

# Quality Committee Annual Report 1 April 2025 to 31 March 2026

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### Appendix 1 Terms of Reference for the Quality Committee

## 1. Period covered by this report

This report covers the work of the Quality Committee for the financial year 1 April 2025 to 31 March 2026.

## 2. Introduction<sup>1</sup>

The Quality Committee has been formally established by the Board of Directors as one of its sub-committees. The Quality Committee has responsibility for providing assurance on: the effectiveness of the Trust's quality, including patient safety, systems and processes; the quality, including patient safety, of the services provided by the Trust; and the control and management of quality, including patient safety, related risks within the Trust.

The committee will monitor and report to the Board of Directors on the effectiveness of these systems and processes, with its key duties being to seek assurance that:

- systems and processes are effective
- the quality, including patient safety, of services that the Trust provides is good and continuously improving
- the quality of the experience of people using our service is good and continuously improving.

The committee carries out its duties to provide assurance to the Board of Directors. In addition to this, it is authorised to seek information that will allow it carry out its purpose. It will:

- Seek assurance on systems and processes to ensure monitoring and assessment of the quality, including patient safety, and improvements in services
- Seek assurance on the mechanisms to involve service users, carers, the public and partner organisations in improving services
- Seek assurance on the systems for identifying, reporting, mitigating and managing quality, including patient safety, related risks including the monitoring of incidents, investigations and deaths; and complaints, claims, and compliments
- Review the Board Assurance Framework to seek assurance on behalf of the Board that those strategic risks where it has been listed as an assurance receiver, are being effectively controlled; that the risk score (which has been determined by the executive team) is at the right level; and that any gaps are being addressed appropriately. It may also inform any deep-dive which it may wish to undertake into any area on which it requires further assurance.
- Seek assurance on compliance against the Care Quality Commission's (CQC's) registration and notification requirements and action plans in response to CQC inspection.
- Monitor, scrutinise and provide assurance to the Board of Directors on the Trust's compliance with national standards, including the CQC's Fundamental Standards, and the quality elements relating

to NHS England's NHS Oversight Framework, the quality elements within the NHS Standard contract, NICE guidance and CQUIN schemes.

- Seek assurance on the quality impact assessments for key strategic programs of work
- Receive assurance on the work carried out and reported to the Trustwide Clinical Governance Group, including: Quality Plan; Quality Account; Infection Prevention and Control; Safeguarding; Research and Development; Clinical Audit and NICE; Continuous Improvements; and Measuring outcomes across Trust services
- Receive assurance on activity within operational services that contributes to the understanding and improvement of quality, including patient safety, within the Trust.
- Review the draft Internal Audit Annual work plan so it can be assured on the sufficiency of the work the Auditors will carry out in respect of clinical matters. Assurance on this sufficiency (or comments on any matters that should be included) will be provided to the Audit Committee to allow it to approve the overall plan.
- Have oversight of relevant data and specific initiatives in relation to the Equality and Inclusion Agenda as requested by the Board of Directors, recognising the importance of inclusion and accessibility in delivering quality services.
- Carry out the duties of the Maternity Board Safety Champion, with the chair of the committee being the named champion.
- Carry out the role of Hip Fracture, Falls and Dementia Champion
- Carry out the role of Learning from Deaths Champion
- Carry out the role of Children and Young People Champion
- Carry out the role of Resuscitation Champion
- Carry out the role of Safeguarding Champion
- Carry out the role of Palliative and of Life Care Champion

Although the committee's general remit is quality of care for patients, some issues affecting patients and staff are best managed with joint assurance, and the committee has currently agreed to lead assurance on sexual safety for staff and patients.

This report covers the work the committee has undertaken at the meetings held during 2025/26. It seeks to assure the Board on the work it has carried out and the assurances received, and to demonstrate that it has operated within its Terms of Reference.

<sup>1</sup> Information taken from the revised Terms of Reference which were ratified on 29 January 2026.

