

**Quality Assurance Committee (QAC)
Chairs Summary Report**

**Public Board
28 May 2026**

Presented for:	Alert, Advice and Assurance
Presented by:	Laura Stroud, Associate Non-Executive Director Chair of QAC
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List of meeting dates:	Thursday 16 April 2026

Freedom of Information Act (FOIA) Exemption	<input type="checkbox"/> YES (restricted from the FOIA) <input checked="" type="checkbox"/> NO (available to the public under the FOIA)
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Link to Strategic Objective	Focus on care quality, effectiveness and patient experience
Link to Provider Capability Assessment	Governance, risk and regulatory
Link to CQC Well-led Statement	Governance, Management and Sustainability
Regulatory Impact	Regulation 9: Person-centred care Regulation 12: Safe care and treatment Regulation 18: Staffing Regulation 20: Duty of candour

Key points:	
This report provides a summary of the key highlights from the QAC meeting and seeks to alert, advice and provide assurance to the Board on the areas discussed.	Alert, Advice and Assurance

Risk Appetite Framework			
Level 1 Risk	Level 2 Risks	(Risk Appetite Scale)	Impact
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	Operating Outside

1. Introduction

Following its last meeting the Committee has considered significant issues and key areas to highlight to the Board under three key categories Alert, Advice, Assurance (AAA):

- Alert - areas that the Committee wishes to escalate as potential areas of non-compliance, that need addressing urgently, or that it is felt Board should be sighted on.
- Advice - on new areas of monitoring or existing monitoring where an update has been provided to the Committee and there are new developments.
- Assurance - specific areas of assurance received warranting mention to Board.

2. Alert

- The Committee was notified of an alert triggered from the Paediatric Intensive Care Audit Network (PICANet) and received detail of the review process that had been enacted in response. Assurance was received that the reviews had identified no failure in system or process and no lapse in the care provided however there was wider consideration by the Committee of an associated risk in the availability of commissioned Paediatric ICU beds. The Committee noted actions were in place to ensure clinical prioritisation to bed availability and were notified that the Trust was actively engaged with NHSE regarding commissioning.
- The Committee received a verbal update from two recent escalations from the Friday weekly quality meeting, whilst there had been no direct harms to patients, as a result the service/s involved had been paused whilst the investigations concluded. The Committee was assured of the actions taken to identify the issue and of the work taking place to understand the cause prior to reactivating the service/s.
- The Committee noted a compliance gap in regard to Sepsis screening and an update was received on the improvement plan to address this. Following discussion, the Committee received information on the structured approach to improvement with a focus on ensuring reliable and accurate data was available and that improvement actions were owned by all staff. A Sepsis Steering Group had been established to support improvement and it was agreed that regular updates would be provided to the Committee until the position improved. Confirmation was received that the Trust's regulators had been made aware of the Trust position through the engagement meetings.

3. Advice

- The Committee received an escalation from the Audit Committee regarding the Mortality Framework Internal Audit Review which had received an overall rating of Limited. The Committee reviewed the recommendations arising from the review and received assurances on the action plan, which would be monitored via the Mortality Improvement Group (MIG) with ongoing assurance against progress to be provided to the Committee via the Learning from Deaths report.
- An update was received by the Committee on the progress made in the identification, monitoring and prevention of harm to patients in acute and emergency care pathways. The update included detail on the action plan that had been established to eradicate corridor care, with assurance received of the Executive ownership of the plan. There was recognition of the impact of the wider system pressures on attendances to the Emergency Department and it was agreed that the Committee would receive regular updates until

improvements were realised. This is also an agenda item for the Board at agenda item 9.5.

- The Committee received the annual update against the Trusts compliance with CQC standards and the outcomes of CQC visits, inspections and engagement during 2025/26. The Trusts' current registration status was registered with the CQC without conditions (compliant) and a copy of the report is provided to the Board at agenda item 9.3.
- The Committee received an update on the current waiting list position and the actions taken to identify and mitigate potential patient harm. It was recognised that the Trust would not be able to fully safeguard from harms however assurance was received on the focus being given to the layers of process applied to mitigate against the risk of potential harm. There was recognition of the clinical prioritisation applied to the waiting list and the Committee considered how deprivation and inequalities would feed into this, with recognition of the ongoing work to continue to understand and inform thinking with respect to overall prioritisation.
- The Committee reviewed and approved the 2026/27 Annual Clinical Audit for Improvement Programme, noting that programme had been informed through a combination of national guidance from bodies such as NICE and the CQC as well as any internal areas identified for improvement.
- The Committee reviewed and endorsed the 2026/27 Quality Goals which would be included within the overall Quality Account which would be presented for Board approval on June. The Board are advised that work to complete the Quality Account is progressing in line with plan and with adherence to national guidelines.

4. Assurance

- The Committee received an update on the effectiveness of the winter planning process. The report had provided a reflective view on the winter plan and the effectiveness of the Full Capacity Plan. It was noted that the Trust had witnessed high attendance over the winter period, alongside high volumes of patients with No Criteria to Reside (NCtR) which had led to a high-pressured winter on resources and staff. A winter wash-up process was scheduled on 20 May 2026 to review learning and embed this into the planning process for the current year, which the Committee would review in August. Work was taking place internally and with partners to address the NCtR position and the Committee was assured of the Executive oversight and response to this challenge.
- The Committee reviewed the Patient Safety Incident Investigations from February 2026 and March 2026, as defined in the LTHT Patient Safety Incident Response Plan (2024-2027). Detail was provided against two Never Events which had occurred during the reporting period both of which were under ongoing investigation. The Committee also received detail on six cases identified via the Perinatal Mortality Review Tool (PMRT) which had also been escalated to the Maternity and Newborn Safety Inspections (MNSI) Team, one had been accepted for further external investigation and five rejected. It was noted that assurance of the identified learning from these cases would be taken forward via the Perinatal Improvement Assurance Committee. Detail was shared on the processes and different formats for sharing learning from incidents with the role of the Improvement Champions noted as a key enabler.
- An update was received on the latest performance position of HCAI and it was noted that mandatory reportable infections were broadly in line with the previous

year. The Trust had not achieved a 10% reduction on the previous year's position however assurance was received of the actions led through the IPC Team to share and embed learning. The IPC Team were regularly reviewing practices with peer trusts to ensure best practice and learning. It is noted that the IPC Team resource is limited and the role of senior leaders in promoting good practices was noted. Additional focus would be placed on the reduction of HCAs via the Integrated Accountability Framework and through the reinforcement and consistency of messaging.

5. Risk review

The Committee noted increased risk across a number of areas as a result of the increased attendances and capacity challenges within the Trust. Assurance was received of the mitigations in place, and the Committee would retain ongoing oversight and provide a forum for the escalation of quality risks.

6. Recommendation

The Board are asked to receive and note the content of this report and be assured that the QAC is fulfilling its assurance function as delegated from the Board and as defined within its Terms of Reference.