NHS
Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday 30th July 2025

Paper title:	MFT Annual Complaints Report 2024/25	**Agenda Item 11.3**
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Meetings where content has been discussed previously	Quality, Safety and Performance Board Committee Professional Board	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

- During 2024/25, the Trust received 8,517 contacts into the Patient Advice and Liaison Service (PALS); this represents a 5% decrease from the 8,964 received in 2023/24.
- The Trust received 1,975 complaints during 2024/25; a 6% decrease from the 2,107 received in 2023/24.
- 23% (452) of complaints were *'upheld'*, 55% (1071) were *'partially upheld'* and 22% (424) were '*not upheld'* based on the Parliamentary Health Service Ombudsman (PHSO) classification).
- 100% of the complaints were acknowledged within three working days. 89% of complaints were responded to within the agreed timescale and 94% of PALS cases were resolved within 10 working days. All of these represent a significant improvement when compared to these performance metrics in last year's report.
- During 2024/25, the PHSO confirmed they had opened new investigations into 15 MFT complaints. The PHSO also confirmed they had completed 10 investigations into MFT complaints, of which 1 was 'upheld', 7 were 'partially upheld', 2 were 'not upheld'.
- Improvement work has continued throughout the year, with a focus on optimising learning from complaints.
- Complaints Review Scrutiny Group is now under the leadership of the Chief Nursing Officer, for additional scrutiny and oversight and the leadership team has implemented a rapid review process for complaints received by the Chief Executive, to ensure immediate attention and action.
- PALS and Complaints management strengthened the data collection of Equality and Diversity Information and implemented changes to improve the accessibility of service, to best meet the needs of patients and families.
- Improvement work and process changes shared with Governors and Members as part of their oversight programme.
- KPMG audit of MFT complaints handling found there was significant assurance, with minor improvement opportunities, and was assured by the appropriately designed controls in place.

Recommendations

The Board of Directors is asked to:

- Understand the performance achieved via the PALS and Complaints processes.
- Recognise the continuous improvement work of the Central PALS and Complaints Department and Clinical Group teams, to ensure that MFT is responsive to concerns and complaints to meet regulatory compliance.
- Support the approach to promote MFT wide learning from complaints and PALS.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☒ **Yes** ☐ **No**

Relationship to the strategic objectives

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

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

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: • MFT/001664 – to ensure timely and appropriate acknowledgement and response to complaints	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☐ Effective ☒ Responsive	☒ Caring ☐ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • CQC regulation 16: Receiving and acting on complaints • The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 • PHSO NHS Complaint Standards	

Main report

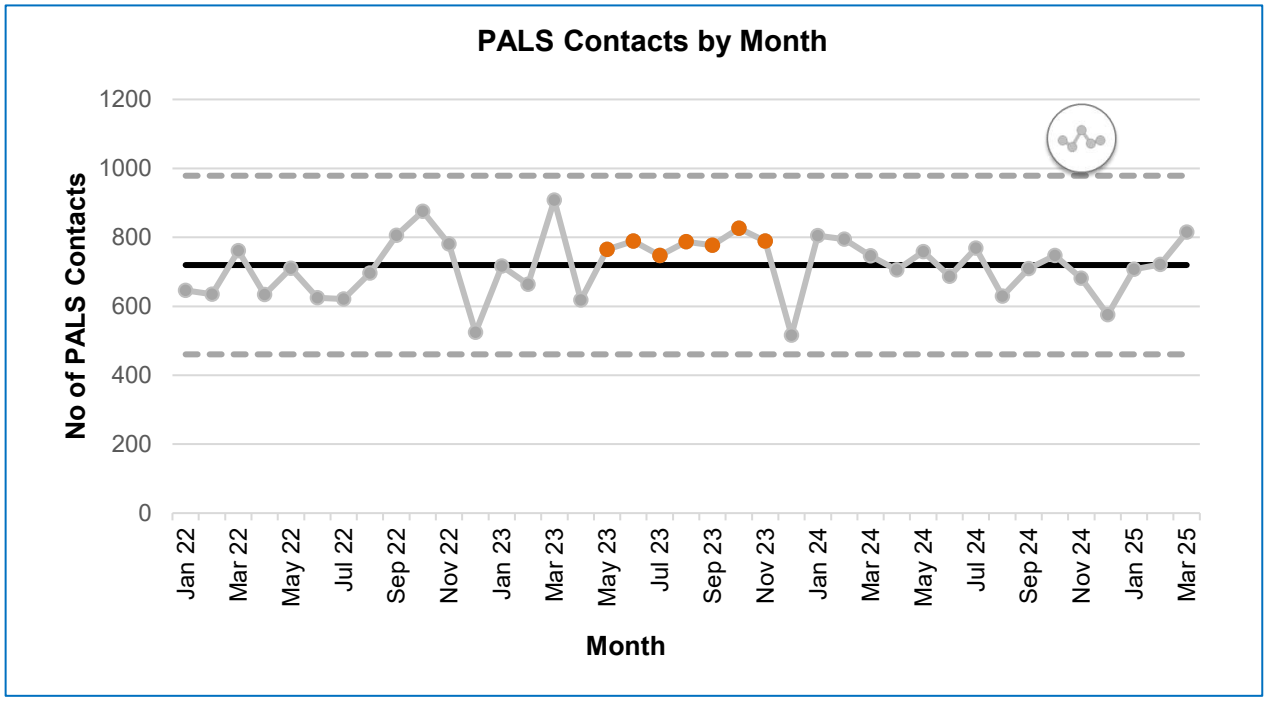
1. Introduction

1.1 Manchester University NHS Foundation Trust's (MFT) Patient Advice and Liaison Service (PALS) and Complaints Team ensure effective complaints handling and monitoring to meet the national regulatory requirements. The team support the operational teams to ensure that learning from

complaints and PALS is used to triangulate with data from other sources in order to improve services for the people who use them, as well as for colleagues working in them.