### **3. Assurance**

The committee receives assurance from the executive director members of the committee and from the subject matter experts who attend the meetings as required dependant on the agenda items being discussed. Assurance is provided through written reports, both regular and bespoke, through challenge by members of the committee and by members seeking to validate the information provided through wider knowledge of the organisation; specialist areas of expertise; attending Board of Directors', and Council of Governors' meetings.

The committee is assured that it has the right membership to provide the right level and calibre of information and challenge and that the right reporting methods, structures and work plans are in place to provide oversight on behalf of the Board in respect of performance in the areas covered by its Terms of Reference.

Part of its assurance role is to receive the Board Assurance Framework (BAF); a primary assurance document for the Board which details those key controls in place to ensure that the risks to achieving the strategic objectives are being well managed. The BAF lists those committees that are responsible for receiving assurance in respect of the effectiveness of those controls, and the Quality Committee will be asked to note, in particular, those where it is listed as an assurance receiver to ensure that it had received sufficient assurance through the reports that come to the committee or to commission further information where there was a lack of assurance (actual or perceived). These are:

- SR1- If there is a breakdown of quality including safety assurance processes, we risk not being able to maintain standards of safe practice, meeting population health needs and compliance with regulatory requirements.
- SR2 - There is a risk that we fail to make the improvements outlined in the Quality Strategic Plan and that this has an impact on how we understand and act on the care of those who use our services.

The committee views an extract of the BAF, containing the details for SR1 and SR2, at each meeting.

### **4. Terms of reference**

In December 2025 the Terms of Reference for the Quality Committee were approved by the members. In January 2026, they were ratified by the Board of Directors.

### **5. Effectiveness of the Quality Committee.**

The committee reviewed its effectiveness in June 2025. It agreed that it remained effective and that no further developments were required.

## 6. Meetings of the Quality Committee.

In 2025/26 the committee met formally on 11 occasions. All committee meetings were held virtually. The dates on which the committee has met during the year are as follows:

- 10 April 2025
- 8 May 2025
- 12 June 2025
- 10 July 2025
- 11 September 2025
- 9 October 2025
- 13 November 2025
- 11 December 2025
- 15 January 2026
- 12 February 2026
- 12 March 2026

## 7. Membership of the Quality Committee and attendance at meetings

Membership of the Quality Committee is made up of two non-executive directors; the Director of Nursing and Professions, the Chief Operating Officer and the Medical Director. The Chief Financial Officer and the Director of People and Organisational Development are also members of the committee and attend meetings as appropriate dependant on the agenda items being discussed.

The committee is chaired by a non-executive director (NED), Prof. Frances Healey, and Zoe Burns-Shore is the other regular NED member of this committee. Should the NED chair be unable to chair the meeting this role will fall to another NED.

Subject area experts are invited to attend the meetings as appropriate, to provide expertise and knowledge on the areas that they are responsible for. On these occasions, they are attendees and do not count towards to membership of the meetings as outlined in the Terms of Reference.

The Trust also invites governors to observe Board sub-committee meetings. This opportunity allows governors to observe the work of the committee, rather than to be part of its work as they are not part of the formal membership of the committee. Governors observe Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors for the operational performance of the Trust.

### Attendance at Quality Committee meetings by substantive members

- ✓ Shows attendance
- Indicates those members who sent apologies
-  Stipulates when the individual was not required at the meeting

### Attendance at Quality Committee meetings by formal attendees

- [illegible]

### Attendance at Quality Committee meetings by governors

[illegible]

## 8. Reports made to the Board of Directors

The Chair of the Quality Committee makes an assurance, escalation and advisory report regarding the most recent meeting of the committee to the next available Board of Directors' meeting. This report seeks to assure the Board on the main items discussed by the committee and should it be necessary to escalate to the Board any matters of concern or urgent business which the committee is unable to conclude. The Board may then decide to give direction to the committee as to how the matter should be taken forward or it may agree that the Board deals with the matter itself.

