

Quality Assurance Committee Chair's Report 16 October 2025

PUBLIC BOARD

27 November 2025

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| Presented for: | Information |
| Presented by: | Laura Stroud, Associate Non-Executive Director & Non-Executive Maternity Safety Champion |
| Author: | Lucy Atkin, Head of Quality Governance |
| Previous Committees: | Summary of Quality Assurance Committee 16 October 2025 |

| Our Annual Commitments for 2025/26 are: | |
|--|---|
| Recognise and act upon moments that matter to our patients | ✓ |
| Support our patients to get home a day sooner | |
| Be in the top 25% for patient experience and efficiency in outpatients | |
| Support each other to act with kindness and compassion | |
| Reduce our carbon footprint by creating greener patient pathways | |
| Support our staff to manage every £ wisely | |
| Make best use of our estate, equipment and digital assets | |

| Risk Appetite Framework | | | | |
|--------------------------------|------------|---|------------------------------|----------------|
| Level 1 Risk | (✓) | Level 2 Risks | (Risk Appetite Scale) | Impact |
| Workforce Risk | | | | |
| Operational Risk | | | | |
| Clinical Risk | ✓ | Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients. | Minimal | Moving Towards |
| Financial Risk | | | | |
| External Risk | ✓ | Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law. | Averse | Moving Towards |

| Key points | |
|--|-----------------|
| 1. To provide an overview of significant issues of interest to the Board, highlight key risks and assurance discussed, key decisions taken, and key actions agreed at Quality Assurance Committee on 16 October 2025. | For Information |
| 2. The Quality Assurance Committee request the Trust Board note the following points of escalation: <ul style="list-style-type: none"> • The six reportable mandatory infections all were at risk of exceeding the internally set threshold within the current financial year. • Confirmation of its assurance of the plans in place to reduce and mitigate patient safety risk over the winter period, and the committees request for further assurance of the effectiveness of the mitigations in place at the December meeting. • The Committee discussed and endorsed extension of the current Patient Safety Incident Response Plan (PSIRP) 2024-26 to allow time for the current framework to be delivered in full and to allow time for the development of an Incident Learning Response Toolkit • Advocate its support in seeking an alternative ongoing funding for the Smoking Cessation Team, with current funding set to expire in March 2026, with recognition of the evidence-based benefits of the prevention work by the team. • The detail within appendix 1 Duty of Candour extract from the Annual Integrated Incidents, Inquests and Claims Report. | To note |
| 3. The Trust Board is asked to note the Quality Assurance Committee Chair's report and receive assurance on the items discussed at the Committee on 16 October 2025 that have been summarised in this report. | For approval |

1. Summary

The Quality Assurance Committee (QAC) provides assurance to the Board on the effective operation of quality governance in the Trust. It does this principally through scrutiny of, and appropriate challenge to, this work. In addition, QAC also conducts more detailed reviews of topic areas, as required. The Committee met on 16 October 2025.

2. SIGNIFICANT ISSUES OF INTEREST TO THE BOARD

The role of the Quality Assurance Committee (QAC) was outlined for all members, attendees, and observers. Members discussed QAC's role in seeking assurance against clinical and quality associated risks. Key topics on the Committee agenda were highlighted and context provided as to how the Committee triangulated and challenged this information to provide assurance to the Board. A pre-meeting was also held with the Chief Medical Officer, Director of Quality and Head of Quality Governance on 15 October 2025 to discuss the assurances required at the meeting.

Escalation from Finance and Performance Committee regarding Emergency Care Standard Delivery and Bed Occupancy Update

Following review and discussion at the Finance and Performance Committee, the Committee reviewed the report making particular reference to the Patient Quality and Safety Letter (PRN01417) received from NHS England which had asked Trusts to assure themselves that actions were being taken to reduce admissions and maximise flow where possible. The Committee agreed this would be triangulated with the detail provided within the 'Maintaining Quality during Winter' report.

Patient & Volunteer Story

The Committee were introduced to the urgent care video which provided an oversight of action taken within the Emergency Department (ED) to support members of the local Homeless population, many of whom often attended the ED. A programme had been developed which included the provision of (basic) mobile phones to vulnerable individuals to enable them to interact with health and social services. Included within the video was examples of anonymous feedback received and a selection of case studies highlighting how this project had helped individuals.

The programme was highlighted for its success in forming connections, offering hope and rebuilding trust with health services for a vulnerable group of patients. Charitable funding had been secured for a further three years which would enable circa 20 phones per month to support people in vulnerable situations. The scalability of the programme was highlighted with the project rolled out across both LGI and SJUH ED and it was hoped that other trusts may consider similar action.

