UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING HELD ON THURSDAY 28 AUGUST 2025 AT 2PM (VIRTUAL MEETING VIA MICROSOFT TEAMS)

Members Present:
Dr A Haynes MBE - Non-Executive Director, and QC Chair
Prof I Browne - Non-Executive Director
Mr A Furlong - Medical Director
Ms J Hogg - Chief Nurse
Ms J Houghton - Non-Executive Director
Ms S Kaur - Associate Non-Executive Director
Mr J Melbourne - Chief Operating Officer

In Attendance:
Ms E Birkin – Assistant Chief Nurse (for Minute 103/25/9)
Mr P Brookes-Baker – Head of Continuous Improvement (for Minute 103/25/8)
Ms E Collins – Head of Infection Prevention (for Minute 103/25/5-103/25/7)
MS J Croysdale – ICB Representative
Ms Z Green – Deputy Head of Infection Prevention (for Minute 103/25/5-103/25/7)
Dr M Habiba – NIPAG Chair (for Minute 103/25/3)
Ms H Makamure - ICB Representative
Ms J Kay – Head of Quality Assurance (for Minute 103/25/2)
Ms H Majeed – Corporate and Committee Services Officer
Ms H Makamure - ICB Representative
Mr R Manton - Head of Risk Assurance
Ms P McParland – Consultant Obstetrician (for Minute 97/25)
Mr M Rahman – Chief Pharmacist
Mr C Walker – Clinical Audit Manager (for Minute 103/25/8)
Ms C Ward – Patient Safety Partner
Mr G Xu – Deputy Medical Director

RECOMMENDED ITEM

97/25 MORTALITY AND LEARNING FROM DEATHS QUARTERLY REPORT

The Committee received the quarterly report on mortality rates and progress against the learning from deaths framework which provided assurance in respect of both the national risk adjusted mortality measure (SHMI) and delivery of Death Certification, Medical Examiner (ME) Scrutiny and Case Record Review as per national statutory requirements (paper G refers).

UHL's crude mortality rates (SHMI and HSMR) were stable and within expected ranges. UHL recorded a higher percentage of patients with zero comorbidities, a new coding practice was implemented in May 2025, with expected impact visible in 4-6 months. The LLR Medical Examiner Service 'turn around times' had improved following the initial 'post implementation phase' and increased winter activity. The team aimed to issue death certificates within 2 days, targeting a 90% success rate. Service reconfiguration was underway to meet this goal. In respect of the learning from deaths programme, four deaths during quarter 1 of 2025-26 had been considered more likely than not due to issues in care, common themes were diagnosis, management, and communication.

The Committee reviewed current trends and assurance processes related to perinatal mortality, with a focus on neonatal deaths and stillbirths. While neonatal mortality rates were declining, a slight increase in stillbirths was noted. The team was actively engaging in external benchmarking and peer reviews to validate internal findings and improve review quality. Structured Judgement Reviews (SJRs) and coding practices were being enhanced to ensure accurate data and timely identification of safety concerns. The Committee expressed confidence in the robustness of internal processes and welcomed external validation to strengthen assurance.

Recommended – that the Mortality and Learning from Deaths quarterly report be endorsed and recommended to the Trust Board for approval. **MD**

RESOLVED ITEMS

98/25 APOLOGIES

Apologies were received from Dr R Abeyratne Director of Health Equality and Inclusion, Ms S Burton, Deputy Chief Nurse and Ms B Cassidy, Director of Corporate and Legal Affairs.

99/25 QUORUM

The meeting was confirmed to be quorate.

100/25 DECLARATIONS OF INTERESTS

Resolved – that no declarations of interests were received in the items being discussed.

101/25 MINUTES

Resolved – that the Minutes of the Quality Committee meeting held on 31 July 2025 (papers A1 & A2) be confirmed as a correct record.

102/25 MATTERS ARISING

Paper B updated Quality Committee on progress against previous actions. Any updates now provided would be reflected in the next iteration of the log. All '5' rated actions would be removed after this meeting.

Resolved – that the discussion on the matters arising log (paper B) and any associated actions be updated accordingly.

