concerns, ensure concerns are addressed promptly, and provide access to designated champions and links. All Year 3 medical students receive Active Bystander training alongside mandatory Trust training. The Report and Support initiative is available, and the Trust has signed the Sexual Safety Charter. Both campuses clearly explain how to raise concerns, the available reporting routes, and how concerns will be addressed and outcomes communicated.	*821 character(s)*
	Contact name:	Deborah Lam	
	Contact role:	Associate Director of Medical Education for EDI	
	Contact email address:	deborah.lam@mft.nhs.uk	
Q6	**For education and training, what have been your organisation's main EDI successes during the reporting period, and what are the main EDI challenges? Summarise the key points and include any actions underway or support needed.**		
	Response	Successes: Ignite Festival - The Trust introduced a month long period of intensive EDI activity throughout July 2026, raising awareness andhaving deep conversations and learning about staff and student experience, particularly in relation to how they feel they belong at MFT. Inclusive Recruitment Initiative: The Trust launced an Inclusive Recruitment Programme in September 2026, which contains actions in relation to developing a cohort of inclusive recruitment panellists; enhanced EDI development support for recruiters; enhanced EDI tools and resources for recruiters. Challenges: WRES and WDES data still shows thatperceptions around career progression is less positive for black, asian and minority ethnic staff and disabled staff. The inclusive recruitment programme has been developed specifically to support this and the impact of the programme will be analysed on a regular basis, with results and progress reported through the Trust's EDI Committee.	*966 character(s)*
	Section completion declaration		

I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	I confirm	*Choose 'I confirm' from the dropdown.*
Name:	Tracey Lakin, Associate Director of Medical Education	
Email address:	tracey.lakin@mft..nhs.uk	

Declaration and final submission

Answered: 4 of 4

This section should be completed once the Provider Self Assessment has been reviewed and approved through the organisation's board-level governance arrangements.

No.	Question / field	Your response	Guidance
	Board level sign-off (Premises, Learning Environment, Facilities, and Equipment)		
	I confirm that our premises, learning environments, facilities and equipment are: suitable for the performance of the Services; accessible, safe and secure; comply with any applicable Health and Safety Legislation, any other Applicable Law, Guidance, appropriate risk management clinical guidance, good healthcare practice and the requirements of any relevant Regulator; and are sufficient to enable the Services to be provided at all times and, in all respects, in accordance with the NHS Education Funding Agreement.	I confirm	
	Board level sign-off		
	I confirm that the responses in this SA have been signed off at board level.	I confirm	
	Name of Board representative for education and training:	Meera Nair	
	Email address:	meera.nair@mft.nhs.uk	
	Role:	Chief People Officer	
	Please confirm the date that board level sign off was received:	25/11/2026	*Enter as dd/mm/yyyy.*

Manchester University NHS Foundation Trust

Escalation and Assurance Report

Finance Board Committee

Report to: Board of Directors
Report from: Mr Trevor Rees, Interim Trust Chair and Chair of the Finance Board Committee
Date of meeting(s): 26 October 2026

Key escalation and discussion points from the meeting
Alert:
The finance chapter of the **Integrated Performance Report** identified liquidity, agency expenditure and delivery of the Value for Patients (VfP) programme as the principal areas required the Committee and Board's attention. It was noted however that agency expenditure remained an alert against a zero target, although the financial impact was not material. These metrics were further reflected and discussed in the **Chief Finance Officer's Report,** which was reported as on plan at Month 6 but remained underpinned by a range of assumptions, non-recurrent transactions and mitigations. An overview of the reported position without these adjustments was also provided. Discussion also focussed on most-likely and best-case forecast position, including the quantum of additional actions that would be required to move from most-likely to best-case position. These forecasts did not include the anticipated benefit of the H2 Reset or associated revised activity plans. The Committee agreed that its report to the Board should highlight the material risks associated with the financial position. The Committee considered the business case for MFT to host the **Greater Manchester NHS Recruitment Hub** from 1 April 2027. The Committee discussed the need for a robust collaboration agreement, including clear entry and exit arrangements that safeguarded the interests of all partners, including MFT as host, and secured the commitment of participating organisations to the transformation required. The contractual arrangements, including associated risks and the proposed 50-day time-to-hire measure during the first year were also outlined. The Committee supported MFT's participation and requested that the business case provide greater clarity on the digital assumptions and associated patient-related benefits prior to submission for approval. A **Contract Award** proposal in respect to Genomics instruments and associated reagents was reviewed by the Committee and recommended to the Board of Directors, in line with the Scheme of Reservation and Delegation, for approval. The Committee received an update on the **PFI contract** arrangements and their impact on the reported financial position. This included ongoing discussions regarding the performance of the Oxford Road PFI contractor. The need for the financial, contractual and service-delivery implications to be considered collectively was noted, with further discussion scheduled for the Board Seminar session.
Advise:
The Committee received an update on the **H2 reset**, which brought together the operational activity and financial requirements for the second half of the year. Confirmation was provided that demand and capacity planning had been undertaken, with additional pace and resource being applied to workstreams

including theatres, outpatients, ambient voice technology and workforce productivity. A fully quantified position would be prepared and presented to private Board in November.

The finance chapter of the **Integrated Performance Report** reflected that financial performance against year-to-date budget was in line with plan and elective income was above plan.

The Committee received a **Value for Patients** update which outlined that the risk-adjusted position had increased to £97.5m and, while remaining below the year-to-date target, continued to demonstrate material progress. Moving into the second part of the year, the programme was increasingly focused on H2 workstreams while maintaining delivery of existing transformation schemes. Changes in internal oversight arrangements and the approach to consider Value for Patients in context of MFT's overall control total, ensuring focus on delivery of the annual financial plan and securing the strongest possible recurrent exit run rate for 2027/28, were described.

An update on MFT's **productivity programme** was provided, with nationally reported measures, including benchmarking opportunities and cost per weighted activity unit, showing an improving position. A productivity blueprint has been developed which provides a consistent approach to identifying, validating and progressing productivity opportunities through to benefits realisation. Focus to date has included building capability across MFT, with increasing clinical engagement generating a pipeline of opportunities for measurable improvement. The Committee noted the application of the approach within cardiac surgery, where opportunities had been identified to improve patient flow and theatre utilisation, and welcomed the strong clinical engagement and focus on improving efficiency whilst maintaining patient safety and experience. Future reports will provide updates on measurable progress and benefits.

The Committee was advised of a revised approach to **Greater Manchester Procurement Hub** arrangements, with the previously proposal no longer progressing in its original form. The new approach will support enhancing the existing Greater Manchester procurement team, hosted by MFT, and consider opportunities to strengthen strategic leadership across the system.

Assure:

No matters to assure.

Key Risks Discussed:

The Committee reviewed the **Board Assurance Framework**, which detailed the two strategic risks within its remit, relating to restrictions on the availability of capital resource and medium-term financial sustainability. Both remained outside the approved risk appetite, with current scores of 20 and no changes proposed. The Committee acknowledged the work under way to manage the risks, however questioned whether the target scores and year-end target dates remained achievable. In relation to the capital risk, it was noted that the current description focused on the external constraint rather than the impact of these to MFT. It was agreed the wording would be reviewed through the Trust Risk Oversight Committee (TROC) to support clearer articulation of the risk, enabling mitigating actions to positively impact on assessed levels as they were completed.

