

## Complaints and PALS Annual Report

### Public Board

31 July 2025

<b>Presented for:</b>	Assurance and Information
<b>Presented by:</b>	Rabina Tindale, Chief Nurse
<b>Author:</b>	Jo Corrigan, Lead Nurse Patient Experience Rosie Horsman, Lead Nurse Patient Experience
<b>Previous Committees:</b>	Quality Assurance Committee, 19 June 2025 & Patient Experience and Engagement Group (PEEG) 22 May 2025

Our Annual Commitments for 2025/26 are:	
Recognise and act upon moments that matter to our patients	✓
Support our patients to get home a day sooner	✓
Be in the top 25% for patient experience and efficiency in outpatients	✓
Support each other to act with kindness and compassion	✓
Reduce our carbon footprint by creating greener patient pathways	
Support our staff to manage every £ wisely	
Make best use of our estate, equipment and digital assets	✓

Risk Appetite Framework				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk				
Operational Risk				
Clinical Risk	✓	Patient Experience Risk - We will comply with or exceed minimum patient experience targets.	Minimal	Moving Towards
Financial Risk				
External Risk	✓	Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	Moving Towards

Key points	
Performance against local timeliness targets remains below the 80% standard that has been agreed.	Information
A complaints action plan has been developed to address complaint timeliness through to the end of 2025.	Information
A PALS action plan is in development to support delivery of improvements in the PALS process.	Information
The Complaints Policy has been reviewed and updated.	Information
The top 80% of all subjects raised continue to relate to communication, treatment, staff interaction, administration, access, admission, discharge, transfer and patient care and nutrition	Information
An internal audit that reported in June 2025 highlighted significant improvements in the Trust complaints process and complaints policy. The Audit Committee asked that this be brought to the attention of the Board.	Assurance

## 1. SUMMARY

This report provides an annual update summarising Trust activity and performance in relation to complaints and PALS during the year. Data for 2023/24 and associated improvement work was reported in the Complaints and PALS paper received at Trust Board in July 2024.

A new complaints action plan 2024-2025 has been developed with a focus on addressing complaint timeliness. This can be seen in **Appendix 1**. A PALS action plan is in development. A draft of this plan was shared at the Patient Experience and Engagement Group (PEEG) in April 2025.

## 2. BACKGROUND

The Trust received 676 complaints between 1 April 2024 and 31 March 2025, this was an increase of 93 (16%) from the 583 received in 2023/24. Of these 676 complaints, 363 (54%) involved one Clinical Service Unit (CSU), 199 (29%) involved more than one CSU and 114 (17%) involved external organisations (Mixed sector)

**Table 1** below, shows the number of complaints received each financial year from 2021/22 to 2024/25 by the complaint type (Single, Multi CSU or Mixed Sector). The percentage after each value indicates the proportion of each year's complaint type. There was a 9 percentage-point increase in single CSU complaints from 2024/25 compared to the previous year. 15 out of 27 CSUs saw an increase in their complaints last year compared

to the previous year. The following summary outlines the total number of complaints received in 2024/25 by each Clinical Service Unit (CSU) which experience an increase, regardless of whether the CSU was the lead or provided supporting input. Each total is accompanied by the numerical difference from the previous year (2023/24), as well as the percentage change.

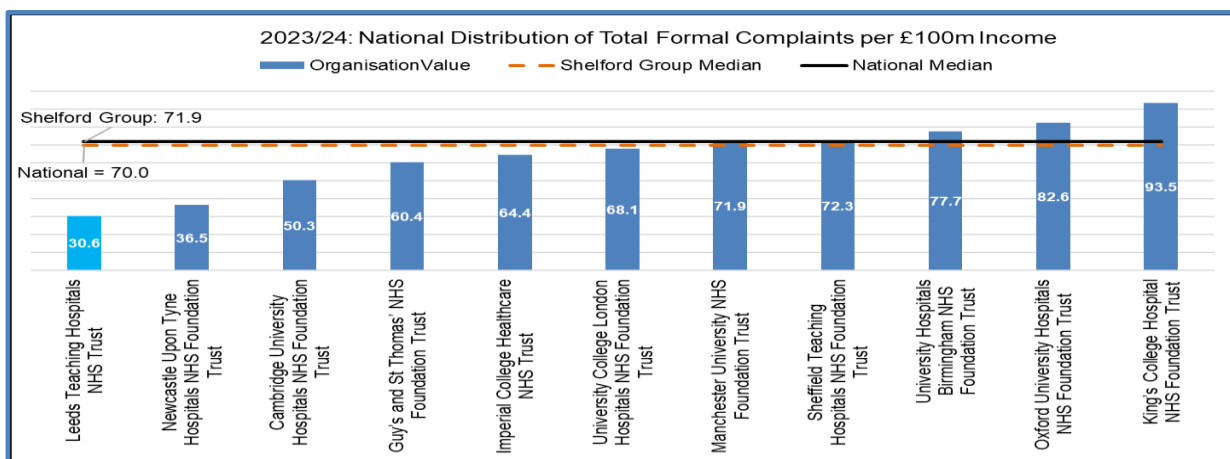
- In 2024/25, the Women's CSU received 89 complaints, an increase of 34 from the previous year (+61.8%).
- Abdominal Medicine & Surgery recorded 141 complaints, up by 27 (+23.7%).
- Specialty & Integrated Medicine saw 81 complaints, an increase of 25 (+44.6%).
- Head & Neck CSU had 33 complaints, which is 17 more than the previous year (+106.3%).
- Children's CSU received 66 complaints, an increase of 17 (+34.7%).
- Oncology had 76 complaints, 16 more than in 2023/24 (+26.7%).
- Radiology (including Medical Illustration) recorded 44 complaints, which is 13 more than the previous year (+41.9%).
- The Chief Nurse CSU saw an increase of 6 complaints, reaching a total of 35 (+20.7%).
- Adult Therapies reported 37 complaints, 4 more than the previous year (+12.1%).
- Urgent Care CSU received 125 complaints, an increase of 4 (+3.3%).
- Medicines Management & Pharmacy Services saw 11 complaints, up by 3 (+37.5%).
- Pathology recorded 15 complaints, 3 more than in 2023/24 (+25.0%).
- Estates & Facilities had 20 complaints, an increase of 2 (+11.1%).
- Outpatients received 7 complaints, up by 2 from the previous year (+40.0%).
- Medical Directorate recorded 5 complaints, an increase of 1 (+25.0%).

**Table 1 – Complaints Received by Year and Type**

Complaint Type	2021/22	2022/23	2023/24	2024/25
Single CSU	301 (51%)	356 (54%)	262 (45%)	363 (54%)
Multi CSU	179 (30%)	188 (28%)	204 (35%)	199 (29%)
Mixed Sector	115 (19%)	119 (18%)	117 (20%)	114 (17%)
<b>Total</b>	<b>595</b>	<b>663</b>	<b>583</b>	<b>676</b>

**Chart 1** below, shows the distribution of the total number of formal complaints (2023/24) per £100m income for LTHT and peer Trusts within the Shelford Group. LTHT received 30.6 complaints per £100m income compared to the national median of 70 and the peer group median of 71.9. LTHT was in the lowest 25% of all Trusts nationally. This data is reported by the Trust to NHS England annually for corporate benchmarking purposes, and data for 2024/25 will not be published until later in 2025/26.

**Chart 1: Distribution of Formal Complaints per £100m Income in 2023/24 – LTHT, National Provider Median and Shelford Group**



### 3. COMPLAINTS UPDATE

#### 3.1 Complaints Improvement Programme

The Chief Nurse commissioned a new Complaints Improvement Programme (CIP) in July 2024 to drive improved timeliness. This commenced with a two-day Kaizen Event in early November 2024, with a focus on testing improvement initiatives, for both the corporate complaints processes and Neurosciences CSU. A second event was held with Urgent Care CSU in March 2025 to continue to test the agreed initiatives and identify further improvement areas to focus on. It was noted that discussions with these CSUs identified differences in areas requiring improvements and that a generic approach was not always an appropriate option. Key focus areas arising from the events were:

- To improve ways of more accurately capturing complainants' questions and desired outcomes on first contact with the complaints team. The complaints team will provide complainants an opportunity to review and agree their concerns for confirmation of accuracy prior to being sent to the CSU and the complaint clock starting.
- Facilitating better understanding of the complaints process to support medical staff to achieve timely input to complaint resolution letters or meetings.
- To review the handling of PALS concerns and examine if more could be handled on entry, by the PALS team, without involving CSUs.
- Increasing PALS and complaints teams' knowledge of service locations and pathways to ensure concerns get to the correct person more quickly.
- Providing opportunity for de-escalation of formal complaints by offering a discussion with a senior member of the clinical team when the complaint is received.
- QA review - testing of 5 complaint responses by UC DCN for clarity and quality prior to being sent to external QA.
- Use of generic scripts for PALS team to refer to when concerns received regarding ED/Wait times.

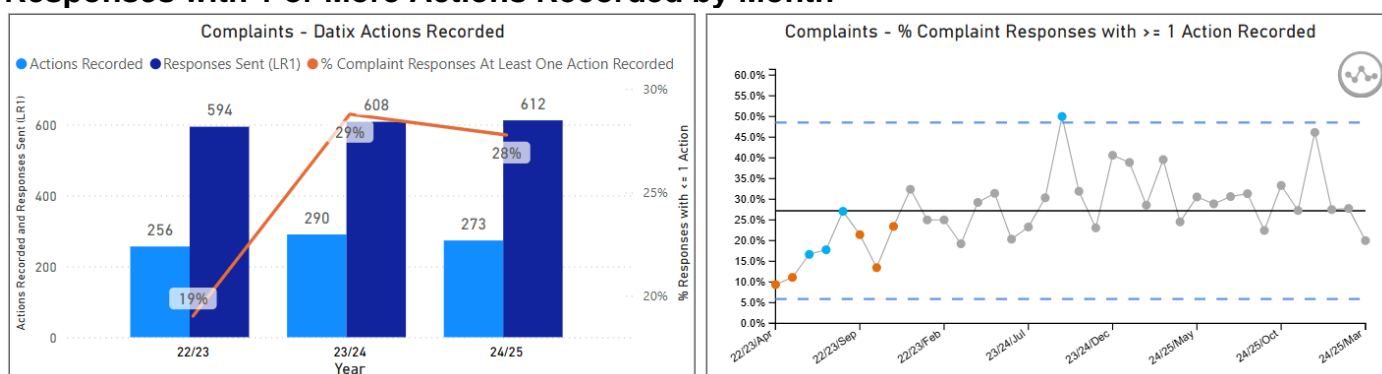
A sharing event was held on 19 May 2025, with representation from CSUs, facilitated by the KPO team. Neurosciences and Urgent Care CSUs presented their improvement work and described how it had impacted on their complaint timeliness and quality of responses. The complaints and PALS team provided an update on the work they are separately progressing to support CSUs and the maternity team shared their reflections of their complaint processes, following conversations with NHSE and feedback from families. The event was very well received, with CSU HoNs requesting complaints sharing events are introduced into Trust business six-monthly.

### 3.1.1 Recording Actions Arising from Complaints

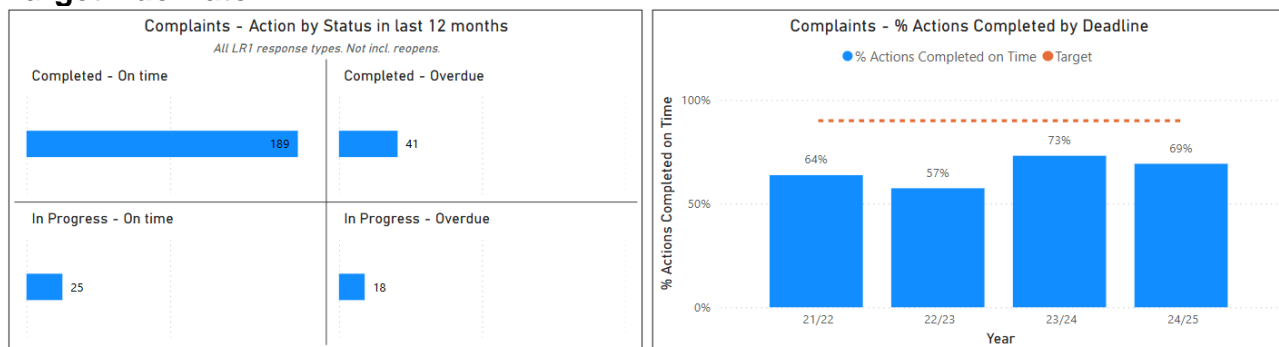
A continued objective of working with CSUs is to improve the recording of actions taken in response to complaints. This is to provide assurance that complaints result in positive action and to share learning, and to continue to support the analysis of themes from the recorded actions, to drive changes and improvement initiatives across the Trust.

In 2024/25 there have been 273 actions arising from complaints recorded. **Charts 2 and 3** below shows the number of actions recorded, the number of responses sent and the percentage of responses with one or more actions recorded for the past three financial years. In the last financial year 28% of responses had one or more actions recorded, this was a reduction of 1% from the previous year. Chart 3 shows normal variation where one or more actions have been recorded. This data demonstrates that not all complaints actions are captured in Datix by CSUs. The number of part upheld and upheld complaints exceeds the number of complaints with actions attached. Further work is needed to ensure all staff know how and why it is important to log actions. Support for improvements will be progressed through the Nursing, Midwifery and Allied Health Professionals Leadership Team (NMALT) meetings.

#### Charts 2 and 3: Actions Recorded by Financial Year and Percentage of Complaint Responses with 1 or More Actions Recorded by Month



## Charts 4 and 5: Actions by Completion Status and Percentage Completed Before Target Due Date



**Table 2** below shows the number of actions logged and responses sent by CSUs during the financial year 2024/25. The data demonstrates that Oncology, Adult Therapies, Trauma and Related Services, Cardio-Respiratory, Chapel Allerton and Urgent Care CSUs are capturing a high number of actions within Datix. The data does however identify that there is variability in compliance across CSUs and supports the need for continued education, and training and awareness raising across the Trust.

**Table 2: Actions Recorded and Responses Sent by CSU in 2024/25**

CSUs	Actions Recorded	Responses Sent (LR1)
Abdominal Medicine & Surgery	7	96
Urgent Care	52	68
Women's	2	68
Specialty & Integrated Medicine	2	61
Oncology	83	53
Centre for Neurosciences		46
Children's	12	44
Trauma & Related Services	43	40
Chapel Allerton Hospital	15	38
Head & Neck		26
Cardio-Respiratory	38	19
Radiology (inc. Medical Illustration)	6	12
Adult Critical Care		7
Adult Therapies	8	7
Leeds Dental Institute		6
Pathology		5
Theatres & Anaesthesia	3	4
Informatics		3
Outpatients	1	3
Finance		2
Chief Nurse	1	1
Corporate Operations		1
Medical Directorate		1
Medicines Management & Pharmacy Services		1
<b>Total</b>	<b>273</b>	<b>612</b>

The types of complaint actions recorded by CSUs in DATIX during 2024/25 are shown in **Table 3** below. (A full breakdown of actions by CSU can be found in **Appendix 2**.)

**Table 3: Action Types from 2024/25 Complaints**

Complaints Actions by Type	Actions
Amend Guideline	5
Buy new equipment	2
Create policy	2
Develop a guideline	7
Feedback to the individual	77
One-off training	8
Overhaul existing equipment	0
Perform risk assessment	0
Replace existing equipment	1
Set up committee	0
Set up ongoing training	4
Share at governance meeting	36
Standard Complaint Process	52
Undertake Audit	8
No Type Recorded	71
<b>Total</b>	<b>273</b>

A review of the actions recorded for 2024/25 has identified that CSU's have implemented changes in the following areas:

- Complaint learning and feedback from patients is being communicated at CSU departmental, governance and quality meetings, including sessions on lessons learnt from complaints, safety huddles and via quality slides for wider dissemination.
- Additional actions show a focus on ensuring this learning is embedded into local Quality Assurance Group (QAG) meetings, and team-based reflective learning sessions, including the circulation of complaint responses to facilitate team learning.
- Actions detail the development of new protocols and materials to support staff to follow correct procedures. Some examples of actions highlighted were, protocols relating to cannula care; capacity assessments; endoscopy, gastrostomy; medication administration; and standardisation of communication for urgent radiology findings in ED; The development and implementation of standard operating procedure (SOPs), for example for the dietetic outpatient area and the discharge processes were also included. Additional examples in Q3 and Q4 included SOPs introduced for documenting telephone consultations and guidance for recording discussions about discharge planning.
- Ensuring discharge letters, test results, and care episode outcomes are communicated to patients and GPs in a timely manner. Updates to patient information materials, including leaflets for services like intravenous (IV) iron replacement and Same Day Emergency Care (SDEC). Communication reinforcing reminder systems for timely discharge was circulated. Additional actions show updates to guidance leaflets to ensure clarity on service expectations, and improved processes for capturing patient preferences during booking and follow-up.



- Organised training sessions on communication, breaking bad news, managing deteriorating patients and ensuring best practices are followed. Staff are reminded regularly through emails, safety huddles and quality forums of key issues like administering time-critical medications and documenting patient concerns accurately. New examples include training on handling telephone communication, documentation expectations following virtual consultations and further focus on refresher training for specialty-specific procedures such as dietetic and radiology handovers.
- Actions focused on improving patient experience during times of service pressures. This included: ensuring accurate measurements for weight and height are manually confirmed; raised awareness of issues such as medication availability and communication with families following a death. Additional examples include actions to improve the clarity of clinical responsibility in the Emergency Department (ED) and clearer pathways for managing deteriorating patients out of hours.
- Regular audits of compliance with procedures such as contacting patients, distributing test results, and managing endoscopy booklets. Implementation of process flows and checklists for managing patient property, improving appointment scheduling, and enhancing overall administrative workflows. Furthermore, recent actions highlighted improved triage processes in outpatient clinics, uploading of guidance documents for administrative teams and the creation of 'welcome' packs to improve patient familiarisation in emergency areas.
- Identifying discrepancies in policies such as valuables and care after death documents. Regular reviews of governance processes related to patient complaints, medical errors, and audit findings.
- Many actions were tracked and shared in CSU Quality Governance Forums for review following implementation and learning.
- Further actions included documenting how complaints are addressed at governance meetings and the role of feedback loops to confirm learning is embedded.

In September 2024 pre-existing Datix incident codes were added to the complaint action form on Datix. This field is now mandatory when recording a complaint action. This data will be included in the monthly complaints and PALS data report from June 2025, and will also be included in the CSU PEEG data packs, which will continue to be reviewed over the next 12 months to determine the most frequently logged action type.

The complaints team have undertaken a focused piece of work to highlight the most frequently raised action type, and to identify the learning from this dataset, which will be shared across the Trust and presented biannually to the Quality Improvement Steering Group (QISG) for dissemination and to identify and support improvements in care.

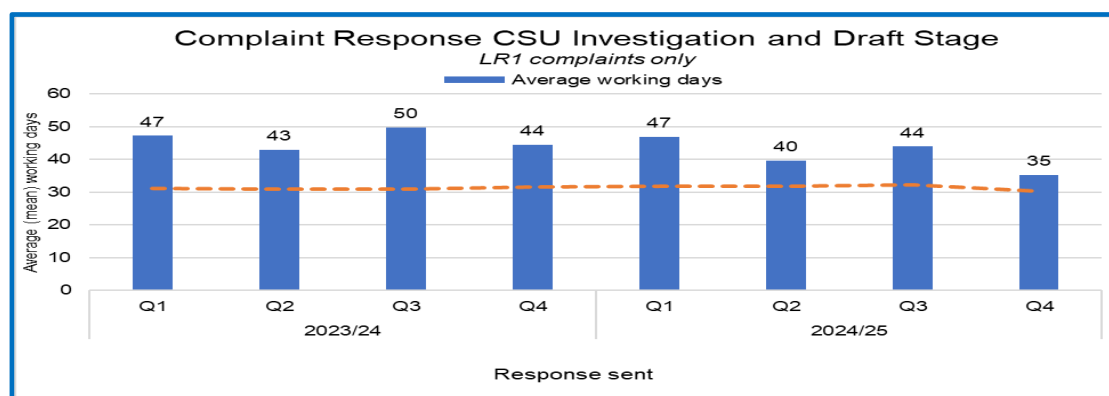
### **3.1.2 Complaint Response Times – Actions Taken to Improve Performance.**

The complaints improvement programme has the objective of identifying ways to positively impact complaint response timeliness. Agreed actions aim to improve the experience of patients and their families and to drive improvement in meeting the locally agreed standards for complaint response times (20, 40 and 60 working days). Performance against local targets has remained below the 80% target during 2024/25. Data shows that



the stage of the complaints pathway which consistently breaches target time is **Investigation and Draft Response Time**. The responsibility for both process steps sits with CSUs. Chart 2 below shows the average time taken for CSUs to complete this process for all target response times, (20,40,60 days) compared to the average of CSU internal target times (12, 27 and 45 working days). This data shows the average time taken for CSU to complete the investigation and draft response over 2024/25 was 42 working days.

**Chart 6: CSU Completion of Process Section, Against Average Internal Target Times**

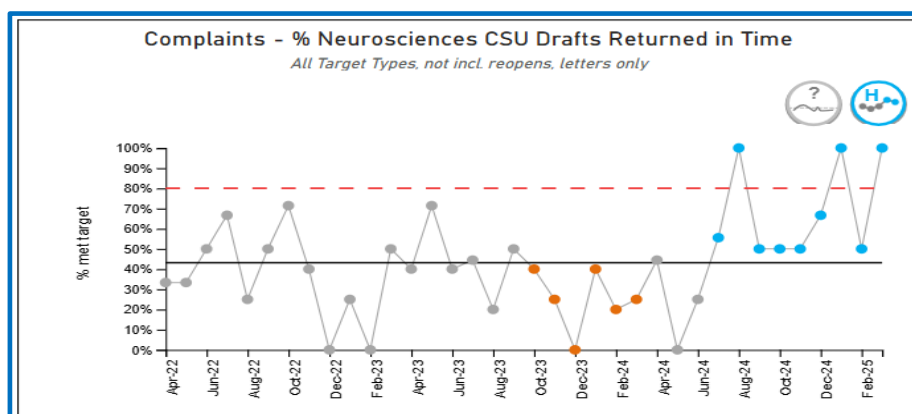
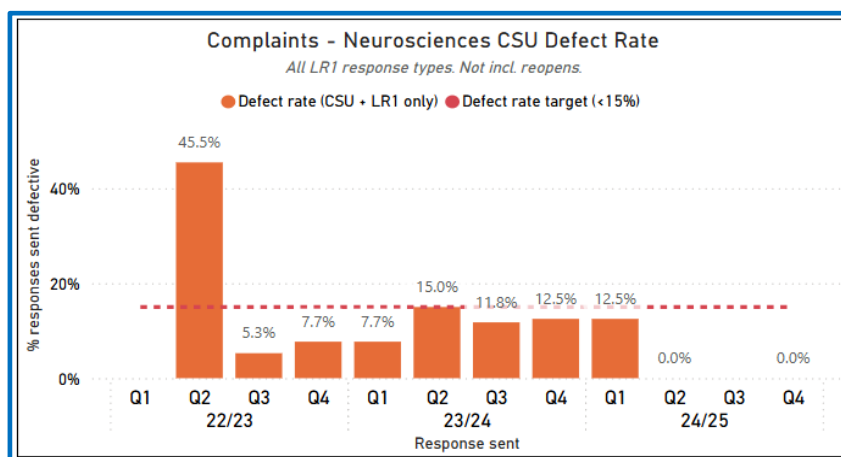


One action, implemented to drive improvements in performance, was tested because of the Kaizen event in November 2024, with the Neurosciences CSU. This saw a change to the internal complaints team processes, where an additional step at the start of the process was introduced. A dedicated complaint handler reviewed the CSU complaints on entry and arranged a telephone call to discuss the concerns in more detail with the complainant, resulting in a comprehensive documented account of their complaint. This documented account was then sent to the complainant by e-mail, for confirmation of accuracy prior to being passed to the CSU for investigation. Monitoring of the timescale for response was then initiated at the point the complaint was passed from there to the CSU. Data from the Target Progress Report at the 90-day mark indicated that this change had been positive, whilst acknowledging that as a result of the small complaint numbers involved and short timeframe of the test, assessment of the full impact of the change will need time for data to fully mature.

