University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 2 July 2020

	Trust Board paper I1
Report Title:	**Quality and Outcomes Committee assurance conference call – Committee Chair's Report** *This was not a formally-constituted virtual Board Committee meeting, and was confined to any time-critical items/governance must-dos only. Its purpose was to provide information on, and assurance of, progress.*
Author:	Kate Rayns – Corporate and Committee Services Officer

Reporting Committee:	**Quality and Outcomes Committee (QOC)**
Chaired by:	Ms Vicky Bailey – Non-Executive Director
Lead Executive Director(s):	Andrew Furlong – Medical Director Natalie Green – Deputy Chief Nurse (on behalf of Carolyn Fox – Chief Nurse)
Date of meeting:	25 June 2020

Summary of key public matters considered by the Committee:

This report provides a summary of the key issues considered at the Quality and Outcomes Committee assurance conference call on 25 June 2020:- *(involving Ms V Bailey, QOC Non-Executive Director Chair, Professor P Baker QOC Non-Executive Director Deputy Chair, Mr A Furlong, Medical Director, Ms N Green, Deputy Chief Nurse (on behalf of Ms C Fox, Chief Nurse), Ms B O'Brien, Deputy Director of Quality Assurance, Miss M Durbridge, Director of Safety and Risk and Ms C West, Director of Nursing and Quality, Leicester City CCG. Apologies for absence were received from Ms C Fox, Chief Nurse. Mr N Bond, Deputy Director of Estates and Facilities, and Dr C Marshall, Deputy Medical Director each attended to present one item):*

- **Summaries of QOC Conference Call held on 28 May 2020** – these were noted, having been submitted to the Trust Board on 4 June 2020.

- **Matter Arising Log** – noted. The matters arising log would be populated with any updates provided at this meeting.

- **Covid-19 Position**
  The Medical Director provided a verbal update in respect of the latest position with regard to Covid-19 noting that there had been little change since the virtual Trust Board discussion session held on 12 June 2020. The Trust's restoration and recovery plans remained on track to deliver 75% of normal theatre capacity by the beginning of July 2020, although the number of cases per list would be reduced. This would be mitigated (in part) by a greater focus on theatre efficiency and ITAPS had implemented a new theatres tool to support this approach. The wearing of masks for all healthcare staff had been implemented on Monday 15 June 2020, with no issues being raised. Throughout June, the daily Covid-19 Sit Rep reports were not demonstrating any real reduction in the total numbers of patients being treated in ECMO/ITU settings (approximately 12 patients) or ward settings (approximately 80 patients). News of a local outbreak in Leicester had not yet translated to an increase in hospital admissions. This was not surprising given the younger age profile of these cases, but the organisation would continue to monitor the position. A few isolated incidents in relation to supply of personal protective equipment (PPE) were being managed appropriately. ED performance was being affected by the process for ascertaining the Covid-19 status for new admissions. Two additional rapid-testing machines were expected to arrive in the next seven days which would make a significant difference. 72 hour pre-operative testing continued for planned admissions. The Deputy Chief Nurse advised that as the Trust increased the focus upon restoration and recovery plans, the frequency of the Tactical and Strategic Group meetings had not been reduced. In addition, the Trust was surveying staff to gain feedback on the lessons learned, what had gone well and what could have been done better during the Covid-19 pandemic. The Deputy Chief Nurse advised that nosocomial Covid-19 positive infections 15 or more days after admission were relatively low (standing at 4.6%). However, the figure was higher for community acquired infections within 2 days of admission (standing at 75%). The Medical Director confirmed that the System-level Recovery Group was still meeting regularly and that a significant submission was being finalised to ascertain the Covid-19 and winter funding requirements going forwards. It was expected (but not yet confirmed) that the block tariff arrangement would be continuing and a letter was expected to be issued in the next week or so confirming the national expectations moving into Phase 3 of the Covid-19 pandemic. Meetings were

due to be held later that day in respect of repatriating the Trauma service to the LRI and re-establishing a surgical take across two sites. Professor P Baker, Non-Executive Director expressed an interest in seeing the theatre activity data by service, noting that an endoscopy list (for example) would be more adversely affected than a standard operating list. In response, the Medical Director advised that some urgent work was taking place in respect of ventilation in clinical areas, noting that a minimum of one hour was required between cases currently. He also advised that papers D and E on the agenda for the PPPC assurance call being held later on 25 June 2020 did provide some theatre activity data. Professor Baker agreed to review these reports and contact the Medical Director if any further data was required.

- **UHL Quality Account 2019/20**
  Ms B O'Brien, Deputy Director of Quality Assurance introduced paper C, seeking Trust Board approval for the UHL Quality Account 2019/20. Due to the timing of the Committees, this document had already been reviewed by the Audit Committee on 19 June 2020. External Audit would usually have reviewed the data quality assurance and pressure-tested two aspects of the data, but this had not been possible for 2019/20. Instead, the Quality Account had been reviewed by a number of external stakeholders and their comments were incorporated into paper C. At the Audit Committee, Non-Executive Directors had expressed their concern about a perceived lack of data quality assurance, but the Deputy Director of Quality Assurance provided some additional contextual information about the role of the Data Quality Forum, which was chaired by the Director of Corporate and Legal Affairs. Under this forum, each indicator within the Quality Account and the Quality and Performance (Q&P) report was reviewed using a proforma and a robust confirm and challenge process, following which each indicator was assigned its own RAG-rating for the quality of the data. Discussion had taken place between the Chief Nurse and the Informatics Team about the scope to include some of this assurance within the Q&P report itself. The overall layout of the Quality Account was commended as being more user-friendly and accessible than in previous years. The QOC Non-Executive Director Chair thanked everyone involved in producing this detailed report, highlighting the discussion held at the Audit Committee in respect of the continued focus on patient quality in addition to improving financial performance. She also noted that the Stakeholder feedback included within the report would be considered when developing the 2020/21 Quality Account. QOC recommended the 2019/20 Quality Account (as appended to this summary) to the Trust Board for appropriate endorsement of the Statement of Directors' Responsibilities.

- **Quality Impact Assessment Process**
  Paper D, as presented by the Deputy Director of Quality Assurance described the revised arrangements for measuring the impact of investment decisions in respect of risk management and patient quality and safety via the Quality Impact Assessment (QIA) process. This iteration of the process had been developed in conjunction with the Director of Productivity with input from external advisors and it had been circulated to leaders of the Clinical Management Groups for their input. Particular discussion took place regarding the arrangements for sharing the outputs of the QIA process with System colleagues with a view to developing further mitigations where required. The Deputy Director of Quality Assurance agreed to arrange for engagement to take place with System colleagues. In addition, the Director of Safety and Risk commented upon the scope to triangulate the QIA process with evidence of any incidents or materialised risks to inform the reviews by the Medical Director and the Chief Nurse. The Non-Executive Director QOC Chair summarised this discussion, noting the robust nature of the QIA process, and the current focus on withholding investments where it was safe to do so. She commented upon the need to recognise new and changed risks in the context of the Covid-19 pandemic, noting also the importance of a System-wide focus going forwards. Members supported the QIA Policy for submission to the Policy and Guideline Committee.

- **Annual Fire Report 2019/20**
  The Deputy Director of Estates and Facilities introduced paper E, providing assurance on the effective arrangements for the management of fire safety and detailing the current state of fire safety provision in all Trust premises. Whilst it was no longer a Statutory requirement for this report to be approved by the Chief Executive via the Trust Board, this was still considered to be good practice going forwards. In summary the Trust had received 252 unwanted fire signals, experienced 5 actual fires, received 2 visits from the Fire and Rescue Service and received 1 letter highlighting a deficiency in the Trust's arrangements. Fire evacuation drills had been suspended in March 2020 due to Covid-19 implications, but these were due to recommence in the near future with a particular focus on those areas operating under the new restrictions of wearing full PPE. In discussion on the report, Professor P Baker, Non-Executive Director observed that approximately 50% of UHL's fires had been caused by fridges and he queried whether some focused fire-prevention work was required in this area. He also sought assurance that the process for completing fire risk assessments would be re-started at the earliest possible opportunity. The Deputy Director of Estates and Facilities reiterated the importance of undertaking and reviewing fire risk assessments, confirming that these would be reinstated as part of the return to 'business as usual' for the departmental risk assessors. He undertook to share these plans with QOC once they were confirmed. In the meantime UHL's Fire Officers had been risk-assessing new layouts within the hospital following modifications to make them more Covid-secure. In her role as Chair of the UHL Health and Safety Committee, the Director of Safety and Risk commended the significant progress being made with the fire agenda, noting also the need to

avoid complacency and ensure that any staff who had been relocated to work in different clinical areas became familiar with their new surroundings. In response to this point, the Deputy Chief Nurse provided assurance that the checklist for opening new ward areas included familiarisation with local fire safety procedures and evacuation plans. In response to a query from the Medical Director the Deputy Director of Estates and Facilities provided additional detail in respect of the fire deficiency that had been notified. This matter had been reported to the Executive Quality Board and it related to penetration of fire compartmentation and replacement of doors along the same corridor. All work was planned to be completed in the current year and the Fire and Rescue Service would be notified once this was complete. The Annual Fire Safety Report 2019/20 was supported for Trust Board approval (as appended to this summary).

- **Patient Experience Annual Report 2019/20**
  The Deputy Chief Nurse introduced paper F, providing an update on the work of the Patient Involvement Patient Experience Assurance Committee (PIPEAC) and progress against the Patient Feedback Plan for 2019/20. During the year, the Trust had received some 146,000 friends and family feedback forms and approximately 120,000 free text comments of which approximately 114,000 were positive, 2,000 were negative and 3,500 were neither positive or negative. Figure 12 on page 12 of paper F identified a dip in the percentage of feedback recommending UHL's maternity services in May 2019 (89.9%), but the service had reacted well and performance in March 2020 had improved to 97.6%. Discussion took place regarding opportunities to improve the amount of feedback from patients and relatives from hard to reach groups. The Director of Nursing and Quality, Leicester City CCG noted an opportunity for joint working between System partners and it was agreed to explore this further via the bi-weekly System Engagement meetings. The Non-Executive Director QOC Chair commended this comprehensive report, noting the potential impact of patient access targets and waiting times on future patient feedback.

- **UHL Dementia Strategy 2018–2020 – End of Year Report 2019/20**
  The Deputy Chief Nurse introduced paper G, providing a summary of activity across the seven strategic Dementia Strategy priorities during 2019/20. She particularly highlighted the contributions made by the Admiral Nursing and the Meaningful Activities services. Assessment of patients' cognitive function was a crucial baseline assessment to ensure that patients were able to be involved in and make decisions about their own care. The Cognitive Assessment flow chart for patients over 65 years was provided at appendix 5 and this was identified as a key focus for improvement in 2020/21.

- **Falls End of Year Report 2019/20**
  Paper H, as presented by the Deputy Chief Nurse, provided an update on progress of the Falls Safety Action Plan for 2019/20 and a high level summary of falls safety initiatives at UHL. Figure 3 on page 2 of paper H illustrated the reduction in the falls rate per 1,000 patients since the enhanced falls reduction measures detailed in appendix 4 had been implemented in July 2019. The detailed falls pathway was provided at appendix 5. QOC commended the progress being made, noting that falls data and associated harms was relatively low for an organisation of UHL's size.

- **Director of Safety and Risk Report**
  Paper I, as presented by the Director of Safety and Risk, provided the detailed key safety events (Serious Incidents, Never Events, RIDDORs, deaths etc) for the month of May 2020. She particularly noted a drop in incident reporting during the Covid-19 pandemic and the associated increase in the rate of incident reports once these were validated. The graph in section 3.1 of the report provided assurance that the overall number of incidents in April and May 2020 remained within the lower limits of the normal range. An increase in staff concerns had been reported to the Executive People and Culture Board and the People, Process and Performance Committee. Particular themes for staff concerns had related to Covid resources (eg PPE), staff redeployment, social distancing arrangements and staff behaviours. She commended the CMGs in respect of closing down their outstanding 'Duty of Candour' evidence. A decrease in the number of inpatient and ED deaths had occurred in May and June. Safety alerts were being responded to in a timely manner. The Director of Safety and Risk advised that one Serious Incident (SI) had been escalated in May 2020 (relating to a foetal death) and 2 incidents had been escalated in June 2020 (one Never Event and one incident which did not meet the criteria for an SI, but was being escalated as a future learning event). Further detail on these 2 incidents would be provided at the 30 July 2020 QOC assurance call. The formal complaints process had been paused during the height of the Covid-19 pandemic but this had re-started on 1 June 2020 and an expected increase had been noted since that date. The Medical Director advised that in-hospital mortality metrics remained with the expected funnel plot for all Midlands NHS Trusts and that UHL's data was slightly below the median. It was expected that NHS Digital would be excluding patient deaths which named Covid-19 as the primary or secondary cause of death from the SHMI data methodology going forwards.

- **The Five Steps to Safer Surgery: Internal Audit Review**
  Paper J, as presented by Dr C Marshall, Deputy Medical Director, provided the detailed findings from the Internal Audit review of the Five Steps to Safer Surgery at UHL. The presentation slides appended to paper J described the development of the National Safety Standards for Invasive Procedures, Local Safety Standards for Invasive

Procedures (LocSSIPs), the launch of the new World Health Organisation (WHO) checklist incorporating Team Brief and Debrief 2017, implementation of the LocSSIP programme in 2016 and its evaluation in 2018. As part of the Trust's Quality Strategy, UHL had established a Safer Surgery and Procedures Team. Weekly meetings of the Operational Group and the monthly meetings of the Safer Surgery and Procedures Board had been paused during the pandemic, but the next progress update was scheduled for presentation to the Executive Quality Board in September 2020. In response to the Internal Audit findings a deep dive into Cardiology procedural areas had been held and LocSSIPs had been launched in the Catheter Lab in 2018. Some excellent engagement work had been held within the Cardiology Service, with some 52 clinicians joining the interactive Skype session. A four-page Theatre Code of Conduct booklet had been prepared highlighting standards of behaviour and how they linked to the Trust's Values and a laminated chart had been produced for all theatre areas, augmented by a suite of videos demonstrating best practice in areas such as checking patient's identification and undertaking prosthetics checks. *The Medical Director and the Deputy Chief Nurse had to leave the meeting at this point to attend another prior engagement.* The Deputy Medical Director continued to describe the project led by Andrew Hughes: Introducing Patient Safety 2 into Theatres. She also described the concept of the Quality Assurance Accreditation scheme including the use of the WHOBARS tool and observational practices being undertaken by nominated 'mystery shoppers'. Finally, she highlighted the key risks to delivery which included videography expertise, Covid-19 time to train, and cost improvement constraints. The Non-Executive Director QOC Chair thanked the Deputy Medical Director for this comprehensive report and the Director of Nursing and Quality, Leicester City CCG commended the resilience of the Safer Surgery and Procedures Team in driving forward the required improvements.

- **Items for noting:**– the following reports were received and noted for information:-
  - **Volunteer Services Annual Report 2019/20 (paper K);**
  - **NIPAG Annual Report 2019/20 (paper L);**
  - **Clinical Audit Quarterly Report (paper M)** – the Deputy Director of Quality Assurance reported on a wider piece of work which was underway to create greater oversight of the Clinical Audit function and the Non-Executive Director QOC Chair commented that the report appeared to be very medically-focused currently;
  - **Clinical Coding and Data Quality Quarterly Report (paper N), and**
  - **EQB actions 14.4.20 and 12.5.20 (papers O1 and O2).**

Public matters requiring Trust Board consideration and/or approval:

Recommendations for approval

- UHL Quality Account 2019/20 (appended), and
- Fire Safety Annual Report 2019/20 (appended).

Items highlighted to the Trust Board for information:

- The verbal update on Covid-19 and the assurance provided that the recent outbreak in Leicester had (so far) not translated into a corresponding increase in Covid-19 related hospital admissions;
- Revised Policy for Quality Impact Assessments;
- Patient Experience Annual Report 2019/20;
- UHL Dementia Strategy 2018-2020 – Annual Report 2019/20, and
- Falls End of Year Report 2019/20.

Matters deferred or referred to other Committees:

None

Date of next QOC assurance conference call:	30 July 2020

Ms V Bailey – Non-Executive Director and QOC Chair Closed 10:14am

Quality Account 2019/20

Author: Becky O'Brien, Deputy Director of Quality Assurance Sponsor: Carolyn Fox, Chief Nurse **Paper C**

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	X
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board	12/5/2020	EQB received a draft of the Quality Account by way of assurance that the document was under development
Trust Board Committee	19/6/2020	Final Quality Account presented to the Audit Committee
Trust Board		

Executive Summary

Context

The Quality Account is an annual report from providers of healthcare about the quality of service delivered.

The first draft Quality Account was presented to the Executive Quality Board in May 2020. The final Quality Account for 2019/20 (attached as Appendix A) was presented to Audit Committee 19th June 2020 and will be presented at Trust Board on the 2nd July 2020 for final sign off.

Conclusion

The Quality Account has been prepared in accordance with Department of Health guidance: The Department of Health toolkit has been reviewed and all mandatory statements have been included.

The content of the quality report is consistent with internal and external sources of information, in that it reflects information presented in Board minutes and papers, papers relating to quality reported to the Board (and quality committees).

A draft of the Quality Account has been shared with the relevant stakeholders.

Input Sought

The Quality and Outcomes Committee is asked to:

- Note that the Quality Account for 2019/20 will be presented to Trust Board on the 2nd July 2020 for final sign off.

For Reference** (edit as appropriate)**:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Yes]
Safely and timely discharge	[Yes]
Improved Cancer pathways	[Yes]
Streamlined emergency care	[Yes]
Better care pathways	[Yes]
Ward accreditation	[Yes]

2. Supporting priorities:

People strategy implementation	[Yes]
Estate investment and reconfiguration	[Yes]
e-Hospital	[Yes]
More embedded research	[Yes]
Better corporate services	[Yes]
Quality strategy development	[Yes]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)?
  N/A

- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required
  Stakeholders have been consulted on the 2019/20 Quality Account. Patient Partners have contributed to the 2019 Quality Account.

- How did the outcome of the EIA influence your Patient and Public Involvement ?
  N/A

- If an EIA was not carried out, what was the rationale for this decision?
  N/A

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	Select (X)	Risk Description:
Strategic: Does this link to a ***Principal Risk*** on the BAF?		

Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None		

5. Scheduled date for the **next paper** on this topic: [2021]
6. Executive Summaries should not exceed **5 sides** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Report to: Quality and Outcomes Committee

Report from: Deputy Director of Quality Assurance

Date: 25th June 2020

Subject: Quality Account 2019/20

1.1. **Background**

1.2. The Quality Account is an annual report from providers of healthcare about the quality of service delivered.

1.3. The first draft Quality Account was presented to the Executive Quality Board in May 2020. The final Quality Account for 2019/20 (attached as Appendix A) was presented to Audit Committee 19th June 2020 and will be presented at Trust Board on the 2nd July 2020 for final sign off.

2. Structure of the Quality Account

2.1. The Quality Account must be produced in line with the Department of Health Toolkit. This mandates the content, who the Quality Account has to be formally shared with for an invitation to comment and how the Quality Account has to be published.

2.2. The Quality Account is structured in the following way:

- A review of quality performance for 2019/20
- Priorities for improvement for 2020/21
- A series of mandated statements

3. Stakeholders commentary

3.1. The draft Quality Account was shared with the following stakeholders at the beginning of April 2020:

- The three Clinical Commissioning Groups within Leicester, Leicestershire and Rutland
- Healthwatch Leicester City
- The Leicester City Council Health and Wellbeing Scrutiny Commission
- The Leicestershire County Council Health Overview and Scrutiny Committee

3.2 Where commentaries have been received, these have been included (verbatim). No comments were received from the Leicester City Council Health Wellbeing Scrutiny Commission or Healthwatch Leicester and Leicestershire.

3.2 All feedback has been carefully considered. No subsequent changes have been made to the Quality Account for 2019/20, however feedback will be considered when developing the Quality Account for 2020/21.

3.3 Our Patient Partners have been involved in the development of the Quality Account and have provided commentary which is also included verbatim.

4. The Statement of Directors' responsibilities in respect of the Quality Account

4.1 Assurance against the Quality Account comes from both internal and external sources and the Trust is required to complete the Statement of Directors' Responsibilities in the Quality Account.

4.1. The statement takes the form of bullet points followed by a signature from the Chairman and Chief Executive and is included at page 57 of Appendix A.

4.2. The text below in bold represents the extract from the statement followed by supporting information.

The Quality Account presents a balanced picture of the Trust's performance over the period covered: The 2019/2020 Quality Account reports back on performance in relation to the priorities set out in the 2018/19 Quality Account as well as a variety of other quality indicators. These quality indicators include those from the NHS outcomes framework (pages 14 & 15) and performance against other national standards (pages 23 – 27).

The performance information reported in the Quality Account is reliable and accurate: The collection of performance information for the Quality Account has been subject to a number of checks and balances including:

- Triangulation with other data sources / reports
- Review by the Assistant Director of Information and his team.
- Review by individual contributors to ensure the most up to date validated information has been included

There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice: Data in the Quality Account has been taken from NHS Digital unless otherwise specified. Trust data sets have been sourced via the information team. Trust reporting is subject to a series of control measures referred to in section 5 of this paper.

The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance: There are close working arrangements with the information department. Performance data is considered, confirmed and challenged at various groups including:

- Trust Board

- NHSi Progress Review Meetings
- People Process and Performance Committee
- Quality and Outcomes Committee
- Executive Performance Board
- Executive Quality Board
- Clinical Management Groups Performance Review meetings
- 'Specialist' committees such as Clinical Audit and the Research and Development Committees
- Contracting meetings with LLR/Specialised commissioner

Data included in the Quality Account is subject to national reporting and therefore associated checks and balances.

The Quality Account has been prepared in accordance with Department of Health guidance: The Department of Health toolkit has been reviewed and all mandatory statements have been included. The toolkit is accessible via http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122540.pdf.

5. General assurance of data quality

5.1. As a general point of assurance the content of the quality report is consistent with internal and external sources of information, in that it reflects information presented in Board minutes and papers, papers relating to quality reported to the Board (and quality committees).

5.2. The Trust takes a number of actions to improve data quality:

- A Data Quality Forum, chaired by the Director of Corporate and Legal Affairs provides assurance on the quality of data reported to the Trust Board. The forum is a multi-disciplinary panel from the departments of information, safety and risk, clinical quality, nursing, medicine, finance, clinical outcomes, workforce development, performance and privacy. The panel is presented with an overview of data collection and processing for each performance indicator in order to gain assurance by best endeavours that it is of suitably high quality. The NHS Digital endorsed Data Quality Framework provides scrutiny and challenge on the quality of data presented against the dimensions of accuracy, validity, reliability, timeliness, relevance and completeness

- Where such assessments identify shortfalls in data quality, the panel make recommendation for improvements to raise quality to the required standards. They offer advice and direction to clinical management and corporate teams on how to improve the quality of their data

- For the management of patient activity data, we have a dedicated corporate data quality team. They respond to any identified issues and undertake daily processes to ensure singularity of patient records and accurate GP and commissioner

attribution. We have been actively working to reduce GP inaccuracy by implementing automated checking against the Summary Care Record. Our weekly corporate data quality meeting challenges inaccurate and incomplete data collection. The data quality team action reports on a daily basis to maximise coverage of NHS number, accurate GP registration and ensures singularity of patient records

- The NHS Digital Data Quality Maturity Index is used for benchmarking against 17 peer Trusts. Data quality and clinical coding audit is undertaken in line with Data Protection and Security Toolkit and mandatory standards are achieved. For clinical coding we have several assurance processes in place to ensure that patient complexity is accurately captured. In 2019 we have improved the information supply chain for clinical coding which has resulted in more documentation being available for the Clinical Coding process. Leicester's Hospitals has a Clinical Coding Steering Group, which aims to develop wider clinical engagement as part of quality improvement

- The Executive Board receive quarterly reports on the Data Quality and Clinical Coding

6. External audit assurance of the Quality Account

6.1 In March 2020, the Chief Operating Officer, NHS England & NHS Improvement wrote to all NHS trusts setting out measure to free up capacity and to prioritise workload. The letter advised that the deadline for the preparation and audit of accounts in 2019/20 was deferred and that work by external auditors to review the Quality Account and testing of quality indicators should cease with immediate effect.