Members discussed the projects impact on reducing health inequalities and were informed that as the project moved forward there had been reduced attendances as individuals were increasingly able to access wider support services. Prior to the project some individuals had been attending the ED multiple times a day as seen as a 'safe place' and due to complex needs were having multiple interactions with clinicians.

The Committee received the update and commended the people-centred work that had taken place, with recognition for the ongoing plans for the project.

Patient Safety Incidents, including Never Events Assurance Report 01 August to 30 September 2025

The Committee received the assurance report on Patient Safety Incidents set within the context of the Patient Safety Incident Response Framework (PSIRF) from the period 01 August to 30 September 2025.

The Committee were advised that the Trust had commenced two Patient Safety Incident Investigations (PSII). An overview of the PSII's that had concluded in this period was provided along with the identified learning and methods of assurance.

All qualifying cases in August to September had been referred to MNSI and the NHS Resolution (NHSR) Early Notification Scheme (ENS) with one case accepted by MNSI for investigation which the Group discussed further.

The Committee were provided with an overview of learning from patient safety events both within the Trust and with systems partners. Including the commencement of a Never Event Rapid Improvement Process Week and a new method of sharing learning through the Learning Cascade to share learning from completed PSIs and the requirement of CSUs and relevant corporate teams to describe how they will consider, act and share the learning.

The Committee discussed and endorsed extension of the current Patient Safety Incident Response Plan (PSIRP) 2024- 26 to allow time for the current framework to be delivered in full and to allow time for the development of an Incident Learning Response Toolkit which would provide a defined structure for responding to specific instances to provide optimal learning. The years extension would enable development and testing time for the system as well as staff training.

The Committee received the report and confirmed their assurance of progress against the PSIRF, and the actions taken to mitigate risks and share learning from Patient Safety Incident Investigation (PSI's).

Annual Report on Incidents, Coroners and Claims

The Committee received the annual report on patient safety incidents, inquests and claims for 2024/25, noting that this had been reviewed at Quality and Safety Assurance Group (QSAG) in September 2025.

The Committee discussed the patient safety incident reporting profile for this period, noting a total of 41,155 Patient Safety Incidents (PSI's) were reported which was a decrease of 3% on the previous year. The top five categories were reported as pressure ulcers, obstetrics, medication, falls and admission, appointment and transfer. A total of seven Never Events were reported (two wrong site surgery, four incorrect implants, one insulin overdose).

There was a 15% decrease in the total number of deaths that the Trust referred to the coroner. A total of 178 inquests involving LTHT were opened which was a 9.2% increase.

168 claims had been reported to NHS Resolution (NHSR) representing a 21.7% increase on the previous year. This was the first increase in claims reported by the Trust to NHSR in over two years and represented the highest number of claims reported during the last eight financial years.

The Committee received the report and noted the actions being taken to mitigate risk and share lessons learnt. Further detail regarding Duty of Candour within Appendix 1.

Healthcare Associated Infection Assurance Report

The report provided an update on the Trust Healthcare Associated Infection (HCAI) performance against national noting that the six reportable mandatory infections all were at risk of exceeding the internally set threshold within the current financial year.

Members discussed the Trust escalating position against the HCAI trajectories and additional actions that were being undertaken to bring the HCAI position back under control which included the KPO Team supporting the relaunch of the Infection Prevention and Control (IPC) Improvement Group which would incorporate learning from all clinical groups and share best practice from specialities across the organisation; the work of the

Vascular Learning Group which had piloted the most effective way of communicating with different staff groups with the learning from this to be rolled out wider to ensure effective IPC communication and the Essential Elements of IPC.

The Committee received the report and confirmed its assurance of the response underway in response to escalating HCAs.

Nursing & Midwifery Quality & Safe Staffing Workforce Report

The Committee received the Nursing & Midwifery Quality & Safe Staffing Workforce Report, which triangulated key quality and staffing information for the period July and August 2025. The report provided oversight of current staffing levels and actions being taken to mitigate vacancies and ensure safe staffing.

The Committee discussed the triangulation with assurance reports provided to Workforce Committee, noting that Quality Assurance Committee would continue to focus on the impact of nursing and midwifery staffing on patient care, experience and outcomes and to determine whether patients had experienced harm as a consequence of staffing challenges.

The Committee also discussed the assurances provided regarding the actions taken to mitigate red shifts and red flags, and the daily process to monitor and manage nurse staffing levels through the safe care system and red flag escalation process, noting that a weekly report continued to be provided to the Chief Nurse and Chief Medical Officer at the Quality Review Meeting.