At the 90-day report out, data showed the CSU lead time reduced by 16 working days from a baseline of 35 to 19 working days for 40 working day complaints. Lead time did increase by 1 working day from a baseline of 34 working days to 35 working days for 60 working day complaints, however this was a reduction on the 30 and 60-day lead time (both 52 working days). The percentage of reopened complaints due to defect reason/s reduced by 7% to 0%, indicating no defective responses had been sent during the reporting period. In addition, a new measure was developed to track the quality of the CSU's PALS resolutions, this tracked the percentage of new complaints received from an unresolved PALS concern; The data showed a reduction by 5% to 30% from a baseline of 35%, although below the target of 20%. CSU staff involved in the complaints investigation and response process provided feedback, and from implementation of the changes the positivity rate increased by 59.5% to 75% from a baseline of 12.5%.

**Table 4: Target Progress Report – Neurosciences CSU and Complaints Team**

#	Metric (units of measurement)	Baseline	Target	30 days 30/11/24	60 days mm/dd/yy	90 days 28/02/25	% Change
1	<b>Lead Time</b> Average Time (median working days) from Received in CSU to <u>Sent</u> back to PET	20 Days -18 40 Days -35 60 Days -34	12 27 45	N/A 25 52	N/A 25 52	N/A 19 35	N/A -16 +1
2	<b>Quality</b> Number of re-opened complaints because of defects	7%	0%	0%	0%	0%	-7%
3	<b>Quality</b> Complaints from unresolved PALS (Median Q1 23 – Q2 24)	35%	20%	33%	33%	30%	-5%
4	<b>Morale</b> Positive Staff Feedback	12.5%	100%	50%	50%	75%	+59.5%

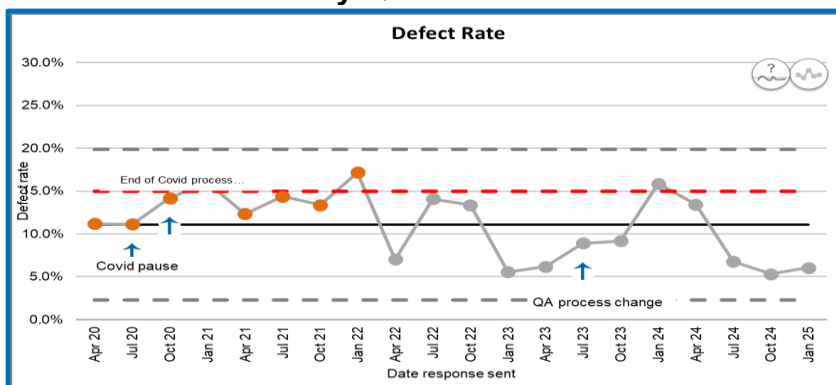
**Chart 7: Percentage of Neurosciences CSU Drafts Returned in Target Time**

**Chart 8: Neurosciences CSU Defect Rate by Quarter**


Another focused action where work has taken place over the past two years has been to remove the quality assurance (QA) review for single CSU complaint responses. This work is almost complete with the responsibility for QA of single CSU complaints now sitting with the CSU Head of Nursing. There is currently only Urgent Care CSU that continues to require external QA support and they have recently engaged in a supported review process working with the complaints team, Deputy Chief Nurse and Head of Patient Experience, to focus on improving the quality of responses, in preparation for autonomous QA responsibility. Data shows that removing the senior nurse quality assurance review from single CSU Trust complaints has improved the timeliness of those complaints and has not negatively impacted the defect rate.

**Chart 9** below shows the overall defect rate by quarter. The defect rate measures the quality of complaint responses; by calculating the percentage of responses sent each quarter which were reopened for a defect reason. Further detail on this measure is provided in section 4.4.

The overall defect rate has shown normal variation; however, this is inconsistent against the 15% target. The rate has remained below the 15% target throughout each quarter of 2024/25. Data collection from the most recent quarter (Q4 2024/25) is not fully matured and so should be read with caution, due to the timescales in which complainants can contact us requesting that their response is re-reviewed - up to three months after the initial response was received.

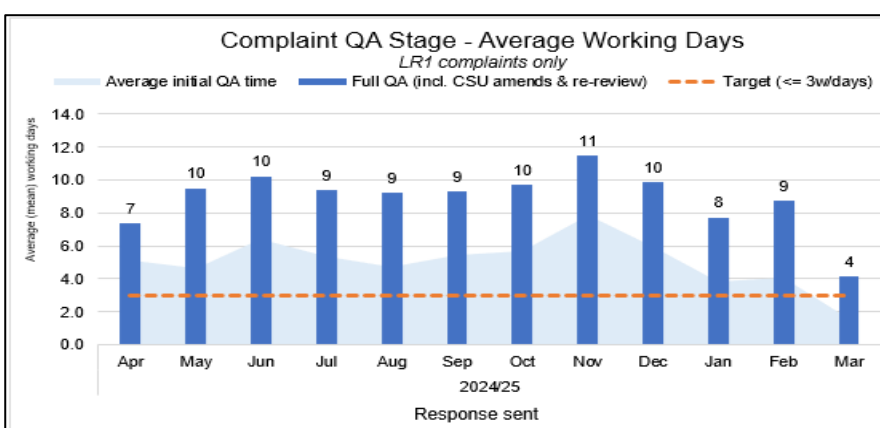
**Chart 9: Defect Rate by Quarter**

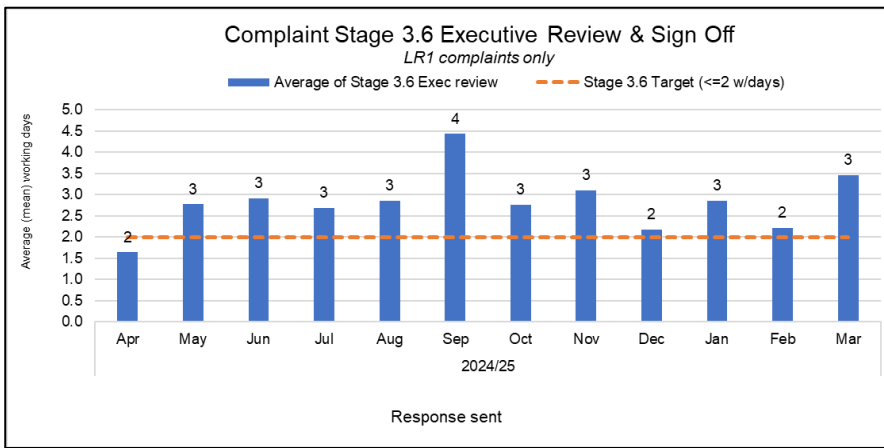


The overall Trust performance for complaint responses sent within the Trust target times of 20, 40 or 60 working days (not including resolution meetings) has shown significant improvements in variation against the 80% standard during the last six months of 2024/25 (Chart 4). This reached 60% in March 2025 and when historical data has been reviewed, this is the best monthly performance recorded since April 2017 when this field was added to DATIX.

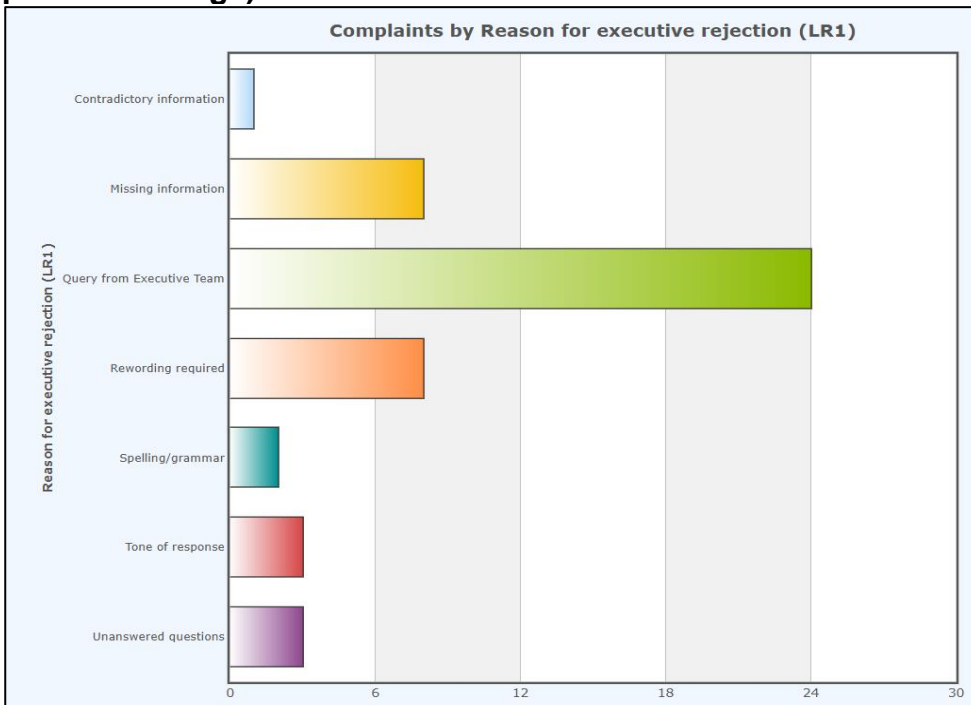
Charts 10 and 11 show that the average working days for the QA and Executive stages of the complaint process exceed their internal target times. Since the QA process change, 685 cases required QA review at LR1, with Executive review data available for 363. Of these, 49 cases (13.5%) were returned for reasons listed in Table X. In comparison, 335 cases did not require QA review; of the 169 with Executive review data, 16 cases (9.5%) were returned.

**Charts 10 and 11: Average QA and Executive Stage Times in 2024/25 by Month**

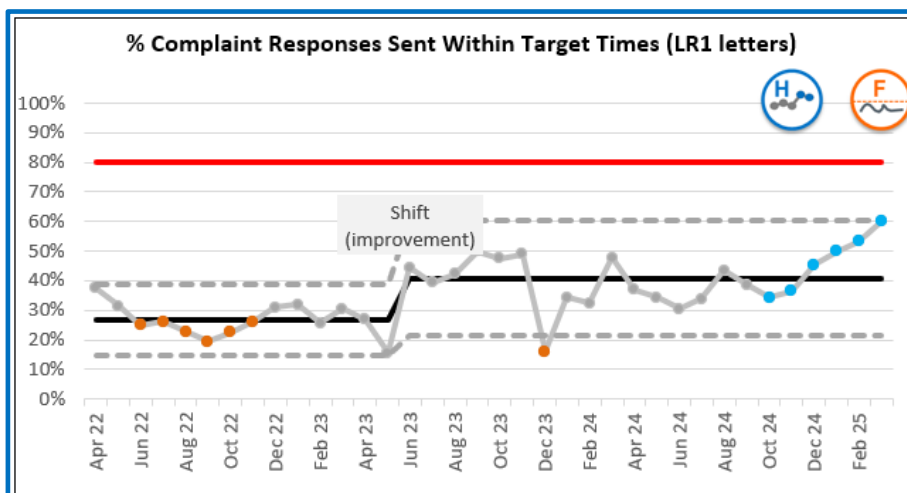




**Chart 12: Executive return reasons for cases requiring a QA review (following QA process change)**



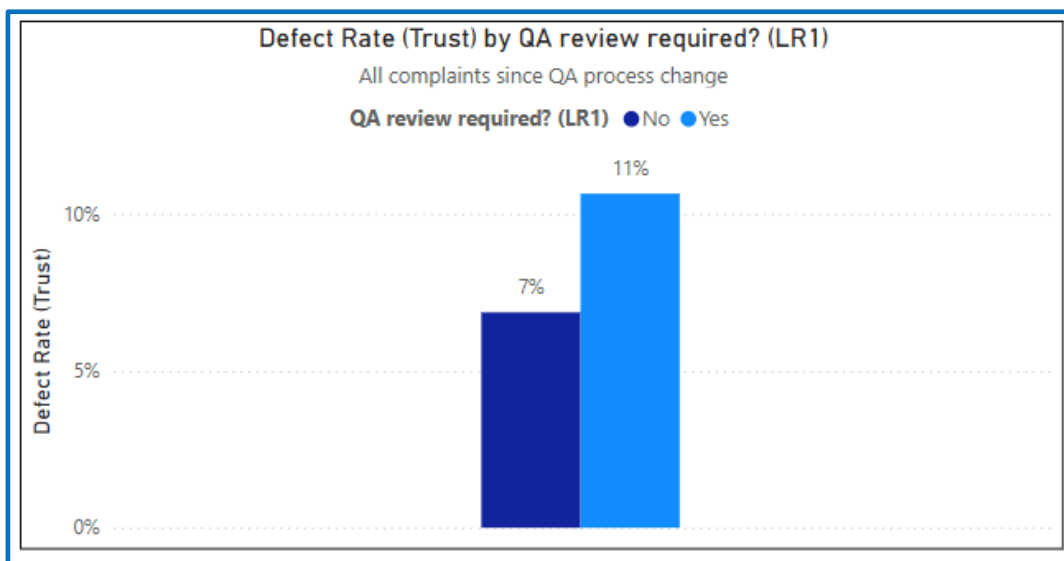
**Chart 13: Complaint Responses Sent Within Target Time.**



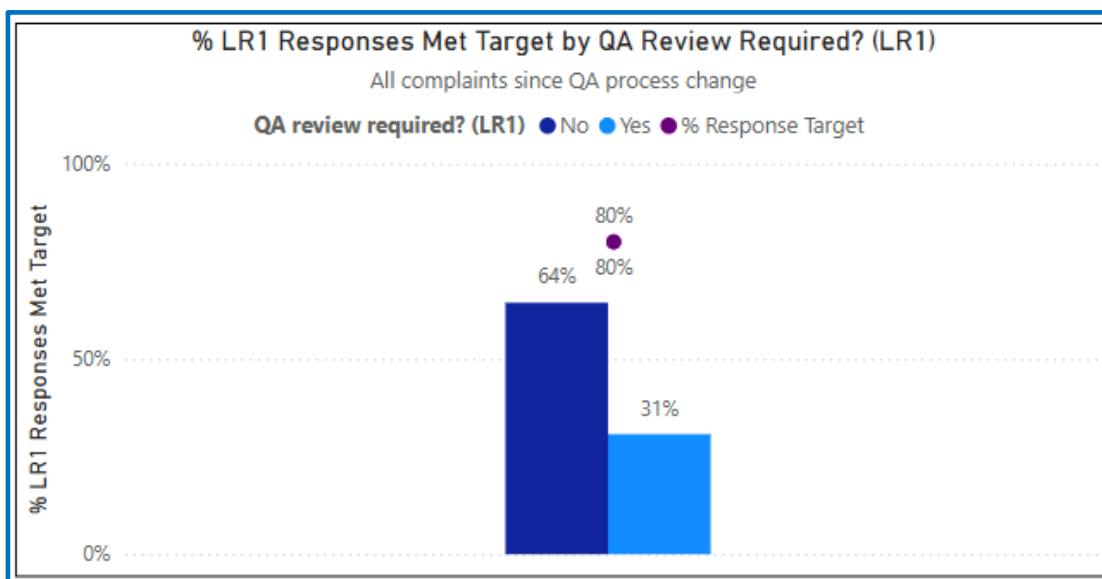
CSU responses that received an external QA check are routinely compared against those that have independent QA responsibility. Chart 14 below shows the defect rate for all responses following the change in the QA process in Q2 23/24. Responses with an external QA review have a slightly higher defect rate (11%) compared to those that did not (7%).

Responses without an external QA review are more likely to achieve the Trust response timeliness target (80%). Chart 15 below shows that since the process change, 31% of responses with a QA review met the timeliness target, compared to 64% of responses without a QA review. It is noted more complex complaints are more likely to receive a QA review by their nature; an example of these cases are where multi CSUs are involved.

**Chart 14: LR1 Response Defect Rate Since QA Process Change In 2023/24**



**Chart 15: Percentage Responses Met Target by QA Review Required**



### 3.1.3 Complaint Resolution Meetings

In Q3 2023/24 it was agreed that complaints resolved at a local resolution meeting would not be subject to the 20, 40, 60 working day internal complaints response time targets. CSUs must, however, meet a five working day local target to provide a draft meeting summary letter to the complaints team for review.

Chart 16 below demonstrates that there has been an increase in the number of local resolution meetings taking place year on year since 2020/21. In 2024/25 there were 92 complaint resolution meetings held which was two less than in 2023/24. The following lead CSUs accounted for just over two thirds of all meetings held last year: Abdominal Medicine and Surgery (20 meetings), Women's (16), Urgent Care (11), Trauma and Related Services (11) and Oncology (12) each). The new timeliness action plan includes objectives which focus on the complaints team working with CSUs to promote resolution meetings with complainants as a resolution method. Initially, support will be focussed on targeting CSUs who have a lower numbers of complaint resolution meetings.

**Chart 16: Complaint Resolution Meetings Held by Financial Year**

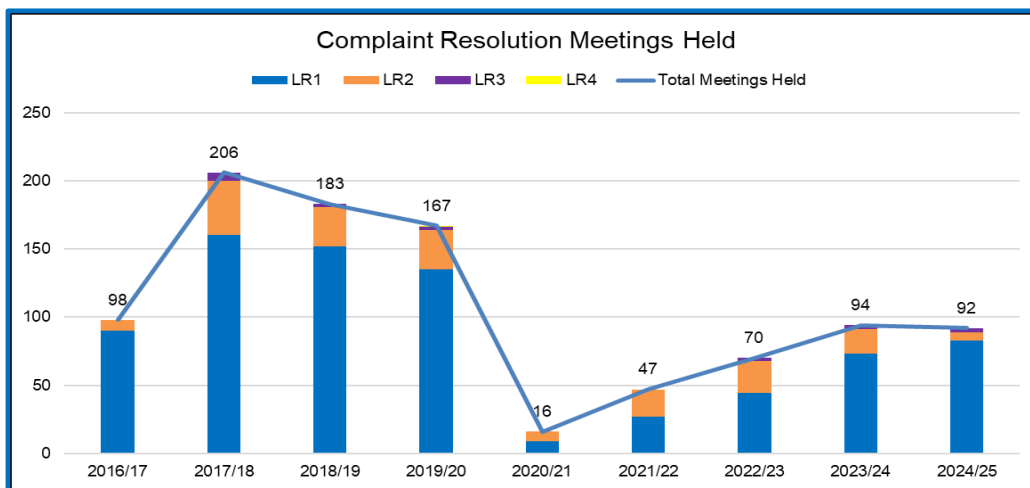
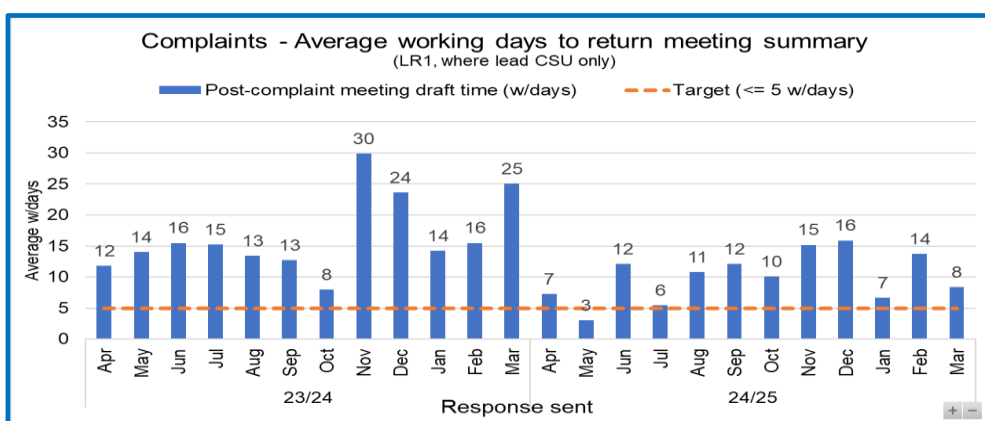


Chart 17 below demonstrates that during 2024/25 CSU average time taken to return a draft summary letter to the complaints team within the five working day local target has not been met. The overall monthly average number of working days for 2024/25 was 10, which is a reduction from 17 in 2023/24.

**Chart 17: Average Working Days to Return Draft Meeting Letter to Complaints Team**



All CSUs continue to be informed of their individual performance through monthly complaints and PALS data reports. Complaints data is presented at every Trust Board in the Integrated Quality and Performance Report (IQPR).

Data is also reported to CSUs annually via the Patient Experience Assurance Programme (PEAP) data packs, which support CSU patient experience presentations at PEEG.

Complaint response times and performance are discussed as key metrics at the CSU quality framework review (performance) meetings. Additional accountability discussions are included in the Deputy Chief Nurse and CSU Heads of Nursing meetings.

Increasing the number of complaint resolution meetings was a point of discussion at the November 2024 Kaizen event, however, was not selected as one of the areas for the teams to focus on and therefore remains an objective to achieve within the complaints timeliness improvement plan.

### **3.2 Complaints Training Programme**

Funding was secured, from continuing professional development monies, to enable an external company to continue to provide complaints training during 2024/25. A decision was made to concentrate on providing the modules that have been evaluated most positively and that have added most value to staff development. These are Complaint Response Writing and Mediation Skills.

126 staff from all disciplines and across all CSUs attended the training delivered through 2024/25.

