

Complaints and PALS Six Month Update 2025/26
Public Board
26 March 2026

Presented for:	Assurance
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Previous Committees:	Quality Assurance Committee, 19 February 2026

Link to Strategic Objective	Focus on care quality, effectiveness and patient experience
Link to Provider Capability Assessment	Quality of care
Link to CQC Well-led Statement	Governance, Management and Sustainability
Regulatory Impact	Regulation 16: Receiving and acting on complaints

Key points	Purpose
A complaints improvement plan has been developed to respond to the CQC regulatory breach relating to complaint timeliness.	<i>Assurance</i>
Key risks to achieving improvement are the increasing numbers of complaints received, the backlog of existing complaints and overdue PALS.	<i>Information</i>
Initial actions in the plan are focussed on reducing the complaints backlog in the poorest performing CSUs, achieving quick resolution when concerns are first identified and removing duplication from the complaints process.	<i>Information</i>
Governance and oversight are being strengthened to maintain momentum with achieving expected progress in delivering the complaints improvement plan.	<i>Assurance</i>

<u>Risk Appetite Framework</u>			
Level 1 Risk	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk	Choose an item.	Choose an item	Choose an item.
Operational Risk	Choose an item.	Choose an item	Choose an item.
Clinical Risk	Patient Experience Risk - We will comply with or exceed minimum patient experience targets.	Cautious	Moving Towards
Financial Risk	Choose an item.	Choose an item	Choose an item.
External Risk	Choose an item.	Choose an item	Choose an item.

1. Summary

This complaints and PALS six monthly update report has previously been presented to the Trust Quality Assurance Committee (QAC) in February 2026 and provides an update summarising Trust performance in relation to complaints and PALS management during Q1 and Q2 2025/26. It also provides details of actions taken since the Trust was notified of a breach of regulation by the Care Quality Commission (CQC).

2. Background

In September 2025, following the Well Led inspection by the Care Quality Commission, the Trust was notified that the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been breached. Specifically, Regulation 16: Receiving and acting on complaints. It was reported:

- The Trust did not have a consistent, effective and accessible system for identifying, receiving, recording, handling and responding to complaints because complaints processes were not consistently completed within targets.

For context the national standard is up to 6 months to respond, however our own internal target times are 20, 40 or 60 working days, this is based upon judged complexity which is agreed when the complaint is received.

Details of actions to address the regulatory breach and to improve the complaints response process can be found in section 5

3. Complaints Performance Q1 and Q2 2025/26

In Q1 and Q2 2025/26 the Trust received 485 complaints. There were 186 more complaints received than in the same period the previous year, representing a 62% increase. See **Table 1a** below.

Table 1a – Comparison of complaints received in last three financial years

Financial Year	Complaint Type			Total
	Single CSU	Multi CSU	Mixed sector	
2022/23	356	188	119	663
2023/24	262	204	117	583
2024/25	362	200	114	676
Comparison with same period last year				
Q1+Q2 2024/25	160	84	55	299
Q1+Q2 2025/26	257	167	61	485
Difference from Q1+Q2 2024/25	97	83	6	185
% Increase from Q1+Q2 2024/25	61%	99%	11%	62%

CSU data for Q1 and Q2 2025/26 compared to the same period the previous year is shown in **Table 1b** below. 22 CSUs reported an increase in complaints. The top three complaint increases were recorded for the following CSUs:

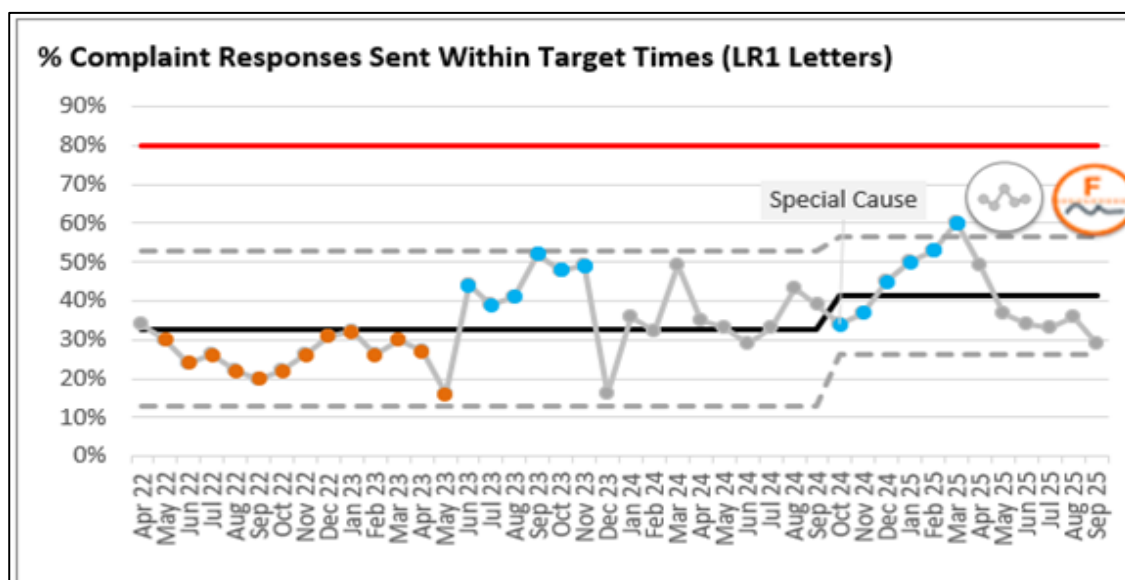
- Women's (an increase of 37 complaints)
- Trauma and Related Services (an increase of 33 complaints)
- Children's (an increase of 32 complaints).

Table1b: Complaints Received by CSU

CSUs	Q1+Q2 2024/25	Q1+Q2 2025/26	Difference	% Change
Women's	29	66	37	128%
Trauma & Related Services	22	55	33	150%
Children's	22	54	32	145%
Abdominal Medicine & Surgery	63	88	25	40%
Urgent Care	58	81	23	40%
Cardio-Respiratory	19	39	20	105%
Centre for Neurosciences	28	46	18	64%
Radiology (inc. Medical Illustration)	18	32	14	78%
Adult Therapies	16	29	13	81%
Oncology	35	46	11	31%
Chapel Allerton Hospital	20	30	10	50%
Pathology	5	14	9	180%
Theatres & Anaesthesia	9	18	9	100%
Leeds Dental Institute	2	9	7	350%
Specialty & Integrated Medicine	46	53	7	15%
Adult Critical Care	7	13	6	86%
Estates & Facilities	9	15	6	67%
Outpatients	3	9	6	200%
Head & Neck	16	20	4	25%
Medical Directorate	2	5	3	150%
Corporate Operations	1	3	2	200%
Finance	1	3	2	200%
Chief Nurse	14	14	0	0%
Informatics	2	2	0	0%
Medicines Management & Pharmacy Services	7	4	-3	-43%

In Q1 and Q2 2025/26 the overall Trust performance for complaint responses sent within the Trust internal target times of 20, 40 or 60 working days, was consistently below the target of 80% (**Chart 2**).

There was a significant improving trend each month from October 2024 to March 2025 which returned to normal variation in the following six months. This can be attributed to the increase in the number of complaints received since the start of 2025.

Chart 2: Complaint responses sent within target time**Table 2: Complaint themes in Q1 /Q2 2023/24 compared to Q1 /Q2 2024/25**

Details of action to identify the causes for delays in response and to address this is details in section 5.

Subject	FQ1&2 24/25	FQ1&2 25/26	Difference	% Change
TREATMENT	454	732	278	61%
COMMUNICATION	520	789	269	52%
ADMIN, ACCESS, PATIENT FLOW	121	256	135	112%
STAFF INTERACTION	264	386	122	46%
OBSERVATION/MONITORING	71	108	37	52%
EQUIPMENT	2	26	24	1200%
MEDICATION	64	88	24	38%
OBSTETRICS	11	27	16	145%
INFECTION	32	47	15	47%
SAFEGUARDING	22	37	15	68%
STAFFING RESOURCES	17	32	15	88%
RECORDS / DOCUMENTATION	4	18	14	350%
PATIENT CARE AND NUTRITION	88	101	13	15%
CONSENT, CONFIDENTIALITY, I.G.	3	15	12	400%
SAFETY OR BEHAVIOURAL INCIDENT	3	10	7	233%
SPECIMENS		7	7	
FACILITIES, ESTATES, SUBSTANCES	5	11	6	120%
FALLS, MOVING & HANDLING	12	17	5	42%
MORTALITY/MORTUARY	3	7	4	133%
PRESSURE ULCER	2	6	4	200%
RADIOLOGY	13	17	4	31%
CARER EXPERIENCE	3	6	3	100%
EMERGENCY DEPARTMENT	30	33	3	10%
NOT RECORDED	1	4	3	300%
LABORATORY INVESTIGATION	1	3	2	200%
PERSONAL PROPERTY	5	6	1	20%
COVID-19	2	2	0	0%
BLOOD TRANSFUSION	3	2	-1	-33%
INTRA-OPERATIVE (THEATRES)	8	5	-3	-38%
Total	1764	2798	1034	59%