The Committee received the report and confirmed it's assurance.

Maintaining Quality during Winter

The Committee received assurance of how patient safety will be maintained for patients waiting for a prolonged period in the ED, and the quality and safety of patients occupying Temporary Escalation Spaces (TES). It was noted that the overall Winter Plan was approved by the Board in September 2025, following review by the F&P Committee.

Members discussed the mitigations that had been developed which included winter funding to temporarily increase the available bed base; support CSU schemes to deliver enhanced admissions avoidance and reduce length of stay and agreement with the ICB for support to reduce the volume of patients with No Criteria to Reside NoCtR (agreement to reduce by 20 per day and bi-weekly meetings in place to support this). Even with these mitigations there was a risk of a deficit bed position during January and February 2026, the Trust will work with partners to ensure bed and capacity utilisation to mitigate this.

The Committee received the report and confirmed its assurance of the plans in place to reduce and mitigate patient safety risks over the winter period, and to maintain the quality and safety of patients. It was confirmed that a further update would be provided to the Committee at its next meeting to allow it to seek assurance of the effectiveness of the mitigations in place.

Perinatal Services Assurance Report

The Committee received the report which provided an overview of the perinatal quality surveillance based on the Ockenden report recommendations and the Maternity Perinatal Incentive Scheme (MPIS) Year 7 Safety Actions.

The Committee received detail of the Perinatal Mortality Review Tool (PMRT) group activity and outcomes, compliance with the Saving Babies' Lives Care Bundle v3 (SBLV3); training compliance and an overview of workforce challenges in Maternity and Neonatology and action being taken to mitigate the risk and ensure the provision of safe and effective staffing.

Members noted that the Maternity and Neonatal Service continued to enhance the report to develop effective assurance and evidence in order to receive full assurance and were advised of the work that had been commissioned to develop and proceed with an organisational perinatal improvement plan which would provide a clear line of sight on the actions being taken and allow the Committee to seek assurance on behalf of the Board of progress. Patient safety would be a key priority, and the plan would bring together the various improvement works requested of/ taking place in the service.

The Committee received the report, and it was confirmed that a new format of reporting would be provided moving forward to allow the Committee to seek and gain assurance.

Members were informed that the Secretary of State (SoS) for Health and Care had met with bereaved families from Leeds that morning with the Trusts current understanding that an independent review of Maternity and Neonatal Services in Leeds would be announced. The Trust had been advised that the outcome of this meeting would be under embargo until the 20 October 2025 when a public announcement would be made. A confidential briefing had been held with the Triumvirate Teams of the Women's, Children and Neonates services to inform them of the formal announcement and to reiterate the support available for them.

Leadership Walkround Programme

The Leadership Walkround Programme 2024/25 Annual Report was provided for information and assurance. The report provided a retrospective view of the Leadership Walkrounds that had taken place in the previous year and the themes emerging from these. A total of 24 visits had taken place of a planned 25 with one visit cancelled due to operational pressures. The summaries from all visits had been reviewed to identify key themes which included staff experience of managing complex and challenging patients, staffing and sharing quality improvement initiatives.

Members discussed insight gained from the CQC Well Led report and discussed how the 2026/27 programme will be shaped to reflect this.

The Committee received the report and noted the review of the Leadership Walkround that would take place to increase Board visibility and specifically out of hours. A copy of the report will be shared with the Board for completeness.

Patients waiting for treatment for Cancer

The report described the current state of the cancer harms review process and provided data on the number of patients waiting beyond 104 days for cancer treatment in 2025. The report described progress against the development of a standardised framework to

increase assurance that all patient harm was identified and addressed at every stage of the cancer care pathway.

Members were advised of the pilot taking place within the lung pathway to develop an improved system of harm assessment. The Lung Transformation Group will review the findings of the pilot with a view to agree a formal process which could then be documented and rolled out across all pathways.

Members discussed how data contained within the Health and Inequalities Dashboard was currently utilised in three key pathways to ensure health inequalities were represented in the process with recognition that individuals in deprived areas and marginalised communities often access healthcare later.

The Committee received and noted the progress update.

Regulatory Report: Care Quality Commission (CQC) Inspections, NHS England Rapid Quality Review and NHS Resolution

The Committee received a report which provided oversight of the ongoing scrutiny and engagement with regulators, specifically the CQC, NHSE and NHSR. Members were advised that the report was provided for assurance regarding the management of regulatory engagement and to support the Committee in its scrutiny role on behalf of the Board of Directors.