- 6 x Mediation Skills 1 Day Programmes
- 9 x Getting it Write ½ Day Programmes

Attendance at these sessions has not been 100% and the sessions have experienced several last-minute cancellations. These last-minute cancellations have predominantly been due to operational site pressures and colleagues being required to maintain clinical services. In Q4 it was agreed with the providers to mitigate against lost places by overbooking by four places. This strategy proved to be a success and the remainder of the sessions were almost fully subscribed.

An application for further funding into 2025/26 has been submitted for consideration to enable continued support to the organisation with complaint response writing and mediation skills training.

In order for the complaints team to support the training for CSUs they have completed the sessions above and are also completing the PHSO online training which underpins the whole complaint process and the PHSO complaints standards. During 2024/25 six LTH staff completed a total of nine training sessions delivered by PHSO. A further seven staff are currently registered.

Corporate benchmarking data for 2023/24, published by NHS England, found that LTHT was in the top 25% of all NHS trusts nationally for members of staff who have received formal complaint investigation training. LTHT recorded 244 members of staff as having received formal complaint investigation training, compared to the following (median averages): 11 in acute NHS Trusts; 18 nationally; and 103 members of staff in NHS trusts



in the Shelford Group. LTHT was only one of four Trusts which recorded a cost of delivering or arranging formal complaints training. Comparable data for 2024/25 is not yet available for review.

### 3.3 Complaints Coaching Programme

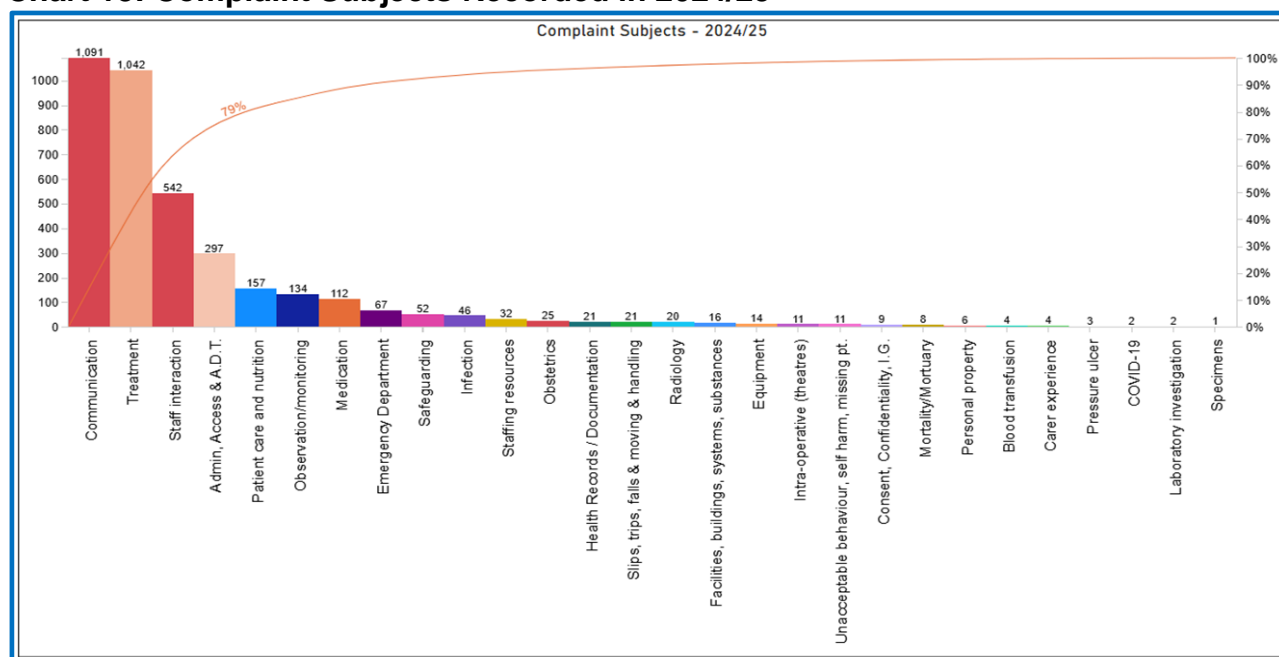
Since the previous report the complaints coaching programme has continued to support CSU teams and is delivered by the complaints team, who provided bespoke input to CSU staff / teams on request. During 2024/25 the complaints team have delivered 9.5 hours of bespoke coaching over five sessions either face to face or virtually via Microsoft teams, to a total of 79 CSU staff. The team also promote the PHSO online training to CSU staff to assist with their role in the management of complaints.

### 3.4 Complaint Themes, Learning and Improving Practice

Complaint subject data is presented at the Corporate Operations team meetings bi-annually. PALS subject data is presented at the same meeting quarterly.

The most common subjects arising from complaints received in 2024/25 are shown in **Chart 8** and remain consistent with the findings presented in 2023/24. The top 80% of all subjects raised relate to communication, treatment, staff interaction, administration, access, admission, discharge, transfer. The top sub-subject for communication relates to communication with patients about their diagnosis or condition. The top 80% of these sub-subjects were linked to (in descending order): Oncology (165 times), Specialty & Integrated Medicine (138), Abdominal Medicine & Surgery (131), Urgent Care (118), Women's (107), and Centre for Neurosciences (71). The top sub-subject for treatment relates to delay or failure in treatment of procedure. The top 80% of the delay in treatment sub-subject was attributed to (in descending order): Oncology (186 times), Specialty and Integrated Medicine (151), Abdominal Medicine and Surgery (143), Children's (124), Neurosciences (112), Urgent Care (112), Trauma and Related Services (110) and Chapel Allerton Hospital (95). Both sub-subjects predominantly linked to the medical staff group where this was known or recorded.

**Chart 18: Complaint Subjects Recorded in 2024/25**



The subjects are shown in **Table 5** below, with a comparison of performance against the same period in the previous year. This shows, there was a decrease in each subject recorded except for the top nine.

There is further detailed analysis of these subjects in section 3.4.1. below. In addition to this, PEEG will receive an annual thematic complaints and PALS report in June 2025, which will provide a more in-depth review of all subjects recorded.

As of May 2025, complaints subject data will be reported bi-annually to the Quality Improvement Safety Group to highlight key Trust wide themes and drive improvement work based on patients experience of their care.

**Table 5: Complaint Subjects in 2023/24 and 2024/25**

Complaint Subjects - 2023/24 and 2024/25				
Subject	23-24	24-25	Difference	% Change
Staff interaction	452	542	90	20%
Observation/monitoring	105	134	29	28%
Patient care and nutrition	148	157	9	6%
Intra-operative (theatres)	6	11	5	83%
Staffing resources	28	32	4	14%
Blood transfusion	2	4	2	100%
Unacceptable behaviour, self harm, missing pt.	9	11	2	22%
Specimens		1	1	0%
Slips, trips, falls & moving & handling	21	21	0	0%
Personal property	7	6	-1	-14%
Facilities, buildings, systems, substances	18	16	-2	-11%
Equipment	17	14	-3	-18%
Laboratory investigation	5	2	-3	-60%
Carer experience	9	4	-5	-56%
Pressure ulcer	8	3	-5	-63%
Radiology	25	20	-5	-20%
Health Records / Documentation	28	21	-7	-25%
Consent, Confidentiality, I.G.	17	9	-8	-47%
Mortality/Mortuary	16	8	-8	-50%
Safeguarding	60	52	-8	-13%
Emergency Department	76	67	-9	-12%
Obstetrics	34	25	-9	-26%
Treatment	1055	1042	-13	-1%
COVID-19	16	2	-14	-88%
Medication	136	112	-24	-18%
Infection	78	46	-32	-41%
Communication	1132	1091	-41	-4%
Admin, Access & A.D.T.	359	297	-62	-17%
<b>Total</b>	<b>3867</b>	<b>3750</b>	<b>-117</b>	<b>-3%</b>

The monthly variation of the top 20 complaint sub-subjects logged is illustrated in **Appendix 3**. Data to the end of March 2025 showed the following significant increases in sub-subjects.

- Communication with patient regarding diagnosis and / or condition, which was predominantly attributed to the medical staff group.
- Communication with relative regarding future treatment and / or plan of care, this was also linked mostly to the medical staff group.
- Lack of compassion, mostly attributed to medical and nursing staff.
- Not following up on an agreed action, predominantly linked to medical staff.

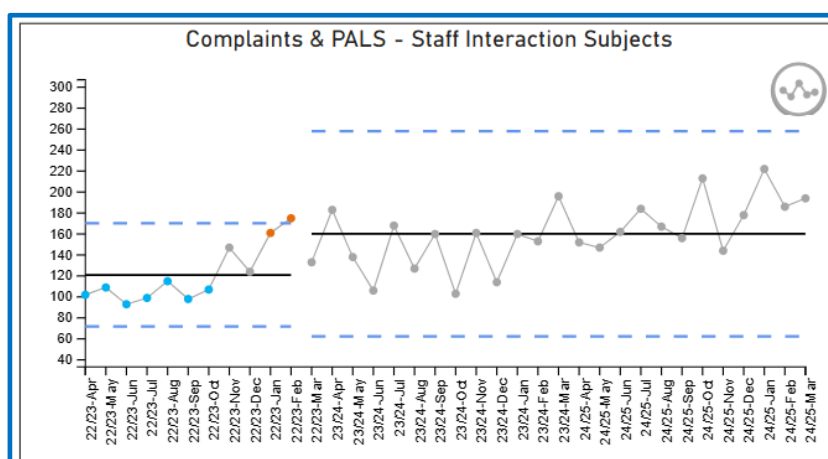
All other sub-subjects in this group showed normal variation. The sub-subjects from the top 20 with the highest monthly average recorded were:

- Delay and / or failure in treatment and / or procedure (20 per month), with the top CSUs linked being: AMS (32 sub-subjects recorded), Children's (26), Oncology (24), Trauma and Related Services (23), Neurosciences (22), Head & Neck (20), Women's (20) and Specialty and Integrated Medicine (18).
- Communication with patient regarding future treatment and / or plan of care (15), this sub-subject was predominantly linked to the medical staff group.
- Communication with patient regarding diagnosis / condition (14), mostly medical.
- Undesirable staff behaviour (14), medical and nursing.
- Lack of compassion (11),

### 3.4.1 Staff Interaction (Staff Attitude and Incivility)

**Chart 19** shows the monthly number of staff interaction sub-subjects reported by complainants via the PALS and complaints services. This sub-subject replaced the previous coding of 'staff attitude' sub-subjects during Q3 2022/23. The change is reflected in the break in the process limit lines from January 2022/23. The average prior to the change was 121 subjects logged per month compared to 160 per month in the period after. The latest data shows normal variation.

### Chart 20: Variation in Complaints and PALS Staff Interaction Subjects



The predominant three sub-subjects in the staff interaction subject category are: undesirable staff behaviour, lack of compassion, and not listening. These three sub-subjects continue to feature routinely in the top 25 complaints and PALS sub-subjects (as seen in appendix 3 and 4).

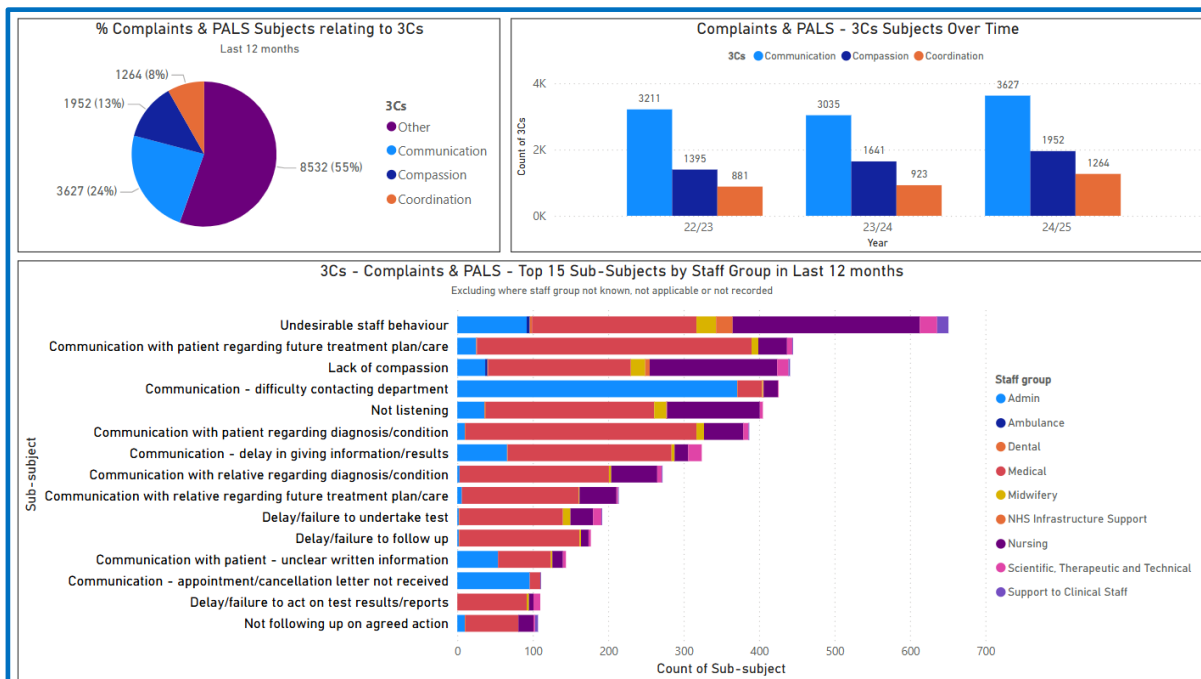
It is known work has taken place within the SIM CSU to address undesirable staff behaviours following a complaint that was received by the service. The team captured the experience of the patient, created a patient story and used it as a tool to help staff develop their skills and understanding as part of an organised CSU work programme.

### 3.4.2 Linking to City Wide Patient Experience Themes

The city-wide 'How Does It Feel For Me' (HDIFFM) programme, initiated after a 2017 CQC system review, has identified that patients consistently report concerns that relate to communication, co-ordination and compassion (3Cs) and consider these themes as most important to their assessment of a good experience.

Complaints and PALS data relating to the 3Cs is shown in Figure1:

**Figure 1: Complaints and PALS Data Relating to the '3Cs'**



This breakdown of subject data from complaints (excluding PALS subjects) shows:

- In the 12 calendar months to the end of March 2025, 45% of all complaints and PALS subjects recorded related to one of the 3Cs.
- In 2024/25 there were 3,627 communication sub-subjects recorded from complaints (increased from 3,035 in 2023/24).
- 1,952 sub-subjects related to compassion (increased from 1,641 the previous year).
- 1,264 sub-subjects related to coordination (increased from 923).

Complaints data for communication and coordination is predominantly linked to interactions with medical staff and compassion to interactions with medical and nursing staff.

The revised Patient Experience Assurance Programme 2024/25 includes CSUs receiving data on their complaints and PALS performance in relation to the 3Cs. There is an expectation that this data is used to inform CSU patient experience improvement plans that are submitted to PEEG throughout the year.

### 3.4.3 Service improvements

Examples of CSUs addressing themes arising from complaints during 2024/25 have been presented at PEEG as part of the Patient Experience Assurance Programme and include:

- The CAH CSU are improving complaint response times and are seeing a reduction in the number of reopened complaints. They recently held a 'blitz week' where all colleagues who are involved in complaint response writing focused on their longest

opened complaints. Complaints were responded to and quality assured in the same week. This enabled them to reduce their open complaints numbers.

- The Abdominal Medicine & Surgery CSU have displayed a wall of 'Our People' in the main entrance of CAH hospital. This enables patients, carers, and relatives as well as staff to identify senior leaders. The team want to spread this out to individual teams and areas within CAH throughout the year.
- The AMS CSU reviewed food provision outside of mealtimes. The Surgical Assessment Unit (SAU) doesn't have an established meal service as the area is meant to be used only for the acute assessment of patients. However, where there are increased site pressures, patients often have a longer wait. In addition, patients on ambulatory pathways can have a longer stay while waiting for tests and treatment. The CSU have worked with the facilities team to ensure that housekeepers can gain access to hot food, as well as cold food for patients at all times.
- The Endoscopy teams have been working to improve patient experiences of sedation when undergoing procedures. This work was in response to a patient complaint about consent for sedation. They are working with T&A CSU to understand how best to increase their GA capacity, as some patients are having procedures under sedation when they would have benefitted from a GA. This includes a number of patients with LD&A.
- The Childrens CSU are holding 'Super Saturday' Phlebotomy clinics, which run at quieter times and help to support the needs of patients. These have been implemented as a direct result of patient feedback.
- Following a complaint, the Out-Patients CSU have worked with the Patient Administration System Leads (PAS) team to change how same sex marriages are recorded on PAS. The CSU are now able to record these appropriately to reflect the patient's status on PAS.
- The Head and Neck CSU have introduced a process of contacting complainants on receipt of complaints and increasing the number of complaint meetings being held. There is a second lead clinician now in the CSU supporting the investigation and letter writing to drive improvements to archive the required targets.

When considering how themes from complaints are shared across the Trust, the team are linked to the Patient Safety Learning Hub which provides an opportunity for emerging themes to be shared Trust wide. CSUs also present their learning and improvement work as part of their bi-annual presentations at PEEG.

### **3.5 Complainant feedback**

Feedback is requested from all complainants who access both the PALS and complaints service.

### **Complaints Survey**

The team have explored different ways to collect feedback. a QR code link was introduced in 2023, which has seen limited responses. In October 2024, following a review of the



feedback processes and wanting to understand how complainants viewed their experience of the complaints service, a paper survey was recommenced. The questions for this were rewritten with a specific link to the 3C's, (Communication, Compassion and Co-ordination). Surveys are posted out with the final response letters and include a self-addressed envelope for return to the complaints team. The same survey questions have also been set up on the FFT self-serve facility with a new QR code. The QR code is visible on all complaint team e-mail addresses and signatures, on the Trust website and is included on response letters. Overall, there was a much-improved response rate compared to previous years, with 30 responses received in total (table 5 below and summary charts shown in appendix 5). This represents approximately 4% of all complainants. Five complainants responded to the electronic survey which was promoted to complainants via a QR code on their response letter. There were 25 responses from complainants to the paper survey.

**Table 5: Complaint Feedback Responses 2024/25**

Survey Question/Category	Survey Type	Responses	Yes	No
Total number of complainants	N/A	667	N/A	N/A
Total survey respondents	Both (Electronic + Paper)	30	N/A	N/A
Electronic survey respondents	Electronic	5	N/A	N/A
Paper survey respondents	Paper	25	N/A	N/A
Fairness (Treated fairly)	Electronic	5	5 (100%)	0 (0%)
Communication during process	Paper	25	13 (52%)	12 (48%)
Updates during process (regular updates given)	Paper	5	1 (20%)	4 (80%)
Satisfaction with response time	Both	29	16 (55%)	13 (45%)
Compassionate process and response	Both	30	15 (50%)	15 (50%)
Response addressed all concerns	Paper	24	6 (25%)	18 (75%)
Hospital response satisfaction	Electronic	5	1 (20%)	4 (80%)
Complaint process well co-ordinated	Paper	25	12 (48%)	13 (52%)
Listened to when complaint first raised	Paper	25	14 (56%)	11 (44%)

Responses received illustrate that 100% of the complaints stated that they were treated fairly with over half stating they felt listened to when they first raised the complaint. The result shows however that 75% of complainants did not have all their concerns addressed in their response. It is anticipated that the work being undertaken by the complaints team to agree the concerns to be responded to with complainants at the beginning of the process should assist in improving this experience.

## PALS Survey

In 2024/25 there have been 53 completed surveys and eight partially completed surveys. The results of this survey are provided in Appendix 6. In summary:

- 37 (66%) out of 56 respondents were patients and 19 (34%) were not (complainants acting on a patient's behalf, with the majority being relatives).
- Respondents contacted the service in relation to: medical care (10, 18%); waiting time for surgery (10, 18%); waiting time for an appointment (9, 16%); poor communication (9, 16%); other (8, 14%); attitude of staff (5, 9%); nursing care (4, 7%); and cancelled surgery (1, 2%).
- 15 (27%) respondents heard about PALS from a website, 10 (18%) from a member of staff and 3 (5%) via a leaflet and 28 (50%) through 'another route', including family and friends in the community, other trusts or having previously used the service before.
- 51 out of 56 (91%) respondents said they found it easy to contact the PALS team, five (9%) did not. Patients who answered what we could do to make it easier to contact the PALS team requested more active listening and action, plain English to assist elderly patients to aid understanding, an opportunity to speak to staff in person to raise concerns and training for staff handling concerns.
- 48 out of 55 (87%) respondents said they would use the PALS service in future, 23 (42%) would not. Reasons given for those not wanting to use the service again were limited but expressed frustration with the process (felt their complaint was pointless or a waste of time).
- 32 out of 55 (58%) respondents said their concerns were fully resolved by the PALS team, 23 (42%) said they were not.
- 48 (86%) out of 56 respondents said they would recommend the PALS service to family and friends, 8 (14%). Seven respondents felt their concerns were not taken seriously, with little or no follow-up from clinical staff. They also raised concern with a sense that PALS lacked the authority or independence to challenge CSU staff effectively.
- 42 out of 56 (75%) respondents felt the PALS process was explained clearly to them. 14 (25%) responded negatively to this question. 10 respondents answered the question about how we could improve our communication. There was a recurring call for greater transparency at the outset of the process, including outlining what complainants can expect once they raise a concern. Participants expressed frustration with a perceived lack of follow-up, emphasising the need to keep individuals informed and updated throughout the complaint process. Several comments noted the importance of active listening and genuine engagement, rather than simply relaying information from the NHS without question. One respondent reminded PALS to consider the age and potential vulnerability of some complainants, underscoring the need for a compassionate and patient-centred approach.
- 42 out of 56 (75%) respondents felt their concerns were dealt with promptly, 14 (25%) did not.
- 12 respondents answered the question about what we could do to improve our service. Many individuals vented frustrations about feeling ignored or left waiting for a response after submitting their concerns, often waiting a lengthy amount of time without updates or unrealistic timescales. Respondents highlighted limited or no communication, with delays and no clear next steps, "Slow and I had to chase up the outcome." One expressed frustration that they perceived PALS to be biased towards the NHS (because of a perception it was independent of the NHS), rather than supporting



patients. Respondents highlighted the importance of clear and timely communication, with multiple comments urging PALS to adhere to their own stated response times.

- When asked what we could have done better, some respondents felt unsure about what PALS actually did with their concerns, highlighting a lack of visibility into actions taken behind the scenes. Others noted discrepancies between what was promised and what was delivered, such as being told someone would follow up but never hearing back. A few also pointed out issues with the accuracy of their medical records and wanted clearer accountability for mistakes.

