UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING HELD ON THURSDAY 31 JULY 2025 AT 2PM (VIRTUAL MEETING VIA MICROSOFT TEAMS)

Members Present:
Dr A Haynes MBE - Non-Executive Director, and QC Chair
Dr R Abeyratne - Director of Health Equality and Inclusion
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 S Barton – Deputy Chief Nurse
Mr R Bell – Clinical Lead Organ (for Minute 88/25/2)
Ms B Cassidy – Director of Corporate and Legal Affairs
Ms H Makamure - ICB Representative
Mr R Manton - Head of Risk Assurance
Ms S McLeod - Head of Patient Experience (for Minute 88/25/3 and 88/25/4)
Ms A Moss – Corporate and Committee Services Officer
Ms Stanhope – Associate Director of Waste and Sustainability (for Minute 88/25/5)

RESOLVED ITEMS

83/25 APOLOGIES

Apologies were received from Mr M Rahman, Chief Pharmacist, Ms C Ward, Patient Safety Partner and Dr G Xu, Deputy Medical Director.

84/25 QUORUM

The meeting was confirmed to be quorate.

85/25 DECLARATIONS OF INTERESTS

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

86/25 MINUTES

Resolved – that the Minutes of the Quality Committee meeting held on 26 June 2025 (paper A) be confirmed as a correct record.

87/25 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.

88/25 ITEMS FOR DISCUSSION AND ASSURANCE

88/25/1 **Board Assurance Framework (BAF) Report**

The Chief Nurse reported that the BAF had been reviewed by herself and the Medical Director. There had been updates noted in the report (paper C). The Chief Nurse highlighted the review of risks relating to the estate and acknowledging there were unknown risks. Dr A Haynes, Non-Executive Director Chair, noted that there was a paper on the agenda with respect to patient

experience which had been identified as a gap at the previous meeting. He considered that the reports addressed the BAF risks falling within the Committee's remit. The Head of Risk Assurance advised that the report on waste management related to a risk under the remit of Our Future Hospitals and Transformation Committee.

Ms J Houghton, Non-Executive Director, asked about the gap in relation to end of life patients not always being recognised in time. The plan was to roll out the Swan Programme. Ms Houghton understood that the Swan Programme was only instigated once the patient had been identified as end of life. The Chief Nurse noted that the Trust had added bespoke elements to the package and learnt from complaints and the Fundamentals of Care Programme.

Resolved – that the report be received and noted.

88/25/2 Organ Donation – Biannual Report

The Clinical Lead for Organ Donation, Mr R Bell, presented paper D which updated the Committee on on-going successes and challenges with respect to organ donation within UHL. The target was for 12 donations per year. There had been 10 last year and three in the current year. This report was considered in light of BAF Risk 1(5).

It was noted that the consent rate in Leicester, at 52%, was lower than the national rate of 59%. Funding had reduced which impacted on the Team's ability to spread the message of organ donation within UHL and the community. In response to a question from Dr A Haynes, Non-Executive Director Chair, it was noted that the reduced funding was a national issue. donation. The Chair questioned whether the shortfall could be supplemented by charitable funds.

The Director of Health Equality and Inclusion asked whether demographic data was available for donors and recipients to provide context with respect to the cultural barriers to donation. The Clinical Lead believed that would be possible for donors and agreed to add the data to the next update. The Director requested that bone marrow donations be included in the next update. **CLf OD**

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

(B) to include demographic data for donors and recipients (if available) and bone marrow transplants in the next update. **CLf OD**

88/25/3 Complaints, PALS and Patient Experience 2024-2025 Annual Report

The Head of Patient Experience presented the Annual Report for 2024/25 (paper E). This report was considered in light of BAF Risks 1(3) 1(4).

The number of formal complaints had reduced and there had been a significant increase in the concerns registered. The main themes were medical care, nursing care and decision-making. Six complaints had been upheld by the Health Services Ombudsman and eight were awaiting an outcome. There was work to do to reduce the number of formal complaints and speed up the process for responding.

The Team had started to collect data relating to the protected characteristics of complainants. There would be a review of best practice from other trusts to ensure different communities were aware of the complaint process and encouraged to provide feedback. The Director of Health Equality and Inclusion advised that the ethnicity statistics should be reported in context and indicate proportionality rather than absolute numbers.

There had been a lot of work around the Accessible Information Standard. It was noted that a significant theme from the patient experience related to wayfinding and a Steering Group had been established.

There had been work to support veterans and a remembrance service had been well attended. A business case to improve the environment for dementia patients had been developed. The costed programme would be £8m and the Head of Patient Experience was working with the Director of Estates and Facilities to look at the art of the possible.