2. An overview and thematic analysis of PALS contacts

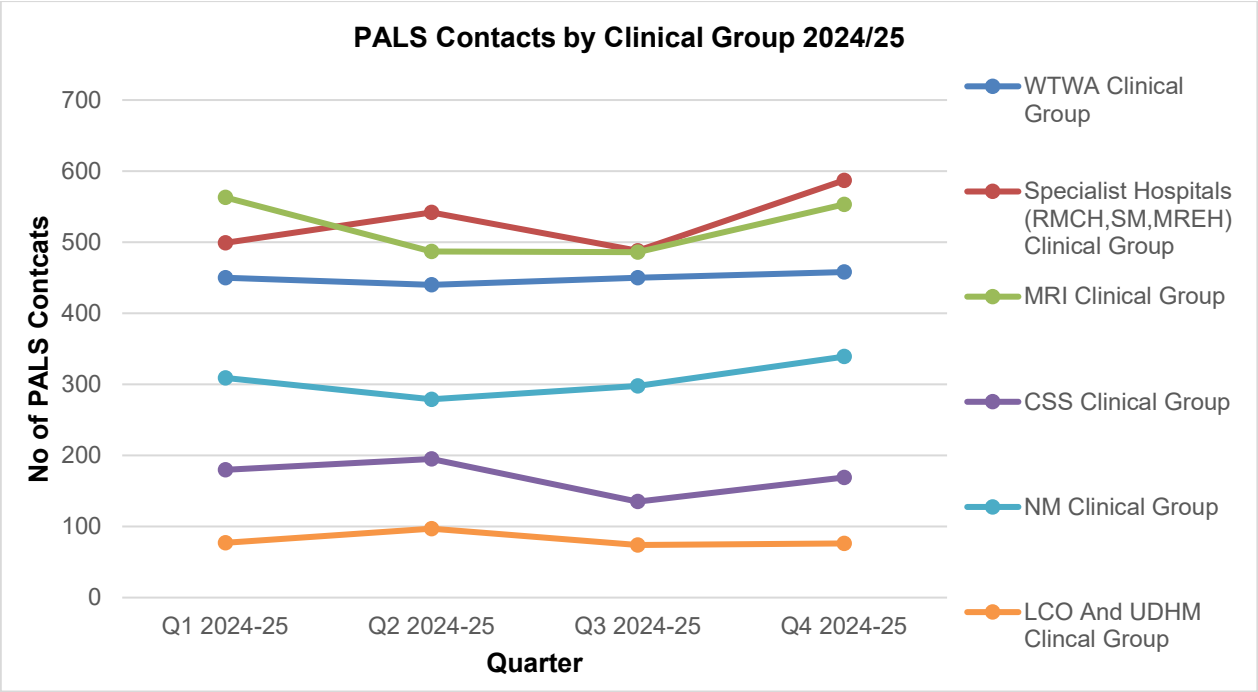
2.1 There was a 5% decrease in PALS contacts in 2024/25, with 8,517 received compared to the 8,964 received in 2023/24. **Graph 1** shows the number of PALS contacts by month, with the most months in 2024/25 receiving fewer than the historic average of contacts in PALS. This marks an improvement from 2023/24, when most months experienced a higher number of contacts than average (highlighted on the graph).



Graph 1: PALS Contacts by Month

2.2 The decrease in PALS contacts throughout the year is partially attributable to a reduction in the number of contacts relating to delays in reporting scans. This is a positive outcome from the actions put in place within the Clinical Scientific Services (CSS) Clinical Group to improve the timeliness in reporting of radiology examinations.

2.3 The PALS Team has also engaged with colleagues from across the Trust with early/local resolution training sessions. These sessions empower and support clinical and operational individuals and teams to resolve concerns locally, to the patient's/family's satisfaction. An element of this training focuses on reducing the practice of signposting people directly to PALS, through staff taking the opportunity to first actively listen and compassionately engage with patients, relatives and carers.

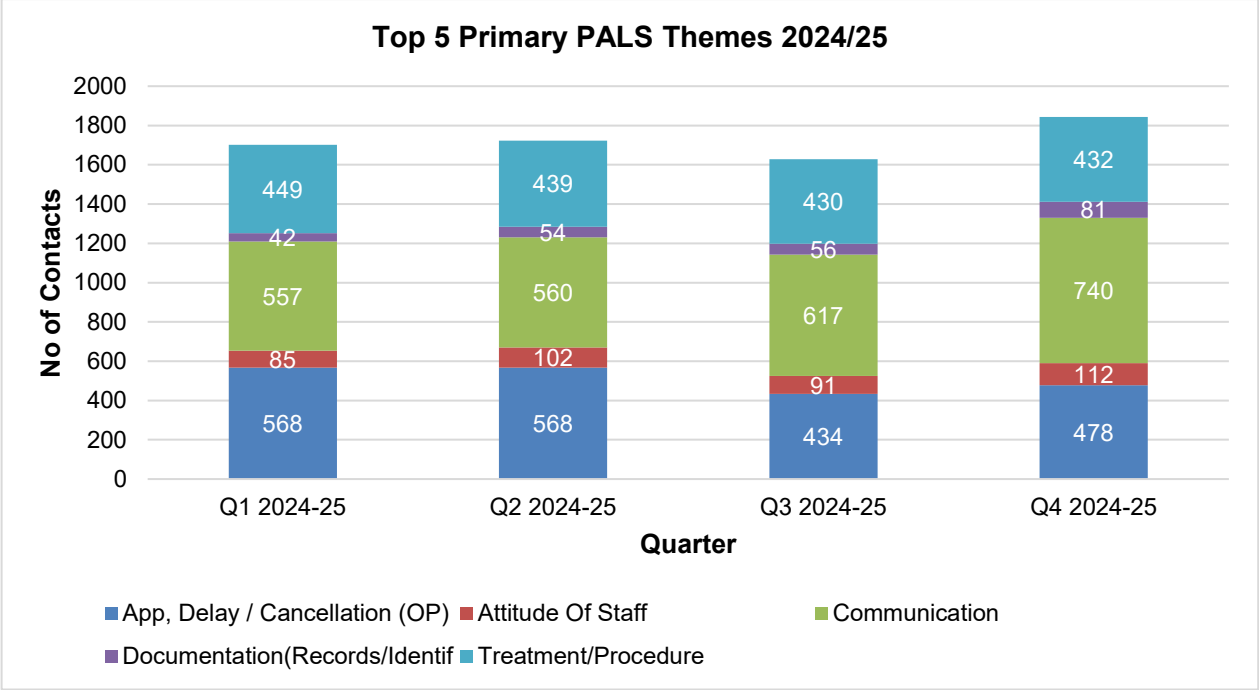


Graph 2: PALS Contacts Received by Clinical Group 2024/25

2.4 **Graph 2** shows the number of PALS contacts received by each Clinical Group per quarter. The Specialist Hospitals Clinical Group, received the greatest number of PALS contacts, receiving 2116, followed by Manchester Royal Infirmary (MRI) Clinical Group with 2089.

