Cover report to the Trust Board meeting to be held on 3 September 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:	Alison Moss – 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 Carolyn Fox – Chief Nurse
Date of meeting:	27 August 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 27 August 2020:- *(involving Ms V Bailey, QOC Non-Executive Director Chair, Mr Ballu Patel, Non-Executive Director, Mr A Furlong, Medical Director, Ms C Fox, Chief Nurse, Ms B O'Brien, Deputy Director of Quality Assurance, Miss M Durbridge, Director of Quality Improvement and Efficiency Transformation, and Ms C West, CCG Representative. Mr C Allsager, Clinical Director, ITAPs, Ms L Fletcher, Head of Operations ITAPs, Ms S Khalid, Clinical Director, RRCV, Ms H Busby-Earle, Clinical Director, MSS, Ms E Broughton, Head of Midwifery, Ms F Lennon, Deputy Chief Operating Officer, and Ms H Brooks, Cancer Clinical Lead, attended to present their respective items).*

- **Summary of QOC Conference Call held on 30 July 2020** – paper A noted, having been submitted to the Trust Board on 6 August 2020.

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

- **COVID-19 Position**
  The Medical Director gave a verbal update with regard to COVID-19, noting that 8 patients with COVID-19 were currently in hospital and no patients were being treated for the virus in ITU. The number of cases in the community had come down, but it was still three times the national average, hence the need for increased vigilance for infection prevention. The nosocomial rates were reported as a positive indicator as no patient had acquired COVID-19 in the hospital setting in the last six weeks. The CQC had reviewed adherence to the Infection Prevention Checklist and would provide a score. Newly issued guidance for Infection Prevention Control addressing PPE, air exchange and practice in theatres was being incorporated into clinical pathways. The System was required to submit plans to NHSE/I for restoration and recovery by 1st September. Winter planning was in train. The Chief Nurse added that the visiting guidance had been reviewed against the national and local network guidance. Whilst some concession could be made, there remained strict and proportionate protocols. These reflected the high rates of infection in the community and respecting that patients were required to self-isolate before coming into hospital for elective procedures. Mr Ballu Patel, Non-Executive Director, sought assurance regarding communication with patients and their families regarding the visiting protocols. The Chief Nurse noted that the overwhelming response had been that patients understood why restrictions were in place.

- **Quality and Performance Report Month 3**
  The Medical Director presented paper C which gave an overview of the Trust's performance against the key quality and performance metrics. In doing so, he highlighted the improved performance for the percentage of Neck of Femurs operated on less than 36 hours based on admissions, referred to the mortality rates which were addressed in more detail in a separate paper, and reported that there had been a Never Event in the Emergency Department. The Never Event, which was subject to a full investigation, concerned the wrong route for medication. There had been no patient harm. The contents of the report were received and noted.

- **Patient Safety Data Report**
  The Director of Quality Transformation and Efficiency Improvement presented paper D which provided the annual

review of moderate plus harm incidents (April 2019 –March 2020), reported on medical care complaints, PHSO consultation and the patient safety data for July 2020. The Director of Quality Transformation and Efficiency Improvement noted that the Trust had a good relationship with the Healthcare Safety Investigation Branch (HSIB). HSIB it had agreed to investigate one of the cases referred and would be visiting in September. This would support quality improvement and learning which could be applied nationally. The annual review of harms demonstrated a reduction in the number of incidents of moderate harm and above from 265 to 139. Whilst the Director of Quality Transformation and Efficiency Improvement cautioned that Quarter 4 data would have been skewed by the reduction in activity, the reduction was positive and reflected on the focus from the Patient Safety Team on harm reduction. The number of Serious Incidents had seen a modest decrease, although this was compared to the number in the previous year which had been the lowest for 8 years. The most common themes were inpatient falls and injury/poor outcome for the mother. This was not unusual and reflected the themes for acute trusts nationally. The number of incidents reported as causing death to a patient was 3 which was the same number reported in 2018/19. For 2019/20 the top five specialities for harm incidents were Maternity, General Surgery, Geriatric Services, Respiratory Medicine and Emergency Department. These specialties accounted for 45% of the moderate and major harm incidents. The Director of Quality Transformation and Efficiency Improvement assured the Committee that the all the incidents and themes were under review and included in a programme of work. The report referenced the consultation regarding the Parliamentary and Health Service Ombudsman's draft Complaints Standards Framework. This created a new focus for the Ombudsman to promote a learning and improvement culture which was welcomed. The Director of Quality Transformation and Efficiency Improvement noted that the patient safety data for July 2020 was included in the report. There were no specific issues to highlight with the exception of two serious incidents. One related to a delay in acting on abnormal results from a New-born Bloodspot sample as part of the national new-born screening programme and the other related to a patient not receiving medication following their operation resulting in a stroke. The contents of the report were received and noted. ***It was agreed that reference to the Annual Harm Review and PHSO consultation be highlighted to the Board (Extract of paper D attached to this summary).***

- **Never Event: Misplaced Nasogastric Tube**
  Paper E, as presented by the Medical Director provided an overview of a root cause analysis investigation into a Never Event that involved a misplaced nasogastric tube. The report outlined the key findings from the investigation and the actions taken to prevent similar occurrences. The actions included a new safety checklist on NerveCentre; images to confirm placement to be carried out on high resolution monitors; increased number of viewing monitors and verbal orders not to be taken or given even in these unprecedented times. The Medical Director considered that the investigation and corrective action was a robust piece of work, the results of which were clinically supported and would have a wider application across acute trusts. Ms Bailey, QOC Non-Executive Director Chair, enquired whether the family had expressed a view about the investigation. This was not known. The contents of the report were received and noted.

- **Learning from Deaths Quarterly Report**
  The Medical Director presented paper F, which presented the quarterly report on Learning from Deaths data. The Medical Director. He noted that the Hospital Standardised Mortality Ratio (HMSR) indicator remained below 100 and the expected outcomes for HSMR were good. It was noted that the Medical Examiner service had functioned well, and during the surge in COVID-19 activity benefited from the service of three professionals returning to the service. There had been a spike in perinatal deaths reported in the last quarter and the ten cases in January had been the subject of a deep dive. Following this there was an action plan which had been enacted and the deaths in February and March were now under review. A further report would be made to EQB and QOC. The appendices to the report provided full transparency with respect to the mortality data. **The contents of the report were received and noted. It was agreed to refer the Report to the Trust Board for approval.**

- **Letter Delays in the Pain Service**
  The Clinical Director, ITAPs, attended the meeting to present paper G, provided an update on the action taken to resolve the delays in sending letters out to patients. He identified the improved systems and processes, including a reporting dashboard and escalation process to monitor performance which in turn was reported to the Quality and Safety Board. A harm review was underway. It was noted that one of the drawbacks with the new system was that clinicians were not alerted to letters being available for signature. Mr Ballu Patel, Non-Executive Director, expressed concern about this and arrangements for clinicians when they were absent. The Head of Operations, ITAPs, noted that this had been addressed in the monitoring process which set triggers for the time taken for letters to be signed and the numbers outstanding, These would be monitored at business meetings. The Clinical Director, ITAPs emphasised the cultural shift required to ensure that sending out letters was seen as integral to the care pathway. The learning would be used to ensure timely action within other ITAPs specialities. The Director of Quality Improvement and Efficiency Transformation noted that the learning was being extrapolated to other CMGs and included in the CMG performance appraisal. She noted that the issues had come to light from the GPs 'confirm and challenge' mechanism which had been valuable. The contents of the report were received and noted and the Chair asked for a further update on the harm review when it had been concluded.