The current areas of regulatory action were highlighted and discussed noting the Trust was moving away from its risk appetite in all areas (Workforce, Operational, Clinical, Financial, and External) and informed that the Risk Management Committee (RMC) would be receiving monthly updates against the Corporate Risk Register (CRR) CRRE1 (CQC registration breaches) and would monitor progress against completion of regulatory breach actions. It was also noted following the publication of the CQC Well led report and three associated breaches of regulation a further risk would be added to the CRR and managed through RMC.

An improvement plan was in development to address all CQC regulatory breaches, NHS England enforcement notice and areas for improvement highlighted within all regulatory reports with oversight and assurance to be provided to the Board via its Committee structure.

Members were provided with an overview of activity with CQC and NHS England since the last report in August 2025 noting that the Chair of the Committee would continue to keep the Board informed, recognising that the situation was evolving rapidly. The Committee received and noted the report.

Public Health & Health Inequalities

The report provided an update on the progress made in developing a new Health Equity and Public Health Strategy 2025-28 and actions progressed throughout 2025 to date. The report had been reviewed by the Quality and Safety Assurance Group (QSAG) and was shared with the Committee for information and assurance.

Members were advised of key workstreams which included the production of a guide of how the Trusts seven annual commitments related to health equity and practical actions

that teams could take; development of an Trust improvement plan in response to NHSE Equality Diversity and Inclusion (EDI) Improvement Plan and the attendance optimisation workstream.

Discussion took place regarding the funding challenge for the continuation of the work led by the Smoking Cessation Team with current funding set to expire in March 2026 and the Committee confirmed it would advocate its support in seeking an alternative ongoing source of funding with recognition of the evidence-based benefits of the prevention work by the team.

The Committee received the report and noted progress to date. It confirmed its support of the priorities highlighted within the Strategy for the coming year.

Leeds Safeguarding Adults Board Annual Report

The Annual Report of the Leeds Safeguarding Adult Board was provided in the Blue Box for information and was received and noted. The Committee recognised and commended the work of the Safeguarding Team and the wider system and recognised their commitment to ongoing learning and improvements.

Regular reports - Essential Metrics Report, Minutes from the Quality and Safety Assurance Group (QSAG), Clinical Effectiveness and Outcomes Group (CEOG) and Patient Experience and Engagement Group (PEEG).

3. Financial Implications

There are no financial implications detailed within this report.

4. Risk

The Quality Assurance Committee provides assurance oversight of the Trust's Patient Safety and Outcomes risks, which cover the Level 1 risk categories (see summary on front sheet). Following discussion at the Quality Assurance Committee meeting there were no material changes to the risk appetite statements related to the Level 2 risk categories however it was noted that as a result of the CQC regulatory breaches related to Maternity, Neonatal Services and Trust wide Well led, and in light of the NHSE support programme, the Trust was moving away from the Board's established risk appetite in the areas of Workforce, External, Regulatory, and Clinical Risk, Patient Safety and Outcomes. A risk has been added to the Corporate Risk register, and this is reviewed monthly by the Risk Management Committee.

5. Communication and Involvement

This report will be available to members of the public, patients, and staff through publication of the Board papers.

6. Equality Analysis

Not applicable

7. Publication Under Freedom of Information Act

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

8. Recommendation

Trust Board is asked to note the Quality Assurance Committee Chair's report and receive assurance on the items discussed at the Committee on 16 October 2025 that have been summarised in this report.

9. Supporting Information

Appendix 1 Duty of Candour extract from the Annual Integrated Incidents, Inquests and Claims Report

Laura Stroud

**Associate Non-Executive Director, Non-Executive Maternity Safety Champion and
Chair of Quality Assurance Committee
November 2025**

Appendix 1 Duty of Candour extract from the Annual Integrated Incidents, Inquests and Claims Report

1.14 Duty of Candour

This section provides information on the application of the Duty of Candour Regulations into incident management processes at LTHT and CSU compliance with these for 2024/25.

1.15 Procedural Framework at LTHT

The statutory Duty of Candour requirements are described in the LTHT *Being Open (Duty of Candour) Procedure 2024*. There are also references to the Duty of Candour requirements in the following LTHT Risk Management procedures:

- *LTHT Patient Safety Incident Response Plan (PSIRP) 2024*
- *Incident Reporting Procedure 2024*
- *Investigation of Incidents and Complaints Procedure 2024*

1.16 Reporting

Patient safety incidents are reported on the Trust's incident reporting system (Datix). If the reporter selects a harm level where the regulatory Duty of Candour applies (moderate harm, severe harm, or fatal), the system prompts the reporter with a message to follow the Duty of Candour process. The reporter is also provided.

with a field to document that an apology has been provided to the patient and/or family and a field to record the acceptable exceptions where these may apply in line with the regulations.