Mr I Browne, Non-Executive Director, noted that the Clinical Management Group (CMG) for Women and Children's had made improvements to their complaints process, and he asked how the learning would be shared. The Head of Patient Experience noted that complaints managers worked across two or three CMGs and there were presentations to quality and safety boards.

The ICB representative asked if there were any specific issues around staff attitudes. Noting the future expansion of virtual wards, she asked if there was any feedback on these from the Friends and Family Test. The Head of Patient Experience agreed to add reference to staff attitudes to the next update. She noted that the Friends and Family Test had only recently gone live for the patients on virtual wards. **HoPE**

Ms S Kaur, Associate Non-Executive Director, asked how the Trust differentiated between a concern and a complaint. The Head of Patient Experience noted that concerns, received by PALS, were more likely to relate to issues that could be resolved easily, such as making an appointment. A complaint was likely to be a complex issue and sit across more than one CMG. These usually related to the standard of care provided. She added that PALS triage the issues and should the patient or family member ask for the issue to be treated as a formal complaint then it would be classed as such.

Ms J Houghton, Non-Executive Director, noted that PALS was face to face at the Leicester Royal Infirmary and wondered if this would be beneficial for the other sites. The Chief Nurse acknowledged that PALS was a new service for the Trust and had proved effective. Whilst it was not possible to extend the service given the financial constraints, consideration was being given to providing cover across the three sites.

Ms J Houghton, Non-Executive Director, asked whether complainants were encouraged to provide feedback on the complaints process. This was confirmed and there was an independent review panel that reviewed a sample of complaints.

Dr A Haynes, Non-Executive Director Chair, noted that communication was an underlying theme in complaints received. He asked whether there were hotspots and what could be done to support improvement. The Head of Patient Experience noted there was significant work on empathy and compassion. The work was being undertaken in partnership with the University of Leicester and the initial focus was on Women and Children's CMG. The programme would be rolled out across the Trust for all disciplines. The Chief Nurse added that, in addition, this was being addressed as part of the Fundamentals of Care Programme which was multi-disciplinary. The Chair asked if there was a timescale for the rollout of the Programme. The Chief Nurse noted that it was being introduced in Medicine initially as it received more complex complaints. Improvements were already being seen in maternity care. The empathy training had been in place for a year and would be on-going, updated and capture new starters.

Dr A Haynes, Non-Executive Director Chair, highlighted the experience of family members not being able to ask someone senior about the patient's care, particularly out of hours. It was also felt that by asking resident doctors on a different day of the week they got a slightly different version of events. The Head of Patient Experience noted that this had been raised at a meeting with carers. The Chief Executive had asked the Chief Nurse and Medical Director to consider how this could be addressed.

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

(B) to add information on staff attitudes to the next update.

88/25/4 <u>Healthwatch Report – Update</u>

The Head of Patient Experience presented outcomes and findings of two Healthwatch investigations (paper F). This report was considered in light of BAF Risks 1(3) 1(4).

The inspections were of Gynaecology Services at Ward 8, and Learning Disability at Leicester Royal Infirmary. The Head of Patient Experience noted progress in relation to the actions.

Ms J Houghton, Non-Executive Director, noted that the Trust did not always communicate clearly. She had been stopped by a patient asking for the Ophthalmology Department when it was signed 'eye clinic'.

Dr A Haynes, Non-Executive Chair, asked about the future of Healthwatch and considered that if it was being disbanded there was a need for something similar.

Resolved – that the report be received and noted.

88/25/5 Waste Management – Update

The Associate Director of Sustainability & Waste presented paper G which updated the Committee on wastes and the Trust's compliance with regulations.

The Trust had seen major improvements in clinical waste segregation which were underpinned by a behavioural change programme. The actions supported the Trust's Green Plan and commitment to achieving carbon net zero (for the emissions it could control) by 2040.

The areas for more focussed work were theatres, pathology, aerosols which contain pharmaceuticals and the over treatment of domestic waste.

Ms S Kaur, Associate Non-Executive Director, asked when the Trust would be compliant with the recycling legislation and what would happen in December 2025 when the Behavioural Change Programme ended. The Associate Director noted there was work to do to ensure segregation at source, storage and how waste is moved around the sites. She anticipated the work would take three to six months. With respect to the behavioural change, she was reviewing the scope of the Programme, in light of the financial constraints, and working with Procurement to market test the proposal to ensure value for money.