- **Cardiology Reconfiguration Update**
  The Clinical Director, RRCV, attended the meeting to present paper H, which provided an update on the Cardiology Registrar workforce position, the bed reconfiguration and medical manpower changes in cardiology. Concern had been raised, through the GMC survey, by trainees who were seeing undifferentiated patients. They felt it did not add value to their training and detracted from their specialised training. Health Education England proposed to remove the trainees from CDU. To resolve the issue a 6-person rota was agreed and recruitment initiated. Unfortunately this was delayed due to COVID-19 and restrictions on travel. Three of the six posts were currently filled and on the rota together with a locum. The remaining three members of staff would join mid to late September. The intention was for HSTs to be removed from CDU by 12 October. The longer term aim was to implement rotation between medicine and cardiology and for medicine to create a general cardiovascular ward which did not need to be under the direct care of a cardiologist. However, there were many issues to be worked through. The Medical Director noted the assurances around processes but expressed concern about the ability to recruit. Mr Ballu Patel, Non-Executive Director, agreed and noted that the plan was vulnerable as a result. The Clinical Director, RRCV, agreed noting that the key to success was the recruitment. It was agreed to receive a further report in November.

- **Ophthalmology – Long Term Follow up of Patients**
  The Clinical Director, MSS, attended the meeting to present paper I which updated the Committee on the actions taken to address the high number of complaints received about the service and in particular appointment delays and cancellations. As a result of the actions taken the number of patients overdue for an appointment had decreased although there remained a significant number due to capacity constraints. The patient waiting the longest had been waiting since February 2018; previously this was September 2017. The patients who should have had an appointment in 2018 and would be seen in 2020. This had been achieved using a manual admin process to validate the patients and manual clinical review. The Clinical Director, MSS, outlined the processes used to review waiting lists, changes to pathways and instigation of harm reviews. Improvements had been achieved as a result of financial investment, the acquisition of Medisight, a patient note system and the LUECS (Leicestershire Urgent Eye Care Services) scheme. She added that further improvement could be made by a shift to community based prescribing but it required investment. The Clinical Director, MSS, acknowledged that because of the COVID-19 pandemic there was been a reduction in capacity which was at 50-60%. The contents of the paper were received and noted. The Committee requested a further report in October and for more time to be given for discussion of the issue.

- **Maternity Safety Update**
  The Head of Midwifery attended the meeting to present paper J, which provided assurance about the Trust's engagement with the national maternity safety strategy noting the progress with the maternity transformation programme. The paper noted the pause in the CMST requirements during the surge in COVID-19 activity and that national funding had yet to be confirmed. Since March 2019, 17 referrals had been made to Healthcare Safety Investigation Branch (HSIB), by the Trust, seven were completed and three were ongoing. Of the remaining seven, two were declined by HSIB for criteria, one declined by the family following HSIB contact and four families did not give consent for the HSIB investigation. There were 19 incidents in Quarter 1 classified as moderate and one classified as a serious incident, with three others awaiting review by the perinatal risk group. The recurring themes were post- partum haemorrhage; fourth degree tears, and unexpected admissions to Neo-natal Unit. All moderate incidents were reviewed by the perinatal risk group to share learning and improve care and escalate if necessary for serious incident investigation. The Chief Nurse added that the national focus on maternity services continued and the Trust had received a maternity self-assessment to complete. There would be a review of maternity services under the guise of one maternity governance review headed up by the Chief Nurse and Head of Midwifery. This would reflect on how maternity governance sat within corporate governance. There would be a report to QOC in due course. The Chair requested that the report on maternity governance be scheduled on the agenda to allow a full discussion.

- **Cancer Performance Recovery 2019/20**
  The Deputy Chief Operating Officer attended to present paper K, which updated the Committee on cancer performance and noting the impact of COVID-19. The Chief Operating Officer noted that in June, the Trust achieved 5 standards against the national targets. The target to reduce the number of patients waiting over 62 days had been achieved and the performance had improved to reduce the backlog of patients which was down to pre-COVID levels. The next challenge was to treat those patients waiting the longest. The referrals were reported to be up to pre-COVID a level which was a positive sign. The Deputy Chief Operating Officer noted that where reference had been made in the report to 0% of patients having been screened that was due to an national pause in screening which had now resumed. The Lead Clinician for Cancer, Ms Brooks, noted concern from patients about attending hospital due to COVID which delay treatment. This was being addressed by work with colleagues in primary care to provide advice and information. It was noted that patients had been reluctant to visit their GP and as consequence the Trust was seeing patients with more advanced cancers. Mr Ballu Patel, Non-Executive

Director, asked how patients could explore their concerns about using health services during the pandemic. Ms Brooks, Lead Clinician for Cancer, noted that all patients were given the telephone number for a clinical nurse specialist and in addition proactive contact was being made to reassure patients. The Chair asked the Medical Director and Deputy Chief Nurse highlight the cancer performance during their reports to Board. The contents of the report were received and noted.

- **Infection Prevention Annual report 2019/20**
  Paper l was presented by the Chief Nurse and reviewed the 2019/20 Infection Prevention successes and challenges for UHL. The declaration of a global pandemic for COVID-19 and the Trust's response was noted. There had been five Methicillin Resistant Staphylococcus Aureus (MRSA) blood stream infections reported. The target was for zero avoidable cases. Three cases were deemed unavoidable. **The contents of the report were received and noted and highlighted to the Board (paper L attached to this Summary).**

- **Bed Spacing and COVID-19 Social Distancing**
  The Chief Nurse introduced paper L2, noting the Government's guidance on social distancing and reporting on how this can be observed in the hospital setting. There were two sets of considerations: adult inpatient beds and neo-Nate cots. The Chief Nurse noted that, in new builds, the distance between beds was prescribed as 3.6m. This was not feasible in old buildings and 2.5m was considered reasonable. The decision had been taken to remove those beds that were less than 2m apart. For those beds between 2m and 2.5m there would be a review, referred to as 'bed watch' which would monitor infection rates and other data. With respect to the neo-Nate cots the guidance had changed which would require the removal of two cots at the Leicester General Hospital. However, these cots were used for short stays and mitigations had been put in place. The Committee noted the contents of the report, the associated risks and impact.