Report approved by: Mr Trevor Rees, Interim Trust Chair and Chair of the Finance Board Committee

Manchester University
NHS Foundation Trust

Agenda:

Finance Board Committee

Date: Monday 26th October 2026
Time: 2:00pm – 4:00pm
Location: Held Virtually via MS Teams

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	2:00pm
2.	**Declaration of interest** (verbal)	Meeting admin	Chair	
3.	**Minutes of the previous meeting** (26th August 2026)	Meeting admin	Chair	
4.	**Action Log**	Discussion	Chair	
5.	**Matters Arising / Hot Topics**	Discussion	Chair	
6.	**Assurance Reporting**			
	6.1 Board Assurance Framework	Discussion	CFO	2.20pm
	6.2 Integrated Performance Report	Discussion	DCFO	2.30pm
7.	**Strategic aim 4: Ensure value for our patients and communities by making best use of resources**			
7.1	**Financial Performance**			
	7.1.1 Chief Finance Officer's Report	Discussion	DCFO	2:40pm
	7.1.2 PFI Contract Overview	Discussion	Trust Legal Counsel	3.35pm
7.2	**Value for Patients Programme Update**	Discussion	DCEO	2.50pm
7.3	**H2 Reset Update**	Discussion	CFO	3.05pm
7.4	**Productivity Update**	Discussion	DCFO (strategic)	3.15pm
7.5	**GM Procurement Hub Update**	Discussion	CFO	3.25pm
7.6	**Contract Award Recommendation Reports:**			
	7.6.1 Genomics Instruments	Support	Procurement Director	3:50pm

	Item	Purpose	Lead	Time
7.7	**Business Cases:**			
	7.7.1 Recruitment Business Case	Support	CPO	2:05pm
Committee business				
8.	**Escalation report** (verbal)	Approval	Chair	3.55pm
9.	**Workplan Review**	Meeting admin	Chair	
10.	**Any Other Business** (verbal)	Discussion	Chair	
11.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	
Date of next meeting: Wednesday 23rd December 2026				
Papers for information • Finance and Commercial Management Committee Escalation Report				

Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday, 25 November 2026

Paper Title:	Chief Finance Officer's Report	**Agenda Item 13.2**
Presented by:	Claire Wilson, Chief Finance Officer	
Prepared by:	Paul Fantini, Deputy Director of Financial Planning and Reporting	
Meetings where content has been discussed previously	n/a	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion ☐ For noting	

Executive summary / key messages for the meeting to consider

At month 6 (September 2026), the Trust reported a £1.8m monthly surplus against a £2.0m plan, with the year-to-date position at breakeven and in line with plan. However, this position relies on non-recurrent measures, and the underlying financial challenge remains significant.

The Trust continues to report a financial forecast in line with its break-even plan, but this requires £56m of mitigations to be delivered to ensure that the best-case forecast is delivered. Mitigation plans are in place within each Clinical Group and corporate team.

The Trust's reset for the second half of the year (H2) brings together financial, operational and workforce plans, with a focus on improving productivity while protecting the quality and safety of patient care. Priorities include theatres, outpatient services and workforce productivity, supported by benchmarking and patient-level costing to identify opportunities for improvement. Stronger accountability and delivery tracking are in place to support and accelerate delivery of the £175m Value for Patients programme. The Trust continues to focus on the recurrent savings needed to improve the ongoing financial position and provide a more sustainable starting point for 2027/28.

Cash remains a key risk, with a balance of £16.8m at the end of September, £21.9m below plan and equivalent to approximately two days of operating cash. The Trust continues close cash monitoring and work with system partners, alongside income recovery and delivery of savings that reduce cash expenditure. Strong cash management processes are in place to ensure robust income and debt recovery alongside daily forecasts.

The forecast capital programme totals £197.4m, including £50.1m of additional confirmed public dividend capital funding, supporting essential estates, digital and medical equipment investment. Year-to-date expenditure was £58.6m against a £71.3m plan, with delivery of some schemes dependent on completion of funding agreements and receipt of cash.

Recommendation(s)
The Board of Directors is asked to: • Note the contents of the report and the work ongoing to deliver the financial plan in 2026/27 and to improve the exit run rate for 2027/28

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

Relationship to the strategic objectives	
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)	
☐ LHL Objective 1	☐ LHL Objective 2
☐ HQSC Objective 1	☐ HQSC Objective 2
☒ HQSC Objective 3	☐ PEW Objective 1
☐ PEW Objective 2	☒ VfP Objective 1
☒ VfP Objective 2	☐ R&I Objective 1
☐ R&I Objective 2	☐ Good Governance
Links to Trust Risks	The work contained within this report links to the following strategic, corporate, or operational risks: • MFT/001760- Implications of national restrictions on capital resource • MFT/005092 -Delivering Financial Sustainability in the medium term • MFT/008655 - Risk of insufficient cash resources to fund Trust operational and strategic requirements in 2025/26 and beyond.
Care Quality Commission domains Please check **all** that apply	☐ Safe ☒ Effective ☐ Responsive ☐ Caring ☒ Well-Led
Compliance & Regulatory Implications	The following compliance and regulatory implications have been identified as a result of the work outlined in the report: •

Manchester University
NHS Foundation Trust

Month 6 2026/27 Financial Position Update

Where Excellence Meets Compassion

Manchester University NHS Foundation Trust

October 2026

Executive Summary

Manchester University NHS Foundation Trust

Area	Narrative
Overview	The Trust continues to work towards its 2026/27 breakeven plan, supported by a £175m Value for Patients savings target. The underlying financial position remains challenging and relies on one-off measures to deliver the reported position. The Trust's reset for the second half of the year brings together financial, operational and workforce plans, with a focus on making better use of existing resources while protecting the quality and safety of patient care. The Trust continues to report a financial forecast position in line with it board approved break even plan.
Risks and Mitigations	Delivery risks remain significant. The month 6 forecast shows a £56.5m adverse variance to plan, reducing to £30.2m in the best case. Stronger accountability and delivery tracking support recovery. Further industrial action, inflation and workforce cost pressures remain risks.
Income, Expenditure and Workforce	At month 6, the Trust reported a £1.8m monthly surplus against a £2.0m plan and a year-to-date breakeven position. This position includes non-recurrent measures. Recovery focuses on productivity opportunities in theatres, outpatient services and workforce. Benchmarking and patient-level costing are helping teams identify variation and turn improvements into recurrent savings, to support a stronger financial exit run rate into 2027/28.
Cash and Liquidity	Cash remains a key risk. The September balance of £16.8m was £21.9m below plan. Close cash monitoring and work with system partners continue. Sustained improvement depends on recurrent savings that reduce cash outflows, alongside converting recognised income into cash.
Capital	The forecast capital programme totals £197.4m, including £50.1m of additional confirmed public dividend capital funding. Investment supports essential estates, digital and medical equipment priorities. Some schemes remain subject to funding agreements and cash receipts. Year-to-date capital expenditure was £58.6m against a £71.3m plan.

Risks and Mitigations

NHS Manchester University NHS Foundation Trust

Risk	Mitigation/Action Being Taken	Timescale	Owner
Cash - If the financial plan is not delivered in line with cash flow assumptions the Trust will potentially need to access revenue support funding and/or need to slow down/reduce capital expenditure plans.	• Weekly Cash Management and Review groups established to support maximisation of Trust cash balances. • Enhanced cash flow monitoring and reporting. • Senior review and approval of all BACs payment runs • Relentless focus on the management of income recovery and debtors. • Working with GM ICB/ MCC and other stakeholders to maximise the Trust's cash position on an ongoing basis. • Application for further Capital PDC available nationally	31 March 2027	Chief Finance Officer
Cash – Withholding of supplier payments is not sustainable and could lead to reputational risk, increased costs for late payment charges, loss of agreed discounts and adverse publicity.	As above, plus: • Discussion and negotiation with suppliers on extension of payment terms and maintenance of any agreed discounts.	31 March 2027	Chief Finance Officer
VfP delivery - Expenditure run rate doesn't reduce to deliver 26/27 financial plan due to delays in identification and delivery of the VFP schemes.	• Earlier identification of schemes than previous years. • Focus on cash outflow reducing savings only for the 26/27 programme. • See separate papers on VFP governance, scrutiny and oversight which has been significantly increased this year	31 March 2027	All Executive Directors and CG CEOs
Industrial Action – Further unfunded industrial action impact on costs of backfill staffing and lost activity and income	• CGs and the Trust centrally will look to minimise additional costs as far as possible and will continue to seek mitigations through the remainder of the year.	31 March 2027	All Executive Directors
Nursing re-evaluation (band 5 to band 6) – There is a potential for costs of nurses re-banded under the NHS re-evaluation process which commenced in April 2026.	• Plans being drawn up by CNO/CPO with close liaison with national and regional guidance. • Escalation of pressure, assumptions and risk to NHSE via Finance, HR and Nursing professional routes	TBC	Chief People Officer Chief Nursing Officer
Commissioner affordability –there remains a risk around commissioners' ability to pay for activity necessary to achieve national improvement targets.	• Monitoring of demand management schemes, working in conjunction with the ICB • Expectation that income will be received if demand management schemes are unsuccessful.	31 March 2027	Chief Delivery Officer Chief Finance Officer

