

STOCKPORT NHS FOUNDATION TRUST ANNUAL PALS & COMPLAINTS REPORT 2025-2026



PALS & COMPLAINTS TEAM 2025-2026

1. Complaints – introduction

The Trust remains committed to listening to patients, families and carers, and to using their feedback to drive meaningful improvement. The PALS and Complaints Teams play a vital role in this work, providing accessible and responsive routes for people to raise concerns, seek advice and share their experiences. Their purpose is to resolve issues as early as possible, ensure learning is captured, and make sure that the voices of patients and service users shape how care is delivered across the organisation.

Throughout 2025–2026, the Trust has continued to operate under sustained and exceptional pressure. For much of the year, the organisation remained at OPEL 3, reflecting major system-wide challenges affecting patient flow, capacity and operational resilience. On occasion, the Trust escalated to OPEL 4, the highest level of operational pressure and elective activity including urgent cancer procedures have needed to be cancelled. These pressures have had a direct impact on patient experience and, consequently, on PALS and Complaints activity.

The year was further affected by a significant norovirus outbreak, with rising cases across several wards despite rigorous infection prevention and control measures. Entire wards were isolated, leaving beds empty and unavailable for admissions until the virus had cleared. Visiting restrictions were introduced and at times fully suspended to protect vulnerable patients. These necessary measures understandably contributed to heightened concern and frustration among patients and families, reflected in increased PALS contacts.

Alongside clinical pressures, the Trust experienced a series of IT system disruptions, particularly relating to the Advantis upgrade and associated systems such as Evolve. These issues affected documentation availability, clinical workflows and communication between teams. While most systems have now stabilised, the disruption contributed to delays and confusion, prompting additional contact with PALS from patients seeking clarity or updates.

Infrastructure challenges also had a notable impact. Repeated lift failures resulted in the cancellation of procedures when patients could not be safely transferred to and from theatre. Planned refurbishment and replacement works, scheduled from September 2025 to March 2026, aimed to address these issues but the interim disruption understandably affected patient experience.

The Trust also introduced significant changes to car parking, following strong feedback from staff, patients and visitors about safety, fairness and the availability of spaces. A new car parking policy was launched on 10 November 2025, alongside the introduction of enforcement measures, upgraded barrier systems and clearer designation of staff and patient/visitor parking areas. Parking Charge Notices (PCNs) are now issued for incorrect parking, supported by ANPR and on-site patrols. While these changes have improved safety and access, they have also generated enquiries and concerns, many of which have been directed to PALS.

Periods of industrial action by resident doctors added further pressure. The Trust developed rotas to maintain essential and emergency services and operated a command and control centre throughout each period of action. While patient safety remained the

priority, industrial action inevitably contributed to delays and cancellations, influencing PALS and Complaints activity. The Trust continues to support all colleagues' right to strike while ensuring patient safety remains paramount.

The planned relocation of outpatient services from Buxton and Cavendish Hospitals to Stepping Hill Hospital from April 2026 also generated a significant number of enquiries. Patients expressed understandable concern about travel, continuity of care and the loss of local services. The Trust acknowledged these concerns and explained that the move reflects national changes in outpatient care, reduced attendance at Buxton clinics, financial pressures and the availability of modern facilities and diagnostics at Stepping Hill.

Against this backdrop, the PALS and Complaints Teams have continued to experience exceptionally high demand. Enquiries are received in person, by telephone, by email, in writing and via the Trust website, which is accessible 24 hours a day. The volume of contacts has remained consistently high and, at the time of preparing this report, the PALS Team is managing a backlog of approximately eight weeks. This backlog has been compounded by periods of sickness within the team alongside sustained high enquiry volumes. To support the service, an additional temporary post advertised and has now been successfully filled as a six-month secondment. It is hoped that this additional capacity will assist the team in reducing the backlog and improving response times.

The Complaints Facilitator Team has also experienced reduced capacity during the year due to staff secondments and sickness. All facilitators have now returned to their substantive posts and it is anticipated that the restoration of full staffing levels will support improved workflow, reduce delays and strengthen the team's ability to progress complaint investigations in a timely manner

Several factors have contributed to the increase in PALS contacts. Many clinic letters no longer include direct contact details for clinical teams, instead directing patients to the Trust switchboard. This has coincided with a rise in patients contacting PALS with queries intended for clinical services. In addition, Trust correspondence is increasingly directing patients to the central enquiries email address, which is then redirected to PALS. Some patients, believing they are contacting different services, are using multiple routes simultaneously, such as the PALS inbox, the Trust enquiries inbox and the online enquiry form, all of which ultimately feed into the PALS Team. A further proportion of enquiries relate to patients being unable to reach the service they require due to phone system issues, high call volumes or phones not being logged in.

The cumulative effect of these pressures is that the PALS Team is unable to keep pace with incoming contacts despite the additional temporary resource. This has resulted in delays in responding to enquiries, including those where patients are seeking urgent support, and has led to an increase in complaints relating to the PALS service itself.

The Trust fully recognises the importance of timely access to the PALS and Complaints Team. We acknowledge that current response times do not reflect the standard of service we aim to provide and understand the distress that delays may cause, particularly for individuals with urgent or complex concerns. Where matters are time-critical or relate to immediate care needs, individuals are encouraged to contact the relevant clinical team or ward directly to ensure concerns are addressed promptly.

Despite the challenges, the PALS and Complaints Teams remain committed to supporting patients, families and carers as effectively as possible. Senior colleagues continue to monitor capacity and demand closely, and actions are in place to strengthen the service.

We are grateful to members of the public for their patience and understanding during this period of sustained pressure.

2. Activity levels

There has been an increase in the number of people contacting the PALS & Complaints team in 2025-2026. **6,622** new contacts were received in the year, which comprised of formal complaints, informal concerns/enquiries, general enquiries (PALS), MP enquiries and compliments. This is an **4.3%** increase from 6,351 in the previous year. Activity within the PALS & Complaints Team has continued to rise year-on-year. Total contacts increased from 4,369 in 2021–22 to 6,622 in 2025–26, representing a **52%** growth over five years. Although growth slowed slightly in 2025–26, overall activity remains at its highest recorded level, highlighting the continued importance of accessible patient feedback and support services.

2.1 General enquiries (PALS):

General enquiries (PALS) are quick enquiries to include requests for information, appointment cancellations or a request for contact details to be update in our medical records.

General PALS enquiries continued to rise significantly during 2025–26. A total of **3,272** enquiries were received, representing a **24.6% increase** on the previous year. This follows an exceptionally sharp rise in 2024–25, when enquiries increased by 67.6% compared with 2023–24. Overall, general PALS activity has more than doubled over the past two years, indicating a substantial and sustained increase in demand for patient support and advice.

2.2 Informal concerns/enquiries:

Informal concerns/enquiries are usually more immediate concerns and enquiries that can be or need to be dealt with within 10 working days. If an informal concern is more complex and will require more than 10 working days to resolve, communication is maintained with the complainant to ensure they are kept up to date and are happy with the timescales. The option of progressing to the NHS formal complaints procedure will also be discussed.

A total of **2,450** informal concerns and enquiries were received in 2025–26, representing a **20.9%** decrease compared with the 3,098 received in 2024–25. However, the decrease in 2025–26 should be interpreted with caution. Due to staff shortages, the service carried a backlog of cases from the previous year, which limited capacity to action and record new concerns in real time. It is therefore likely that the fall in reported informal concerns reflects operational pressures rather than a genuine reduction in patient issues or demand for support.

2.3 MP enquiries

On occasion, patients may prefer to share their concerns with their MP. The MP will then contact the Trust and share their constituents concerns and request a response from the Trust. This may involve specific concerns about the patient's care or it may be that the MP may wish to receive a general response with regards to a decision made by the Trust about the provision of services.

There were **59** enquiries received from MPs in 2025-2026. This is an increase from the 35 received in 2024-2025.

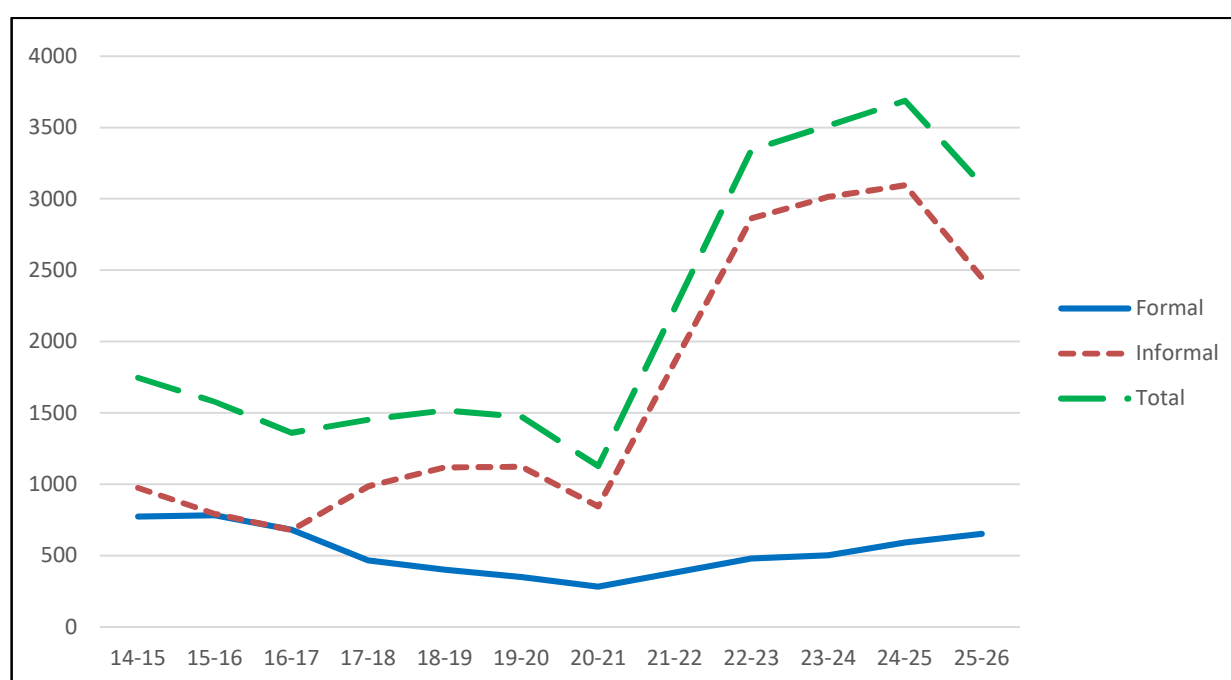
2.4 Formal complaints:

Formal complaints continued to rise during the reporting period. A total of **651** formal complaints were received in 2025–26, representing a **9.9%** increase on the 592 received in 2024–25. The sustained upward trend indicates growing demand for formal investigation and Chief Executive-level responses.

In 2025–2026, a total of **1,190,824** patients accessed services at Stockport NHS Foundation Trust. This activity included 41,397 elective admissions (5,682 ordinary elective and 35,715 day cases) and 45,665 non-elective admissions. Outpatient services delivered 374,046 attendances, comprising 137,884 new appointments and 236,162 follow-up attendances. The Emergency Department saw 112,360 attendances and community teams provided 617,356 face-to-face contacts during the year.