Items for noting:– the following reports were received and noted for information:-

- **Executive Quality Board (EQB) Action Notes – 11.8.2020 (paper M)**
- **Appraisal and Validation Update (paper N)**
- **Learning from Claims and Inquests (paper O)**

Public matters requiring Trust Board consideration and/or approval:

Recommendations for approval

- **Learning from Deaths Quarterly Report (updated paper F attached to this summary) –** This paper provides the quarterly report on learning from Deaths data required by the Clinical Negligence Scheme for Trust's Maternity Incentive Scheme.

Items highlighted to the Trust Board for information:

- **Patients Safety Data Report (extract of paper D attached to this summary) –** The relevant section of the paper reports on the Annual Review of Harms and highlights the consultation regarding the office of the Parliamentary and Health Service Ombudsman.
- **Infection Prevention Annual Report 2019/20 (paper L attached to this summary**) – This paper reviewed the 2019/20 Infection Prevention successes and challenges for UHL.

Matters deferred or referred to other Committees:
None

Date of next QOC assurance conference call:	24 September 2020

Ms V Bailey – Non-Executive Director and QOC Chair

Closed 10:08am

UHL Mortality and Learning from Deaths Report

Author: [Head of Outcomes & Effectiveness & Deputy Medical Director] Sponsor: [Medical Director]

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
Mortality Review Committee (MRC)	04/08/20	Discussion
Executive Board	EQB 11/08/20	Assurance
Trust Board Committee	QOC 27/08/20	Assurance
Trust Board		

Executive Summary

1. Context

1.1 UHL's crude and risk-adjusted mortality rates, and the work-streams being undertaken to review and improve review these, are overseen by the Trust's Mortality Review Committee (MRC), chaired by the Medical Director

1.2 MRC also oversee UHL's "Learning from Deaths" framework which includes learning identified through the:

- Medical Examiner Process
- Bereavement Support Service
- Specialty Mortality Reviews using the national Structured Judgement Review tool
- LLR Child Death Overview Panel reviews and Perinatal Mortality Review Group reviews using the national Perinatal Mortality Review Tool
- Clinical Team reviews and reflections
- Patient Safety Incident Reviews, Investigations and Complaints
- Inquest findings and Prevention of Future Death letters

1.3. One of the national Learning from Deaths requirements is for Trusts to publish their Learning from Deaths data on a quarterly basis and this is also one of the requirements of the Clinical Negligence Scheme for Trusts' (CNST) Maternity Incentive Scheme.

2. Questions

2.1 What are the data telling us around UHL's mortality rates and what actions are being taken to improve these?

2.2 Are we making good progress with our Learning from Deaths framework and what learning has taken place?

2.3 Are we meeting the national reporting requirements?

3. Conclusion

3.1 A summary of UHL's mortality rates, both risk adjusted and crude, are set out in the slide deck (Appendix 1). As expected, UHL's crude mortality for Quarter 1 of 20/21 was higher than usual, due to Coronavirus related deaths - mainly in April. As can be seen on slide 4 the number of deaths in June and July were similar to previous years but our crude mortality is still higher due to the reduced elective activity. Slide 6 shows that the weekly number of COVID-19 deaths has been in single figures for the 4 weeks of July.

Our latest SHMI is 96 for the Financial Year 2019/20 (published mid-August) and our HSMR for the same time period is 94.7. No individual diagnosis groups are above expected in the SHMI. At the last MRC we agreed to review those diagnosis groups with a meaningful difference in SHMI across the 3 sites. Further analysis and review is being undertaken to understand the reasons behind the differences and whether there is any learning for clinical pathways.

There are no new diagnosis groups with a 'CUSUM' alert in the HSMR but there is a new procedure group 'Repair of thoracic or unspecified aortic aneurysm'. Members of MRC noted that UHL's outcomes for both ruptured and elective repair of aortic aneurysm was better than the national average and that cross matching with UHL's Learning from Deaths database is being undertaken to confirm if there were any themes identified through either Medical Examiner screening or the Specialty M&M process.

Members of MRC noted that NHS Digital have confirmed coronavirus related activity and deaths will be removed from both the SHMI and HSMR datasets but as the latest data only goes up to the end of March 20, it is not yet known what impact this will have on UHL's results.

3.2 The 19/20 (Q1-4) and 20/21 (Q1) "Learning from Deaths" activity is summarised in Appendix 3

There was a quarter on quarter increase in the number of adult deaths in 19/20 having the cause of death discussed with the Medical Examiner with 93% of all deaths being discussed for the year. This increased to 97% in Quarter 1 of 20/21. We are now looking to increase child and neonatal deaths being discussed with the Medical Examiner. We have also agreed to provide a Medical Examiner service for LOROS

Although we saw an increase in the number of deaths at the end of March with the start of the Coronavirus (COVID) admissions, we were able to meet our 95% threshold for screening in Quarter 4 and 99% of all adult deaths in 2019/20 been screened. We have been able to further improve screening performance in Q1 (99.9%) despite the significant increase in the number of deaths. We have also been able to improve on the number of bereaved relatives spoken to by the Medical Examiner especially at the Glenfield hospital with 90% of bereaved relatives (for adult deaths across all 3 sites) being spoken to during Quarter 1. This is particularly pleasing due to the difficulties caused by visiting restrictions during the Coronavirus pandemic.

During the financial year 19-20, 1017 (32%) of adult cases screened by Medical Examiners have been referred for further review – 316 were for a Structured Judgement Review (SJR). A further 122 SJRs have been or are also being undertaken for child (36) and neonatal (87) deaths.

Of the 316 SJRs requested for adult deaths in 2019/20, a death classification has been agreed for 254 (80%). Although we have not met our internally set standards, some of this has been due to the cessation of M&M Meetings during the COVID pandemic. M&M meetings are now taking place and good progress is being made with catching up on the backlog and also with completion of SJRs requested in Quarter 1 for this financial year.

1 death (Jan 20) has been reported as more likely than not due to a problem in care since the last report to MRC, details of which was reviewed by the MRC on 4th August. Problems were around complications related to chemotherapy and the death is being investigated by the Patient Safety Team as a Serious Incident.

Cross cutting themes from both clinical reviews and SJRs continue to be around communication with patients and relatives, recognition of patients approaching end of life and reviewing / interpretation of observations and investigations.