Once the incident has been submitted it is sent to a senior member of the specialty team/CSU to review. The reviewer of the incident is responsible for ensuring that Duty of Candour regulations have been applied where appropriate. Updates have been made to the Duty of Candour fields in Datix to provide CSUs with more detailed data on incidents that meet the threshold for the regulatory Duty of Candour.

1.17 Monitoring

The CSUs are responsible for ensuring that all relevant notifiable patient safety incidents have had the regulatory Duty of Candour correctly applied. Duty of Candour is included in the CSU Quality Assurance guidance and is also included in the standard agenda (template) for CSU and specialty governance meetings. To support CSUs in monitoring compliance, a Duty of Candour dashboard is included in Datix for each CSU to access and monitor all relevant incidents to ensure compliance with the regulatory requirements. The Patient Safety & Quality Managers attend CSU governance forums to provide support and advice, including compliance with the Duty of Candour process. Additional support and advice are provided by the Trust Risk Management team.

1.18 Assurance (Internal)

The Duty of Candour dashboard on Datix is used to support the CSU quality framework (performance) meetings, providing senior corporate oversight of compliance with the Duty of Candour process. As explained above, all new Duty of Candour applicable incidents (categorised as moderate harm, or above) are reviewed weekly as a standing agenda item at the Risk Management team meeting, led by the Medical Director (Governance and Risk) and Director of Quality, providing

advice to CSUs to ensure Duty of Candour has been considered, applied correctly and, where not completed, suitable justification has been provided.

The CSU Duty of Candour Datix dashboards provide CSUs with more detailed data on incidents that meet the threshold for the regulatory Duty of Candour and support exemption validation of data for the Quality Framework Review process.

1.19 Assurance (External)

Duty of Candour is subject to external scrutiny from Internal Audit, External Audit, and the Care Quality Commission (CQC).

The external audit team (Price Waterhouse Cooper) has introduced CSU compliance audits to the annual audit cycle, which includes a review of Duty of Candour compliance through a sample of incident investigation reports.

External Audit select a sample of Duty of Candour applicable incidents as part of their review of the incident data supplied for the Trust's Quality Account. The Trust is required to provide evidence that the Duty of Candour process has been completed for this sample of incidents.

As part of the CQC regulatory inspection process a sample of Duty of Candour applicable incidents is provided to demonstrate compliance with the Duty of Candour requirements. Information is also provided to the CQC relationship manager in response to enquiries that are received by the CQC, and monitored through the monthly engagement meeting, for assurance.

1.20 Training and Communication

Duty of Candour training is not currently a mandatory or priority training topic for the organisation. The LTHT Duty of Candour Learning tool has been refreshed and is available for staff to refer to on the intranet, which includes relevant clinical examples of when to apply the Duty of Candour.

Duty of Candour is referenced in the induction training for all new members of staff joining the organisation. It is also covered during the Incident Investigation Skills training programme and ad-hoc Datix training provided to individuals or groups. The Risk Management intranet site has a range of resources dedicated to Duty of Candour, including template letters to support clinical teams and a learning tool with clinical examples to guide staff in practice. Advice is provided to clinical teams by Risk Management, including from the Medical Directors, to support staff in the implementation of the Regulation.

A Quality & Safety Matters Bulletin focusing on the requirements of the Duty of Candour Regulation has been circulated to all staff via the Chief Nurse e-mail on five separate occasions to summarise the requirements and highlight the actions staff are required to take. A monthly forum with CSU governance leads is in place to support them in implementing the quality governance and assurance framework, including providing advice regarding Duty of Candour and sharing good practice to support improvements in compliance.

