University Hospitals of Leicester NHS
NHS Trust

Trust Board paper G1

Meeting title:	Trust Board
Date of the meeting:	11 September 2026
Title:	**Escalation Report from the Quality Committee (QC): 25 June 2026**
Report presented by:	Jill Houghton, Non-Executive Director
Report written by:	Jill Houghton, Non-Executive Director

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						
BAF risk 01 (Quality)						
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

QC met on 25 June 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 QC's level of assurance.

There is 1 item which is recommended to the Trust Board from the June 2026 QC meeting.

This escalation report follows a 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
BAF01 Quality 1 and 3 Preliminary Antibiotic Resistance Report This report provided an overview of antimicrobial stewardship and antimicrobial resistance across UHL. It highlights shortfalls in workforce capacity and data analytics capability. There had been no progress since the last report to QC. **(Limited Assurance)**	The UHL Medical Director, Interim Chief Nurse and Chief Pharmacist agreed to meet and identify actions to progress antimicrobial stewardship.
BAF 01 Quality 1,2 and 3 Human Tissue Authority Designated Individual Report This report provided an update to QC on the current operational situation of the UHL mortuary service, progress on action plans and information on Communications from the Human Tissue Authority (HTA) in relation to reportable incidents, inspections, regulatory updates and alerts. Most notably the Glenfield mortuary re-opened following a major refurbishment. The lead HTA Inspector visited the site in April 2026 and was very complimentary about the new facilities and also pleased with the progress against action plans. **(Moderate Assurance)**	The Group Director of Midwifery and the Human Tissue Authority Designated Individual will work together on the recent Ockendon Report findings from Nottingham University Hospitals (June 2026) and consider whether there are any additional actions for UHL to take in this area
Positive Assurance taken	**Decisions taken**
Reports reviewed: Contribution of the Built Environment to Healthcare Infections within UHL Quality and Safety Performance Report Month 2 Patient Safety Quarterly Report Update on implementation of Group Clinical Strategy Safeguarding Assurance Committee Report Perinatal Report Patient Safety Committee Report **(Moderate Assurance)**	

Quality Committee 25 June 2026 – Non-Executive Director Committee Chair's escalation report

Items recommended for Board approval:
Adult Learning Disability, Mental Health and Autistic People 2025-2026 Annual Report (attached).
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

University Hospitals of Leicester NHS
NHS Trust

ANNUAL REPORT

Adult Learning Disability, Mental Health and Autistic People

April 2025 – April 2026

1. INTRODUCTION

Welcome to the second combined Adult Mental Health, Learning Disability and Autistic People annual report, which describes the work undertaken across the Trust to support adults with mental health, learning disability and autism.

The report includes contributions from the Trusts subject matter experts who describe in detail the achievements and priorities for the year ahead

The report provides an update of the work undertaken throughout the year; provides assurance about how we satisfy ourselves that our service meets and exceeds statutory requirements and ~~to~~ outlines our work priorities for the year ahead.

2. OUR COMMITTMENT

In the past year, UHL has continued to work alongside our partners to strengthen the contribution that the organisation makes to support people with their mental health, those who are autistic or those with a learning disability. The past year saw some significant changes to how local NHS systems worked, with proposed changes to NHS structures and reductions to the local workforce.

This has caused some uncertainly across the system and delays in decisions for the future plans for the service developments.

Leicestershire Partnership Trust is the local provider, of specialist Mental Health, Learning Disability and Autism services.

The Integrated Care Board for Leicester, Leicestershire and Rutland have been instrumental in supporting work to improve service provision through the LLR Mental Health Collaborative and Learning Disability/ Autistic People Collaborative.

The Childrens Hospital manage and oversee child Mental Health and Learning disability services, and produce a separate report for this patient group.

The Group Associate Director of Nursing Emergency Care, chairs the Trusts Mental Health, Learning Disability and Autistic People Steering Group. Now in its third year the group, with representation from CMGs and external partners, has the oversight and influence to support change. This report reflects the steering groups work.

3, **KEY ACHIEVEMENTS**

Notable achievements within the past year include:

- We increased the training provision for Part 2 Oliver McGowan training, to make the face to face training more accessible to staff.

- We held workshops with Leicestershire Partnership Trust, to improve patient pathways for people in UHL with a Mental Health illness

- We strengthened the links between Mental Health services and our Enhanced Patient Observation team. To better understand how to support people with disregulated behaviours.

- We developed a bespoke e learning mental health training package, which will be launched in the summer of 2026.