Summary – M6 Position – September 2026

Manchester University NHS Foundation Trust

I&E Category	2026/27 Original Plan £000s	Current Month - M6 Original Plan £000s	Current Month - M6 Actual £000s	Current Month - M6 Variance £000s	YTD Original Plan £000s	YTD Actual £000s	YTD Variance £000s
Total Clinical Income	*2,819,419*	*236,822*	*236,234*	*(588)*	*1,412,844*	*1,422,777*	*9,933*
Total Other Income	*331,055*	*27,588*	*28,480*	*892*	*165,527*	*163,934*	*(1,593)*
Total Income	**3,150,474**	**264,410**	**264,714**	**304**	**1,578,371**	**1,586,711**	**8,340**
Total Substantive Pay	*(1,769,354)*	*(147,447)*	*(158,342)*	*(10,895)*	*(884,682)*	*(945,576)*	*(60,894)*
Total Bank Pay	*(90,138)*	*(7,511)*	*(7,496)*	*15*	*(45,066)*	*(41,120)*	*3,946*
Total Agency Pay	*(6,504)*	*(541)*	*(522)*	*19*	*(3,246)*	*(3,288)*	*(42)*
Apprenticeship Levy	*(6,655)*	*(555)*	*(583)*	*(28)*	*(3,329)*	*(3,507)*	*(178)*
Total Pay Costs	**(1,872,651)**	**(156,054)**	**(166,944)**	**(10,890)**	**(936,323)**	**(993,490)**	**(57,167)**
Total Non Pay Costs	**(1,221,003)**	**(101,689)**	**(91,346)**	**10,343**	**(610,273)**	**(562,148)**	**48,125**
Total Financing Costs	**(58,082)**	**(2,972)**	**(3,020)**	**(48)**	**(39,944)**	**(37,502)**	**2,442**
Surplus / (Deficit) before adjustments	**(1,262)**	**3,695**	**3,403**	**(292)**	**(8,169)**	**(6,430)**	**1,739**
Adjust PFI revenue costs to UK GAAP basis	*1,262*	*(1,651)*	*(1,582)*	69	*11,385*	*9,666*	(1,719)
Surplus / (Deficit) for CT purposes	**0**	**2,044**	**1,821**	**(223)**	**3,216**	**3,236**	**20**
Total I&E Excluded from CT	**(82,361)**	**(1,142)**	**(43)**	**1,099**	**1,064**	**(3,212)**	**(4,276)**
Surplus / (Deficit) after CT excluded items	**(82,361)**	**902**	**1,778**	**876**	**4,280**	**25**	**(4,255)**

Summary

The Trust reported a **£1.8m surplus** against a **£2.0m surplus plan** for month 6, £0.2m adverse to the plan. Year to date the Trust reports a breakeven position to plan.

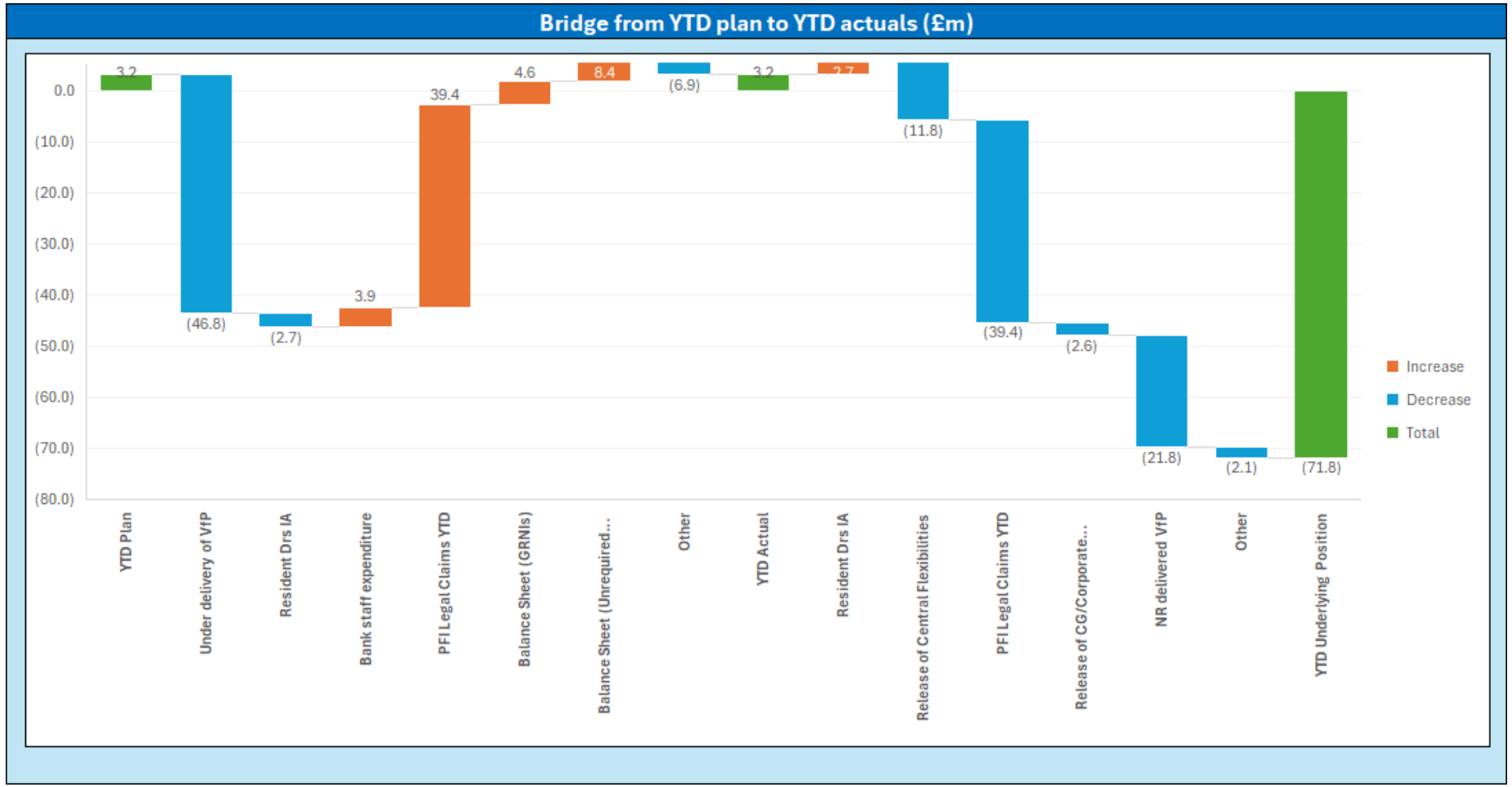
The key drivers of the YTD position are:

- Non-recurrent measures totalling **(£56.1m)**: Includes, recognition of PFI penalties and rebates, owed hours on e-Roster, and recognition of a partially completed spells income accrual and VAT rebates.
- April Resident Doctors Industrial Action costs of **(£2.7m)**.
- Underperformance against the VfP programme plan by **(£46.8m)**, the plan has been profiled in equal 12ths with higher actual delivery expected in later months.

Both income and pay actuals include £0.8m YTD for the change to the CUF for the Resident Drs pay scale changes, with some arrears paid in month 6 and budget transacted to Clinical Groups. Work is ongoing by the Medical Staffing team to finalise the remaining list of medics due the uplift with the aim of paying the arrears in month 7 .

The underlying position is shown on the next slide which sets out the non-recurrent elements included in the month 6 and YTD position.

M6 Waterfall Chart – September 2026



The chart bridges the main reasons for the difference between the YTD plan of a £3.2m surplus to the YTD actual position of a £3.2m surplus.

This position is bridged further to the YTD ***underlying*** position, showing a deficit of £71.8m.