2.5 **Graph 3** shows the distribution of the top five PALS themes (more than one theme is recorded for each contact where appropriate), with the greatest proportion of PALS concerns in 2024/25 relating to 'Communication', particularly regarding 'Staff Communication with Patients and Relatives'. The largest proportion of concerns and complaints were regarding communication between administrative staff and patients and relatives relating to outpatient appointments.

2.6 Work is already underway to improve communications to patients regarding appointments, with the 'MFT Digital First Appointment Details for All Project', with concerns and complaints included as a monitoring tool to assess the impact of this, throughout 2025/26. The Trust has also implemented a Waiting Safely improvement project, which proactively support patients on waiting lists by providing wellbeing resources and focuses on improving communication with patients.



Graph 3: Top 5 Primary PALS Themes 2024/25

3. PALS responsiveness and key performance indicators (KPI)

3.1 The PALS Team deliver a timely service to patients and their representatives, with 94% of PALS cases resolved within 10 working days during 2024/25. This a continuance of PALS consistently achieving >90% compliance with the Trust response deadlines for the past two years.

	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Total
Total resolved	2191	2118	2063	2150	8522
% resolved within 10 working days	94%	94%	93%	93%	94%

Table 1: Percentage of PALS cases resolved within 10 working days 2024/25

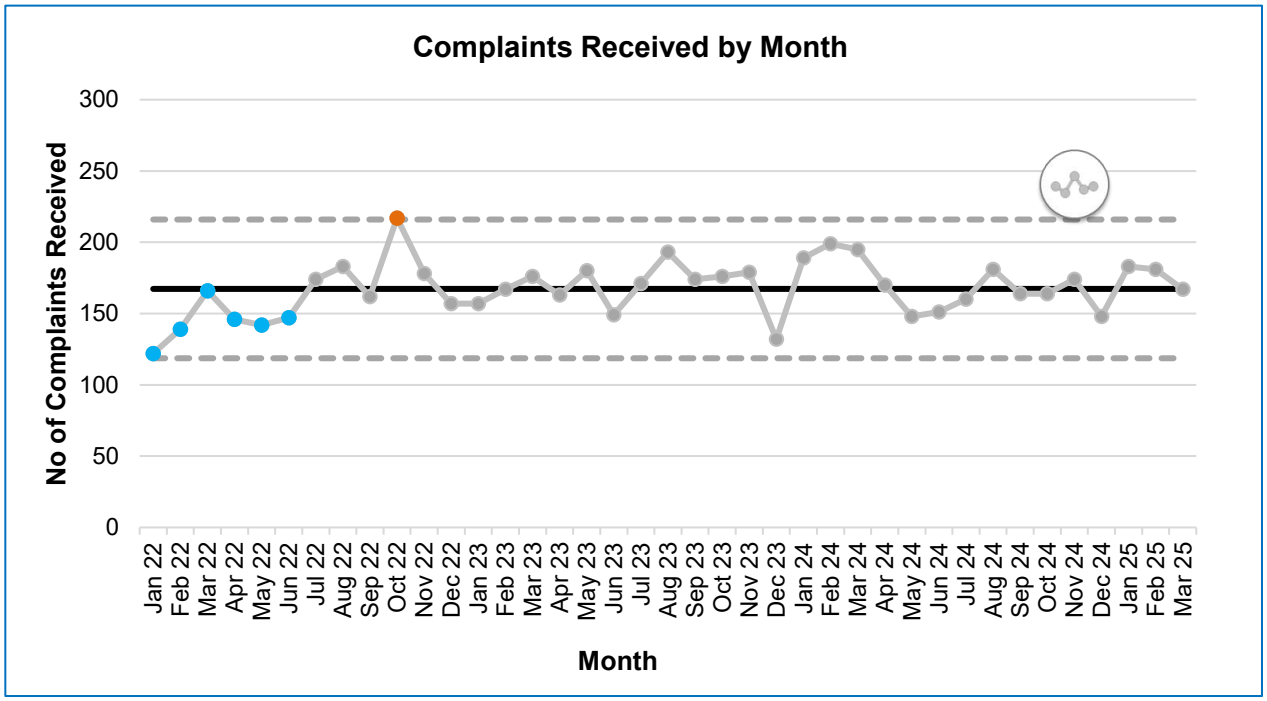
3.2 **Table 2** shows the number of PALS cases that were escalated to formal complaints and vice-versa. There has been a continued focus on achieving early resolution of concerns to improve the process and satisfaction outcomes for both patients and staff. The data evidences a reduction in the number of cases escalated from PALS to complaints compared to 2023/24 and demonstrates a sustained higher proportion of cases managed successfully through PALS, to support a real or near time response to concerns raised and positive outcome for patients.

	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Total
Number of PALS cases escalated to complaints	23	51	41	34	149
Number of complaints de-escalated to PALS	114	104	124	110	452

Table 2: Number of PALS cases escalated to complaints and complaints de-escalated to PALS concerns 2024/25