103/25 ITEMS FOR DISCUSSION AND ASSURANCE

103/25/1 **Board Assurance Framework (BAF) Report**

The Committee received the BAF noting the risk scores remain unchanged (paper C). There was a detailed discussion particularly in relation to understanding how the inclusion of Key Risk Indicators could provide early warning signals to show whether a strategic risk on the BAF may be getting better or worse. In discussion, it was noted that the Quality & Safety dashboard and the Quality Strategy contained relevant metrics to help the Committee anticipate any issues, focus attention on where risks may deteriorate, and assure that mitigation is working, but there was a need to explicitly map these to the BAF risks in order to strengthen assurance. The Head of Risk Assurance highlighted the need to link existing dashboard indicators to BAF risks and undertook to map these for further review with the Chief Nurse and Medical Director, aiming to clarify how indicators reflected risk movement. The Committee Chair proposed using the Executive summary of the quarterly Quality Strategy update to focus on BAF risks. The need to review possible different formats of the BAF cover report (to a pictorial/graphical presentation) and ensuring agenda items visibly addressed BAF gaps was also suggested. In conclusion, it was agreed the approach would be refined with the aim to finalise a clearer format and process by the October 2025 Quality Committee. **HRA**

Resolved – that (A) the report be received and noted, and **HRA/ HQA/ HPS/ CN/ DCLA/ MD**

(B) the Head of Risk Assurance with support from colleagues to link existing dashboard indicators to BAF risks and map these for further review with the Chief Nurse and Medical Director, aiming to clarify how indicators reflected risk movement including review of different formats of the BAF cover report (to a pictorial/graphical presentation).

103/25/2 Quality Strategy – Quarter 1 Update

The Head of Quality Assurance presented paper D, a comprehensive update on progress during quarter 1, against UHL's Quality Strategy 2025–28. The report aimed to assure on key quality

improvement initiatives, focusing on safety, amplifying patient voice, delivering outstanding care quality, and ensuring equitable care experiences, while also informing future priorities and decision-making. Members were assured with the work undertaken and noted the need to align some of the impact measures on a quarterly basis (as per discussions of the BAF report above) which would give a better understanding of progress.

Resolved – that the contents of this report be received and noted.

103/25/3 NIPAG Annual Report 2024/25

Paper E, as presented by the NIPAG Chair highlighted a post-COVID decline in new procedure applications at UHL, though adoption of NICE-recommended interventions remained stable. Assurance processes were in place to monitor safety and effectiveness, with strong engagement from Clinical Directors. Cost-effectiveness was not yet formally assessed but was expected to become a future consideration. In response to a query from Ms J Houghton, Non-Executive Director re. whether NICE or the Trust set a minimum number of interventions for clinician competence, the NIPAG Chair advised that NIPAG process monitored the first 20 procedures for complications, after which ongoing monitoring was delegated to the service. Responding to a query from the Committee Chair, the NIPAG Chair undertook to draft communications for Consultants as a reminder re. the NIPAG registration process so that this could be sent out via the Medical Director. **NIPAG Chair**

Resolved – that (A) the contents of this report be approved and highlighted to the Trust Board, for information, and

(B) the NIPAG Chair to draft communications for Consultants as a reminder re. the NIPAG registration process so that this could be sent out via the Medical Director. **NIPAG Chair**

103/25/4 Report from the Deputy Medical Director

Resolved – that this Minute be classed as confidential and taken in private accordingly.

103/25/5 Infection Prevention governance and assurance 2025/26 – quarter 1

The Head of Infection Prevention presented paper H1, the key infection prevention priorities and risks, with a focus on communication, tuberculosis response, estates-related infection risks, and mask fit testing compliance.

The Committee Chair queried the estate and ventilation risks, water safety, and the importance of system-wide collaboration, in response, the Head of Infection Prevention confirmed that resources were being monitored and would be escalated if necessary.

In response to a query from Ms S Kaur, Associate Non-Executive Director, the Head of Infection Prevention undertook to present a comprehensive report to the Quality Committee in December 2025 on the state of the estate (3 hospital sites and other sites within UHL) in relation to current environmental issues, particularly ventilation, physical environment and water management and how these factors contributed to infection prevention. **CN/ HoIp**

Resolved – that (A) the contents of this report be received and noted, and

(B) the Chief Nurse/Head of Infection Prevention to present a comprehensive report to the Quality Committee in December 2025 on the state of the estate (3 hospital sites and other sites within UHL) in relation to current environmental issues, particularly ventilation, physical environment and water management and how these factors contributed to infection prevention. **CN/ HoIP**

103/25/6 Surgical Site Infection Surveillance Report

The Deputy Head of Infection Prevention presented paper H2, an update on the Trust's position regarding the UHL Surgical Site Infection Reduction Programme. This report outlined the Trust's current position, recommendations, and the steps to be taken for improved outcomes and to reduce the number of associated infections. The Trust had conducted a comprehensive review of over 2,600 surgical cases, identifying elevated Surgical Site Infection (SSI) rates in several

specialties – most notably cardiac, spinal, breast, and bowel surgeries. The report highlighted significant cost burdens, gaps in theatre infection control practices, and variable compliance with NICE guidelines. Immediate training and engagement with theatre teams had been initiated, and a system-wide infection reduction strategy was being developed. The Committee agreed to quarterly reporting via the Infection Prevention assurance reports, deeper dives via the Patient Safety Committee, and trials of new wound care technologies and digital surveillance tools to improve outcomes and reduce infection rates. **DHIP/ HIP**

Resolved – that (A) the contents of this report be received and noted, and

(B) to present deep dives at the Patient Safety Committee and include updates within the quarterly Infection Prevention reports to QC. **DHIP/ HIP**

103/25/7 Infection Prevention Annual Report 2024/25

Paper H3 was noted, and it was highlighted that it was a successful year from an infection prevention perspective.