6.2 The Quality Account attached as Appendix A has therefore not been subject to review by our external auditors (Grant Thornton).

7.0 Recommendation to the Quality and Outcomes Committee

7.1 The Quality and Outcomes Committee is asked to:

- Note that the Quality Account for 2019/20 will be presented to Trust Board on the 2nd July 2020 for final sign off

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

Becoming the best

Quality Account 2019/2020

Contents

Section 1

1 Introduction from the Acting Chief Executive

Reflecting on the last year, it has been a year of challenge and change. The ongoing Covid-19 continues to require extraordinary effort, energy and hard work, but also skill, compassion and sacrifice. I'm humbled every day by what I see from teams across our hospitals and the lengths they go to, to provide compassionate high-quality care.

We are thankful that we have been able to save lives and return people to their families, but we are mindful that the pandemic has claimed lives too and the faces of those patients will be etched in our memory. Our thoughts are with every family that lost a loved one across these months.

I believe much of what we have been able to achieve these past few months lies in the collective Becoming the Best journey that we began in 2019 to create a step-change in our culture and service delivery.

There are green shoots of progress in this quality account. A 'good' from the government's health regulator, the Care Quality Commission (CQC), our best since 2009, improvements in waiting times, more same-day emergency care, a reduction in Never Events, a renewed focus on EDI and research - so intrinsic to what sets our Trust apart. There is much to be proud of in the progress we have made so far, but as you review you will also see that there is much we still need to do; and two never events are two too many.

We know many of our obstacles come from services split across sites, and so the confirmation of £450 million of national funding means to embark on Leicester's long-awaited hospital transformation programme could not have come at a better time. What fantastic news to have had at the beginning of a three-year improvement programme. Not only will the reconfiguration of our sites enable us to replace outdated buildings with state-of-the-art facilities but it will also transform how we work and put the public right in the heart of the future of healthcare in Leicester, Leicestershire and Rutland as we work with them to address the needs in our communities as part of our public consultation.

Despite visible progress and positive news, it would be remiss of me to not address our serious financial deficit. To truly realise sustainable performance for our patients this is the obstacle we must overcome. Whilst this is sure to make what is already a difficult year more challenging, both I and the Executive Team at Leicester's Hospitals are committed to delivering a sustainable financial model and igniting transformational change in 2020 and beyond.

Rebecca Brown

Acting Chief Executive

Section 2

2 About Leicester's Hospitals

Our Trust Board

Karamjit Singh CBE
Trust Chairman

John Adler
Chief Executive

Vicky Bailey
Non-Executive Director

Rebecca Brown
Chief Operating Officer

Andy Carruthers
Acting Chief Information Officer

Prof. Philip Baker
Non-Executive Director

Carolyn Fox
Chief Nurse

Darryn Kerr
Director of Estates & Facilities

Colonel (Ret'd) Ian Crowe
Non-Executive Director

Andrew Furlong
Medical Director

Hazel Wyton
Director of People and OD

Kiran Jenkins
Non-Executive Director

Simon Lazarus
Finance Director

Stephen Ward
Director of Corporate and Legal Affairs

Andrew Johnson
Non-Executive Director

Mark Wightman
Director of Strategy and Communications

Ballu Patel
Non-Executive Director

Martin Traynor OBE
Non-Executive Director

Our Values

Becoming the best

We treat people how we would like to be treated

- We listen to our patients and to our colleagues, we always treat them with dignity and we respect their views and opinions
- We are always polite, honest and friendly
- We are here to help and we make sure that our patients and colleagues feel valued

We do what we say we are going to do

- When we talk to patients and their relatives we are clear about what is happening
- When we talk to colleagues we are clear about what is expected
- We make the time to care
- If we cannot do something, we will explain why

We focus on what matters most

- We talk to patients, the public and colleagues about what matters most to them and we do not assume that we know best.
- We do not put off making difficult decisions if they are the right decisions
- We use money and resources responsibly

We are passionate and creative in our work

- We encourage and value other people's ideas
- We seek inventive solutions to problems
- We recognise people's achievements and celebrate success

We are one team and we are best when we work together

- We are professional at all times
- We set common goals and we take responsibility for our part in achieving them
- We give clear feedback and make sure that we communicate with one another effectively

One team shared values

Section 3

3 Review of quality performance in 2019/20

3.1 Our aims for 2019/20

Leicester's Hospitals have many strengths. Some of our clinical services are genuinely class leading in terms of their clinical outcomes. Many of our specialist services are underpinned by strong research portfolios and perhaps most of all, we recognise, as do others, (the Care Quality Commission for example) that our teams are overwhelmingly caring and compassionate.

And yet, despite these inherent strengths we have struggled to achieve and particularly maintain consistently high standards of quality and performance. Some of this arises out of the historic lack of investment in Leicester's Hospitals. So, for example it is interesting to contrast how cutting edge technology and equipment has been designed into our new Emergency Department and at the same time our outpatient clinics are reliant on an army of people pushing around patient notes in trolleys. In the same vein, the fact that our staff are recognised as being caring and compassionate is creditable but if we don't have enough staff, it makes creating the time to care more difficult.

Whilst it is recognised that some of the issues we want to address require significant investment, or in the case of staffing, simply more new nurses out of training, there are many other improvements we can make that don't necessarily carry a huge price tag.

We have spent a great deal of time lately looking at the characteristics of successful and high quality hospitals; in doing so, some themes emerge, most notably that the best hospitals have two things in common. First, a clearly understood and universally practised approach to quality improvement that starts with the Trust Board. And second, a determined focus on a relatively small number of key quality priorities. That being the case, and reflecting on our approach to date, we have not got this right, yet. Specifically, we have not had a universally understood approach to quality improvement and we have tried to do too much at once.

In response to this analysis, in 2019/20, we launched our 3 year quality strategy.

Our quality strategy sets out:

- **how** we will move towards 'becoming the best' through the implementation of an evidence based Quality Improvement methodology (shown out in the blue cog in the diagram right) and
- **what** we will be focussing on as we continue on our journey to become the best (shown in the pink and green cogs in the diagram right)

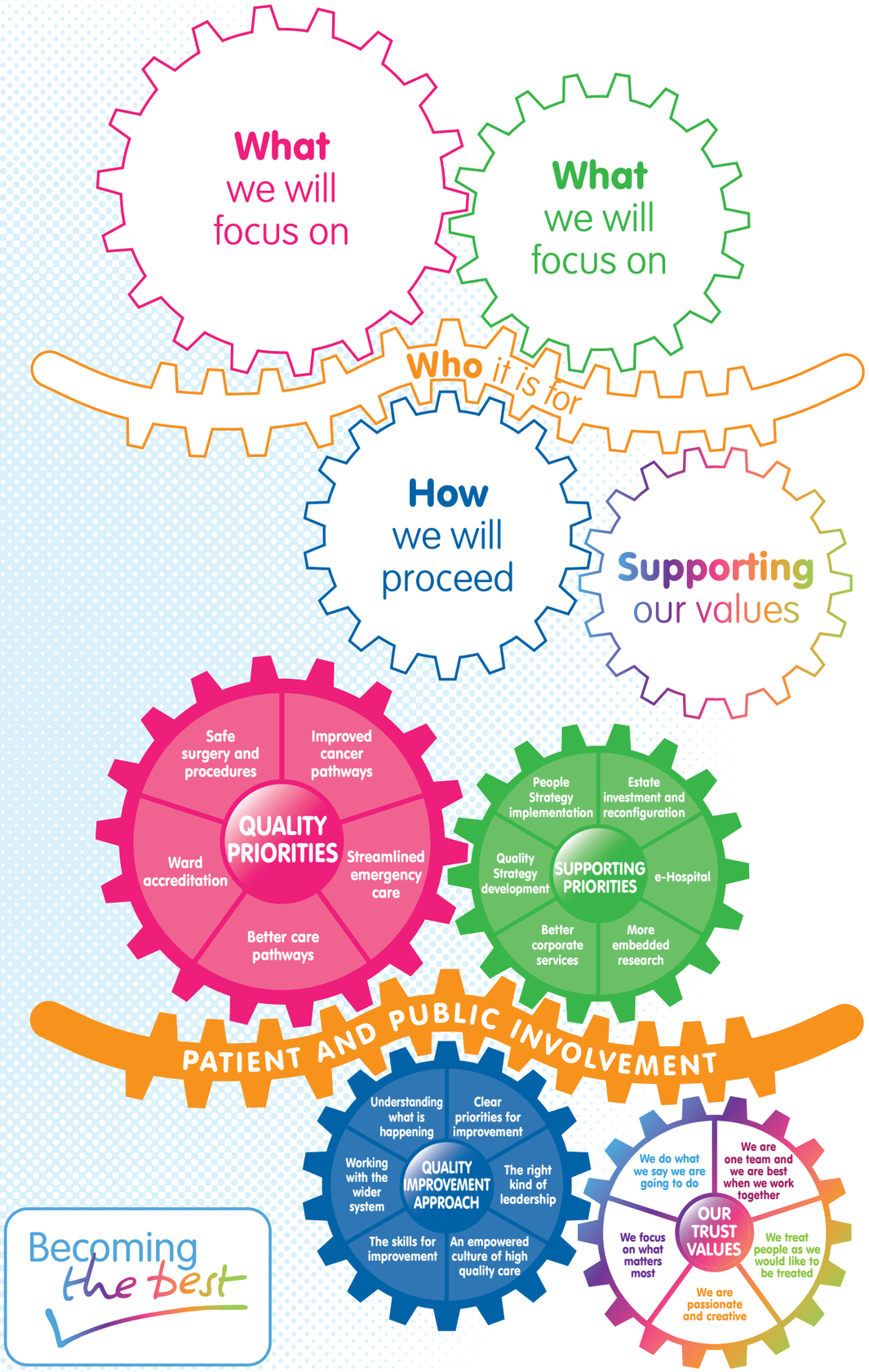
Linking the cogs together is the chain of patient and public involvement which reminds us that our patients and the wider public are the people we are trying to get this right for. The final cog in the picture outlines our values as these underpin all that we do.

In summary, our quality priorities focus on:

- Ward accreditation
- Safe surgery and procedures
- Improved cancer pathways
- Streamlined emergency care
- Better care pathways

Our quality priorities are enabled by our supporting priorities:

- Quality strategy implementation
- People strategy implementation
- Estates investment and reconfiguration
- E-hospital programme
- More embedded research
- Better corporate services



3.2 Review of last year's quality priorities

This section outlines the detail behind each of our quality priorities and provides a summary of what we have achieved through the year. Our priorities were designed to be 3 year priorities and we recognise that there is much work still to be done to achieve our goal of 'Becoming the Best' for every patient, every time.

Ward accreditation

We said we would:
"Embed safe and effective care in every ward by introducing a Trust wide assessment and accreditation framework"

Achievements in 2019/20:

Our assessment and accreditation framework is designed around 15 standards that align to the Care Quality Commission's essential standards.

Each standard is sub-divided into elements of care, environment and leadership and also incorporate national performance indicators as well as local indicators developed from lessons learnt arising from complaints, concerns, adverse events and quality improvement work.

The assessment process is undertaken by the lead nurse for assessment and accreditation. Each ward is assessed against the 15 standards with each standard being red, amber green (RAG) rated individually and when combined an overall ward RAG rating is produced.

The reassessment of the wards is dependent on the overall RAG rating.

The Ward Sister / Charge Nurse, Matron and Head of Nursing are responsible for formulating a ward improvement plan, ensuring that it is tracked and disseminated to all members of the ward team. The results and action plans from the assessment contribute to individual service reviews, and the data collated as a whole is presented to our Executive Quality Board and Quality Outcomes Committee.

For a ward to be recommended for consideration to a panel for 'Caring at its Best' they must have achieved green status on three consecutive occasions thus demonstrating sustainability in delivering high standards of care.

Key to RAG ratings		
RED	6 red standards or more	Re-assess in 2 months
AMBER	3 – 5 red standards	Re-assess in 4 months
GREEN	0 – 2 red standards plus 8 or more green standards (standard 15 must be Green)	Re-assess in 6 months
Caring at its Best	3 consecutive green assessments, Successful panel review Annual successful panel review	Re-assess in 12 months

Results (August – December 2019)

- 32 first ward assessments were completed resulting in **7 green, 17 amber and 8 red**
- 1 reassessment was completed in November demonstrating **improvement from red to amber**

Following the initial 32 ward assessments the results by standard highlighted the need for focused work within standard 3 (safe environment) standard 5 (infection prevention) and standard 14 (effectively managed)

Standard 3 - safe environment:

Areas of focus include:

- Appropriate action is taken in response to risk assessments
- Risk assessment are reviewed in line with Leicester's Hospitals guidelines
- All patients wear a clean and accurately printed identity band

Standard 5 - infection prevention:

Areas of focus include:

- Equipment is cleaned prior to storage and labelled as such
- Staff can articulate what the iFIVE acronym means
- Staff can name the elements on the infection prevention risk assessment

Standard 14 - well-led:

Areas of focus include:

- Staff are aware of Leicester's Hospitals strategy and can describe changes to practice following ward involvement in quality improvement projects
- The uniform policy is adhered to by all staff on duty
- The Ward Sister / Charge Nurse plans and chairs monthly ward meetings

Assessment and accreditation allows wards to recognise what they do well and identify areas for improvement, by driving information to front line teams.

Wards are able to rapidly demonstrate improvements through subsequent reassessments.

Safe surgery and procedures

We said we would:
"Consistently implement the safest practice for invasive procedures, with a focus on consent, NatSSIPS and the Five Steps to Safer Surgery; and we will improve our learning when things go wrong"

Achievements in 2019/20:

- Appointed a specialist quality improvement nurse to lead on safer surgery checklists to ensure that they are fully implemented in all areas
- Audited our compliance with safer surgery checklists
- Developed a methodology for standardising the audit of safer surgery checklists
- Developed a theatre code of conduct aligned to our values for all staff in theatre to follow
- Developed and piloted our first electronic safer surgery checklist using NerveCentre technology
- Established a patient information committee to lead on developing standardised patient information for all our surgical procedures to make it available on our public facing website
- Undertaken focused work with specific clinical teams to improve the safety culture in their departments to become Outstanding.

Safe and timely discharge

We said we would:
"Implement safe and timely discharge for all patients in our care, 7 days a week, by embedding safer discharge processes and eliminating avoidable delays"

Achievements in 2019/20:

- Established a collaborative group working with 3 wards (22, 25 & 33 at the Leicester Royal Infirmary) to undertake small change pilots such as instigating a new sticker in stroke patients notes to show when referral has been accepted and where patient is being transferred to. This has greatly improved the Multidisciplinary team communication
- Speeded up patient transfers to rehabilitation beds by changing daily bed conference calls from 12pm to 10am.

Improved cancer pathways

We said we would:
"Provide high quality and timely diagnosis and treatment for patients on cancer pathways by redesigning those pathways in conjunction with our partners"

Achievements in 2019/20:

- Direct to CT pathway and RAPID CT scan reporting
- Leicester Optimal Lung Cancer Pathway virtual triage Monday to Thursday
- Lung cancer nurse specialists meeting patients at their CT scan
- Lung cancer nurse specialists telephone patient the same day as they are discussed in virtual triage
- Next steps co-ordinators track and book the patient's next steps
- A reduction of lung cancer referrals via Emergency Department
- Pulmonary Function Test and Echocardiogram appointment slots available on the same day as RAL
- Additional Endoscopic Bronchial Ultrasound equipment and appointments
- Patients happy and relieved to know outcome of CT scan promptly.

Streamlined emergency care

We said we would:

"Work as a system to create safe, efficient and timely urgent and emergency care, with a focus on embedding acute frailty and Same Day Emergency Care"

Achievements in 2019/20:

Governance:

- Streamlined Emergency Care Board Set up
- Set up of new reporting structure taking on Quality Improvement Methodology including development of measures and project meeting.

Priorities:

- TTOs (to take out; medicines given to patient on discharge from hospital stay):
  - New process and practice across 12 medical wards at LRI tested and in implementation
  - New letter for GP successfully trialled
  - Dedicated ward pharmacists trialled on 2 medical wards LRI to support prompt medicines reconciliation, resolution of medication issues earlier in the patient journey, pre-emptive supply of medications and to take an active role in TTO planning and completion
- Reduce variation in practice on Board Rounds and Ward Rounds:
  - Led by 2 medical Consultants work to improve board round processes and decision - making as a driver of improved care delivery on Ward 31 LRI (a test ward)
- Discharge Lounge:
  - Maximising use of discharge lounge
  - Improving processes
  - Established a Discharge Lounge Collaborative
  - Worked in partnership with TASL to ensure timely booking of Transport for patients
- The "Community Offer" Operational Understanding:
  - Improved knowledge base of frontline MDT on what is available in the community and how to access
- Discharge Collaborative:
  - Established a collaborative group working with 3 medical wards at the Leicester Royal Infirmary to undertake small change pilots. (In early stages of set up - Several tests of change in working progress)
  - Quality Improvement Methodology approach taken
  - Early tests of change completed:
    - Speeded up patient transfers to rehabilitation beds
    - Improved communication in Medical notes relating to Stroke patients referral and transfer
- Same Day Emergency Care (SDEC):
  - Maximise the use of Same Day Emergency Care pathways reducing number of patients being admitted to a hospital bed unnecessarily.

Better care pathways

We said we would:

"Provide high quality, efficient integrated care by redesigning pathways in key clinical services to manage demand, improve use of resources and deliver financial improvement"

Achievements in 2019/20:

- Identified 24 clinical pathways that have systems wide leadership to improve pathways from prevention through to end of life care
- Outline business case drafted for new treatment centre at Glenfield Hospital
- Successfully implemented transforming transcription in many areas.

3.3 Patient Safety Improvement Plan

Leicester's Hospitals continue to have a strong ambition to reduce avoidable death and harm and to improve patient safety. Having embedded many of our Sign Up to Safety actions we now focus on two areas of improvement. First, we have adopted the key priorities within the new National Patient Safety Strategy, and second, we continue to focus on our six clinical priorities described within our quality strategy.

The National Patient Safety Strategy has the following broad aims:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information **(Insight)**
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system **(Involvement)**
- designing and supporting programmes that deliver effective and sustainable change in the most important areas **(Improvement)**

In line with the national strategy, we will continue to develop and train our own patient safety specialists, learn from HSIB investigations and increasingly use a human factors approach to incident investigation. Our quality improvement and patient safety training this past year have enabled staff to use these approaches and show a promising trend in terms of reducing serious incidents and Never Events.

Duty of Candour

On 1st April 2015 the statutory Duty of Candour (Regulation 20 Health and Social Care Act 2008) regulated by the Care Quality Commission, came into force for all health care providers. The intention of the regulation is to ensure that providers are open and transparent in relation to care and treatment provided. It also sets out specific requirements to ensure patients and their families are told about 'notifiable patient safety' incidents that affect them.

To help staff understand the duty of candour requirements we have:

- Added a short training video and letter guidance to our hospital intranet
- Included duty of candour training in all of our patient safety training
- Improved our level of compliance and ability to monitor this, by adding a mandatory duty of candour prompt on our incident management system so that when incidents are finally approved as moderate harm or above staff are directed to record the relevant information and take the appropriate action
- Increased our compliance with copies of letters being uploaded centrally as further evidence of compliance from 68% last year to 94% this year.

3.4 National Patient Safety Alert compliance

Patient safety alerts are issued via the Central Alerting System, a web-based cascading system for issuing patient safety risks, alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations.

NHS trusts who fail to comply with the actions contained within patient safety alerts are reported in monthly data produced by NHS Improvement and published on the NHS Improvement website. Compliance rates are monitored by Clinical Commissioning Groups and the Care Quality Commission. Failure to comply with the actions in a patient safety alert may compromise patient safety and leads to a red performance status on the NHS Choices website.

The publication of this data is designed to provide patients and their carers with greater confidence that the NHS is proactive in managing patient safety and risks.

Within Leicester's Hospitals there is a robust accountability structure to manage patient safety alerts. The Medical Director and Chief Nurse oversee the management of all patient safety alerts and the Heads of Nursing take an active role in the way our Clinical Management Groups manage alerts at operational and service level. Our Executive Quality Board and Quality and Outcomes Committee monitor this process and internal assurance meetings also scrutinise Clinical Management Group performance. Any alert that fails to close within the specified deadline is reported to the Executive Quality Board and Quality and Outcomes Committee with an explanation as to why the deadline was missed and a revised timescale for completion.

We have formed a patient safety alert panel to monitor performance and to audit how the recommended actions from these alerts are applied, working closely with clinicians and managers to ensure a coordinated response within prescribed timescales wherever possible.

During 2019/20 we received six patient safety alerts. None breached their due date.

Table 1: National patient safety alerts received during 2019/20

Title	Due date	Current Status
PSA-RE-2019-002 Assessment and management of babies who are accidentally dropped in hospital	08/11/2019	Closed
(NHSI PSA) CH T-2019-001 Alert from the Central Alerting System Helpdesk Team - The introduction of National Patient Safety Alerts	16/12/2019	Closed
NatPSA-2019-001 Depleted batteries in intraosseous injectors	05/05/2020	Closed
NatPSA-2019-002 Risk of death and severe harm from ingesting superabsorbent polymer gel granules	01/06/2020	Open
NatPSA-2019-003 Risk of harm to babies and children from coin/button batteries in hearing aids and other hearing devices	11/09/2020	Open
NatPSA-2020-001 Ligature and ligature point risk assessment tools and policies	03/06/2020	Open

3.5 Never Events 2019/20

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

In 2019/20, two incidents occurred which met the definition of a Never Event. Thorough root cause analysis is undertaken for Never Events and robust action plans are developed to prevent a similar occurrence.

The following table gives a description of the two Never Events, their primary root cause, the key recommendations to prevent reoccurrence and the level of patient harm. Patients and / or their families were informed of the subsequent investigations and involved throughout the process.

Table 2: Summary of Never Events during 2019/20

Never Event type	Description of incident and level of harm	Primary root cause	Recommendations
Wrong site surgery – wrong site block (June 2019)	A 14 year old patient was listed and consented to undergo a left open orchidopexy. The patient was given a block into his groin on the right hand side. One of the team realised that the 'Stop before you block' moment had not been completed and that the surgical site had not been exposed and that the block was being administered to the wrong side. The procedure was stopped immediately and the patient then had a site block and procedure performed to the correct side. **Minor Patient Harm**	There was a failure to follow the safer surgery policy in omitting to perform a Stop Before You Block (SBYB) moment.	The Trust's Safer Surgery Committee is asked to review the layout of the safer surgery checklist in relation to the timing and sign-off of the SBYB moment. All Theatre staff are reminded that a Team Brief should be performed after a change of personnel. The SBYB poster is reviewed and then there is a relaunch of the SBYB moment making it clear that this should take place prior to the start of a nerve block procedure i.e.. before the intended site is exposed or cleaned. The revised SBYB poster is displayed in all anaesthetic rooms and ODP procedure rooms where blocks are undertaken Consideration is given to installing information boards outside of anaesthetic rooms for central display of alerts and notifications to minimise written notices on walls inside anaesthetic rooms Patient's undergoing surgery in the genital / groin region should have undergarments completely removed after the patient has been anaesthetised so that surgical site mark is visible before any block or other procedure is undertaken.
Retained foreign object post procedure – retained guidewire (September 2019)	A 2 week old patient with known congenital abnormalities was transferred to the Catheter Lab in order to have a Right Ventricular Outflow Tract (RVOT) stent placed. This procedure required sheathed catheters to be placed in both the femoral vein and pulmonary artery to access the right ventricle of the heart. Two days later an ECHO was undertaken from which it was identified that there appeared to be a foreign body located within the right ventricle of the heart. This was identified to be a retained part of a guidewire. **No Patient Harm**	A generic failure within UHL Catheter Labs to follow local and national guidance in recognising guidewires as accountable items, resulting in an absence of a robust process to account for and check the integrity of guidewires used as part of invasive procedures within the Catheter Labs.	There needs to be appropriate LocSSIPs developed for all procedures that take place within Cath Labs. The UHL 'accountable items' guidance needs to include the confirmation of the integrity of the guidewires, not just the number of guidewires, and any other equipment/items that is/are inserted into a cavity at the end of any procedures.