The priority for Quarter 2 will be to complete outstanding SJRs and Clinical Reviews in order to collate and theme identified learning and to confirm actions being taken to improve care of all patients.

3.3 In March 2020, NHS Resolution advised that "In recognition of the current pressure on the NHS and maternity services in response to Covid-19" Reporting requirements relating to the maternity incentive scheme (MIS) 10 safety actions will be paused until Monday 31 August 2020.

On July 9th 2020, the Trust was contacted by the MBRRACE-UK Perinatal Lead informing the Trust of an increase in perinatal deaths in the first half of 2020. This increase had already been noticed by the maternity team and further analysis has shown that the increase is due to deaths in the first 3 months of the year and a cluster review has been completed for the 10 cases that occurred in January 2020.

Members of MRC received and reviewed the Quarterly report from the Perinatal Mortality Review Group and the updated Stillbirth cluster review undertaken earlier this year. The review identified issues with care that may have affected the outcome for the baby identified for 2 cases. Both of these cases are being investigated as Serious Incidents. One of the SI investigations is being carried out by the HSIB, the other one is being undertaken locally with an external consultant being sought to sit on the RCA panel.

An action plan has been developed to address the issues identified and all have been completed with the exception of the action relating to ultrasound as significant changes were made to ultrasound scan scheduling as a result of COVID and the impact of these changes are now being reviewed to inform future plans.

A further review is due to be undertaken to encompass stillbirths in February and March which will be reported to the September meeting of the MRC and thence to September QOC meeting. It will also be taken through the Local Maternity Systems Boards and the UHL Perinatal Mortality Lead is liaising with the MBRRACE team.

Input Sought

To receive and note the content of this report.

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	[Not applicable]

2. Supporting priorities:

People strategy implementation	[Yes]
Estate investment and reconfiguration	[Not applicable]
e-Hospital	[Yes]
More embedded research	[Not applicable]
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 N/A
- 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?	Yes	Principal Risk 2
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: December 2020

6. Executive Summaries should not exceed **5 sides** [My paper does comply]]

APPENDIX 1

Quarterly Learning from Deaths Report

UHL's Mortality Rates

August 2020

How many In-patients have died in our Trust?

UHL's Crude In-Patient Mortality
2014/15 to 2020/21 (to end July 20)

Discharged During…	All Discharges (incl Day Case)	All In-Patient Deaths	In-Patient Crude Mortality Rate
2020/21 YTD (Apr - July 20)	**55,035**	**1166**	**2.1%**
FY 2019/20	261,647	2906	1.10%
FY 2018/19	260,301	2921	1.12%
FY 2017/18	259,539	3016	1.20%
FY 2016/17	250,233	3114	1.20%
FY 2015/16	244,776	2993	1.20%
FY 2014/15	234,889	2997	1.30%

COVID related deaths have led to an increase in UHL's crude inpatient mortality for 2020/21 to date.

This increase has started to come down since May and our latest 'Year to Date' Crude Mortality is now 2.1%

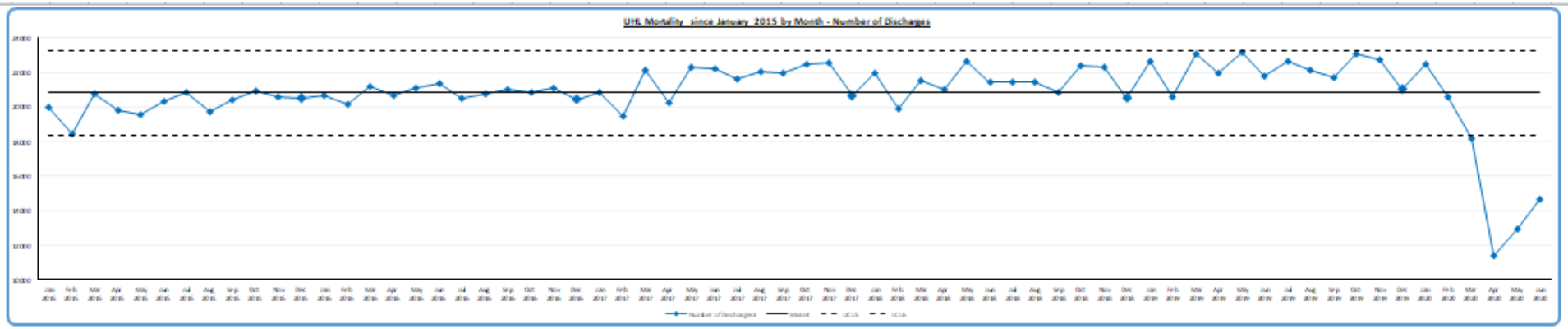
This reduction is due to both fewer deaths and also an slight increase in elective admissions although this was still 50% below normal activity levels for June and July.

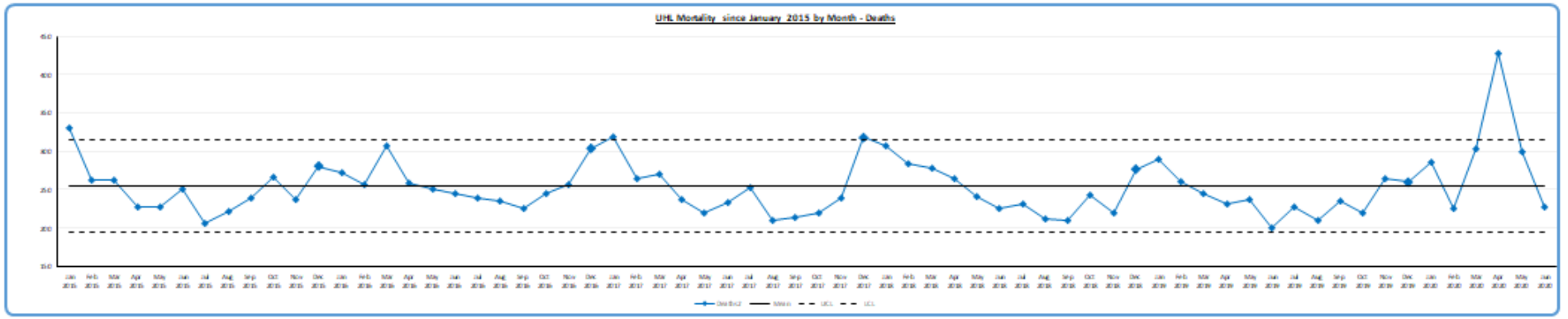
Monthly Admissions & Deaths by Type of Activity