During 2025–2026, the Trust received 651 formal complaints, compared with 592 in the previous year. This equates to 0.05% of all patients accessing our services, a slight increase in both the number and proportion of formal complaints year on year.

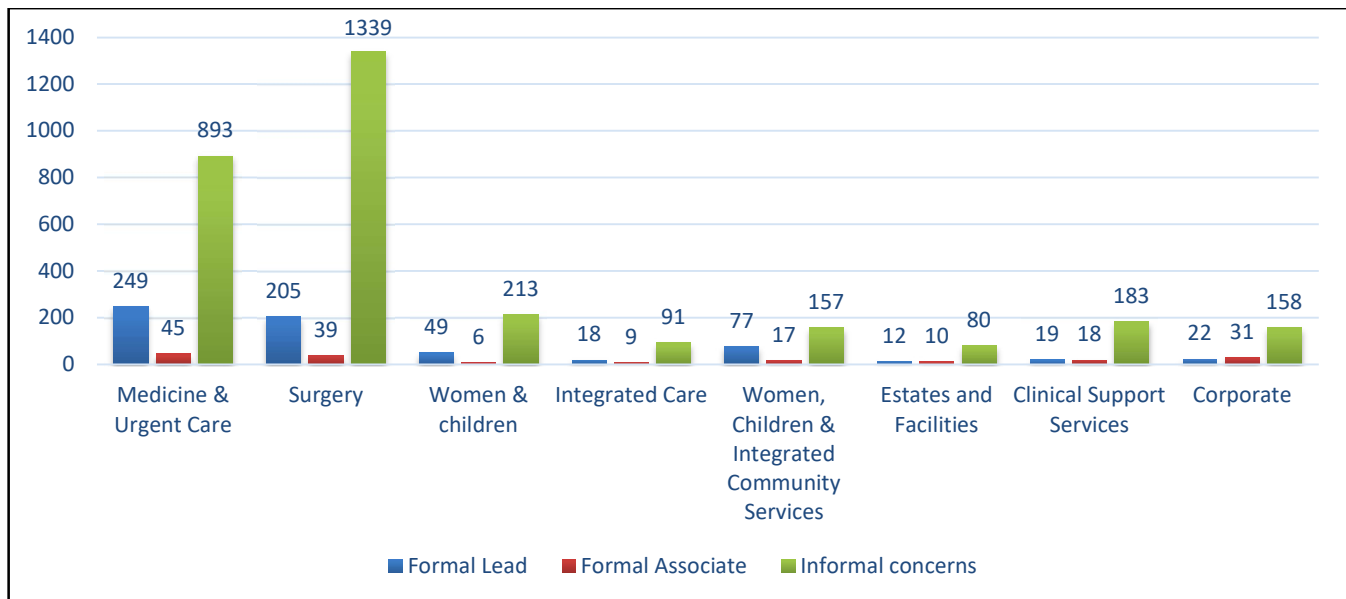
Figure 1: Informal concerns and formal complaint activity



2.4 New complaints by division

Many complaints involve more than one division, in such cases, the division with the majority of the concerns will act as the lead division and the remainder will be referred to as the associate division. The lead division take primary responsibility for the investigation and response of a formal complaint. The associate division will provide comments on their involvement. The table below shows the number of investigations undertaken by each of the divisions.

Figure 2: Informal concerns and formal complaint activity by Division



2.4 Compliments

Compliments are valuable, welcome and important and enable Stockport NHS Foundation Trust to understand that the care and treatment being provided is to our patients' satisfaction. Positive feedback not only helps with organisational and service development but provides a morale boost for our extremely hard-working staff.

The Trust continues to receive a wide range of compliments from patients, families and carers, including thank you cards, letters, gifts and verbal feedback. Recording this feedback enables the Trust to capture valuable insight into what patients appreciate most about their care. Themes consistently highlight compassion, empathy, kindness, and the commitment of staff and teams working together to deliver patient-centred care.

In 2025–26, the Trust recorded **1,995** compliments. While this represents a strong level of positive feedback, it is a decrease compared with 2,466 compliments in 2024–25 and 2,342 in 2023–24.

This reduction is unlikely to reflect a genuine fall in positive patient experience. Feedback from services indicates that many wards and departments continue to receive large numbers of thank you cards and verbal expressions of appreciation, but not all of these are being formally recorded on Datix. Ongoing staffing pressures and competing operational priorities may have contributed to inconsistent reporting at ward level.

As a result, the Trust believes that the recorded figures under-represent the true volume of compliments received and is required within divisions to strengthen local reporting processes to ensure positive feedback is captured more reliably in future years.

Shown below are extracts from compliments received in 2025-2026:

"My father sadly passed away on ward B2 on 29th January 2026. Myself, my brother, and his wife, would like to take the opportunity to send our thanks to all the staff on B2 who showed such exemplary care to our dad during his last days. The nursing staff always had

time to talk to us and update us on his condition, and the medical team spent a good amount of time on the phone with us to keep us informed. When the decision was made to stop active treatment and to move to supportive care, it was explained to us with great empathy and compassion. The communication skills were excellent. Thanks must also go to the care assistants. My dad always looked fresh and comfortable, and it was lovely that they took the time to help him shave. People can often be quick to complain, so it's important to recognise good care when it's given. Please pass on our sincere thanks to all the staff involved, and for making a difficult time so much easier. both for my dad and us. With very best wishes."

"I would like this email to get to the correct staff in RHESUS, Acute Medical Ward 1 and the Respiratory Ward. I was brought into the hospital on Saturday March 29th at approximately 7pm by ambulance as an emergency. I was having difficulty breathing and lacked oxygen. The ambulance arrived within 5 minutes and I was blue lighted all the way and went straight into RHESUS. I wasn't too confident about my survival at that time. From that time onwards, I was met with the most extraordinary care which definitely saved my life. Nurse who stayed with me throughout was a very calm, kind and reassuring presence. The clinician and all the doctors were professional, kind and diligent. I was treated with the utmost care and consideration. I was particularly impressed by the kind way the doctor, I think from Acute Medical 1, who needed to ask how much intervention I wished to undergo in the event of a deterioration. He knelt beside me and it felt a very personal conversation and one I was relieved to have. The nurse took me to Acute Medical Ward 1 and I was looked after there for several days, being given oxygen and really good care. I found the support staff particularly empathetic and dedicated. I also witnessed the verbal abuse that staff suffer and the rudeness and lack of respect and yet through it all they were even tempered and caring.

Finally, I went to the Respiratory Ward, much larger but still with the same attention to care. Sleeping was difficult and so I was especially impressed when the team were on night duty. The quiet efficiency meant all was dark, nurses were quiet and the atmosphere felt secure and conducive to sleep. I know it is invidious to give special mention to some staff but I felt the nurse was outstanding. She was just so caring, I felt wrapped in a blanket of warmth and security. I would be so grateful if this could be passed on to the relevant wards and staff as they do such a difficult job, properly get many moans but they definitely need the reinforcement of praise and the awareness that they are appreciated and have done an excellent job. Thank you very much to you all. You have done a great service on my behalf. Very good wishes to you all and for the future of the hospital."

"My son was submitted to your HASU Department via NWS on the evening of Friday 4th April 2025. He is only 38 and had suffered a Stroke. I attended at the HASU together with his wife and was informed how serious the situation was with a blood clot on the brain and a swelling of the brain. There were 2 young doctors who initially attended to my son and they were later joined by a third doctor. They explained how serious it was and that in consultation with other medics, it was decided to give him a clot buster drug and all possibilities were outlined. It was a dreadful experience but knowing what was taking place and that he was in the safe capable hands of those doctors was reassuring although we realised any outcome was possible. He was transferred to Salford Royal Resus and HASU shortly after the drug was administered It was again explained how serious it was and he may need surgery for the swelling on the brain Miraculously after being in Hospital he was discharged with medication and a follow up plan. He has been very lucky I would like to thank all the doctors at your HASU who I have no doubt due to their expertise and swift

actions they saved my son's life. What might have happened doesn't bear thinking about. For what they did we will be eternally grateful".

"Today I had an appointment with the Colorectal Nurse Specialist about my Care Plan going forward after my cancer surgery in December. The care I have received has been incredible. The patience that the Nurse Specialist Colorectal Team have shown me has been so supportive and so caring. I literally owe them my life, not only to the consultant and the surgical team but the post-operative care. The Colorectal Nurse Specialist explained and answered all my concerns and worries and was so caring. She validated all my concerns and explained everything comprehensively, I can't compliment the Nurse Specialists enough. I am deeply touched by the support I have received post-operatively. I owe them my life."

"I was admitted to ward D2 on Tuesday 10th June 2025 and discharged on Friday 13th June, I would like to say one of the HCA who is a credit to the hospital, she throughout her shifts while I was there went above and beyond her duties, treating every patient she was looking after with the same brilliant service, on Friday while I was waiting to be discharged I was watching while she was doing her job she never once took the smile of her face and never ignored any patient, if she was dealing with somebody and another patient shouted her she went to them and politely said she was dealing with somebody else and when she had finished she would be straight back to them which she did, I just thought I would get in touch and let you now because I think people are too quick to get in touch and complain but never to praise members of your team."

"Often people are quick to complain and unfortunately not as fast to compliment. I would like to put forward a compliment for a nurse from ward A10 at Stepping Hill hospital. The nurse has looked after my grandfather since he was admitted on Thursday 17th July 2025. Unfortunately, my grandfather passed away on Sunday 20th July 2025. Although it was not the outcome we had hoped, we could not have asked for better care for him. The nurse looked after him with dignity, respect and care throughout his final days. The nurse went out of his way to speak to family and keep them well informed. He often approached us on the ward, introduced himself and updated us on his care. As a family, we take a lot of comfort in knowing how well cared for my grandfather was and we will forever be grateful for the care he received. The nurse is an absolute credit to Stepping Hill and encompasses all the positive values of the NHS and hospital trust."

"I am writing to provide feedback about my experience during the investigation process following the unexpected passing of my mum on 4th November 2024. A Duty of Candour and Patient Safety Incident Investigation were opened by the Trust. During this extremely difficult time, my point of contact was the Governance and Quality Manager, Division of Surgery. I wanted to formally express my sincere gratitude for the exceptional support she provided throughout the entire process. From the outset, she showed me nothing but kindness, empathy, and compassion. She didn't just listen to me — she truly heard and understood how I was feeling, and she took everything I said seriously. She was open and honest at all times and never attempted to deflect or minimise any of my concerns or questions. Because of this, I trusted her completely, which is something I never imagined would be possible in such a painful and emotional situation. She supported me through the most difficult time of my life, and when the investigation came to an end, I felt genuinely sad that I would no longer be in contact with her. It takes a very special kind of person to do the

work that she does, and I will always be deeply grateful for the care, professionalism, and humanity she showed me during such an incredibly challenging period. I hope this feedback can be shared with her and her management team, as she truly deserves recognition for the way she carries out her role."