Action to address themes from complaints:

Examples of CSUs addressing themes arising from complaints have been presented at Patient Experience and Engagement Group (PEEG) and for the reporting period include:

Adult Critical Care

The team identified from feedback that many patients struggle with not knowing what has happened to them whilst they have been on the unit and a lack of communication about this, as they have little recollection of their time there. The team have introduced an informal diary which staff fill in with notes about each day. This is given to the patient when they leave the unit. Feedback from patients has been excellent about this initiative.

Urgent Care

Volunteer support has expanded at St James's Emergency Department, where 16 volunteers have been recruited to assist with tasks such as offering refreshments, monitoring patient waits and responding to queries. This has enhanced communication and support for patients and relatives, topics that frequently come up in complaints.

The team have also introduced an approach to manage simple complaints where patients are offered a phone call with a senior member of staff before the complaint process formally commences. These early conversations have been successful in resolving some concerns.

Estates & Facilities

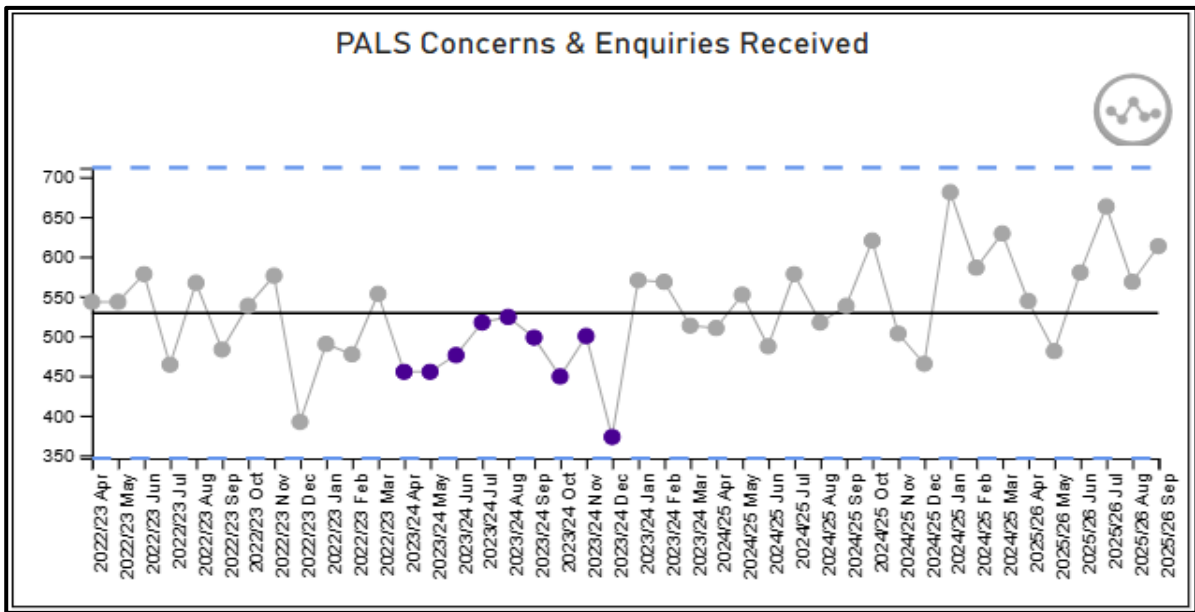
The CSU receive complaints about hospital food and in response have supported the provision of hot meals after hours during Ramadan and the blessing of food for Passover. The CSU have also involved children in hospital in the design of the Christmas day menu.

Plans to address trust wide themes from complaints are in development, this will feature in the new governance and reporting structure.

4. PALS Performance Q1 and Q2 2025/26

In Q1 and Q2 2025/26, the PALS team received 3,448 PALS concerns and enquiries. This was an increase of 266 from the same period the previous year (**Chart 3**).