Resolved – that the contents of this report be approved and highlighted to the Trust Board, for information.

103/25/8 Audit and Quality Improvement Update (AQIP)

The Committee received paper I, comprehensive report on AQIP from the Head of Continuous Improvement and Clinical Audit Manager, highlighting progress, challenges, and strategic developments in embedding a culture of continuous improvement across UHL. In response to a query from Ms J Houghton, Non-Executive Director about support for governance meetings and the impact of staffing shortages, it was noted that strategic cultural improvement governance was still developing and that new recruits were joining the team.

Resolved – that the contents of this report be received and noted.

103/25/9 National Audit of Inpatient Falls (NAIF) & UHL Falls Analysis

The Assistant Chief Nurse presented paper J, the NAIF Falls Update which highlighted a rise in eligible cases following the expansion of NAIF criteria. While UHL had shown improvement in blood pressure monitoring and medication reviews, persistent gaps remained in vision assessments, delirium assessments, and safe manual handling. Compliance with the new Multifactorial Assessment to Optimise Safe Activity (MASA) standard was low, prompting targeted quality improvement actions and a planned relaunch of the Falls Prevention Steering Group to drive progress and embed best practices across the Trust. The 2025 NAIF national report (based on 2024 data) was expected in September 2025. The Committee Chair requested that an update be presented in six months' time to track progress on actions put in place to address inpatient fall management. **ACN**

Resolved – that (A) the contents of this report be received and noted, and

(B) to present an update in six months' time to track progress on actions put in place to address inpatient fall management. **ACN**

103/25/10 Quality and Safety Performance Report

The Chief Nurse presented paper K, the key highlights of the quality and safety key performance indicators from July 2025. She advised that work was ongoing to improve blood transfusion traceability. The Committee also discussed the increase in instances of violence and aggression against staff, with reassurance provided that security staff were equipped with body-worn cameras and legal action was pursued where appropriate. The Trust continued to monitor and report on these issues to support staff and maintain safety.

Resolved – that the contents of this report be received and noted.

103/25/11 Quality and Safety Quarterly Report including PSIRF

The Chief Nurse presented paper L, the patient safety quarter 1 report for 2025-26. Members noted that the Trust was making steady progress in the implementation of PSIRF, with strong performance in incident reporting and ongoing improvements across key work streams. Ms J Houghton, Non-Executive Director, noted that it was helpful that the report had flagged that work was in progress regarding the health inequalities workstream. The Chief Nurse advised that Internal Audit's review of PSIRF implementation at UHL would be presented to QC in due course. **CN**

Resolved – that (A) the contents of this report be received and noted, and

(B) to submit to QC, Internal Audit's review of PSIRF implementation at UHL. **CN**

103/25/12 Patient Experience Report

The Chief Nurse presented paper M, the 2025-26 quarter 1 patient experience update including PALS/complaints turnaround times, FFT feedback and Chaplaincy Service update. Patient moves at night was raised as a concern affecting patient experience. In response, the Chief Nurse advised that while operational constraints (particularly in relation to ambulance flow) made it challenging to eliminate night moves entirely, a task and finish group had been convened, and work was underway to bring discharges earlier in the day. Some "red lines" had been established for winter, with Executive and Senior team support, and continued focus was being given to reducing excessive moves, ensuring no patients experienced multiple transfers. Responding to a query from Ms J Houghton, Non-Executive Director, about actions to address staff attitude, the Chief Nurse confirmed that empathy training was being delivered as part of the fundamentals of care programme. In response to a query from Ms S Kaur, Associate Non-Executive Director, the Chief Nurse undertook to request the Head of Patient Experience to include in future reports, detail in terms of demographic representation particularly in relation to PALS and FFT including actions being taken to target the groups that were underrepresented. **CN/ HPE**

Resolved – that (A) the contents of this report be received and noted, and

(B) to include in future reports detail in terms of demographic representation particularly in relation to PALS and FFT including actions being taken to target the groups that were underrepresented. **CN/ HPE**

103/25/13 Dementia Services Annual Report

Members noted the Dementia Services and Enhanced Care Annual Report 2024-25 (paper N) as presented by the Chief Nurse. It was highlighted that the team had made significant progress in improving the quality of life for the Trust's patients living with dementia, providing critical support to families, and contributing towards UHL's quality and medical dementia strategy. It was also noted that, although the Dementia and Delirium Strategy Action Group had overseen key actions, areas for improvement remained, as highlighted by the National Dementia Audit. Environmental factors were raised as a priority, with ongoing collaboration with Estates and Facilities colleagues to create dementia-friendly wards. A further update in six months' time was requested focussing on the summary of achievements and actions. **CN/ LN**

Resolved – that (A) the contents of this report be approved and highlighted to the Trust Board, for information, and

CN/ LN

(B) to present an update to QC in six months' time highlighting achievements and progress on actions.