Where the Board wants greater assurance on any matters that are within the remit of the Terms of Reference of the committee the Board may ask for these to be looked at in greater detail by the committee. The table below outlines the dates that the assurance and escalation reports were presented by the Chair of the Quality Committee to the Board of Directors meetings.

| Date of Quality Committee meeting | Date of Board of Directors' meeting |
|-----------------------------------|-------------------------------------|
| 10 April 2025                     | 29 May 2025                         |
| 8 May 2025                        | 29 May 2025                         |
| 12 June 2025                      | 31 July 2025                        |
| 10 July 2025                      | 31 July 2025                        |
| 11 September 2025                 | 25 September 2025                   |
| 9 October 2025                    | 27 November 2025                    |
| 13 November 2025                  | 27 November 2025                    |
| 11 December 2025                  | 29 January 2026                     |
| 15 January 2026                   | 29 January 2026                     |
| 12 February 2026                  | 26 March 2026                       |
| 12 March 2026                     | 26 March 2026                       |

## 9. The work of the Quality Committee during the year

During 2025/26 the committee has carried out its role in accordance with its Terms of Reference. Further details of all of these areas of work can be found in the minutes and papers of the committee.

A high-level presentation of areas of work on which the committee has received assurance and during 2025/26 are as follows:

### Quality risks, priorities and strategy

- The committee is the assurance lead for the Board Assurance Framework (BAF) Strategic Risks one and two. At each meeting in 2025/26 the committee viewed strategic risks one and two so that it could be mindful of its responsibilities to assure that these risks were being adequately controlled through the course of the meetings.

- The Committee received and approved the final version of the 2024/25 Quality Account in May 2025, acknowledging the effort of the teams involved in the collation of the document.
- The Committee received the draft Internal Audit Plan and the Clinical Audit Priority Plan for 2026/27 and was assured that they addressed the appropriate risk areas.

### **Reports the Committee receives frequently**

- The committee reviewed the Combined Quality and Workforce Performance Report (CQWPR) at each meeting.
- The committee received the Complaints, Concerns, PALS, Compliments and Patient Safety Report (which included quarter four data on Claims, Central Alert System compliance and compliance with some other types of safety notifications, reported incidents, incidents reported on the Strategic Executive Information System (StEIS), and Duty of Candour). It acknowledged that the current format was data heavy with very detailed charts, and despite welcome improvements in some sections, other sections had limited information on themes, learning and actions taken, whilst some data duplicated CQWPR. The committee agreed that this report would be replaced with an Annual Report on Complaints and PALS, with the first report scheduled for May 2026, plus amends to the CQWPR and extra sections in other reports already received by the Quality Committee.
- The committee received regular verbal updates on the work of the Trust Wide Clinical Governance Group, Nursing and Professions Council, Infection Prevention and Control Group, Trustwide Safeguarding Committee and CQC Steering Group.
- The committee received reports which provided a summary of the Trust's quarter four progress against its 2024/25 organisational priorities and quarter one progress against its 2025/26 organisational priorities. It was assured on the Trust's position in relation to quality priorities. It was also assured that the Trust had robust systems and processes in place for monitoring and supporting the delivery of each priority's high-level milestones and underpinning tasks.
- The committee received quarterly reports outlining the key quality indicators for patients placed in out-of-area (OOA) acute and Psychiatric Intensive Care Unit beds. It received assurance on the oversight, escalation and sign off processes for incident investigations when they related to a service user who was in an OOA placement bed. It noted the challenges faced in securing consistent quality data for service users that were in spot purchased OOA beds. It agreed on the importance of the committee as a minimum receiving data on restraint, seclusion and self-harm to be assured on the quality of the OOA placements and suggested that further discussions should take place to ascertain why quality data could not be shared.
- The committee received six-monthly reports which provided an update on the work being undertaken in relation to the Improving Health Equity Strategic Plan 2025-2029. It was assured that the ambitions within the Improving Health Equity Strategic Plan were being progressed via the agreed programme delivery plans and the governance arrangements in place to support this work.
- The committee received six-monthly reports which provided an update on the development of a

trustwide strategy on self-harm and suicide prevention. It acknowledged the progress made in implementing NICE guidance and cultural change around self-harm and suicide prevention. The committee was assured on the future plans to finalise a self-harm strategy within the organisation and agreed that the next update would include concrete timelines for drafting and finalising the self-harm strategy.