3.6 NHS Outcome Framework Indicators

Table 3: NHS Outcome Framework Indicators

NHS Outcomes Framework domain	Indicator	2018/19	2019/20	National Average	Highest Score Achieved	Lowest Score Achieved
Preventing people from dying prematurely	SHMI value and banding	99 Oct17 - Sep18 Band 2	95 Jan – Dec 19 Band 2	100 Jan – Dec 19 Band 2	119 Jan – Dec 19 Band 1	68 Jan – Dec 19 Band 3
	% of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (contextual indicator)	27.5% Oct17 - Sep18	31% Jan – Dec 19	36% Jan – Dec 19	60% Jan – Dec 19	10% Jan – Dec 19
Helping people to recover from episodes of ill health or following injury	Patient reported outcome scores for groin hernia surgery	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017
	Patient reported outcome scores for hip replacement surgery (Hip replacement Primary)	NHS digital data not available	NHS digital data not available	NHS digital data not available	NHS digital data not available	NHS digital data not available
	Patient reported outcome scores for knee replacement surgery (Knee replacement Primary)	NHS digital data not available	NHS digital data not available	NHS digital data not available	NHS digital data not available	NHS digital data not available
	Patient reported outcome scores for varicose vein surgery	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017
	% of patients <16 years old readmitted to hospital within 28 days of discharge	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below
	% of patients <16 years old readmitted to hospital within 30 days of discharge*	9.8% Apr18 - Mar19 Source: CHKS	8.8% Apr19 - Mar20 Source: CHKS	NHS digital data not available	NHS digital data not available	NHS digital data not available
	% of patients 16+ years old readmitted to hospital within 28 days of discharge	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below
	% of patients 16+ years old readmitted to hospital within 30 days of discharge*	9.1% Apr18 - Mar19 Source: CHKS	8.9% Apr19-Mar20 Source: CHKS	NHS digital data not available	NHS digital data not available	NHS digital data not available

Table 3: NHS Outcome Framework Indicators (continued)

NHS Outcomes Framework domain	Indicator	2018/19	2019/20	National Average	Highest Score Achieved	Lowest Score Achieved
Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs (Patient experience of hospital care)	67.5 (Jul17)	68.1 (Jul18)	67.2 (Jul18)	85.0 (Jul 18)	58.9 (Jul18)
Treating and caring for people in a safe environment and protecting them from avoidable harm	% of staff who would recommend the provider to friends or family needing care	65% Source: National NHS Staff Survey 2018	67% Source: National NHS Staff Survey 2019	71% Source: National NHS Staff Survey 2019	87% Source: National NHS Staff Survey 2019	40% Source: National NHS Staff Survey 2019
	% of admitted patients risk-assessed for Venous Thromboembolism	95.8% Apr18 - Mar19 Source: UHL	98.1% Apr19 - Feb20 Source: UHL	95.5% Q2 2019-20 (Jul19 - Sep19) Source: NHS England	100% Q2 2019-20 (Jul19 - Sep19) Source: NHS England	71.2% Q2 2019-20 (Jul19 - Sep19) Source: NHS England
	Rate of C. difficile per 100,000 bed days	38.6 Apr18 - Mar19 Source: NHS Digital	20.21 Apr19 - Mar20 Source: UHL data	35.6 Apr18 - Mar19 Source: NHS Digital	168 Apr18 - Mar19 Source: NHS Digital	0.0 Apr18 - Mar19 Source: NHS Digital
	Rate of patient safety incidents per 1000 admissions (IP, OP and A&E)	16.8 Apr18 - Mar19 Source: UHL data	16.6 Apr19 - Mar20 Source: UHL data	21.4 Oct17 - Mar18 Source: NHS Digital	124 Oct17 - Mar18 Source: NHS Digital	0.0 Oct17 - Mar18 Source: NHS Digital
	% of patient safety incidents reported that resulted in severe harm and death	0.1% Oct17 - Mar18 Source: NHS Digital	0.1% Oct18 - Mar19 Source: NHS Digital	0.4% Jan19 - Mar19 Source: NHS Digital	4.3% Oct18 - Mar19 Source: NHS Digital	0.0% Oct18 - Mar19 Source: NHS Digital

*NHS Digital data out of date so alternative national indicator used (30 days readmissions).
Where NHS Digital data is unavailable, alternative data sources (specified) have been used.

Preventing people from dying prematurely

Summary Hospital Level Mortality Indicator (SHMI)

The Summary Hospital Level Mortality Indicator (SHMI) is a measure of mortality developed by the Department of Health. It compares our actual number of deaths with our predicted number of deaths.

For the period January to December 2019, Leicester's Hospitals SHMI was 95. This is in line with the national average.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reason:

Our patient deaths data is submitted to the Secondary Uses Service and is linked to data from the Office for National Statistics death registrations in order to capture deaths which occur outside of hospital.

The University Hospitals of Leicester NHS Trust intends to take the following action to reduce mortality and so improve the quality of its services, by:

- Implementation of our Quality Strategy priorities, specifically:
  - better care pathways with a focus on diabetes in pregnancy and cardiac symptoms
  - streamlined emergency care with a focus on cross site transfers
  - safe and timely discharge with a focus on implementing the ReSPECT process for end of life patients (ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices)
- Sustained use of e-Obs and sepsis clinical rules in Nervecentre (our clinical information system) to support earlier recognition of sepsis
- Embedding the Acute Kidney Injury Alert and Care Bundle and Fluid Balance Assessment and Care Bundle in Nervecentre.

As part of our mortality monitoring and investigations, we continue to make use of our Medical Examiners. At the end of March 2020 our Medical Examiners had screened over 3,000 adult patient records (98% of all adult deaths between April 19 and March 20). 10% of these records were referred for a Structured Judgement Review as part of the Specialty Mortality and Morbidity process and 10% were referred for clinical review by the patient's clinical team for learning and actions.

Helping people to recover from episodes of ill health or following injury

Patient reported outcome scores

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering two clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

The two procedures are:

- hip replacements
- knee replacements

PROMs, which have been collected by all providers of NHS-funded care since April 2009 consists of a series of questions that patients are asked in order to gauge their views on their own health.

For example, patients are asked to score their health before and after surgery. We are then able to understand whether patients see a 'health gain' following surgery. Participation rates and outcome data is published by NHS Digital.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

The latest available PROM's data (April 2018 - March 2019) shows a decrease in patients reporting a worsened pain score post-surgery compared to April 2017 - March 2018:

- A 1.7% decrease in knee replacement (based on the Oxford knee score) and;
- A 1.2% decrease in hip replacement (based on the EQ-5D Index).

Within both pre and post operative surveys Leicester's Hospitals are reporting within a 1% margin from the English average score.

Leicester's Hospitals participation rate for pre-operative questionnaire was 86.2% compared with the national average of 85.9%.

The response rate for post-operative questionnaires was 66.8% compared with the national average of 69.7%.

The University Hospitals of Leicester NHS trust intends to take the following actions to improve the quality of its services:

Leicester's Hospitals will continue to collect PROMs data to help inform future service provision.

The percentage of patients readmitted to hospital within 28 days of discharge

Data for the percentage of patients readmitted to hospital within 28 days of discharge is not available on NHS Digital. Leicester's Hospitals monitors its readmissions within 30 days of discharge.

The data describing the percentage of patients readmitted to hospital within 30 days of discharge is split into two categories: percentage of patients under 16 years old and percentage of patients 16 years and older. This data is collected so that Leicester's Hospitals can understand how many patients that are discharged from hospital, return within one month. This can highlight areas where discharge planning needs to be improved and where Leicester's Hospitals need to work more closely with community providers to ensure patients do not need to return to hospital.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

Data shows that the overall level readmission rate has reduced in patients aged under 16 years in age, but increased in patients aged over 16 years in age.

The University Hospitals of Leicester NHS trust intends to take the following actions to improve the quality of its services:

- Improving communications with GP practices so that they can do more effective patient follow up work
- Working more closely with care homes, including a pharmacist review of any patient discharged with more than eight medicines
- Targeting key areas, including respiratory, to ensure patients with multiple readmissions are flagged for community review by specialist teams
- Readmission/discharge lead identified to work on pilot on Clinical Decisions Unit to prevent multiple admissions/readmissions by frequent attenders
- Making better use of Nervecentre, our electronic clinical information system, to record patients reasons for readmission
- Actively using the developed Standard Operating Procedure for managing patients at high risk of readmission within 30 days (using the PARR30 model).

Ensuring people have a positive experience of care

Responsiveness to inpatients' personal needs

This indicator provides a measure of quality; a composite score is based on five questions taken from the Care Quality Commission national inpatient survey. They are:

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition after you left hospital?

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

- Overall across the five questions Leicester's Hospitals have been successful in sustaining quality of care as measured by feedback from patients. This has been achieved by focused improvement activity in relation to involving patients in decisions about their care and information provision at the point of discharge
- This is illustrated as the question "were you involved as much as you wanted to be in decisions about your care and treatment" has improved for the second year in a row.
- There has also been an improvement of 0.1 in the question "Did a member of staff tell you about medication side effects to watch for when you went home".

The University Hospitals of Leicester NHS Trust intends to take the following actions to improve the quality of its services:

- To ensure that the elements of care that matter most to patients continue to be our focus, Leicester's Hospitals have reviewed the questions asked in the inpatient feedback forms. These now reflect the questions in the National Inpatient Survey. Allowing real time feedback to be available to front line staff, which then can instigate change/improvements
- Feedback forms are available in all wards allowing patients, carers and family members the opportunity to give feedback about their experience of care and any suggestions for improvement
- Clinical teams will be encouraged and supported to review and responding to feedback received, allowing improvements in the experience of patients and families in their care

- Details of improvements made in response to feedback received by the clinical teams are displayed in the clinical areas on "Patient Feedback Driving Excellence" boards
- Details of excellent work that has taken place in response to feedback is showcased in a bi-monthly bulletin, which is circulated throughout Leicester's Hospitals to help to drive improvements in other areas.

Treating and caring for people in a safe environment and protecting them from avoidable harm

Percentage of staff who would recommend the provider to friends or family needing care

The NHS staff survey is one of the largest workforce surveys in the world and has been conducted every year since 2003. It asks NHS staff in England about their experiences of working for their respective NHS organisations.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

- The NHS staff survey asks respondents whether they strongly agree, agree, disagree or strongly disagree with the following statement: "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation"
- The results for this element of the NHS staff survey (67% of respondents said they would be happy with the standard of care) remains unchanged from the previous (2017) NHS staff survey

The University Hospitals of Leicester NHS Trust intends to take the following actions to improve this and so the quality of its services:

- To make more progress Leicester's Hospitals need to do something different. One of the most important aspects of this is having the right culture which is powered by the right leadership behaviours. This will be at the heart of our quality strategy

Venous thromboembolism (VTE)

Assessing inpatients to identify those at increased risk of venous thromboembolism (VTE) is important to help to reduce hospital associated VTE. We work hard to ensure that not only are our patients risk assessed promptly but that any indicated thromboprophylaxis is given reliably.

The University Hospitals of Leicester considers that this data is as described for the following reasons:

- Matrons and lead nurses undertake a monthly review of VTE occurrence as part of the safety thermometer
- VTE risk assessment rates are reviewed by Leicester's Hospital VTE Prevention Task and Finish Group and in our Quality and Performance Report presented to the Quality and Outcomes Committee on a quarterly basis.

The University Hospitals of Leicester has taken the following actions to improve this and so the quality of its services:

- Provided VTE risk assessment rate data to clinical areas and presented to the VTE Prevention Task and Finish Group and Clinical Quality Review Group to highlight where changes to clinical practice where required
- Carried out a VTE Prevention audit which demonstrated we had increased our rates of assessing patients for their risk of a VTE event whilst in hospital and maintained our high performance for subsequent thromboprophylaxis prescribing year on year
- Provided pharmacological and / or mechanical thromboprophylaxis to eligible patients
- Carried out root cause analysis from case notes and electronic patient information systems for all inpatients who experience a potentially hospital associated VTE during their admission or up to 90 days following discharge
- Embedded an electronic VTE risk assessment module within our existing electronic clinical information systems which now allows us to monitor our performance against this NICE quality indicator in real time and effect changes in a timely fashion as needed.
- Revised our patient information for the prevention of VTE both on admission and on discharge. These are available in paper and electronic forms and can also be downloaded via scanning QR codes.

Clostridium Difficile (CDiff)

CDiff is a bacterial infection which can be identified in patients who are staying in hospital.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

- Clostridium difficile numbers are collected as part of alert organism surveillance. Numbers are reported to and collated by Public Health England on behalf of the NHS
- A weekly data set of alert organism surveillance is produced by the infection prevention team within Leicester's Hospital and disseminated widely throughout the organisation.

The University Hospitals of Leicester has taken the following actions to improve this and so the quality of its services:

- The weekly data set is used to inform clinical governance and assurance meetings that take place. Clinical teams are then able to direct the focus of actions and interventions to continue to ensure that infection numbers are as low as possible.

Patient safety incidents

A patient safety incident is an unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

- Patient safety incidents are captured on Leicester's Hospitals patient safety incident reporting system, Datix and are also uploaded to the National Reporting and Learning System (NRLS)
- Moderate, major and death harm incidents are validated by the corporate patient safety team and this process is subject to external audit every other year
- Themes and trends are reported monthly and quarterly to provide a local and national picture of patient safety incidents
- Our top three reported incidents are pressure sores, lack of nursing staff and slips / trips / falls.

The University Hospitals of Leicester NHS Trust has taken the following action to improve the percentage of harm incidents by:

- Having a clear focus on the issues that have caused the most preventable harm to patients as a key focus within our quality priorities
- Actively encouraging a culture of open reporting and widespread sharing of learning from incidents to improve patient safety
- Being open and transparent about our safety work, our incidents and our actions for improvement
- Undertaking a structured programme of work to ensure that we learn and improve and we will continue to work with NHS Improvement, the Healthcare Safety Investigation Branch and other groups to maximise our efforts
- Focusing on culture and leadership as well as supporting national, system-wide barriers to reducing harm events

An annual patient safety report is produced each summer and is available on Leicester's Hospitals website.

3.7 Learning from deaths

During Quarters 1 to 4 in 2019/20, 3,332 patients were part of the Learning from Deaths process within Leicester's Hospitals, as follows:

Table 4: Number of deaths included in the Learning from Deaths process in 2019/20	
Time period	Number of deaths
April 2019 to end December 2019	3,332
Q1	768
Q2	748
Q3	880
Q4	936

By the end of December 2019, 188 case record reviews and 10 investigations were carried out in relation to the 2,395 deaths. In eight cases, a death was subject to both a case record review and an investigation.

Table 5: Number of case record reviews during 2019/20	
Time period of death	Deaths Reviewed or Investigated (as at end of May 2020
April 19 to March 2020	257
Q1	93
Q2	84
Q3	56 to date
Q4	24 to date

9 (0.27% of 3,332) deaths reviewed or investigated (as at the end of May 2020) were judged 'to be more likely than not to have been due to problems in care provided to the patient'. All were investigated confirmed to be a serious incident. This consisted of:

Table 6: Number of deaths reviewed or investigated during 2019/20 (to date) and judged to be more likely than not to have been due to problems in the care provided to the patient	
Time Period	Deaths reviewed or investigated and judged to be more likely than not to have been due to problems in the care provided to the patient (% of all deaths in that period)
Q1	4 (0.52%)
Q2	2 (0.27%) Data not yet complete
Q3	3 (0.34%) Data not yet complete
Q4	Data not yet available

16 (0.67% of 2,395) deaths were found to have problems in care but these were considered unlikely to have contributed to the death.

These numbers have been calculated by undertaking a case record review using the national Structured Judgement Review template and the University Hospitals of Leicester NHS Trust death classification criteria or an investigation using the Serious Incident Framework.

Learning identified through our case record reviews, has included:

- Need for electronic transfer of ECG recordings between Ambulance crews and Coronary Care Unit (CCU) and the Emergency Department and CCU
- Recognition of bowel obstruction post operatively
- Timeliness of Lymphoma diagnosis
- Interpretation of growth charts and scheduling of ante natal scans
- Diabetes management during pregnancy
- The importance of good communication with both patients and relatives about prognosis and management plans.

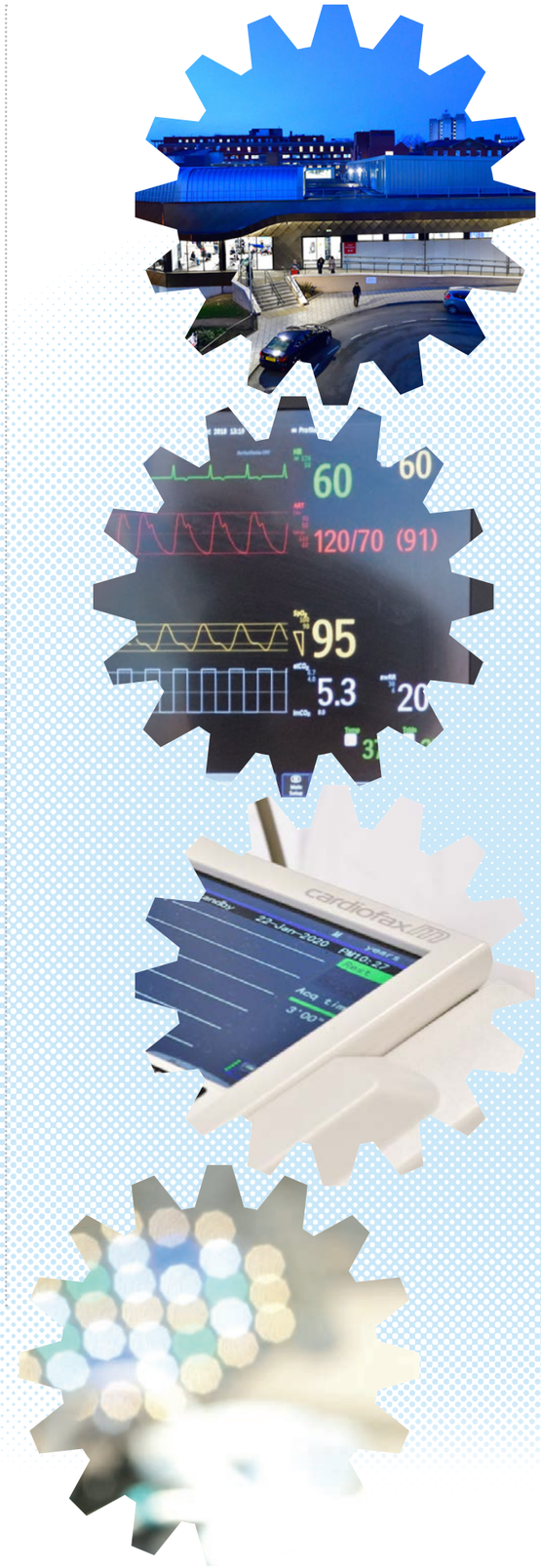
In most of the cases reviewed, actions were around raising awareness and disseminating the lessons learnt to clinical teams. The other key action has been to further embed use of assessments and care bundles and transmission of ECG recordings in Nervecentre.

Our Mortality Review Committee reviews the themes from our case record reviews and ensures that we have the appropriate work streams in place to take forward lessons learned. The Mortality Review Committee will assess the impact of actions taken to in response to lessons learnt from case record reviews.

439 deaths were subject to case record reviews as part of specialty mortality and morbidity review in 2018/19.

143 case record reviews and investigations were completed after 2018/19 which related to deaths which took place before the start of the reporting period.

Following the completion of these additional 143 case record reviews, there were in total, eight out of 3,340 deaths in 2018/19 (0.24%) which were considered to be more likely than not, to have been due to problems in care. All of these eight cases were investigated by the patient safety team.



3.8 Seven day hospital services

The seven day service national survey covers the management of patients admitted as an emergency, measured against the four priority standards.

Priority Clinical Standards			
Standard 2 Time to Consultant Review	**Standard 5** Diagnostics	**Standard 6** Consultant directed interventions	**Standard 8** On-going daily consultant-directed review
All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital	Hospital inpatients must have scheduled seven-day access to consultant-directed diagnostic tests and completed reporting will be available seven days a week: - Within 1 hour for critical patients - Within 12 hours for urgent patients	Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols	All patient with high-dependency needs should be reviewed twice daily by a consultant and all other inpatients should be reviewed by a consultant once daily seven days a week, unless it has been determined that this would not affect the patient's care pathway

Progress towards standards is measured twice a year through a 7 Day Service Self Assessment tool. All acute NHS provider trusts undertake and submit a sample of case notes reviews for standards 2 and 8 across a seven day period and complete a self assessment for standards 5 and 6.

We have completed 2 clinical note audits based on Clinical Standards 2 and 8 during the past year the results of which were presented at our Quality and Performance Board and subsequently at our Quality and Outcomes Committee with learning shared with the services.

Although we still face challenges in achieving these standards we have either maintained our previous performance or shown improvement overall year on year.

Of note we have improved our respiratory medicine performance against standard 2.

We have embedded our processes for monitoring our performance against the 7 day services standard through the new Board Assurance Framework

We continue to face challenges in achieving these standards, however benchmarking across the East Midlands and across the country show that we are well within national and regional parameters.

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3.9 Performance against national standards

Indicators

ED 4 hour wait and ambulance handovers

Table 7: Performance against the ED targets			
Performance Indicator	Target	2019/20	2018/19
ED 4 Hour Waits UHL	95%	69.2%	77.0%
ED 4 Hour Waits UHL + LLR UCC (Type 3)	95%	78.8%	83.2%

Key: Green = Target Achieved Red = Target Failed

The emergency department provides an integrated front door approach for all patients whether as an acute emergency arriving by ambulance, self-referrals or by NHS111. There are separate facilities for adults and paediatrics (children).

The adult emergency department is comprised of a 12 bedded emergency room, 32 individual major bays, 4 of which have been designed for those with mental health needs or living with dementia, in addition there are 11 ambulance assessment cubicles in the ambulance assessment area with separate entrance and eight triage rooms. There is room for 13 ambulances to attend the department at any one time.

The paediatric ED comprises of 10 major areas (including three high dependency areas), four primary care rooms, five streaming rooms and six minor injury rooms.

In addition to the ambulance assessment area, the emergency department has expanded into a purpose-built pod where patients are dropped off by ambulances when the department is full and are cared for by ambulance staff.

The aim of the pod is to allow ambulances to get back out onto the road to attend emergencies as quickly as possible. The pod is staffed by NHS paramedics and ambulance technicians.

There have been significant challenges all year with providing timely care at the Leicester Hospital's emergency department. Leicester's Hospitals have not met the target to treat and discharge a minimum of 95% of patients within four hours.

Despite the high number of patients in the department at any one time we have strived to meet the urgent care standards but the increased demand for emergency care has inevitably put additional pressure on the ability to deliver a consistently high standard of care for patients.

We continue to work with partners across Leicester, Leicestershire and Rutland to improve our emergency performance and the quality of care provided on the emergency care pathway.