M6 Forecast Clinical Group Position

Manchester University NHS Foundation Trust

Forecast outturn and variance to plan by group, £m — brackets denote adverse

Group	Plan	FOT most likely	FOT best case	Variance most likely	Variance best case	% of exp. budget most likely	% of exp. budget best case
CSS	(388.4)	(415.4)	(413.5)	**(26.9)**	(25.1)	5.6%	5.2%
LCO	(171.6)	(175.1)	(174.1)	**(3.4)**	(2.4)	1.8%	1.3%
MRI	(60.8)	(80.4)	(70.0)	**(19.7)**	(9.2)	4.4%	2.1%
NMGH	31.0	26.6	30.9	**(4.4)**	(0.1)	2.1%	0.1%
SHCG	(265.7)	(294.4)	(292.1)	**(28.8)**	(26.4)	4.4%	4.1%
WTWA	(15.0)	(31.6)	(30.5)	**(16.6)**	(15.5)	3.4%	3.2%
Corporate	(511.4)	(519.6)	(516.4)	**(8.2)**	(4.9)	1.5%	0.9%
R&I	(1.9)	(1.9)	(1.9)	**0.0**	0.0	0.0%	0.0%
Exchequer – Financial Services	(41.5)	(42.2)	(42.2)	**(0.7)**	(0.7)	–	–
Exchequer – Income	1,419.1	1,430.2	1,432.3	**11.1**	13.2	–	–
Exchequer – Reserves	5.0	47.3	47.3	**42.3**	42.3	–	–
PFI below-the-line adjustment	1.3	(0.0)	(0.0)	**(1.3)**	(1.3)	–	–
Trust-wide forecast	**0.0**	**(56.5)**	**(30.2)**	**(56.5)**	**(30.2)**	**1.8%**	**1.0%**

SHCG £(28.8)m and CSS £(26.9)m account for over half of the most likely adverse variance (total before reserves offset); CSS is also the largest as a share of its expenditure budget at 5.6%.

MRI shows the widest gap between cases (£10.4m), reflecting the additional VFP schemes and run-rate actions assumed in the best case. Reserves release of £42.3m (including £4.6m net central adjustments) offsets group pressures centrally.

M6 Value for Patients – September 2026

Manchester University NHS Foundation Trust

CG / Corporate Area	YTD Target £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	% YTD Target Delivered %	FY Target £000s	Programme Value £000s	% Identified %	Risk Adjusted £000s	% Identified Risk Adjusted %
CSS	16,774	7,121	5,957	(10,816)	36%	33,547	17,675	53%	13,277	40%
LCO & UDHM	4,909	2,095	2,064	(2,844)	42%	9,817	5,557	57%	4,401	45%
MRI	12,305	3,648	3,597	(8,708)	29%	24,610	12,406	50%	9,448	38%
NMGH	6,739	8,498	6,349	(389)	94%	13,477	12,643	94%	10,778	80%
SHCG	18,183	10,181	8,397	(9,786)	46%	36,365	22,668	62%	19,056	52%
WTWA	13,584	5,400	5,400	(8,184)	40%	27,168	13,802	51%	12,316	45%
Corporate	11,932	8,837	11,416	(516)	96%	23,863	22,170	93%	17,892	75%
Total	£84,424	£45,780	£43,181	(£41,243)	51%	£168,847	£106,922	63%	£87,169	52%
Trust	3,077	7,500	7,500	4,424	244%	6,153	40,000	650%	7,500	122%
MFT Total	£87,500	£53,280	£50,681	(£36,819)	58%	£175,000	£146,922	84%	£94,669	54%

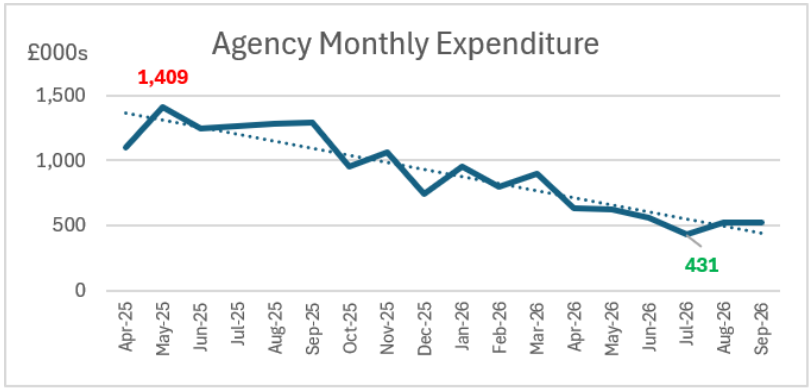
Information on this slide is taken from Wave. The difference between the YTD VFP gap on Wave (£36.8m) and the ledger (£46.8m) is primarily due to the categorisation of the partially completed spells adjustment in the ledger (£7.5m) and smaller differences across several CG and corporate areas totalling £2.5m. Work to align the two systems is underway.

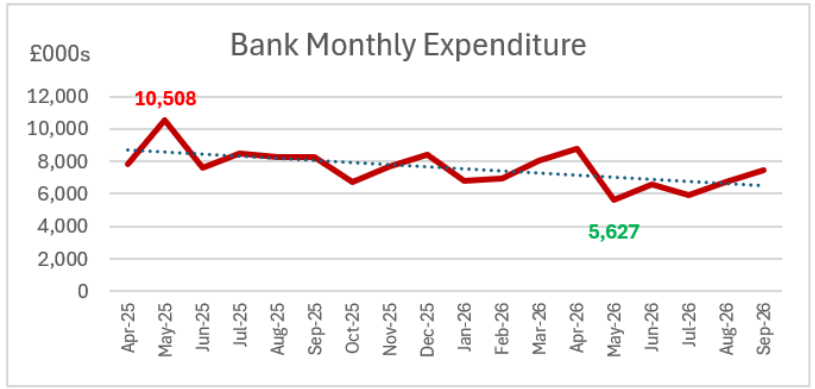
Against the full year target, the risk adjusted delivery shows 54% would be delivered based on the maturity levels of each scheme.

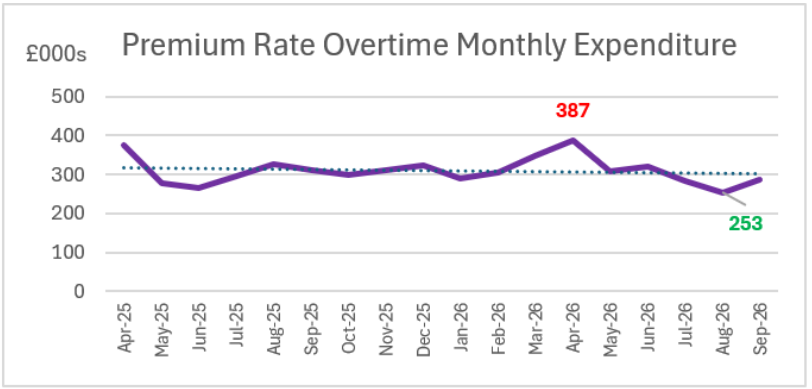
This is an improvement on the risk adjusted delivery of 51% at month 5 and equates to £94.7m.