4. An overview and thematic analysis of complaints

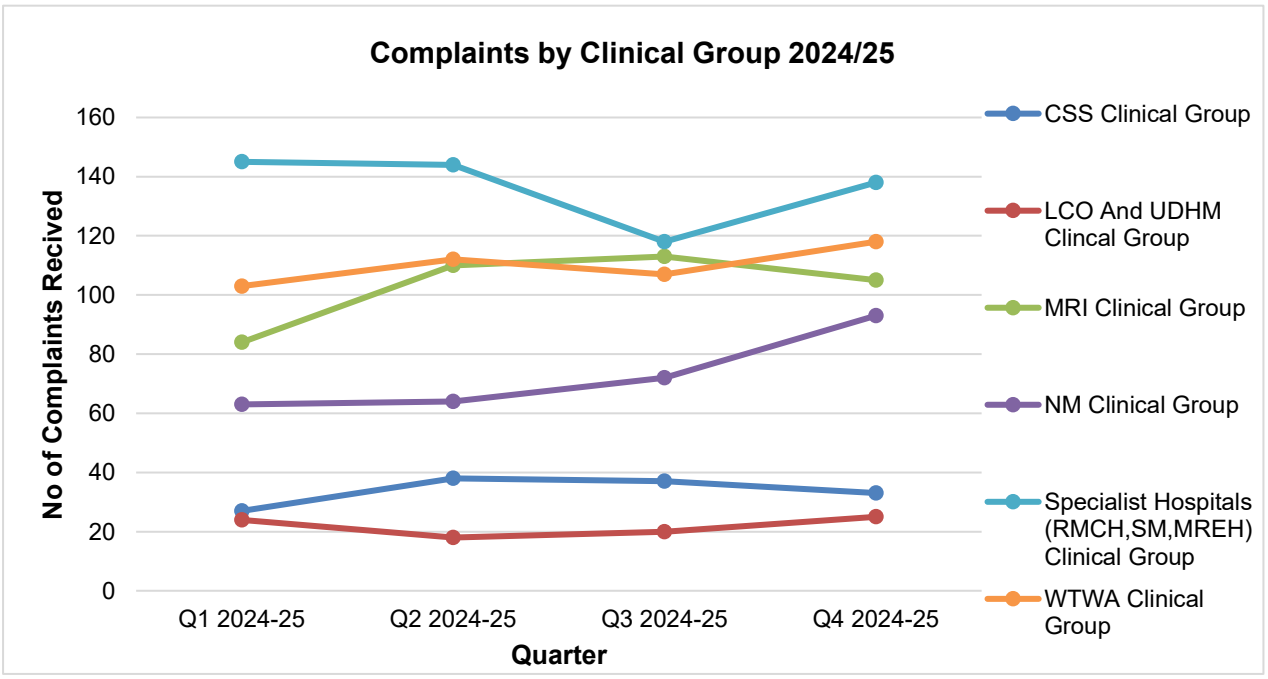
4.1 There was a 6% decrease in complaints received during 2024/25, with 1,975 new complaints received compared to the 2,107 received during 2023/24. **Graph 4** shows the number of complaints received per month.



Graph 4: Complaints Received by Month

4.2 The reduction in complaints is very positive as it is mainly driven by a decrease in concerns related to 'Appointment Delays/Cancellations', which correlates with the work that has been done as part of the Trust's updated Elective Access Policy.

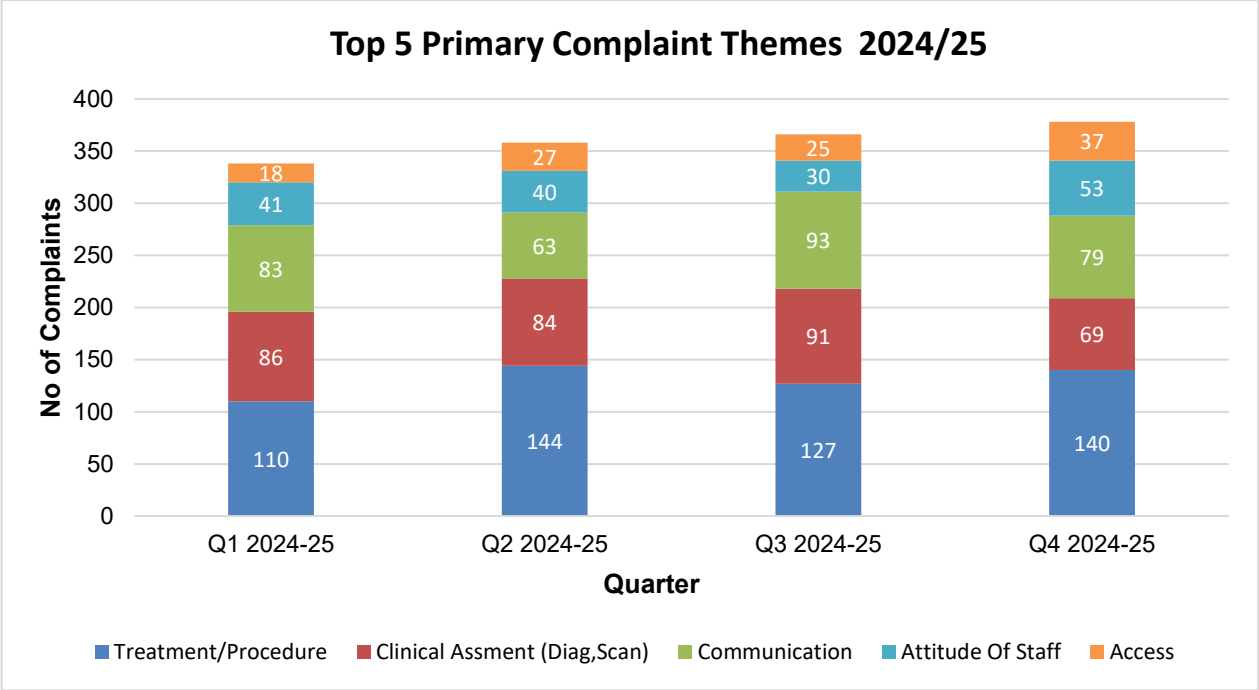
4.3 **Graph 5** shows the number of complaints received by each Clinical Group. The Specialist Services Clinical Group received the greatest number of complaints (545), followed by WTWA Clinical Group (440).



Graph 5: New Complaints Received by Clinical Group 2024/25

4.4 'Treatment/Procedure' was the top theme of complaints in 2024/25, followed by 'Clinical Assessment (Diagnostics/Scans)' and 'Communication'. **Graph 6** shows that these were consistently the top three complaint themes, throughout the year at MFT and noting the alignment with the top three national complaint categories.

4.5 As noted above, there has been a marked reduction in complaints relating to 'Appointments Delays/Cancellations', with that theme no longer being in the top 5 for MFT. There was an increase in the number of complaints related to 'Attitude of Staff'. To support this, the Trust is encouraging colleagues to attend the Civility Saves Lives training and the 'Sage and Thyme' customer service and communication skills training sessions. PALS and Complaints Management are also collaborating with the Corporate Lead Nurses for Workforce, to deliver PALS and customer service training at NMAHP leadership and development days and at ward and departmental level. This training focuses on compassionate engagement with patients and families, as well as de-escalation of challenging situations. Further training and engagement work is planned, throughout 2025/26, with a focus on supporting clinical and administrative staff in this area.