104/25 REPORTS FROM QUALITY COMMITTEE SUBCOMMITTEES

104/25/1 Patient Safety Committee (PSC) (15.7.25) Report

The Committee noted the report (paper O1 refers) from Patient Safety Committee meeting on 15 July 2025.

Resolved – that the report be received and noted.

104/25/2 Perinatal Assurance Committee

The Committee noted the report (paper O2) , the key discussions from the UHL Perinatal Assurance Committee on 2 July 2025. In response to a query from Ms J Houghton, Non-Executive Director relating to the impact in terms of risks and mitigation of vacancy gaps for AHPS which were unfunded posts, the Chief Nurse undertook to liaise with the Clinical Director, W&C and provide a response. **CN**

Resolved – that (A) the report be received and noted, and

(B) to liaise with the Clinical Director, W&C and provide an update to Ms J Houghton, Non-Executive Director re. her query relating to the impact in terms of risks and mitigation of vacancy gaps for AHPS which were unfunded posts. **CN**

105/25 LLR QUALITY BOARD

105/25/1 Feedback from and escalation to LLR System Quality Board

None

106/25 ITEMS FOR NOTING

Resolved – that the following reports be received and noted:

1. **Integrated Performance Report – Month 4 (2025-26) (paper P1);**
2. **Perinatal Surveillance Scorecard (paper P2), and**
3. **Data Quality and Clinical Coding Report August 2025 (paper P3).**

107/25 ANY OTHER BUSINESS

107/25/1 Hellen, Makamure – ICB Representative

The Committee Chair noted that this would be the last QC meeting for Ms H Makamure, ICB Representative and he thanked her for her significant contribution to the Committee, which had been very helpful.

Resolved – that the verbal update be noted.

108/25 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the following matters be brought to the attention of the Trust Board for information:

- Minute 97/25 - the Mortality and Learning from Deaths;
- Minute 103/25/3 – NIPAG 2024-2025 Annual Report;
- Minute 103/25/4 – Report from the Deputy Medical Director;
- Minute 103/25/6 - Surgical Site Infection Surveillance Report;
- Minute 103/25/7 - Infection Prevention Annual Report 2024/25, and
- Minute 103/25/8 - Dementia Services and Enhanced Care Annual Report 2024-25.

109/25 ITEMS NOT RECEIVED IN LINE WITH THE WORK PLAN FOR THIS MONTH

- Learning from Claims and Inquests – deferred to September 2025 QC
- Regulation 28 Report – deferred to September 2025 QC
- QC terms of reference review – deferred to September 2025 QC
- 104+ day cancer quality standard report – deferred to September 2025 PSC and QC
- National cancer patient experience survey 2023 results – deferred to September 2025 QC
- Gynaecology Service Briefing – deferred to September 2025 QC

110/25 DATE OF THE NEXT MEETING

Resolved – that the next meeting of the Quality Committee be held on Thursday 25 September 2025 from 2pm via Microsoft Teams.

The meeting closed at 4.22 pm Hina Majeed – **Corporate and Committee Services Officer**

Cumulative Record of Members' Attendance (2025-26 to date).

Present

Name	*Possible*	*Actual*	*% Attendance*
A Haynes (Chair)	*5*	*5*	*100*
R Abeyratne	*5*	*3*	*60*
I Browne	*5*	*4*	*80*
M Farmer	*0*	*0*	*N/A*
A Furlong	*5*	*4*	*80*
J Hogg	*5*	*5*	*100*
J Houghton	*5*	*5*	*100*
S Kaur (from May 2025)	*4*	*4*	*100*
J Melbourne	*5*	*4*	*80*
T Robinson (until May 2025)	*3*	*0*	*0*

In attendance

Name	*Possible*	*Actual*	*% Attendance*
D Burnett	*5*	*0*	*0*
S Burton	*5*	*2*	*40*
B Cassidy	*5*	*4*	*80*
R Manton	*5*	*4*	*80*
C Pheasant	*5*	*0*	*0*
M Rahman	*5*	*4*	*80*
C Ward (PP)	*5*	*3*	*60*
Gang Xu	*5*	*4*	*80*
ICB Representative	*5*	*5*	*100*