"I attended A and E via ambulance with my dad yesterday as he had severe back pain and was feeling generally unwell. We arrived at approximately 18:00-19:00. It was extremely busy in the department with 7 patients including my father being cared for on the corridor. I do not have names of everyone involved but would like to say that it felt very calm, caring, organised and friendly on the corridor. Lots of examples of teamwork and collaboration were going on with members of staff from others areas of A and E popping along to the corridor to offer to help with patient transfers and discharges and the general movement of patients through the system. Lots of friendly, busy porters dashing about.

Everyone being polite to each other. Privacy and dignity was respected with screens being pulled around patients on the corridor for assessments with doctors, and staff moving corridor patients to the triage area behind curtains for personal care and examinations. The sister (navy uniform) finishing her day shift spotted my dad's severe pain and poor veins and made sure he had a cannula inserted just before she was handing over to the night shift in case he was prescribed IV pain relief. She could easily have left this to the next shift. She was also taking the time to teach a newly qualified member of staff. As she said she is "very good" with difficult cannulation and she was right, she got it. He needed the cannula later when IV fluids and antibiotics were administered and this ensured that care was not delayed. The sister (navy uniform) who took over the corridor care on the night shift was extremely caring, calming a patient who was distressed and being quite challenging with other staff members on the earlier shift. Making sure relatives could sit and water was available for patients, on top of all her other clinical duties and demands. The senior sister (red) spotted how uncomfortable my dad was and that he was having severe muscle spasms and escalated to medics which meant he got Diazepam prescribed, which massively helped with his back pain, long before he could have a full physical examination with a doctor.

We know you do not want to provide care on corridors, or for us to be waiting hours for assessment and beds, and I imagine you get a lot of challenge from patients and their loved ones regarding this. However, I really feel that people were genuinely cared for and a very professional and organised impression was given of corridor care last night."

"I would like to highlight the excellent and prompt care I have received from you. I feel we hear too much about how the NHS is struggling, waiting lists, poor care; this is simply not my experience. In my case I experienced symptoms on November 20th, contacted the GP and was seen by a GP that afternoon. She was very thorough and professional and referred me to gynaecology. My first appointment at Stepping Hill was one week later for a colposcopy with a second appointment for a scan and hysteroscopy 5 days later. I was given the reassurance that there was no abnormality and given a prescription for my symptoms immediately. The whole process took under two weeks. I was treated brilliantly by all staff- so supportive, professional, thorough and efficient - and felt reassured that they were really looking after me to the best of their ability. I could not have asked for better care. I would be grateful if you could share this email with the GP I saw and with the staff in the Jasmine Suite at Stepping Hill."

"We had to take the time to write to you. My mother passed away on Tuesday 25th November. She was a patient in ward B6, firstly in bed 9 and then bed 1. The care and consideration we received in her last 26 hours were exceptional. I cannot praise enough the professionalism and kindness shown to my mum by all the ward staff. They treated her with both respect and dignity in her final hours. It was very important for us as a family to have my mum pass quietly and privately. We were very concerned this would be in the ward, with little privacy and we expressed our concerns to the staff who worked very hard to provide a quiet room for her. We know this wasn't easy an easy task and will be forever grateful. This gave my mum the dignified and peaceful passing she would have wanted. It is impossible for us to name all the wonderful people. It was too much for us to process names. But we can honestly say, without hesitation that everyone played their part for my mum and for us. Thank you so very much."

"I am writing to make you aware of my experience as an inpatient in Stepping Hill Hospital. I attended casualty late on Saturday with a nasty ankle fracture caused by my dog pulling me over. Following a lengthy stay in casualty where I received pain relief, and reduction of the dislocated fracture I was admitted to ward M4 early on Sunday morning. Although my stay on M4 was short every member of staff treated me with kindness and professionalism for which I am extremely grateful. On Monday I was transferred to ward M6. My experience on M6 was a real eye opener. I do not exaggerate when I say how impressed I was by how very hard every member of staff worked to maintain the high standard of care provided to the patients in their charge. At a time when negativity regarding the NHS and Stepping Hill is rife my experience did not in anyway reflect such opinion. The staff on M6 are an impressive team and I feel privileged to have had the benefit of their expertise and kindness."

I witnessed the nursing staff work extremely long hours but always with a smile and a kind word for whoever needed their attention or help. I was however aware that conditions within the hospital make it so much harder for the staff do their job. For example, at one stage during my stay only one lift was working in the whole hospital, this made it very difficult for the porters to transport me to and from other departments such as x ray and theatre. Even given these difficult circumstances my comfort remained priority. The staff on M6 are a credit to the hospital and deserve every possible form of support they require to do their jobs efficiently. I would also like to highlight how impressed I was with the orthopaedic surgical teams. I was assessed by several senior Doctors all of whom made sure I was fully informed and understood what my treatment plan would be and the rational for the decisions that were made. I received excellent care in timely fashion and am confident that thanks to the team's skill and expertise I will make a full and speedy recovery. I feel it is extremely important that positive experiences are highlighted and acknowledged and the staff members involved applauded for their hard work caring attitude and dedication to their roles. Keeping morale high when staff are working in difficult circumstances should be paramount. In conclusion I would like to express my sincere thanks to everyone involved in my care during my hospital stay".

"I just wanted to send a message of thanks to the District Nurse team who provided palliative care to my mother. The entire team were kind, caring & respectful of my mother's needs. They took time to explain what was happening to me & were very supportive in what was a difficult time for the family. The nurse who came after my mother passed away was both professional & considerate. I very much felt supported & comforted by all the District Nurses who attended my mother. I do not recall all their names but I would be grateful if you could pass on my thanks and appreciation to the team."

"I honestly cannot praise Stepping Hill Hospital enough for the incredible care my babies and I received. From the moment I arrived, every single member of staff — from the reception team to the midwives, consultants and support staff — made me feel seen, valued, cared for and completely supported. Their kindness, patience and professionalism turned what could have been an overwhelming and frightening experience into one filled with reassurance and trust. I never once felt alone.

I have had two previous pregnancies at this hospital, which is exactly why I chose to return — because I already knew how special the care was. But my twin pregnancy was truly beyond anything I could have ever wished for. The level of attention, compassion and expertise I received was out of this world.

A very special and heartfelt thank you must go to my consultant, and my Multiple Pregnancy Midwife. The expertise, compassion and constant reassurance they provided were genuinely life-changing. From the very beginning, they were honest with me, realistic when needed, but always hopeful and supportive. They guided me through every stage of what could have been an incredibly daunting journey. Even with the immense strain the NHS faces every single day, I was always treated as a person — not just a patient. They knew me. They listened to me. They cared about me. That personal touch meant more than I could ever express.

When I went into threatened preterm labour at 28 weeks, I was absolutely terrified. In that moment, all I could think about was my babies. The way the staff in Triage cared for me was beyond amazing, and the Delivery Suite team handled everything with calm, controlled professionalism. Despite dealing with ongoing emergencies at the same time, they never once made me feel like anything less than their priority. They acted quickly, gave me every medication possible to stop my labour, and at the same time prepared everything in case my babies needed to be delivered that day.

Even the NICU team came to see me beforehand to explain exactly what would happen and showed me the ward where my babies would be cared for if needed. That level of transparency and preparation helped ease fears I didn't even know how to voice. Every action, every word, every reassuring look made me feel safe, heard and protected — even in the middle of chaos.

Because of their dedication and belief in me, they helped me carry my babies all the way to 37 weeks. I genuinely do not know how I would have coped without their support, encouragement and expertise. They gave me strength when I didn't feel strong.

Spending time on Maternity 2 Ward — including going into the New Year there — was made so much easier because of the incredible staff. (Name redacted), one of the midwives on the ward, was such a big part of our journey. Her kindness, her calm nature and the way she checked in on me so genuinely meant more than I can put into words. She didn't just provide care — she provided comfort.

Over time, these incredible people became my hospital family. They weren't just professionals doing their job — they became familiar faces I trusted wholeheartedly. They cared for me emotionally as well as physically. When the babies were born and members of the team came to see me, it touched my heart more than I can describe. That simple act showed me just how much they truly cared. I felt so safe around them. Completely safe. Supported. Protected. Cared for not just as a patient, but as a mum, as a woman, as a person.

When I was admitted ahead of my planned C-section, the hospital kindly allowed me to stay earlier than planned because I was worried about going into spontaneous labour and not getting there in time. That level of understanding and compassion eased so much anxiety before anything had even happened. I went to bed preparing for my planned C-section the next morning, feeling nervous but ready. What I didn't expect was how quickly everything would change.

An incredible midwife named (redacted name) heard a fetal deceleration — from another patient's bedside — and immediately rushed through to me, calling the emergency team without hesitation. I will never forget her vigilance, her quick thinking, and the calm reassurance she gave me in that moment. She made me feel safe when everything suddenly felt uncertain. Because of her decisive action, everything moved exactly as it needed to. I was told the babies needed to be born by Category B Emergency C-Section within 75 minutes. It all happened so quickly, yet I never felt panic — only support.

As I was taken into theatre, despite the urgency, it did not feel frightening. The atmosphere was calm, focused and full of reassurance. The ladies supporting me were phenomenal — one of them I even recognised from when I first went into threatened preterm labour, which brought me an unexpected wave of comfort in such a critical moment. The anaesthetist, explained everything so clearly while placing my cannula and spinal block. His calm voice and kind nature grounded me. I felt completely reassured in his care. My surgeon, was truly outstanding. He delivered my twins just two minutes apart, alongside the doctor, and I will be forever grateful to them both. Their skill and composure brought my babies safely into the world. My daughter was born first — like a little ballerina ♡, my son followed just two minutes later.

When my son needed breathing support, the reassurance my partner and I received was nothing short of beautiful. While the NICU team cared for my son, the team supporting me and my daughter never left my side emotionally. The NICU team did everything possible to stabilise our precious boy and bring him back to us on the ward. Their empathy, patience and dedication during such a vulnerable moment will stay with us forever.