- The committee received six-monthly reports outlining the improvement work that had been undertaken to change the Trust's approach to enhanced care and observations and to engage with the national Enhanced Therapeutic Observations and Care (ETOC) Programme. It agreed on the importance of service user feedback and welcomed the work undertaken to capture this.
- The committee received six-monthly reports on the work being undertaken to change the Trust's approach to clinical risk assessment. It recognised the success of the roll out of the Risk Assessment and Safety Planning (RAMP) tool and acknowledged the key factors in the successful rollout, which included clear identification of subject matter experts, decision-making authority for service representatives and dedicated project leadership.

## **Annual reports**

- The committee reviewed presentations from the following services, which provided the highlights of their Annual Quality Reports, focusing on how the services had scored themselves against the Learning, Culture and Leadership (LCL) Framework and the STEEEP dimensions of quality to enable the conditions for high quality care to flourish:
  - o Acute and Crisis Service
  - o Children and Young People's Mental Health Service (Mill Lodge)
  - o Children and Young People's Mental Health Service (Red Kite View)
  - o Children and Young People's Mental Health Service (Deaf CAMHS)
  - o Forensic Service
  - o Older People's Service
  - o CONNECT Eating Disorders Service
  - o Rehabilitation Service and Community Rehabilitation Enhanced Support Team
  - o Gender Identity Service
  - o Community Mental Health Teams
  - o Liaison Service
  - o Perinatal Service
  - o Addictions Plus Service
  - o Attention Deficit Hyperactivity Disorder (ADHD) Service
  - o Northern Gambling Service
  - o Leeds Autism Diagnostics Service
  - o Personality Disorder Service
  - o Learning Disability Service

Overall, the committee was assured that the services had good systems in place for understanding their quality issues and to drive improvements, and good knowledge of their strengths and weaknesses in relation to learning, culture and leadership. The committee was also assured that the

Executive Team had a clear understanding of the services' strengths, weaknesses, challenges and blind spots and how issues were being managed.

- The committee received a paper which provided an update on the progress made against the priorities and aims identified in the Trust's Patient and Carer Experience and Involvement Strategy. It acknowledged the number of involvement and co-production projects and initiatives offered across the Trust, agreeing that co-production felt embedded across the Trust. Overall, the committee agreed that it was assured on the systems and processes in place to involve, and collect feedback from, the Trust's service users and carers. It also recognised the contribution and value that the Patient Experience and Involvement Team brought to the Trust.
- The committee received the Annual Falls Report which provided data on reported falls in the Trust between April 2024 and March 2025. It was pleased to hear that there had been a 13% reduction in reported falls in 2024/25 compared to 2023/24 and acknowledged the progress that had been made in this area since the committee last received an update in September 2024. The committee was assured that falls reported in the Trust were being considered in a robust and governed way and that data was being used to drive improvement work.
- The committee received and discussed an Annual Report on CQC Activity which provided an overview of activity relating to the CQC in 2024/25.
- The committee received the Safeguarding Team's Annual Report for 2024/25. It was assured that the Trust prioritised the safety of all children and adults at risk who are or whose parents or carers were in receipt of services. It was also assured that the Safeguarding Team supported the Trust in meeting its statutory requirements for Safeguarding. It acknowledged the extensive activity and improvement work outlined within the report, which included:
  - o Working with the Risk Assessment and Safety Planning Project Group to ensure routine enquiry was embedded within the Risk and Management Plan, which included providing guidance for staff on how to complete routine enquiry and providing lunch and learn sessions available to all Trust colleagues
  - o The findings from the Voice of the Adult clinical re-audit, which sought to ascertain whether adults' views and wishes in relation to safeguarding concerns were being sought by practitioners, documented, and addressed accordingly. Of the 50 safeguarding contact forms audited, 94% of cases showed that the adult's views and wishes were sought by practitioners and recorded in the safeguarding contact form
  - o The development of a training package to address how to make a good quality referral when requesting support from Adult Social Care and the delivery of this training to by the Interim Head of Safeguarding along with ICB colleagues to an audience of participants from across all services in Leeds.
- The Committee received the Annual Report on Medical Devices and was assured on the governance, monitoring, and management of medical devices in the Trust.
- The committee received the Sexual Safety Annual Report which provided a detailed analysis of the sexual safety incidents reported during 2024/25, outlined the Trust's response to these incidents and

evaluated progress in creating safer, more inclusive care environments. It was assured that sexual safety standards were being met across services and that safeguarding, reporting, and response protocols aligned with national guidance and regulatory expectations.