  We hosted a learning disability partnership workshop, inviting other local services that provide support to adults with a learning disability to showcase our service and strengthen networks
- We launched a new service at Loughborough Hospital , for patients with a learning disability who require blood tests to be undertaken under sedation.

3. PARTNERSHIP AND COLLABORATION

The best way in which services can develop is through co ownership and collaboration. Across Leicester, Leicestershire and Rutland there is a Mental Health Collaborative and Learning Disability and Autism Collaborative. Both have representation from health, social care and voluntary organisations who work together to develop services and joint working initiatives.

These partnerships are invaluable for the Trust being able to access specialist resources and to understand issues and priorities for the local communities. It has presented opportunities for closer working with partner agencies, and to link into wider initiatives aimed at improving access to services in the community. At a time of significant changes to the NHS, the Trust remained an active partner in local networks, recognising the importance of joint working.

During 2025 in collaboration with Leicestershire Partnership Trust, work was promoted which provided community based alternatives for people in mental health crisis. In particular the use of crisis support, including the use of NHS 111 # 2.. In adults the improved accessibility to support services has seen an increase in demand and work continues to manage this. The local support services have also been promoted amongst staff networks to help staff to access mental health support.

4. DESCRIPTION OF SERVIVES PROVIDED BY THE TRUST FOR ADULT MENTAL HEALTH AND LEARNING DISABILITY

The main NHS provider of services for people with autism, mental health and learning disability is Leicestershire Partnership Trust. Service developments and monitoring is through a Mental Health collaborative and a Learning Disability / Autism Collaborative which are both hosted by the partnership Trust.

Whilst the Trust is not commissioned to provide mental health services or learning disability services for adults, the Trust has a steering group whose membership includes representatives from Leicestershire Partnership Trust, Integrated Care Board and a Service user. During 2025 the Chairing arrangements changed from the Chief Allied Health Professional to the Group Associate Chief Nurse for Emergency Care. Administration of the steering group is through the Trusts corporate safeguarding team.

Within the Trust, Dr Mark Williams is the Mental Health Clinical Lead and represents the Trust on a number of mental health forums in conjunction with the Head of Safeguarding. In addition there is a Matron for the Emergency Department and lead mental health practitioner for the Childrens Hospital. Their role is to maintain oversight of all mental health patients in the Emergency Department and to liaise with mental health liaison services, to ensure effective care provision

The Trust also has a small team of adult learning disability nurses, who provide specialist advice and support to adults with a learning disability whilst in hospital. They also will support patients attending outpatient appointments and requiring specialist treatments. It is recognised that demand for this service is high, and the team are not always able to respond to requests. To address this a service prioritisation tool is in place, to ensure that high risk patients receive support at all times. During 2026 it is planned to explore options to improve availability of the team

5. PERFORMANCE

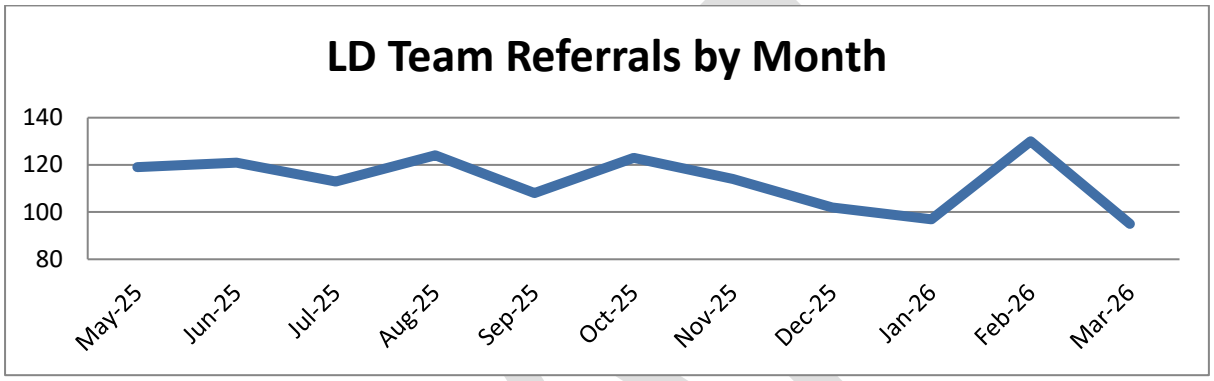
The Trust's MH, LD and AP steering group oversees performance and activity across the Trust. . During 2025, a new patient administration system was introduced to record patient activity. It had been an ambition of the steering group, to provide more detailed activity data. Unfortunately due to some early issues with how data is recorded this has not been possible, but work is in progress to address this with the Trusts informatics department.