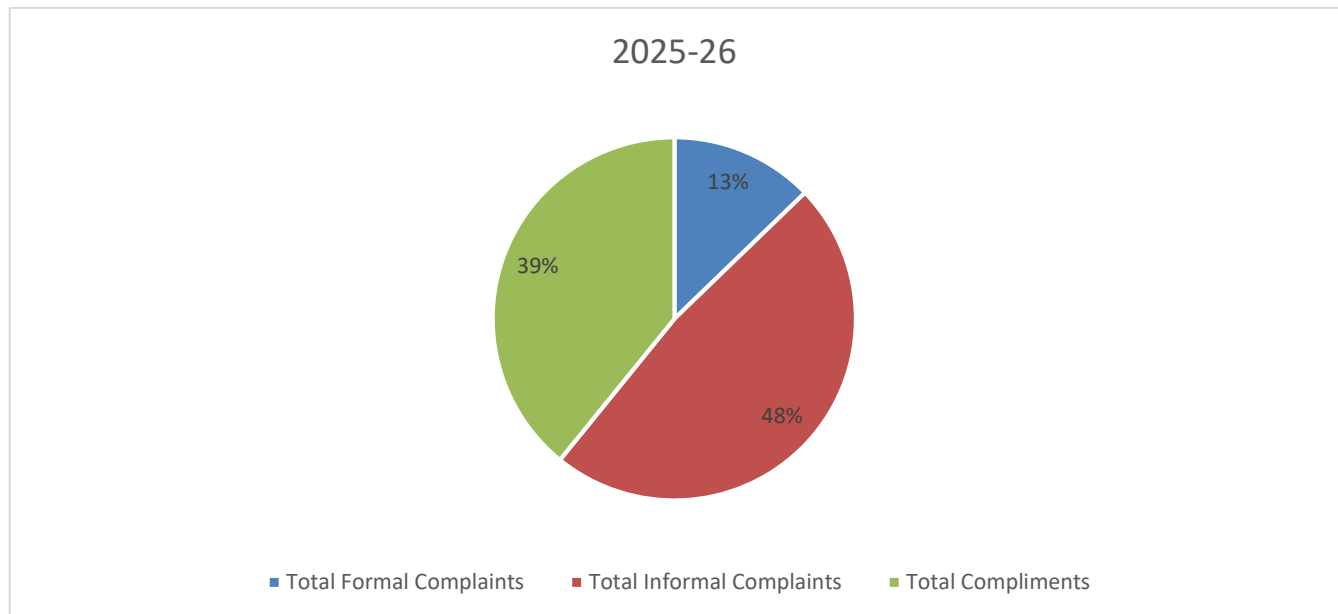
(Name redacted) from Maternity 2 was always checking in on me, making sure I was okay both physically and emotionally. (name redacted), who took my blood pressure and helped me with the twins, brought warmth and positivity into the room every single time — she genuinely lifted my spirits. Even the ward clerk, who kindly made me cups of tea during those very long first nights with the twins, made a difference bigger than she will ever know. The team who looked after me during my iron infusions were equally kind and attentive — even routine treatments felt supportive because of them.

From the sonographers at every scan and Doppler check, to the cleaners who stopped for a chat, to every doctor, midwife and support staff member — every single person played a part in making me feel safe, valued and cared for.

Naming people personally means so much to me, because every single one of you made a lasting impact on our journey. You weren't just faces in uniforms — you were the hands that held us, the voices that reassured us, and the hearts that cared for us during one of the most important times of our lives. I am endlessly grateful to every single person who cared for us. You didn't just deliver my babies — you carried our whole family through an experience that could have been terrifying and turned it into one filled with compassion, strength, hope and love. You will always be more than the hospital where my children were born — you became the family who carried us through one of the most important chapters

of our lives. The impact of your care will stay with me forever. With all our love and deepest gratitude.”

Figure 3: Ratio of formal, informal/early resolution complaints and compliments received



3. Performance

3.1 Acknowledgement of complaints

Under the NHS Complaints Regulations (2009), all formal complaints received by the Trust must be acknowledged within three working days. Each complaint is allocated to a case officer, who contacts the complainant within this timeframe, either by telephone or in writing, to begin the process.

During this initial stage, the case officer is responsible for obtaining the appropriate consent to handle the complaint. This includes consent from the patient, or from an authorised representative if the patient is unable to provide it. Consent is also required where the investigation involves individuals or organisations outside Stockport NHS Foundation Trust. A core part of the case officer’s role is to identify and clearly define the issues raised in the complaint. This forms the scope of the investigation, which is drafted and shared with the complainant for agreement. This step is a key requirement of the NHS Complaints Standards, as it ensures both parties have a shared understanding of the concerns, the impact experienced and the outcomes the complainant is seeking. Agreeing the scope at the outset helps build trust, reduces the risk of misunderstanding, and provides assurance that every aspect of the complaint will be investigated thoroughly.

The acknowledgement also sets out the expected timeframe for completing the investigation, in line with regulatory requirements and Trust policy.

The Complaints Team aims to acknowledge 95% of formal complaints within three working days. Despite significant staffing shortages in 2025–26, including periods of unplanned leave that reduced capacity within the team, the Trust achieved **100%** compliance with this target. This represents a particularly positive achievement given the operational pressures experienced during the year.

3.2 Response rate

Under the Local Authority Social Services and NHS Complaints Regulations (2009), the Trust is legally required to provide a complaint response “as soon as reasonably practicable.” The Regulations do not set a fixed statutory timescale for completing investigations. Instead, the NHS Complaints Standards require organisations to agree a realistic timeframe with the complainant at the outset and to keep them informed if this changes. The Trust’s internal target to respond to **95%** of complaints within the agreed timeframe is therefore a local performance measure, designed to support good practice and timely resolution, rather than a legal requirement.

In 2025–26, the Trust achieved a response rate of **89.9%**. While this is below the 95% target, it should be viewed in the context of the significant pressures experienced during the year. The number of formal complaints increased from 592 in 2024–25 to 651 in 2025–26, adding to the volume of investigations requiring detailed input from clinical and operational teams. Each complaint involves reviewing records, gathering statements and validating findings. As complaint numbers rise, the capacity of services to provide this input within the agreed timeframe becomes more limited.

This challenge was compounded by staff absences, both within the Complaints Team and across the wider organisation. Periods of industrial action and times when the Trust operated at higher OPEL levels further reduced the availability of staff needed to support investigations. During these periods, clinical teams are focused on maintaining safe operational delivery, which naturally limits the time they can dedicate to progressing complaint responses. In line with the NHS Complaints Standards, when it becomes clear that a response cannot be completed within the agreed timeframe, the Complaints Team contacts the complainant, explains the reasons for the delay, and agrees a revised completion date. This approach maintains transparency and helps preserve confidence in the process.

Despite increased complaint volumes and significant operational pressures, achieving an 89.9% response rate demonstrates the Trust’s continued commitment to delivering thorough, high-quality complaint investigations. Notably, there have also been clear signs of improvement, with response rates rising to **97% in March 2026** and **98.2% in April 2026**, reflecting sustained focus and progress despite ongoing pressures

Figure 4: Trust response rates

Month	Sent out	in time	Trend	Response rate
Q1	146	141	↓	96.60%
Q2	168	150	↓	89.30%
Q3	168	149	↓	88.70%
Q4	171	147	↓	86%
Total 25-26	653	587	↓	89.90%

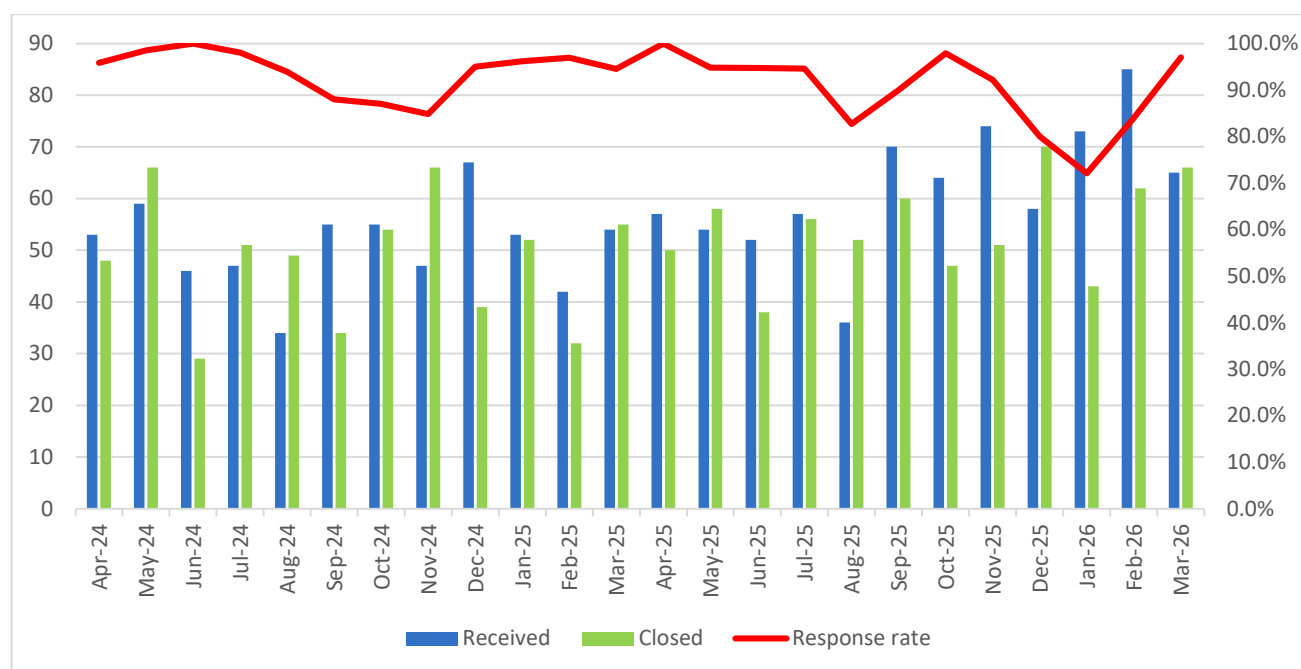
The response rate for the divisions for 2025-2026 is shown in the table below.

Figure 5: Response rate by Division

	Integrated Care	Medicine & UC	Surgery	Women & Children	WCICS	Clinical Support	Estates & Facilities	Corporate
April 25	100%	100%	100%	100%		-	-	-
May 25	100%	100%	93.3%	85.7%		100%	100%	100%
Jun 25	100%	100%	100%	83.3%		-	-	100%
July 25	100%	95.2%	94.7%	100%		100%	0%	100%
Aug 25	100%	80.8%	83.3%	66.7%		100%	100%	100%
Sep 25	88.9%	89.4%	90.6%	84%		100%	66.7%	100%
Oct 25	100%	100%	100%	83.3%	-	100%	-	100%
Nov 25	-	89.5%	94.4%	88.9%	100%	100%	-	100%
Dec 25	75%	75%	85.7%	60%	100%	100%	100%	100%
Jan-25	-	75%	75%	-	61.5%	100%	-	100%
Feb-25	-	78.8%	95%	-	80%	-	-	
Mar-25	-	96%	100%	-	100%	100%	66.6%	100%

The table below shows the performance against timescale for response:

Figure 6: Performance against timescale



Across **2025–26**, the monthly data shows a clear pattern of fluctuation in both complaint volumes and response rates. The year began with relatively strong performance, with several early months achieving response rates in the mid-90% range. However, as the year progressed, pressures across the organisation became more pronounced.

The most challenging period occurred between December 2025 and February 2026, when the Trust recorded some of the highest numbers of complaints received alongside the lowest response rates of the year. This coincided with a period of winter pressures, including staff shortages, industrial action, and times when the Trust was operating at higher OPEL levels. These pressures reduced the availability of clinical and operational staff who are essential to progressing investigations, such as providing statements, reviewing records

and validating findings. As a result, the capacity to close complaints within agreed timeframes was significantly constrained.

Performance improved again by March 2026, with response rates rising to 97%, demonstrating the team's ability to recover when operational pressures ease.

The pattern across the year highlights that response rates are not linear and naturally fluctuate over time. Periods of lower performance often align with months where a higher volume of responses are issued, reflecting the operational pressure associated with closing a significant number of cases within the reporting period. Importantly, these dips do not necessarily indicate a deterioration in process. Instead, they reflect the cumulative impact of workload, complexity, staffing availability and timing across the end-to-end complaints pathway.