- The committee received the Annual Report of Infection Prevention and Control (IPC) and Antimicrobial Stewardship for 2024/25 and the IPC BAF. It was assured on the activity of the IPC Team and thanked the team for its work during 2024/25. It was also assured that the Trust continued to follow all national infection, prevention and control guidance and that the Director of Infection, Prevention and Control had oversight of outbreak management within the Trust. The committee acknowledged the extensive activity and improvement work outlined within the report, which included:
  - o IPC policy and procedural documents being reviewed and updated to align with the National Infection Prevention and Control Manual
  - o A significant reduction in airborne transmission outbreaks such as influenza and covid-19 compared to 2023/24
  - o Overall antibiotic use remaining low within the Trust in comparison to acute trusts
  - o Antimicrobial stewardship within the Trust optimised safe, appropriate, and economic use of antimicrobial agents. This has led to improved patient outcomes from infection while minimising negative consequences such as healthcare associated infections and the development of antimicrobial resistance.
- The committee received and discussed the Restrictive Interventions Annual Report 2024/25. It welcomed the reduction in the use of physical restraint compared to 2023/24 but acknowledged that levels of physical restraint used in 2023/24 were higher than in previous years, partly due to a small number of patients with exceptional needs. It suggested that the work undertaken around reducing physical restraint in nasogastric feeding could be shared with NHS England as a positive case study. It acknowledged that the report referred to workforce challenges, including levels of vacancies, agency and bank use, as likely having contributed to the use of restrictive practices in some services, despite overall reductions between 2023/24 and 2024/25, and referred this to the Workforce Committee for further consideration of these issues.
- The committee received the Medicines Optimisation Group Annual Report for 2024/25 and agreed that the Medicines Optimisation Group was fulfilling its Terms of Reference. It noted the challenges that had been faced by the Pharmacy Service during the year relating to vacancies and business continuity but was reassured on the progress that had been made against the recovery plan.
- The committee reviewed reports which provided a summary of the approach taken by the Trust to develop its efficiency and productivity programme and detailed the schemes that had been through quality and equality impact assessments in 2025/26. The committee was assured on the process for assessing the efficiencies, the governance arrangements in place to monitor the Trust's efficiency and productivity programme, and the rigour of the quality and equality impact assessment process.
- The committee received the Learning from Deaths six-monthly reports, along with the number of learning responses commissioned and key themes from the learning identified. It was assured of the work ongoing within the Trust to improve mortality review and subsequent improvement action across the organisation.

- The committee received and discussed a report which contained a high-level summary of the metrics from the 2024 National Staff Survey that were relevant to quality, to enable an understanding of the Trust's culture, processes and the impact on the quality of care.
- The committee reviewed the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Trust Safety Scorecard for 2025 which provided key indicators and benchmarking data designed to support quality improvement. It noted the 100% completion by the Trust of NCISH questionnaires, compared to a national rate of 91%, and agreed this was excellent practice that should be commended.
- The committee received the Annual Report on Resuscitation which provided an update on all aspects of resuscitation in the Trust, including emergency incidents, training, do not attempt cardiopulmonary resuscitation (DNACPR), ReSPECT, the system used to manage the Trust's emergency equipment and the work of the Resuscitation Committee. It discussed training compliance and noted that a plan was in place for the Trust to train in-house instructors for infant emergency life support to reduce reliance on external providers. It approved the approach to make resuscitation training mandated for bank staff within a six-month timeframe, however acknowledged that there may be different requirements in different areas dependent on risk. It noted that the actions would be followed up and monitored via the Workforce Committee for onward monitoring.

