Meeting title:	Boards of Directors of Kettering General Hospital NHS Foundation Trust (KGH), Northampton General Hospital NHS Trust (NGH) (University Hospitals of Northamptonshire NHS Group - UHN) and the University Hospitals of Leicester NHS Trust (UHL) Meeting together (Public)
Date of the meeting:	11 June 2026
Title:	**3.4 Escalation Report from the Quality Committee (QC): 28 May 2026**
Report presented by:	Jill Houghton, QC Non-Executive Director Member
Report written by:	Jill Houghton, QC Non-Executive Director Member

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						
Board Assurance Framework (BAF) - Quality Risks (BAF reference: 01-Quality): 1) Safe care environment and learning safety culture 2) Patients, families and carers involvement 3) Consistently high quality care across services 4) Health inequalities in access, experience and outcomes						
Impact assessment						
N/A						

Purpose of the Report

To provide assurance to the Trust Board on the work of the Trust's Quality Committee (QC).

Summary

Quality Committee met on 28 May 2026 and was quorate. The attached escalation report identifies any issues which the Committee either needs to recommend, or wishes to highlight, to the Trust Board, and sets out the QC's level of assurance.

This escalation report follows the new quadrant template, focusing on assurance levels and aiming to provide an 'at a glance' report from the Board Committees. The template covers: **key escalations**; **actions to take outside the Committee**; **positive assurances**, and **decisions taken**.

The escalation report also sets out any items recommended for Trust Board approval, and any items referred to other Committees.

The report is not intended to be a narrative account of all issues discussed at the meeting.

Key escalations to notify the Board	Actions to take outside of the committee
BAF 01 Quality 1-4 Patient Experience Update. This report provided an overview of Patient Experience activity and performance across UHL during Q4. It brought together intelligence from PALS, complaints, Friends and Family Test, targeted surveys, volunteering surveys and governance processes, highlighting both areas of improvement and also areas requiring continued focus. This paper was enhanced by a report headed Patients' Use of Artificial Intelligence (AI) to formulate complaints. This paper provided assurance to the Quality Committee that the ongoing use of AI by patients and families to assist them with drafting complaints had been considered, including implications for complaints handling, legal risk and governance, and that policy changes were not required. This approach by patients and their families does not currently alter UHL's legal duties, regulatory obligations or governance arrangements. (Moderate Assurance/Substantial Assurance) BAF 01 Quality 1-4 Perinatal Assurance and Accountability Framework. This Framework strengthens the governance, assurance and escalation architecture through which key perinatal risks are identified, triangulated, monitored and acted upon. Quality Committee members discussed and approved this Framework. (Moderate Assurance)	None
Positive Assurance taken	**Decisions taken**
Other Reports reviewed: Quality and Safety Performance Report Personal Dosimetry Report 2025 Quality Strategy Update Q4 Pharmacy and Medicines Optimisation (including Controlled Drugs) Assurance Report Infection Prevention Governance and Assurance Quarter 4 Report Surgical Site Infection Prevention Surveillance Reduction Update Q4	

Nursing, Midwifery, and AHP Committee Escalation Report Patient safety Committee Assurance Summary May 202 (Moderate Assurance)	
Items recommended for Board approval:	
BAF 01 Quality 1-4 UHL Quality Account 2025/26. This document provided assurance to the Quality Committee that the key risks to quality of care at UHL are actively managed and supported by clear evidence of improvement and ongoing oversight. While the report acknowledges ongoing risks such as waiting times, workforce pressures and service demand, overall, it provides assurance that these are being actively mitigated through targeted quality improvement initiatives and strategic planning, indicating a mature and embedded approach to quality management. (Moderate Assurance) BAF 01 Quality 1-3 Mortality and Learning from Deaths Quarterly Report. The UHL Learning from Deaths Framework provides assurance in respect of both the national risk adjusted mortality measure (SHMI) and also delivery of Death Certification, Medical Examiner scrutiny and Case Record Review as per national statutory requirements. (Moderate Assurance) BAF 01 Quality 1-4 UHL Quality Committee Annual Report 2025/26. This report provides the Trust Board with assurance that the Quality Committee meetings have covered all essential areas within it's remit which are aligned to best practice and its Terms of Reference. (Significant Assurance)	
Items referred to other committees:	
None	

SIGNIFICANT ASSURANCE	Clear understanding of the issues with a robust, deliverable plan which will achieve the required outcomes. Only insignificant residual risk. There may be external evidence to corroborate this view
MODERATE ASSURANCE	Good understanding of the issues, a clear plan with timescales that are credible and deliverable but some action still required. The residual risk is more than insignificant
LIMITED ASSURANCE	Recognised material weaknesses which may be incomplete understanding of the issues or an action plan which is not comprehensive, credible or deliverable. A significant amount of residual risk remains
NO ASSURANCE	A fundamental failure to understand the issues. An action plan is inadequate with fundamental gaps, weaknesses or breakdown in compliance. A significant of residual risk remains and immediate action is required

Meeting title:	TRUST SAFETY COMMITTE
Date of the meeting:	May 2026
Title:	UHL MORTALITY AND LEARNING FROM DEATHS QUARTERLY REPORT
Report presented by:	Gang Xu, Medical Director
Report written by:	Rebeca Broughton, Head of Learning from Deaths

Action – this paper is for:	Decision/Approval		Assurance	X	Update	
Where this report has been discussed previously						

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

The UHL Learning from Deaths (LfD) framework provides assurance in respect of both the national risk adjusted mortality measure (SHMI) and also delivery of Death Certification, Medical Examiner (ME) Scrutiny and Case Record Review as per national statutory requirements.