Adult Learning Disability Referral Data

The table below shows the number of referrals received by the Trusts Adult Learning Disability Team over the past seven years.

Since the launch of the Oliver McGowan training in 2023 the teams activity has significantly increased. During the past year, the team had to reduce its service, following staffing shortages, which meant that patients receiving outpatient care and attendance to the Emergency Department were not able to be seen by specialist learning disability nurses.

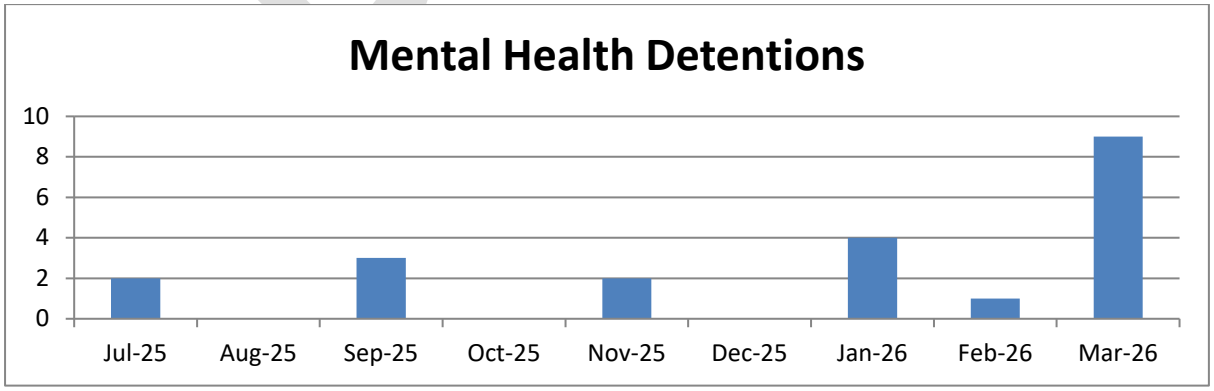
It had not been possible to secure funding, and has highlighted the vulnerability of some specialist services, that are not commissioned by the LLR Learning Disability Collaborative.



Applications for Mental Health Act Detentions

The Trust has a service level agreement with Leicestershire Partnership Trust, to administer Mental Health Act detentions. Patients may be detained under the Mental Health Act, to receive psychiatric treatment and assessment whilst in the Trust.

The chart below shows the number of approved detentions . During 2025/2026 work between the LPT Mental Health teams and the UHL Enhanced Patient Observation has resulted in the development of joint patient safety plans and improved outcomes for patients. This collaborative working demonstrates clear benefits to patient care.



Assessment waiting times

The Trust benefits from an on-site mental health liaison team. There are agreed assessment times from the time of referral to be seen
For the Emergency Department 1 hour
Wards at the LRI 24 hours and
48 hours for the Glenfield and General Hospitals.

The Trust does not currently monitor these response times but has been requested to do so. This is in response to a request by NHS England following an LLR review of Mental Health provision.

6. GOVERNANCE AND ASSURANCE

The arrangements for governance and assurance of mental health, learning disability and autism provision are overseen by steering group through to the Trust's Safeguarding Assurance Committee, with updates of work being provided to the Trust's Quality Committee on a quarterly basis.

During 2025 a work plan and audit schedule programme was followed

The Trusts Mental Health strategy was reviewed and updated in 2025, which sets out the priorities for the year ahead. The steering group also ensures that learning from the deaths of people with learning disabilities is embedded into clinical practice.

Through the work undertaken, the steering group is beginning to understand the risks and service pressures. The following risks have been considered as priorities for further work.

Specialist workforce capacity to care and support patients with learning disability, autism and mental health. Due to the lack of any commissioned service and increased activity

To improve identify performance data, and to monitor this to understand trends. In particular length of stay and response times for mental health assessments.