### **Additional updates**

- The committee received a report which provided an update on the work being undertaken to embed outcome measures across the Trust.
- The committee received and discussed a report which provided data on the number of incidents of patients being classed as absent without leave (AWOL), absconding or missing from inpatient services between 1 April 2024 and 31 March 2025 and outlined the work being undertaken within the Trust to manage these incidents. It agreed that, going forward, details on the management and prevention of AWOL incidents, plus any harm that occurred as a result of the incidents, should be incorporated into the reports received by the committee, although in subsequent discussions later in the year it was agreed that the Mental Health Legislation Committee should lead on absconding and missing patients, including those who were informal patients.
- The committee received and discussed a report which provided an update on the Trust's ongoing review and service development work for individuals with Severe Mental Illness, following national concerns raised by the 2023 Nottinghamshire case and subsequent NHS England guidance. It was assured on the work that was underway to action any areas for improvement.
- The committee received a report which outlined the work being undertaken by the Safeguarding Team in response to the Domestic Abuse, Stalking and Honour-based Violence (DASH) audit, to improve compliance of staff completing the DASH form. It was agreed that six-monthly updates would be provided on this work.
- The committee received a report which described the outcomes from a review of NHS England's

Patient Safety Healthcare Inequalities Reduction Framework (PSHIRF) against the Trust's Improving Health Equity Strategic Plan 2025-29 to ensure the Trust's plan aligned with the PSHIRF. It was assured that the PSHIRF guiding principles and further opportunities for local delivery were captured within existing programme delivery plans.

- The committee reviewed the Equality Delivery System Annual Report, noting that for 2025/26, in-depth equality assessments had been carried out for the Eating Disorder Service, the East Crisis Service and the East Community Mental Health Team with EDS action plans agreed. The committee discussed the information provided and praised the work undertaken in this area.
- The committee received an update on the development of the quality dashboard and the work being undertaken against the Quality Strategic Plan. It was clarified that the dashboard would be used as an improvement tool for services as opposed to an assurance tool for the Board. The committee suggested further work was required to identify the appropriate Trust level quality assurance metrics.
- The committee received a paper which outlined the Trust's current position on the quality monitoring of clinical services commissioned from third-sector providers. It noted that a recent review of the 21 contracts the Trust held had identified gaps in the Trust's current approach to monitoring quality, assurance, and performance, noting that these included inconsistent quality metrics, variable monitoring practices, and limited reporting, creating a risk to the Trust's ability to demonstrate robust oversight. It was reassured that a programme of improvement was underway to strengthen governance and introduce a more consistent and transparent framework. The committee agreed how assurance would be reported going forward and welcomed the progress made in this area.
- The committee supported a proposal to extend the term of the Trust's Research Strategy from three to five years.
- The committee received a report which provided information on the arrangements to ensure patient safety in clinical trials.
- The committee reviewed the Patient Safety Incident Response Framework (PSIRF) Internal Audit Report and the thematic report on the rollout of PSIRF in other organisations. It acknowledged that an opinion of significant assurance had been given in relation to the Trust's systems and processes for monitoring PSIRF compliance and escalation at the Trust.
- The committee received and discussed a report titled "Service User Health & Safety Data". It agreed that further work was required to define when incidents involving a patient were Health & Safety incidents and therefore assurance and improvement would be best led via the Health and Safety Committee and Audit Committee route or where assurance and improvement would be best led via the clinical quality groups and Quality Committee route, and/or managed through a group like the Clinical Environments Group.

## **Part B of the Quality Committee**

- The Quality Committee holds a private Part B meeting to discuss information that is personal to individual staff or patients, or for other limited reasons (e.g. need to protect detail related to methods of self-harm).

## **10. Conclusion**

The Chair of the Quality Committee would like to assure the Board of Directors that the committee has fulfilled its Terms of Reference during 2025/26. Throughout the year the committee has monitored quality and gained assurance on how quality matters are considered and addressed. It has added value by maintaining an open and professional relationship with officers of the Trust and has carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of any possible issues or risks.

Members of the Quality Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

**Prof. Frances Healey**  
**Non-executive Director and Chair of the Quality Committee**  
**28 April 2026**

**Kerry McMann**  
**Head of Corporate Governance**  
**28 April 2026**