This report provides details of actions being taken in respect of LfD actions relating to the Risk 3961

3961 – ME staffing to meet the requirements for expanding the ME service into primary care (Risk Score 9)

Impact assessment

- Monitoring Quality of Care for patients who die in UHL
- Improving Outcomes of future patients

Acronyms used:
LfD – Learning from Deaths; ME – Medical Examiners; MCCD – Medical Certification of Cause of Death; SJR – Structured Judgement Review (Case Record Review)' SHMI – Summary Hospital Mortality Index (all inpatient deaths and deaths within 30 days of discharge to the community setting); HSMR – Hospital Standardised Mortality Ration (56 diagnosis groups in hospital deaths); CUSUM - Cumulative Sum Control Charts; NICOR (the national cardiac surgery audit data); PSII Patient Safety Incident Investigation

Purpose of the Report

To receive an update on UHL's Mortality Rates and Learning from Deaths programme which includes

- Bereavement Services Office – Death Certification
- Medical Examiner Process – both within UHL and across the Leicester, Leicestershire and Rutland (LLR) Healthcare System
- Bereavement Support Service
- Specialty Mortality Reviews using the national Structured Judgement Review tool
- LLR Child Death Overview Panel reviews and Perinatal Mortality Review Group reviews using the national Perinatal Mortality Review Tool
- Clinical Team reviews and reflections

Summary

The committee is asked to assured by actions taken including:

- Monitor our crude and risk adjusted mortality rates using SHMI and HSMR.
- Ongoing work to meet the Statutory requirements in respect of the expanded Medical Examiner process implemented across all of Leicester, Leicestershire and Rutland (LLR).
- Progress and learning from the annual child death report and the Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries group – (MBRRACE)

Mortality:

UHL's crude mortality rate has been on a downward trend for the past 4 years and compares favourably against the England average

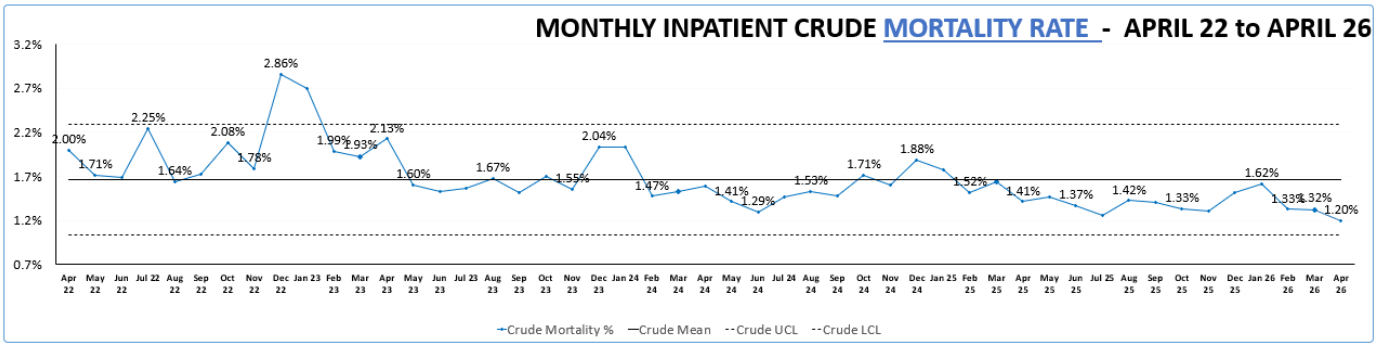

Figure 1 – UHL's Crude Inpatient Mortality Rate (SPC Chart)

Indicator	Value	England average
Admission method		
Crude percentage mortality rate for elective admissions	1.0	1.0
Crude percentage mortality rate for non-elective admissions	2.4	3.4

Figure 2. UHL's crude mortality compared with the England Average – as reported by NHS Digital