Graph 6: Top Primary Complaint Themes 2024/25

4.6 As a measure of performance, the number of complaints should be considered in the context of organisational activity. **Table 3** below shows the number of complaints in the context of Inpatients, Outpatients and Emergency Department attendances for 2024/25 compared to previous years.

4.7 The Trust has seen a decrease in complaints across both inpatient and outpatient services, and its Emergency (ED) Departments. This is despite the number of inpatient episodes and ED attendances increasing.

		2021/22	2022/23	2023/24	2024/25
Inpatient	Formal Complaints Received (FC)	531	624	632	**623**
	Episodes of Care	455,841	450,081	415,093	**438,949**
	Rate of FCs per 1000 Episodes of Care	1.16	1.39	1.52	**1.42**
Outpatient	Formal Complaints Received (FC)	665	919	1062	**861**
	Number of Appointments	1,470,442	1,854,418	2,644,348	**2,316,684**

	Rate of FCs per 1000 Appointments	0.45	0.50	0.40	**0.37**
ED	Formal Complaints Received (FC)	270	314	315	**311**
	Number of Attendances	482,908	483,880	515,260	**524,396**
	Rate of FCs per 1000 attendances	0.55	0.65	0.61	**0.59**

Table 3: Number of complaints received by patient activity 2021/22 – 2024/25

5. Complaint responsiveness and key performance indicators (KPI)

5.1 Under the NHS Complaints Regulations (2009), there is a requirement that all new complaints are acknowledged within three working days of receipt of the complaint; MFT is committed to achieving this in 100% of cases. This indicator was met during 2024/25, with all complaints acknowledged on time.

5.2 Against the Trust's standard of 90%, the Trust achieved closure of 89% of complaints within the agreed timescale during 2024/25. A number of changes were embedded during Q1 and sustained improvement has been achieved throughout the rest of the year, as seen in **Table 4**. The aim is to continue to see an increase in compliance with further improvements being achieved throughout 2025/26.

	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
Total resolved	500	482	474	491
Total resolved in timescale	403	431	431	458
% resolved in agreed timescale	**81%**	**89 %**	**91%**	**93%**

Table 4: Number and percentage of complaints resolved by timeframe 2024/25

5.3 **Table 5** details the breakdown of complaints closed within the agreed timescale by Clinical Group. Good and sustained improvement has been achieved in MRI. To address the lower compliance achieved within Specialist Hospitals Clinical Group, the Clinical Governance Teams are providing additional bespoke support to the Divisions of Paediatric Surgery and Gynaecology, with escalations to the Clinical Group Senior Leadership Team (SLT) including additional KPI meetings with areas as required. Further work in the coming months will focus on early interventions and escalation where any challenges are anticipated.

	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
CSS	97%	100%	100%	97%
LCO and UDHM	88%	96%	96%	100%
MRI	66%	83%	97%	96%
NM	98%	97%	95%	97%
Specialist Hospitals	62%	80%	74%	81%
WTWA	100%	100%	100%	99%

Table 5: Comparison of complaints resolved by timeframe by Clinical Group 2024/25

6. Complaint outcomes

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

6.2 During 2024/25, 23% (452) of complaints were 'upheld', 55% (1071) were 'partially upheld' and 22% (424) were 'not upheld'. This represents a large increase in the number of complaints 'upheld', from the previous year (12% in 2023/24).

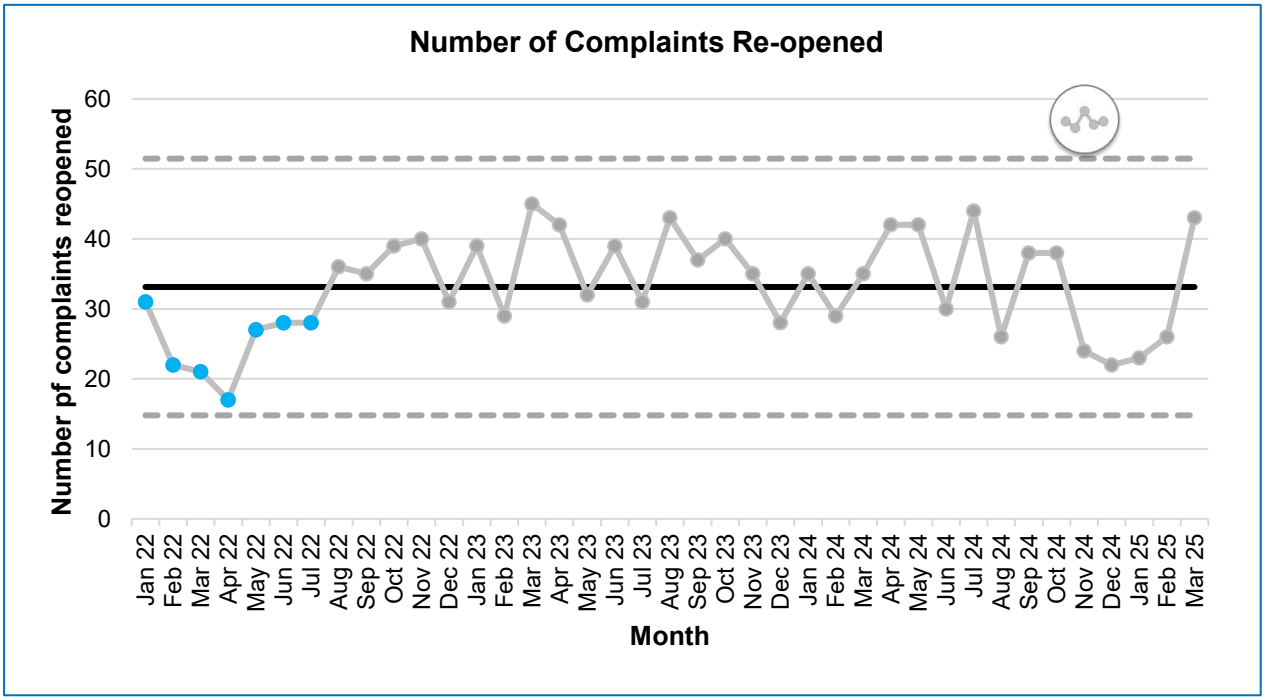
7. Re-opened Complaints

7.1 **Graph 7** demonstrates the number of complaints which were re-opened (which currently includes the request for a meeting). The number of re-opened complaints is used as an indicator to measure the quality of the initial response.