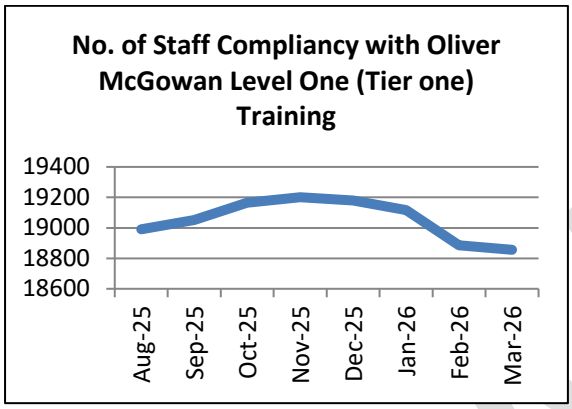
Lack of service provision for people with autism and people who are neuro divergent

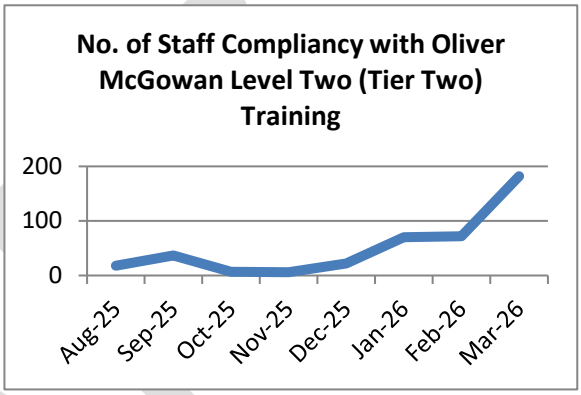
Management of ligature risks, and requirement to audit compliance of the clinical environment in paediatric areas against new guidance

7. TRAINING AND DEVELOPMENT

In early 2023, NHS England launched the Oliver McGowan training in learning disability & autism, which is mandatory training for all Health and Social Care staff. The Training is in two parts, Part 1 is online awareness training that all staff should complete. Part 2 is either an online live interactive training session or full day face to face training depending on job role.

The Trust launched Part 1 training in June 2023 and the chart below illustrates compliance until 31st March 2026. Part 2 training has been introduced across the Trust, but is reliant on training places being made available via NHS England and there are insufficient places to offer this training.





An e learning Mental Health awareness package was developed following extensive consultation, this will be launched in the summer of 2026. The package has been developed in consultation with University Hospitals of Northampton.

Bespoke mental health training was also developed in conjunction with Browne Jacobson for senior clinical staff. Who are required to make court applications for patients with mental health illness requiring urgent medical treatments.

8. LEARNING FROM SERIOUS INCIDENTS, AUDIT AND CASE REVIEWS

There is a statutory duty for the Trust to participate in multi-agency reviews when someone has died who has a learning disability or autism, through the national Learning from Deaths programme. Learning from cases is shared with the steering group quarterly along with changes in practice. The Trust has also undertaken reviews into serious incidents affecting patients with mental health illness.

As a result of this work changes have been made to practice which include –

- A new referral process used in the Emergency Department to request mental health assessments, using NERVECENTRE
- The introduction of a new ligature risk assessment process, and use of the Trusts enhanced patient care team to provide observation to patients at risk of self-harm
- Providing access to the LPT All Age Mental Health team to NERVECENTRE to improve record keeping
- Development of mental health training packages
- Using the cancer information sharing records system, to track and monitor progress of patients with a learning disability undergoing cancer treatment

LeDeR update: 25 SJR's were completed for LeDER 25-26. UHL contribute to LeDeR governance where cases are reviewed to understand learning and ensure that this is disseminated into each organisations.

9. KEY PRIORITIES AND RISKS FOR 2025

During 2026/ 7 work will progress to strengthen and make improvements to care. Through this work the steering group has identified future work priorities and areas of potential risk, and are reflected in the Trusts revised work plan, in particular

- Launch of the reasonable adjustment flag onto NerveCentre
- To begin work with University Hospitals of Northampton to where possible harmonise and standardise practice and policies
- To work with people services to explore approaches to support staff and their managers who have autism / neurodivergent conditions
- Continue to promote the use of LLR JOY and raise awareness of NHS 111 #2.
- LeDeR Programme have a priority of Falls next year, and work with the patient harm team will focus on this.
- UHL LD team will have a focus on End of Life Care, work has commenced to audit ReSPECT forms and consider how we are planning for end of life care. Working with the new chair of the End of Life Committee

10. CONCLUSION

The aim of this report is to outline the work undertaken during 2025 - 2026 to promote the welfare of people with Mental Health, Learning Disability and Autism. As stated within the report, there have been significant developments, with work focussed on creating robust governance and reporting structures.

Moving into 2026 the Trust will continue to make improvements as part of a continuous journey to provide excellent care. As outlined in this report

Michael Clayton
Head of Safeguarding with contributions from the UHL adult clinical leads for Learning Disability, Autism and Mental Health
April 2026