While performance in 2025–26 shows more pronounced variation than in the earlier part of 2024–25, the underlying drivers remain consistent: increased complaint volumes, organisational pressures and reduced staff availability all influence the Trust's ability to meet agreed timeframes.

3.3 Complaint outcomes

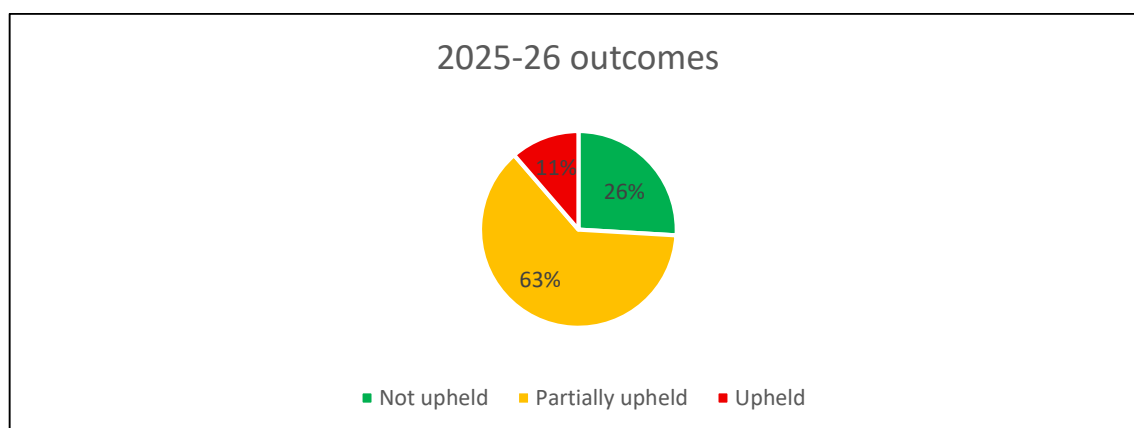
In 2025-2026, **653** formal complaints responses were sent from the Trust.

In the final response, the Trust set out each of the issues the person has complained about. We will explain how we looked into the complaint, who undertook the investigation and who was spoken to. The response will explain what happened based on the evidence seen and the accounts heard. It will also set out what should have happened and compare this to what happened. If something did go wrong, details will be provided of that failing and any impact this had.

On completion of the investigation, the findings are reviewed and a record is made on whether the complaint has been upheld by the Trust. The outcomes for complaint investigations completed in 2024-2025 were:

- 26% of complaints were not upheld
- 63% were partially upheld
- 11% were upheld

Figure 7: Complaint outcomes



3.4 Returned complaints (comebacks)

The data for 2025–26 shows an increase in the number of complainants who contacted the Trust again after receiving their formal response. However, this should be interpreted with caution. During the year, the Complaints Team identified a recording error whereby some cases that had been closed due to no consent being received were incorrectly logged as reopened when consent was later provided. These cases should have been recorded as new complaints, as they had not previously progressed to investigation. A complaint should only be recorded as a comeback when a complainant has received a full written response and subsequently contacts the Trust to express dissatisfaction or request further clarification.

The Trust aims to “get it right first time”, but some complainants may remain dissatisfied or have additional questions after reviewing their response. When this happens, the PALS & Complaints Case Officer works closely with the complainant to understand their concerns and agree the most appropriate next steps. This may include further investigation, additional written correspondence, or arranging a local resolution meeting.

Local resolution meetings provide an opportunity for the complainant to meet directly with the staff involved in their care or the investigation. These meetings allow concerns to be explored in more depth, provide space for open discussion, and can help rebuild confidence by demonstrating that the Trust has taken the complaint seriously. When conducted well, with the right staff present, they can resolve issues that may not be fully addressed through written communication alone.

In 2025–26, a total of 96 complainants contacted the Trust again following receipt of their response. Of these:

- 56 cases received a further written response following additional investigation
- 5 cases were invited to and attended a local resolution meeting
- Not all of these comebacks relate to complaints received or responded to within 2025–26; some originated in 2024–25, reflecting the natural flow of the complaints process

This represents a modest increase compared with 79 comebacks in 2024–25, although the recording error identified means the figures for 2025–26 should be interpreted with care. Recording processes have now been corrected to ensure that only genuine comebacks where a complainant is dissatisfied with the Trust’s response are captured going forward.

If the Trust believes that all reasonable local resolution options have been exhausted and there is nothing further we can do to address the complainant’s concerns to their satisfaction, we will inform the complainant of this and remind them of their right to contact the Parliamentary and Health Service Ombudsman.

4. Complaint themes

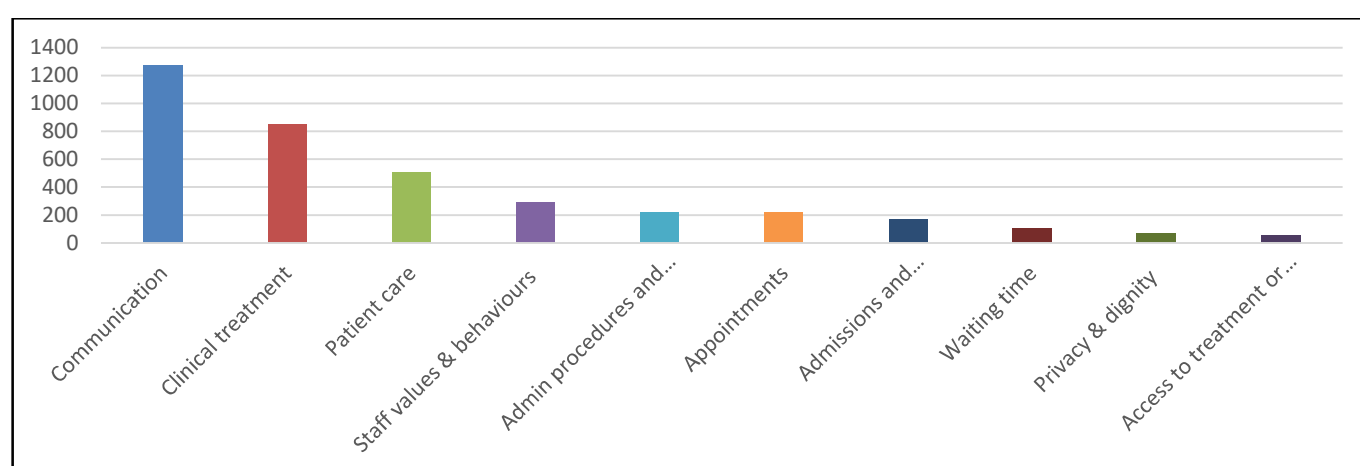
Every formal complaint is recorded and categorised by both subject and location to support the Trust in identifying themes, trends and areas for improvement. Subjects are allocated according to the issue with the greatest impact on the patient, meaning that clinical concerns are generally recorded as the primary subject where complaints relate to treatment, clinical decision-making or nursing care.

4.1 Themes for formal complaints

In 2025–2026, a total of 3,935 subjects/themes were recorded for formal complaints. This represents a 25.6% increase compared with 3,134 subjects recorded in 2024–2025. The number of subjects is higher than the total number of complaints received, as many complaints raise multiple issues and may involve more than one service area or location.

The table below presents the top ten concerns raised within formal complaints during 2025–2026. Concerns relating to communication, particularly communication with the patient, were the most frequently reported theme during the year.

Figure 8: Formal complaints – Themes



** Please note the figures may total more than the number of complaints received as each complaint may raise numerous issues.*

The highest areas of concern for formal complaints were:

- **32.5%** of all subjects related to **communication**, making this the most frequently reported theme with 171 patients not feeling listened to.
- **21.5%** of subjects related to **clinical treatment**, including delays or failures in treatment, diagnosis, or identification of conditions such as fractures.
- **12.9%** of subjects concerned patient care, with 231 complaints highlighting that care needs were not adequately met.
- **7.3%** related to **staff values and behaviours**. These concerns typically involved allegations of unprofessional conduct or rudeness.

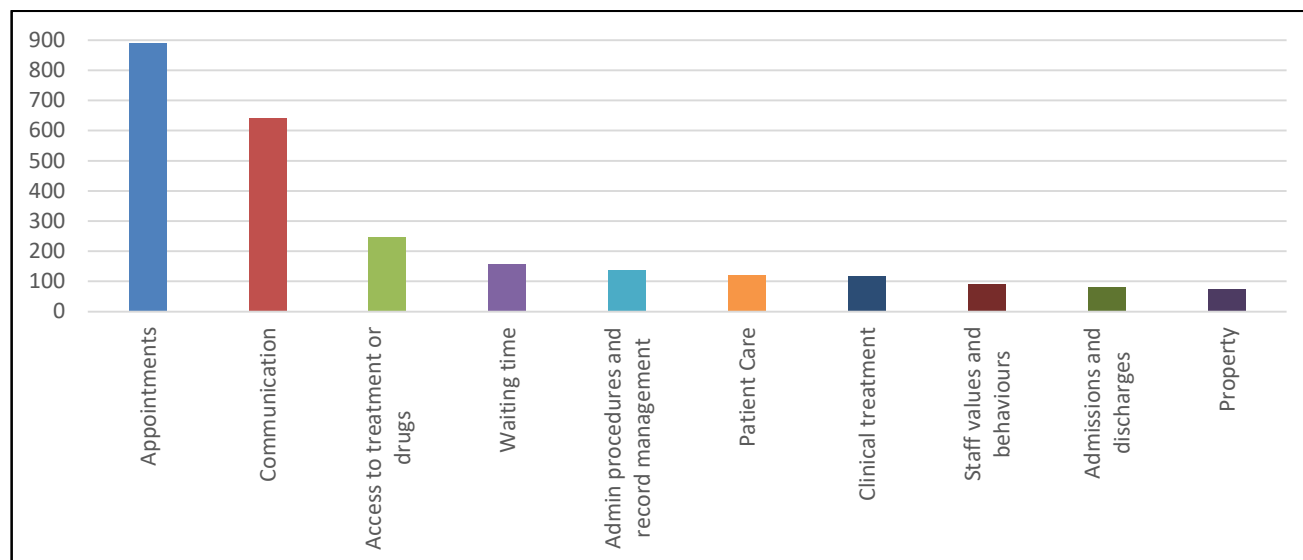
The top themes remain broadly consistent with those reported in 2024–2025, with communication continuing to be the highest area of concern. However, administrative procedures and record management showed a notable increase this year, rising from 112 subjects in 2024–2025 to 219 in 2025–2026, indicating a significant upward trend in concerns relating to administrative processes to include access to health records and patients querying the accuracy of health records.

4.2 Informal concerns/enquiries

There were **2,696** subjects recorded for informal concerns/enquiries in 2025–2026. The highest number of contacts related to appointments (33%), in particular, the delay of

appointments, followed by concerns about communication (23.8%). The top ten areas of concern were as follows:

Figure 9: Informal concerns - Themes



In 2025-2026 we continued to receive a high number of concerns from patients about the delay and waiting time for their appointment.