As the Environment Agency was due to visit the Trust it was agreed to receive a further report in six months' time. **Assoc Dir**

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

(B) a further update be provided in six months' time. **Assoc Dir**

88/25/6 Quality and Safety Performance Report

The Chief Nurse presented the Quality and Safety performance report for June 2025 (paper H) which noted the key performance indicators for quality and safety, providing data at both Trust and CMG level. This report was considered in relation to BAF Risk 5(1) and 5(2).

It was reported that the Trust had maintained an improved position across key safety and quality performance areas. Falls were low, hospital acquired pressure ulcers under the trajectory, moderate and serious harm incidents were comparable to the previous month, statutory and mandatory training was at target (95% compliance).

Ms S Kaur, Associate Non-Executive Director, asked whether there were any hotspots for patient falls. The Deputy Chief Nurse reported that the overall number of falls was low and tended to be in inpatient bathroom, cardiac, and care of the elderly areas. The Falls Team was able to provide addition support in clinical areas. Dr A Haynes, Non-Executive Director Chair suggested it would be useful to understand the compliance against the National Falls Audit. The Deputy Chief Nurse agreed to report back. **DCN**

Ms S Kaur, Associate Non-Executive Director, asked for an update on the nurse alarms. It was noted there was a new risk for patients requesting assistance and the alarms not working due to the systems deteriorating and being obsolete. The Chief Nurse noted this mainly related to Leicester General Hospital and interim measures had been put in place. The newly appointed Director of Estates and Facilities was reviewing a number of risks relating to the aging estate and identify a plan to remedy compliance issues

Ms S Kaur, Associate Non-Executive Director asked what was being done to address the low uptake of cybersecurity training and turnaround time for complaints. The Chief Nurse noted that the training referred to was Level 3 and for a small number of colleagues. One of the issues was that it was delivered face to face and at specific times. Communication would be sent to learners

to urge them to complete the training. With respect to complaints the Chief Nurse noted that the turnaround times had improved but that was unlikely to be sustained due to vacancies in the team.

Ms J Houghton, Non-Executive Director, asked why there had been a drop in VTE assessments. The Medical Director noted that the reduction was not significant. There were specific issues in Emergency Department but overall, the Trust was performing well.

Ms J Houghton, Non-Executive Director, asked about benchmarking for quality metrics. The Deputy Chief Nurse noted there was national interest in this, but there would be a lot of work involved as each organisation reported in slightly different ways.

Dr A Haynes, Non-Executive Director Chair, highlighted the statistics for blood traceability and that the data relied on manual adjustments. Noting the delay in Clinical Management Groups completing incident reports and the vacancy in the Complaints Team, he highlighted the need to monitor the impact of workforce reduction on performance.

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

(B) a report on compliance against the National Falls Audit be presented to a future meeting. **DCN**

88/25/7 Health Equality and Inclusion Update

The Director of Health Equality and Inclusion presented an update on health inequalities improvement at UHL (paper I). This report was considered in light of BAF Risk 1(5).

There had been a pilot project focussed on high frequency users of the Emergency Department. The cross-sector multidisciplinary team approach had reduced attendances and 'did not wait' episodes. Whilst there was an increase in the length of stay for this cohort, it was likely to reflect improved engagement and complexity of need.

The Trust Board had asked for examination of disparities in attendance and waiting times for urgent and emergency care. The Director presented initial findings noting Black or Asian people and those from deprived groups were overrepresented in attendances, often with lower acuity. Older, white and people from less deprived communities had the longest wait.

The Director highlighted the importance of understanding how the data is used to make decisions. The report noted three key implications for how the Trust used data through the lens of equity: ensuring a representative analysis; identifying who was affected; and understanding the drivers. The next steps were noted. A revised Equality and Health Inequality Impact Assessment had been developed and piloted across the Trust.

The Director reported on Equality Delivery System and one of the three domains for commissioned or provided services. The findings for chaplaincy services; intermediate care; and perinatal mental health services, were summarised in the report.

The Director noted that the Trust would be assessed against the Performance Oversight Framework 2025/26 which had six domains. Whilst there were specific health inequalities metrics, the Director recommended that, where appropriate, they were disaggregated for equity, for example, percentage of patients waiting over 52 weeks.

Ms S Kaur, Associate Non-Executive Director, asked about the impact of the work undertaken and whether the Trust had enough data on protected characteristics. The Director considered the Trust had enough data, although it was not perfect. There was a tracker of active projects which had not been included in the report. She noted that discussions were being had with operational colleagues about the Urgent and Emergency Care data and what could be done before winter in relation to high frequency users. The Chair asked for an update on the active projects in the next report. **DHE&I**

Ms J Houghton, Non-Executive Director, reflecting on previous initiatives for GPs to support frequent users of urgent and emergency care, noted the resources for neighbourhoods were constrained. She asked what impact UHL could have. The Director highlighted the need for

greater intelligence to ensure that limited resources were focussed on the actions that had the biggest impact.