7.2 During 2024/25, 17% of complaints were reopened, against the Trust tolerance threshold of 20%, which is the same proportion as the previous year. The main reason for complaints being re-opened, however, was due to new questions being raised which is not a direct reflection on the quality of the initial response. This marks a positive change from 2023/24, when the majority of complaints were re-opened due to the response letter not addressing all issues raised. Further focus will be applied to this area in the coming year.

7.3 Improvements have been supported through the complaint investigation and response writing training sessions, delivered by the Complaints Team management to hundreds of staff across the Trust. These sessions aim to equip staff, who investigate complaints, with the skills and knowledge required to conduct thorough investigations and write clear and easy to understand complaint responses in a compassionate manner, to ensure complaints are resolved first time.

7.4 There is a continued drive to offer more local resolution meetings when complaints are first received. These meetings enable staff to meet with patients, relatives and carers, to hear and discuss their concerns offer apologies and share the findings and learnings from the investigations either in person or virtually.



Graph 7: Number of Re-opened Complaints

8. Lessons learned from complaints

8.1 Patient complaints offer opportunities for both learning and improvement that can be used to change practice and improve patient experience and outcomes. Each Clinical Group holds regular forums where themes and trends relating to complaints are discussed with focused actions agreed for improvement. In addition to this, the Complaints Review Scrutiny Group (CRSG), chaired by the Assistant Chief Nurse, Quality and Patient Experience and supported by a nominated Non-Executive Director and Governor, met on 12 occasions during 2024/25 reviewing 20 complaints in total. The extract below * provides examples of learning from complaints and the changes applied to practice.

8.2 The terms of reference for CRSG have been refreshed and strengthened, in collaboration with the Chief Nursing Officer and Non-Executive Director, to refocus the purpose of the meeting to increase learning from complaints across MFT and to provide more senior leadership scrutiny. During 2025/26 CRSG will include representation from members of the Clinical Group SLTs. This will focus on the Clinical Group Complaints and PALS dashboards which scrutinise the number of complaints and PALS, compliance with response times, re-opened complaints and PHSO escalations and the quality of complaint responses with a focus on identifying organisational learning through the triangulation of complaints data and themes. The CRSG will be reviewed in six months, to assess effectiveness and share learning.

***Examples of Learning from Complaints**

You said…	We did…
Concerns regarding poor discharge process and patient discharged with another patient's medication.	Medical ward round in the morning to include specific instructions to prepare patients for discharge appropriately, including the removal of any invasive lines, and completing medical discharge notes. The senior nursing team in the clinical area utilised huddles and team meetings to engage staff in discussion in relation to the need for bed space cleaning and emptying of medicine boxes post discharge/transfer of patients. Quality improvement project to ensure a robust system is in place for patient transfer and discharge from the ward. Checklist produced to ensure all tasks are completed prior to transfer/discharge from the ward. Daily audits and spot check audits to ensure safe storage of medicines.
There was a delay on the day of discharge, due to waiting for take home medication	Pharmacist and coordinating nurse to ensure early escalation for TTO (medications to take out for discharge), to allow for adequate medication preparation time and to prevent discharging without TTOs. Discharge and medication process discussed at ward meetings and daily safety huddles, with ward staff and Pharmacist also in attendance. There is currently a Trustwide workstream looking at how systems and processes can be improved to facilitate safe and effective discharge home, including that of TTOs.

Staff were unsympathetic when a patient with disabilities attended their scheduled appointment but rescheduled due to illness, Staff also marked the patient as a “Did Not Attend”.	Refresher training on the Trust’s Access Policy, in particular about the appropriate coding of appointments, was arranged for all department administration staff. Staff were engaged in understanding the importance of supporting reasonable adjustments and respecting patient choice.
Concerns regarding end-of-life care, and lack of face-to-face palliative care provision.	The Palliative Care team, supported by the Head of Nursing for Palliative and End of Life Care, are delivering a programme of education to enhance the knowledge and skills of staff in delivering end-of-life care. This end-of-life care ‘champion’ programme began in September 2024 and will provide essential training in relation to end-of-life care and provide the necessary training materials for the champions to cascade information back in their clinical area. The department will complete a quality improvement programme to ensure that all staff are compliant with acute illness management training and the mandatory training acute care management module. All ward areas to identify a member of the team to become an End-of-Life Champion to share education and provide support to team members, patients and relatives. Topic of effective, caring, compassionate communication and clear and concise documentation shared with all members of the team through “Themes of the Week” programme delivered to staff at twice daily patient safety huddles and handovers. To reduce health inequalities the senior nursing team educated the staff in relation to providing patients with appropriate interpretation services to support informed decision making and discussion.
A patient’s nutrition and hydration needs were not met, whilst they were an inpatient on a ward.	The Ward Manager undertakes regular audits of the MUST (Malnutrition Universal Screening Tool) to ensure patients’ usual weight is captured to ensure the correct MUST score is calculated. The audit also ensures patients with a MUST score of 2 or more are referred to the Dietician. A Trustwide nutrition and hydration and food improvement group is in place to identify and implement improvements across the Trust and improve patient experience of care.
There was a complication from a Ferinject infusion.	A new patient information leaflet, on iron infusions, was co-produced in collaboration with the Maternity and Neonatal Voice Partnership, with all patients to receive a leaflet, prior to administration of Ferinject. Lead consultant has provided feedback to the Obstetric Team to ensure communication and information is provided to patients requiring Ferinject and confirmation of patient understanding is clearly documented at the point of consenting to the infusion.
Patient pain management and onward referrals were not managed effectively.	Department to ensure that patients’ referral to treatment time (RTT) pathway is not stopped, when they are referred to the pain team for optimisation, to prevent any delays to their surgery date. Direct instructions, with regards to additional pain