Improvements have been made to PALS processes because of survey responses in 2023/24. These include changes made to the voicemail message to reduce the amount of information provided and to allow more time for the number to be read out, and modifying the information provided in the 'bounce back' e-mail to clarify the differences between the PALS and the Complaints processes.

Survey feedback is reviewed monthly by the PALS Manager; all responses will be reviewed and analysed in full again at the end of 2025/26 and reported in the next Complaints and PALS annual board report.

### **3.6 Equality and Diversity**

The Lead Nurse for Patient Experience with responsibility for Equality and Diversity is made aware of all complaints where a concern has been raised that describes someone feeling they were treated less favourably because they had a protected characteristic. This provides oversight that enables trends and patterns of discrimination or harassment to be identified.

In January 2024 the Patient Experience Team held its first complaints Independent Complaints Review Panel (ICRP) to review the Trusts' handling of a sample of formal complaints. Following this pilot and test of concept a further meeting was held in September 2024. This saw the format for the meeting, frequency and TOR agreed and the election of a Trust Partner to chair the meetings. Going forward the panel will be provided with a selection of single and multi-CSU closed complaints with responses, one month prior to the scheduled meetings. Their reviews of these will inform suggestions for improvements. The panel will review complaints related documents, policies, and survey results at the required intervals. The outcomes and suggestions from the panel will support changes where required in the language and presentation of responses and their contribution will be shared through the bi-annual updates at PEEG. The next meeting is planned for May 2025.

To improve understanding of the experiences of people with protected characteristics who raise complaints, the complaints team undertook a trial using a set of demographic questions between August 2024 and March 2025. The trial, conducted by two case handlers, aimed to assess the feasibility and impact of enhanced demographic data collection. Early findings showed improved recording of key patient demographics, particularly NHS number, age, postcode, and gender, with some additional gains in ethnicity, religion, sexual orientation, and disability data. However, collection was more consistent when the patient was the complainant, with limited data available for complainants acting on behalf of others.

Following consideration of the trial findings, a new process was introduced to link the NHS number recorded in Datix with demographic data from PAS and PPM systems. This

change removes the need for manual collection and anonymised analysis and reporting of demographic and health equity data of those patients using the complaints service. In parallel, demographic data for complainants (when they are not the patient) is now gathered via a feedback survey sent to all complainants. This ensures the organisation continues to meet its equality monitoring obligations, while further reducing the need for frontline data collection.

Of the PALS concerns and enquiries and complaints recorded on Datix in 2024/25, 5,769 patient NHS numbers (666 for complaints and 5,103 for PALS) were recorded and anonymously matched with data available via the Trust's Patient Administration System (PAS). The resulting data is shown in **Appendix 7**. The demographic data shows key differences from the latest available Leeds and Yorkshire and the Humber Census data (2021). Findings of note are that BAME individuals and males are underrepresented in both the PALS and Complaint datasets when compared to the Leeds Census percentage. However, this underrepresentation is not as large when compared to the data from patient admissions data in 2024/25. There is a noticeable skew toward female patients when comparing PALS and Complaint patient data to census data. Older adults (65+) are overrepresented compared to the general population, while children (0–15) are underrepresented. Religion data shows a disproportionately high number of Christian patients, although this is largely due to the exclusion of those with no religion or unstated beliefs. Disability data is limited, especially for PALS, which highlights a gap in demographic recording.

Trust-wide data on discrimination is included for the last three financial years and the current year to date in **Table 6**. This data is captured through PALS concerns and complaint sub-subjects. In 2024/25, the predominant types of discrimination reported were race (44 times), disability (36 times), mental health (21), lifestyle (21) and age (11). This data is provided to CSUs through PEAP data dashboards.

**Table 6: Complaints and PALS Concerns Relating to Alleged Discrimination Type**

PALS Concerns & Complaints Relating to Alleged Discrimination			
Discrimination Type	22/23	23/24	24/25
age	24	11	11
complaint	3	1	3
disability	102	50	36
gender reassignment	3	2	3
harassment	2	1	
lifestyle	40	17	21
Mental Health	35	9	21
Not disclosed / recorded	2	4	5
pregnancy/maternity (inc. breast feeding)	7	1	
race	47	41	44
religion and/or beliefs	4	6	3
sex	6	3	4
sexual orientation	2	3	1
social	6	3	3
<b>Total</b>	<b>283</b>	<b>152</b>	<b>155</b>

The bar charts in **Appendix 8** show postcodes for complainants and patients linked to PALS and complaints received in 2024/25 by their linked Index of Multiple Deprivation (IMD) Decile. This excluded any postcodes not matched with postcodes listed in the 2019 Government dataset for IMD and for any complainants who were not relevant for this analysis, such as Members of Parliament or external organisations. Of note this data shows that:

- 33% of postcodes linked to PALS complainants and patients were from the two most deprived deciles (1 and 2), this was almost double the proportion of those postcodes in the least deprived deciles (9 and 10). This is consistent with last year's findings.
- Complainant and patient postcodes showed different findings for formal complaints. Deciles 1 and 2 represented 24% of complainants, which was equal to those in deciles 9 and 10. However, 35% of patient postcodes were in deciles 1 and 2 compared to 12% in deciles 9 and 10.
- This compares to 36% of postcodes from all LTHT hospital admissions in 2024/25 in IMD deciles 1 and 2 and 15% admissions from patients in postcodes in IMD deciles 9 and 10.

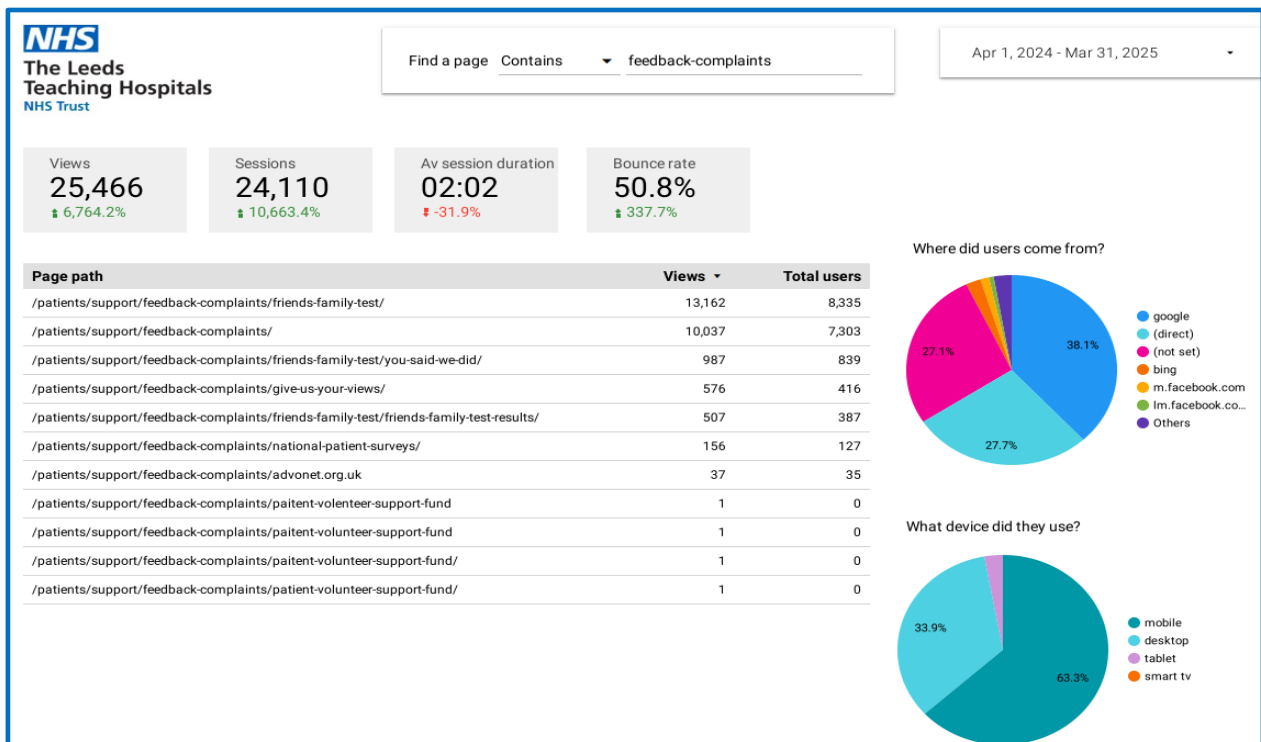
These findings are consistent with our understanding of our local population and service users; this disparity aligns with broader public health evidence showing that individuals in more deprived areas tend to have greater and more complex health needs due to factors like higher rates of chronic illness, require mental health care, experience limited access to preventative care, and social determinants such as poor housing, lower income, and reduced health literacy. As a result, they are more likely to interact with healthcare services more frequently, which increases the likelihood of both experiences being captured through complaints and feedback mechanisms.

### **3.7 Complaints and PALS Intranet and Web Pages**

#### **Complaints & PALS Web Pages**

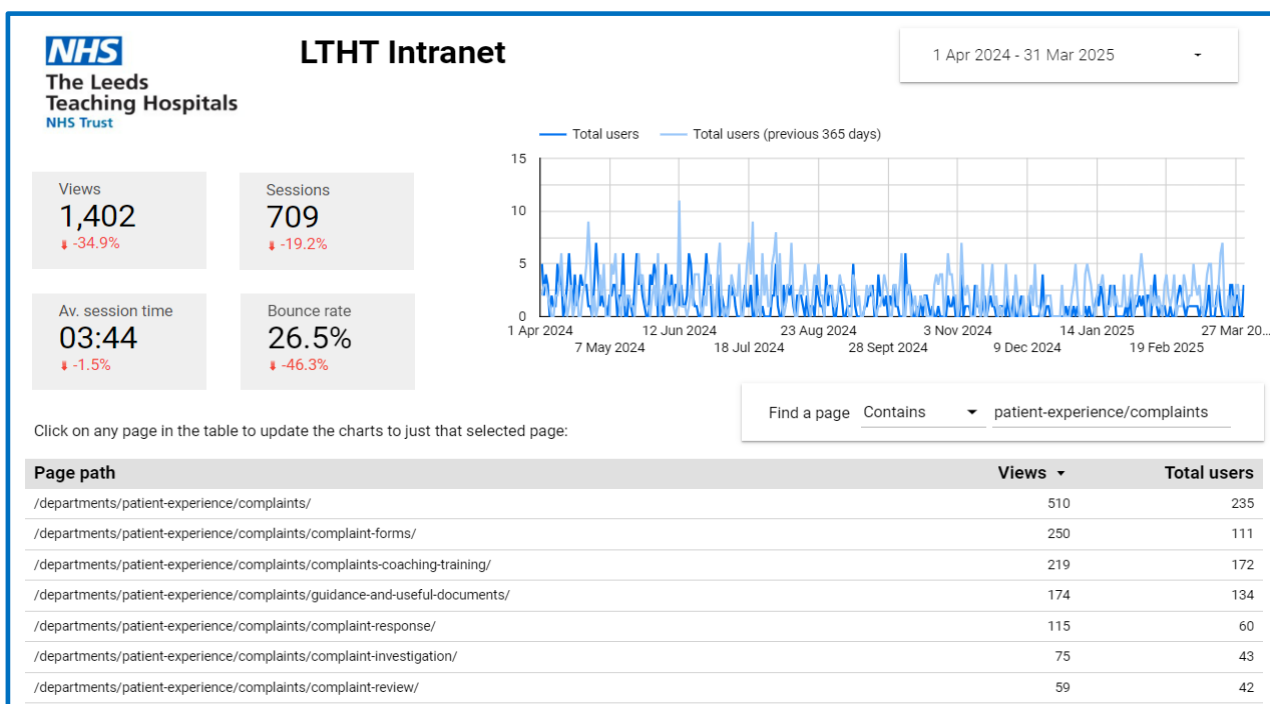
In 2024/25 the public patient feedback web page on the new LTHT website received 25,466 views. Whilst this is 1,465 less views than was received in 2023/24, it is similar and the reduction in views could be in part due to the changes and updates to the format of the Trust's new website to meet accessibility standards. This was published prior to the 2024/25 financial year, on 21st March 2024. It is noted the total views includes some pages linked to non-complaints and PALS feedback, namely LTHT Friends & Family Test and National Survey pages.

There was a bounce rate of 50.8%. This is a metric that measures how engaged visitors are with a webpage, indicating the percentage of users who leave without taking any action, such as clicking a link or interacting with the content. There were 24,110 sessions with an average session duration of 2 minutes and 2 seconds. Most users (63.3%) accessed the website via a mobile device, with 34% using a computer desktop internet browser and the remainder using tablets (2.8%). 38.1% of users accessed the link to the website via the Google search engine, 27.7% via a direct website link and 27.1% remainder via an unknown origin. The remainder of users (7.1%) accessed the links via the Bing search engine, Facebook, or another source. Figure 2 below provides an overview of this data.

**Figure 2: Complaints & PALS Web Page Data –2024/25**

## Complaints Intranet

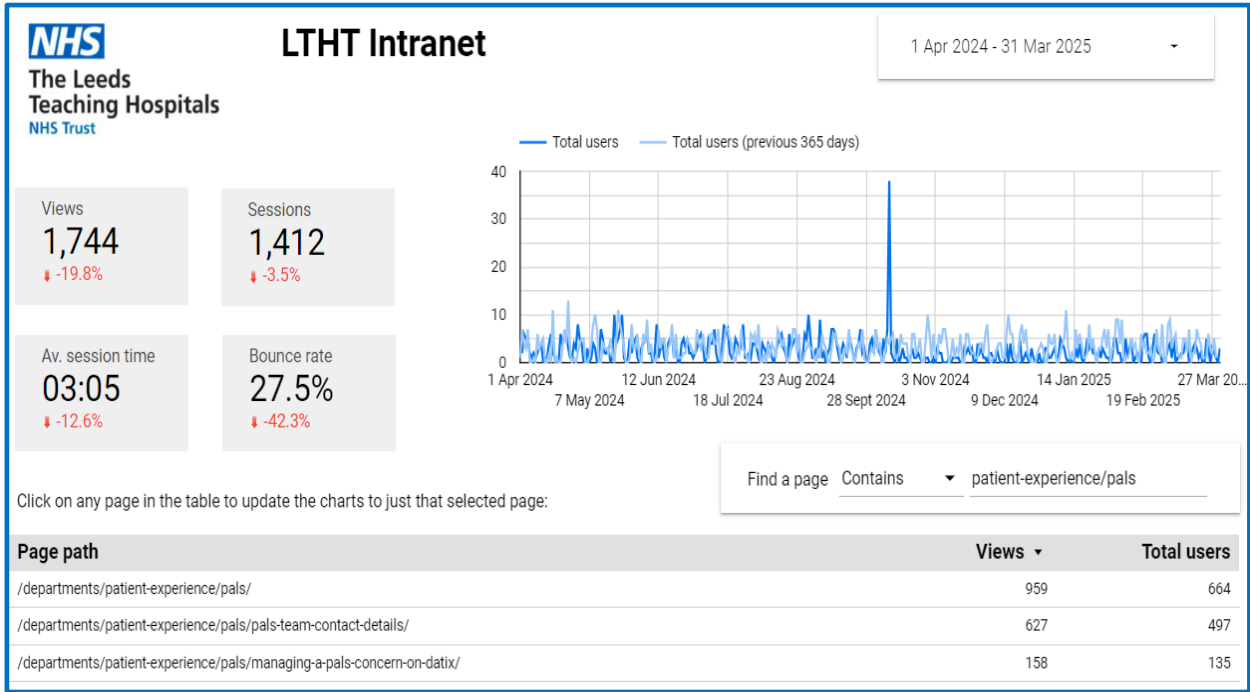
Figure 3 below shows that in 2024/25 the Complaints intranet pages have been viewed 1,402 times. There were 709 sessions recorded, with an average session time of 3 minutes 44 seconds.

**Figure 3: Complaints Intranet Data –2024/25**

PALS Intranet

PALS intranet pages received 1,744 views. There were 1,412 sessions recorded, with an average time of 3 minutes and 5 seconds. This can be seen in figure 4 below:

Figure 4: PALS Intranet Data in 2024/25



The team have completed the annual review of the Trust webpages in May 2025 and identified that the new website has several steps to the PALS and complaints landing page. In addition, some of the information that is presented was inaccurate. The team have met with the Trust website team to update the information. Changes are also being made to the navigation platform of the website, to enable easier access to information and contact details for patients who are wanting to raise concerns.

4. COMPLAINTS DATA

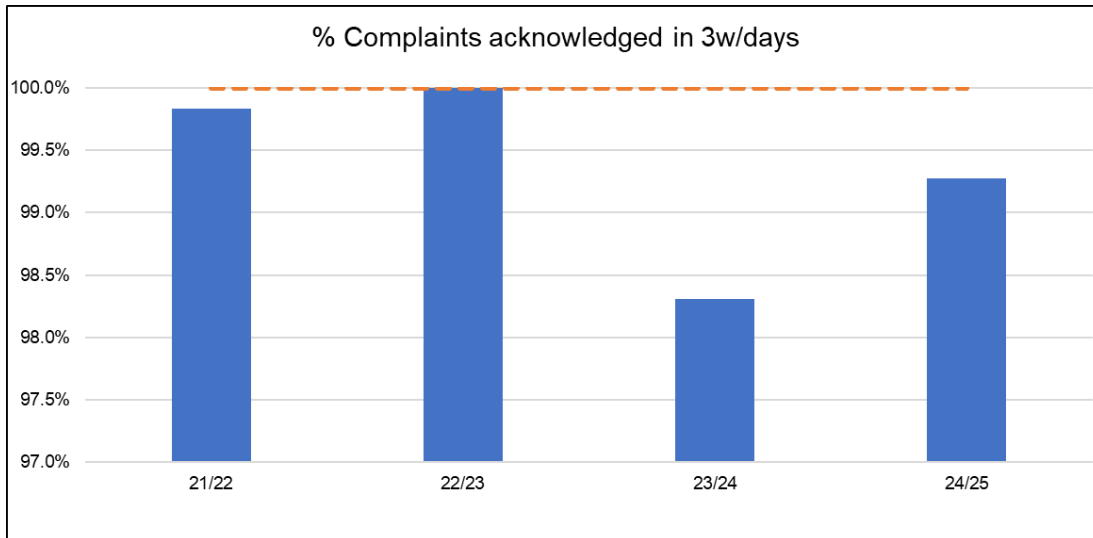
Complaints activity is reported to PEEG every six months through the Standard Indicator Report.

4.1 Activity

In 2024/25, the Trust received 676 complaints (**Table 1, page 2**). This is an increase of 93 (+16%) compared to the same period for the previous year (583).

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 states that all complaints are to be acknowledged within three working days of receipt. In 2024/25 672 (99.4%) complaints were acknowledged within three working days of receipt. Four of the 676 (0.6%) complaints cases were not acknowledged withing three working days. Of the four complaints that missed the target, three were due to increased activity in the complaints team and one was a delayed handover from PALS to complaints team. Chart 12 below shows the previous three financial years for comparison.

**Chart 21: % of Complaints Received Acknowledged Within Three Working Days From 2021/22 To 2024/25.**

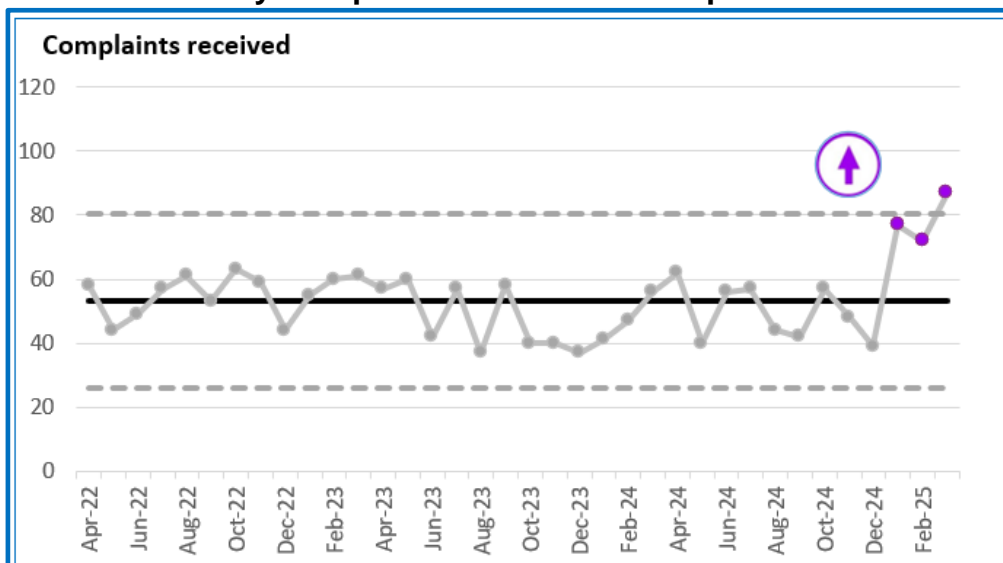


**Chart 22** shows a special cause (increasing) variation for the number of complaints received for the three months from January to March 2025.

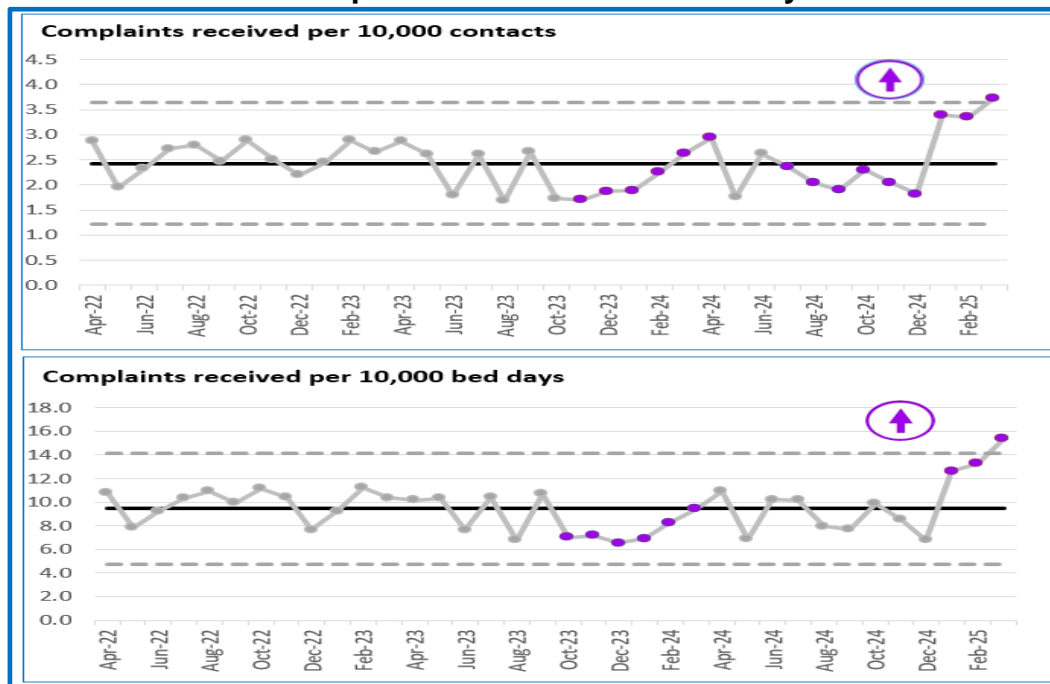
To compare the number of complaints received with Trust activity the number of complaints received are calculated as a rate of inpatient activity (occupied bed days data from the Midnight Bed State Report) and outpatient activity (patient contacts data obtained from Early Activity Reports, excluding Pathology). This data is shown below as a rate of complaints received per 10,000 patient bed days (chart 15) and 10,000 units of patient activity (chart 16). Caution should be applied to this data in terms of linking them to a point in time. Complaints received often relate to episodes of care which took place historically. 57% of complaints received in 2024/25 related to an episode of care over one month prior, with the most historic concerns relating to an episode one to three years prior.