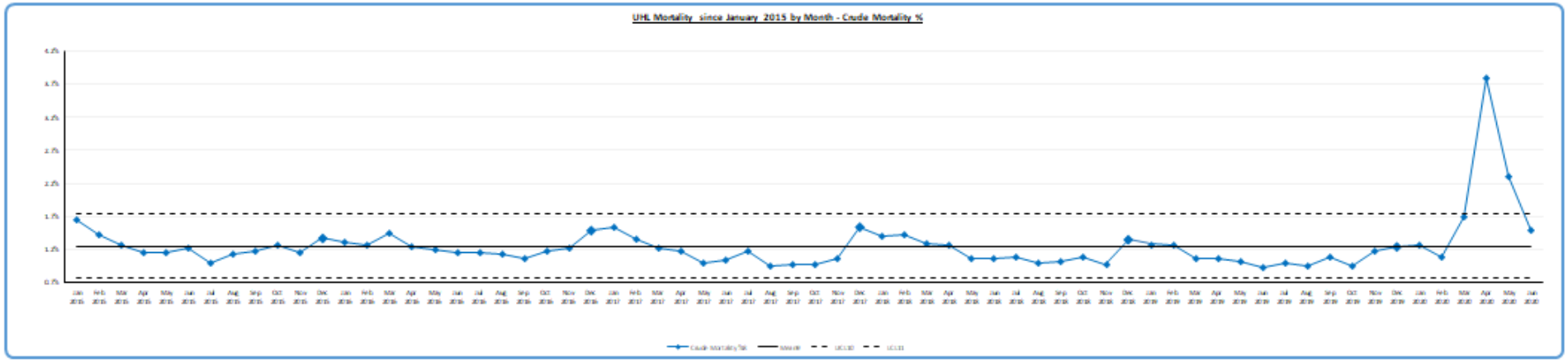
ELECTIVE		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	All
2019 / 2020	Spells	10524	11010	10414	11108	10604	10199	11165	11051	9546	10606	9982	7986	**124195**
	Deaths	5	3	5	11	7	6	2	4	4	5	5	12	**69**
	Crude Rate	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%	0.2%	**0.1%**
		April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**All**
2020 / 2021	Spells	**3253**	**4036**	**5297**	**6095**									**18687**
	Deaths	**2**	**1**	**4**	**5**									**12**
	Crude Rate	**0.1%**	**0.0%**	**0.1%**	**0.1%**									**0.1%**

EMERGENCY		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	All
2019 / 2020	Spells	11403	12169	11338	11531	11548	11538	11904	11653	11497	11885	10795	10182	**137443**
	Deaths	226	235	196	217	203	230	218	261	256	280	223	292	**2837**
	Crude Rate	2.0%	1.9%	1.7%	1.9%	1.8%	2.0%	1.8%	2.2%	2.2%	2.4%	2.1%	2.9%	**2.1%**
		April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**All**
2020 / 2021	Spells	**8115**	**8905**	**9403**	**9225**									**36348**
	Deaths	**425**	**298**	**223**	**208**									**1154**
	Crude Rate	**5.2%**	**3.3%**	**2.4%**	**2.1%**									**3.2 %**

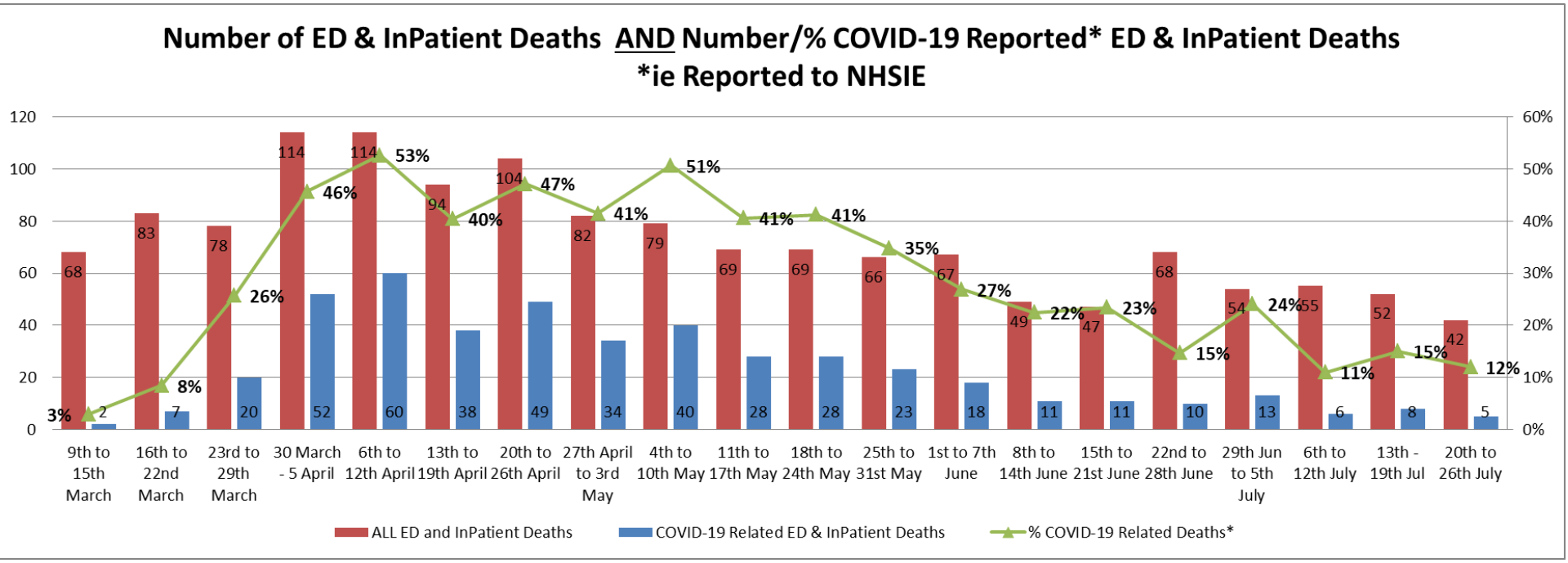
UHL's Crude In-Patient Mortality using SPC







COVID RELATED MORTALITY – as reported to NHSIE



NHSIE Reporting Criteria are:

- Positive Swab within 28 days of death irrespective as to whether there have been negative swabs in the meantime or the patient was believe to have died from a completely unrelated cause

and/or

- COVID 19 is included in the Death Certificate as a direct or contributory cause of death

SHMI: Summary Hospital Mortality Index
ie risk adjusted mortality where patients die either in UHL or within 30 days of discharge (incl those transferred to a community trust)