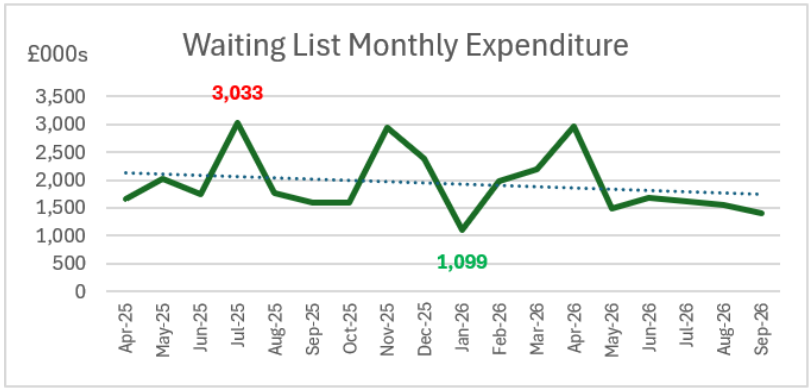
Monthly profile of expenditure for each cost type

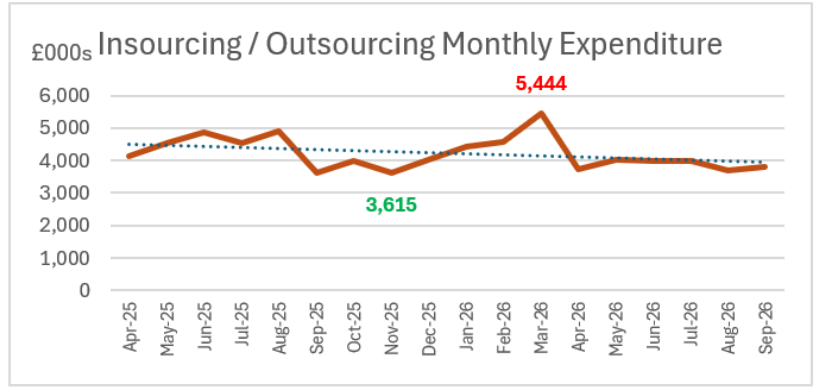
Manchester University NHS Foundation Trust

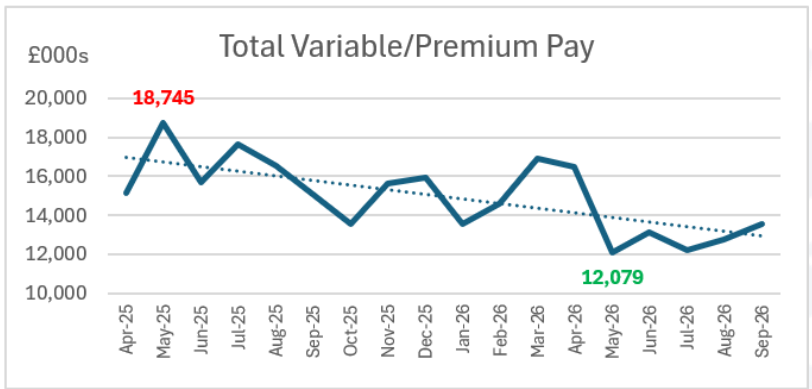












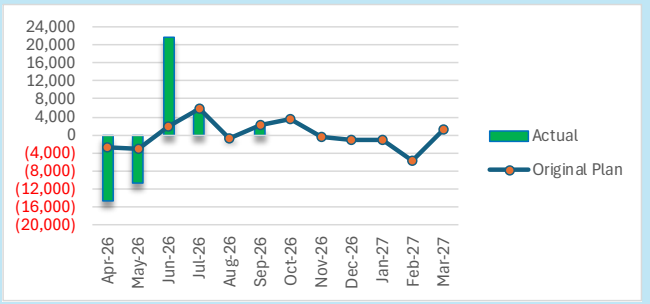
I&E Run Rates vs CT – September 2026

Manchester University NHS Foundation Trust

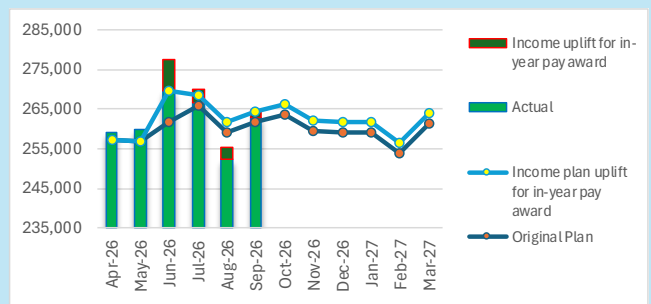
I&E category	Apr-26 £'000	May-26 £'000	Jun-26 £'000	Jul-26 £'000	Aug-26 £'000	Sep-26 £'000
Income	259,290	259,795	269,809	266,838	252,454	263,004
Income uplift for in-year pay award			7,697	3,353	2,763	1,710
Staffing Costs	(168,428)	(163,561)	(158,031)	(159,599)	(163,116)	(165,233)
Pay cost increase for in-year pay award			(7,697)	(3,353)	(2,763)	(1,710)
Non Pay	(100,940)	(102,133)	(85,589)	(96,881)	(85,259)	(91,346)
Financing Costs	(22,550)	(3,013)	(2,909)	(3,012)	(2,998)	(3,020)
PFI revenue costs on a UK GAAP basis	17,887	(1,683)	(1,580)	(1,691)	(1,685)	(1,582)
I&E Performance vs CT	**(14,741)**	**(10,595)**	**21,700**	**5,655**	**(604)**	**1,821**

Note: increase due to pay award YTD in June, July and August is matched to income and plan

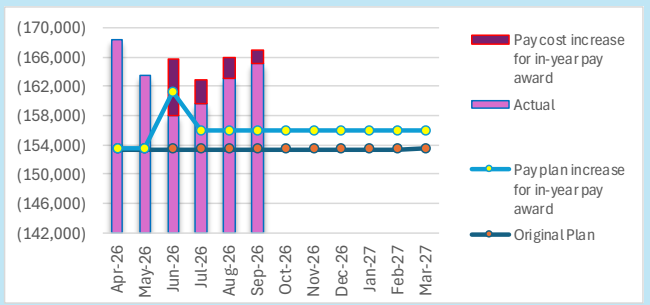
I&E performance vs CT (£000s)



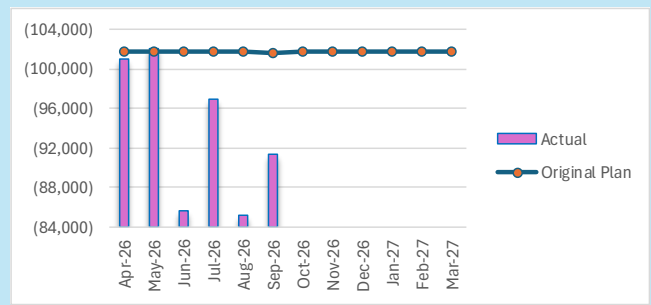
Income (£000s)



Staffing Costs (£000s)



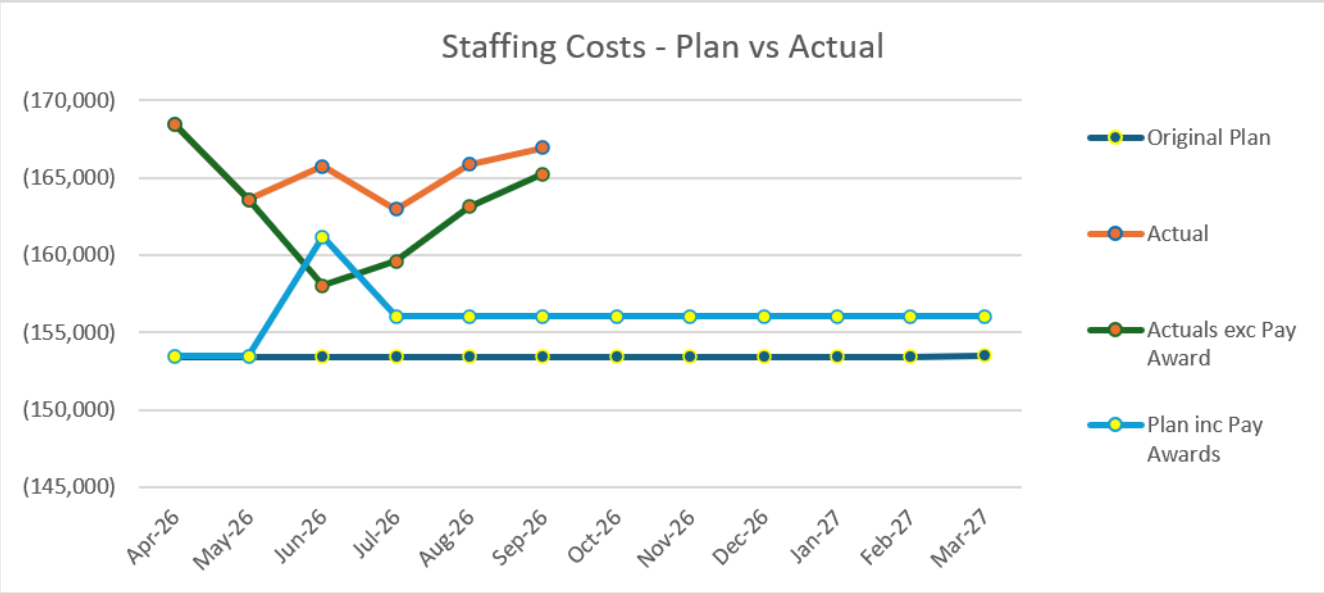
Non Pay Costs (£000s)



- The charts show the monthly run rate vs the plan.
- The expenditure run rate needs to significantly reduce over the rest of the financial year, driven by the delivery of VfP.
- Both income and expenditure include £0.8m YTD for the increase to Resident Drs nodal points on the pay scales. The plan has not yet been adjusted upwards for this.
- The impact of Resident Doctors industrial action in April is included in staffing costs at an estimated £2.7m. There is no national funding to support these costs.