Review of Quality Performance

Referral to treatment (RTT)

The RTT incompletes standard measures the percentage of patients actively waiting for treatment. The RTT target was not achieved in 2019/20.

Planning guidance for 2019/20 sets out the expectation that providers will achieve a smaller waiting list size at the end of March 2020 than March 2019. Changes to national pension contribution resulted in a 25.9% reduction in non-contracted sessions. This, alongside increased emergency demand over winter, resulted in reduced capacity with Leicester's Hospitals not achieving the planning guidance target.

The impact of winter and pension change was also felt in the number of patients waiting over 40 weeks for treatment. Through strong operational processes we were able to avoid any patients breaching the 52 week standard for treatment. This remains a key quality standard nationally and will remain priority for us throughout 2020/21.

The factors that have impacted on our ability to deliver the 92% standard are:

- Changes to national pension contribution resulted in a reduction in capacity. 297 fewer non contracted sessions were completed per month (25.9%) across all jobs roles. The impact was particularly felt within the surgical workforce who committed to 179 (31.8%) fewer non contracted sessions per month
- High demand for emergency medical beds above led to an increase in medical outliers across surgical beds over winter
- A further 7.5% increase in two week wait referrals, after a 15.5% increase in 2018/19 resulting in capacity being moved from routine Referral to Treatment patients at longer waits to potential cancer patients at shorter waits
- Available financial resources within Leicester, Leicestershire and Rutland to support treatment for patients.

Although the number of patients waiting over 18 weeks has increased year on year, our focus remains treating the most clinically urgent and longest waiting patients.

We continue to have capacity constraints within some key services, notably adult and paediatric ENT, General Surgery, Urology and Orthopaedics. This is being addressed by reviewing and improving efficiency within these services and working closely with commissioners to reduce demand.

Table 8: Performance against the referral to treatment

Performance Indicator	Target	2019/20	2018/19
RTT - incomplete 92% in 18 weeks	92%	76.5%	84.7%
RTT - waiting list size	2019/20 – 64,404 2018/19 – 64,751	64,559	64,506

Key: Green = Target Achieved Red = Target Failed

Winter care

In the Winter of 2019/20, in common with many other acute trusts, Leicester's Hospitals experienced compromised emergency department performance, increased numbers of patients in hospital for over seven days and high levels of occupancy (the number of beds filled). Despite the high demand on our hospital beds we ensured that over the winter months our patients were safe and received treatment as quickly as possible.

Having modelled the shortfall in beds against the predicted demand for 2020/21 we will be keeping our winter extra capacity beds open throughout the year in order to mitigate the shortfall in beds.

Winter planning for 2020/21 has already started and we will:

- Ensure that our plan addresses both the physical and mental health needs of our patients
- Ensure we have robust efficiency plans in place to decrease bed occupancy and facilitate flow
- Develop a system wide plan for winter which includes social care, primary care and community care
- Ensure robust staffing over holiday periods
- Ensure realistic phasing of elective activity throughout the year to decrease the risk of cancellations
- Ensure that our most urgent and cancer patients are not cancelled due to non-clinical reasons
- Ensure that Red2Green (a process for minimising both internal and external delays for patients) is as effective as possible, reducing occupancy prior to winter
- Ensure that long stay patients are kept to a minimum throughout the year and especially over winter
- Ensure robust planning and management of infectious diseases throughout the year and over the winter months when incidence is higher.

Cancelled operations and patients rebooked within 28 days

Cancelled operations in quarter 1 for 2019/20 outperformed the previous financial year. Unfortunately from quarter 2 Leicester's Hospitals experienced an increase in capacity related cancellations due to higher levels of emergency patients reducing the availability of surgical beds for elective surgery.

The increase in cancellations also regrettably lead to an increase in the number of patients not offered a date within 28 days of a cancellation. Available capacity is prioritised with, clinically urgent, cancer and longest waiting patients and this sometimes means we are unable to re-book a patient within 28 days of their cancellation.

Increased competing pressures on available theatre capacity with clinically urgent patients, patients on a cancer pathway and long waiters means Leicester's Hospitals will continue to struggle to meet this target of zero.

Our Surgical Care Program will continue to work on reducing short notice cancellations for patients. This will also have a positive impact on our 28 day performance indicator.

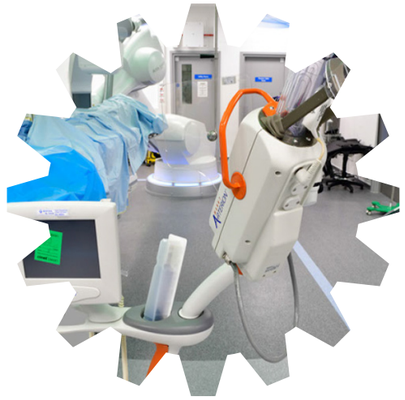


Table 9: Performance against the cancelled operations targets

Performance Indicator	Target	2019/20	2018/19
Cancelled operations	1.0%	1.3%	1.1%
Patients cancelled and not offered another date within 28 days	0	353	248

Key: Green = Target Achieved Red = Target Failed

Diagnostics

Leicester's Hospitals maintained a steady performance against the routine six week to scan target throughout 2019. However, due to increased demand and unplanned machine downtime in the first quarter of 2020, Leicester's Hospitals failed to meet the year-end target of 1% for diagnostic wait times.

Table 10: Performance against the diagnostic waiting times target

Performance Indicator	Target	2019/20	2018/19
Diagnostic Test Waiting Times	1.0%	4.6%	0.9%

Key: Green = Target Achieved Red = Target Failed

Cancer targets

In 2019 / 20 we saw an increase in referrals to cancer across all the tumour sites; this is good news as an increase in referral rate enables us to diagnose and treat cancer much quicker. There are national challenges in Urology capacity, Oncology staffing and regionally in robotic provision and we are working to manage this both internally and with regional teams. Despite the growth in referrals, we have seen the performance targets remain relatively stable.

20/21 brings the new Faster Diagnosis Standard for cancer (FDS) where patients referred on a cancer pathway must be told if they have cancer or not by day 28. This will ensure earlier communication to patients during a worrying time and enable next steps to enable treatment to occur quicker.

In 2019/ 20 we progressed the optimal lung pathway work and the rapid prostate pathway; both are now fully embedded and we are seeing better access and faster diagnosis a s a result. We are awaiting the funding allocation for 20/21 once received this will enable further transformational work.

For those cancer standards that are not being met, Leicester's Hospitals has agreed a cancer recovery plan with commissioners. This has resulted in some clear signs of improvement that will continue into 2020/21.

Table 11: Performance against the cancer targets

Performance Indicator	Target	2019/20	2018/19
Cancer: 2 week wait from referral to date first seen - all cancers	93%	93.0%	92.3%
Cancer: 2 week wait from referral to date first seen, for symptomatic breast patients	93%	95.9%	79.3%
All Cancers: 31-day wait from diagnosis to first treatment	96%	92.8%	95.2%
All Cancers: 31-day for second or subsequent treatment - anti cancer drug treatments	98%	99.6%	99.6%
All Cancers: 31-day wait for second or subsequent treatment - surgery	94%	81.1%	86.1%
All Cancers: 31-day wait for second or subsequent cancer treatment - radiotherapy treatments	94%	87.1%	97.9%
All Cancers: 62-day wait for first treatment from urgent GP referral	85%	73.6%	75.2%
All Cancers: 62-day wait for first treatment from consultant screening service referral	90%	84.0%	82.3%

Key: Green = Target Achieved Red = Target Failed

MRSA

In 2018/19 there were 5 Meticillin Resistant Staphylococcus aureus (MRSA) blood stream infections reported, against a trajectory of zero avoidable cases. All 5 cases were deemed un-avoidable.

A Post-Infection Review (PIR) of all patients who have a Trust or non-Trust apportioned MRSA identified is undertaken. This is in accordance with the standard national process and involves a multiagency review of the patients care to determine if there have been any lapses of care which would have contributed to the infection and where lessons maybe learned to prevent further occurrence.

Table 12: Performance against the MRSA targets

Performance Indicator	Target	2019/20	2018/19
MRSA (All)	0	5	3

Key: Green = Target Achieved Red = Target Failed

Pressure ulcers

Leicester's Hospitals are committed to reducing year on year the number of pressure ulcers that occur in our hospitals. This year we changed our approach to reviewing hospital acquired pressure ulcers to ensure that any learning from patient incidents is shared.

Through this scrutiny and challenge process Leicester's Hospitals have seen a year on year reduction in the number of avoidable pressure ulcers.

This year we introduced a number of initiatives to improve care, including:

- Reviewing our approach to pressure ulcer validation , to ensure that all reported hospital acquired pressure ulcers are formally reviewed
- The celebration of national pressure ulcer day to raise awareness of strategies to prevent pressure ulcers, using a twitter campaign and local ward events
- Providing detailed analysis of all hospital acquired pressure ulcers, and aligning reporting in line with national guidance from NHS Improvement

Table 13: Performance against the pressure ulcer targets

Performance Indicator	Target	2019/20	2018/19
Pressure ulcers category 4	0	0	0
Pressure ulcers category 3	27	4	7
Pressure ulcers category 2	84	61	62

Key: Green = Target Achieved Red = Target Failed

3.10 Mental Health

We are seeing an increasing number of patients attending our hospitals with either a primary or secondary mental health problem. We have a responsibility for ensuring that all patients seen at Leicester's Hospitals have access to the right treatment at the right time with the right healthcare professionals.

The number of referrals for a mental health assessment in the emergency department has continued to increase.

The process for referring for a mental health assessment is well established in the emergency department. A new service mode, jointly developed with Leicester Partnership Trust to deliver the Core 24 service standard, will commence in the Spring / Summer of 2020.

Funding for the service, which will be based at the Leicester Royal Infirmary site will enable the recruitment of additional Consultant Psychiatrist posts (providing clinical leadership for the service, strengthening the interface with the acute hospital, supporting the training and education function and providing dedicated medical cover for the ED) and well as additional mental health practitioners. Mental health support in the Emergency Department will be modelled on three staff per shift over a 24 hour period, to ensure sufficient capacity to provide a one hour response time.

Patient experience

benefits of the Core 24 liaison mental health service include:

- Swift and compassionate assessment of mental health needs for patients presenting with mental health problems (in the Emergency Department or hospital wards)
- A reduction in inappropriate general hospital inpatient admissions
- Improved discharge planning and coordination
- Shorter lengths of stay and reduced general hospital re-admissions
- Signposting to other appropriate services

Clinical effectiveness

benefits of the Core 24 liaison mental health service include:

- The ability to assess patients quickly, establish their needs and develop appropriate intervention plans
- Improvements in physical healthcare outcomes through the provision of NICE recommended psychosocial brief interventions and where needed, outpatient follow up appointments
- Increased capacity to work with the Emergency Department Integrated Discharge Team Frequent Attender Nurse to address mental health comorbidities and socio-economic problems
- Increased level of education and training, increasing the range of skills and expertise

Improvements are being made to our electronic systems used to collect data and monitor outcomes, with a focus on shared access to patient records across the system with our partner organisations.

We have developed a training pack to support the roll-out of our recently reviewed ligature risk assessment policy and procedures.

The delivery of mental health care within Leicester's Hospitals is monitored by our mental health steering group, which reports to our Quality and Outcomes Committee.

3.11 Equality & diversity

Our refreshed equality, diversity and inclusion (EDI) strategic plan has a clear focus on disability, gender, race and lesbian, gay, bisexual, transgender / transsexual and other groups (LGBT+) and is based upon:

- Outstanding health outcomes and experiences for all our patients, regardless of their social background
- A diverse, talented and high performing workforce
- An inclusive, accessible and civil culture

We are developing our evidence base for change and evaluating where there are differential outcomes for patients and staff.

We have worked with a wide range of both internal and external colleagues to develop the objectives and actions which underpin our plan including:

- Identifying EDI champions at Trust Board level
- Ensuring all of our leaders have an EDI objective in their annual appraisal
- Embedding EDI into our leadership and management development
- Evaluating lessons learned from our Reverse Mentoring Programme
- Designing and developing an Equality Analysis Framework
- Developing an Active Bystander Programme to promote an inclusive and compassionate culture and to address inappropriate and unacceptable behaviours
- Developing our staff network to include gender and LGBT+ representation
- Developing a communication and engagement strategy to support the implementation of EDI activity across Leicester's hospitals
- Holding an EDI conference, covering all aspects of equality
- Ensuring our workforce race equality standard (WRES) and workforce disability equality standard (WDES) action plans underpin our EDI strategic plan

Key Achievements in 2019/20

- The successful rollout of cohort 1 of our reverse mentoring programme
- The establishment of a local 'stepping up' programme
- A pilot of 'dignity gowns' in partnership with the local community
- The implementation of Trans inclusion policies for patients and staff
- Achieved "Good" in the CQC's Well-Led review where our EDI work was commended
- Completed the National NHS Employers Partners EDI Programme (year 1&2)
- Launched the cultural ambassadors programme
- Provided EDI training for all of our Improvement Agents

Interpreting and Translation Service

Our written patient information asks patients, their relatives or carers to contact Leicester's hospitals if information is required in a different language or format. This guidance is written in the top five languages as well as English.

If a leaflet cannot be translated in time for an appointment, the patient will be offered an interpreter to translate the leaflet.

Key actions for 2020/2021 include:

- Exploring best practice from other Trusts
- Raising awareness with staff in how to use the interpreting and translation service
- Work with our interpreting and translating provider to deliver training in the use of translation services
- Including a specific objective for translation services in the EDI strategic plan.

3.12 Patient and public perspective

Information for public and patients

We produce a quarterly magazine called 'Together' for staff, our members and the general public. In this, we share news, research, innovations, information and opportunities to get involved, from across our hospitals.

Our communications team manages several social media accounts such as Twitter, Facebook, Vimeo, Instagram and YouTube, which we use to share information, images and advice. We respond to issues / concerns raised by members of the public through these forums as well as responding to comments posted on NHS Choices and Patient Opinion about our services.

Our public website (www.leicestershospitals.nhs.uk) provides patients and visitors with information about our hospitals and services. We regularly issue press releases about good news and interesting developments within our hospitals, along with 'news alerts' for those who have signed up to receive notifications.

Patient and public involvement strategy

Our patient and public involvement strategy sets out the ways in which Leicester's hospitals:

- Communicates and engages with stakeholders
- Involves patients and the wider community in service development
- Is working to achieve high quality stakeholder, patient and public involvement

Our patient and public involvement strategy is regularly refreshed and was reviewed in June 2019 to ensure that it aligns closely with our Quality Strategy.

Our patient and public involvement strategy sets out our journey to greater co-production of our services and describes how we work with our patients to ensure that their voice remains at the centre of what we do. It also sets out our growing programme of community engagement and relationship building with other local stakeholders.

Our patient and public involvement strategy describes how we work with our Patient Partners to ensure that the patient voice remains at the centre of what we do. It also sets out our programme of community engagement and relationship building with other stakeholders.

Patient Partners

Patient Partners – Comments by Martin Caple, Chair, Patient Partner Group

"Within Leicester's Hospitals the patient voice is mainly represented through Patient Partners who are members of the public selected to provide an independent lay perspective on the work within the hospitals. We are involved and consulted at all stages of the patient journey in Leicester's Hospitals and interact with all levels of staff. As individuals we provide feedback and work with staff to address patient matters whilst at the same time sharing our collective thoughts and concerns with senior managers at our regular bi-monthly meetings. There are now 16 people fulfilling this role from a diverse range of backgrounds and experiences.

Following an evaluation and review of the role of Patient Partner the emphasis has changed in what we do. From being attached to Clinical Management Groups (CMGs) it was decided that most of our work should be aligned to the Trust's Quality Strategy and its key Priorities whilst still being involved in initiatives that enhance the patient experience. Indeed patient and public involvement is at the heart of the Quality Strategy and the Trust Board's aspiration is for there to be "co-production" with patient groups and the public on key issues in the future. Whilst this transition in our role has been slow in its implementation there has been some initial involvement with the Quality Priorities and other important and relevant work has taken place on CMGs and across the Trust in the past year.

Our work and role in the past year includes the following main activities:

- Three Patient Partners are members of the Trust's Quality Outcomes Committee
- Two Patient Partners sit on an Independent Complaints Review Panel reviewing completed complaints files
- Involvement in a streamlined emergency care initiative
- Membership of a Leicester's Hospitals Dementia Board
- Advising on end of life care within the Trust
- Sitting on a Neurology Task and Finish Group
- Learning Difficulties Support Group
- Membership of mental health forums
- Membership of several strategic committees, including Safeguarding, Pharmacy, Adverse Events, a Safe and Timely Discharge Collaborative and Nutrition and Hydration
- Undertaking patient surveys
- Involved in serious incident review panels
- One Patient Partner has been involved in a national patient safety strategy giving feedback from a local perspective
- Advise on new projects and building developments
- Improved facilities for patients in the Emergency Department
- Facilitation of patient user events where patients and relatives share their experiences and give feedback to doctors and nurses
- Independent assessments of clinical areas

This list of activities is not exhaustive but demonstrates our involvement in a wide breadth of health issues ensuring the patient voice and viewpoint is heard and actions are taken accordingly. The outcomes and positive benefits emanating from these activities varies in each case. The latter 3 activities listed above are good examples of where Patient Partners make a significant difference.

In the Emergency Department comments and complaints were received from patients regarding the lack of information, availability of drinks, wi fi access and inadequate signage. As a result a Patient Partner, in conjunction with a Doctor, spoke to 150 patients over a 4 week period about the issues and ensured changes were made including: improved signage, posters indicating free wi fi, the provision of a Housekeeper with a drinks trolley when the vending machine was out of order and a revised seating arrangement so everyone could see the screens. Feedback from patients after 4 weeks of the new arrangements was 100% positive.

Patient User Events are regularly held involving former Intensive Care Unit patients across all 3 hospitals. Patient Partners facilitate such events, also attended by Doctors and nurses, and feedback is received from the patients and relatives in relation to their stay in hospital, where discharge arrangements and prescriptions delays are often at the forefront. Action plans for improvements are then made. These events also provide an opportunity for patients to extend their gratitude to staff for their care.

Another example of where the patient experience has been improved in 2019 stems from independent assessments of clinical areas by Patient Partners with staff. Such assessments, based on a national initiative called the "15 Steps Challenge", (the first 15 steps being considered to be a good indication of the general area), were conducted in all 3 Intensive Care Units and Theatres. Looking at these areas in a fresh objective manner highlighted any shortcomings from a patient perspective. The outcomes were improved waiting areas, less clutter, improved posters, signage and information all benefiting patients and visitors.

As a group our main concerns and priorities which we have brought to the attention of the Board this year are:

- Patient communication
- Cancer performance targets
- Cancelled operations
- Timely and safe discharge arrangements
- End of Life Care
- Patient food and nutrition
- Nursing staffing levels

The approval of £450 million from Central Government for several key reconfiguration projects, including a new Children's Hospital and Maternity Unit, was warmly welcomed by everyone and demonstrates a vote of confidence in the Board and senior management. The recently published report of the Care Quality Commission showing the outcome of their 2019 review was also very encouraging with the overall rating of "Good" a boost for both staff, patients and the public alike.

At the time of writing this report, (in March 2020), the main concern and emphasis was on the coronavirus which is having such dramatic effects on everyone with the NHS being at the forefront. The steps being taken in the Trust and the increased pressures on staff in Leicester's hospitals are immense. As Patient Partners we see at first hand the planning and diligence of all staff at this difficult time and we are extremely grateful and supportive of their efforts. We have every faith in the leadership and commitment of all staff to deal with and overcome these challenges.

With regard to the future it is hoped that the profile and role of Patient Partners and wider patient and public engagement is enhanced further and they become key components of not only the Quality Strategy but all key activities in the Leicester Hospitals. By doing that true "co-production" will become more of a reality.

Martin Caple
20th March, 2020

Community engagement

As part of a programme of community engagement, Leicester's Hospitals run quarterly "Community Conversations" events. The aim of these events is to enable Trust Board members to be more visible in the local community, to listen to a diverse range of views on our services and promote and publicise the work of our Hospitals. These events are held in a variety of different community venues across Leicester, Leicestershire and Rutland. Most recently we held a successful event with Leicester's Somali community. During the event our Chairman and other members of the Trust Board heard first-hand about how the community felt about their hospital experience.

Patient feedback

Leicester's Hospitals actively seek feedback from patients, family members and carers. This feedback is used to help develop services and in turn the overall experience of our patients and visitors to our hospitals.

Clinical areas display "Patient Feedback Driving Excellence" boards which highlight actions that have been taken in the area in response to the feedback; this can be suggestions for improvement or how positive feedback has been shared.

Feedback is collected from patients, family members and carers using various methods including:

- Patient experience feedback forms, both paper and electronic
- Family, Carers and Friends feedback forms, both paper and electronic
- SMS/texts sent to patients who attend outpatient appointments
- Recorded patient stories
- Community conversations, conducted by the Engagement Team
- Volunteer surveys
- Message to Matron cards
- NHS Choices / Patient Opinion
- Compliments and complaints provided to the Patient Information and Liaison Service (PILS)
- Leicester's Hospitals website.

Friends and Family Test

The Friends and Family Test is a nationally set question that is asked in all NHS Hospitals.

The Friends and Family Test is used across all clinical areas in Leicester's Hospitals allowing patient led services. The response to this question from patients is monitored at ward/department level in real time enabling feedback from patients to guide improvements.

Leicester's Hospitals have set a minimal target to achieve a recommended score in the Friends and Family Test of 96% recommend across all inpatient and day case services which has been achieved continually during 2019-20 and this has been above the national average for 2019-20.

This is a similar picture in outpatients services with Leicester's Hospitals achieving a Friends and Family Test score above its set target of 94% recommend for the year which is also above the national average for the same period.

There are various methods adopted within Leicester's Hospitals to collect the Friends and Family Test feedback, this includes paper feedback forms in the inpatient and day case areas, electronic devices in some clinical areas and outpatients and an SMS / texting service which is available for patients who have attended outpatient appointments. The SMS / texting service and our website give patients and family members the opportunity to give feedback when they have left the hospital.

To ensure inclusivity, the feedback forms are available in an easy read format and also in the top three spoken languages in Leicester, Leicestershire and Rutland; Gujarati, Punjabi and Polish.

Leicester's Hospitals actively seeks feedback from family members, carers and friends. There is a form designated for them to complete, to give their views and to rate their experience which is available in the ward areas.

During 2018 NHS England has conducted an extensive period of engagement and has announced that the question will be changing nationally from 1st April 2020 to the following question:

"Thinking about our ward...

Overall how was your experience of our service?"

It is felt that this question is more appropriate to the hospital setting and easier for patients and their families to answer, than the present question, which asked if they would recommend the ward to family and friends.

The Friends & Family Test

There continues to be six options for the respondent to choose, these however have also changed and range from very good to very bad. Leicester's Hospitals have chosen the following question to give the respondent the opportunity to explain why they have given their answer:

"Please tell us why you gave this answer and anything we could have done better"

The timing of the question is also changing; traditionally patients and their families were given the opportunity to give feedback about their care on discharge from hospital or following their appointment. The new guidance advises that feedback can be given at any time and as often as patients and their families wish to do so.

Leicester's Hospitals are preparing for these changes to ensure that all processes are ready for the national launch on 1st April 2020.

Patient Information and Liaison Service (PILS)

Feedback from our patients, their families and carers gives us a valuable opportunity to review our services and make improvements. The Patient Information and Liaison Service is an integral part of the corporate patient safety team. The PILS service acts as a single point of contact for members of the public who wish to raise complaints, concerns, compliments or have a request for information.

The service is responsible for coordinating the process and managing the responses once the investigations and updates are received from relevant services or individuals. They are contactable by a free phone telephone number, email, website, in writing or in person.