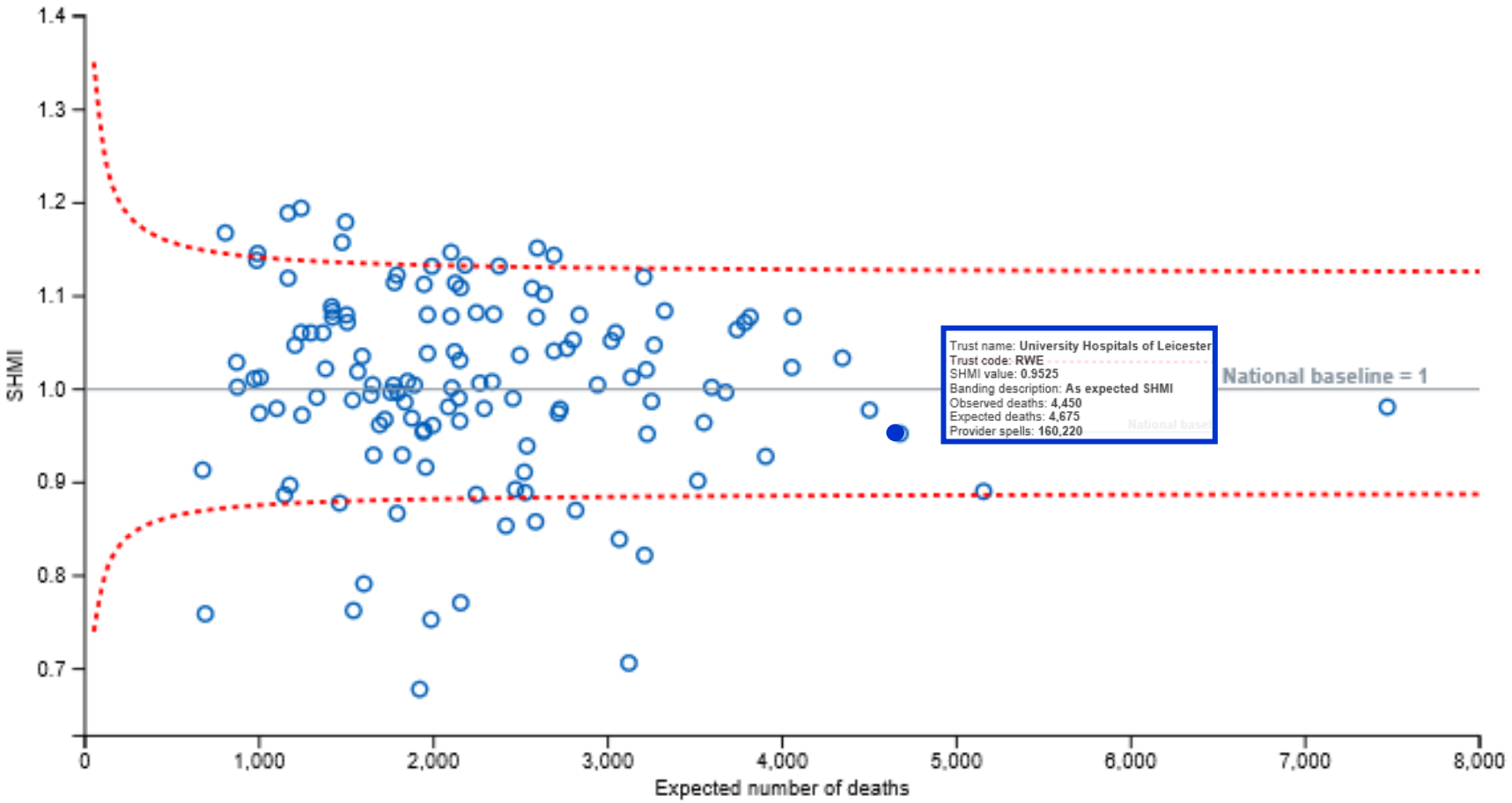
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge. **COVID-19 deaths are excluded from the SHMI**. The expected number of deaths is calculated from statistical models derived to estimate the risk of mortality based on the characteristics of the patients (including the condition the patient is in hospital for, other underlying conditions the patient suffers from, age, gender, method of admission to hospital, month of admission and birthweight).

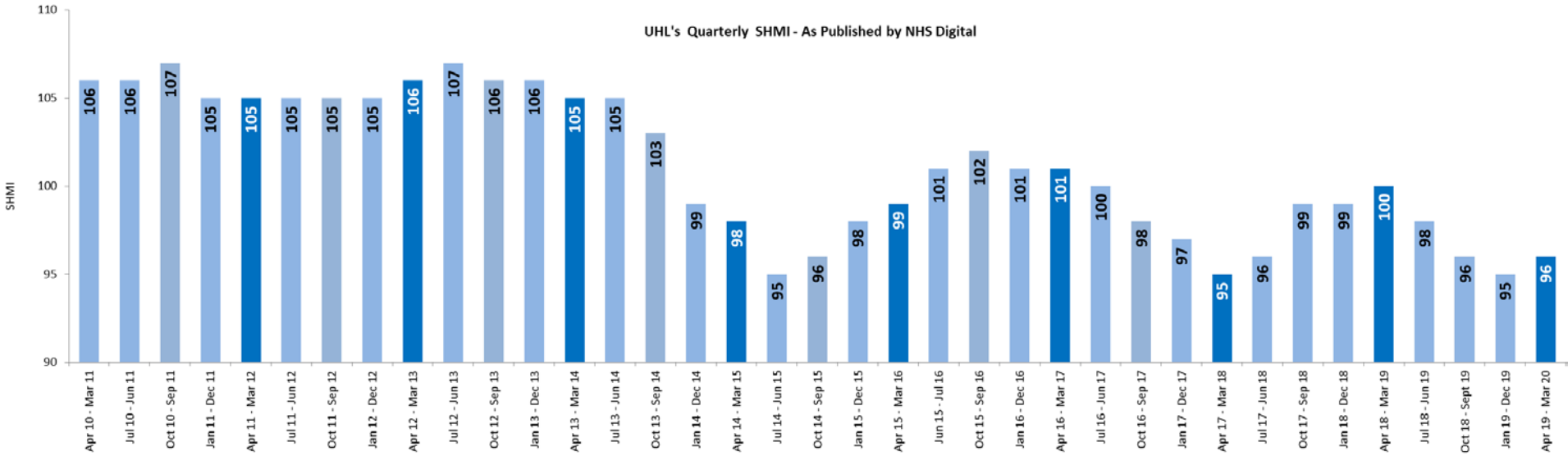
The data used to produce the SHMI are generated from data the trusts submit to the Secondary Uses Service (SUS). The data are processed by NHS Digital to create Hospital Episode Statistics (HES) data, which are then linked with death registrations data from the Office for National Statistics (ONS) to allow deaths which occur outside of hospital to be captured. A combination of finalised and provisional HES data is used in the calculation of the SHMI to ensure that the indicator is as timely as possible.