Chart 3: PALS concerns and enquiries received by month

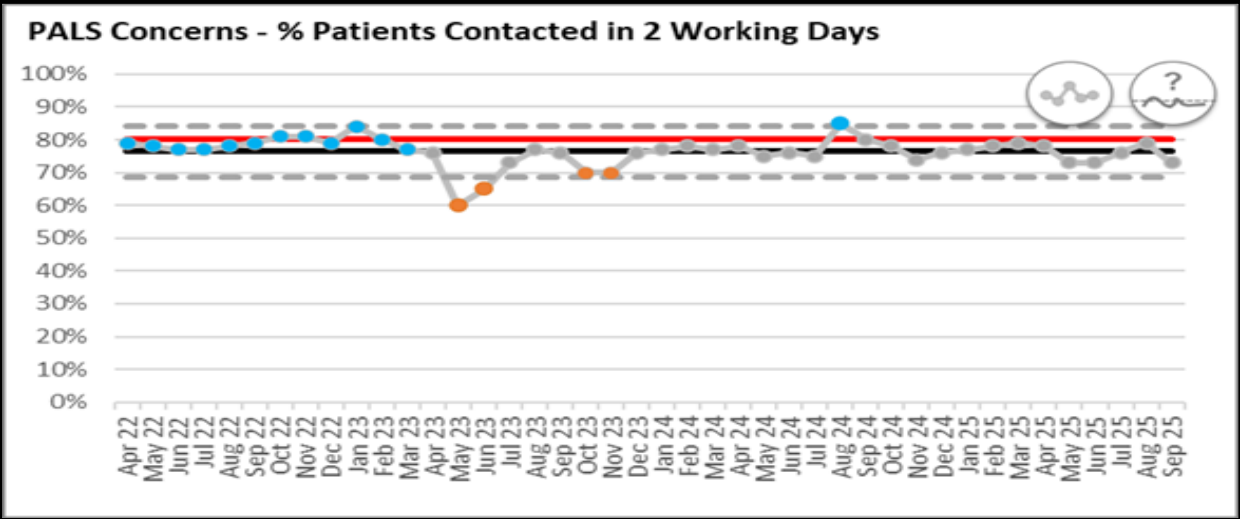


The two key performance indicators (KPIs) for PALS concerns are:

- 80% of PALS users to have CSU contact within two working days
- 80% of PALS to be resolved within ten working days

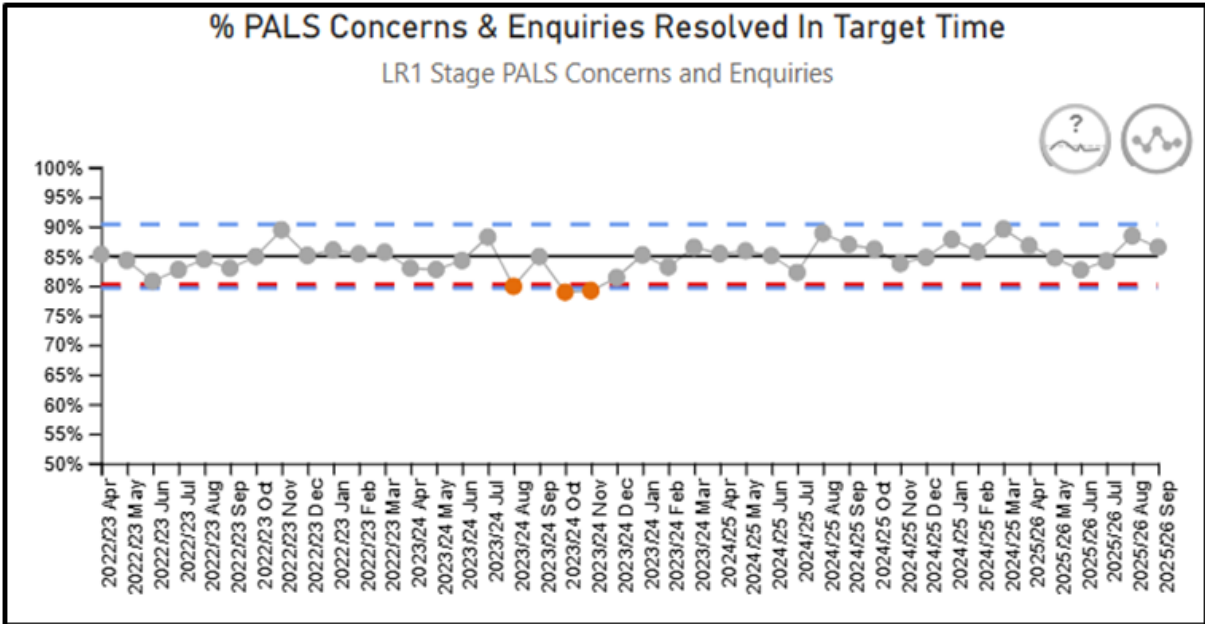
Chart 4 shows the percentage of PALS complainants who raised a concern and were first contacted within the target time of two working days.

