Public Trust Board paper F4

Meeting title:	Trust Board
Date of the meeting:	9 October 2025
Title:	**Escalation Report from the Quality Committee (QC): 25 September 2025**
Report presented by:	Ms Jill Houghton, Non-Executive Director (Acting Chair)
Report written by:	Hina Majeed, Corporate and Committee Services Officer

Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	Not applicable					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which

Yes. BAF risk within the remit of QC is listed below:
Quality Risks (BAF reference: 01-Quality)
1) There is a risk that a positive safety culture is not consistently embedded across services, due to underreporting and variable staff confidence in raising concerns and learning from incidents, leading to patient harm, low morale, reputational damage, and non-compliance with safety standards
2) There is a risk that hospital-acquired infections and harm do not reduce as planned, due to inconsistent delivery of fundamentals of care, overcrowding and variable protocol compliance, leading to avoidable harm, longer stays, cost pressures, and reduced confidence in care
3) There is a risk that patients, families, and carers are not fully engaged in service development and feedback, due to limited access to and responsiveness of engagement mechanisms, leading to unmet needs, dissatisfaction, and increased complaints
4) There is a risk that care for patients with mental health needs, learning disabilities, autism, dementia, or at end of life remains inconsistent, due to variable screening, staff training, and service capability, leading to poorer outcomes, readmissions, and non-compliance with national standards
5) There is a risk that patients from underserved groups continue to experience poorer access, communication, and outcomes, due to insufficient data insights, inconsistent reasonable adjustments, and language/cultural barriers, leading to continued health inequalities and dissatisfaction among diverse patient groups, missed appointments, and reputational damage

Impact assessment

N/A

Acronyms used:
ICB – Integrated Care Board
AHP– Allied Health Professionals

1. Purpose of the Report

To provide assurance to the Trust Board on the work of the Trust's Quality Committee and escalate any issues as required.

2. Summary

The Quality Committee met on 25 September 2025 and was quorate. It considered the following items, and the discussion is summarised below:

3. Discussion Items

3.1 Board Assurance Framework (BAF)

The Committee reviewed the BAF and supported that the risk scores remain unchanged.

3.2 Blood Traceability Report - compliance with the use of BloodTrack System

An update was provided on the blood traceability system, outlining compliance rates, technical challenges with obsolete devices, manual workarounds, and ongoing efforts to improve traceability. It was highlighted that while 100% blood traceability was achieved over the past year, 7.2% of transfusions required manual tracing due to incomplete use of the BloodTrack system. Key issues include outdated iPods, poor device maintenance, inconsistent staff training, technical failures, and non-use during emergencies - all of which posed risks to patient safety. Despite improvements from 70% to 93% compliance, the report stressed the need for device upgrades, better training, and integration with the Nerve Centre system. Device replacement had been escalated to IT, and a group was reviewing options. The Patient Safety Committee would continue to monitor progress, with any issues being escalated to Quality Committee, as appropriate.

3.3 104 Day+ Cancer Quality Standard Report – Quarter 2 & 3 2024/25

The Quality Committee considered the above-referenced report which outlined the process currently in place for the reporting of cancer harm as monitored by the Cancer Centre. The 104+ day process reported actual physical harm to a patient from the date of receipt of their two-week wait referral to their first definitive cancer treatment. The report illustrated the Trust's position for quarters 2 & 3, along with individual tumour site data including key themes and actions identified to improve waiting times. The Committee supported the ongoing work and noted that future harm reviews would reflect recent capacity losses in certain tumour sites.

3.4 National Cancer Patient Experience Survey, UHL – 2024 results

The report summarised the results of the 2024 national cancer patient experience survey, highlighting areas of improvement and deterioration, workforce risks, data representativeness, and plans for action. There was concern about the sustainability of improvements due to fixed-term posts ending in March, with business cases being developed to support key roles. Action plans were being developed at tumour site and organisational levels, with a focus on addressing inequalities in survey responses and improving patient engagement, particularly among underrepresented groups. Responding to a query in respect of representativeness of survey data, especially regarding ethnicity and tumour site distribution, it was noted that efforts were underway to compare sample submissions with response demographics and concerns would be fedback nationally.

3.5 Quality and Safety Performance Report 2025/26 Month 5

The report highlighted improvements in risk assessments, falls, and safety metrics, while highlighting ongoing challenges with overdue complaints and incidents. Mandatory training compliance remained low, partly due to the high number of local modules. The Deputy Medical Director noted the need to review and potentially reduce the number of modules, balancing national requirements with local learning needs and suggested to bring a proposal in November/December, as appropriate.

3.6 Risks Arising from the Vacancy of Principal Pharmacist – Antimicrobials

The Committee received a report on the current position of antimicrobial stewardship, describing workforce shortages, the need to reconfigure stewardship responsibilities, and the importance of collective responsibility. The Committee acknowledged the high risk, supported the need for a new approach, and advised that recruitment and business case processes should proceed through the appropriate management channels. The Chief Pharmacist undertook to liaise with the Medical Director regarding whether an external review should be undertaken.

3.7 Temporary Escalation Spaces (TES) Assurance

The report provided an update on the current position on usage (noting a decrease in use) and quality assurance of TES during periods of system pressure, specifically to enhance flow out of the Emergency Department. Monthly oversight was being maintained, metrics had been clarified, and benchmarking showed UHL was among the lowest users of TES in the Midlands. No increase in TES had been planned for winter, and pressures would be managed within policy.

3.8 Options Appraisal: Strengthening Assurance on Complaints Responses for Non-Executive Colleagues

The report summarised 3 options for strengthening Non-Executive Director (NED) involvement in complaints oversight. In discussion there was support for a blended approach by enhancing the existing quarterly panel with NED involvement (option 1) while piloting monthly sampling (option 2) to provide more regular assurance. Real-time review (option 3) may be reserved for high-risk services or specific cases where additional oversight

is needed. The Deputy Chief Nurse undertook to discuss the practical implementation details with relevant colleagues and ensure it was taken forward, as appropriate.

3.9 Patient Safety Committee (PSC) Terms of Reference and Annual Review – Effectiveness
The Quality Committee approved the PSC ToR and Annual Report.

4. Reports from Quality Sub-committees

- **Safeguarding Assurance Committee Report** – an update was provided on safeguarding service activity and developments, highlighting the significant increase in the number of abandoned children in the Emergency Department. A thematic review of these cases had been declined by the Local Authority. In discussion on this matter, the ICB Representative undertook to escalate this. The report also highlighted the increase in the number of adult neglect cases presenting to the Trust, which would also be escalated by the ICB Representative. A deterioration in level 3 safeguarding children training compliance had been noted, a blend of online and face to face training was being offered to improve uptake. Work was being undertaken in Maternity Services to support women who are pregnant, with mental health illness. With regard to learning from case reviews, new documentation for case conferences had been introduced to improve partner understanding of children's complex heath needs.

- **Patient Safety Committee 16.9.25** – noted

- **Nursing, Midwifery and AHP Committee Summary Report** – the Committee noted progress made with the Fundamentals of Care workstream and changes to the Leicester Excellence Accreditation Framework (LEAF) metrics to improve assurance and oversight of individual wards quality metrics, robust oversight of the challenges in relation the AHP workforce and stability of nursing and midwifery vacancies.

5. Items for Noting

- Integrated Performance Report – Month 5 (2025-26)
- Perinatal Surveillance Scorecard