Table 14: PILS activity (formal complaints, verbal complaints, requests for information and concerns) by financial year - April 2015 to February 2020

	2016/17	2017/18	2018/19	2019/20
Formal complaints	1574	1467	1886	2260
Verbal complaints	439	321	143	118
Requests for information	2205	2440	2002	1662
Concern (excludes CCG & GP)	4218	4228	4031	4040
Total	**9% increase**	**0.2% increase**	**4.7% decrease**	**0.2% increase**
% change of total against previous year	**1574**	**1467**	**1886**	**2260**

Learning from complaints

Leicester's Hospitals Patient Information and Liaison Service (PILS) administer all formal complaints and concerns. Between April 2019 and March 2020 we received 2,536 formal complaints and 1,680 concerns.

Leicester's Hospitals achieved 77%, 76% and 67% for the 10, 25 and 45 day formal complaints performance respectively.

The most frequent primary complaints themes are Medical care, Appointment issues and Waiting times.

Complaints are a vital source of information about the views of our patients, families and carers about the quality of our services and standards of our care. We are keen to listen, learn and improve using feedback from the public, HealthWatch, feedback from our local GPs and also from national reports published by the Local Government and Parliamentary Health Service Ombudsman.

We have continued to work collaboratively with commissioners and primary care on the transferring care safely process and the management of GP concerns. This year we have seen a 17.2% decrease in GP concerns, the process is now embedded across the clinical commissioning groups with good engagement from the majority of GP Practices.

The most frequent GP concern themes are related to inaccurate discharge summaries and requests for GPs to undertake tasks that are not appropriate.

The Transferring Care Safely Board has reviewed the consultant to consultant policy and an updated version of this will be circulated to Leicester's Hospital's consultant body. It is the hope that with the circulation of the updated policy the prevalence of these themes will decrease.

Learning from complaints takes place at a number of levels. The service, department or specialty identifies any immediate learning and actions that can be taken locally.

A bi-annual report identifies themes, trends and suggestions for improvement based on a variety of feedback (complaints, friends and family test, social media, Patient Choices etc). This report is discussed at our Patient Involvement and Patient Experience Assurance Committee, Executive Quality Board and Quality Outcomes Committee.

Complaint data is triangulated with other information such as incidents, serious incidents, freedom to speak up data, inquest conclusions and claims information to ensure a full picture of emerging and persistent issues is recognised and described. This is undertaken in part at the Adverse Event Committee. Learning from complaints is shared with staff at a variety of meetings and is built into our safety and complaint training.

Many of the actions identified from complaints form part of wider programmes of work such as in our quality priorities and the safe and timely discharge work stream.

An annual complaints report is produced each summer and is available on Leicester's Hospitals website.

Table 15: Number of GP concerns by financial year

Year	Number of GP Concerns
2017/18	592
2018/19	1,275
2019/20	1,106

Reopened complaints

Table 16: Number of formal complaints received and number reopened by quarter April 2017 to March 2020

	Formal complaints received	Formal complaints reopened	% resolved at first response
2017/18 Q1	394	46	88%
2017/18 Q2	483	51	89%
2017/18 Q3	491	33	93%
2017/18 Q4	518	68	87%
2018/19 Q1	533	42	92%
2018/19 Q2	587	49	92%
2018/19 Q3	551	63	89%
2018/19 Q4	589	69	88%
2019/20 Q1	620	71	89%
2019/20 Q2	645	75	88%
2019/20 Q3	660	82	88%
2019/20 Q4	611	50	92%
Total	**6,682**	**699**	**90%**

Improving complaint handling

Throughout 2019/20, Leicester's Hospitals continued to participate in the Independent Complaints Review Panel process.

This panel reviews a sample of complaints and reports back on what was handled well and what could have been done better.

This feedback which is used for reflection and learning included:

- Complaints handling overall in line with NHS Complaints regulations and meetings are offered to complainants where appropriate
- There is a need to reduce the amount of medical jargon used. The PILS team are encouraged to mirror the language and terminology used by the complainant to provide the most appropriately worded responses
- Responses do not consistently include actions/ improvements that will be taken as a result of the complaint.

This year to improve our complaints process and handling of cases we have:

- Updated our PILS patient information leaflet
- Started work on revising the consent element within the complaints process in line with best practice and national guidance.
- Started work to develop an electronic complaint satisfaction survey
- Been part of the Early Dispute Resolution pilot programme with the Parliamentary Health Service Ombudsman
- Developed and finalised our complaints intermediate training programme.

In 2020/21, we will:

- Implement the electronic complaint satisfaction survey
- Launch and promote our Complaints Intermediate Training Programme
- Implement the revised consent element within the complaints process in line with best practice and national guidance.

Continue to collaborate on the Early Dispute Resolution pilot programme with the Parliamentary Health Service Ombudsman

Parliamentary Health Service Ombudsman

This year we have again had less investigated and less upheld cases by the Parliamentary Health Service Ombudsman, further details are provided below.

Table 17: Parliamentary Health Service Ombudsman complaints - April 2016 to March 2020

	2016/17	2017/18	2018/19	2019/20	Total
Awaiting outcome validation	0	0	0	1	**1**
Enquiry only - no investigation	0	0	1	0	**1**
Investigated - not upheld	3	6	4	0	**13**
Investigated - partially upheld	2	2	4	2	**10**
Investigated - upheld	1	0	0	0	**1**
Total	**6**	**8**	**9**	**3**	**26**

3.13 Staff perspective

Staff survey results

In 2019 12% of Leicester's Hospitals staff reported that they had experienced harassment, bullying or abuse at work from managers in the last 12 months (compared to 13.1% nationally). This compares with a score of 13.7% in 2018.

In 2019 19.4% of Leicester's Hospitals staff reported that they had experienced harassment, bullying or abuse at work from other colleagues in the last 12 months (compared to 20.3% nationally). This compares with a score of 21.7% in 2018.

In 2019 81.7% of staff reported that they believed that Leicester's Hospitals believes that the organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age (compared to 84.4% nationally). This compares with a score of 81.1% in 2018.

Freedom to Speak Up Guardian

The Freedom to Speak up role at Leicester's Hospitals has been in place since February 2017, providing a confidential service to support staff in 'speaking up' and raising patient safety concerns. There are different avenues that staff can access to raise confidential concerns. Listening to staff is a priority of the service which ultimately leads to an improved patient safety culture and better staff engagement.

Avenues for reporting staff concerns are as follows:

- 3636 confidential telephone line
- Freedom to Speak up mailbox
- Freedom to Speak Up Guardian's telephone number
- Junior Doctor Gripe tool
- Anti-bullying and Harassment Service
- Counter Fraud Management Services
- CQC.

There are three main ways that staff at Leicester's Hospitals can raise concerns:

3636

3636 is a confidential telephone line that enables a staff member to report safety concerns 24 hours a day, 7 days a week. Their concern is escalated to the Director on Call to follow up appropriately. This ensures an immediate, senior and impartial response to serious safety concerns.

The Guardian will:

- Escalate to The Director on Call for that day for investigation
- Those concerns raised that are felt belong with Human Resources or Staff Side Trust Union and signposted to
- Logged concerns are reviewed weekly and contact is made to the staff member (if they have shared their details) for updates
- Updates are also requested from the senior colleagues managing the concern

Freedom to Speak up Concerns

The Freedom to Speak up Guardian responds to emailed concerns and telephone calls directly from staff members.

The Guardian will:

- Arrange to meet with the staff member and explain the Guardians role
- Escalate to appropriate most senior manager/ executive, Head of Operations, Head of Nursing or Clinical Director
- Those concerns raised that are felt belong with Human Resources or Staff Side Trust Union and signposted to
- Logged concerns are reviewed weekly and contact is made with the staff member (if they have shared their details) for updates
- Updates are also requested from the senior colleagues managing the concern.

Junior Doctor Gripe Tool

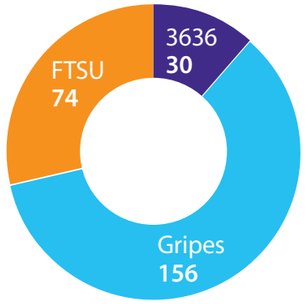
The Junior Doctor Gripe tool enables Doctors to report confidentially any concerns they have in relation to patient safety, staffing issues and indeed anything that is impacting on them to deliver quality patient care.
They can access the tool through Leicester's Hospitals intranet.

The gripe is:

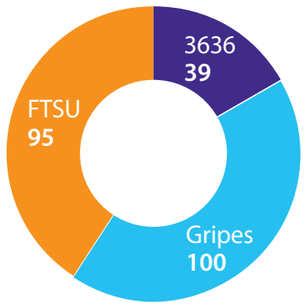
- Escalated to appropriate Clinical Director of a Clinical Management Group
- The Junior Doctor is thanked for their concern being raised
- Reported on the Gripe Tool Spreadsheet but will be recorded on DATIX from April 2020
- Feedback to the Junior Doctor that raised the concern is contacted to keep up to date with progress
- Updates are also requested from the senior colleagues managing the concern

The number of concerns raised in 2019/20 was a total of 260. These are broken down into the mechanisms we report on (please see below) compared to 2018/19 there has been an increase in reporting staff that have used the Junior Doctor Gripe tool which is really encouraging and shows that the awareness and willingness to report staff concerns is becoming embedded into the culture.

Staff concerns 2019/20



Staff concerns 2018/19



Our Executive People and Culture Board and People, Process and Performance Committee receive a quarterly report covering the themes and trends of concerns raised, together with actions taken or proposals for the Board. The Freedom to Speak Up Guardian will continue to attend the Trust Board when invited to present the data acquired, to share staff stories and outcomes of actions, and continue to have governance support by meeting bi-monthly with the Chief Executive and Chief Nurse and Monthly with the Director of Safety and Risk.

Doctors' rotas

In line with the requirements of Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, a quarterly guardian of safe working report is submitted to the Trust Board. Each report includes the number of junior medical staff vacancies at Leicester's Hospitals.

In comparison to the figures provided for the Quality Account in 2018/2019, when we reported the highest being 12% in June 2017 and the lowest being 6% in February 2019, the position has improved as per the figures below:

Time period	% Vacancy
March - May 2019	7%
June - August 2019	6%
September - November 2019	5%

Vacancies are pro-actively managed with a rolling programme of trust grade recruitment to fill junior medical staff vacancies, by filling substantive posts where possible to avoid locum backfill and premium pay.

4 Our Plans for the Future

4.1 Quality improvement at Leicester's Hospitals

Leicester's Hospital's Quality Strategy, "Becoming the Best", seeks to learn from trusts which have shown significant and sustained improvement. Its goal is to enable us to deliver Caring at its Best to every patient, every time and thus be judged to be an outstanding organisation.

Building on our strengths whilst also addressing what we need to do better, or differently, our Quality Strategy is designed to be a comprehensive, evidence-based approach, capable of transforming our organisation.

The development of our Quality Strategy has involved a wide range of people, particularly those with quality improvement and organisational development expertise. It has also had extensive input through Trust Board thinking days and through our leadership and consultant conferences.

Our Quality Strategy sets out our improvement methodology and our priorities for improvement; a "unified programme" approach will mean a single programme incorporating all the key things that we need to do using the overall approach set out in this strategy. It reframes our approach into one of constant learning and improvement and ensures that quality improvement is our organising principle.

The success of our Quality Strategy will depend on a complete commitment from the top level of the organisation to the approach we have set out.
This includes visible championing of the approach and changing the way in which we do things. It also depends on creating the head space for everyone to talk about how best to pursue this ambition.

In order to measure and evidence the impact of our investment in quality improvement, we will carry out a systematic review of our reporting structures and processes to ensure that they are fit for purpose.
We will introduce processes to ensure the basic quality and functioning of all our clinical services, combining both quality control and quality assurance.

The approach of Leicester's Hospitals has been to implement a range of quality improvement capability and capacity building.

The initial phases to be delivered in 2019 to 2020 are:
Board & Senior Leadership Development Programme
A programme of workshops for board & senior leaders with action learning phases
Capability building
An 'Advancing Practitioner' programme to develop cohorts of expert quality improvement practitioners / coaches, medical leaders & a whole organisation awareness of quality improvement e-learning module
Collaborative Programme
A collaborative programme to support quality improvement projects across the organisation to deliver on the key strategic objective of 'Safe and Timely Discharge'

The collaborative programme

Leicester's Hospitals have set out to develop and embed a learning culture of quality improvement and by way of an example we have developed a collaborative programme for teams to learn about how improvement programmes support the strategic aims of the organisation.

The safe and timely discharge collaborative

This learning collaborative focuses on how we can help achieve safe and timely discharge for patients. This work is a direct driver of our 'Streamlined Emergency Care' quality priority. The collaborative is part of a Leicester Hospital's wide approach to improving services for our patients and staff.

We have started this programme with teams from three medical wards, to help make "breakthrough" improvements in quality while reducing or maintaining costs. The driving principle behind this is that sound science that exists on the basis of which is, the costs and outcomes of our current health care practices across the system can be greatly improved, but much of this science lies fallow and unused in our current daily work. There is a gap between what we know and what we do.

The programme to date has co-developed and tested the implementation of 'Shared Decision Making' across multiple clinical teams and health partners using quality improvement methodologies. The approach, an acknowledged quality improvement science methodology designed to facilitate rapid change at scale using three 'Learning Events' and three 'Action Periods' has reached a state of maturity and the signs are positive with the ward teams engaged and motivated and eager to learn how to improve.

The ward teams have improvement ideas as projects and these multiple projects for a programme. As this work matures, we will develop outcome data and this data will be shared in our next Quality Account. In the interim, progress will be reported at the relevant Trust and partnership boards in new performance dashboards using statistical process control charts (SPC).

The discharge lounge

Leicester's Hospitals operate discharge lounges at two sites. They are a key resource that enables us to free up beds on wards with a quicker turn-around time, and this enables us to manage and reduce the amount of time it takes us to discharge a range of patients.
This improvement project is using quality improvement methods to learn about how we get the best use out of the discharge lounge facilities and for Leicester's Hospitals to discharge as many patients as possible as soon as possible.

We have co-designed this project with the involvement and support of our 'Patient Partners' (volunteer members of the public who help us to improve our service) and they have an active role in the evaluation of the tests of change that we are implementing. The Patient Partners are undertaking interviews and collecting data about the experience of patients using the discharge lounge so that we better understand what is important to them as we work to provide our best service.

The involvement of Patient Partners in our methods of quality improvement is a core element of our quality strategy and this principle runs throughout our approach, these examples will also serve as a learning opportunity for the Trust to get the best from our relationship with Patient Partners. This learning can then be shared and spread to other projects and services across Leicester's Hospitals.

Leicester's Hospitals have implemented an 'Improvement Agent' philosophy inviting anyone to undertake improvement work within their own areas. Starting in May 2019 with 108 Improvement Agents, there are now over 300 agents across our hospital sites.

4.2 Quality plans for 2020/21

The five quality priorities set out in section three of this Quality Account remain the key areas for improvement across Leicester's Hospitals.

Transformation programmes to improve cancer & emergency care pathways and implement sustainable transformation of care pathways are embedded within the priorities of our partners across the wider Leicester, Leicestershire and Rutland health and care system as part of the local response to the requirements within the NHS Long Term Plan.

These five quality priorities continue to align with feedback from both our staff and patients in terms of areas they would like to see improved.

We have reviewed our supporting priorities in light of the release of the NHS Long Term Plan which mandates some areas that were not reflected within our original supporting priorities:

1. 'Sustainable finances' replaces 'Quality Strategy development'
2. 'Estate investment and reconfiguration' has been amended to 'Investment in sustainable estate and reconfiguration'. This includes our commitment to, for example, reduce the use of avoidable single use plastics and to tackle air pollution and travel with our partners
3. 'Better working across boundaries' replaces 'Better corporate services' to reflect the need for corporate and clinical services to work collaboratively both within the Trust and the wider health and social care system
4. 'Embedded research, training and education' replaces 'More embedded research'.

5 Statements of Assurance from the Board

5.1 Review of services

Leicester's Hospitals comprises of three acute hospitals; the Leicester Royal Infirmary, the Leicester General and Glenfield hospital and the midwifery led birthing unit, St Mary's.

The Royal Infirmary has the only Emergency Department which covers the area of Leicester, Leicestershire and Rutland. The General provides medical services which include a centre for renal and urology patients, and Glenfield provides a range of services which include medical care services for lung cancer, cardiology, cardiac surgery and breast care.

During 2019/20 Leicester's Hospitals and the Alliance provided and / or sub-contracted in excess of 120 NHS services. These include:

- Inpatient - 64 services (specialties)
- Day Case - 61 services (specialties)
- Emergency - 68 services (specialties)
- Outpatient - 86 services (specialties)
- Emergency Department and Eye Casualty
- Diagnostic Services - including Hearing Services, Imaging, Endoscopy, Sleep Studies and Urodynamics
- Direct access - including Imaging, Pathology, Physiotherapy and Occupational Therapy
- Critical Care Services in Intensive Therapy Unit (ITU), High Dependency Unit (HDU), Post Anaesthesia Care Unit (PACU), Coronary Care Unit (CCU), Paediatric Intensive Care Unit (PICU), Obstetrics HDU, Neonatal Intensive Care Unit (NICU), Extra Corporeal Membrane Oxygenation (ECMO), Special Care Baby Unit (SCBU) and also Paediatric and Neonatal Transport Services
- A number of national screening programmes including Retinal Screening (Diabetes), Breast Screening including age extension (Cancer), Bowel Screening (Cancer) and Abdominal Aortic Aneurism (AAA), Cervical screening, foetal anomalies, infectious diseases of the newborn, newborn infants physical examination, newborn blood spot and sickle cell thalassemia

Services are also provided at:

- Dialysis units in Leicester, Loughborough, Grantham, Corby, Kettering, Northampton and Peterborough
- The Alliance partnership at Ashby & District Hospital, Coalville Hospital, Fielding Palmer Hospital, Hinckley & District Hospital, Loughborough Hospital, Melton Mowbray Hospital, Rutland Memorial Hospital and St Luke's Hospital
- The national Centre for Sports and Exercise Medicine at Loughborough University

The University Hospitals of Leicester NHS Trust has reviewed all the data available, on the quality of care in these NHS services. The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by Leicester's Hospitals for 2019/20.

Examples of how we reviewed our services in 2019/20

A variety of performance and quality information is considered when reviewing our services. A few examples include:

- A Quality and Performance report (available at http://www.leicestershospitals.nhs.uk/) is presented at the Executive Quality Board, Executive Performance board and in a joint session between the Quality and Outcomes Committee and the People, Processes and Performance Committee
- Monthly Clinical Management Group Assurance and Performance Review Meetings chaired by the chief operating officer
- Service level dashboards (e.g. women's services, children's services, fractured neck of femur and the Emergency Department)
- Ward performance data at the Nursing and Midwifery Board and Executive Quality Board
- The assessment and accreditation process
- Results from peer reviews and other external accreditations
- Outcome data including mortality is reviewed at the Mortality Review Committee
- Participation in clinical audit programmes
- Outcomes from commissioner quality visits
- Complaints, safety and patient experience data
- Review of risk registers
- Annual reports from services including the screening programmes.

5.2 Participation in clinical audits

Leicester's Hospitals are committed to undertaking effective clinical audit across all clinical services and recognises that this is a key element for developing and maintaining high quality patient-centred services.

National clinical audits are largely funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP), which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP).

Most other national audits are funded from subscriptions paid by NHS provider organisations. Priorities for the NCAPOP are set by the Department of Health.

During the 2019/20 period Leicester's Hospitals participated in 97% (59 out of 61) of the national clinical audits. Of the six national confidential enquiries, Leicester's Hospitals has participated in 100% of the studies which have commenced and which it is eligible to participate in.

The national clinical audits and national confidential enquiries that Leicester's Hospitals participated in and for which data collection was completed during the 2019/20 period are listed below alongside the number of cases submitted to each audit or enquiry where possible.

National Clinical Audits

Name of Audit	Did Leicester's Hospitals participate?	Stage / % of cases submitted
Assessing Cognitive Impairment in Older People (Care in Emergency Departments)	Yes	Awaiting national report
Cystectomy	Yes	Data collection ongoing
Female Stress Urinary Incontinence Audit	Yes	Data collection ongoing
Nephrectomy Audit	Yes	Data collection ongoing
Percutaneous Nephrolithotomy (PCNL)	Yes	Data collection ongoing
Radical Prostatectomy Audit	Yes	Data collection ongoing
Care of Children (Care in Emergency Departments)	Yes	Awaiting national report
Intensive Care National Audit and Research Centre (ICNARC)	Yes	Data collection ongoing
Elective Surgery (National PROMs Programme)	Yes	Data collection ongoing
Endocrine and Thyroid National Audit	No	Insufficient resources to undertake audit at present
Fracture Liaison Service Database	NA	Leicester's Hospitals do not have a Fracture Liaison Service
Fracture Liaison Service Database / Vertebral Fracture Sprint Audit	NA	Leicester's Hospitals do not have a Fracture Liaison Service
National Audit of Inpatient Falls	Yes	Data collection ongoing
National Hip Fracture Database	Yes	Data collection ongoing
Inflammatory Bowel Disease (IBD) Audit	No	No funds available to buy audit Infoflex system
Trauma Audit & Research Network (TARN)	Yes	Data collection ongoing
Mandatory Surveillance of HCAI	Yes	Data collection ongoing
Mental Health (Care in Emergency Departments)	Yes	Awaiting national report
Paediatric Asthma Secondary Care	Yes	Data collection ongoing
Adult Asthma Secondary Care	Yes	Data collection ongoing
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	Data collection ongoing
Pulmonary rehabilitation - organisational and clinical audit	Yes	Data collection ongoing
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Data collection ongoing
National Audit of Cardiac Rehabilitation	Yes	Data collection ongoing
National Audit of Care at the End of Life (NACEL)	Yes	Data collection ongoing
National Audit of Dementia (care in general hospitals)	Yes	National report published
National Audit of Pulmonary Hypertension (NAPH)	NA	Leicester's Hospitals do not provide this service
National Audit of Seizure management in Hospitals (NASH)	Yes	Awaiting national report

Statements of Assurance

Name of Audit	Did Leicester's Hospitals participate?	Stage / % of cases submitted
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Data collection ongoing
National Bariatric Surgery Registry (NBSR)	Yes	Data collection ongoing
National Cardiac Arrest Audit (NCAA)	Yes	Data collection ongoing
National Audit of Cardiac Rhythm Management (CRM)	Yes	Data collection ongoing
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Data collection ongoing
National Adult Cardiac Surgery Audit	Yes	Data collection ongoing
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Data collection ongoing
National Heart Failure Audit	Yes	Data collection ongoing
National Congenital Heart Disease (CHD)	Yes	Data collection ongoing
National Clinical Audit of Anxiety and Depression (NCAAD): Core audit	NA	Leicester's Hospitals do not provide this service
Psychological Therapies Spotlight	NA	Leicester's Hospitals do not provide this service
National Diabetes Foot Care Audit	Yes	Data collection ongoing
National Diabetes Inpatient Audit (NaDIA) - reporting data on services in England and Wales	Yes	Awaiting national report
NaDIA-Harms - reporting on diabetic inpatient harms in England	Yes	Data collection ongoing
National Core Diabetes Audit	Yes	Data collection ongoing
National Diabetes Transition	Yes	Data collection ongoing
National Pregnancy in Diabetes Audit	Yes	Data collection ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Data collection ongoing
National Emergency Laparotomy Audit (NELA)	Yes	Data collection ongoing
National Oesophago-gastric Cancer (NOGCA)	Yes	Data collection ongoing
National Bowel Cancer Audit (NBOCA)	Yes	Data collection ongoing
National Joint Registry (NJR)	Yes	Data collection ongoing
National Lung Cancer Audit (NLCA)	Yes	Data collection ongoing
National Maternity and Perinatal Audit (NMPA)	Yes	Awaiting national report
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Data collection ongoing
National Ophthalmology Audit (NOD)	Yes	Data collection ongoing
National Paediatric Diabetes Audit (NPDA)	Yes	Data collection ongoing
National Prostate Cancer Audit	Yes	Data collection ongoing
National Smoking Cessation Audit 2019	Yes	Data collection ongoing
National Vascular Registry	Yes	Data collection ongoing
Paediatric Intensive Care Audit Network (PICANet)	Yes	Data collection ongoing
Perioperative Quality Improvement Programme (PQIP)	TBC	Data collection ongoing
Prescribing Observatory for Mental Health (POMH-UK) Subscription-based programme	NA	Leicester's Hospitals do not provide this service
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes	Data collection ongoing
Sentinel Stroke National Audit programme (SSNAP)	Yes	Data collection ongoing
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	TBC	Data collection ongoing
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Data collection ongoing
Surgical Site Infection Surveillance Service	Yes	Data collection ongoing
UK Cystic Fibrosis Registry	Yes	Data collection ongoing
UK Parkinson's Audit	Yes	Data collection ongoing

National Confidential Enquiries

Name of Enquiry	Did Leicester's Hospitals participate?	Stage / % of cases submitted
Long-term ventilation in children, young people and young adults (NCEPOD)	Yes	Data collection ongoing
Perinatal Mortality Surveillance (MBRRACE)	Yes	Data collection ongoing
Maternal Mortality surveillance and mortality confidential enquiries (MBRRACE)	Yes	Data collection ongoing
Dysphagia in Parkinson's Disease (NCEPOD)	Yes	Data collection ongoing
In-hospital management of out-of-hospital cardiac arrest (NCEPOD)	Yes	Data collection ongoing
Acute Bowel Obstruction (NCEPOD)	Yes	Data collection ongoing

Leicester's Hospitals have reviewed the reports of 43 national clinical audits and 395 local clinical audits in 2019/20.