The SHMI is not a measure of quality of care. A higher than expected SHMI should not immediately be interpreted as indicating poor performance and should instead be viewed as a 'smoke alarm' which requires further investigation. Similarly, an 'as expected' or 'lower than expected' SHMI should not immediately be interpreted as indicating satisfactory or good performance. The SHMI cannot be used to directly compare mortality outcomes between trusts and it is inappropriate to rank trusts according to their SHMI.

SHMI Values for all Trusts Mar 19 to Feb 20



UHL's Quarterly SHMI – as published by NHS Digital



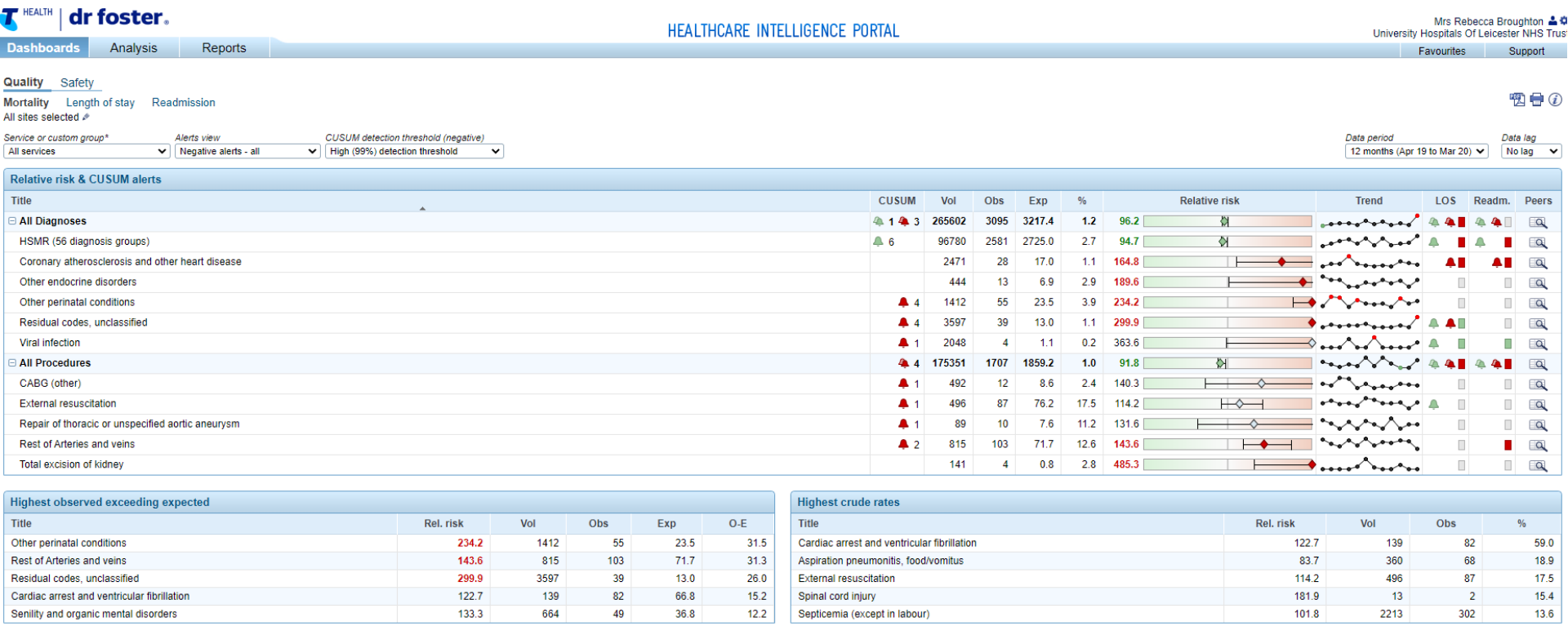
- The latest SHMI covers the financial year 2019/20 and was published on 13th August
- NHS Digital have advised all COVID-19 activity (ie all patients coded with U07.1 or U07.2 anywhere in the spell) will be excluded from the SHMI. Also any deaths within 30 days of discharge where COVID-19 is mentioned on the death certificate.
- The 12 month period includes March 20 which was when we first saw changes – both in activity and numbers of deaths due to the COVID-19 pandemic.
- NHS Digital are going to provide contextual data to show the number of cases excluded and it appears this data will be publically accessible.
- In March 2020 there were 194 (0.12%) patients with COVID-19 coding who have been excluded from our SHMI dataset.

HSMR:
Hospital Standardised Mortality Ratio

HSMR is risk adjusted mortality where patients die in hospital (either in UHL or if transferred directly to another NHS hospital trust) **over a 12 month period within 56 diagnostic groups**
(which contribute to 80% of in-hospital deaths).

The HSMR methodology was developed by the Dr Foster Unit at Imperial College (DFI) and is used as by the CQC as part of their assessment process

DR FOSTER INTELLIGENCE QUALITY DASHBOARD



HEALTH | dr foster.

HEALTHCARE INTELLIGENCE PORTAL

Mrs Rebecca Broughton
University Hospitals Of Leicester NHS Trust

Dashboards | Analysis | Reports | Favourites | Support

Quality | Safety

Mortality | Length of stay | Readmission

All sites selected

Service or custom group* : All services
Alerts view : Negative alerts - all
CUSUM detection threshold (negative) : High (99%) detection threshold
Data period : 12 months (Apr 19 to Mar 20)
Data lag : No lag

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 3	265602	3095	3217.4	1.2	96.2				
HSMR (56 diagnosis groups)	6	96780	2581	2725.0	2.7	94.7				
Coronary atherosclerosis and other heart disease		2471	28	17.0	1.1	164.8				
Other endocrine disorders		444	13	6.9	2.9	189.6				
Other perinatal conditions	4	1412	55	23.5	3.9	234.2				
Residual codes, unclassified	4	3597	39	13.0	1.1	299.9				
Viral infection	1	2048	4	1.1	0.2	363.6				
All Procedures	4	175351	1707	1859.2	1.0	91.8				
CABG (other)	1	492	12	8.6	2.4	140.3				
External resuscitation	1	496	87	76.2	17.5	114.2				
Repair of thoracic or unspecified aortic aneurysm	1	89	10	7.6	11.2	131.6				
Rest of Arteries and veins	2	815	103	71.7	12.6	143.6				
Total excision of kidney		141	4	0.8	2.8	485.3				

Highest observed exceeding expected

Title	Rel. risk	Vol	Obs	Exp	O-E
Other perinatal conditions	234.2	1412	55	23.5	31.5
Rest of Arteries and veins	143.6	815	103	71.7	31.3
Residual codes, unclassified	299.9	3597	39	13.0	26.0
Cardiac arrest and ventricular fibrillation	122.7	139	82	66.8	15.2
Senility and organic mental disorders	133.3	664	49	36.8	12.2