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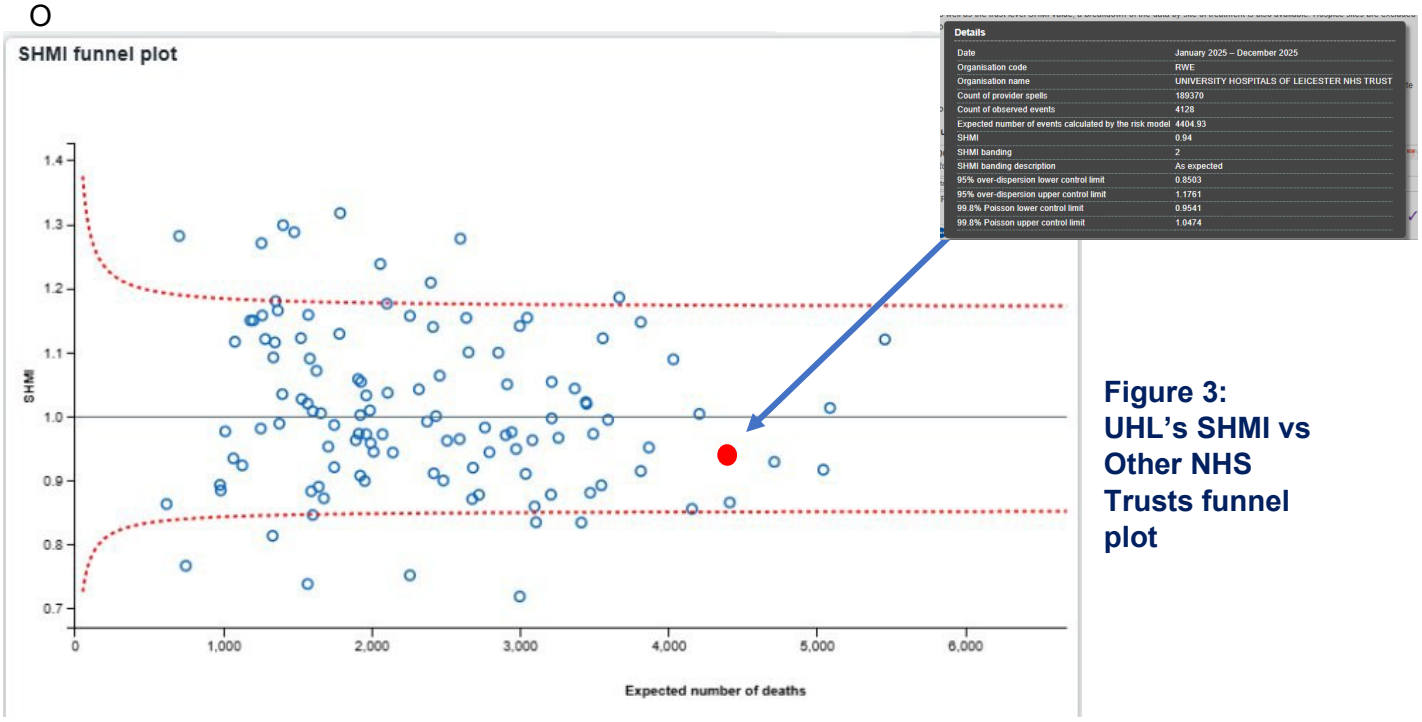


Figure 3: UHL's SHMI vs Other NHS Trusts funnel plot

At the February TSC we reported that our SHMI had gone above 100 due to having more deaths than expected, this was because our data included a high number of cases with 'Invalid Primary Diagnosis' codes. Our data has now been amended and resubmitted and our latest SHMI value is 94 (Figure 3).

As shown in the chart below (Figure 4), we continue to see an improvement in our depth of coding.

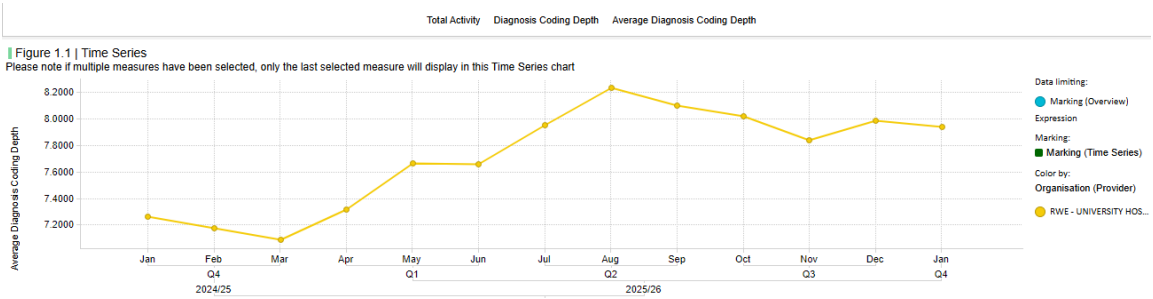
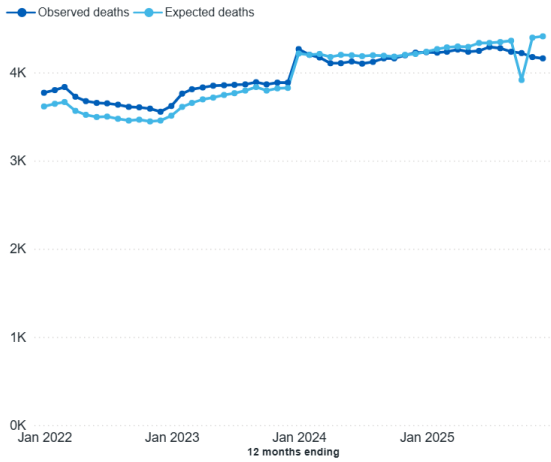