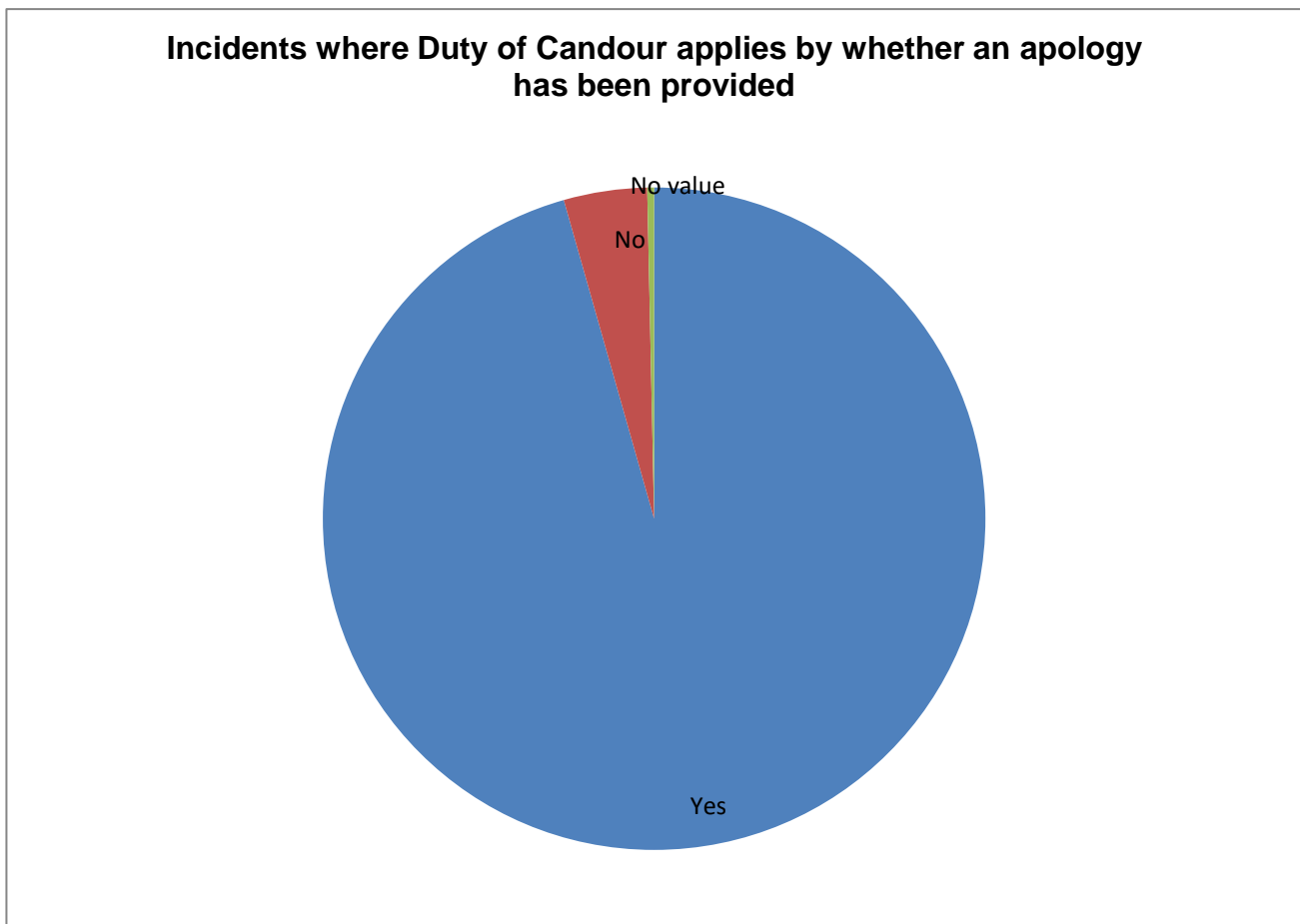
1.21 Compliance

Of the total number of patient safety incidents reported via the LTHT Datix incident reporting system in 2024/25, **1432** (4%) met the requirement for Duty of Candour due to a recorded severity of moderate harm, or above. This is 629 fewer incidents than the previous year which met the threshold for the Duty of Candour regulation.

Graph 1 below demonstrates that almost 96% of eligible records had a verbal apology recorded. 73 records (4%) were recorded as "No apology". These figures are in line with the previous year. 6 records did not contain data. This is a recognised issue in Datix and occurs when the severity is