Dr A Haynes, Non-Executive Director Chair, emphasised the importance of the System understanding the health population data and needed further discussion.

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

DHE&I

(B) an update on live projects be included in the next report.

88/25/8 Report of the Medical Director

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

89/25 REPORTS FROM QUALITY COMMITTEE SUBCOMMITTEES

89/25/1 Nursing, Midwifery and AHP Committee Escalation Report

The Committee noted the report from the Nursing, Midwifery and Allied Health Professional Committee. The Chief Nurse highlighted the work on the Fundamentals of Care Programme and noted that there was work to simplify processes for risks assessments. Funding from the East Midlands Acute Provider Network had been secured to review care planning using NerveCentre.

Resolved – that the report be received and noted.

89/25/2 Patient Safety Committee (PSC) (15.7.25) Report

The Committee noted the report from Patient Safety Committee.

Resolved – that the report be received and noted.

90/25 LLR QUALITY BOARD

91/25/1 Feedback from and escalation to LLR System Quality Board

The ICB Representative noted that the report on the visit to the Clinical Decisions Unit at Glenfield Hospital would be shared shortly. She acknowledged the challenges faced by the Emergency Department with respect to abandoned children and a System-wide review of processes would be undertaken.

Resolved – that this information be noted.

92/25 ITEMS FOR NOTING

Resolved – that the following reports be received and noted:

1. **Integrated Performance Report – Month 3 (2025-26)**
2. **Perinatal Surveillance Scorecard**
   Dr A Haynes, Non-Executive Director Chair, asked whether the stable performance for postpartum haemorrhage was due to a specific intervention. The Chief Nurse confirmed. The Chief Nurse reported that the latest report on the maternity heat map shown that UHL had significantly improved its position. Two years ago, it was the second worst in the region and now it was the fourth best. She added that this was a significant achievement as UHL was a multi-site service.
3. **Paediatric Audiology Update**
   It was noted the report would be the last to the Committee.
4. **NICE Compliance - 2024/25**
5. **Cost Improvement Programme Quality Impact Assessments: 2025/26 Quarter 1 Review**

93/25 ANY OTHER BUSINESS

Ther was no other business.

94/25 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 88/25/2 - Organ Donation – Biannual Report (demographic data and inclusion of bone marrow donation)
- Minute 88/25/3 - Complaints, PALS and Patient Experience 2024-2025 Annual Report (to be appended to the
- Minute 88/25/7 - Health Equality and Inclusion Update (how the Trust effectively uses data in decision-making and disaggregating data where appropriate)
- Minute 88/25/8 - Report of the Medical Director
- Minute 92/25 - Perinatal Surveillance Scorecard (improvement in maternity care)

95/25 ITEMS NOT RECEIVED IN LINE WITH THE WORK PLAN FOR THIS MONTH

- Learning from Claims and Inquests – deferred from May 2025 – date to be confirmed.
- Update on Quality Strategy – deferred to August 2025.

96/25 DATE OF THE NEXT MEETING

Resolved – that the next meeting of the Quality Committee be held on Thursday 28 August 2025 from 2pm via Microsoft Teams.

The meeting closed at 4.00 pm

Alison Moss – **Corporate and Committee Services Officer**

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

Present

Name	*Possible*	*Actual*	*% Attendance*
A Haynes (Chair)	*4*	*4*	*100*
R Abeyratne	*4*	*3*	*75*
I Browne	*4*	*3*	*66*
M Farmer	*0*	*0*	*N/A*
A Furlong	*4*	*3*	*75*
J Hogg	*4*	*4*	*100*
J Houghton	*4*	*4*	*100*
S Kaur (from May 2025)	*3*	*3*	*100*
J Melbourne	*4*	*3*	*75*
T Robinson (until May 2025)	*3*	*0*	*0*

In attendance

Name	*Possible*	*Actual*	*% Attendance*
D Burnett	*4*	*0*	*0*
S Burton	*4*	*2*	*50*
B Cassidy	*4*	*4*	*100*
R Manton	*4*	*3*	*75*
C Pheasant	*4*	*0*	*0*
M Rahman	*4*	*3*	*75*
C Ward (PP)	*4*	*2*	*50*
Gang Xu	*4*	*3*	*75*
ICB Representative	*4*	*4*	*100*