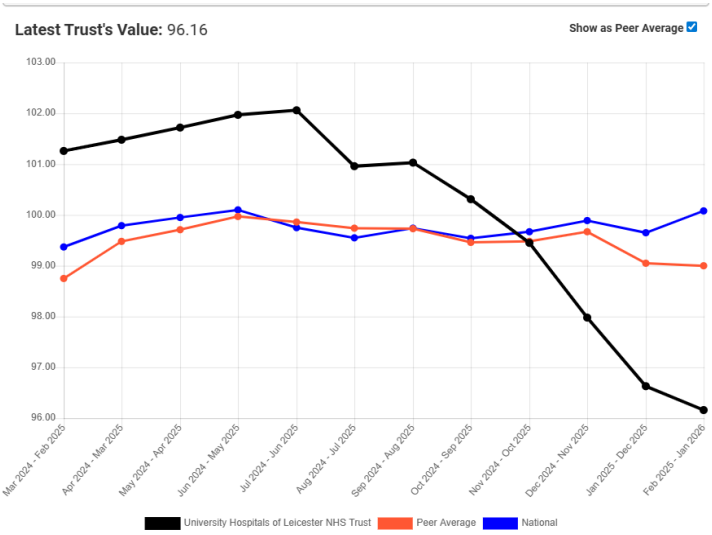
Figure 4: Diagnosis Coding Depth –Jan 25 to Jan 26 (taken from HED Data Quality Module).

This increased depth of coding is having a positive effect on our SHMI as the risk adjustment means that we are now having fewer deaths than expected (Figure 5). (Note the 12 month period Oct 24 to Sept 25 includes the high number of 'invalid primary diagnosis' cases).



PERIOD_END	Observed deaths	Expected deaths	SHMI value	Banding description	Provider spells
January 2024	4,200	4,200	0.9998	As expected SHMI	161,375
February 2024	4,170	4,210	0.9907	As expected SHMI	163,845
March 2024	4,105	4,175	0.9842	As expected SHMI	165,065
April 2024	4,105	4,200	0.9776	As expected SHMI	167,670
May 2024	4,125	4,195	0.9833	As expected SHMI	169,970
June 2024	4,100	4,185	0.9797	As expected SHMI	171,265
July 2024	4,120	4,195	0.9817	As expected SHMI	173,085
August 2024	4,160	4,190	0.9931	As expected SHMI	174,080
September 2024	4,160	4,180	0.9942	As expected SHMI	175,150
October 2024	4,195	4,200	0.9997	As expected SHMI	177,090
November 2024	4,225	4,210	1.0035	As expected SHMI	177,810
December 2024	4,230	4,235	0.9980	As expected SHMI	179,220
January 2025	4,225	4,265	0.9899	As expected SHMI	180,370
February 2025	4,235	4,285	0.9877	As expected SHMI	181,110
March 2025	4,260	4,295	0.9916	As expected SHMI	181,300
April 2025	4,235	4,290	0.9872	As expected SHMI	181,325
May 2025	4,245	4,335	0.9792	As expected SHMI	182,005
June 2025	4,290	4,335	0.9891	As expected SHMI	182,610
July 2025	4,275	4,345	0.9839	As expected SHMI	183,775
August 2025	4,235	4,360	0.9710	As expected SHMI	184,340
September 2025	4,220	3,915	1.0774	As expected SHMI	185,490
October 2025	4,175	4,395	0.9501	As expected SHMI	186,510
November 2025	4,160	4,410	0.9434	As expected SHMI	188,060

Figure 5: UHL's Observed vs Expected Deaths (as reported by NHS Digital)



This improvement is also being seen in our HSMR which is 96 for the latest 12 months (Feb 25 to Jan 26)

Figure 6: UHL's Rolling 12 month HSMR data (Mar 24/Feb 25 to Feb 25/Jan 26) compared with Peer Trusts and the England Average)

UHL PERINATAL MORTALITY - QUARTERLY UPDATE

MRC received the Quarterly update on UHL's Perinatal Mortality which was presented by Dr Robin Miralles.

	Total SB	Corrected Stillbirths	SB rate	Total NND	Corrected Neonatal deaths	NND rate
2009	86			48		
2010	77			49		
2011	63			43		
2012	70	65		51		
2013	47	45	4.55	50	27	2.65
2014	56	51	4.59	46	23	2.37
2015	52	43	4.23	50	29	2.98
2016	55	47	4.25	52	25	2.39
2017*	43	37	4.05	39	21	2.18
2018	33	26	3.48	56	28	2.69
2019	34	29	3.46	46	24	2.45
2020	48	40	3.74	45	24	2.51
2021	56	50	4.52	36	28	2.76
2022	46	39	3.86	66	34	3.28
2023	45	32	3.24	65	37	3.06
2024	55	44	3.65	66	33	2.88
2025**	51	43		54	22	
2026 Jan to March	13	11		9	8	

Figure 7: UHL's Perinatal Mortality (Crude and Corrected)

Although our stillbirth rate for 2024 was comparable to our peer group, this was an increase compared to 2023. For neonatal deaths we remain more than 5% higher than our peer group, though we recognise that we are part of a small very high risk subset of that peer group, due to the presence of the congenital heart service and ECMO within Leicester

Members were advised by the Dr Miralles that following review of the data, the main notable change was that our previously noted high rate of extreme preterm births has increased further and has now reached statistical significance and will contribute disproportionately to the overall mortality rate. This group of deaths will be looked at in more detail.

Members also received details of the reviews undertaken for babies born between July and December 2025. The Perinatal Mortality Review Group (PMRG) considered that there were 2 babies where different management may have affected outcome. Actions are in progress for both.