The rate of complaints received per patient activity levels showed the same significant increase in the first three months of 2025.

**Chart 22: Monthly Complaints received from April 2022 to March 2025**



## Charts 23 and 24: Complaints Received Per Bed Days and Patient Contacts



On 26 March 2025 there were 204 open complaints, of which 45 (22%) had not met the required response target date. This includes reopened complaints. The number of overdue cases reported every two weeks from November 2024 to 26 March 2025 are shown in chart 16 below. Of the 45 cases overdue, 19 had been open over four months:

- One case had been open for 7 months;
- Three had been open six months.
- Six had been open for five months.
- Nine had been open 4 months.

At the time of writing (28 April 2025) eight of these 19 cases remained open.

Every two weeks the CSUs are provided with the Complaints Awaiting Action report. This assists them with monitoring the complaints they are managing and provides an escalation process for the complaints senior management team to support CSU with all aspects of complaints pathway management. A review of this open report was undertaken in Q2 2024/25 by the Complaints Manager, Lead Nurse, and Patient Experience Information Analyst and changes were subsequently made to the format. This was undertaken in response to feedback received from CSUs. A revised two-weekly **Complaints Awaiting Action Report** was launched in November 2024/25. This report tracks both the Trust total open complaints and show how many of these cases have exceeded the final response due date. The CSU view of the report will show all complaints awaiting action from each CSU *and* a sub-set of these complaints, where the response is overdue. A screenshot of the new report is provided in Appendix 7.

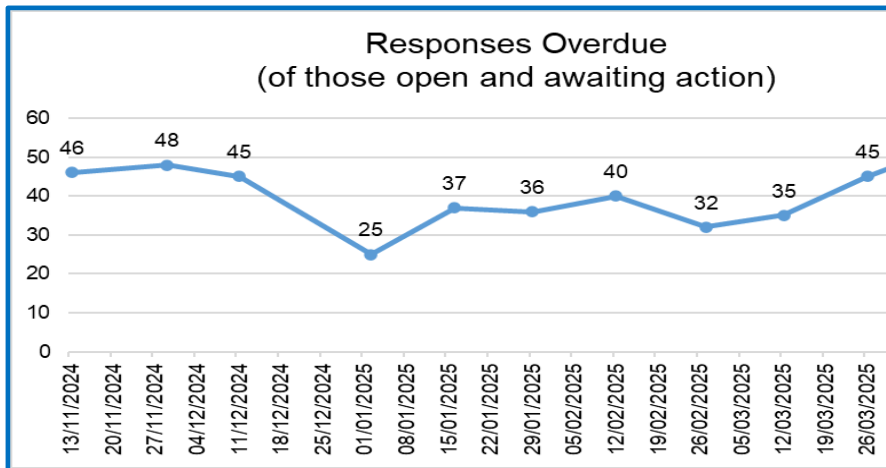
Cases at later stages of the complaint process will continue to be included and overseen by the complaints team; for example, cases awaiting quality assurance or Executive review will still appear on live Datix CSU dashboards and on the CSU report under 'Other'. This change will enable the reporting of performance over time for:



At Trust level: 1) the number of complaints open and 2) how many are overdue against the initial response due date.

At CSU level: 1) the number of cases awaiting action from CSUs and 2) the number of those cases awaiting action which have exceeded the initial final response due date.

**Chart 25: Responses overdue**



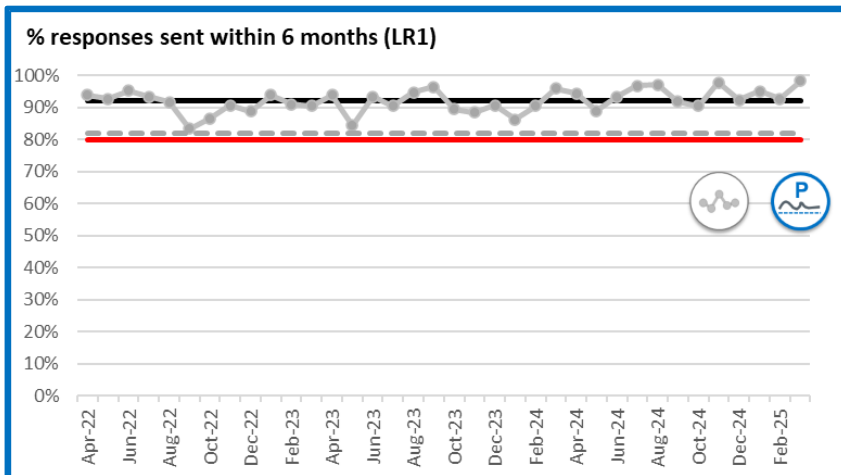
## 4.2 Response Times

The NHS Complaints Regulations (2009) state that all complaint responses should be sent to the complainant within a locally agreed timescale. Should this timescale not be met within six months, the reasons for the delay should be provided to the complainant in writing and a realistic revised response timescale agreed. Of the responses (LR1) sent to complainants in 2024/25, 94% were sent within six months of being received by the Trust. For comparison in 2023/24 and 2022/23 91% of responses were sent in this timeframe.

**Chart 26** shows that performance against the six-month standard has been consistently above the Trust's internal 80% target since April 2022.

Previously CSUs were not performance managed against this target, and consequently this was introduced into the PEAP dataset from May 2024. CSUs are expected to identify solutions to perform within expected target and will report actions taken to improve this at PEEG, where performance is below this. Of responses sent in 2024/25, all CSUs saw performance against target on or above 80%, except for Chapel Allerton (74%), and Outpatients (67%) CSUs.

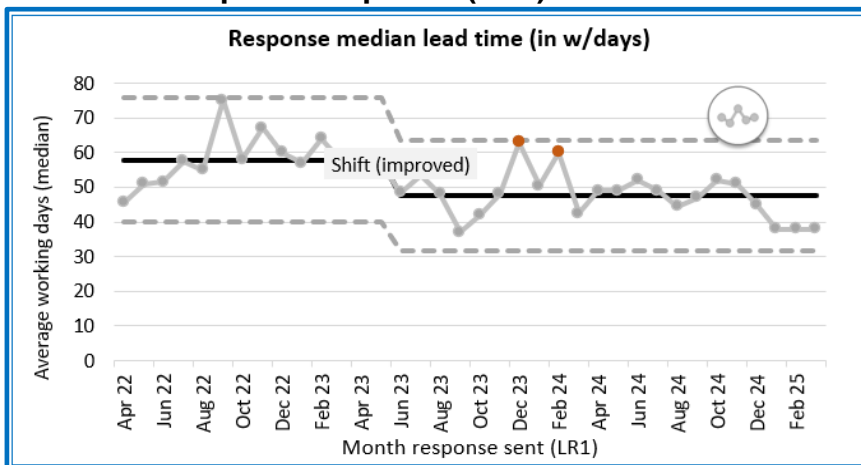
**Chart 26: Percentage of Complaint Responses (LR1) Sent Within Six Months of Date Received**



Lead Time (LT) is used to measure performance within the CIP and calculates the median average number of working days experienced by a complainant when waiting for a response, from receipt of the complaint to the response being posted out.

**Chart 27** shows normal variation for LT, with a significant improvement in LT from June 2023 onwards which is reflected in the reduced process limits. This has been due to the removal of the QA process for single CSU complaints, improved performance from CSUs in reducing the amount of time taken to respond to overdue complaints and responding to a greater proportion of complaints within the required timeframe. It is of note however that the LT fell to below 40 working days in the first three months of 2025, which is below the typical response target time for the majority of complaints (40 working days). This represents a dramatic reduction compared to the LT prior to the start of the complaint's improvement programme in 2020.

**Chart 27: Complaint response (LR1) median Lead Time**



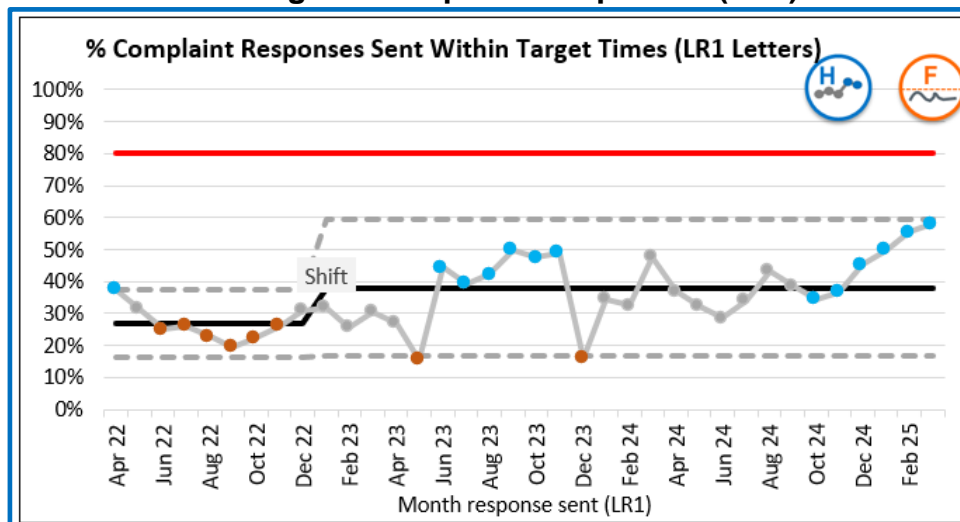
Individual CSU LT for the previous four full financial years can be found in **Appendix 9**.

**Chart 28 and Table 7** show the percentage of complaints sent within the 20, 40 and 60 working day complaint response time standards. The chart shows that complaint responses are not meeting the 80% target, however it demonstrates that there is significant improving variation over the past six months (Oct 24 - March 2025) and this has reached 60% in March 2025.

The following explanations can be given for not meeting the 80% timeliness target.

- delays in the CSU investigation/draft stage
  - delays in the corporate QA review stages (QA and Executive review)
- Both of the above are exceeding their internal targets times.

**Chart 29: Percentage of Complaint Responses (LR1) Sent Within Trust Target Time**



**Table 7: Percentage of Complaints Responses Which Met Target: 2022/23 to 2024/25**

% Complaint responses met target			
LR1 letter complaints only. All target types			
Target Response Time (LR1)	22/23	23/24	24/25
20	30%	54%	55%
40	28%	37%	45%
60	22%	25%	16%
<b>Total</b>	<b>27%</b>	<b>37%</b>	<b>42%</b>

### 4.3 Reopened complaints

128 complaints were reopened by the Trust in 2024/25. 75 of these were reopened at the second resolution stage (LR2) and eight at the third resolution stage (LR3). This data can be seen in **Table 8**. The reasons for reopened (LR2) complaints is provided in section 4.4 below.

The final 'end of resolution' stage (EXLR) saw a total of 61 EXLR cases recorded in 2024/25; these are not considered as reopened complaints. This figure is one more than the 62 cases in 2023/24 and 18 more than 43 cases in 2022/23.

**Table 8 : Reopened Complaints and End of Resolution Stage**

Local Resolution Stage	2022/23	2023/24	2024/25
LR2	118	108	75
LR3	10	10	8
EXLR	43	62	61

#### 4.4 Complaint response defect rate

The response defect rate has been used to measure the quality of complaint responses within the CIP and calculates the percentage of first stage complaint responses reopened for a reason which the CSU/s involved can influence. The reasons are:

- Disputed information in previous response.
- Factual errors in previous response
- Incomplete previous response (e.g. question not answered, no response from a CSU, etc.).
- Poor previous response (e.g. lack of detail / clarity / no evidence of learning / poorly worded, etc.).

Historical data about defect rates can change, as it is based on the quarter when the response was sent to the complainant. The rates for recent quarters may differ from earlier reports because the data is updated monthly, and reopened complaints are added. A response is only marked as defective when a complaint is reopened, which usually happens between one and three months after the initial response was sent.

**Chart 9 (section 3.1.2, page 11 above)** shows the long-term quarterly defect rate. Whilst long-term performance is inconsistent against target it has been below target each quarter of 2024/25. The 15% target represents one and half responses reopened for a defect reason for every 10 responses sent. The training for staff involved in complaint response writing has continued throughout 2024/25 and bespoke coaching sessions for CSUs have also been available.

**Appendix 10** shows a summary table of individual CSU defect rate. Defect rate is included in the Patient Experience Assurance Programme. Although data for 2024/25 is not yet fully mature, this currently shows all CSUs as having met the target, with the exception of Finance CSU. Percentage is high as the complaints received are very low (50%). Almost all these complaints relate to overseas charges.

**Table 9** shows the reasons for complaints reopening, with the areas highlighted in orange illustrating the areas measured when calculating defect rate. More than one reason can be selected per reopened complaint.

**Table 9: Complaints Reopened (LR2) by Financial Year and Reasons**

Financial Year	2020/21	2021/22	2022/23	2023/24	2024/25
Redress request	4	1	2	1	3
Copy of document requested	8	12	2	0	5
End of local resolution process	12	19	20	7	36
Meeting requested	8	11	13	16	11
New questions	54	83	86	67	88
Disputed information	61	92	76	62	72
Factual errors	7	3	1	0	4
Incomplete response	8	11	8	7	14
Poor response	6	8	4	2	8
<b>Total</b>	<b>168</b>	<b>240</b>	<b>212</b>	<b>162</b>	<b>241</b>

<b>Sub-Total Non-Defect Reasons</b>	86	126	123	91	143
-------------------------------------	----	-----	-----	----	-----

Sub-Total Defect Reasons	82	114	89	71	98
Complaints reopened (LR2)	95	130	118	108	120

A review of Patient Experience metrics presented to PEEG in October 2024 recommended a review of the reopened reason '**disputed information**' to reassess whether all complaints reopened under this category are within the gift of CSUs to prevent. The complaints team reviewed a number of reopened complaints responses where the disputed information field alone was entered as a reason for re-opening the complaint. This work highlighted that of the 7 cases reviewed the findings have shown that:

- the disputed information category remains relevant
- some complaints have been incorrectly categorised
- the team can now take action to improve accuracy of recording

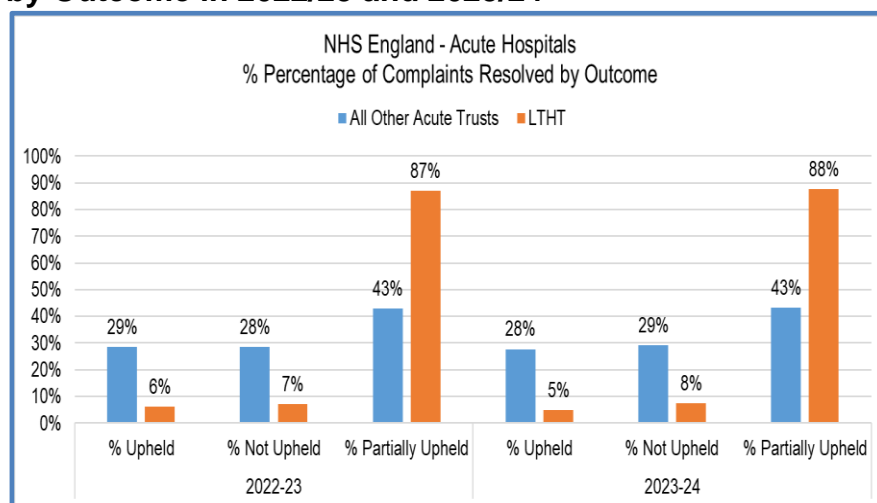
## 4.5 Complaint outcomes

The outcome of complaints for 2024/25 and the previous two years are shown in **Table 10**. **Chart 30** provides the latest available national data for comparison.

**Table 10: Complaint outcomes for last 3 financial years**

Financial Year Received	Outcome			Total
	Upheld	Partially Upheld	Not Upheld	
2022/23	38	562	45	645
2023/24	26	493	42	561
2024/25	28	470	37	535
	% Upheld	% Partially Upheld	% Not Upheld	
2022/23	6%	87%	7%	
2023/24	5%	88%	7%	
2024/25	5%	88%	7%	

**Chart 30: NHS England - Acute Hospitals - % Percentage of Complaints Resolved by Outcome in 2022/23 and 2023/24**



In 2024/25, 100% of complaints received a risk score on receipt. There were 13 complaints with a score of 15 or above (red risk).

Six complaints were received in 2024/25 from a Member of Parliament (MP). This compares to four complaints in all of 2023/24. None of these were referred to the Parliamentary and Health Service Ombudsman (PHSO).

In 2024/25 the PHSO commenced review of 29 complaints. Of these, 3 were directed back to the Trust for further local resolution (including financial redress) and 15 were closed without investigation. In the same period the Trust received the outcome of 8 upheld or partially upheld PHSO reviews. Of these, 8 required an action plan, seven required an apology and 4 required a financial payment. Two were investigated and not upheld There are 16 complaints are currently open with the PHSO.

#### 4.6 Complaint Resolution Meetings

The percentage of first stage (LR1) complaint resolution meetings being held has increased each year as a proportion of all responses following the Covid-19 pandemic (**Table 11 below**).

**Table 11: Percentage of responses via meeting (LR1)**

Response Type	Financial Year Complaint Received (LR1)				
	2020/21	2021/22	2022/23	2023/24	2024/25
Telephone call and letter	7	11	11	11	9
Meeting (not recorded) and letter	3	5	10	6	3
Meeting (recorded) and letter	6	23	51	56	59
Letter only	447	546	573	491	462
<b>Total Responses</b>	<b>463</b>	<b>585</b>	<b>645</b>	<b>564</b>	<b>533</b>
% Responses Meetings	2%	5%	9%	11%	12%

**Table 12: Percentage of responses via meeting (all reopened complaints)**

Response Type	Financial Year Complaint Reopened (LR2 and 3)				
	2020/21	2021/22	2022/23	2023/24	2024/25
Telephone call and letter	2	2	2	4	0
Meeting (not recorded) and letter	1	3	4	6	1
Meeting (recorded) and letter	9	18	22	13	11
Letter only	90	110	87	88	93
<b>Total Responses</b>	<b>102</b>	<b>133</b>	<b>115</b>	<b>111</b>	<b>105</b>
% Responses Meetings	10%	16%	23%	17%	11%

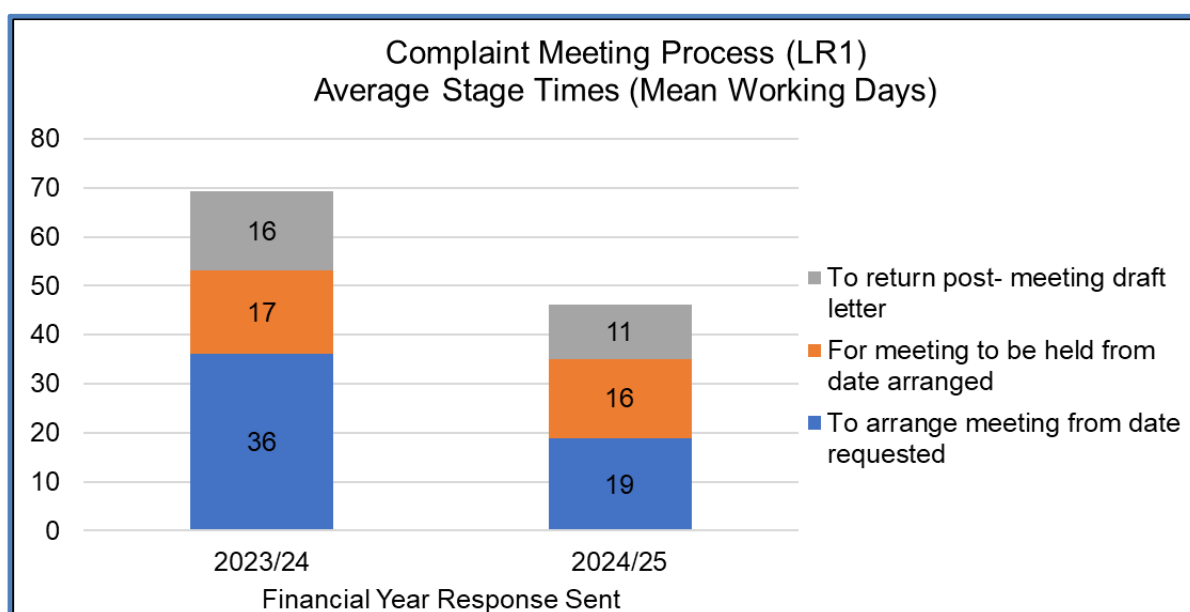
It is known that resolving complaints by holding a meeting tends to result in higher satisfaction from complainants and less likelihood of complaints reopening. However, data shows this may impact upon the timeliness of closing a complaint, due to the average time

taken to organise a meeting and the average time taken to complete a response once a meeting has been held.

**Chart 31** provides the average times for three stages of the process for arranging a meeting. The first stage is the date the complainant formally requests a meeting (blue bar in chart). The second stage is the date the meeting was arranged (date confirmed with all parties, orange bar). The third stage is the average time taken for the lead CSU to return the draft meeting summary letter, after the meeting has been held (grey bar). In total the average time for meetings was 46 working days in 2024/25, compared to 69 working days for responses sent in 2023/24.

To further drive improved complaint timeliness, data has been made available to CSUs on their complaint meeting related performance through the patient experience data pack to encourage improvements in this area from May 2024.

**Chart 31: Average meeting arrangement times**



#### 4.7 Internal Audit of Complaints (2025)

An internal audit review of the Trust complaints process was commenced in February 2025 and reported in June 2025. The review revealed a significant improvement on previous audit findings and a satisfactory level of compliance with the complaints process within CSUs. Clear evidence of the Trust's commitment to resolving and documenting complaints effectively was noted.

The following areas of good practice were identified:

- Improvements in the Trust Complaints Policy
- Detailed complaints reporting across a range of useful metrics in both PALS and complaints, with data stored in Datix being used effectively and key information shared across the Trust.