4.2 Location

4.2.1 Formal Complaints

In addition to reviewing the themes raised within complaints, the Trust also monitors the locations where concerns arise to help identify areas of pressure, high activity, or recurring issues. When a formal complaint is received, the concerns raised may relate to more than one location within the Trust, and each location referenced is recorded accordingly.

The locations with the highest number of concerns recorded in 2025–2026 were:

- The Emergency Department (ED)
- Outpatient Department B
- The Treehouse Children's Unit
- Acute Medical Unit (AMU)

While these areas received the highest number of concerns, it is important to note that they also experience some of the highest patient footfall within the Trust. In many cases, these locations were not the primary focus of the complaint but were referenced as part of the patient's overall journey. A single complaint may also raise multiple issues relating to the same location.

Emergency Department (ED)

In 2025–2026, 74 complainants raised concerns relating to the Emergency Department. In several cases, the ED was not the main focus of the complaint but formed part of the wider patient pathway. Concerns included allegations of missed or incorrect diagnosis, delays or failures in treatment or procedures, waiting times, and issues relating to the treatment received.

Outpatient Department B

There were 34 complaints that referenced Outpatient Department B. These complaints were not specifically about the department itself but related to appointments that took place in this location. As such, the complaint may be categorised under the relevant clinical speciality, while the location is recorded as Outpatient Department B because this is where the appointment occurred.

The Treehouse Children's Unit

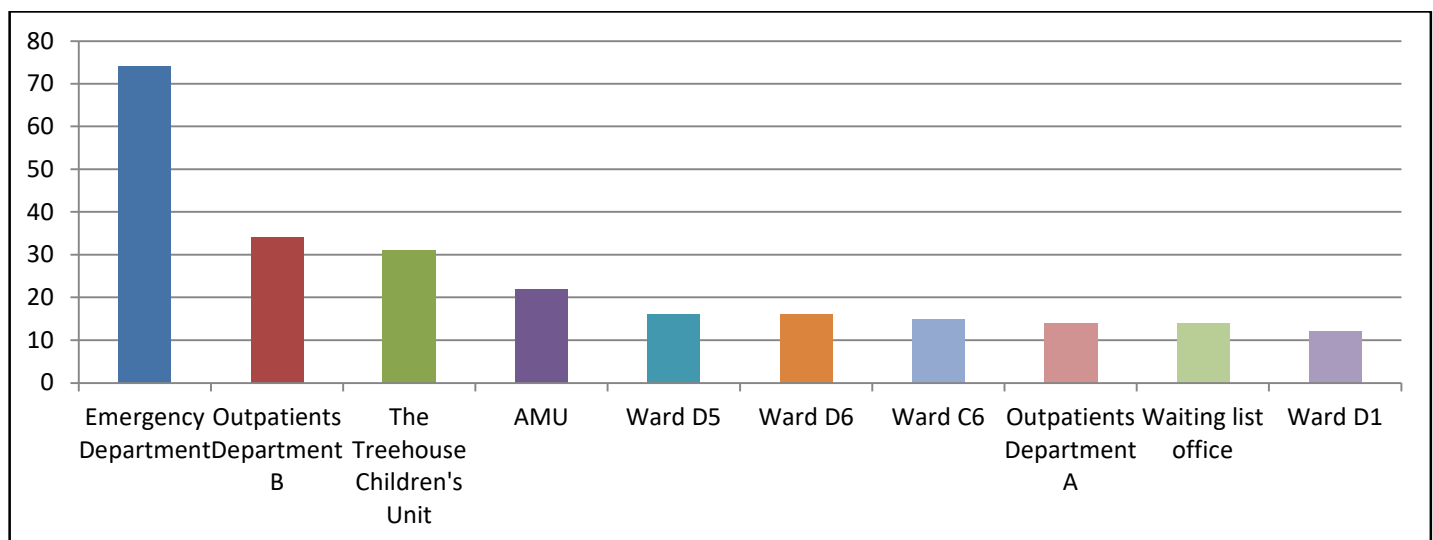
A total of 31 complainants raised concerns relating to The Treehouse Children's Unit. The majority of these concerns related to communication, clinical treatment, patient care, and staff values and behaviours, with additional issues noted regarding admission and discharge processes.

Acute Medical Unit (AMU)

There were 22 complaints referencing the Acute Medical Unit. These concerns included allegations of delays or failures in treatment, issues relating to communication, concerns about end-of-life care, and reports of lost property.

The table below provides a breakdown of the top ten locations where concerns were raised within formal complaints during 2025–2026.

Figure 10: Formal Complaints by Location



** Please note the figures may total more than the number of complaints received as each complaint may raise numerous issues regarding different locations.*

4.2.2 Informal Concerns

In addition to reviewing the themes raised within informal concerns, the Trust also monitors the locations referenced by complainants. As with formal complaints, a single concern may relate to more than one area of the organisation. The three most frequently recorded locations for informal concerns in 2025–2026 were:

- The Call Centre (appointments booking team)
- The Emergency Department (ED)
- Waiting List Office

Call Centre (Appointments Booking Team)

There were 501 concerns recorded in relation to the Call Centre booking team. The majority of these were not about the team's conduct or processes directly, but instead related to delays in appointments, including difficulties securing appointments, long waits for follow-up, or delays in referral processing.

Emergency Department (ED)

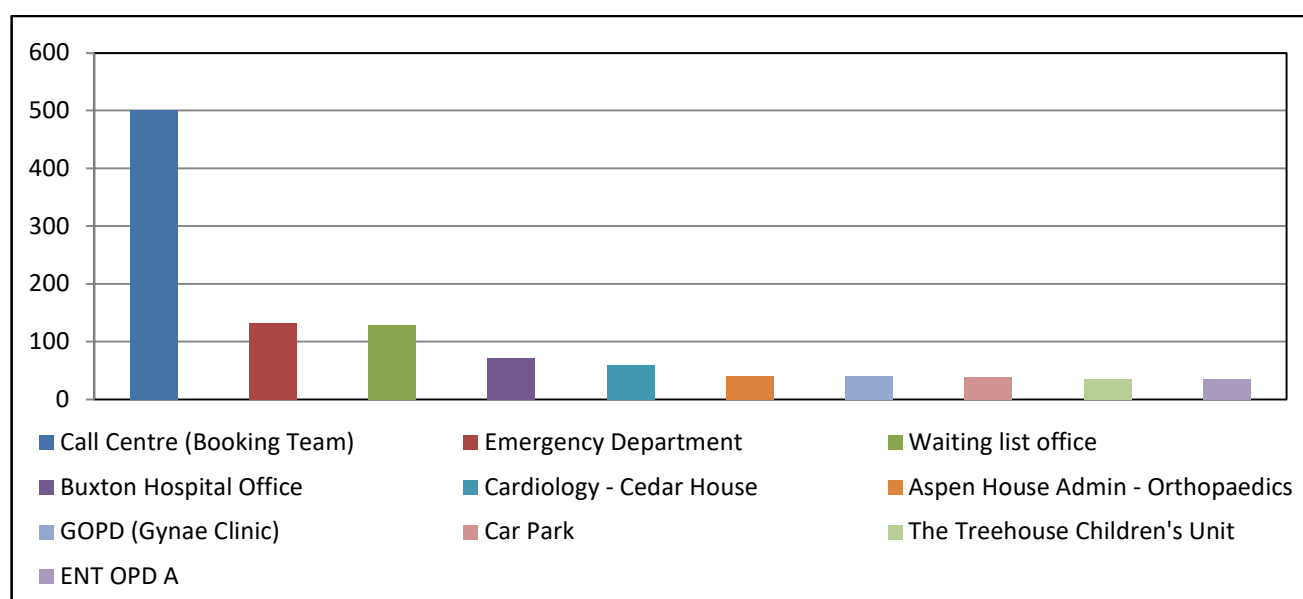
There were 132 concerns raised about the Emergency Department. The highest-volume issues related to communication with the patient, waiting times, concerns about diagnosis or treatment.

Waiting List Office

A total of 129 concerns were recorded in relation to the Waiting List Office. While these were not directed at waiting list officers specifically, the issues predominantly related to extended waiting times for procedures and the cancellation of scheduled operations.

The following table provides a breakdown of the top ten locations where informal concerns were recorded during 2025–2026.

Figure 11: Informal Concerns by Location



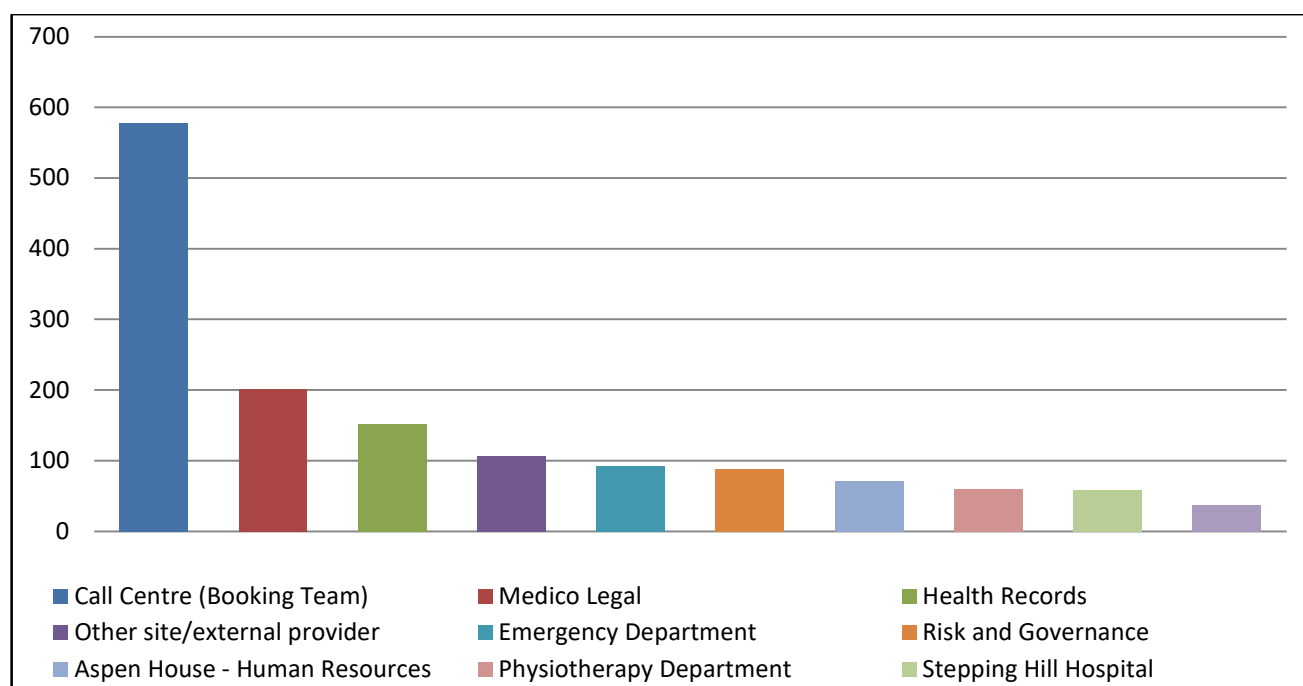
4.2.3 PALS Enquiries

PALS enquiries are logged when the enquiry does not require an investigation but may involve redirecting the contact or providing advice. PALS enquiries also involve the case officer providing information or signposting, such as how to request a copy of medical records or how to make a formal complaint whether this be about Stockport NHS Foundation Trust or about another organisation.