Members were advised that the Peer Review meetings with Newcastle have been held looking at both UHL and Newcastle cases.

Bereavement Services

In March 26, the Bereavement Service - with support from the Chair of the Organ Donation Committee, Medical Examiner service and Mortuary team – began implementation of the Eye Donation Scheme (EDS) at the Glenfield site. Where the deceased meets the criteria and is within time the family is approached to see if they would be agreeable to discussing eye retrieval with the National Organ Donation team.

The plan is to take the scheme to the LRI and LGH sites in August. Currently eyes are retrieved by the National team but in time UHL's Mortuary team will be trained up to do the retrievals themselves.

Whilst there is some limited funding available to increase staffing to support the EDS work, we are looking at other workstreams currently managed by the Bereavement office as we need to increase capacity, particularly to cope with the increased numbers in the winter months - one of these is the management of Lost Property as this does not seem to be a 'natural fit' with Bereavement services. The LfD Business Manager is working with the Bereavement Services Manager to look at alternative options.

The Manager of the Bereavement Office and LfD Manager are also in discussion with Estates in respect of the lack of a Bereavement Family Room at the Glenfield Hospital

LLR Medical Examiner Service:

There were over 2,313 deaths subject to Medical Examiner scrutiny in Quarter 4 with 784 of these being UHL deaths. As can be seen from the Dashboard below, the average turn around times for ME scrutiny is 2 days from receipt of the death being referred and 4 days from date of death.

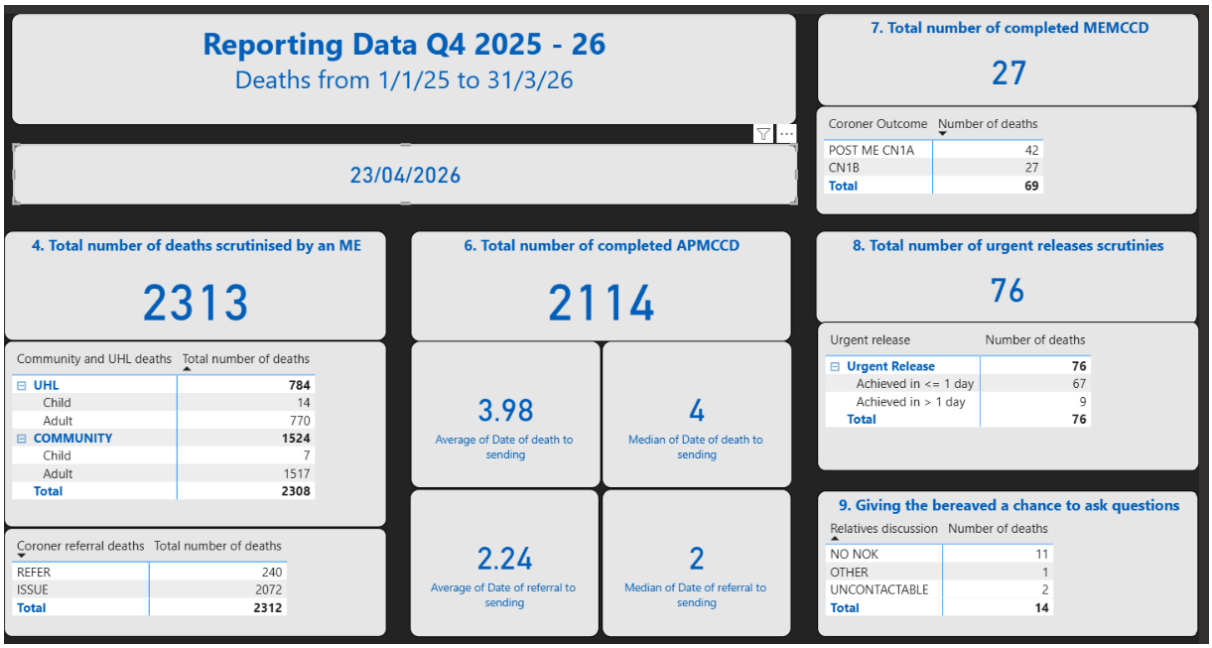


Figure 8 Days from Date of Death and Receipt of Referral to MCCD being sent to the Registrars

We have submitted our Quarter 4 data to the National ME Office. Next steps will be to collate themes from both the ME screening and feedback from the bereaved.

The National Medical Examiner has recently disseminated ME Standards and preliminary review suggests we are meeting the majority of these. A full 'gap analysis' is in progress to consider if any actions needed.

Learning from Deaths in UHL:

At time of reporting, 176 SJRs have been requested for Adult Deaths (all neonatal deaths are automatically subject to review by the Perinatal Mortality Review Group (PMRT) and all child deaths are reviews as part of the Child Death Review (CDR) process). 11 adult deaths have been reviewed through the PSIRF process with 5 going onto a PSII

89 SJRs, 14 CDRs and 73 PMRTs have been completed

3 adult deaths were thought to be more likely than not due to problems in care. There has also been one neonatal death where it was felt that different management would probably have affected outcome.

The number of reviews or investigations completed and how many deaths thought to be more likely than not due to problems in care will be published in our Annual Quality Accounts. Currently we will be reporting that 0.13% of deaths in 2025/26 were due to problems in care. A review of other Trusts' Quality Accounts has found that there is a wide range (0% to 13%).