Chart 4: Monthly percentage of patients contacted within two working days



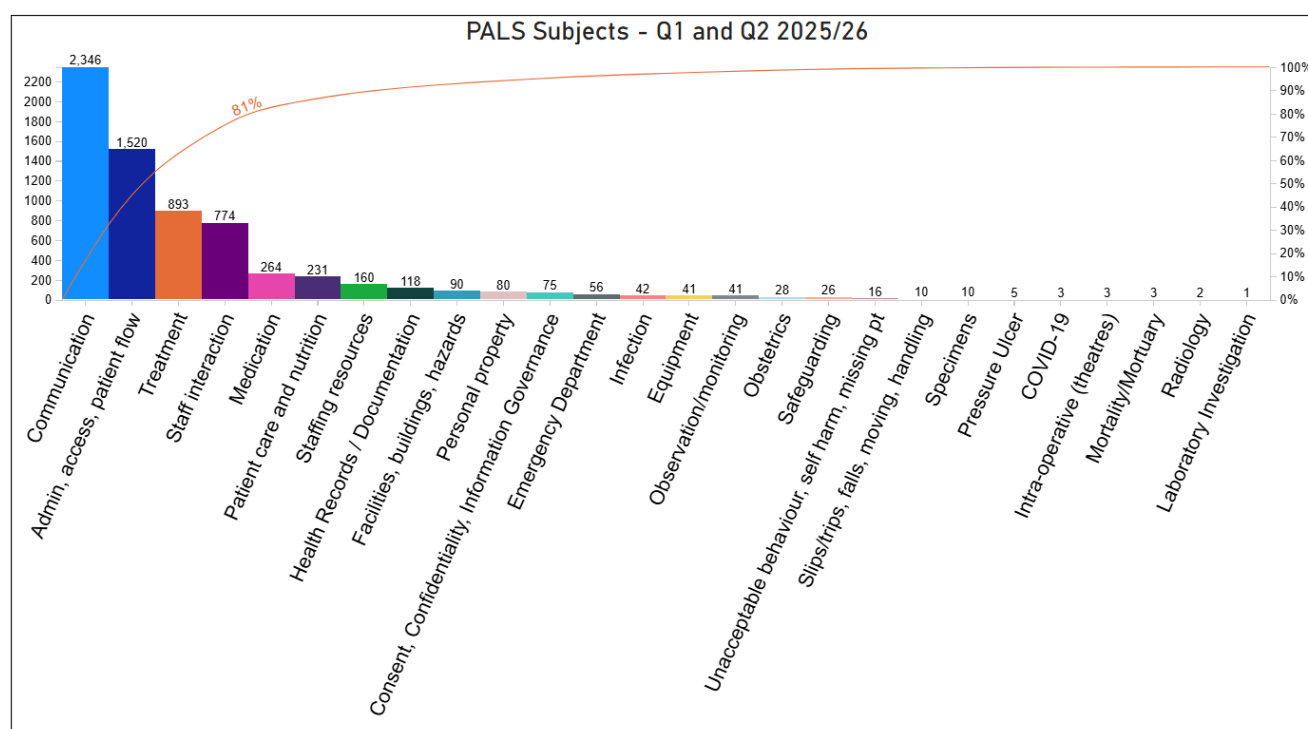
The percentage of PALS concerns resolved within the target time of 10 working days is shown in **Chart 5**.

Chart 5: Percentage of concerns resolved within 10 working days



The most common subjects from PALS concerns can be seen in **Chart 6**.

Chart 6: PALS subjects in Q1 and Q2 2024/25



An increase in PALS contacts for the following areas have all see increases:

- Delay or failure in treatment or procedure
- Communication with relatives and patients
- Missing or lost referrals

Actions taken in response to PALS themes by CSUs:

Collaboration with the Urgent Care CSU has led to the development of new template response letters for addressing the top five PALS concern that are frequently reported for ED, these are:

- long waits in Emergency Department,
- prolonged bed waits in the Emergency Department,
- mental health and well-being,
- noise
- nutrition and hydration

Responses are now being sent directly from the PALS team to the complainants. This change aims to eliminate delays in communication. The new process was implemented in December 2025.