In 2025-2026 there were **3274** enquiries logged, with 25.6% of the PALS contacts handled by the team related to appointment queries to include requests to cancel an appointment and communication from the patient to confirm they accept the appointment date. 9% of queries were in relation to obtaining a copy of medical records and requesting updates on where these were up to. A further 6.7% enquiries were from patients wishes to make updates to their health records, to include updating home address or telephone number.

The following table indicates the top ten locations for PALS enquiries received:

Figure 12: PALS Enquiries by Location



5. Learning from complaints

Good complaints handling extends beyond providing a response or remedy to the individual complainant. It is equally about ensuring that the feedback received through complaints is used to drive learning and support meaningful service improvement. We recognise that, for many people, the primary motivation for raising a complaint is the desire to ensure that what happened to them or their loved one does not happen again.

As part of every investigation, where it is identified that something has gone wrong, the Trust will offer a meaningful apology, explain what occurred, and outline the actions being taken to address the issue. We also describe how the learning from the complaint will be used to improve services for future patients, ensuring that the concerns raised contribute directly to safer, more effective and more compassionate care.

Examples of the learning from complaints in 2025-2026 is included below.

- Ward D5 are undertaking a review of how advocacy needs, support adjustments, and communication preferences are documented and shared within the ward, so that individuals do not have to repeatedly explain their circumstances. This includes updates to how we flag advocacy arrangements and reasonable adjustments for neurodivergent patients across the ward.
- Ward D5 are reviewing their training materials to ensure that autism awareness and communication needs are embedded more effectively into staff learning and practice.
- Steps are being put into place to address the typing backlog
- The team on Ward D8 are being reminded to clearly distinguish between documented medical diagnoses and observed behaviours or information provided in supportive care documents.

- We are reviewing how information from documents such as “This Is Me” is incorporated into the patient’s care plan, to ensure it is used to support person-centred care without leading to inaccurate assumptions or diagnoses.
- Training on stoma and wound management is being refreshed for all staff.
- Compliance with basic care delivery is now being closely tracked through both internal audit and peer-to-peer accountability measures.
- The use of pain relief will be discussed with the consultant and the wider team, to ensure that all staff consistently follow best practices, to support improved patient comfort and outcomes going forward
- We are encouraging earlier engagement with the palliative care team when complex symptom management is anticipated, to ensure optimal comfort.
- IV safety: Refresher sessions on cannula care and extravasation have been delivered, with further skills updates for the nurse involved.
- Nursing and medical teams will receive refresher training on accurate discharge documentation and communication with NOK.
- Mealtime champions will monitor patients requiring assistance during meals.
- Dementia Matron will deliver toolbox sessions to improve dementia care during mealtimes.
- AMU staff have been reminded that the use of personal phones and accessing social media is not allowed whilst on duty.
- The secretarial team are to ensure that urgent letters are sent immediately, rather than waiting for the Clinical Outcome Form (CLIO) to be updated.
- All Emergency Department staff will be reminded of the importance of thoroughly documenting patients’ medication histories.
- The Sister will share the findings of the HFCEP with the nursing staff on the ED for their reflection and learning to prevent such lapses of care happening to other patients in future.
- Nursing and Medical staff have been reminded of the importance of reading the Patient Passport in order to be fully aware and have a more in-depth understanding of the patient’s requirements.
- Staff are being reminded of the importance of consistently meeting patients’ care needs, even in pressured environments, so that dignity and compassion remain central to the care we provide.
- We are strengthening monitoring of corridor care to ensure vulnerable patients are identified quickly, prioritised for appropriate spaces, and actively supported with food, fluids, and personal care.
- To further improve care, the escalation plan has recently been reviewed, this now includes identifying a cubicle to remain available during periods of extreme demand, so that patients nursed in corridor areas can be escorted into a private space to have their personal needs attended to.
- Reminder to Ward D2 staff of the importance of notifying the next of kin well in advance of any discharge, particularly for patients who lack capacity.
- Adoption of Christie NHS Foundation Trust competency documents for Port-a-Cath access.

- Engagement with GM Cancer Academy and Greater Manchester Cancer Alliance to develop regional training materials and skills lab programs
- Review of infection prevention communication and escalation processes for immunocompromised patients.
- Ongoing estates work in the Maternity Triage area, which includes the development of a dedicated telephone triage room with enhanced soundproofing to protect patient confidentiality.
- Correct practice for keeping women informed of delays with induction of labour will be reinforced with the delivery suite team.
- Consistent breastfeeding assessments will be used to identify concerns.
- A review of the Trust's Children's Occupational Therapy and the Children's Adaptation and Equipment Service is currently ongoing with the expectation that it will result in recommendations for changes to improve the experience of families who need this support.
- The Trust will review and reinforce protocols to ensure that emergency ultrasound scans are accessible over weekends, including escalation to on-call radiology consultants or use of portable scanning equipment when clinically indicated.
- We will remind staff that patients who re-present with worsening symptoms should trigger prompt repeat investigations, even if initial observations appear stable. This will be included in clinical training and reflective practice.
- We will review weekend consultant cover arrangements to ensure timely senior clinical input, particularly for patients admitted with complex or evolving conditions.
- The Matron will ensure that the ward team will participate in educational sessions focused on compassionate care, particularly around early pregnancy loss, to improve emotional support and communication with patients.
- We have reinforced correct practice for growth scan appointments with the maternity triage team.
- Standard practice to remove all bedding and monitoring equipment when a patient is transferred to theatre has been reinforced with the delivery suite and theatre teams.
- Copies of referral submissions will now be printed and uploaded to patient records to create a clear audit trail.
- The contraindications for hydrotherapy have been reinforced with all referring clinicians to avoid setting unrealistic expectations regarding treatment options.
- The bookings team will in future consider telephoning patients when there is short notice for an appointment.
- The current processes and timelines for clinic cancellations will be reviewed.
- All paediatric and maternity staff will receive a reminder and additional training on the importance of explaining care plans clearly to families, including rationale for extended observation periods and any changes to treatment plans.
- A new system will be implemented to ensure dietary requirements are flagged and carried forward for all meal orders during a patient's stay.
- Additional training will be provided for maternity support workers and housekeepers on managing dietary requests and liaising with catering teams.

- Development of patient-friendly materials explaining analgesia regimes and timing, alongside staff training to reinforce proactive pain management and communication.
- Mandatory infant feeding study days have been reinstated for all staff, and new competencies for breast pump use are being introduced. Additional peer support training will be provided to maternity support workers.
- Estates will review bathroom drainage issues to prevent water pooling and trip hazards.
- Where a chaperone is present, staff must explain their role and ensure this is documented appropriately.
- Ward teams have also been reminded that languages other than English must not be used during clinical procedures unless this directly supports patient care. This expectation has been raised in safety huddles and will be monitored by senior staff.
- Senior nurses have increased the frequency of observational walk rounds to monitor communication, professionalism and compassionate care.
- Issues regarding equipment such as blood pressure machines are being escalated promptly, with more frequent checks now in place.
- Additional training needs identified have been scheduled with Clinical Practice Facilitators.
- Further education on consent and communication is being delivered across the ward teams.
- Both wards have engaged the Acute Pain Team to provide educational toolboxes to strengthen practice in analgesia, escalation and communication.
- Additional infection prevention training has been delivered, supported by joint walk rounds with the Infection Prevention Team.
- Staff have been reminded of the need to document pain scores consistently and review the effectiveness of analgesia.
- Senior nurses are reinforcing the importance of tailoring care to each individual patient, including pain assessment, hygiene support and ensuring call bells are visible and accessible.
- Staff have been reminded about timely and accurate documentation, especially relating to procedures, patient concerns and care plans.
- More robust bedside handovers have now been implemented across the ward to ensure clear communication and continuity of care.
- Staff are reminded to check electronic prescribing alerts and fully review medication plans during handover.
- Introduction of a results book to ensure that any tests taken on the ward are appropriately followed up if a patient is discharged before they are returned. Delivery Suite also plans to implement the same process to strengthen continuity of care.
- A daily meeting has now been established between shift leads from all maternity areas and the neonatal unit lead to review any babies and parents receiving care across both areas, helping to improve communication and coordination between teams.

Learning from complaints is a core part of the Trust's governance framework. Themes, outcomes and identified improvements from complaints are incorporated into the monthly Governance Report, which is presented to the Corporate Quality Group. Through this forum, the Trust maintains its commitment to continuous improvement, proportionate to the risks and quality priorities of the organisation. The group promotes a culture of openness, risk awareness and high-quality, safe services across the Trust. Members are asked to take assurance that learning is being identified and acted upon as a result of incidents, inquests, claims and complaints.

To strengthen oversight further, the Quality Committee established the Patient Experience Group (PEG). This group provides assurance to the Committee that the Trust is effectively managing all aspects of the patient experience and public engagement agenda. PEG oversees the development and delivery of the Trust's Patient Experience Framework, ensuring that high standards of care are maintained and that systems supporting the achievement of corporate objectives are functioning effectively. Patient feedback is central to this work. PEG receives quarterly PALS and Complaints reports, which provide insight into themes, trends and areas requiring improvement. These reports support the group in confirming that lessons are being learned and that improvements are being embedded across services.

To enhance scrutiny, PEG established a dedicated Complaints Review Panel. The purpose of the panel is to provide independent oversight of complaint handling processes and to ensure that systems remain robust and fit for purpose. The panel meets quarterly and reviews one complaint from each division. It is chaired by the Deputy Director of Quality Governance and includes representation from each division, the safeguarding team and the patient experience team. The panel provides an opportunity to reflect on the quality of complaint responses and to consider whether:

- all aspects of the complaint were fully addressed
- the response was open, honest and transparent
- the tone and language used were appropriate
- learning was clearly identified and articulated
- examples of good practice were recognised

Following each meeting, a Key Issues Report is submitted to the Patient Experience Group. This ensures that areas of good practice are shared, and any concerns or gaps identified by the panel are escalated for action and assurance.

6. Equality Monitoring

Between 1 April 2025 and 31 March 2026, the Trust received 651 formal complaints, of which **8** included concerns relating to discrimination. At the time of preparing this report, one investigation remains ongoing.

Complaint 1

The complainant reported feeling treated differently from patients of British origin. They alleged that nursing staff engaged more positively with other patients, offered refreshments more promptly and responded inadequately when assistance was requested. They also expressed concern that information regarding their discharge arrangements was not communicated as promised. The complainant questioned whether these experiences were linked to their minority background and requested assurance that all nursing staff and managers receive training on treating all patients with dignity and respect, including those from minority groups.

Investigation ongoing at the time of reporting.

Complaint 2

The complainant believed their son did not receive appropriate treatment due to their race and ethnicity.