Preliminary review of learning identified through SJRs found communication and documentation as the main recurring themes.

In respect of the 4 cases thought to be due to problems in care the issues relate to the themes identified as safety improvement priorities:

- Patient who was discharged from the Emergency Department with abnormal blood results and then represented in cardiac arrest
- Patient who was given breakfast when Nil By Mouth post surgery, subsequently vomited and aspirated.
- Patient where there appears to have been delays with diagnosis of Aortic dissection – arrested in CT
- Perinatal death where mother had a a massive upper gastrointestinal bleed caused by erosion of her gastric stent into the splenic artery. Appears to have been taken off the waiting list for removal of the stent under General Anaesthetic before she became pregnant.

All are currently undergoing a PSII

In respect of learning identified through all completed SJRs, in the majority of cases, the action was to feedback to teams or individuals with review of guidance documents being the other main action.

In addition to following up the outstanding SJRs, the Corporate LfD team will be seeking updates on agreed actions.

University Hospitals of Leicester NHS
NHS Trust

Meeting title:	**Boards in Common**
Date of the meeting:	**11 June 2026**
Title:	**Quality Committee Annual Report 2025-26**
Report presented by:	**Andy Haynes – Non-Executive Director and Quality Committee Chair / Jill Houghton - Non-Executive Director and Acting Chair of Quality Committee 28 May 2026**
Report written by:	**Hina Majeed – Corporate and Committee Services Officer**

Action – this paper is for:	**Decision/Approval**	**x**	**Assurance**	**x**	**Update**	
Where this report has been discussed previously	**None**					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
This report aligns with the requirements of the Head of Internal Audit Opinion and provides assurance that effective controls are in place to ensure that the Quality Committee is undertaking its duties, and that the Committee is in compliance with its Trust Board approved terms of reference.

Impact assessment
There is no expected impact upon patients or staff.

Acronyms used:
QC – Quality Committee
PSC – Patient Safety Committee

Purpose of the Report

The information contained within the report will provide QC itself and the Trust Board with assurance that QC meetings have covered all essential areas within its remit which are also aligned with best practice and its terms of reference. The report covers the period 1 April 2025 to 31 March 2026.

Recommendation

The UHL Trust Board is invited to approve the report.

Key Issues, Options and Risks

1. Introduction

The Quality Committee's terms of reference require that the Committee produce a report on an annual basis, providing an overview of its effectiveness in undertaking its duties and its compliance with its Trust Board approved terms of reference.

2. Meeting Attendance

During the period of this report, the Quality Committee met on 12 occasions. The Committee membership consists of 3 Non-Executive Directors, 1 Associate Non-Executive Director, the Chief Nurse,

the Medical Director, the Chief Operating Officer and the Director of Health Equality and Inclusion. Members are required to attend a minimum of 75% of meetings on a rolling 12-month basis. Attendance throughout the period was as follows: -

Voting Members	Role	Possible	Actual	% Attendance
A Haynes (Chair)	Non-Executive Director/Chair of QC	12	11	92
R Abeyratne	Director of Health Equality and Inclusion	12	8	67
I Browne	Non-Executive Director	12	11	92
M Farmer	Non-Executive Director	0	0	N/A
A Furlong (until January 2026)	Medical Director	10	7	70
H Hendley (from October 2025)	Chief Operating Officer	6	6	100
J Hogg	Chief Nurse	12	10	83
J Houghton	Non-Executive Director	12	11	92
S Kaur (from May 2025 – Mar 2026)	Associate Non-Executive Director	11	8	73
J Melbourne (until September 2025)	Chief Operating Officer	6	4	67
T Robinson (until May 2025)	Non-Executive Director	3	0	0
G Xu (MD from Feb 2026)	Medical Director	2	2	100

In Attendance	Role	Possible	Actual	% attendance
D Burnett	Director of Midwifery	12	1	8
S Burton	Deputy Chief Nurse	12	9	75
B Cassidy	Director of Corporate and Legal Affairs	12	11	92
R Manton	Head of Risk Assurance	12	11	92
C Pheasant	Chief Allied Health Professional	12	0	0
M Rahman	Chief Pharmacist	12	11	92
C Ward (PP)	Patient Partner	12	10	83
Gang Xu (DMD until January 2026)	Deputy Medical Director	10	8	80
ICB Representative		12	10	83

The Chief Executive, Trust Chair, other Non-Executive Directors, representatives of Internal and External Audit also all have a standing invitation to attend QC.

All the meetings held were quorate. The quorum is 4 members (to include 2 Non-Executive Directors and 2 Executive Directors) and this is confirmed at the start of each meeting. QC provides a written escalation report of its meetings to the Trust Board, aligning the discussions to the BAF risks within QC's remit and highlighting information needing to be flagged to the Trust Board.

3. Effectiveness of the Quality Committee in delivering its Core Functions

This section provides an overview of the core areas where the Committee is expected to operate its statutory function and provides assurances that the Quality Committee has fulfilled its duties. The position listed below reflects the updated terms of reference effective from December 2025.

The purpose of the Committee is to seek and receive assurance on the appropriateness and effectiveness of the Trusts overall quality governance arrangements. This Committee has delegated authority from the Board to gain assurance on the robustness of quality governance across the Trust to ensure safe care to patients.