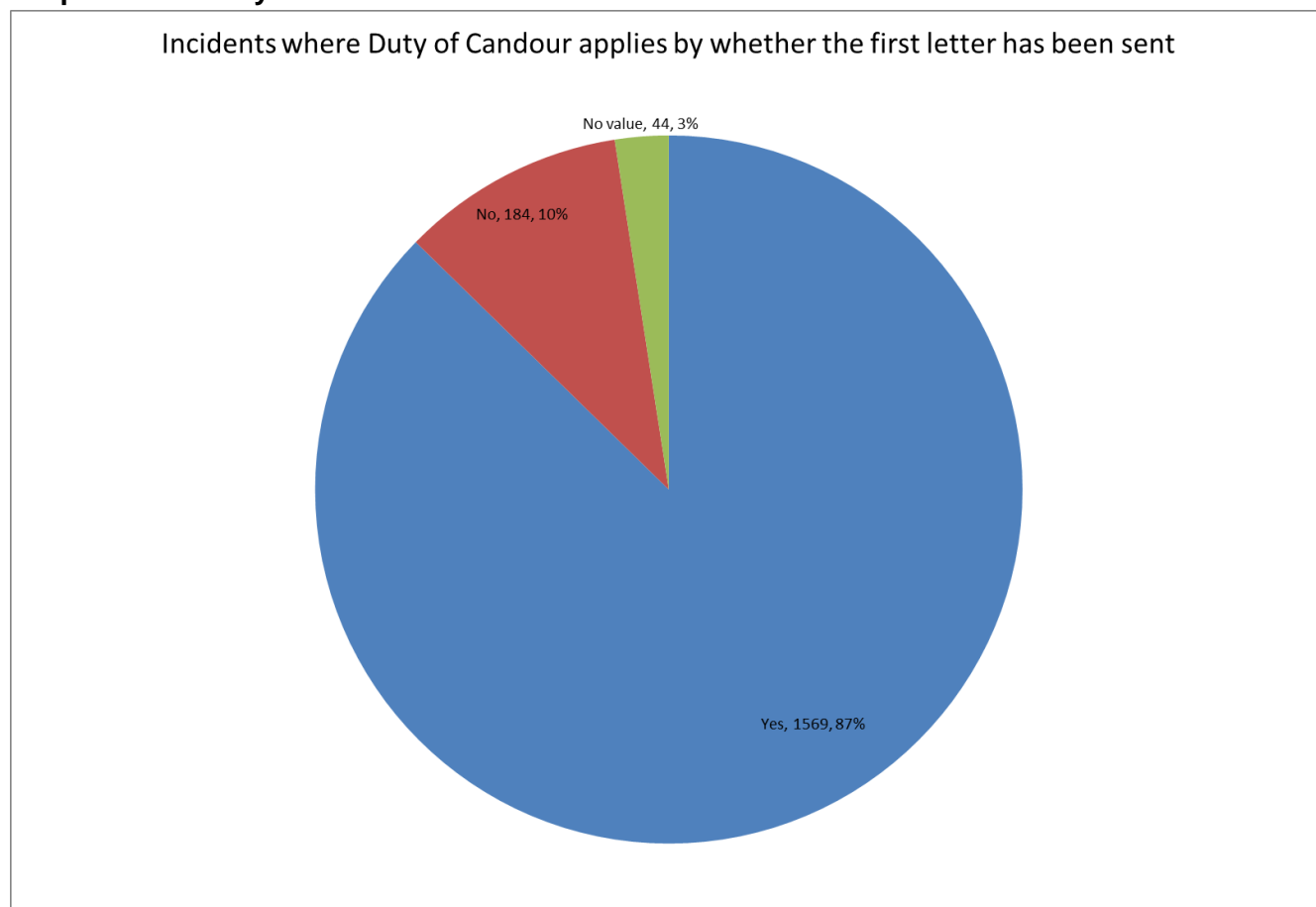
increased by the reviewer after the incident has been entered with a no harm or low harm severity level.

Graph 1: Documented apology provided to patient and/or family



Graph 2 below demonstrates that 1569 records (87%) had evidence on the Datix record that the first Duty of Candour letter had been sent. 10% of records stated that the letter had not been sent; the majority of these had an approved rationale provided. There were 44 records (3%) where the record had not been completed to demonstrate the first duty of candour letter had been sent. These figures are in line with last year but noting the decrease in Patient Safety Incidents meeting the threshold for Duty of Candour this year.