A review of the number of out of time PALS in the Women's CSU has been undertaken with the CSU HoN and a process was agreed for the PALS team to contact complainants and offer a resolution meeting with dedicated clinical and management team representation from the CSU. This process commenced in January 2026; impact will be evaluated in Q1 2026/27.

The PALS team implemented changes to the quality assurance process for written PALS responses in January 2026. All PALS response letters are now quality assured by the CSU HoN and a field is completed in Datix to confirm that this has happened. This change ensures the HoN has oversight of PALS responses which supports improvement in response quality and a reduction in re-opened PALS.

5. Actions Completed in Response to Regulatory Breach

Improvement action to address the regulatory breach in identifying, receiving, recording, handling and responding to complaints has commenced, this includes:

The PHSO organisational self- assessment tool has been completed and highlighted areas where complaint management could be strengthened (**Appendix 1**). A process mapping exercise has been undertaken which highlighted the complexity of our system, this has identified opportunities to streamline our process and reduce duplication. This has informed the development of the Trust Complaints Improvement Plan.

A complaints improvement event was held on 10 February 2026 supported by the Trust Improvement Team, Chief Nurse, Deputy Chief Nurse and a Director of Nursing (DoN). All CSUs were invited and to identify an individual improvement project they will take forward in support of delivering the Trust complaints improvement plan.

A plan to deliver staff Complaint Response Writing and Mediation training in Q4 2025/26 has been progressed. The training sessions are provided by an external company. Funding is being identified to continue the training into 2026/27.

Complaint Response Writing training sessions have been held to train new staff and refresh existing teams on good practice; more sessions are planned.

Two Mediation skills training sessions have been held with three more planned. DoNs are supporting their CSUs to identify staff to attend the training sessions so that available spaces are maximised.

Work is underway to improve early resolution of concerns, to achieve this the following actions have been taken:

- SIM CSU have proposed developing relative clinics in the CSU to listen to queries and concerns as they arise.
- Women's CSU are proposing introducing a call to complainants on complaint entry to CSU, as of 1 April 2026.
- Trauma and Related Services CSU are considering implementing a CSU e-mail address patients and relatives can use to raise concerns.
- Head of Nursing and Matrons are reviewing time in clinical areas to improve visibility and access.
- The Chief Nurse team have introduced a 'back to the floor' programme to commence in Q1 2026/27- this will take place during afternoon visiting times, this will give patients and families access to the senior teams.

The complaints team are reviewing the current Quality Assurance review process of complaint responses to streamline the process, with an aim to reduce duplication of work and improve response times.

In addition, the Trust improvement team and Head of Patient Experience are reviewing potential AI solutions to establish if this could support our work and improve timeliness and quality of responses.

6. Next steps

A full review of the governance and reporting of the Patient Experience team is underway, anticipated changes will include the introduction of a complaints management meeting, this will ensure clear oversight of the improvement plan, sharing of best practice across the organisation, and that we identify and the key themes for to address at CSU and organisational level

7. Financial Implications

There are no financial implications to this paper.

8. Risk

The key risk for the Trust relates to a breach of Regulation 16: Receiving and acting on complaints, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This risk is on the Risk Register, **Reference 9301, risk score of 9**. Controls and mitigating actions have been reported at PEEG on 27 January 2026 and to the Audit Committee on 04 March 2026.

There is a risk that the CSU improvement approach described in this paper will not deliver the required improvement. However, this has been mitigated by the introduction of a monthly complaints working group with the objective of closely monitoring the work and data presented, so that early intervention can take place when there is little evidence that reported activity is having an impact.

9. Communication and Involvement

The patient experience team are currently engaging with Healthwatch Leeds and Leeds Involving People (LIP) Deaf Forum for support in making the complaints process and related information more accessible. Both organisations have reviewed the PALS leaflet and LIP have reviewed the Trust website information on complaints for accessibility. Trust PALS posters have been adapted in response to feedback received to include clearer information about the availability of a textphone number to contact the service.

The Leeds Society of Deaf and Blind People have committed to producing a British Sign Language (BSL) version of the PALS leaflet, once the leaflet review has been completed. This will be added to the Trust website when completed.