	management, to be clearly provided in clinic outcome letters to GPs.
A patient had to wait for four hours for a neck strap whilst in triage and had to lay down on the bed.	A review was commissioned of the training needs for all Paediatric Emergency Department nursing staff, in relation to triage. Additional triage audits have been undertaken, and one-to-one educational support has been provided, as required.
There was a delay in treatment for a patient experiencing urinary retention, due to the lack of bladder scanners.	12 new bladder scanners have been purchased and there is a supporting training programme to ensure that staff are competent and able to use the new machines.
There were long waits for results from colonoscopies.	The Histopathology Department is recruiting to vacancies within the Consultant Histopathologist Team to support a reduction in the number of cases that need to be sent to external services. This feedback provided an opportunity to review current cover arrangements between teams and work together to overcome challenges to service delivery. As a result of this an office staff contingency plan between the two Histopathology offices has been created. This will allow the department to utilise the wider administrative and clerical staffing to support when one office experiences staff shortages. This resilience plan will ensure timely upload of externally reported cases and prevent the delays experienced.
Care plans were stored in more than one location and were not accurately shared with the patient's school.	A Standard Operating Procedure has been developed, so that all members of the team can follow the correct process, including communication to parents. The process of storing care plans on shared drives will be stopped and all information contained in the shared drives will be reviewed. An audit will then take place, to ensure this is maintained. Care plans and training needs were added as a standing item for team meetings to ensure that all staff are aware of the correct processes and individual training needs identified for staff have been addressed, with all staff now aware of the correct processes
There was a lack of information provided regarding eligibility for IVF funding.	A fertility information leaflet is to be given to patients attending their initial investigations, which will include a link to the Greater Manchester Integrated Care Board (ICB) Assisted Conception Policy.

9. Parliamentary Health Service Ombudsman (PHSO)

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

9.2 During 2024/25, the PHSO opened new investigations into 15 MFT complaints. The PHSO informed the Trust of 10 completed investigations into MFT complaints, of which 1 was 'upheld', 7 were 'partially upheld', 2 were 'not upheld'.

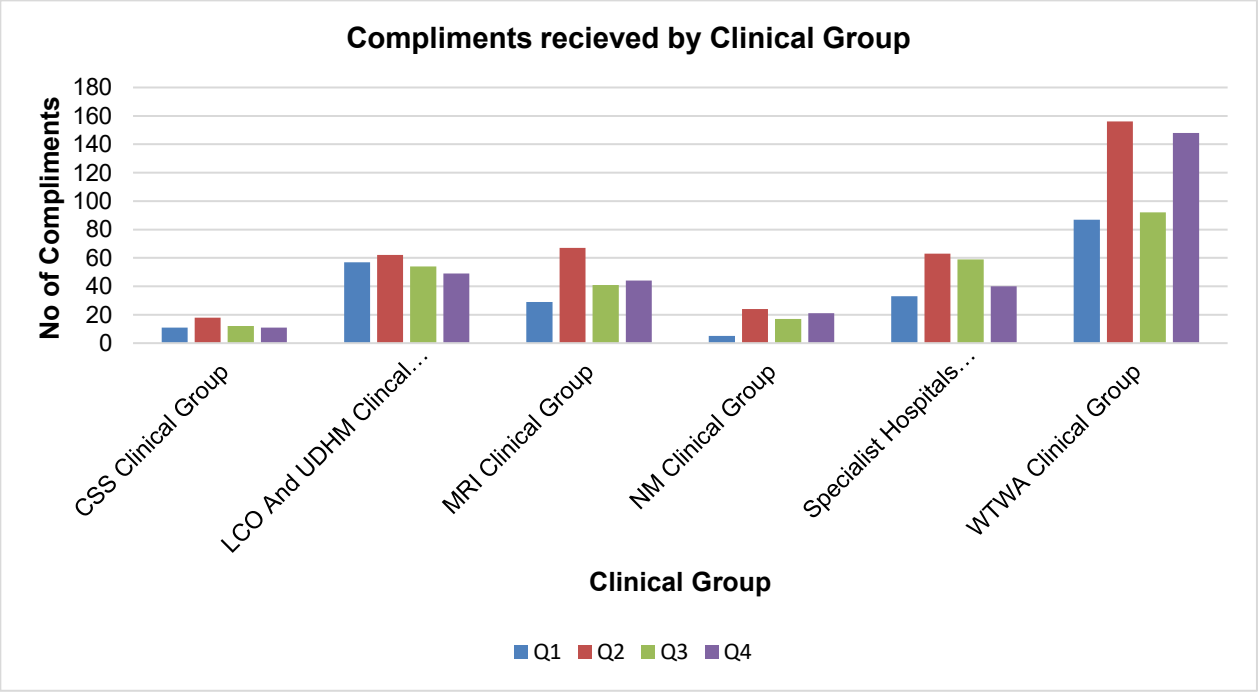
9.3 In addition to the completed investigations, the Trust successfully liaised with the PHSO and patients/families to resolve cases through early resolution and the PHSO determined that no further investigations were required for many of the cases it initially reviewed, as it was assured that MFT had handled the complaints appropriately in line with the regulations and standards.

10. Compliments

10.1 Compliments received from members of the public provide valuable feedback and the opportunity to learn from positive experiences. The Customer Services Manager and Patient Experience Manager review compliments, alongside positive patient experience feedback, and are making improvements to how compliments are recorded. This will enable thematic analysis of positive feedback, which will provide greater opportunities to identify wider learning from good practice to drive Trustwide quality improvement initiatives.

10.2 **Graph 9** shows the number of compliments, received from members of the public about MFT Clinical Groups, recorded on the Trust's Customer Services Database during 2024/25. WTWA Clinical Group recorded the most compliments (483).

10.3 To make it easier for people to share compliments and positive experiences with staff, the Customer Services Manager has worked with the Communications Team to develop an online compliments form, which will enable people to submit compliments directly through the MFT website.



Graph 8: MFT compliments received by Clinical Group 2024/25

11. Equality and Diversity Monitoring Information

11.1 The Trust is committed to collecting data from complaints relating to Equality Diversity and Inclusion (EDI) to ensure all patients and representatives are supported and have equal access to providing feedback on services, which is shown in the table in **Appendix 1**. Fundamental to this is the provision of an accessible PALS and Complaints service.

11.2 The PALS and Complaints Department made 'Health Inequalities' the theme of their Customer Service Week, in 2024. This focussed on improving access to provide feedback for people with disabilities or in different languages. PALS are also exploring options to increase the ways children and young people can raise concerns about their own care and experience.