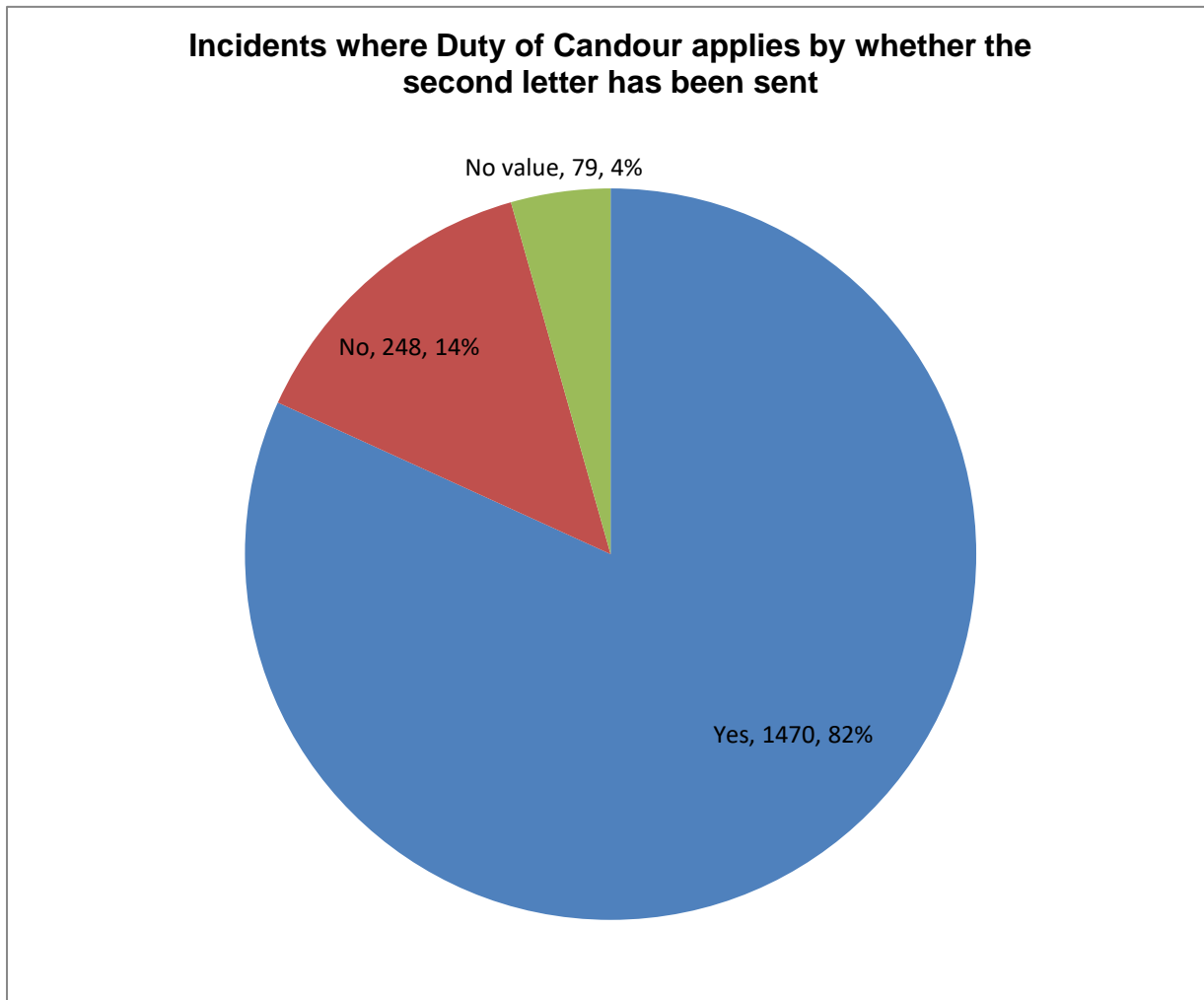
Graph 2: First duty of candour letter marked as sent on Datix



1559 records where Duty of Candour applies have been marked as closed following completion of the patient safety review. At this stage the second Duty of Candour letter should be sent explaining to the patient or family the findings of the review and offering a further apology for the harm caused.

Graph 3 demonstrates that 1470 records (94%) reflect that the patient/family had been sent a second Duty of Candour letter following completion of the Patient Safety Review. Of the 248 records marked to state that a second duty of candour letter had not been sent, all but 9 (0.6%) had a documented rationale. Exemptions are now validated by the risk team, ensuring compliance is met.

There were 79 records where the field demonstrating the second letter had been sent was left blank. 61 less than 2023/24. Increased awareness and monitoring of duty of candour processes may explain this reduction. The figure for 2023/24 represented 8.4% of total incidents, whereas 2024/25 this figure is 5% of applicable incidents. Although some incident reviews had not been completed at the time this report was written, therefore the second Duty of Candour letter cannot yet be sent, in most cases, reviews have been completed, and this field has simply been left blank.

Graph 3: Second duty of candour letter marked as sent on Datix

1.22 Action to Improve Evidence of Compliance

Additional fields have been added to the Datix record to allow the recording of how the initial verbal apology has been delivered i.e., by phone or in person, coding for why an apology has not been provided and dates that the letters have been sent.

Renewed Duty of Candour dashboards are in place and are being used by the Quality Framework Review process to validate any exemptions entered for incidents that meet the threshold for Duty of Candour.

It is planned that a further Quality and Safety Matters Bulletin will be circulated as a reminder to staff of the need to complete the data fields on Datix and upload the relevant evidence with support to reiterate this message across the CSUs being provided by the Patient Safety and Quality Managers.