There is an Easy Read version of the Trust PALS leaflet which has been developed with support from the Trust Learning Disability and Autism Partners.

10. Improving Health Equity

Data shows that members of the public access the complaints and PALS service from across the indices of multiple deprivation (IMD) deciles, with proportionally higher usage of the services from people more likely to be experiencing poverty in IMD 1 and 2. The proposals in this paper positively impact on equality in supporting more timely responses to concerns and complaints and enabling action to be taken more quickly when it is needed.

11. Publication Under Freedom of Information Act

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

12. Recommendation

The Board are asked to note the contents of the report and be assured that appropriate actions have been taken to respond to the regulatory breach and to monitor impact of these, which can be seen in the Trust Well-Led plan, included in **Appendix 2**.

13. Supporting Information

None

Appendix 1: Parliamentary and Health Service Ombudsman (PHSO) NHS Complaint Standards Self-Assessment

NHS Complaint Standards

Organisational assessment tool

Domain	Info gathered so far	Current Maturity	Target	Evidence to support	RAG	Areas to strengthen
Promoting a learning culture						
Openness & Freedom to Speak Up	Staff training in compassionate communication; escalation of concerns; leadership walkarounds	Early progress	Firm progress	staff survey, training records		Targeted training for managers, Embed Freedom to Speak Up Guardians, Evidence of senior staff visibly encouraging openness to learning.
Supporting staff to learn from complaints	Staff receive regular information about complaints in their service.	Basic	Early progress	Complaints learning forum minutes		Formalise reflective practice sessions, Integrate learning into PDPs; track how learning

						changes practice.
Demonstrating a learning culture	Patient Experience improvement plan; governance dashboards.	Early progress	Mature	Sharing of learning in established forums. Reduction in complaints.		Organisation-wide activity on embedding learning culture, including complaint learning in staff objectives.
Visibility of senior staff	Walkarounds, listening sessions, Board feedback loops	Early -Firm progress	mature	Board reports, walkaround logs		Evidence senior leaders routinely engaged in complaints, not just oversight, Publish examples of leadership action taken.
Listening & responding to complaints	Root-and-branch review; robust feedback mechanisms; patient forums.	Early progress	mature	Patient feedback, FFT scores		Capture detailed feedback against Trust values, Publish “you said, we did” reports, Involve service users in co-design.

Embedding QI culture	Linking complaint outcomes to QI initiatives; governance reporting.	Basic to early progress	Firm progress	Governance dashboards		Integrate complaints, claims, and patient safety data into a single QI dashboard, Report progress regularly at Quality Committee.
Welcoming complaints in a positive way						
Advertising the complaints process	Review of PALS/Complaints function; improved signposting planned.	Basic	Mature	Feedback on clarity of the process		Ensure visible, welcoming language across all channels, Staff proactively remind service users.
Accessibility	Multiple channels of accepting complaints, Information provided on how to access independent support services.	Early progress	Mature	Feedback from patients and relatives about		Expand to “no wrong door” approach; collaborate with advocacy groups, Ensure reasonable adjustments.

Supporting staff who complained are about	To be confirmed.	None to basic	Firm progress	Feedback from staff		Develop support pathway for staff, Provide feedback and reflective opportunities; embed wellbeing support.
Timescales	Aim to meet NHS standards, Aware of NHS regulations KPIs.	Basic to early progress	Mature	Meeting KPIs as needed.		Publish KPIs; provide tailored timeframes to complainants.
Being thorough and fair						
Training and support for complaint handling	Compassionate communication training; Staff reporting extra time needed to deal with complaints.	Early progress	Maturity	Increased training uptake. Reported increased confidence and competence from staff. Reduced caseloads for staff		Introduce investigative skills, mediation, and advanced training, Allocate protected time for complaint handling' Reduce caseloads for complaint handlers.
Complaints process	There is a complaints procedure in place	Early progress	Firm progress	Comprehensive complaints		Review and streamline the

				procedures aligned with acceptable behaviours. Procedure that is available in multiple formats.		complaint process. Define measurable outcomes for each stage.
Meaningful engagement	Engagement in place but not yet consistently across all stages	Early to firm progress	Mature	Feedback from both patients and staff.		Share emerging views during investigations, not just final responses. Formalise staff support pathways and reflective practice sessions. Evidence meaningful involvement through patient stories and staff feedback loops
Strategic oversight and multi-service complaints	There is collaboration with others linked to the complaint to coordinate a response.	Early to firm progress	Mature	Evidence of coordinated multi-service responses.		Strengthen the Governance reporting. Stronger escalation routes.