The consultant responded by confirming that all patients are treated in line with Trust and national professional standards, with clinical priority determined solely by need. The investigation found no evidence of discriminatory practice. However, it identified that communication during the patient's attendance did not meet expected standards, leaving the complainant feeling unheard and uncertain about clinical decisions. While clinical assessments and decisions were appropriate, the Trust acknowledged that the way information was conveyed did not provide the clarity and reassurance required.

Complaint 3

Concerns were raised regarding delays in care for a patient with a learning disability in the Emergency Department. The family reported that despite alerting staff to the patient's needs and requesting the Learning Disability Nurse on four occasions, no additional support was provided.

The Trust clarified that it does not have a dedicated Learning Disability Liaison Nurse; instead, support is provided by the Adult Safeguarding Team. Although information on accessing this support is displayed throughout the Trust, we recognise that this does not replace timely, proactive assistance when requested. The Trust outlined the process for notifying the Safeguarding Team once a patient is admitted and confirmed that reasonable adjustments are guided by the Trust's Standard Operating Procedure for patients with learning disabilities.

To improve future practice, the Emergency Department and Adult Safeguarding Team will strengthen staff awareness of support pathways and reinforce escalation processes through staff meetings. All Emergency Department staff complete mandatory learning disability training, monitored by the Education Team.

Complaint 4

The complainant, who identifies as LGBTQ, a foreign national and of Romani heritage, reported concerns about the behaviour of a ward manager, describing interactions as dismissive and aggressive. They questioned whether unconscious bias or discrimination influenced their experience.

During the investigation, the matron discussed the concerns with the ward team to ensure learning is embedded. The ward manager was reminded of the importance of open communication, timely escalation, and adherence to care plans. The matron also emphasised the need for compassionate, individualised care and asked the ward manager to reflect on the impact of the experience on the patient.

Complaint 5

The complainant raised concerns about accessibility within the Urgent Treatment Centre, explaining that consulting rooms could not accommodate the patient's electric wheelchair, resulting in the doors remaining open and compromising privacy.

The Trust explained that while the new Emergency Department is fully wheelchair accessible, the Urgent Treatment Centre is part of the older estate and is undergoing

renovation, due for completion in early 2026. Apologies were offered for the impact on the patient's experience. Staff were reminded that larger rooms are available and should be used when assessing patients with mobility or accessibility needs.

Complaint 6

The complainant expressed concerns about delays in disability adaptations to their home and believed that changes in staffing had resulted in discriminatory treatment towards their family and others.

The investigation confirmed that concerns raised by the complainant were escalated to Stockport Homes appropriately. Stockport Homes reported that delays were due to difficulties arranging access and cancelled appointments rather than discriminatory practice. The Trust acknowledged that the overall timescale was unacceptably long and recognised the frustration this caused. An external review of the Trust's Children's Occupational Therapy and Physiotherapy services is underway and is expected to recommend improvements to service delivery.

Complaint 7

The patient's family raised concerns about perceived delays and lapses in treatment and questioned whether racial bias contributed to these issues.

The Trust's investigation found no evidence that racial bias influenced clinical decision-making or contributed to delays. The patient's care pathway reflected the complexity of her symptoms and the need for multidisciplinary involvement, with all decisions made in her best interests.

Complaint 8

The complainant raised concerns about delays in treatment, staff interactions and an unfair referral to social services. They believed they were treated with less care and respect due to racial and language discrimination, noting that they do not speak with a native English accent.

The investigation confirmed that the patient received clinically appropriate care and that arrangements were made, at the complainant's request, for beds during transfer to the children's unit. A MASSH referral was made due to concerns arising from the complainant's attempt to move the patient without clinical supervision. No evidence of discrimination or bias was identified.

Summary and Themes

Across the eight complaints raising concerns about discrimination, investigations found no evidence of discriminatory practice. However, several important themes emerged:

- **Communication:** In multiple cases, the way information was shared left patients or families feeling dismissed, unheard or insufficiently reassured, even where clinical care was appropriate.
- **Awareness of support pathways:** Particularly in relation to learning disability support, families reported uncertainty about how to access specialist assistance.
- **Accessibility and reasonable adjustments:** Physical accessibility issues and the need for clearer, more proactive adjustments were highlighted.

- Perception of bias: Even where investigations found no discriminatory behaviour, the perception of bias had a significant impact on patient experience and trust.

The following tables provide a breakdown of the characteristics of the patients who contacted our service to make a formal complaint:

Please note the figures may total more than the number of complaints received as some cases may involve multiple patients.

Table A – Age of patient

Age of patient	2023-2024	2024-2025	2025-2026
0 to 16	62	58	60
17 to 30	43	60	84
31 to 50	111	151	161
51 to 70	127	140	147
71 to 90	146	156	167
91 +	28	16	19
Not known	11	14	13

Table B – Gender of patient

Gender of patient	2023-2024	2024-2025	2025-2026
Female	293	344	416
Male	207	244	231
Not recorded/not given	7	7	4

Table C – Disability recording

Disability	2024 - 2025	2025-2026
Yes	65	93
No / Not disclosed	530	558

Many patients have multiple conditions recorded, for example a learning disability and visual and/or hearing impairment.

Table D – Ethnicity

Ethnicity	2024 - 2025	2025-2026
Bangladeshi	0	0
Black African	0	0
Black Caribbean	0	0
Chinese	1	1
Indian	1	0
Mixed White and Asian	3	2
Mixed White and black African	0	0
Mixed white and black Caribbean	0	1
None recorded	179	0
Not stated	10	0
Asian or Asian British – Any other Asian background	9	8
Asian or Asian British – Indian	0	1
Other Black	2	0
Other ethnic category	3	4
Other mixed	1	0
Pakastani	1	0

White – British	379	231
White – Irish	4	2
White – other white	2	0

7. Second stage complaints: Parliamentary and Health Service Ombudsman (PHSO)

If a complainant remains dissatisfied after the Trust's complaints procedure has been completed, they may ask the Parliamentary and Health Service Ombudsman (PHSO) to review their case. The PHSO will first carry out an initial assessment to determine whether the complaint meets the criteria for investigation.

When the PHSO accepts a complaint for investigation, they examine whether the Trust acted properly, fairly, and in line with relevant standards. Their approach involves establishing what should reasonably have happened at the time, taking into account applicable legislation, policies, guidance, and professional expectations. They then compare this with the actions actually taken to identify any failings.

If the PHSO finds that something went wrong, they consider the impact on the complainant and whether the Trust has already acknowledged or addressed the issues identified. These factors inform their final decision on whether a complaint is upheld in full, upheld in part, or not upheld.

Throughout the year, the Trust continued to work constructively with the Parliamentary and Health Service Ombudsman (PHSO) and, where relevant, the Local Government Ombudsman (LGO). Activity remained steady across all four quarters, with a consistent flow of new enquiries, concluded investigations, early-resolution opportunities and ongoing case management.

New Enquiries and Intake Decisions

Across the year, the Trust received a total of 26 new enquiries from the PHSO and one enquiry from the LGO. These requests typically involved the provision of clinical records, complaint files and relevant policy information to support the Ombudsman's initial assessment.

Across all quarters:

- 12 cases were closed at intake, with the Ombudsman confirming that a full investigation was not required.
- The LGO enquiry related to a multi-agency complaint and required information from the Transfer of Care Team, including records, minutes and associated policies.

No systemic risks or emerging themes were identified at the intake stage.

Concluded Investigations

Across the year, the PHSO concluded 10 investigations, with a range of outcomes:

- Four cases were not upheld, with the Ombudsman finding that the Trust had acted appropriately.
- Four cases were partly upheld, with identified issues including delays in referrals, aspects of communication, elements of clinical risk assessment and post-operative management. In each case, the Trust has issued or is preparing acknowledgement letters and is implementing agreed action plans.

- Two cases were resolved through mediation, avoiding the need for full investigation. These included:
 - A reassurance letter and a £1,000 financial remedy relating to concerns about bowel tumour management.
 - A letter of apology and a £600 financial remedy in recognition of distress caused for a patient who experienced a delay in diagnosis.
- One case was upheld, relating to a delay in treatment for a gallbladder infection. While the Trust accepted this finding, it disputed several additional elements of the Ombudsman's assessment. Following negotiation, a revised set of actions was agreed, after which the Ombudsman discontinued the investigation.

Themes and Learning

Several themes emerged from the year's Ombudsman activity:

- Clinical risk assessment: A partially upheld case highlighted the need for consistent application of VTE assessment criteria, including BMI-related risk factors.
- Communication and accessibility: Mediation cases reinforced the importance of ensuring equitable access to interpreting services and maintaining clear communication with patients and families.
- Inter-organisational coordination: The LGO enquiry emphasised the need for robust multi-agency documentation and clarity of responsibility at transfer of care.
- Effective early resolution: Multiple cases were resolved without full investigation, demonstrating constructive engagement and a proactive approach to addressing concerns.

Year-End Position

At the end of 2025-2026:

- 12 Ombudsman cases remain open, spanning early enquiry, assessment, full investigation and mediation stages.
- The Complaints Team continues to coordinate timely submissions and ensure that learning from concluded cases is shared with relevant divisions.

8. Summary and recommendations

2025–2026 has seen continued growth in PALS and Complaints activity against a backdrop of sustained operational pressures across the Trust. High OPEL levels, infection outbreaks, IT disruption, industrial action and major estates and car parking changes all contributed to increased demand for support and a rise in formal complaints and general enquiries.

The PALS Team has faced particular challenges due to high enquiry volumes, sickness absence and the redirection of queries intended for clinical teams. This resulted in a backlog of approximately eight weeks. The temporary six-month secondment post now in place is expected to support recovery of response times. The Complaints Facilitator Team has returned to full staffing, which should improve the timeliness and quality of complaint investigations. Despite these pressures, the Trust continues to receive a substantial volume of positive feedback, reflecting the dedication and compassion of staff across services. Work is required to strengthen the consistency of compliment reporting to ensure positive feedback is fully captured. Themes identified through PALS and Complaints activity continue to provide valuable insight into areas where patient experience can be

strengthened, particularly communication, access to services and responsiveness during periods of operational pressure.

The Patient Experience Group are asked to note the content of this report, the work undertaken by all staff involved in handling and responding to complaints which is wider than the complaints team, to improve the experience of our patients. The Quality Committee are asked, in line with statutory requirements, to provide approval for the report to be published on the Trust's website.

Key recommendations from the report for noting

1. Note the continued increase in PALS and Complaints activity, reflecting sustained operational pressures and rising demand for patient support.
2. Note the impact of high enquiry volumes and sickness on PALS capacity, resulting in an eight-week backlog at the time of reporting.
3. Note the appointment of the temporary six-month secondment post, which is expected to support backlog recovery and improve response times.
4. Note that the Complaints Facilitator Team has returned to full staffing, strengthening the team's ability to progress investigations in a timely manner.
5. Note the operational factors contributing to increased PALS contacts, including reduced direct access to clinical teams and phone system issues.
6. Note the need for improved compliment reporting, as current figures under-represent the volume of positive feedback received.
7. Note that learning from PALS and Complaints continues to inform service improvement, with themes shared through governance structures.
8. Note that capacity pressures remain on the Trust's risk register, with ongoing monitoring and mitigation in place.