University Hospitals of Leicester NHS Trust intends to take the following action to improve the quality of healthcare provided:

- An audit summary form is completed for all audits and includes details of compliance levels with the audit standards and actions required for improvement including the names of the clinical leads responsible for implementing these actions. These summary forms are available to all staff on our intranet
- There are various examples within this Quality Account of the different types of clinical audits both national and local being undertaken within our hospitals and the improvements to patient care achieved
- Each year we hold a clinical audit improvement competition for projects that have improved patient care. This year's winner was the National Chronic Obstructive Pulmonary Disease (COPD) secondary care audit

5.3 Participation in clinical research

The number of patients receiving NHS services provided by or subcontracted by the University Hospitals of Leicester in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 13,618.

The University Hospitals of Leicester were involved in conducting 974 clinical research studies. Of these 792 (81%) were adopted onto the National Institute for Health Research portfolio, and 229 (24%) of the total were commercially sponsored studies. Leicester's Hospitals used national systems to manage the studies in proportion to risk and 90% of the studies given approval were established and managed under national model agreements.

In 2019/20 there were over 550 full papers published in peer reviewed journals.

Leicester's Hospitals formed Leicestershire Academic Health Partners with Leicestershire Partnership Trust and the University of Leicester to work together on strategically important research projects that translate into healthcare improvements for the benefit of local patients. Leicester's \hospitals were accepted onto the Advanced Therapy Treatment Centre – Midlands and Wales with the aim of introducing pioneering treatments that use modified cells or new genetic material to enhance patient care.

Cardiologist Professor Andre Ng successfully performed the UK's first catheter ablation to treat atrial fibrillation with software that lets surgeons see a real-time 3D map of heart during the procedure. This enables unprecedented accuracy and precision, increasing the operation's effectiveness and reducing the risk of complications.

A new blood test for TB showed potential in a small scale trial led by Dr Pranabashis Haldar (consultant in respiratory medicine). As well as identifying people with active TB, two out of three people with latent TB who also tested positive later went on to develop the disease more than six months later. By identifying these patients early, the spread of TB could be reduced. A larger scale trial is now underway.

A family recruited by Professor Julian Barwell (consultant in clinical genetics) to the 100,000 Genomes project were informed that two of the three sisters carried a genetic variant that significantly increases their risk of developing breast cancer. A fourth sister who was not part of the original study has since been found to carry the same PALB2 mutation. The findings suggest families with a strong history of breast cancer but who have tested negative for BRCA1 and BRCA2 could consider testing for PALB2.

Using UK Biobank data from nearly half a million people, Professor Tom Yates et al. showed that those who reported a slow walking pace had a lower life expectancy than faster walkers, regardless of a person's body weight or obesity status. This suggests that physical activity levels may be a better indicator of life expectancy than BMI and that brisk walking may add years to people's lives.

5.4 Use of the CQUIN Payment Framework

In 2019/20 Leicester's Hospitals had:

- Five mandated National CQUINS, each with a minimum weighting of £1,208,280
- Five NHS England Specialised CQUINS with a total value of £3,457,000

The combined 2019/20 CQUIN schemes were worth £9,579,260.

Further details of the agreed goals for 2019/20 are available electronically at:

https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

Payment with this year's National CQUIN schemes was based on performance falling between the minimum and maximum thresholds for each indicator, during each financial quarter with overall payment based on Q1-4 combined performance.

- If performance was at or below the minimum threshold, no payment will be achieved
- If performance was between the minimum and maximum thresholds, payment will be proportionate
- If performance reached or exceeded the maximum threshold, the payment achieved was 100%

Leicester's Hospitals did not fully meet the maximum threshold for 4 of the National CQUINs, with the biggest financial loss associated to two of the CQUINs:

Three high impact actions to prevent hospital falls

There were three falls preventative actions to this CQUIN. The CQUIN sought to ensure that admitted patients aged over 65 years; with length of stay at least 48 hours received the following:

- Lying and standing blood pressure recorded at least once
- No hypnotics / antipsychotics or anxiolytics given during stay, unless indicated
- Mobility assessment documented with 24hrs of admission and a walking aid provided if indicated

Nationally, due to the small number of patients having all 3 high impact interventions completed in Q1 the National CQUIN team took the decision to remove quarter 1 performance from the 2019/20 performance and payment calculation for this CQUIN. Performance in quarter 2 and quarter 3 for Leicester's Hospitals was above what was expected and therefore the financial risk against this CQUIN was lessened.

Antimicrobial Resistance - Lower Urinary Tract Infections (UTI) in older people

This CQUIN sought to achieve 90% of antibiotic prescriptions in patients over 65 years meeting NICE guidance for lower UTIs.

There were four audit criteria in the NICE guidance for this group of patients, one of which is that 'urine dipsticks' should not be used to diagnose a UTI.

As with the three high impact actions to prevent hospital falls CQUIN, the National CQUIN team took the decision to remove quarter 1 performance from the 2019/20 performance and payment calculation for this CQUIN. Despite this the CQUIN continued to be challenging.

As with quarter 2, quarter 3 audit results remained poor. As this is a CQUIN for 2020/21 further clarity of the guidelines will be considered, in order that evidence based best practice is being followed. Further education and training is also required throughout the services to ensure evidence based practice guidelines are being followed.

The five NHSE specialised CQUINS progressed well, with the continued support of the services. These CQUINS, unlike the National CQUINS, did not have the same level of risks associated with the payment triggers this year and were fully achieved.

At the end of quarter 3, the financial loss associated with the CQUINS was £1,285,096.

5.5 Data quality

University Hospitals of Leicester NHS Trust will be taking the following actions to improve data quality:

- The Data Quality Forum is chaired by the Director of Corporate and Legal Affairs to provide assurance on the quality of data reported to the Trust Board. The forum is a multi-disciplinary panel from the departments of information, safety and risk, clinical quality, nursing, medicine, finance, clinical outcomes, workforce development, performance and privacy. The panel is presented with an overview of data collection and processing for each performance indicator in order to gain assurance by best endeavours that it is of suitably high quality. The NHS Digital endorsed Data Quality Framework provides scrutiny and challenge on the quality of data presented against the dimensions of accuracy, validity, reliability, timeliness, relevance and completeness
- Where such assessments identify shortfalls in data quality, the panel make recommendation for improvements to raise quality to the required standards. They offer advice and direction to clinical management and corporate teams on how to improve the quality of their data
- For the management of patient activity data, we have a dedicated corporate data quality team. They respond to any identified issues and undertake daily processes to ensure singularity of patient records and accurate GP and commissioner attribution. We have been actively working to reduce GP inaccuracy by implementing automated checking against the Summary Care Record. Our weekly corporate data quality meeting challenges inaccurate and incomplete data collection. The data quality team action reports on a daily basis to maximise coverage of NHS number, accurate GP registration and ensures singularity of patient records
- The NHS Digital Data Quality Maturity Index is used for benchmarking against 17 peer Trusts. Data quality and clinical coding audit is undertaken in line with Data Protection and Security Toolkit and mandatory standards are achieved. For clinical coding we have several assurance processes in place to ensure that patient complexity is accurately captured. In 2019 we have improved the information supply chain for clinical coding which has resulted in more documentation being available for the Clinical Coding process. Leicester's Hospitals has a Clinical Coding Steering Group, which aims to develop wider clinical engagement as part of quality improvement
- The Executive Board receive quarterly reports on the Data Quality and Clinical Coding.

5.6 NHS Number and General Medical Practice Code Validity

The University Hospitals of Leicester NHS Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was:
  - 99.8% for admitted patient care
  - 99.9% for outpatient care
  - 99.1% for emergency department care
- which included the patient's valid General Medical Practice Code was:
  - 100% for admitted patient care
  - 100% for outpatient care
  - 100% for emergency department care.

5.7 Clinical coding error rate

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records.

The University Hospitals of Leicester NHS Trust was not subject to a Payment by Results clinical coding audit during 2019/20.

5.8 Data Security and Protection Toolkit Score

University Hospitals of Leicester NHS Trust's Data Security and Protection Toolkit score was 100% for both 2018/19 and 2019/20.

We recognise the importance of robust information governance. During 2019/20, the chief information officer retained the role of senior information risk owner and the medical director continued as our caldicott guardian.

All NHS Trusts are required annually to carry out an information governance self-assessment using the NHS Data Security & Protection Toolkit.

This contains 10 standards of good practice, spread across the domains of:

1. Robust Patient Confidential Data processes
2. Staff training around Patient Confidential Data
3. Staff training for General Data Protection Regulation (GDPR)
4. PCD is accessed by appropriate personnel
5. Policy and Process Review Strategy in place
6. Cyber Attack Prevention
7. Continuity Plan in place for Data
8. Unsupported Software Strategy
9. Cyber Attack Strategy
10. Contract Management

As with the previous year of the toolkit, Leicester's Hospitals are not required to meet a specified target to be considered a trusted organisation. Leicester's Hospitals were complaint with all mandatory assertions. Any non-mandatory assertions would require an action plan to achieve within a specific time frame set by Leicester's Hospitals.

Our information governance improvement plan for 2019/2020 was overseen by our information governance steering group, chaired by the data protection officer.

Our information governance improvement plan for 2018/19 was overseen by our information governance steering group, chaired by the data protection officer.

5.9 Care Quality Commission (CQC) ratings

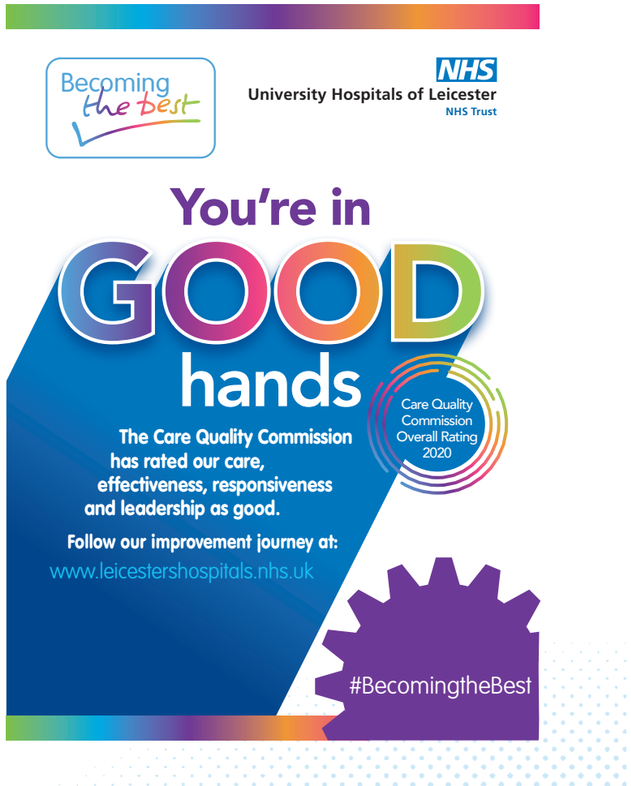
University Hospitals of Leicester NHS Trust is required to register with the CQC and its current registration status is 'Good'.

In September and October 2019, the Care Quality Commission (CQC) carried out unannounced inspections of our services. This was followed by an announced well-led review in November 2019. The aim of these inspections was to check whether the services that we are providing are safe, caring, effective and responsive to people's needs and are well-led.

This inspection covered six of the nine core and additional services across three locations:

- Urgent and emergency services (A&E) at the Leicester Royal Infirmary
- Medical care (including older people's care) at the Leicester Royal Infirmary and Glenfield Hospital
- Maternity services at the Leicester Royal Infirmary
- Children & Young People at the Leicester Royal Infirmary
- End of Life care at the Leicester Royal infirmary
- Outpatients at the Leicester General Hospital
- Surgery at the Leicester Royal Infirmary and the Leicester General Hospital

Where services were not inspected by the CQC in 2019, they retain their rating from the previous comprehensive inspection in 2017.



The reports from this inspection have been published are available on the CQC's website along with their ratings of the care provided, a summary of which is:

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding

Overall Trust Ratings					
Safe	Effective	Caring	Responsive	Well-led	**Overall**
Requires Improvement	Good	Good	Good	Good	**Good**

Royal Infirmary						
	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Urgent & emergency services	Good	Good	Good	Good	Good	Good
Medical Care (including older people's care)	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Surgery	Good	Good	Good	Requires Improvement	Good	Good
Critical Care	Good	Good	Good	Good	Good	Good
Maternity	Good	Good	Good	Good	Good	Good
Services for children & Young People	Good	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of Life Care	Good	Requires Improvement	Good	Good	Good	Good
Outpatients	Requires Improvement	N/A	Good	Requires Improvement	Requires Improvement	Requires Improvement
Diagnostic imaging	Requires Improvement	N/A	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

Glenfield Hospital						
	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Medical Care (including older people's care)	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Surgery	Requires Improvement	Good	Good	Good	Good	Good
Critical Care	Good	Good	Good	Good	Good	Good
Services for children & Young People	Good	Outstanding	Good	Good	Good	Good
End of Life Care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Outpatients and Diagnostic imaging	Good	N/A	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

General Hospital						
	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Medical Care (including older people's care)	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Requires Improvement	Good	Requires Improvement
Critical Care	Requires Improvement	Good	Good	Good	Good	Good
Maternity	Requires Improvement	Good	Good	Good	Good	Good
End of Life Care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Outpatients	Good	N/A	Good	Good	Good	Good
Diagnostic imaging	Requires Improvement	N/A	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

St Mary's Birth centre						
	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Maternity	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Of the 115 ratings in total (for each domain of each main service grouping):

- 1 is 'outstanding' (for the effectiveness of our East Midlands Congenital Heart Service at Glenfield)
- 80 are 'good'
- 29 are 'requires improvement'
- None are 'inadequate'
- Five are unrated for technical reasons

Through their inspections, the CQC found a strong link between the quality of overall management of Leicester's Hospitals and the quality of its services.

University Hospitals of Leicester NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

During their The CQC found an number of examples of outstanding practice, including:

- The Nursing Associate Programme delivered as part of a formal academic partnership arrangement between Leicester's hospitals and the local university which is the only model of its kind in the United Kingdom
- Our 'Assessment and Accreditation' process
- The relationships that Leicester's hospitals have developed with a number of local community and voluntary sector partners
- Sensory equipment in the paediatric emergency department in a dedicated room to care for children and moveable accessories that can be used in the adult emergency department
- 'Memory lane', a specially designed area for patients living with dementia
- The 'happy times café' where patients can eat meals together supported by meaningful activities facilitators and a portable café called Rita's for patients who are bed bound
- The 'suite of tranquillity', an aromatherapy suite for children, young people and their families who are undergoing treatment for cancer
- Support from the pain team for children and young people in how to manage their pain in a number of different ways including mindful relaxation

The CQC has taken enforcement action against University Hospitals of Leicester NHS Trust during 2020 as follows:

In February 2020 the CQC issued a Section 29A Warning Notice in relation to urgent and emergency services provided at the Leicester Royal Infirmary (A&E).

The CQC found that during a focused inspection on the 27th January 2020, the emergency department was overcrowded and that there were long delays for patients trying to access the service.

6 Other Statements

6.1 Statements from our stakeholders

Statement from Healthwatch Leicester and Leicestershire

We welcome this opportunity to comment on the University Hospitals of Leicester Quality Account for 2019/20.

Patient and Public Involvement is taken seriously by UHL and the Trust's PPI strategy continues to be implemented. In this process, Healthwatch meets quarterly with the Chief Executive to share its success and any failures and is an opportunity to highlight issues as they emerge.

Patients continue to report that clinical care is mostly positive. There are some complaints of minor inefficiencies.

The Trust is facing increasing demand for Emergency services. Waiting times is an area of concern as highlighted by Healthwatch and the CQC report in January. In response to this, UHL opened another waiting area in the Emergency Department, to ease the delay in ambulance handover. The level of demand requires an NHS system-wide response to reduce any unnecessary attendance to the ED.

We continue to value the positive and open relationship between the local Healthwatch and Leicester Hospitals.

Harsha Kotecha

Chair Healthwatch Leicester and
Healthwatch Leicestershire.

Statement from the Leicestershire County Council Health Overview Scrutiny Committee

LEICESTERSHIRE COUNTY COUNCIL HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON THE UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST QUALITY ACCOUNT FOR 2019/20

May 2019

The Leicestershire Health Overview and Scrutiny Committee thanks UHL for a candid and balanced Quality Account which fairly reflects the Trust's performance over the 2019/20 year. We are aware that it has been a challenging year for Leicester hospitals and it is pleasing that the Trust fully acknowledges the areas where performance has been below the required standard and has put plans in place to improve performance. The Committee congratulates UHL for achieving an overall rating of "Good" from the CQC in an inspection report dated 5 February 2020 despite the challenges, though is concerned to note that as a result of a separate inspection carried out on 27 January 2020 the CQC issued a Section 29 Warning Notice in relation to urgent and emergency services provided at UHL. The Quality Account would benefit from more information regarding this. The Committee is aware the main concerns of the CQC in relation to the Emergency Department related to Ambulance handover and the use of the Escalation POD. It is pleasing that the Escalation POD is no longer in use. Ambulance handover and flow through the hospital has long been a concern of the Committee. The Quality Account states that the Emergency Department has not met the target to treat and discharge a minimum of 95% of patients within four hours, and it is pleasing that the Quality Account recognises that partnership working is one of the ways to tackle this problem and that the new Emergency Department was not going to improve the flow working in isolation.

We are aware that the 2019/20 winter period was particularly challenging and the spread of COVID19 has added to those pressures. These issues are given due recognition in the report. It is reassuring that winter planning for 2020/21 has already started and the Committee hopes that work can be undertaken to address the gap between capacity and demand, though the full impact of COVID19 remains to be seen.

The Committee notes that the Quality Account is built around UHL's 3 year Quality Strategy and the Committee welcomes the approach of UHL towards quality improvement. It is pleasing that UHL acknowledges that culture changes need to take place within the organisation, and the leadership styles of UHL staff need to be developed, to ensure that improvements in quality are sustained whilst ensuring that quality monitoring does not prevent staff from focusing on patient care. The Committee does have reservations as to how the Quality Improvement philosophy will be implemented with bank staff and agency workers.

The Committee welcomes that safe and timely discharge has been and continues to be a priority for UHL. The Committee has scrutinised this area in the context of a report from Healthwatch Leicester and Leicestershire regarding the patient experience of being discharged from UHL. The key finding from this report was that patients felt they were spending too long in the discharge lounge, waiting too long for medication to be provided, wanted to be given accurate expectations of how soon it would be before they would be leaving hospital and wanted to be part of their own discharge planning. It is therefore pleasing that the Quality Account indicates that UHL has focused on involving patients in decisions about their care, providing accurate information at the point of discharge and that UHL is using feedback from patients to improve the discharge lounge.

The Committee has concerns regarding UHL's performance against the cancer targets therefore it is pleasing to note that improving cancer pathways is a priority for UHL and that UHL has agreed a cancer recovery plan with commissioners which has resulted in signs of improvement. The Committee has requested further information regarding the reasons behind the cancer performance figures and will delve deeper into the issues at a future Committee meeting.

The Committee has concerns regarding recruitment and retention of staff at UHL and how this will be managed going forward. The Committee is pleased to note from the Quality Account that nurse staffing levels is a priority for UHL. The Committee intends to consider recruitment issues in more detail at a future meeting in the context of the NHS People Plan.

The Committee welcomes the £450 million from Central Government for several key reconfiguration projects, including a new Children's Hospital and Maternity Unit. Committee members look forward to reviewing UHL's plans for consultation on the reconfiguration scheme and taking part in the consultation itself.

In conclusion, the Committee would like to thank UHL for presenting a clear Quality Account and, based on the Committee's knowledge of the provider, is of the view that the Quality Account is accurate.

Statement from the Leicester City Council Health and Wellbeing Scrutiny Commission

Leicester City Council Health and wellbeing Scrutiny Commission were invited to comment on this year's Quality Account, but no comments were received.

Other Statements

Statement from the Clinical Commissioning Groups

Commissioner Quality Account Statement for University Hospitals of Leicester NHS Trust (UHL) 2019/2020

The Leicester, Leicestershire and Rutland Clinical Commissioning Groups (CCGs) have reviewed the DRAFT Quality Account for University Hospitals of Leicester Trust (UHL) 2019/2020 and welcome the ongoing work of the Trust within improving the quality and safety of the services it provides.

As Commissioners we acknowledge and welcome the work the Trust has undertaken in the development of six quality indicators including; Ward accreditation, Safe surgery and procedures, Safe and timely discharge, Improved cancer pathways and Better care pathways, and that whilst some positive improvements have been made to date, we welcome that the Trust has decided to roll these quality indicators over into 2020-2021. However, we would suggest that further detail should be provided within the final published Quality Account to demonstrate how patients were involved in the process that the Trust used to decide upon these priorities for improvement.

We are pleased with the work so far that the Trust has undertaken in respect to delivering in their 3 year Quality Strategy "Becoming the Best" and how this is being utilised within day-to-day practice within the organisation through the implementation of an evidence-based Quality Improvement methodology.

As Commissioners we are pleased with the work the Leicester's hospitals are continuing to undertake in respect to their ambition to reduce avoidable death and harm and to improve patient safety, noting that this includes the adoption of the key priorities within the new National Patient Safety Strategy, and the continued commitment to focus on the six local clinical priorities.

We are acutely aware that the Trust has had a number of challenges during the last year:

In 2019/2020 the Trust reported two serious incidents which met the definition of a Never Event and undertook thorough local investigation, which included root cause analysis, and development of robust action plans to prevent a similar occurrence. However, whilst it is disappointing for any organisation to have a Never Event, we noted that this was a considerable improvement from the eight Never Events that were reported during the previous year (2018/2019). Also, the Trust has had significant challenges all year with providing timely care at the Leicester Hospital's emergency department, however, despite continued high numbers of patients resulting in increased demand, we are pleased with the work undertaken between the Trust and key partners across Leicester, Leicestershire and Rutland to improve emergency performance and the quality of care provided on the emergency care pathway.