	Governance reporting structures in place.			Regular joint meetings with key services to act on learning.		Proactively coordinate multi-service responses with a single lead. Publish cross-organisational “learning from complaints” reports. Embed system-level co-design with advocacy groups and patient forums
Giving fair and accountable responses						
Quality of complaint responses	Aiming for compliance with NHS standards; thematic learning reports available. There is a process of Quality assuring responses.	Basic- Early progress	Mature	Evidence of responses consistently aligned to Trust standards.		Ensure responses are empathetic, evidence-based, and reference standards; Embed sharing initial views with complainants.

Openness and accountability		Basic to early progress	Mature	Transparent, detailed acknowledgement of failings and impacts. Staff trained to explicitly acknowledge unintended impacts; publishing “You Said, We Did” reports, Embedding accountability statements in all responses.		Full accountability, including unintended impacts.
Quality of remedy	Responses not consistently taking ownership and responsibility as can at times appear defensive. Remedies are offered (apologies, resolution meetings), but systemic remedies and governance oversight of	Early progress	Mature	Staff have the confidence to put things right using a wide range of options and comfortable with resolution as a default. Uptake of staff training on compassionate communication.		Increased resolution cases not progressing to formal grievances.

	remedies are not yet embedded.					
Acting on learning	Learning is identified and shared internally, but not consistently embedded. forums; linking to QI	Early progress	Mature	Demonstrating a learning culture - thematic analysis, reflective practice, Reduction in complaints.		Formalise thematic analysis of complaints, Publish learning internally and externally triangulating with other key data i.e patient safety and claims, Track systemic improvements.

Appendix 2: Trust Well-Led Plan: Complaints Section

Status	Summary
Not Started	0
On Track	1
Off Track	0
Completed (Evidence Valuation)	4
Evidenced and Assured	1
At Risk	0

The Trust will deliver actions to achieve compliance with CQC Regulation 16 receiving and acting on complaints in relation to timely response and improve the effectiveness of responses.									
Ref	Improvement activity	Responsible owner	Accountable Owner	Method of Assurance	Target Date	Date Implemented	Status	Updates - Please date stamp each update.	Link
1. Improve the Trust responsiveness to complaints									
1.1	Complete a root and branch review of the current patient experience service and function (PALS and Complaints) to understand current position and develop actions	Deputy Chief Nurse	Chief Nurse	Outcome report of root and branch review. Patient Experience Improvement Plan to address findings.	31/12/2025		Completed (Evidence Valuation)	Review has been done	1.1

	focused on tools and training to support early resolution.								
1.2	Develop Patient Experience improvement plan to address findings of the review in 1.1	Deputy Chief Nurse	Chief Nurse	Tracked through PEEG & QAC	28/02/2026		Evidenced and Assured	Event on 10/2/26 for specific CSU actions. Completion date to come from the engagement event. Progress to feed into PEEG	
1.3	Deliver Patient Experience improvement plan (1.2)	Deputy Chief Nurse	Chief Nurse	Actions tracked through PEEG Delivery of the action plan report through to QAC regularly	01/04/2027		On Track	Plan submitted will be monitored	
2. Improve the effectiveness of complaint response									
2.1	Complete PHSO and NHS Complaint Standards organisational assessment tool in order to understand the Trust maturity level	Deputy Chief Nurse	Chief Nurse	Completed maturity assessment presented at PEEG	31/12/2025		Completed (Evidence Valuation)	This is complete but a more detailed review to understand maturity level this will be understood more from workshop on the 10th Feb	2.1

	and present the findings at PEEG.								
2.2.	After completion of the assessment incorporate the key actions into the improvement plan in 1.2.	Deputy Chief Nurse	Chief Nurse	Actions arising from the completed maturity assessment incorporated in the Patient Experience Improvement Plan	31/01/2026		Completed (Evidence Valuation)		
2.3	Review the current capacity within the patient experience team to determine whether this is sufficient to deliver the identified short, medium and longer term goals.	Deputy Chief Nurse	Chief Nurse	Paper to NMALT to propose options. If agreed relevant documentation submitted to TERG.	31/12/2025		Completed (Evidence Valuation)	Workforce review has taken place - issues with staffing - efficiencies will be better understood once process has been mapped to understand waste 2.3	