11.3 PALS and Complaints colleagues have worked with patient, families and carers through established Trust groups and focus group sessions in the community, to coproduce new PALS and Complaints posters and leaflets. The new literature is available in different and more accessible formats, as well as multiple languages, and is being distributed to all wards, departments and services across the Trust.

11.4 A new British Sign Language (BSL) PALS information video has also been developed, which will be played on patient-facing screens in MFT hospitals and will be available on the MFT website. In addition to this, PALS and Complaints colleagues work closely with the Interpretation and Translation Service (ITS), to ensure that interpreters are available to support patients, relatives and carers, to raise concerns in languages other than English.

12. Conclusion and recommendations

12.1 In October 2024, KPMG, an audit and professional services company, shared the outcome of its internal audit of MFT's Complaints Handling. KPMG found there was significant assurance with minor improvement opportunities. KPMG was assured by the appropriately designed controls in place for complaints handling at the Trust, including adherence to national regulations and PHSO standards and the utilisation of KPIs and monitoring tools to achieve high compliance with response timescales.

12.2 The recommendations from the audit have been fully implemented, which include an updated MFT Complaints, Concerns and Compliments Policy and MFT complaints framework, to standardise the process of managing complaints across the Trust and to embed a culture of learning from complaints and seek continuous improvement

12.3 The Board of Directors is asked to note the content of this 2024/25 Complaints Report and the ongoing work of the Corporate and Clinical teams, to ensure that MFT is responsive to concerns and complaints raised and learns from patient feedback to seek continuous improvement.

12.4 The Board of Directors is asked to support a proposal to receive reports relating to complaints handling and performance on a six-monthly basis.

12.5 The Board of Directors is asked to note that, in line with the MFT Management of Change, the Complaints and PALS teams will move to the leadership of the Director of Clinical Governance in September 2025.

Appendix 1

Complaints Equality Diversity and Inclusion Monitoring Data 2024/25

	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	2024/25
Disability					
Yes	50	57	54	61	222
No	65	66	57	82	270
Chose Not To Disclose	354	382	368	379	1483
Total	**469**	**505**	**479**	**522**	**1975**
Disability Type					
Learning Disability	0	2	3	3	8

Long-Standing Illness Or Health Condition	16	14	16	18	64
Mental Health Condition	6	7	4	10	27
Other - Please State In Details Box	2	2	3	2	9
Physical Disability	11	15	7	11	44
Sensory Impairment	3	3	6	4	16
Chose Not To Disclose	426	454	430	465	1775
Autism	5	8	10	9	32
Total	**469**	**505**	**479**	**522**	**1975**
Gender					
Man (Inc Trans Man)	189	196	189	212	786
Woman (Inc Trans Woman)	272	308	282	299	1161
Non Binary	0	0	0	0	0
Other Gender	1	1	0	3	5
Chose Not To Disclose	7	0	8	8	23
Total	**469**	**505**	**479**	**522**	**1975**
Sexual Orientation					
Chose Not To Disclose	363	398	380	411	1552
Bisexual	0	0	4	3	7
Gay Or Lesbian	4	7	6	6	23
Heterosexual Or Straight	95	96	88	96	375
Not Known	6	4	1	6	17
Something Else	1	0	0	0	1
Total	**469**	**505**	**479**	**522**	**1975**
Religion/Belief					
Christian: Church Of England	35	45	35	33	148
Christian: Roman Catholic	27	14	11	18	70
Christianity (All Denominations)	1	2	1	1	5
Christian: Free Church	1	2	1	0	4
Christian: Orthodox	1	1	0	1	3
Islam	13	12	16	21	62
Judaism	0	1	2	3	6
None	31	35	31	46	143
Other	1	4	0	3	8
Prefer Not To Answer	10	8	4	12	34
Chose Not To Disclose	346	376	372	379	1473
Paganism	0	0	1	0	1
Buddhism	0	0	0	1	1
Hinduism	0	2	2	0	4
Humanism	1	0	0	0	1
Atheism	2	3	3	4	12
Total	**469**	**505**	**479**	**522**	**1975**
Ethnic Group					
Asian Or Asian British - Bangladeshi	0	0	0	3	3

Asian Or Asian British - Indian	2	10	8	8	28
Asian Or Asian British - Other Asian	6	3	2	5	16
Asian Or Asian British - Pakistani	16	14	23	14	67
Black Or Black British - Black African	4	6	5	11	26
Black Or Black British - Black Caribbean	5	6	4	4	19
Black Or Black British - Other Black	5	4	2	5	16
Chinese Or Other Ethnic Group - Chinese	1	0	3	3	7
Mixed - Other Mixed	4	4	3	6	17
Not Stated	119	139	143	142	543
Other Ethnic Category - Other Ethnic	3	5	4	10	22
White - British	208	210	182	196	796
White - Irish	4	1	6	5	16
White - Other White	10	7	6	8	31
Chose Not To Disclose	73	86	76	91	326
Prefer Not To Answer	2	4	2	6	14
Mixed - White And Asian	1	0	3	4	8
Mixed - White And Black African	2	3	4	0	9
Mixed - White And Black Caribbean	4	3	3	1	11
Total	**469**	**505**	**479**	**522**	**1975**

Strategic objectives (Key)

Work with partners to help people live **longer, healthier lives**	**LHL objective 1**	Work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.
	LHL objective 2	Improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so people are cared for in the most appropriate place
Provide **high quality, safe care** with excellent outcomes and experience	**HQSC objective 1**	Provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience and outcomes wherever they are seen.
	HQSC objective 2	Strengthen our specialised services and support the adoption of genomics and precision medicine
	HQSC objective 3	Continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.
Be the place where **people enjoy working**, learning and building a career	**PEW objective 1**	Make sure that all our colleagues feel valued and supported by listening well and responding to their feedback. We will improve staff experience by embracing diversity and fairness, helping everyone to reach their potential
	PEW objective 2	Offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here
Ensure **value for our patients** and communities by making best use of our resources	**VfP objective 1**	Achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.
	VfP – objective 2	Deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships
Deliver world-class **research & innovation** that improves people's lives	**R&I – objective 1**	Strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part
	R&I – objective 2	Apply research & innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide
Good governance	**GG**	Deliver a safe, legally compliant and well run organisation