In respect to promoting and learning from patient and public involvement, we were pleased to note that within 2019/2020 the Trust reviewed their patient and public involvement strategy and continues to work to ensure that the voice of the patient remains at the heart of care. It is also heartening to read about the positive work that Patient Partners are bringing to the work of the Trust, and how seemingly simple innovations such as Clinical areas displaying "Patient Feedback Driving Excellence" boards are being used to promote effective communication exchange by highlighting how patient and public feedback comments have been converted to positive improvements.

It was noted that the draft Quality Account document provided for Commissioners to review did not indicate how the Trust safeguards patients. It is therefore recommended that a statement to this respect should be included in the final published Quality Account.

Finally, Commissioners considered that the style, content and format of the Quality Account was very readable with complex terms explained in an easy to understand language and with medical abbreviations being clearly explained throughout the document.

The CCG has a positive relationship with the Trust and looks forward during 2020/2021 to continued collaborative partnership working to ensure high quality acute services for the people of Leicester, Leicestershire and Rutland, as well as providing commissioner support with the improvement actions outlined within this Quality Account.

6.2 Statement of Directors' responsibilities in respect to the Quality Account

The directors at Leicester's Hospitals are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with Department of Health guidance

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board.

Karamjit Singh CBE, Chairman

John Adler, Chief Executive

7 Appendices

7.1 Feedback form

We hope you have found this Quality Account useful.

In order to make improvements to our Quality Account we would be grateful if you would take the time to complete this feedback form.

1 How useful did you find this report?

- Very useful ☐
- Quite useful ☐
- Not very useful ☐
- Not useful at all ☐

2 Did you find the contents?

- Too simplistic ☐
- About right ☐
- Too complicated ☐

3 Is the presentation of data clearly labelled?

- Yes, completely ☐
- Yes, to some extent ☐
- No ☐

4 Is there anything in this report you found particularly useful?

5 Is there anything you would like to see in next year's Quality Account?

Return to:

CQC Project Manager
Leicester's Hospitals
Leicester Royal Infirmary
Infirmary Square
Leicester
LE1 5WW

Email: Helen.harrison@uhl-tr.nhs.uk

If you would like this information in another language or format such as EasyRead or Braille, please telephone **0116 250 2959** or email **equality@uhl-tr.nhs.uk**

اگر آپ کو یہ معلومات کسی اور زبان میں درکار ہیں، تو براہِ کرم مندرجہ ذیل نمبر پر ٹیلی فون کریں۔

ਜੇ ਤੁਸੀਂ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਵਿਚ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਗਏ ਨੰਬਰ 'ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ।

إذا كنت ترغب في الحصول على هذه المعلومات بلغةٍ أُخرى، الرجاء الاتصال على رقم الهاتف الذي يظهر في الأسفل

Aby uzyskać informacje w innym języku, proszę zadzwonić pod podany niżej numer telefonu

જો તમને અન્ય ભાષામાં આ માહિતી જોઈતી હોય, તો નીચે આપેલ નંબર પર કૃપા કરી ટેલિફોન કરો.

@Leic_hospital leicester'shospitals LeicesterHospitalsNHS leicestershospitals

Design and photography by UHL Medical Illustration 0116 258 5904 (52013037)

Annual Fire Report 2019/20

Author: Michael Blair Sponsor: Darryn Kerr

QOC paper E

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	X
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board		
Trust Board Committee		
Trust Board		

Executive Summary

Context

The purpose of this report is to inform the Executive Quality Board of the current level of Fire Safety provisions across the Trust portfolio, highlight where improvements have been made and indicate where further Fire Safety related improvements and investments are necessary.

Questions

1. *What is the current status of the Fire Risk Assessment programme?*
2. *Is the Fire Safety Training provided fit for purpose and relevant to Risk?*
3. *Aside from prioritising and addressing backlog Fire Safety issues what areas of improvement have been identified and included in the work plan for the year 2020/21?*

Conclusion

1. *The Fire Risk Assessment register continues to show high levels of compliance.*
2. *The Fire Safety Team continues to provide the required capacity for all staff to complete 'Face to Face' Annual Fire Safety. Fire Training compliance has risen significantly to 92% and we are*

confident of continuing with this upturn. In addition specific evacuation training and Fire Warden training uptake continues to improve.

3. *There are a number of areas that are to be focused on in the coming year within the Fire Safety Team but the greatest priority is to recruit and retain competent fire safety advisors to continue to drive improvements across the Trust such as:*
   a) *Policy Review planned for Quarter 2;*
   b) *Improved recording (classification) and reporting of all Fire Signals by Switchboard;*
   c) *Reduction of Unwanted Fire Signals across all 3 acute sites and the assessment of the implementation of the new procedure at the Glenfield Hospital;*
   d) *Responding to the "new normal" following changes brought about via COVID-19;*
   e) *Implement the new Fire Evacuation Procedure Training;*
   f) *Provide Fire Evacuation Drills to all stand-alone buildings and Clinical Education Centres.*
   g) *Provide the Capital Team with advice and assistance on all Capital Schemes taking place and also those in the planning stage.*

Input Sought

We would welcome the EQB's input regarding the content of the report and to:

- Recognise the progress being made in relation to Fire Safety across the Trust.
- Request that report is endorsed to enable the annual fire statement to be signed.

For Reference:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Not applicable]
Safely and timely discharge	[Not applicable]
Improved Cancer pathways	[Not applicable]
Streamlined emergency care	[Not applicable]
Better care pathways	[Not applicable]
Ward accreditation	[Not applicable]

2. Supporting priorities:

People strategy implementation	[Not applicable]
Estate investment and reconfiguration	[Yes]
e-Hospital	[Not applicable]
More embedded research	[Not applicable]
Better corporate services	[Not applicable]
Quality strategy development	[Not applicable]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)?
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required
- How did the outcome of the EIA influence your Patient and Public Involvement?
- If an EIA was not carried out, what was the rationale for this decision? – not required

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?		
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None	X	

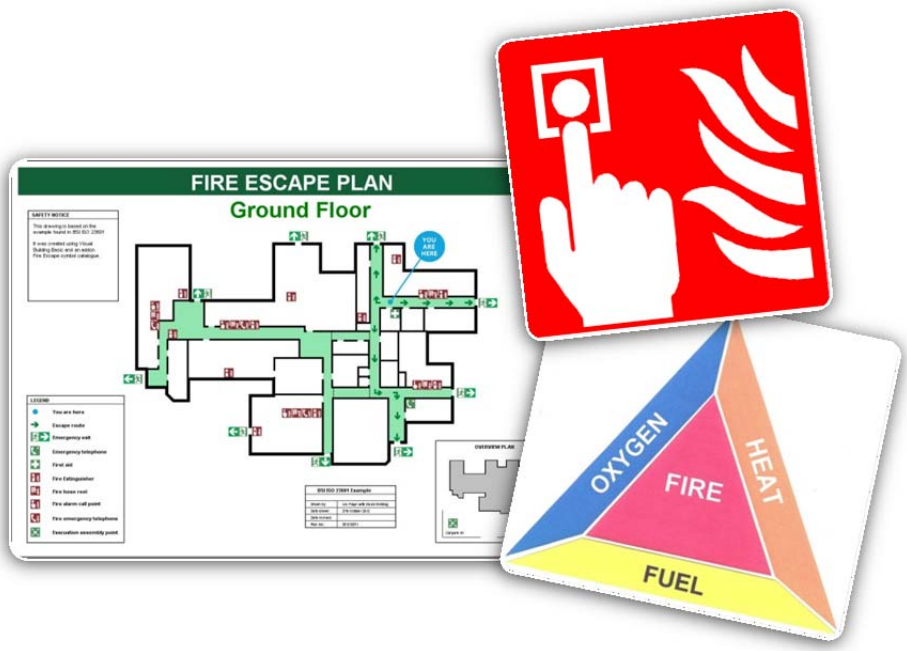
5. Scheduled date for the **next paper** on this topic: [TBC]
6. Executive Summaries should not exceed **5 sides** [My paper does comply]

University Hospitals of Leicester NHS Trust

Annual Fire Report

University Hospitals of Leicester
2019/20

University Hospitals of Leicester NHS Trust
Michael Blair – Head of Compliance (interim)



Contents

1.0 Introduction

1.1 The University Hospitals of Leicester (UHL) NHS Trust has a statutory duty to ensure that all of the premises owned and operated by the Trust comply with current fire safety legislation. This is achieved by following Department of Health Guidance.

1.2 The Trust must ensure that effective arrangements are in place for the management of fire safety and implement any necessary improvements or adjustments required which relate to an increased potential risk of fire.

1.3 The purpose of this report is to inform the Trust Board, all other stakeholders and interested parties of the current state of fire safety provision in all Trust premises, and indicates where further fire safety related improvements are necessary.

1.4 It should be noted that the COVID-19 Virus has adversely affected the standard Fire Safety working process in Quarter Four; consequently the figures provided in regards to Training, LFRS Visits and the Fire Risk Assessment Review process will provide significant anomalies.

2.0 Executive summary

2.1 The Reporting Period 2019/20 has seen a consolidation of the Fire Safety services provided by the Trust; the Fire Safety Team has managed to maintain a high level of compliance in regards to Fire Risk Assessments (FRA) and Annual Fire Training.

2.2 The Fire Risk Assessment (FRA) register continues to show high levels of compliance. A total of 220 FRA's were undertaken in the reporting period; these were a mixture of new FRA's and FRA Reviews. This is a 13% rise on the previous reporting year.

2.3 The COVID-19 Virus has had a major impact towards the end of the reporting year and consequently the decision was made to postpone all FRA Reviews in order to avoid potential cross contamination. New FRA's will continue to be carried out when required.

2.4 The hoarding provided to a number of areas across the Trust has been assessed by the Fire Safety Team to ensure that it does not pose a significant risk in regards to fire and significantly affect the means of escape. The Fire Safety Team will continue to monitor the locating and movement of hoarding over the next reporting period.

2.5 Fire Training compliance remains high and at the end of the reporting year was at 92% compliant. The aim over the forthcoming year is to attain the Trust benchmark of 95%.

2.6 Due to the COVID-19 Virus; all 'Face to Face' fire training has been cancelled however; the E-Learning Module is still available and staff are still required to ensure that they complete the E-Learning in a period not to exceed one year. The use of the E-Learning will be reviewed over the next reporting year.

2.7 The new call out procedure for the Switchboard in relation to fire calls at the LRI has been a huge success over its first 10 months. With actual fire alarm occurrences still

remaining high, the Leicester Fire and Rescue Service (LFRS) attendance has been reduced to an all-time low. In the first two months of the year with the old system in place the LFRS attended the site 17 times to Unwanted Fire Signals (UwFS); the following 10 months with the new procedure has seen them attend on only 7 occasions for UwFS. All 7 attendances during the new system were at the request of the Duty Manager due to uncertainty and safety concerns.

2.8 The Trust is currently embarking on an extended period of large Capital Works Schemes; the Fire Safety Team has provided advice and guidance on numerous schemes across all three acute sites. The most assistance and advice has been provided to the East Midlands Congenital Heart Centre (EMCHC) Kensington Scheme and the Roof Top Wards, ITU Extension and Interventional Radiology Schemes at the Glenfield Hospital.

2.9 The LFRS has made only two Risk Visits over the reporting period however: following an UwFS at the Victoria Building a decision was made to carry out an Audit of the Victoria Basement Level. Following the inspection the LFRS provided the Trust with a Deficiency Letter highlighting areas for improvement in regards to the Fire Compartmentation. This information was passed on to the Head of Estates for completion. The LFRS indicated that no follow up visit was required.

2.10 There were 5 reported fires within the reporting period; three at the LRI and two at the LGH. All five fires were well dealt with and there were no injuries/casualties resulting from these fires. The most significant fire occurred in a kitchen between Wards 15 and 16 at the LRI while the area was under CDM due to a large refurbishment of the area. The fire resulted from a suspected electrical fault with an under counter fridge and although the products of combustion were contained within the kitchen compartment, the decision was made to evacuate Wards on the same level and above as a point of safety. In total 109 patients were successfully evacuated and returned later that evening to their original Wards.

3.0 Covid-19 Response

3.1 In March 2020 the COVID-19 Virus began to have a significant impact on the operational running of all three main acute sites. In response to those operational changes, the Fire Safety Team made a number of changes that impacted on the normal ‘day to day’ work processes in regards to Fire Safety.

3.2 Due to Infection Control measures significant amounts of hoarding has been added to areas of all three Hospitals. The locations of the hoarding have been assessed by the Fire Safety Team to ensure that it does not significantly affect the available Means of Escape (MOE). Drawings of the hoarding locations have been located onto FRA Review Documents that were specifically designed for the COVID-19 Virus.

3.3 The FRA Review form provides specific information in regards to the safe use of electrical equipment in Oxygen enriched atmospheres and also any increased risks in regards to evacuating in the event of fire.

3.4 In order to prevent the risk of cross contamination; the decision was made to postpone all FRA Reviews other than those specifically for COVID-19 patient areas. It should be noted that these areas already have a suitable and sufficient FRA.

3.5 The decision whether to simply delay all reviews for approximately 4 to 6 months or send out a Remote FRA Review form for completion by Departments will be made in the next Reporting Year. A Remote FRA Review form has been created in preparation.

3.6 The Fire Safety Team will continue to provide new Fire Risk Assessments where they are required.

3.7 Due to unforeseen issues in regards to Fire Extinguishers in Critical Care locations, the decision was made to purchase 60 new appliances (30 x Foam and 30 x CO2)

3.8 Following concerns raised at the Glenfield Hospital in regards to provision of suitable Fire Assembly locations; the decision was made to locate 2 Fire Extinguishers (1 x Foam and 1 x CO2) inside the hoarded areas containing Intensive Care for COVID-19 patients; this allows staff to potentially tackle and extinguish a small fire without leaving the 'dirty area' to acquire the appliance.

3.9 All 'Face to Face' fire training has been cancelled until further notice; the decision when to reinstate 'Face to Face' training will be made in the next reporting period. It should be noted that the E-Learning is still available to all staff and they are expected to complete this training in a period not to exceed one year. Current statistics indicate that staff are using the E-Learning as the compliancy figures are still high despite the cancelation of courses.

3.10 Fire Warden Training has been cancelled until further notice in line with Trust Guidelines. It was also cancelled in order to not remove 'front line' staff from there operational clinical priorities.

3.11 All Fire Evacuation Training planned for the next reporting period has been postponed and a new plan to provide evacuation training will be created in the next reporting year.

3.12 No fire drills will be carried out until further notice in order to allow administrative staff to social distance in line with Government Guidelines.

4.0 Fire Safety Committee

4.1 The UHL Fire Safety Committee continues to act as a subcommittee to the UHL Health and Safety Committee chaired by the Director of Safety and Risk for the Trust. The meetings which are now chaired by UHL's Head of Compliance are planned quarterly to enable any issues raised to be escalated to the Health and Safety Committee in a timely manner. Following the promotion of the Committee at the Quality and Safety Boards, there has been an increase in Clinical CMG attendance.

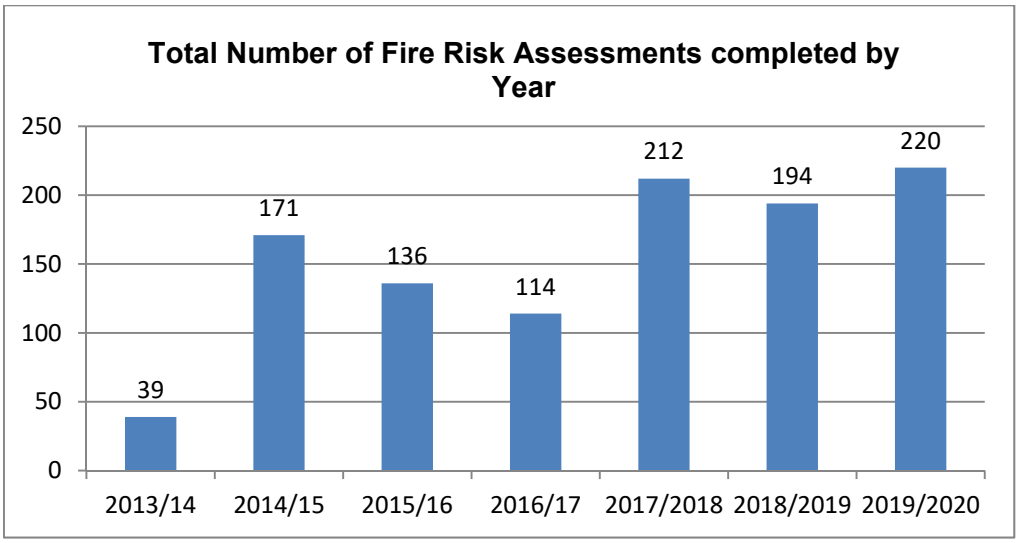
4.2 The Committee continues to meet on a quarterly basis with the meetings currently taking place in May, August, November and February. The aim is to sit in the month prior to the H&S Committee which allows any issue escalation to be raised in a timely manner.

5.0 Fire Risk Assessment (FRA)

5.1 In the reporting period 2019/2020 a total 220 Fire Risk Assessments (FRAs) and FRA Reviews were undertaken and completed across the three acute sites.

5.2 The total number of FRAs highlights a 13% increase in FRAs compared to the previous reporting year.

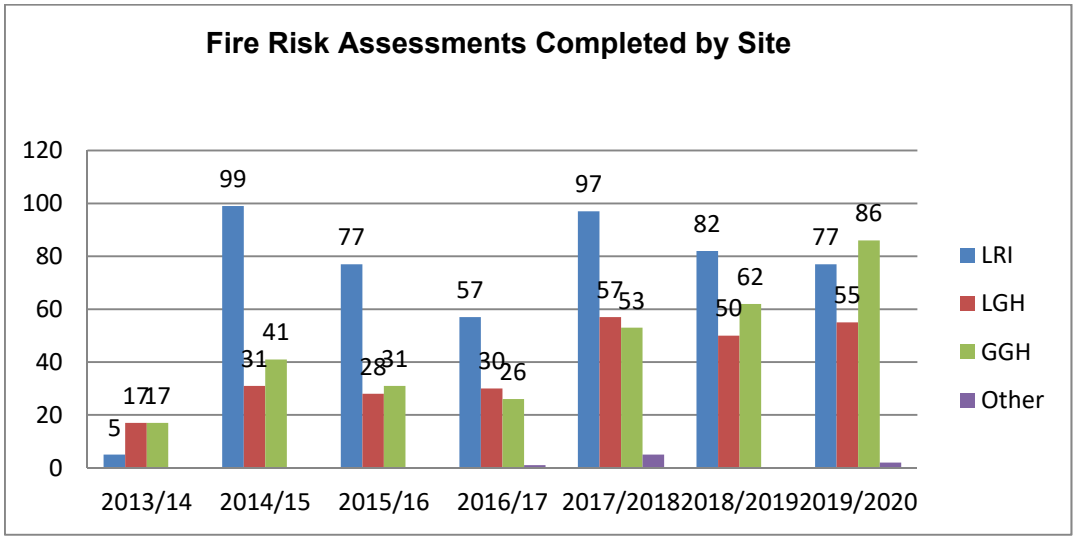
5.3 Chart 01: Fire Risk Assessments completed



5.4 The graph above demonstrates the progress that has been made in relation to the completion of FRA's since 2014.

5.5 The Fire Risk Assessment audit is only one part of the process to ensure that the Trust has robust Fire Safety Procedures, and in some cases it is only the first step in identifying what needs to be addressed, rectified and in some cases replaced. It also drives both backlog maintenance and capital expenditure. It also identifies training needs and drives policy development and implementation.

5.6 Chart 02: Fire Risk Assessments Completed by Site



5.7 The COVID-19 Virus and its impact across the three acute sites has driven a change in focus in regards to Fire Safety. In quarter four, the FRA Review procedure was 'frozen' due to the risk of cross contamination between clinical areas containing vulnerable patients and in order to monitor the changes in regards to structure around COVID-19 patients. The changes around the Review Procedures are documented within Section Three of this Report.

6.0 Common Themes Fire Risk Assessments

6.1 The main issues identified within the FRA Significant Findings are listed below and how we are trying to resolve these issues is also recorded.

Observations and Actions:

6.2 Fire resisting door sets; damaged heat and smoke seals/failing to close into frame/insufficient fire resisting potential.

a) The Fire Safety Department are informing all staff during annual training sessions, the requirement for them to report damage to fire resisting door sets. They are also being advised of the impact on maintenance completion, if issues are not reported in a timely manner.
b) Early in the reporting period, a scheme was run by the Capital Team to replace specific Compartment door sets at the Glenfield and LRI sites. A similar scheme was created in the early stages of quarter four; this time the door sets to be replaced were to be across all three sites.

6.3 Fire resisting doors into hazard rooms wedged or held open by irregular means.

a) The Fire Safety Department are informing all staff during annual refresher training, corporate induction and fire warden training, of the potential hazards which can result from this practise. Department managers are informed at the time of Fire Risk Assessments (FRA), when fire resisting doors are found wedged open and wedges are removed. The information along with photographs is recorded in within the FRA report, which is sent to Department managers. All their staff should be subsequently informed of any Hazards identified within the report.
b) A way of preventing the wedging of doors would also be to repair and improve the air conditioning systems where required as the door wedging tends to increase during the summer months.

6.4 The lack of fire alarm mimic/display/repeater panels within specific areas; Glenfield/Kensington/ Balmoral Level 2/Sandringham.

a) This has been raised through the Capital Team and progression to be made during new Capital Projects. All Staff are informed of safe investigation techniques, during annual fire training sessions and Fire Risk Assessment visits.

6.5 Departments with no Fire Wardens and not carrying out monthly inspections.

a) This is identified during Fire Risk Assessment visits/reports. The situation has improved significantly however the continuing need to train more staff is evident

due to the initial starting position in regards to Fire Wardens and the continual staff movements between Departments.

b) The maximum number of trained staff in this reporting year was 180 persons (12 courses of 15 trainees) In order to increase the number of available Fire Wardens; the Fire Warden Course in the next reporting year will now provide an annual maximum capacity of 240 persons (6 courses of 40 persons). This increase in course occupancy combined with a reduction in the required training sessions will prove to be a more economical use of the Fire Safety Teams time.

6.6 No suitable Emergency Evacuation Plans.

a) A standardised 'Fire Evacuation Procedure' template is sent to Responsible Persons on request and also provided to staff during the Fire Warden course. The Responsible Persons are informed of their requirement to create and complete the template. They are then required to inform all local team members, by visually displaying the procedure in prominent areas and cascading through local team meetings. A copy of the Fire Evacuation Procedure is contained within the Fire Safety Policy (Appendix C) and the Fire Risk Assessment template.

b) Where assistance is required; the Fire Safety Team provides on-site advice to the Responsible Persons and assists in the creation of the procedure.

6.7 Storage and waste located within the Means of Escape (MOE).

a) Awareness is raised during annual fire training and hazards identified during Fire Risk Assessment visits; the Fire Safety department have been informed that Estates & Facilities will continue to provide 'Dump Your Junk' days; this is to facilitate the removal of items.

7.0 Capital works

7.1 There are a significant number of large Projects 'in progress' or awaiting a start date following the completion of a Capital Works Business Case; the list of Projects is below:-

a) GH - Interventional Radiology (In progress and a completion date of May 2020).
b) GH - AICU Extension (In progress and a completion date of approximately June 2020).
c) GH - Three Modular Wards provided to the roof area (In progress; completion date planned for June 2020 and occupation planned for April 2021).
d) GH – Temporary Decontamination Unit (Completed during this reporting period).
e) GH – New purpose built Decontamination Building (Planned to start during next reporting period)
f) GH - MRI Extension (In progress with completion date in next reporting period).
g) GH – Catheter Laboratory C (Completed during this reporting period).
h) LRI – Kensington EMCHC (In progress with a completion date in next reporting period)
i) LRI – Wards 15 & 16 Refurbishment (Completed during this reporting period).
j) LRI – Ward 8 Refurbishment (Completed during this reporting period).
k) LRI – Ward 21 Refurbishment (Completed during this reporting period).
l) LRI – Ward 22 Refurbishment (Planned to start during next reporting period).
m) LGH – Fluoroscopy Rooms in Radiology (Completed during this reporting period).