There were three low risk findings:



- A lack of clarity in relation to the requirement for complaint responses to undergo quality assurance checks in Datix.
- Two instances were identified from the sample of fifty complaints tested where complaint responses were not recorded in Datix.
- Suggested improvements to the documentation of actions and lessons learned discussed between the PALS and Complaints teams.

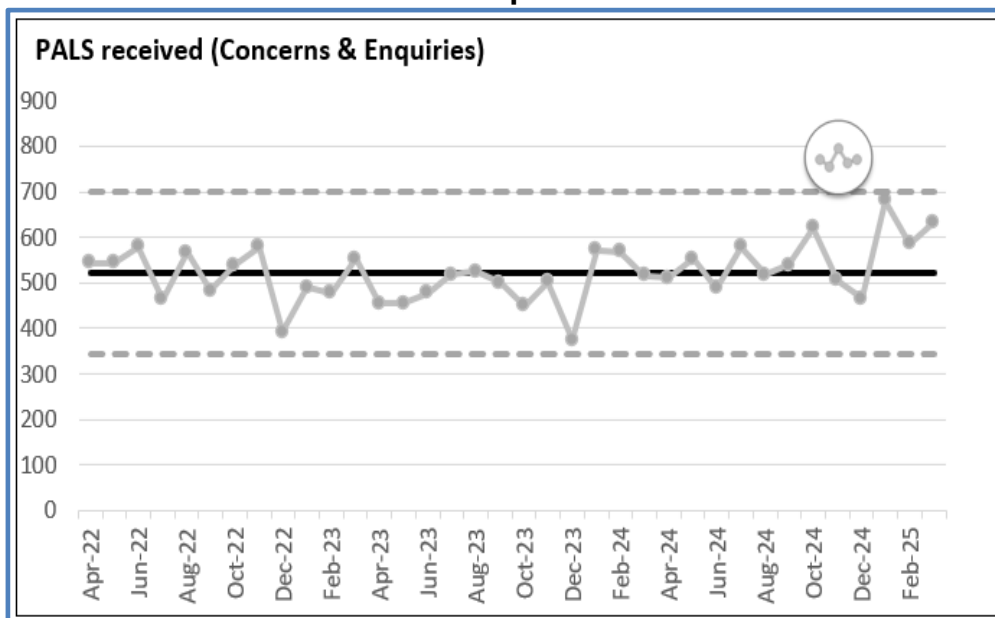
An action plan is in place to address the findings which are expected to be completed by December 2025.

## 5. PALS ACTIVITY

In 2024/25, the PALS team received 6,674 PALS concerns and enquiries (up by 764 from 5,910 in 2023/24, a 13% increase from the previous year). **Chart 32** presents the monthly volume of PALS concerns and enquiries resolved either by the PALS team or Clinical Service Units (CSUs) over the 24-month period ending March 2025. The data demonstrates normal variation.

Notably, 680 cases were received in January 2025, which, while not exceeding the upper process control limit (701, indicated by the grey dashed line), approaches this threshold closely. This proximity suggests heightened activity warranting continued monitoring which supports the increasing activity reported by the PALS team since the turn of the calendar year, though it remains within expected statistical bounds. Each quarter of 2024/25 compared to the same quarter the previous year shows an increased number of concerns and enquiries received; there were 255 more PALS received in Q1 and Q2 2024/25 and 509 more in Q3 and Q4 compared to the same six-month period in the previous year.

**Chart 32: PALS concerns and enquiries received**



A full breakdown of PALS activity is provided in **Table 14** for the past three years.

**Table 13: PALS cases received by type**

PALS Activity Type	2022/23	2023/24	2024/25	Difference from previous year
PALS concern	5112	4585	5584	+999
Advice/enquiry (resolved by CSU)	465	832	828	-4
Compliment	624	599	585	-14
Information request (resolved by PALS team)	630	493	262	-231
Signposting	47	32	43	+11
For information only	70	26	86	+45
Information for outside organisation (Complaints)**	6	15		
Out of time complaint*	5	2	2	0

\*Requests for information from external organisation related to a mixed sector formal complaint, where there is no complaint against LTHT.

\*\*Formal complaint which has been raised outside of the timeframe for raising a complaint (based criteria set out in on National Complaint Regulations, 2009).

During 2024/25 the Trust recorded 7,388 PALS contacts. **Table 14** below shows the different categories for all contacts with the Trust PALS Team.

**Table 14: PALS Activity by Type and Financial Year 2023/24 and 2024/25**

PALS Activity Type	2023/24	2024/25
PALS concern	4,585	5,584
Advice/enquiry (CSU)	832	828
Advice/enquiry (PALS team)	493	262
Out of time complaint	2	2
Signposting	32	43
Compliment	599	585
Other	93	87
<b>Total</b>	<b>6,604</b>	<b>7,390</b>

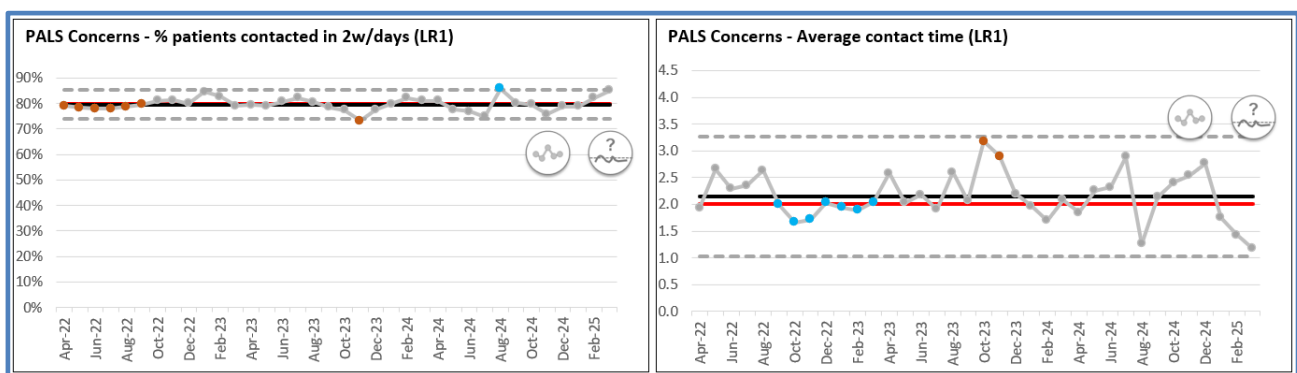
6,412 concerns and enquiries required input from clinical teams. These were shared with the relevant management teams for contact within two working days. Wherever possible, the team provide a resolution to a concern at initial point of contact; 262 concerns were resolved on the day by the PALS team. Two concerns were investigated, despite being out of time to be managed as a formal complaint and were shared with clinical teams to ensure the service user received a written response.

1,257 concerns or enquiries were categorised as ‘red risk’ which requires clinical services to contact patients on the same day. These include concerns relating to current inpatient care or other urgent or important matters. 9% of concerns required input from more than one CSU which remains the same as the previous year.

## 5.1 Resolution quality and timeliness

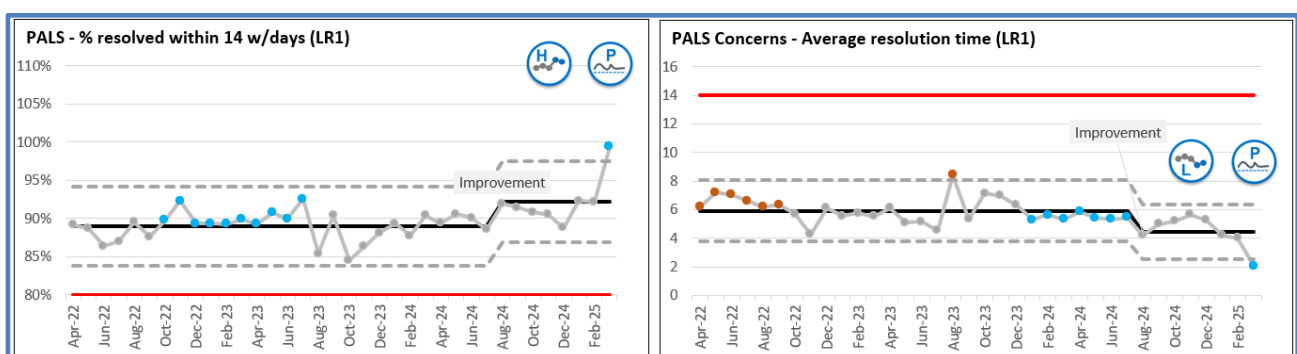
**Chart 33** shows the percentage of PALS complainants who raised a concern and were contacted within two working days. **Chart 34** shows the average contact time for PALS concerns. The latest data to the end of March 2025 shows performance for both measures is inconsistent long-term against the respective targets and normal variation.

### Charts 33 and 34: % Patients contacted within two working days and average contact time in working days



Average resolution time is the average number of working days taken for all issues to be resolved, following first contact being made by the lead CSU. **Charts 25 and 26** show this is flagging as a special cause of an improving nature and is consistently below the 14 working day target.

### Charts 35 and 36: % concerns resolved within 14 working days and average resolution time

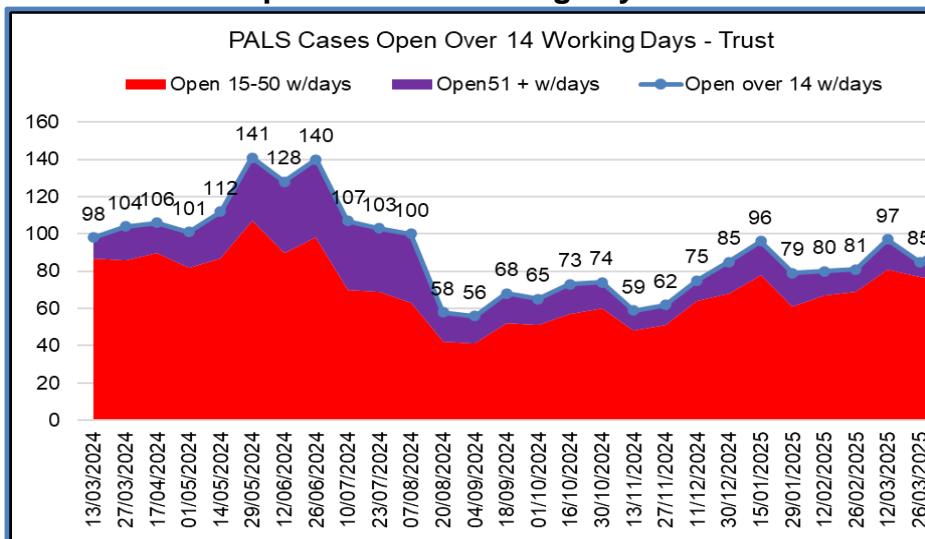


For all four measures discussed above, it has been observed that more recent month's data excludes cases which have yet to be contacted or all issues resolved. These four datasets will therefore mature as any outstanding contact and resolution dates are recorded by CSUs in proceeding months. These measures continue to be monitored monthly to identify if there are any concerning changes in performance.

It is acknowledged that the above metrics only track the average resolution time for those cases which have been resolved and do not provide assurance regarding long-running open cases still awaiting resolution. A new metric (**Chart 37**) was added to monitor performance on such cases. This tracks Trust-wide and CSU performance of cases awaiting resolution over the 14-working day target. Data on all PALS cases open is shared with CSUs every two weeks and this also provides data on the number of those cases open over 14 working days. This data is shared with CSUs via their PEAP data pack.

On 26 March 2025 there were 228 PALS cases open and 85 of those had been open over 14 working days (77 of those open for from 15 to 50 working days, and 8 over 50 working days).

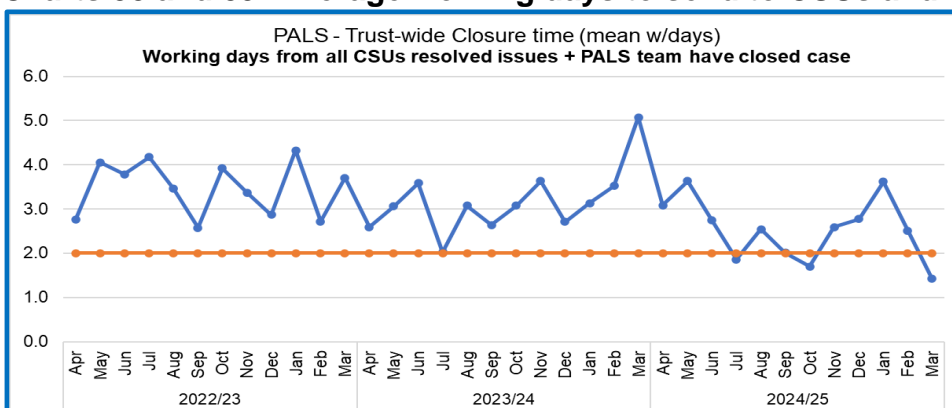
**Chart 37: PALS open over 14 working days**

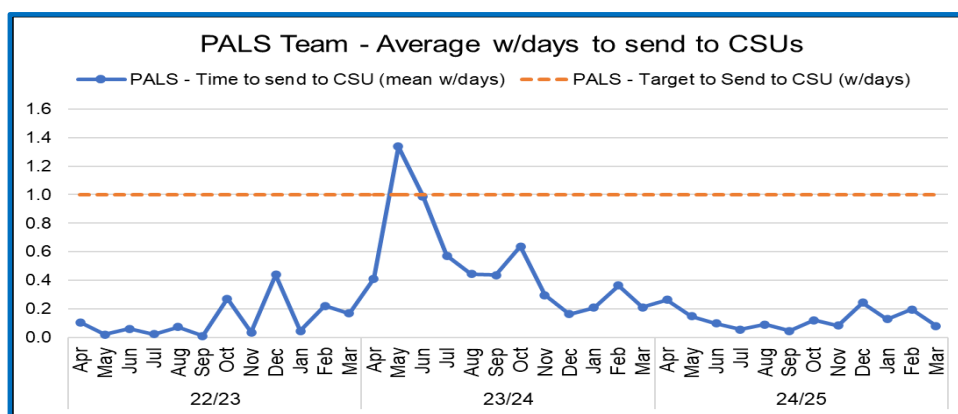


The review of Patient Experience metrics presented to PEEG in October 2024 recommended changing the target for PALS resolution from 14 to 10 working days from Q1 2024/25. This was agreed by the group.

**Chart 38** shows the average (mean) time in working days for the PALS team to send a concern to CSUs and **Chart 39** shows the average (mean) time to close the concern record on Datix once CSUs have resolved all issues. The orange line indicates the internal target time.

**Charts 38 and 39: Average working days to send to CSUs and closure time**

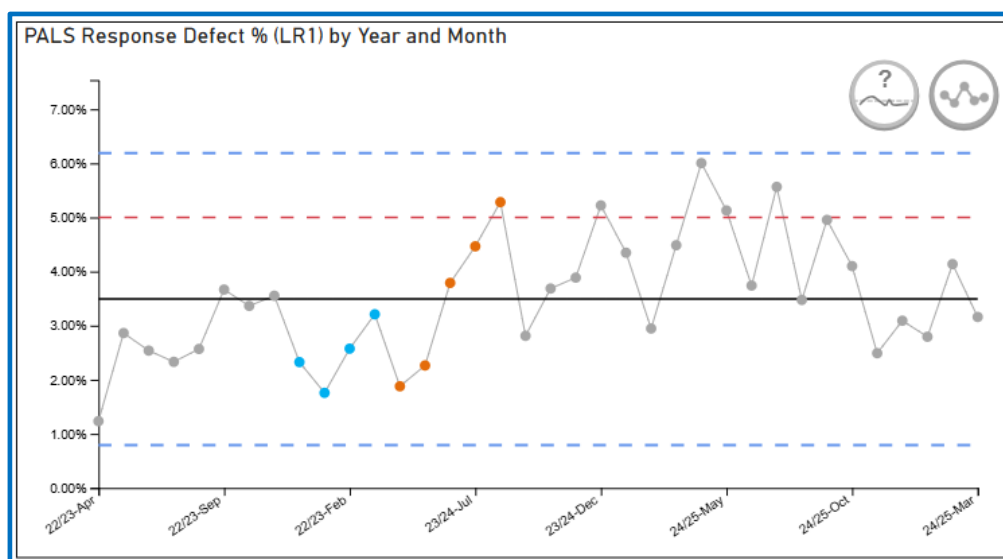




**Chart 40** below shows the percentage of PALS first local resolution stage (LR1) responses which were reopened for a defect reason. This shows normal variation and is long-term inconsistent against the 5% target. Defect reasons are:

- **Incomplete previous response** (e.g., not all original questions answered)
- **Factual errors in previous response**
- **Not satisfied with previous CSU resolution or personnel**

**Chart 40: PALS response defect rate (%)**



**Table 15 below** shows the most common reasons for reopened PALS concerns in 2024/25, with potential defect reasons highlighted in orange text. More than one reason can be selected per reopened case.

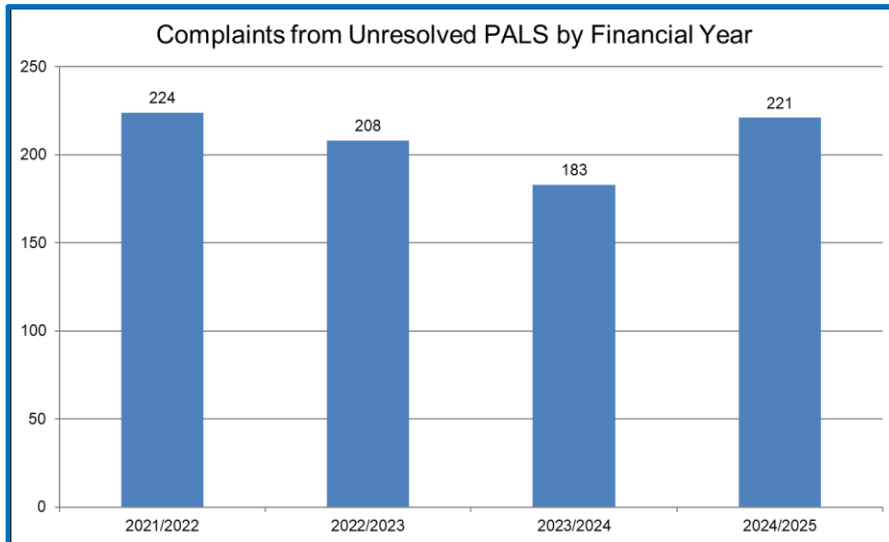
**Table 15: PALS Reasons for Reopening – 2024/25**

Reason/s for Reopened PALS	PALS Reopen Stage			All
	LR1	LR2	LR3	
New questions	232	21	5	258
<b>Incomplete previous response</b>	201	37	5	243
<b>Not satisfied with previous CSU resolution or personnel</b>	121	20	2	143
Ongoing waiting list for appointment/procedure - no date set	39	9	1	49
Cancelled procedure/appointment after resolution	26	8	1	35

Disputed information in previous response	16	3	0	19
Written response requested	10	2	0	12
Compensation/redress requested	4	0	0	4
<b>Factual errors in previous response</b>	4	0	0	4

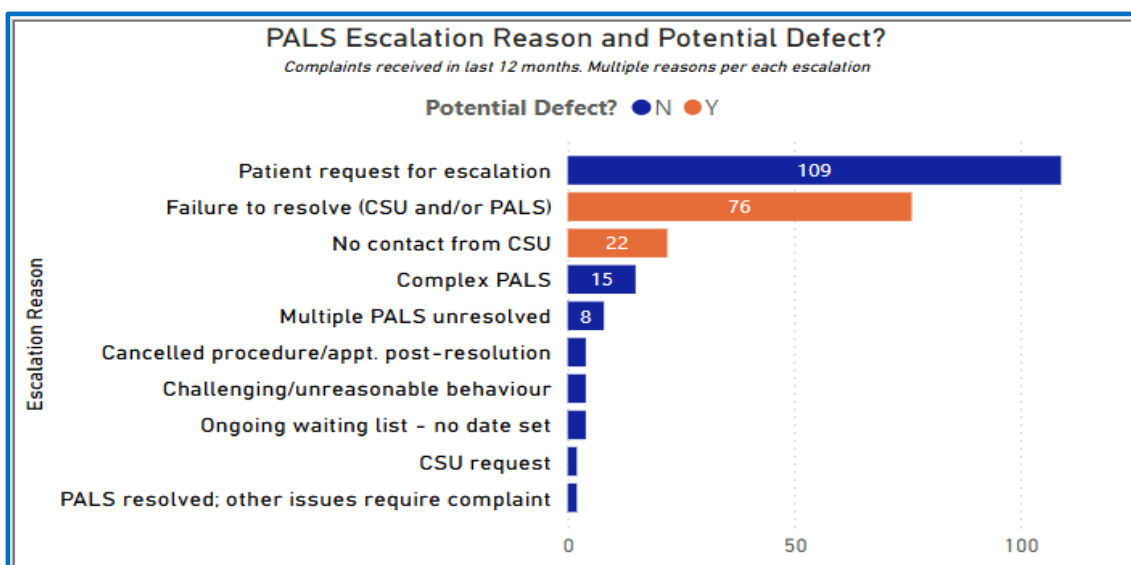
In 2024/25 there were 221 complaints received which were a result of unresolved PALS. This compares to 183 in 2023/24. **Chart 41** shows a year-on-year decline in PALS escalations to complaints from 2021/22 to 2023/24, before increasing by 38 in 2024/25.

**Chart 41: Complaints received which were unresolved PALS concerns**



**Chart 42** shows the reasons for escalation to the formal complaints process for the past two financial years and the current financial year to date. Defect reasons are highlighted. More than one reason can be selected for each escalation. The three most frequent reasons for escalations in 2024/25 were: patient request; failure to resolve; and no contact from CSU. Potential defect reason bars are shown in orange.

**Chart 42: Reasons for escalation to complaint from unresolved PALS**



It is probable that the increase in the number of PALS concerns which are escalated to the formal process has in part been impacted by the increasing complexity of concerns being raised, as evidenced in the increase in number of sub-subjects recorded at point of entry. It is also related to the increased number of PALS concerns coming through the system. All potential escalations continue to be reviewed by the PALS Manager, or Lead Nurse when they are not available.

The number of concerns escalated continues to be monitored monthly by both the PALS and formal complaints' management teams. This data is also included within CSU data packs for PEAP and is monitored via the PALS team Datix dashboard.