Staffing Costs – Run Rates

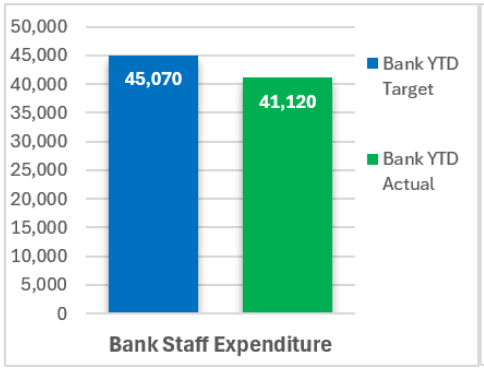
Staffing Costs	Apr-26 £000s	May-26 £000s	Jun-26 £000s	Jul-26 £000s	Aug-26 £000s	Sep-26 £000s
Plan inc Pay Awards	(153,488)	(153,488)	(161,185)	(156,054)	(156,054)	(156,054)
Original Plan	*(153,488)*	*(153,488)*	*(153,488)*	*(153,488)*	*(153,488)*	*(153,488)*
Actuals	(168,428)	(163,561)	(165,728)	(162,951)	(165,879)	(166,944)
Actuals exc Pay Award	*(168,428)*	*(163,561)*	*(158,031)*	*(159,599)*	*(163,116)*	*(165,233)*
Variance	**(14,940)**	**(10,073)**	**(4,543)**	**(6,897)**	**(9,825)**	**(10,890)**

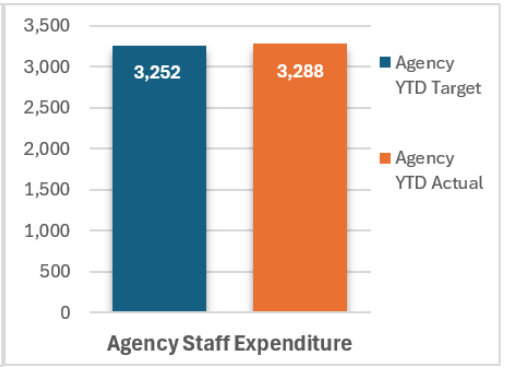


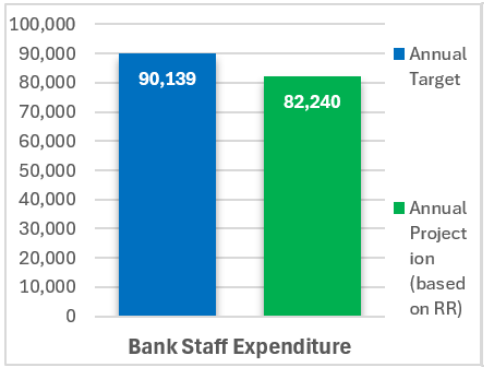
- The original workforce plan has been profiled in equal 12ths in line with VFP and cash requirements
- April 2026 included an estimated £2.8m of cost related to Resident Drs industrial action, with favourable adjustments to this estimate made since of £0.1m.
- A YTD adjustment for the agreed pay awards was included in month 3 with arrears paid from 1st April included.
- A further uplift to YTD actuals for the revision to Resident Doctors terms and conditions has been included YTD of £0.8m affecting months 4 to 6 but the plan has not yet been uplifted for this change.

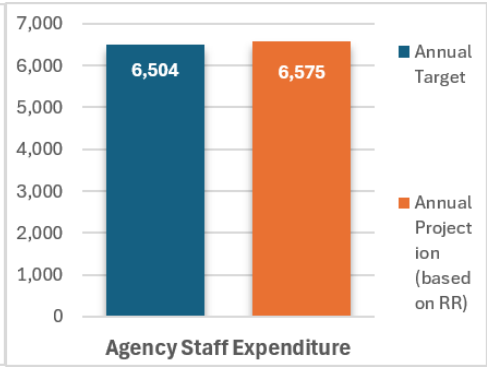
Bank & Agency Expenditure vs Target

Clinical Group	Bank YTD Target £'000	Bank YTD Actual £'000	Bank YTD Variance £'000	Bank YTD Variance %	Agency YTD Target £'000	Agency YTD Actual £'000	Agency YTD Variance £'000	Agency YTD Variance %	Bank Annual Target £'000	Agency Annual Target £'000	Bank Projection (unmitigated) £'000	Agency Projection (unmitigated) £'000
Clinical & Scientific Services	3,719	3,258	**461**	**12.4%**	728	1,324	(597)	(82.0%)	7,438	1,455	6,517	2,648
Corporate	1,134	2,378	(1,244)	(109.7%)	65	128	(63)	(98.1%)	2,268	129	4,757	255
Facilities	996	0	**996**	**100.0%**	54	0	**54**	**100.0%**	1,991	108	0	0
Exchequer Reserves & Central	0	0	**0**	**0.0%**	0	0	**0**	**0.0%**	0	0	0	0
LCO & Dental	1,913	1,699	**214**	**11.2%**	21	37	(17)	(80.7%)	3,826	41	3,399	74
Manchester Royal Infirmary	8,814	8,367	**447**	**5.1%**	665	821	(157)	(23.6%)	17,628	1,329	16,734	1,643
North Manchester General Hosp	8,941	8,116	**824**	**9.2%**	938	475	**463**	**49.4%**	17,881	1,876	16,233	950
Research & Innovation	66	96	(31)	(47.1%)	0	0	**0**	**0.0%**	131	0	193	0
Specialist Hospitals	10,903	9,458	**1,445**	**13.3%**	325	98	**227**	**69.9%**	21,806	649	18,915	195
WTWA	8,585	7,746	**839**	**9.8%**	459	405	**54**	**11.7%**	17,170	917	15,492	810
Total	**45,070**	**41,120**	**3,950**	**8.8%**	**3,252**	**3,288**	(36)	(1.1%)	**90,139**	**6,504**	**82,240**	**6,575**



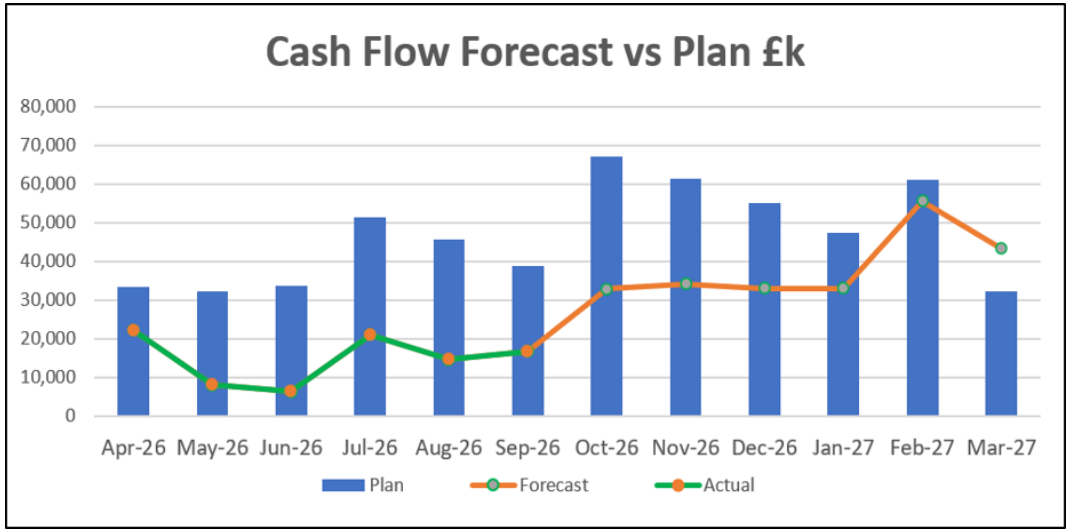






- Targets for B&A reduction are based on the FOT expenditure at M6 25/26 with a c30% reduction in agency expenditure and a c10% reduction in bank expenditure required in 26/27.
- At M6 the Trust is underspent against the bank cap and marginally overspent against the agency cap when apportioned into equal 12ths.
- Good progress is being made against the caps and VfP measures will reduce expenditure on bank and agency further over the coming months.