General Composition and establishment		Yes	No
1	Does the Quality Committee have written terms of reference, and have they been approved by the Board?	✓	
2	Are the terms of reference reviewed annually?	✓	
3	Has the committee formally considered how it integrates with other committees that are reviewing risk?	✓	
4	Are the outcomes of each meeting and any formal recommendations reported to the next Board meeting?	✓	
5	Does the committee prepare an annual report on its work and performance for the Board?	✓	
6	Has the committee established a work programme for the year?	✓	
7	Are committee papers distributed in sufficient time for members to give them due consideration?	✓	

The Quality Committee terms of reference were last reviewed by QC in November 2025 and subsequently approved by the Trust Board in December 2025. An established plan is in place to review these annually on a rolling basis. The annual reporting process has been embedded into the Committee's work programme.

The Board Assurance Framework risks (and their risk ratings) that are within the Committee's remit are considered at each meeting.

Subject to availability, the agenda and papers are usually circulated 3 days prior to each meeting via the Team Engine electronic Board portal. In the event of exceptional circumstances, the Committee Chair would be requested to agree to a report relating to an additional agenda item being circulated at short notice.

Specific Duties of the Committee:		Yes	No
1	**Quality and Effectiveness**		
1.1	Does the Committee agree the Trust Quality Priorities and receive assurance for the performance against those priorities agreed?	✓	
1.2	Does the Committee receive CQC updates in a timely manner and monitor ongoing compliance with CQC fundamental standards and oversight of the implementation of agreed action plans?	✓	
1.3	Does the Committee monitor the Trust's compliance with CQC registration requirements and where there are changes?	✓	

1.4	Does the Committee receive assurance the Trust has appropriate staffing establishments which are reviewed in a timely manner via the Nursing, Midwifery and AHP committee?	✓	
1.5	Does the Committee receive, review and approve the Annual Quality Report prior to formal approval at the Board?	✓	
1.6	Does the Committee monitor the impact on the Trust's quality of care of cost improvement programmes?	✓	
1.7	Does the Committee receive assurance that the Trust's approach to Quality Improvement is robust and embedded across the organisation. Does the Committee receive updates on the outcomes of Quality Improvement initiatives?	✓	
1.8	Does the Committee receive 6-monthly assurance updates on clinical audit activity (with the option to roll the second six months into the annual report).	✓	
1.9	Does the Committee receive all limited assurance internal audit reports pertinent to the remit of this committee seeking assurance on the actions being taken to address the risks identified?	✓	
1.10	Does the Committee escalate appropriate concerns to the System Clinical Quality Executive Group?	✓	
1.11	Does the Committee receive updates on health equality and inclusion?	✓	
1.12	Does the Committee receive an annual update on waste management?	✓	
1.13	Does the Committee review the external annual PLACE inspection? *NB: This was presented to UHL/UHN Boards in Common.		✓*
1.14	Does the Committee receive a biannual update on the national cleaning standards?	✓	
1.15	Does the Committee receive a 6-monthly report on any quality and safety feedback from the Non-Executive Director site visits? *NB: The visits have only formally started in April 2026, therefore the first report is scheduled in June 2026.		✓*
1.16	Does the Committee updates on patient experience and complaints?	✓	
1.17	Does the Committee receive – for noting – quarterly updates on data quality and clinical coding (the substantive reporting route is through OFHTC)?	✓	
1.18	Does the Committee receive – for noting – the monthly Integrated Performance Report?	✓	
2	**Safety**		
2.1	Does the Committee review the quality and safety performance report at each meeting, including updates as appropriate on: - Patient Safety Incident Response Framework (PSIRF), patient safety priorities and themes, trends, learning from incidents (including Duty of Candour issues) and TCS concerns - 104+ cancer quality standard, and harms as a result of cancer performance - Mortality and Learning from Deaths - learning from claims and inquests - pharmacy and medicines optimisation (oversight of appropriateness of medicines management, prescribing, administration and safety and medication errors)	✓	