7.2 Despite the design of a number of these Projects already being agreed; many of them are under constant review/change and the Fire Safety Team are mostly kept in 'the loop' regarding these changes.

7.3 A Fire Prioritisation Meeting mid-way through the reporting period identified areas requiring capital funding. A decision was made to direct the Fire Budget Capital Funds to the areas listed below (6.4). The funding decisions were based around risk priorities in regards to life and also potential impacts on the operational running of the Trust.

7.4 LGH – Fire Alarm upgrade to Radiology and Diabetes compartments (scheduled start in next reporting year).
LRI – Balmoral Fire Alarm upgrade (scheduled start in next reporting year).
LRI – Kensington Fire Alarm upgrade (to be completed following EMCHC works).
GH – Fire compartmentation to the Hospital Street (scheduled start in next reporting year & to be carried out in selected areas on a rolling scheme schedule).

7.5 The GH fire compartmentation works are to be carried out over an extended period of time due to the capital required. A meeting was held with Envirograph this reporting year to confirm the fire stopping materials available for use in the Hospital.

7.6 Following discussions with regards to the Fire Alarm system at the LGH; it was decided to place stand-alone systems into the Radiology Department and Diabetes area. The systems will be installed by Siemens which will allow them to 'talk' to the existing system within the rest of the Hospital. This will also enable further improvements as it will free up valuable capacity on the current alarm system. The Radiology and Diabetes Departments were chosen in line with the current reconfiguration plan.

7.7 Due to restricted time constraints around the installation of the new Balmoral Fire Alarm system; a decision was made by the Capital Team to move forward the replacement of the Sandringham Fire Alarm system and to move the Balmoral system to the next reporting period. The new Sandringham Fire Alarm system is currently being installed and is estimated for completion in May 2020.

8.0 Training

8.1 During Quarter 2 the Senior Management Team were presented with a proposal regarding alterations for Fire Safety Training. These changes were accepted and have been implemented and came into effect during Quarter 4.

8.2 Since January 2020 face to face training sessions were reduced to one session per site per month as a result of a decline in attendance due to staff members using the e-Learning alternative.

8.3 Since January 2020; Fire Warden training will take place every 2 months and with an increased capacity that will also allow us to increase the potential annual trained fire wardens by up to 60 persons with a reduced training time of 50%.

8.4 Since January 2020; the Corporate Induction training has been slimmed down to 15 minutes and new staff will be expected to attend a 'face to face' session or carryout

the e-learning programme on HELM within 4 weeks of arrival. New starters will be provided with a local induction form and fire safety handbook.

8.5 Since January 2020; Fire Evacuation drills are to be carried out on all stand-alone buildings and in the Clinical Education Centres. The drills have been postponed since the COVID-19 Virus and will start at a suitable time in the next reporting year. Two fire drills were carried out prior to their suspension.

8.6 From April 2020 (the next reporting year) a decision was made to provide fire evacuation training to all inpatient areas however; the decision was made in March 2020 to suspend this due to COVID-19 implications.

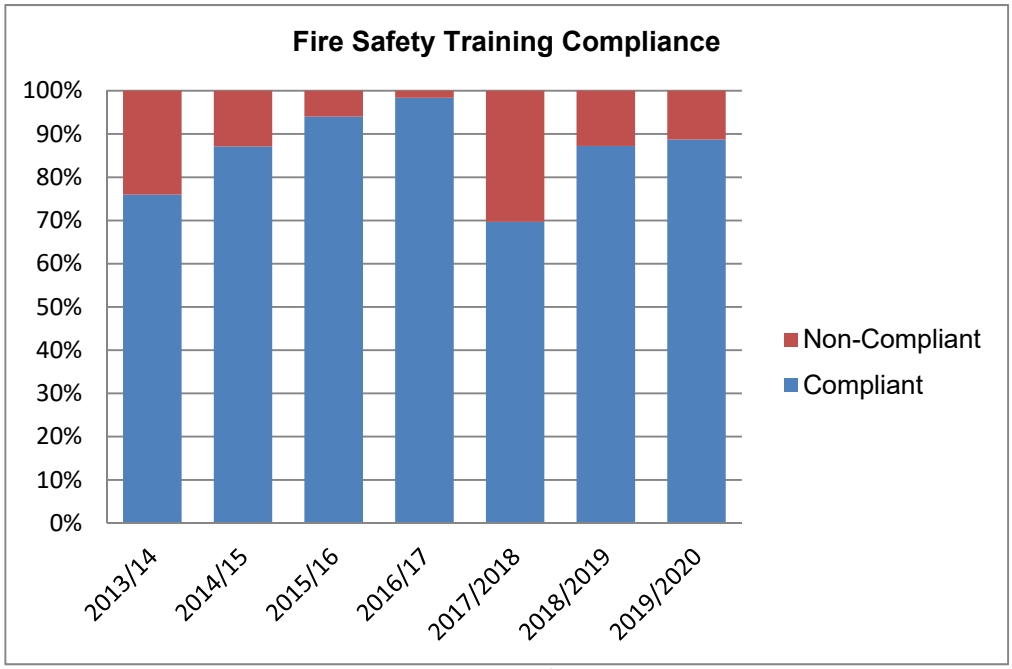
8.7 Currently the reporting figures on HELM show compliancy for Fire Safety Training at 92%. This figure has increased significantly from the previous year due to a new training package being implemented for Estates & Facilities staff.

Table No 1 – Mandatory/Specialist Fire Safety Training Sessions provided for reporting year:

Training/Department/Type	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Totals
Annual Refresher	20	17	18	6	**61**
Induction	11	18	9	11	**49**
Fire Warden	4	4	8	2	**18**
Evacuation Training	1	3	6	0	**10**
DMU Students	0	0	3	3	**6**
Paediatric Induction	1	0	0	2	**3**
Volunteer	2	3	2	2	**9**
Total	39	45	46	26	**156**

8.8 Chart 04 shows the percentage of compliance in regards to Fire Safety Training since 2014. After a large reduction in the compliance during 2017/18; there has been a significant upturn within the reporting period and we are hopeful that this rise can continue as it had done throughout the previous years.

8.9 Chart 03 – HELM Training figures



8.10 Fire Safety Training is offered and delivered in a number of ways to ensure compliance.

a) Fire Safety Induction (Corporate & Volunteer)
b) Fire Safety Induction (Local)
c) General Fire Safety: Face to Face sessions (Lecture Theatres).
d) General Fire Safety: E-Learning

8.11 A total number of 91 Fire Wardens have been trained throughout the year with the training has been well received by all new trainees.

8.12 During Quarter 4 a Practical Fire Simulator was invested in to allow the facility for providing simulated Fire Training. This training is to be included within Fire Warden Training and ad-hoc drop in sessions across all three sites.

9.0 Unwanted Fire Signals (UwFS)

9.1 The occurrence of an unwanted fire signal is detrimental to the operation of any healthcare establishment. Such instances can lead to disruption of service and patient care, increased costs, and unnecessary risk to those required to respond to the alarm raised. Therefore, no unwanted fire signal is considered acceptable.

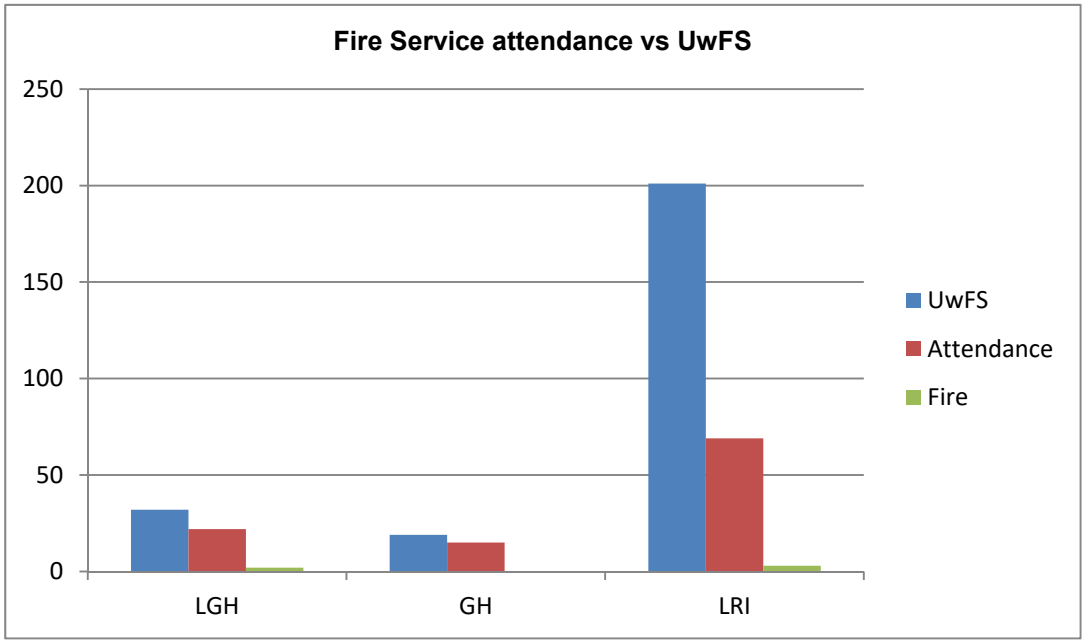
On the 4th June 2019 at 09:00 a new Switchboard procedure for the LRI was introduced which placed a 5 minute delay on making a '999' call to the Fire Service; this allows for a suitable investigation to take place. At any time during the 5 minute delay; Switchboard may place a '999' call on request.

9.2 The new Switchboard procedure has decreased the ammount of UwFS attended by the Fire Service significantly; due to the success of the new call out procedure, we will assess the potential for implementing the same procedure at the Glenfield and LGH sites; this will be done in the next reporting year. The Tables and Charts below (Table 02 & Chart 06) demonstrate the progress made in reducing Fire Service attendance over the past three reporting years; the reduction by 42% demonstrates the Trusts commitment to reducing Fire Service attendance during UwFS occurrences.

Table 02 - UwFS vs LFRS attendance last 3 years

Year	UwFS	Attended	%
2017/18	246	163	66
2018/19	221	108	49
2019/20	252	69	27

Chart 06 – Fire Service attendance vs UwFS last year



9.3 The Table below (Table 03) demonstrates how the change in Switchboard procedures has reduced the Fire Service attendance at the LRI for Unwanted Calls. LFRS attended the LRI for 17 false alarms in the first two months of the reporting period; the following 10 months resulted in a mere 7 attendances to false alarms. It should be noted that all 7 attendances for the false alarms were on request from the Duty Manager/Fire Response Team on a point of concern or safety.

Table 03 – Fire Service attendance since introduction of new switchboard process

		Occurrences	Attend	False Alarm	Special Service	Fire
Old Process	01/04/2019 to 4/6/19	43	18	17	1	0
New Process	5/6/19 to 31/3/20	166	14	7	6	1

9.4 During 2019-20 a third party was engaged to install a new Fire Alarm System in the Windsor Building this was requested to help reduce the number of UwFS and also provide a 'double knock' on smoke detection within the building. Still 'early days' in regards to assessing the effect on reducing UwFS within the building; the overall impact will be assessed during the next reporting period.

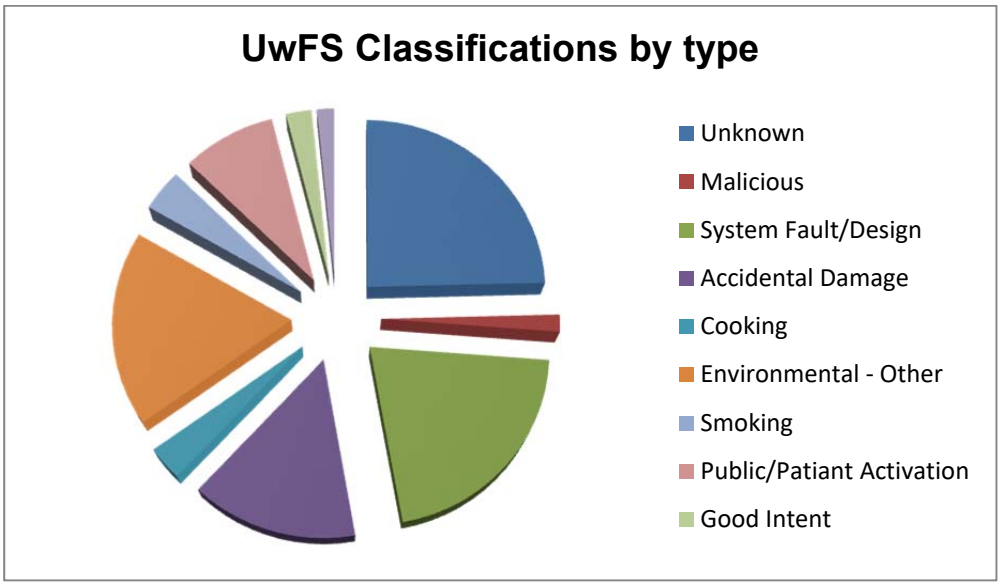
9.5 The table below (Table 04) identifies the location of all UwFS at the LRI that requires LFRS attendance for the reporting year 2019/20. It should be noted that the Balmoral Building accounted for almost 50% of the call outs and consequently the replacement of the current alarm system is at the top of the 2020/21 Fire Capital Budget list.

Table 04 – UwFS Locations at LRI Site

	Balmoral	Windsor	Kensington	Osborne	Sandringham	Jarvis	Estates	Genetics	Victoria	Total
April	2	1	3	0	0	1	0	1	0	8
may	6	0	1	0	0	0	1	0	0	8
Jun	0	1	0	0	1	0	0	0	0	2
Jul	2	0	0	0	0	0	0	0	0	2
Aug	0	0	0	0	0	0	0	0	0	0
Sep	0	0	0	1	0	0	0	0	0	1
Oct	0	0	0	0	0	0	0	0	0	0
Nov	1	0	0	0	0	0	0	0	0	1
Dec	0	0	0	0	0	0	0	0	1	1
Jan	0	0	0	0	0	0	0	0	0	0
Feb	0	0	0	0	0	0	0	0	1	1
Mar	0	0	0	0	0	0	0	0	0	0
Total	11	2	4	1	1	1	1	1	2	24

9.6 Unwanted fire signals should be categorised in order to identify their causes, record and report their occurrence, and allow appropriate actions to be decided on for their reduction. Following any UwFS an investigation should take place to identify the cause. The table below (Chart 09) shows the identified causes of UwFs across all three sites.

9.7 Chart 09 – UwFS by classification type



9.8 The total UwFS across the UHL sites in this reporting period totalled 252 with the highest percentage originating from the LRI site. It is however worth relating this figure to the number of detectors (c.6000) located at this site.

9.9 Incidents involving the improper use of toasters have reduced significantly with only 8 recorded cases of UwFS caused by Cooking.

9.10 The reporting of the UwFS has improved significantly however the amount of unknown causes is still a concern despite reducing from 70% of all call outs to 25%.

The aim in 2020/21 will be to reduce this even further by improving the reporting process.

9.11 During the next financial year the Fire Safety Team plan to reduce UwFS by installing new Fire Alarm Systems within the Sandringham building and Leicester General Hospital Sites. We expect the new Sandringham system to have a significant impact on the current false activations within that building and the disruption caused to staff.

10.0 Fires

10.1 There have been five fires within the reporting period:

a) Leicester General Hospital – Public Car Park – 28th May 2019 at 14:34
   - Patient's vehicle caught fire on the public car park, there were no injuries and the incident was dealt with by the LFRS.

b) Leicester Royal Infirmary – Ward 15&16 – 26th July 2019 at 17:52
   - Under counter fridge fire, the Fridge was in a kitchen within the circulation space between Wards 15 & 16 in the Balmoral Building. The area was under CDM at the time of the fire and consequently no Trust staff were actively engaged in the immediate area.

c) Leicester General Hospital – ITU Kitchen – 30th August 2019 at 14:34
   - A member of the ITU clinical staff identified a small flame/external sparking at the bottom front of the fridge where LED lights are situated; the fire alarm was not sounding. The Department activated a 'break glass manual call point' and followed this up with a '2222' call. The Switchboard made an immediate '999' call to the Fire Service. After raising the alarm the Department Staff then extinguished the fire with the use of a single 2kg CO2 extinguisher.

d) Leicester Royal Infirmary – Research Department – 30th October 2019 at 11:30
   - Whilst photocopying in the Research Department at the LRI a member of staff observed smoke appearing from inside the photocopier. On witnessing the incident; the Department immediately isolated the photocopier by turning it off at the socket and removing the plug. After a short period of time; the smoke ceased emanating from the unit.

e) Leicester Royal Infirmary – Estates Department – 5th December 2019 at 06:22
   - Night manager reported hearing the Fire Alarm sounding; upon investigation they discovered a fire in the estates ground floor front office. The fire was within the radio battery charging unit/ batteries (figures 4, 5). The electrics were isolated and fire was extinguished.

10.2 Each reported fire is fully investigated to gain an understanding of the immediate, underlying and root causes and where improvements can be implemented in order to prevent a reoccurrence.

10.3 The findings of the reports are shared at the Executive Meetings by the Director of Estates and Facilities as a "hot topic" item and submitted for inclusion in the Health and Safety Committee meeting.

10.4 Any lessons learned are shared with staff via the members of the Fire Safety Committee.

11.0 Freedom of information requests

11.1 During the reporting period the Trust has received two Freedom of information requests the first was a request from the BBC requesting details of cladding use across UHL sites. The second was a request from a student requesting details regarding passive and active Fire Safety provisions across the trust. Both requests were responded to and no further requests were made.

12.0 Enforcement

12.1 No Enforcement notices were issued to the Trust in the reporting period however; a failure to comply deficiency letter was sent to the Trust in regards to the compartmentation in the Victoria Building Basement. The Trust is planning to rectify the failings in the early stages of the next financial year and consequently there is no further action pending from LFRS. The work required was discussed by the Fire Safety Team and Head of Estates.

12.2 Leicestershire Fire and Rescue Service (LFRS) have conducted two visits at the LRI site; these are listed below. Three further visits were arranged however; two were cancelled due to LFRS Emergency Call Out reasons and the third due to COVID-19.

a) Quarter 3 – LRI – Sandringham/Kensington/Balmoral - review access and risers

b) Quarter 4 – LRI – Victoria Basement – audit generating Deficiency Letter.

13.0 Estates Return Information Collection (ERIC)

13.1 The ERIC report is a mandatory information return required by the Department of Health for all NHS Trusts including Ambulance Trusts. It comprises information relating to the costs of providing and maintaining the NHS Estate including buildings, maintaining and equipping hospitals, the provision of service e.g. laundry and food, and the costs and consumption of utilities.

13.2 The ERIC data relating to Fire Safety for 2019/20 has been submitted as outlined below:

13.3 Table 05 UHL ERIC Return for FIRE 2019/20

Ref	Field	Definition	Unit(s)
01	Fires recorded	Total number of fires recorded as required by HTM 05-01: Managing healthcare fire safety. https://www.gov.uk/government/publications/managing-healthcare-fire-safety	5
02	False alarms – No call out	Total number of false alarms that were dealt with by the organisation, without the fire and rescue service being called out.	192
03	False alarms – Call out	Total number of fire alarms that were attended by the fire and rescue service, but which the cause was a false alarm.	60
04	Number of deaths resulting from fire(s)	Total number of deaths of patients, visitors and staff resulting from fire(s).	0
05	Number of people injured resulting from fire(s)	Total number of patients, visitors and staff injured resulting from fire(s).	0
06	Number of patients sustaining injuries during evacuation	Total number of patients injured during evacuations, caused by fires or false alarms.	0

14.0 Fire Safety Resources

14.1 The Fire Safety Team currently employs three Fire Safety Advisors equating to two and a half full-time equivalent posts. There is currently one vacancy for a full time fire advisor. There has been a successful re-banding exercise with the positions now being banded at band 7, the vacancy has been advertised and the recruitment process is to be completed during Quarter 1.

14.2 The roles are required to support University Hospital of Leicester NHS Trust (UHL) and Leicester Partnership Trust (LPT) across multiple premises in Leicester, Leicestershire and Rutland.

14.3 UHL are supported by two full-time Fire Safety Advisors (Currently one)

14.4 LPT are supported by two part-time Fire Safety Advisors

15.0 Fire Safety Work Plan / Priorities for 2020/21

15.1 There are a number of priority areas that are to be focused on in the coming year within the Fire Safety Team including:

a) Improved recording and reporting of all Fire Signals by Switchboard including the reduction of recorded “unknown” causations as illustrated in Chart 09.
b) Reduction of UwFS across all 3 acute sites and the assessment of the implementation of the new procedure at the Glenfield Hospital.
c) Development and improvement of documented local evacuation procedures.
d) Continue to increase the number of suitably training Fire Wardens across the Trust.
e) Continuation of the development and implementation of local Fire Log books.
f) Development of new training presentations for the varied training sessions provided: Induction / Annual / Volunteer / Fire Warden.
g) Maintain and potentially re-organise the Fire Risk Assessment schedule to ensure compliance following the COVID-19 Virus.
h) Implement the new Fire Evacuation Procedure Training.
i) Provide Fire Evacuation Drills to all stand-alone buildings and Clinical Education Centres.
j) Provide the Capital Team with advice and assistance on all Capital Schemes taking place and also those in the planning stage.

16.0 Appendix A – Annual Fire Statement

Annual Fire Safety Statement: 2019/20

NHS Organisation: University Hospitals of Leicester NHS Trust (UHL)
I confirm that for the period 1st April 2019 to 31st March 2020, all premises which the organisations owns, occupies or manages have had Fire Risk Assessments undertaken in compliance with the Regulatory Reform (Fire Safety) Order 2005, and (please 'check' the appropriate boxes)

1	There are no significant risks arising from the fire risk assessments.	☐
2	The organisation has developed a programme of work to eliminate or reduce to a reasonably practicable level the significant risks identified by the risk assessment. (limitations / cuts on available budgets may place constraints on what risks can be targeted / prioritised / rectified)	☒
3	The organisation has identified significant risks, but does not have a programme of work to mitigate those significant risks.	☐
4	Where a programme to mitigate significant risks has not been developed, please insert the date by which such a programme will be available, taking account of the degree of risk.	☐
5	During the period covered by this statement, the organisation has not been subject to any enforcement action by the fire and rescue authority. Please outline details of enforcement action in Annex A Part 1.	☒
6	The organisation does not have any on-going enforcement action pre-dating this Statement. Please outline details of on-going enforcement action in Annex A Part 2.	☒
7	The organisation achieves compliance with the Department of Health's fire safety policy by the application of HTM 05 or some other suitable method.	☒

Chief Executive (Acting)	Rebecca Brown
Signature:	
Date:	

Director of Estates and Facilities:	Darryn Kerr
Signature:	
Date	

Fire Safety Manager:	Michael Blair
Signature:	MBlair
Date:	11 May 2020
Completed Statement to be retained for future audit.	

ANNEX A
Part 1 – Outline any enforcement action taken during the past 12 months and the action taken or intended by the organisation. Include, where possible, an indication of the cost to comply.
No enforcement action taken in the last 12 months
Part 2 – Outline any enforcement action on-going from previous years and the action the organisation has taken so far. Include any proposed action needed. Include an indication of the cost incurred so far and, where possible, an indication of costs to fully comply.
Not Applicable – no on-going enforcement from previous years.