Cash and Liquidity



Cash Plan vs Actuals - M6	£m
Plan Cash Balance	38.6
Actual Cash Balance	16.8
Variance - Higher/(Lower) than plan	**(21.9)**
Revenue Operating Cash Days	**2.0**
Monthly Low	16.6
Monthly High	213.0

Cash

The Trust cash balance of £16.8m at the end of September equates to 2.0 days of revenue operating cash (1.8 days at the end of August). This balance is £21.9m below plan but £1.4m above forecast. The most significant factor in the variance to plan is the level of PFI contract penalties recognised in the financial position which are still to be realised in cash, rather than the delivery of cash releasing VfP.

Adverse variances against plan include:

- Planned £45m revenue support cash was not drawn down.
- Receivables £38m higher than plan, largely due to PFI contract management actions.
- Net capital cashflows (invoice settlement less PDC funding) £7m adverse.

Favourable variances against plan include:

- Management of supplier payments giving £34m benefit, down from £52m in August.
- £11.6m benefit from receipt of SLA advance payment from MCC in July.
- Receipt of unplanned £10m payments on account from GM ICB.
- £14.8m provider capital support received in September

Significant focus continues to be given to maximising the Trust's cash position. Delivery of the financial plan in line with the planned profile and delivery of VfP on a cash releasing basis is key to management of the monthly cash position.

During September £14.8m of provider capital support was received, funding capital spend that previously had been paid for using internally generated cash, This has allowed the Trust to pay down a proportion of the overdue supplier payments held previously due to cash constraints.

Capital

	Current Month - M6			YTD			Forecast		
	Original Plan £'000	Actual £'000	Variance £'000	Original Plan £'000	Actual £'000	Variance £'000	Original Plan £'000	FOT @ M5 £'000	Variance £'000
GM Envelope (including IFRS 16 Leases)	5,087	2,191	2,896	22,976	21,696	1,280	46,468	47,490	(1,022)
Other Capital (PDC, grant and charity, PFI)	13,544	10,224	3,320	48,311	36,878	11,433	100,803	149,910	(49,107)
Total Capital	18,631	12,415	6,216	71,287	58,574	12,713	147,271	197,400	(50,129)
CDEL (net of intra-DHSC group eliminations) included in Total Capital above	12,132	9,498	2,634	64,888	52,480	12,408	132,254	182,484	(50,230)

- MFT's 2026/27 capital plan is a total of **£147.3m** including capital spend on IFRS 16 leases, PDC funded schemes, grant and charity schemes and the capital expenditure associated with the Trust's PFIs.

- **GM Envelope (inc. IFRS 16)** - Allocation for 2026/27 is £46.5m.

- **Other capital (PDC, grant, charity and PFI)** – £100.8m planning allocation.

- **Additional PDC -** £50.1m. As at M6, NHSE have confirmed additional PDC funding will be awarded to MFT in year relating to Estates Safety £9.8m, NHP £16.3m, RAAC £11.7m, Project Red £5.3m, plus £7.0m made up of various smaller schemes.

- **Year to date spend -** £58.6m compared with £71.3m plan. £22.1m 2026/27 PDC funding received as of M6 - Several (27% of total value) of the PDC schemes included in the 2026/27 capital plan are still pending receipt of MOUs. Related expenditure for these schemes is dependent upon receipt of MOUs and cash receipts. YTD expenditure relates to spend on essential and health and safety related capital schemes, including Revenue to Capital Schemes (£7.5m), Digital, Medical and Estates schemes, and schemes already in train from 2025/26.

- **Total Capital** - Forecast total capital outturn is £197.4m. This reflects the original plan of £147.3m, plus additional confirmed PDC funding of £50.1m.

Manchester University
NHS Foundation Trust

Escalation and Assurance Report
Audit and Risk Committee

Report to: Board of Directors
Report from: Mr Nic Gower, Non-Executive Director and Chair of Audit and Risk Committee.
Date of meeting(s): 3 November 2026

Key escalation and discussion points from the meeting
Alert
The Committee considered and supported the proposed changes, as agreed by the Trust Leadership Team Committee, to the Trust's **commercial insurance** arrangements such that the Trust no longer purchases additional top-up cover in relation to property damage and business interruption. Consideration was given to MFT's claims history, the value for money of the additional cover, relevant HM Treasury guidance and the arrangements available through NHS Resolution. The Committee was satisfied that the residual risk could be managed within the Trust's risk appetite and supported the proposal, subject to a formal review in 12 months to confirm that the approach remained appropriate. The Board is asked to note the Committee's support for this change.
Advise:
The **Internal Audit Progress Report** confirmed continued progress against the 2026/27 Internal Audit Plan. The Committee noted a slight increase in actions requiring extensions, although these were generally short-term, distributed across services and not considered indicative of a wider concern. An advisory review of workforce systems had been completed in the reporting period, identifying opportunities to further strengthen current arrangements. Progress against actions will be included within the follow-up process. The Committee noted the changes to Grant Thornton's External Auditor Team for MFT, as confirmed in the **External Audit Progress Report.** It was confirmed that planning and early interim testing for the 2026/27 audit would commence in December, with the External Audit Plan due to be presented to the Committee in February 2027. Initial year-end accounting matters had been discussed with the External Auditor as part of routine planning. The **Local Counter Fraud Progress Report** confirmed that delivery against the annual programme was on track, with referrals and reactive activity tracking above the previous year. Updates on the current caseload was provided. The Committee considered emerging risks arising from AI-enabled fraud and CEO spoofing and emphasised the importance of raising awareness of these risks. The Committee received the findings of the **Counter Fraud Salary Overpayments** review, undertaken in the context of changes to national Counter Fraud arrangements for investigating potentially fraudulent high-value salary overpayments. The review identified that overall, MFT had a wide range of well-designed preventative and detective controls in place across payroll, HR and finance, but highlighted the need for more timely and consistent application in every instance to reduce the risk of overpayments. Recommendations focused on management action, effective use of available controls, escalation of

significant concerns and targeted support or training where recurring issues were identified. The Committee emphasised the importance of routine budget scrutiny and payroll variance information in identifying anomalies, and noted the wider risks associated with delays in processing leavers, including continued access to Trust premises, systems and equipment. Opportunities to strengthen consistency in review processes would be considered through the ongoing thematic review of financial governance.

The **losses and special payments** report, for the six months to 30 September 2026, was presented to the Committee. Whilst the value reported was lower than in the equivalent period in the prior year, caution was advised in making a direct like-for-like comparison. An update was also provided on the work to standardise overseas and private patient arrangements, with next steps including the development of best practice guidance for consistent application across MFT. The Committee was informed that an Internal Audit review of overseas and private patient arrangements would be completed as part of the current-year Internal Audit programme.

The Committee received the **Tenders Waived** report, which confirmed nine tender waivers above £50k and eight quotation waivers under £50k, of which two were retrospective. Discussions focussed on the pro-active contract monitoring arrangements in place to reduce reliance on retrospective waiver arrangements, with the ambition to eliminate retrospective waivers noted.

The Committee received the **Trust Risk Oversight Committee and Board Committee Escalation Reports** and requested that future reporting provide a clearer, Board-focussed summary of the key risks being managed through TROC. This was further discussed as part of the meeting reflections with a suggestion that more information on the number, nature and direction of the Trust's highest-rated risks would be helpful for the Audit and Risk Committee to receive. Additionally, the Committee also discussed its remit in respect to both audit and risk assurance and suggested amendments to its workplan and terms of reference for 2027/28. This will be included in the Annual Committee Effectiveness Review.