## **Compliments**

In 2024/25 there were 585 compliments received by the PALS team, compared to 599 in 2023/24 (a decrease of 14, or -2%). The table below breaks this data down by CSU. Compliments are recorded on Datix, and where a location is known or specified by the person giving the compliment, this is documented. The compliments are then shared with the responsible service so the feedback can be celebrated and shared with any member of staff who is mentioned. From this data, we can ascertain that: 189 compliments (32%) did not have a physical location recorded, either due to the nature of the service being delivered remotely (e.g. by phone) or because the location was not known; 82 (14%) related to urgent and emergency care settings including the Emergency Departments, Surgical Assessment Unit, Minor Injuries Unit, Same Day Emergency Care or Extended Observations; 169 (30%) related to theatres, inpatient wards, units or assessment clinics; 25 (4%) related to radiology or phlebotomy services; and the remaining 115 (20%) related to administrative service areas, outpatient departments, or other Trust locations such as car parks, headquarters, or specific hospital wings.

An informal review of the available free-text compliment data for 2024/25 has identified several recurring themes. A significant proportion of responses referenced staff members' helpfulness and willingness to offer support, particularly in explaining complex information and providing timely assistance. Kindness, empathy, and respectful care were also commonly recognised, with many individuals expressing appreciation for how they were made to feel safe, valued, and reassured. Professionalism, including clear communication and expert knowledge, featured frequently, contributing to an overall sense of trust and confidence in the care received.

Compliments also highlighted examples of high-quality care in specific services and settings. One patient described their positive experience while under the care of the surgical team on ward J46P in the Lincoln Wing Discharge Pod at St James's Hospital, praising the team's continuous and dedicated efforts. Another compliment was submitted by the wife of a patient who had passed away under the care of the respiratory team; she expressed deep gratitude for the compassionate and dignified care shown by all staff, from housekeepers to doctors. Additionally, a patient who underwent hernia surgery at Bexley Wing theatres shared appreciation for two recovery staff members who demonstrated exemplary compassion and person-centred care during an extended recovery period caused by a delay in bed availability. These and other compliments reflect not only individual acts of kindness but also a wider demonstration of professionalism and patient-centred care across the Trust.

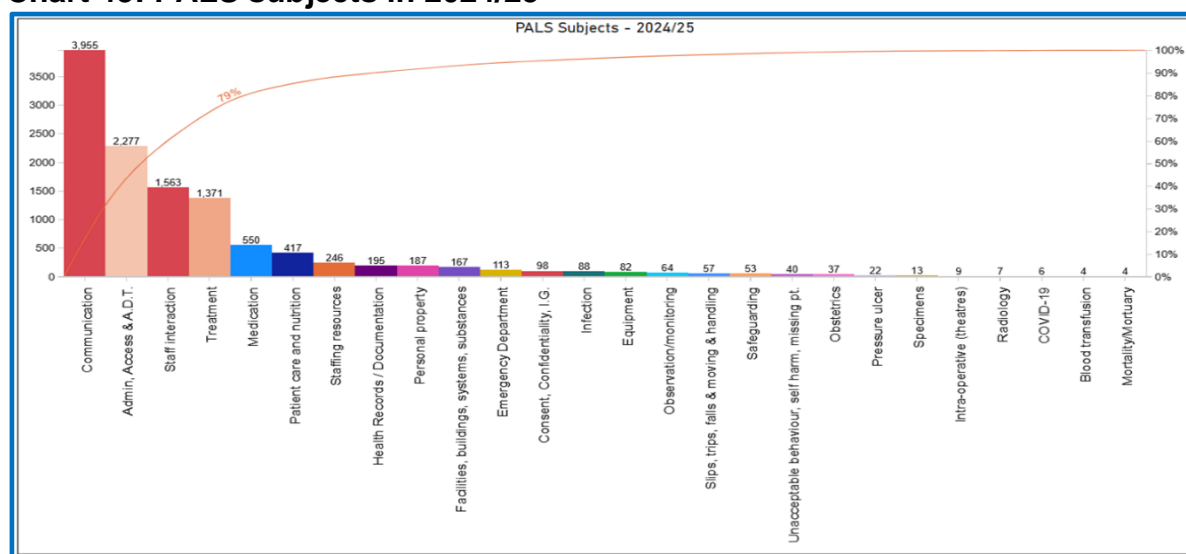


**Table 16: PALS Compliments received in 2023/24 and 2024/25 by CSU**

Clinical Service Unit	2023/24	2024/25	Change
Abdominal Medicine & Surgery	63	63	0
Adult Critical Care	7	6	1
Adult Therapies	13	16	-3
Cardio-Respiratory	36	24	12
Centre for Neurosciences	26	31	-5
Chapel Allerton Hospital	32	33	-1
Chief Nurse	36	56	-20
Children's	28	30	-2
Estates & Facilities	9	7	2
Head & Neck	38	32	6
Leeds Dental Institute	3	12	-9
Medicines Management & Pharmacy Services	2	2	0
Oncology	42	27	15
Outpatients	13	6	7
Pathology	1	2	-1
Radiology (inc. Medical Illustration)	43	31	12
Specialty & Integrated Medicine	17	21	-4
Theatres & Anaesthesia	22	18	4
Trauma & Related Services	24	23	1
Urgent Care	92	87	5
Women's	52	58	-6
<b>Total</b>	<b>599</b>	<b>585</b>	<b>14</b>

## 5.2 PALS themes

The most common subjects from PALS concerns in the last 12 months of available data can be seen in **Chart 43** below.

**Chart 43: PALS subjects in 2024/25**


The top 80% of all PALS subjects recorded in 2024/25 were:

- Communication (3,955 subjects logged)
- Administration, access, admission, transfer and discharge (A.D.T.) (2,277)
- Staff interaction (1,563)
- Treatment (1,371)

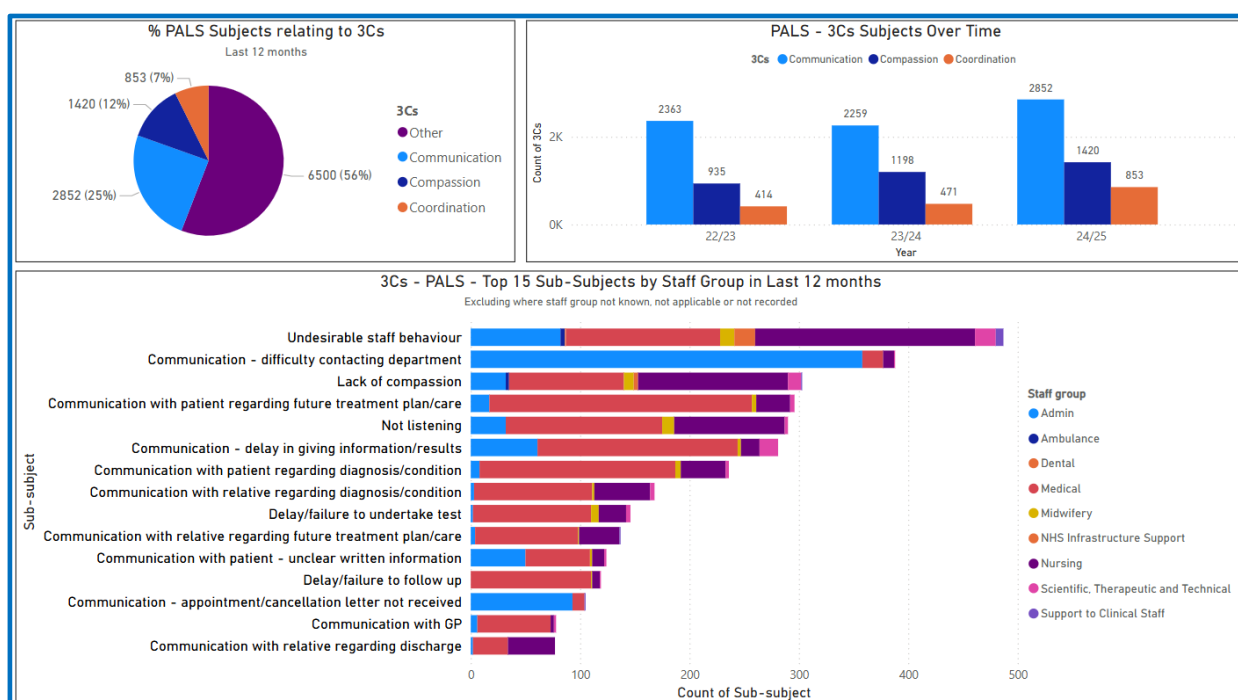
**Table 16** shows the top 15 PALS sub-subjects from the five priority subjects above.

**Table 16: Top 15 PALS Sub-subjects 2024/25**

PALS Top 15 Sub-Subjects - Linked to Top 4 Subjects	
Sub-subject	24-25
Waiting list time (outpatient)	985
Undesirable staff behaviour	644
Communication - difficulty contacting department	571
Communication with patient regarding future treatment plan/care	486
Lack of compassion	407
Delay/failure in treatment/procedure	398
Communication - delay in giving information/results	388
Communication with patient - telephone call/text	374
Not listening	342
Communication with patient regarding diagnosis/condition	325
Cancelled/rescheduled clinic/appointment	235
Communication failure within department	211
Communication - appointment/cancellation letter not received	195
Waiting list time (inpatient)	192
Cancelled/rescheduled surgery/procedure	189
<b>Total</b>	<b>5942</b>

PALS sub-subjects have been reviewed and those relating to the 3C's – Communication, Compassion and Co-ordination identified. **Figure 5** below provides an overview of these themes and sub-themes in 2024/25.

**Figure 5: PALS Concerns relating to Communication, Compassion & Coordination**



### 5.3 PALS Service Accessibility

**Table 17** shows that service users contact PALS predominantly via email and telephone. Whilst most other contact methods remained similar in proportion to the previous year, the previously reported decrease in telephone calls appears to have reversed for the year to date, with a 10 percentage-point increase when compared to the proportion of calls in 2023/24. There has also been a notable drop in the number of complaint forms received.

#### Table 17: PALS contact methods

In 2024/25 there were 3,743 emails (51% of all contacts logged on Datix). All emails receive an automated reply and a member of the PALS team contacts the enquirer within one working day.

There were 3,456 telephone calls to PALS (47% of all contacts). The remainder of contacts were received via other routes, such as in person, letter, via Chief Executive or Chair, social media, bereavement team referral, or Member of Parliament.

Not all calls to PALS are logged on Datix. A breakdown of all calls to the PALS service for the past two financial years with percentage comparisons is outlined in **Table 17**.

In total there were 20,097 calls to PALS in 2024/25 compared to 19,079 the previous year (+1,018, 5% increase).

#### Table 17. PALS telephone call data

Call category	2023/24	2024/25	2023/24 (%)	2024/25 (%)
Transferred to PALS call queue	9102	10,454	48%	52%
PALS voicemail (all handlers engaged)	4247	441	22%	19%
Out of hours	2837	2,755	15%	14%
Redirected to external organisations	2524	2,629	13%	13%
Transferred to the Complaints team voicemail	369	441	2%	2%
2023/24		2024/25		
Of calls transferred to PALS queue (where data available)	9,078	10,431		
Calls answered	4,804	6,611	53%	63%
Abandoned	119	132	1%	1.3%
Redirected by handlers to the PALS voicemail	4,155	3,688	46%	35%

Call statistics	2023/24	2024/25
Average time to answer (seconds)	15	13
Longest time to answer (seconds)	41	41
Average abandonment (seconds)	16	18
Longest abandonment (seconds)	38	40
Average connected call duration, n (minutes (m), seconds (s))	5m 57 s	6m 27s

The PALS team aim to respond to all voicemails within one working day.

There are several factors which impact on service reliability, including the number of PALS handlers available to answer calls due to vacancies or staff training and the volume of incoming calls to the service.

There were 6,836 recorded resolutions of PALS contacts received in 2024/25. 80% of enquirers were contacted within the two working day target (also 80%). Callers are always asked what their preferred method of contact would be. 68% were resolved via telephone call; 14% by email; 5% by discussion on the ward; 2% via a meeting or discussion in clinic; 2% by letter; 3% were escalated to a formal complaint or sent a complaint form; 1% were passed to Risk Management; and 1% were closed when unable to contact the complainant.

## 5.4 PALS Service Improvements / Developments

The data analyst provides an open PALS report to CSUs every two weeks. This identifies the numbers of open PALS and how many service users are awaiting contact and resolution.

The PALS management team and data analyst adapted the report in March 2024. Open cases are now grouped into the following four colour coded categories. The middle two categories will be changed in Q1 2025/26 to reflect the change to the resolution target from 14 to 10 working days.

- 0 to 3 working days;
- 4 to 14 working days;
- 15 to 50 working days;
- 51 working days and over.

There has been a long-standing request from CSU management teams to only show cases awaiting resolution for their area of responsibility when there is more than one CSU involved in the concern (multi-PALS). This change has now been made and will provide CSUs with an accurate picture of their open case load and will support them in prioritising resolution for long-running unresolved cases (red and purple cases; over 14 working days). Whilst the report production process is being embedded to ensure reliability and reduce potential errors, feedback will be sought from CSUs and corporate managers to assess the effectiveness and usability of the report.

Two new Datix dashboards have also been developed. One shows the frequency and detail of cases escalated to the formal complaints team; this will support the complaints action plan by identifying potential learning from escalated PALS and identifying actions to support earlier resolution and a better experience for complainants. Additionally, a live weekly production board has been created, displaying the number of cases logged and closed on Datix by the team.

## 6. FORWARD PLAN

The plan for 2025/26 includes:

- Share outputs of the Complaints Sharing event with CSUs and consider introducing these as regular events.
- Continue to explore the removal of the external quality assurance review, testing this in the domain of simple multi complaints.
- Continue to drive increases in the use of complaint resolution meetings.

- Improving the recording of actions taken in response to complaints and monitoring the completion of these.
- Use complaints and PALS data to drive improvements in communication, co-ordination, and compassion.
- Capture patient stories where complaint themes are arising in CSUs and use these to support improvements.
- Respond to the findings of the PALS and Complaints feedback surveys.
- Develop skills in early resolution of concerns within CSUs.
- Improve the monitoring of PALS that remain open longer than 40 days.
- Review the process for the quality assurance of PALS letters.
- Deliver actions arising from the findings of the internal audit of complaints currently underway.
- Work with Healthwatch Leeds to review the PALS and Complaints processes to identify areas for improvement.
- Continue to provide organisational complaints response writing and mediation skills training Trust wide to staff.

## **7. PUBLICATION UNDER THE FREEDOM OF INFORMATION ACT**

This paper has been made available under the Freedom of Information Act 2000.

## **8. RISK**

QAC provides oversight of the Trust's PALS and Complaints activities contributing to the well-led development and preparations for future inspection. There was no material change to the risk appetite statement related to the level 2 risk categories and the Trust continues to operate within the risk appetite for the level 1 risk categories (clinical and external risk) set by the Board.

## **9. RECOMMENDATIONS**

QAC are asked to receive the report and be assured on the actions that are being taken to improve the experience and response to complaints and PALS.

**Jo Corrigan and Rosie Horsman**  
**Lead Nurses, Patient Experience**

**09 June 2025**

**Appendix 1: Complaints Timeliness Action Plan 2024-2026**

<b>Complaints Timeliness Action Plan –</b>			
<b>Area of Improvement</b>	<b>Action</b>	<b>Target date</b>	<b>Responsibility</b>
1) Respond to CSU feedback that a major cause of delay in returning complaint responses is a lack of engagement from doctors in the process.	A) Deliver a two-day Kaizen event focussing on improving medical engagement, with the Neurosciences CSU	November 2024	<b>KMW</b>
	B) Report out of 30, 60, and 90, day progress.	December 2024, January 2025 February 2025.	<b>KH DP SR RH</b>
	C) Deliver a multi-CSU event to share the learning across all CSUs, with the request that each progresses a workstream to address their internal barriers to medical engagement. Trust Medical Directors to promote medical attendance and engagement at the event.	May 2025	<b>KMW/ER/KK/JC</b>
	D) Provide dates to medical staff for a workshop on complaint response writing.	March 2025	<b>DP/JC – AKD Solutions</b>
	E) Monitoring of CSU progress against workstream plans to be included in Quality Review meetings.	March 2025	<b>ER</b>

<p>2) Respond to CSU feedback that delays are incurred in the complaints Quality Assurance process.</p>	<p>A) Implement a test with two CSUs to remove the quality assurance review from simple multi-CSU complaints. (20 OR 40 DAYS) This will be where the lead CSU has only involved only one other CSU and the complaints are not complex.</p> <p>B) Identify the cohort from data captured in DATIX.</p> <p>C) Review data to assess if there has been a positive impact on timeliness.</p> <p>D) Review data to assess impact of responses on defect rate.</p> <p>E) Roll out Trust-wide if data evidences a positive impact has been achieved.</p>	<p>July 2025</p> <p>December 2024</p> <p>Sept 2025</p> <p>Sept 2025</p> <p>Sept 2025</p>	<p><b>DP</b></p> <p><b>JDI/JB</b></p> <p><b>JDI/DP</b></p> <p><b>JDI/DP</b></p> <p><b>DP/JC</b></p>
<p>3) CSUs who have not earned autonomy for QA of single CSU complaints have longer complaint pathways.</p>	<p>A) Undertake a data review of QA returns and defect rates for all CSU and remove external QA where appropriate to do so.</p> <p>B) Where CSUs require ongoing support, agree a plan with DCN`s to move forward with the aim of achieving earned autonomy.</p> <p>C) Review data to assess if able to achieve autonomy for all single CSU complaints.</p>	<p>December 2024</p> <p>July 2025</p> <p>March 2025</p>	<p><b>JDI/KK/JC</b></p> <p><b>ER/DCN</b></p> <p><b>JDI/KK/JC</b></p>



<p>4) Respond to CSU feedback that some complaint responses are impacted as a result of responses awaited from organisations external to LTHT</p>	<p>A) Review data relating to all external multi-sector complaints to assess impact on overall Trust performance – identify if this impacts achievement of 80% complaints completed in target.</p> <p>B) Review process for multi-sector complaints and consider if there are opportunities to report differently, where the LTHT response is ready within target.</p>	<p>December 2024</p> <p>May 2025</p>	<p><b>JDI/DP</b></p> <p><b>JC/DP</b></p>
<p>5) Complaints resolved through a meeting are more likely to result in resolution and are less likely to reopen. Aim is to increase number of meetings.</p>	<p>A) Identify two willing CSU's with large number of complaints, to take forward an improvement exercise in collaboration with complaints team, focussing on increasing the number of complaint resolution meetings.</p> <p>B) Meet with CSU to assess any further support required.</p> <p>C) Test the plan over 4 meetings.</p> <p>D) Deliver a multi-CSU event to share the learning across all CSUs, with the request that each progresses a workstream to increase the number of resolution meetings.</p> <p>E) Monitoring of CSU progress against workstream plans to be included in Quality Review meetings.</p>	<p>May 2025</p> <p>June 2025</p> <p>June 2025</p> <p>May 2025</p> <p>June 2025</p>	<p><b>DP/JC</b></p> <p><b>KK/JC/DP</b></p> <p><b>JC/DP</b></p> <p><b>KK/JC/DP</b></p> <p><b>ER</b></p>
<p>6) Complainants are not always explicit in</p>	<p>A) 2 Day Kaizen Event to identify improvement. workstreams and Develop PDSA for rapid implementation.</p>	<p>November 2024</p>	<p><b>JC/DP</b></p>

<p>their specific concerns and what they want to achieve by making a complaint.</p> <p>This can lead to re-opened complaints, increased CSU time spent.</p> <p>Concerns to be responded to are not currently confirmed with the complainant before being sent to CSUs to respond to.</p>	<p>B) Test a process of agreeing concerns to be responded to, and desired outcomes with the complainant directly. Process will not commence until the complainant has confirmed concerns. with dedicated complaint handlers and CSU.</p> <p>C) Review learning, share with CSUs and implement appropriate Trust wide initiatives arising from this exercise.</p>	<p>December 2024</p> <p>May 2025</p>	<p><b>JC/DP</b></p> <p><b>JC/DP</b></p>
<p>7) The backlog of complaints in the Trust makes it difficult for CSUs to keep on top of new complaints received.</p>	<p>A) Review data on backlog of complaints to understand numbers and hold-ups and create new fortnightly report to share with CSU.</p> <p>B) Offer help with interpreting data to all those who receive this.</p> <p>C) Initiate a request that CSUs undertake a targeted exercise to close long standing complaints over a three-month period.</p> <p>D) Monitoring of CSU progress against workstream plans to be included in Quality Review meetings.</p>	<p>November 2024</p> <p>December 2024</p> <p>January 2025</p> <p>March 2025</p>	<p><b>JDI/DP</b></p> <p><b>DP/JDI</b></p> <p><b>KK/DCN</b></p> <p><b>ER</b></p>

8) High performing Trusts have a process to approve complaint extensions which require senior sign off.	<p>A) Review number of Complaints where targets not met.</p> <p>B) Consider a process when extensions are required, it is the responsibility of the CSU to phone the complainant and indicate the reason for this.</p> <p>C) Consider SBAR to be written and presented to NMALT to explore options for DCN approval of an extension to target time.</p> <p>D) SOP to be developed for agreed extension process.</p>	<p>January 2025</p> <p>January 2025</p> <p>February 2025</p> <p>March 2025</p>	<p><b>JDI/JB</b></p> <p><b>DP/JC</b></p> <p><b>ER/KK</b></p> <p><b>JB</b></p>
9) CSUs have consistently advised that the 20-day target is too difficult to achieve	<p>A) Review the data on 20-day target and consider Trust performance against this metric, proportion of complaints failing to meet this standard and how this compares to data for 40- and 60-day performance.</p> <p>B) If the data suggests an adjustment to the 20-day target is appropriate, progress a proposal for a new target through PEEG.</p> <p>C) SBAR to be written and presented to PEEG to explore options for approval of adjusted target time.</p>	<p>December 2024</p> <p>January 2025</p> <p>February 2025</p>	<p><b>JDI</b></p> <p><b>DP/JC</b></p> <p><b>DP/JC</b></p>
10) There are some instances where		February 2025	<b>KK/JC</b>

external QAs of multi-CSU complaints are taking an unacceptable length of time to be completed and are failing KPI.	A) Review and update current QA list to assess ongoing support and how competence is maintained, given the reducing number of complaints requiring QA.	January 2025	<b>KK/JC</b>
	B) Consider an alert / escalation process when external QAs have not been completed in a timely manner.	April 2025	<b>KK/JC</b>
	C) Resurrect the QA Forum to continue to provide a support and updates to QA role.		
11. Risk Management reviews affect the timeliness of responses, particularly where this relates to an incident/coroner's enquiry/litigation/redress.	A) Review data for those complaints requiring risk QA to assess volume and average length of time taken.	January 2025	<b>JDI/DP</b>
	B) Explore impact on timeliness of complaints.	January 2025	<b>DP/JC</b>
	C) Highlight collective negative impact on timeliness of complaints, to prompt a discussion on potential improvements to the process.	February 2025	<b>KK/ER</b>
12. Review all stages of corporate complaints process to identify if any stage is contributing specifically to delays and develop bespoke action plan to address this.	A) Review the DATIX the data to capture time taken for each stage of the internal complaints processes: <ul style="list-style-type: none"> <li>• Exec sign off.</li> <li>• Draft responses from CSU</li> <li>• Initial complaint From PET to CSU</li> <li>• PET drafting</li> <li>• Proof reading</li> <li>• Pre-risk Review</li> <li>• DCN sign off.</li> <li>• Meeting arrangements/ responses</li> </ul>	December 2024	<b>JDI/DP</b>
	B) Where a stage has a negative impact on timeliness, develop an improvement plan.	January 2024	<b>DP/JC</b>