2.2	Does the Committee receive updates on perinatal surveillance, maternity safety and CNST (via MAC where appropriate)	✓	
2.3	Does the Committee receive biannual updates on mortuary services	✓	
2.4	Does the Committee receive a quarterly update on Infection Prevention matters (including annual review and endorsement of the IP BAF en route to Trust Board for approval)	✓	
2.5	Does the Committee receive regular updates on safeguarding issues	✓	
2.6	Does the Committee receive 6-monthly updates on fragile services *NB: To be included within the Clinical Strategy update from June 2026.		✓*
2.7	Does the Committee receive updates on and oversee – via the Patient Safety Committee – the following issues: - the deteriorating patient, resuscitation and end of life and palliative care - falls - pressure ulcers - implementation of the mental health strategy	✓	
3	**Core Responsibilities and Sub-Group reporting**		
3.1	Does the Committee review and support the Trust's core strategies associated within the committee's remit?	✓	
3.2	Does the Committee monitor, review and assess the level of assurance received on the quality risks, controls and governance processes identified in the Board Assurance Framework delegated to the committee by the Board, providing reports to the Board of Directors and/or Audit Committee when requested?	✓	
3.3	Has the Committee reviewed the reporting subcommittee structure to ensure both efficiency and effectiveness of reporting, including any addition of new subgroups or working groups as required?	✓	
3.4	Does the Committee escalate issues of concern requiring Board attention?	✓	
3.5	Does the Committee develop and maintain an annual work programme to reflect and enable assurance in relation to the above duties?	✓	
3.6	Does the Committee Annually review the committee terms of reference to ensure they remain fit for purpose and align with annual work programme?	✓	
3.7	Does the Committee produce an annual report incorporating its effectiveness to adhere to the duties placed upon it?	✓	
3.8	Does the Committee receive Healthwatch reviews (annual)?	✓	
3.9	Does the Committee receive and approve a biannual report re: organ donation?	✓	
3.10	Does the Committee receive and approve annual reports from:		
(i)	➢ Complaints, PILS, and Patient Experience	✓	
(ii)	➢ Safeguarding	✓	
(iii)	➢ Learning disability, autistic people and mental health	✓	
(iv)	➢ Infection Prevention Control	✓	
(v)	➢ Serious incidents *NB: Since the implementation of PSIRF on 1 April 2024, where the focus of thematic review is not just based on moderate and		✓*

	above harm incidents, quarterly patient safety reports are now presented to QC which provide a thematic analysis of patient safety incidents and Transferring Care Safely (TCS) concerns.		
(vi)	➢ Patient involvement and experience	✓	
(vii)	➢ Clinical audit *NB: an annual summary is provided as part of the Quality Account.	✓ *	
(viii)	➢ Dementia	✓	
(ix)	➢ NICE compliance	✓	
(x)	➢ Radiation Safety	✓	

3.3 The Quality Committee has been confirmed as compliant in respect of 40 out of the 44 core functions set out above (90% compliant).

4. **Operation of the Committee**

A summary of the findings from the "Committee Effectiveness" self-assessment checklist survey is provided below and supporting additional comments are made on any potential areas of exception.

No	Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to Answer	Comments/Action
Theme 1 – composition, establishment and duties							
1	The committee has written terms of reference, and they have been approved by the Board.	6	0	0	0	0	
2	The terms of reference are reviewed annually.	5	1	0	0	0	
3	The outcomes of each meeting and any internal control issues are reported to the next Board meeting.	6	0	0	0	0	
4	The committee prepares an annual report on its work and	6	0	0	0	0	

No	Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to Answer	Comments/Action
	performance for the Board.						
5	The committee has established a plan of matters to be dealt with across the year.	5	1	0	0	0	
6	Committee papers are distributed in sufficient time for members to give them due consideration.	4	2	0	0	0	
7	There are clear arrangements in place in terms of how the committee works within the integrated care system.	2	3	1	0	0	Assuming this is likely to change given new structures in the ICB
Theme 2 – committee focus							
8	Committee members contribute regularly to the issues discussed.	5	1	0	0	0	
Theme 3 – committee team working							
9	The committee has the right balance of experience, knowledge and skills to fulfil its role.	4	2	0	0	0	
10	The committee ensure that the relevant executive director attends meetings to enable it to	5	1	0	0	0	

No	Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to Answer	Comments/Action
	understand the reports and information it receives.						
11	Management fully briefs the committee on key risks and any gaps in control.	4	2	0	0	0	
12	The committee environment enables people to express their views, doubts and opinions.	5	1	0	0	0	
Theme 4 – committee effectiveness							
13	The quality of committee papers received allows committee members to perform their roles effectively.	3	3	0	0	0	
14	Members provide real and genuine challenge – they do not just seek clarification and/or reassurance.	4	2	0	0	0	
15	Debate is allowed to flow, and conclusions reached without being cut short or stifled.	5	1	0	0	0	Sometimes that may make it difficult to complete the agenda in the allotted time
16	The committee provides a written summary report of its	5	1	0	0	0	

No	Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to Answer	Comments/Action
	meetings to the Board.						
Theme 5 – committee engagement							
17	The committee challenges management and other assurance providers to gain a clear understanding of their findings.	5	1	0	0	0	
Theme 6 – committee leadership							
18	The committee chair has a positive impact on the performance of the committee.	4	1	0	0	0	
19	Committee meetings are chaired effectively.	4	1	0	0	0	
20	The committee chair is visible within the organisation and is considered approachable.	1	2	0	0	1	
21	The committee chair allows debate to flow freely and does not assert his/her own view too strongly.	4	1	0	0	0	
22	The committee chair provides clear and concise information to the Board on committee	4	1	0	0	0	

No	Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to Answer	Comments/Action
	activities and gaps in control.						

5. Conclusion and Recommendations

The UHL Trust Board is requested to approve this report : -

5.1 To review the terms of reference given that (i) PSIRF was now in place and there was no requirement for an annual report of serious incidents, and (ii) an annual summary of clinical audit is provided via the Quality Account and there was no requirement for a Clinical Audit annual report.

5.2 To ensure that the fragile services updates were scheduled for Quality Committee, accordingly.

5.3 To ensure that the work plan was updated further to the review of the terms of reference (as per recommendations 5.1 and 5.2 above), and

5.4 To consider undertaking a review of how QC integrates with other Committees which are reviewing risk.

4.6.26