Assure:

The **Internal Audit Progress Report** provided assurance that MFT had benchmarked favourably against other organisations through the 2025/26 Data Security and Protection Toolkit review.

The Committee considered the annual **Internal Audit Effectiveness Review** which had been completed by Audit and Risk Committee Members, Executive Directors, Senior Responsible Officers and audit participants. The findings were positive overall, and the Committee was satisfied that the Internal Audit service remained effective, independent and value-adding. Opportunities for further development will be considered as part of future audit planning.

Report approved by: Mr Nic Gower, Non-Executive Director and Chair of Audit and Risk Committee.

Agenda:

Manchester University
NHS Foundation Trust

Audit and Risk Committee

Date: Tuesday 3rd November 2026
Time: 10:00am – 12:00 noon
Location: Main Boardroom, Cobbett House, Oxford Road Campus

Agenda

	Item	Purpose	Lead	Time
1.	Apologies for absence & confirmation of quoracy (verbal)	Meeting admin	Chair	10:00am
2.	Declaration of interest (verbal)	Meeting admin	Chair	
3.	Minutes of the previous meeting (8th September 2026)	Meeting admin	Chair	
4.	Action Log	Discussion	Chair	
5.	Matters Arising / Hot Topics	Discussion	Chair	
6.	**Internal Audit:**			
6.1	Internal Audit Progress Report	Discussion	Internal Audit (KPMG)	10.05am
7.	**External Audit:**			
7.1	External Audit Progress Report	Discussion	External Audit (GT)	10.15am
8.	**Local Counter Fraud:**			
8.1	Local Counter Fraud Progress Report	Discussion	Local Counter Fraud (KPMG)	10:25am
8.2	Local Counter Fraud Review: Salary Overpayments	Discussion	Local Counter Fraud (KPMG)	10.35am
Management Assurance				
9.	Insurance Paper Update	Discussion	Operational Finance Director	10:45am
10.	**Items for Noting and / or Information**			

	Item	Purpose	Lead	Time
10.1	Losses and Compensations (including special payments) for the period 1 April - 30 September 2026, including Standardisation of Private Overseas Patients Arrangements	Noting	Operational Finance Director	10.55am
10.2	Tenders Waived for the period 1 August to 30 September 2026	Noting	Procurement Director	11:05am
Good governance				
11.	Minutes and escalation reports from Board Committees and Trust Risk Oversight Committee	Noting	Trust Board Secretary	11.15am
12.	Private Item: Internal Audit Effectiveness Review	Discussion	Chief Finance Officer	11:25am
Committee business				
13.	**Escalation report**	Discussion	Chair	11.45am
14.	**Workplan Review**	Meeting admin	Chair	
15.	**Any Other Business** (verbal)	Discussion	Committee Members	
16.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	
Date of next meeting: Tuesday 2nd February 2027 at 10:00am – 12:00pm, Main Boardroom, Cobbett House, ORC				

NHS
Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday, 25 November 2026

Paper Title:	Board of Directors' Register of Interests	**Agenda Item 14**
Presented by:	Interim Trust Chair	
Prepared by:	Deputy Director of Corporate Business	

Meetings where content has been discussed previously	n/a	
Purpose of the paper Please check **one** box only:	☐ For approval ☒ For discussion	☐ For support ☐ For noting

Executive summary / key messages for the meeting to consider

The Register of Interests is presented to support transparency, accountability, and good governance in accordance with the statutory requirements and the Trust's Standards of Business Conduct Policy.

Recommendation(s)

The Board of Directors is asked to:

- note the MFT Board of Directors' Register of Interests (November 2026)

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

Relationship to the strategic objectives

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

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

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

Main report

Introduction

In line with the MFT constitution and standing orders, the Board of Directors is required to hold a Register of Interests and review it every 6 months.

The register must include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors of the Board.

The Register is available to the public on MFT's website.

Recommendation

The Board is asked to receive the MFT Board of Directors' Register of Interests.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

REGISTER OF DIRECTORS' INTERESTS

(November 2026)

BOARD OF DIRECTORS

Name	Position	Declaration
Non – Executive Directors		
Trevor Rees	Interim Trust Chair	• Chair of the Audit Committee of GB Taekwondo • Member to the Board of the College of Policing.
Angela Adimora	Non-Executive Director	• Council of Governors, Salford University • Chief People Officer, HC One (a Welltower portfolio company)
Professor Ashley Blom	Non-Executive Director	• Vice President and Dean at the University of Manchester
Mathew Bonam	Non-Executive Director	• Employed at Health Data Research UK. • Owns shares in AstraZeneca Pharmaceutical
Mark Gifford OBE	Non-Executive Director	• CEO, First Choice Homes Oldham • Member, Oldham Integrated Care Partnership • Member, Greater Manchester Housing Providers • Director, New Living Homes (unremunerated post and subsidiary of FCHO)
Nic Gower	Non-Executive Director	• Non-Executive Director, North West Ambulance Service NHS Trust
Jackie Hanson MBE	Non-Executive Director	• No interests to declare
Samantha Liscio	Non-Executive Director	• Industry Advisor, Kainos Software Ltd
Chris McLoughlin OBE	Senior Independent Director (SID) / Non-Executive Director	• Executive Director of People and Neighbourhoods Stockport MBC • Director of Children's Services, Stockport MBC • Member of Association of Director of Children's Services Ltd • Chair of Greater Manchester Start Well & School Readiness Board • Member of the Greater Manchester Safeguarding Alliance • Member of Greater Manchester Integrated Care Partnership • Member of the ICB children and young people system leadership group • Member of Greater Manchester Live Well Board
Executive Directors		
Mark Cubbon	Trust Chief Executive	• National Priority Programme Director – Planned Care, NHSE/DHSC • Board Member, Health Innovation Manchester

Name	Position	Declaration
		• Shelford Group CEO Group member • Director of Oxford Road Corridor • Chair of the LGBTQIA+ Network NHS Confederation
Darren Banks	Deputy Chief Executive	• Spouse – Chief Finance Officer, Wrightington, Wigan & Leigh NHS FT • Board Member, The Corridor, Manchester
Kimberley Salmon-Jamieson	Deputy Chief Executive / Chief Nursing Officer	• Visiting Professor at Manchester Metropolitan University • Strategic Advisor, on the Advisory Council, Youth Leads, Manchester • Shelford Group CNO Meeting (deputy Chair) • Shelford Group Safer Nursing Care Tool Steering Committee member • Member of the Strategic Advisory Group – Chief Nursing Officer for England • Director of KSJ Consultancy Ltd (dormant company / not trading)
Matt Makin	Joint Chief Medical Officer (interim)	• Spouse is GP Partner at Middlewood Medical Group • Medical Director of Supportive Care UK, Independent Provider of Palliative Care Services • Private Practice at The Christie Private Clinic • Member of Shelford MD Group • School Governor Broomwood Primary School • Honorary Professor, Health and Behavioural Sciences (Bangor University)
Sohail Munshi	Joint Chief Medical Officer	• Spouse is Programme Manager for Creative Health, GMCA • Honorary Professor of Practice at the University of Manchester
Meera Nair	Chief People Officer	• Vice Chair and Member - Shelford HRD group • Chair, The Maya Centre
Tom Rafferty	Chief Strategy Officer	• No interests to declare
David Walliker	Chief Digital and Information Officer	• Governor, Ysgol Penmorfa, Prestatyn • Honorary Chair, Manchester University
Claire Wilson	Chief Finance Officer	• Trustee of HFMA (Healthcare Financial Management Association). • Trustee of HOME (independent cinema, theatre and art in Manchester). • Husband is Group CFO of GMCA; NED of Lancashire and South Cumbria NHS Foundation Trust; Director of MIDAS (Manchester's Inward Investment

Name	Position	Declaration
		Agency); Director of Southway Housing Trust; Trustee of Moyà Cole Hospice.
Advisors to the Board of Directors		
Nick Gomm	Director of Corporate Business / Trust Board Secretary	• Wife works for Greater Manchester Mental Health Trust in their CAMHS team in Trafford