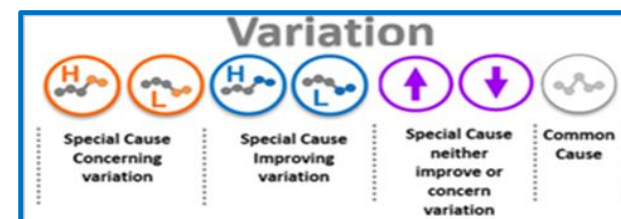
	C) Report changes Improvements through PEEG	April 2024	<b>DP/JC</b>
--	---	------------	--------------

**Appendix 2: Complaint Action Types by CSU – 2024/25**

CSU	Action Type											Total
	Amend Guideline	Buy new equipment	Create policy	Develop a guideline	Feedback to individual	One-off training	Replace existing equipment	Set up ongoing training	Share at governance meeting	Standard Complaint Process	Undertake Audit	
Trauma & Related Services	0	0	0	0	34	1	0	0	0	5	0	40
Urgent Care	0	2	0	3	11	1	1	0	3	19	0	40
Oncology	0	0	0	0	9	0	0	0	20	7	2	38
Cardio-Respiratory	0	0	0	0	11	3	0	3	5	9	2	33
Chapel Allerton Hospital	2	0	0	2	2	0	0	1	8	0	0	15
Children's	0	0	0	0	4	1	0	0	0	6	0	11
Adult Therapies	3	0	2	0	1	1	0	0	0	1	0	8
Radiology (inc. Medical Illustration)	0	0	0	2	2	0	0	0	0	0	2	6
Theatres & Anaesthesia	0	0	0	0	0	0	0	0	0	3	0	3
Abdominal Medicine & Surgery	0	0	0	0	0	0	0	0	0	0	2	2
Specialty & Integrated Medicine	0	0	0	0	1	1	0	0	0	0	0	2
Women's	0	0	0	0	1	0	0	0	0	1	0	2
Chief Nurse	0	0	0	0	0	0	0	0	0	1	0	1
Outpatients	0	0	0	0	1	0	0	0	0	0	0	1
<b>Total</b>	<b>5</b>	<b>2</b>	<b>2</b>	<b>7</b>	<b>77</b>	<b>8</b>	<b>1</b>	<b>4</b>	<b>36</b>	<b>52</b>	<b>8</b>	<b>202</b>

### Appendix 3 - SPC Summary Table - 2 year monthly variation of most frequently logged complaint sub-subjects

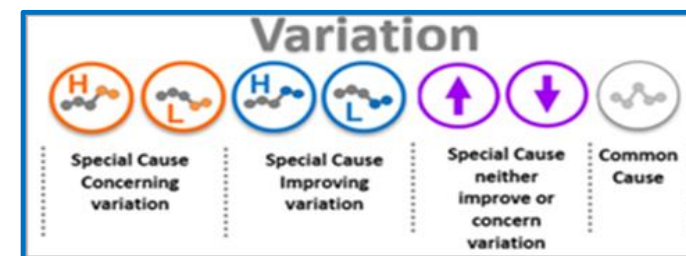
Complaints - Top 20 Sub-Subject Variation - Last 24 Months				
Sub-Subject	Latest Date	Value	Average	Variation
Communication Between Medical Teams	24/25/Mar	4	5	
Communication Failure Within Department	24/25/Mar	10	10	
Communication With Patient Regarding Diagnosis/Condition	24/25/Mar	20	14	
Communication With Patient Regarding Future Treatment Plan/Care	24/25/Mar	25	15	
Communication With Relative Regarding Diagnosis/Condition	24/25/Mar	12	10	
Communication With Relative Regarding Future Treatment Plan/Care	24/25/Mar	14	7	
Delay/Failure In Treatment/Procedure	24/25/Mar	30	20	
Delay/Failure To Act On Test Results/Reports	24/25/Mar	9	7	
Delay/Failure To Diagnose	24/25/Mar	7	9	
Delay/Failure To Follow Up	24/25/Mar	7	6	
Delay/Failure To Undertake Test	24/25/Mar	9	5	
Discharge - Patient Not Fit For	24/25/Mar	8	6	
Dispute Regarding Diagnosis	24/25/Mar	13	6	
Failure To Follow Up On Observations/Recognise Deteriorating Patient	24/25/Mar	5	5	
Inadequate Pain Management	24/25/Mar	7	5	
Lack Of Compassion	24/25/Mar	25	11	
Not Following Up On Agreed Action	24/25/Mar	11	6	
Not Listening	24/25/Mar	11	9	
Undesirable Staff Behaviour	24/25/Mar	14	14	
Waiting List Time (Outpatient)	24/25/Mar	6	5	



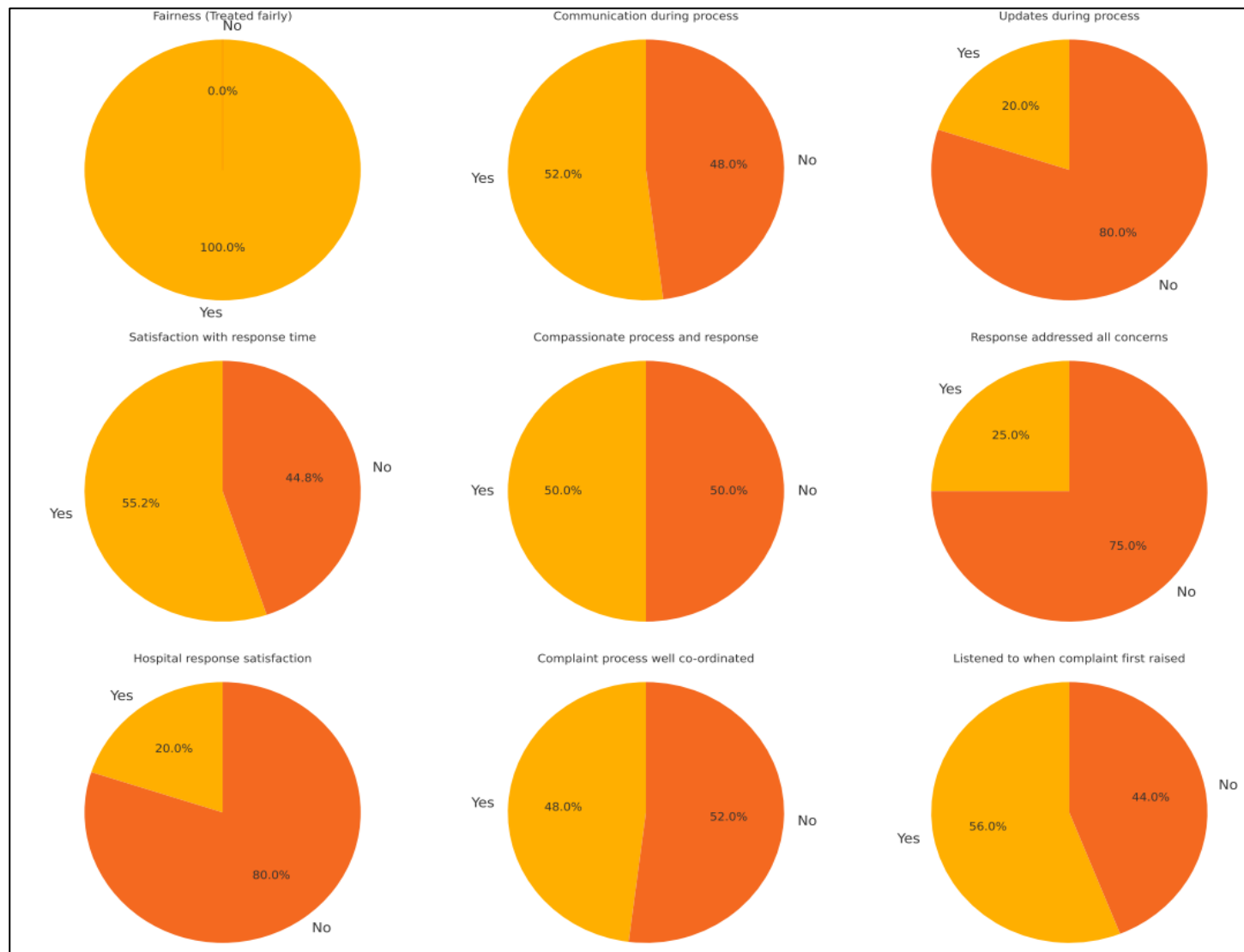


## Appendix 4 - SPC Summary Table - 2 year monthly variation of most frequently logged PALS sub-subjects

PALS - Top 20 Sub-Subject Variation - Last 24 Months				
Sub-Subject	Latest Date	Value	Average	Variation
Cancelled/Rescheduled Clinic/Appointment	24/25/Mar	32	20	
Cancelled/Rescheduled Surgery/Procedure	24/25/Mar	16	16	
Communication - Appointment/Cancellation Letter Not Received	24/25/Mar	25	24	
Communication - Delay In Giving Information/Results	24/25/Mar	34	31	
Communication - Difficulty Contacting Department	24/25/Mar	66	39	
Communication Failure Within Department	24/25/Mar	18	17	
Communication With Patient - Telephone Call/Text	24/25/Mar	32	25	
Communication With Patient Regarding Diagnosis/Condition	24/25/Mar	33	24	
Communication With Patient Regarding Future Treatment Plan/Care	24/25/Mar	54	33	
Communication With Relative Regarding Diagnosis/Condition	24/25/Mar	22	16	
Communication With Relative Regarding Future Treatment Plan/Care	24/25/Mar	13	14	
Delay/Failure In Treatment/Procedure	24/25/Mar	58	28	
Education And Competency Of Staff	24/25/Mar	25	14	
Lack Of Compassion	24/25/Mar	28	30	
Loss Of Belongings	24/25/Mar	12	15	
Not Listening	24/25/Mar	32	27	
Undesirable Staff Behaviour	24/25/Mar	61	51	
Unwelcome Message	24/25/Mar	6	11	
Waiting List Time (Inpatient)	24/25/Mar	12	15	
Waiting List Time (Outpatient)	24/25/Mar	119	74	



## Appendix 5: Complaint Survey Feedback Highlights –2024/25



## Appendix 6: PALS Survey Feedback – 2024/25



## Appendix 7: PALS and Complaints Patients Demographic Data

### Ethnicity

Ethnicity Proportion	White (%)	BAME (%)
Leeds (2021 Census)	79	21
Yorkshire & The Humber (2021 Census)	85	15
LTHT Complaints Patients 2024/25	84	16
LTHT PALS Patients 2024/25	86	14
LTHT Health Equity Admissions Data (2024/25*)	76**	24**

\*LTHT Health Equity Admissions Data (2024/25) includes data from 1<sup>st</sup> April 2024 to 30<sup>th</sup> March 2025 (not including admission data from 31<sup>st</sup> March 2025).

\*\* Ethnicity data disclosed above does not include those where patient ethnicity is 'not known' on PAS.

### Sex (PAS)

Category	Male (%)	Female (%)
Leeds (ONS 2023 Estimate)	49	51
Yorkshire & The Humber (ONS 2023 Estimate)	49	51
LTHT Complaints Patients 2024/25*	37	63
LTHT PALS Patients 2024/25*	40	60
*PAS data matched to Complaints and PALS patients includes intersex patients for recording of 'sex', which is not the case for the ONS 2023 estimate		

### Learning Disability and Autism

Type	Autism	Learning Disability
Complaint	15 (2.2%)	12 (1.8%)
PALS Concern and Enquiry	85 (1.3%)	81 (1.2%)

LTHT Health Equity Admissions Data (2024/25*)	723 (0.6%)	976 (0.8%)
--	------------	------------

## Age Groups

Age Group Proportion	Age 0 - 15	Age 16 - 64	Age 65+
Complaints Patient Age Groups (2024/25)	12%	60%	28%
PALS Patient Age Groups (2024/25)	10%	59%	31%
Leeds ONS Population Estimates (2023)	19%	66%	16%
LTHT Health Equity Admissions Data (2024/25***)	Age 0 to 16 18%	Age 17 to 65 51%	Age Over 65 31%

\*\*\*please note that age group categories used in admission data differ to other rows in table above but are provided here to provide a broad comparison.

## Religion

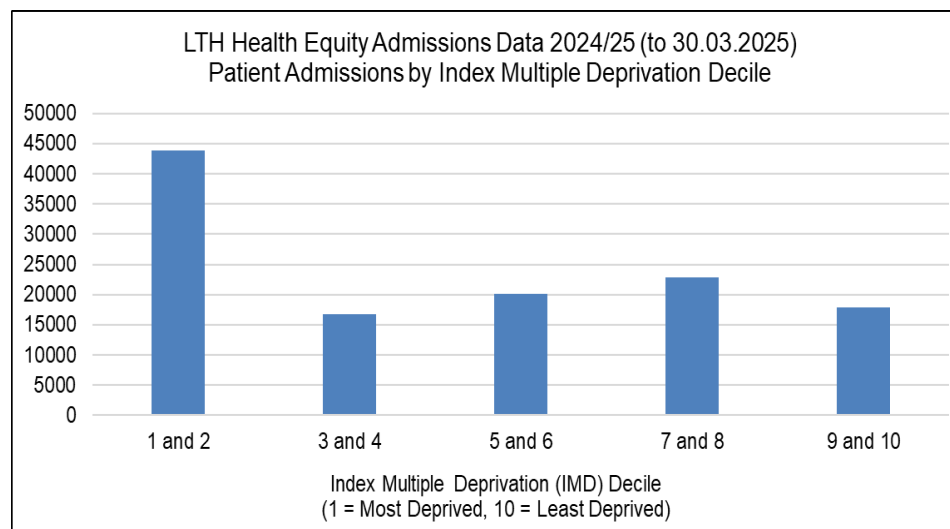
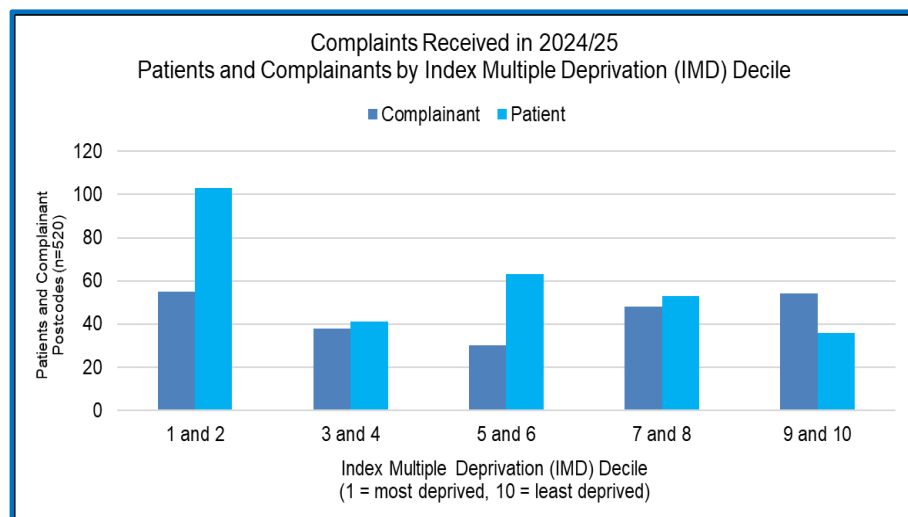
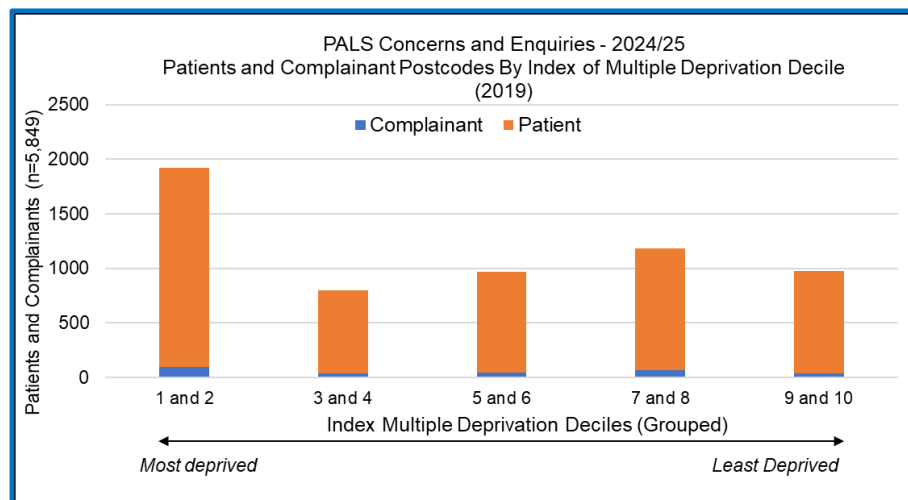
Religion*	Complaint Patients (PAS)	PALS Patients (PAS)	Leeds (Census, 2021)	Yorkshire and The Humber (Census, 2021)
Christian	86.8%	89.8%	42.3%	44.9%
Muslim	9.8%	6.5%	7.8%	8.1%
Sikh	1.5%	1.3%	1.2%	0.4%
Jewish	0.7%	1.4%	0.8%	0.2%
Hindu	1.0%	0.7%	1.1%	0.5%
Buddhist	0.2%	0.3%	0.4%	0.3%
Other religion	0.0%	0.0%	0.4%	0.4%

\*ONS data does not include no religion, therefore for comparison the PALS and Complaints patient data (PAS) excludes those patients without a religion or where not stated

## Disability

19 out of 666 (2.8%) patient details recorded for complaints identified they were living with one of the following categories of disability, with some patients disclosing more than one option: including learning disability, a physical disability, long-standing illness, mental health condition, another disability or preferred not to say. There was no data recorded for PALS nor was this data obtained via PAS.

## Appendix 8 – PALS and Complaints Received in 2024/25 by Patient and Complainant Postcodes Linked to Index Multiple Deprivation (IMD) Deciles.





## Appendix 9 - Complaint response lead time by lead CSUs

% Complaint Responses Sent Within Target Time Where CSU is lead for complaint. LR1 complaints only.				
CSUs	21/22	22/23	23/24	24/25
Infection Prevention			100%	
Medical Directorate	100%		50%	100%
Adult Therapies	86%	50%	100%	29%
Chief Nurse	100%	0%	0%	100%
Finance		0%	100%	50%
Medicines Management & Pharmacy Services	0%			100%
Radiology (inc. Medical Illustration)	36%	36%	73%	50%
Children's	56%	47%	38%	53%
Head & Neck	44%	36%	59%	52%
Informatics	50%	50%	0%	100%
Leeds Dental Institute	50%	31%	55%	40%
Theatres & Anaesthesia	40%	20%	67%	50%
Abdominal Medicine & Surgery	11%	19%	52%	78%
Urgent Care	26%	44%	35%	40%
Oncology	21%	22%	47%	41%
Outpatients	50%	50%	0%	33%
Research & Innovation		50%	0%	
Adult Critical Care	8%	29%	75%	60%
Centre for Neurosciences	33%	25%	15%	37%
Trauma & Related Services	8%	28%	42%	24%
Cardio-Respiratory	23%	23%	38%	25%
Specialty & Integrated Medicine	12%	26%	22%	36%
Estates & Facilities	14%	50%	20%	
Corporate Operations	0%	50%		0%
Chapel Allerton Hospital	36%	21%	13%	12%
Women's	28%	13%	6%	21%
Pathology	50%	0%	0%	20%
<b>Total</b>	<b>26%</b>	<b>28%</b>	<b>37%</b>	<b>42%</b>

Complaint response lead time by CSU Where CSU is lead for complaint. LR1 complaints only.				
CSUs	21/22	22/23	23/24	24/25
Chapel Allerton Hospital	58	63	78	95
Pathology	58	82	164	44
Trauma & Related Services	67	72	58	66
Cardio-Respiratory	61	60	46	56
Informatics	38	119	58	25
Centre for Neurosciences	40	53	63	56
Research & Innovation		44	73	
Specialty & Integrated Medicine	88	58	53	52
Chief Nurse	23	132	76	20
Abdominal Medicine & Surgery	83	75	43	27
Adult Critical Care	57	74	40	21
Oncology	62	81	46	46
Women's	45	62	57	54
Theatres & Anaesthesia	59	48	40	53
Urgent Care	62	48	51	49
Finance		51	45	42
Estates & Facilities	45	33	54	
Children's	40	44	55	39
Corporate Operations	41	33		44
Leeds Dental Institute	31	36	46	55
Outpatients	34	45	80	64
Head & Neck	38	44	37	36
Radiology (inc. Medical Illustration)	42	46	27	41
Adult Therapies	39	38	26	39
Medical Directorate	19		72	28
Infection Prevention			32	
Medicines Management & Pharmacy Services	40			20
<b>Total</b>	<b>59</b>	<b>58</b>	<b>54</b>	<b>47</b>

**Appendix 10 - Complaint response defect rate by CSU**

% Complaint response defect rate by CSU			
Responses sent at LR1 stage where CSU was involved			
CSUs	22/23	23/24	24/25
Abdominal Medicine & Surgery	9.5%	7.1%	7.4%
Adult Critical Care	15.8%	14.3%	6.3%
Adult Therapies	6.9%	0.0%	8.8%
Cardio-Respiratory	9.5%	11.6%	3.2%
Centre for Neurosciences	12.5%	12.1%	3.2%
Chapel Allerton Hospital	6.3%	17.1%	9.1%
Chief Nurse		16.7%	
Children's	15.2%	5.6%	8.2%
Corporate Operations	0.0%		
Estates & Facilities	4.3%	8.0%	
Finance			50.0%
Head & Neck	10.3%	12.5%	3.2%
Infection Prevention		0.0%	
Informatics	0.0%		0.0%
Leeds Dental Institute	7.1%	7.1%	
Medical Directorate			0.0%
Oncology	7.0%	6.9%	5.4%
Pathology	0.0%		
Radiology (inc. Medical Illustration)	2.9%	10.5%	0.0%
Specialty & Integrated Medicine	17.1%	14.1%	9.7%
Theatres & Anaesthesia		4.8%	
Trauma & Related Services	15.7%	6.2%	11.8%
Urgent Care	9.8%	11.9%	4.1%
Women's	2.9%	3.5%	6.4%