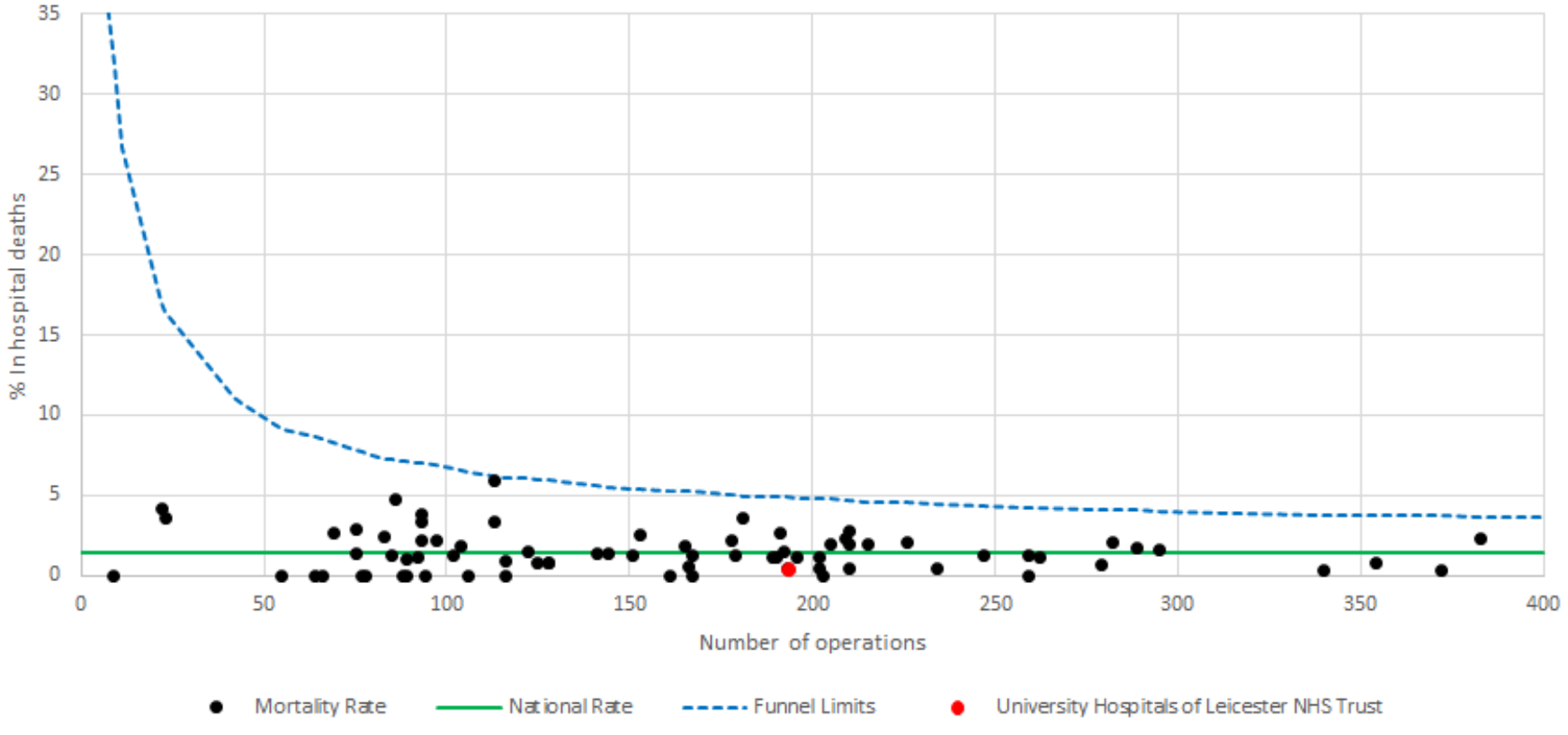
Highest crude rates

Title	Rel. risk	Vol	Obs	%
Cardiac arrest and ventricular fibrillation	122.7	139	82	59.0
Aspiration pneumonitis, food/vomitus	83.7	360	68	18.9
External resuscitation	114.2	496	87	17.5
Spinal cord injury	181.9	13	2	15.4
Septicemia (except in labour)	101.8	2213	302	13.6

- There are no new two diagnosis groups with a ‘CUSUM’ alert in the HSMR but there is a new procedure group ‘Repair of thoracic or unspecified aortic aneurysm’
- The next slide shows UHL’s mortality data for Aortic Aneurysm repair as reported by the National Vascular Registry and confirms that our in-hospital Mortality is below the national rate.
- The 10 deaths observed in the Dr Foster tool will be cross matched with our LfD dataset.

National Vascular Registry 2019 Annual Report

Abdominal Aortic Aneurysm Summary Mortality



Trust Name	Adjusted in-hospital mortality (2016-2018) for Elective Infra-Renal AAA Repair	% Adjusted in-hosp mortality (2016-2018) for Repair of Ruptured AAA
University Hospitals of Leicester NHS Trust	0.5%	34.90%
National Average	1.40%	35.40%

UHL's CRUDE AND RISK ADJUSTED MORTALITY

- UHL's crude In-Patient mortality was stable during 2019/20
- There was a statistically significant increase in the number of In-Patient deaths in April but this is directly related to the number of COVID related deaths
- Our SHMI has continued to be below 100 for the last 4 Quarterly 'published SHMIs'
- There are no new diagnosis groups with a higher than expected SHMI or HSMR and data from the National Vascular Registry 2019 Annual Report shows that our Aneurysm Repair mortality is better than average.
- NHSIE have advised COVID admissions / deaths will be excluded from the SHMI dataset but the current reporting period is not affected by this.
- We will continue to monitor our crude and risk adjusted mortality

APPENDIX 2

Learning From the Deaths of Patients in our Care

19/20 Q1-Q4 (Updated) and 20/21 - Quarter 1

AUGUST 2020

UHL's "Learning from Deaths" Framework – All Patients

- **Medical Examiners (MEs)** – (Currently 12 MEs working the 0.5- 2 PA a week). ME process includes all ED and Inpatient adult cases – MEs support the Death Certification process and undertake Mortality Screening – to include speaking to the bereaved relatives/carers and 'proportionate scrutiny' of the deceased's clinical records (paper and electronic) .
- Where Screening identifies potential areas for learning by the clinical team(s), the case will be sent to the relevant Specialty for further review.

- **Specialty Mortality & Morbidity Programme (M&M)** – involves full Mortality Reviews (SJRs) where meet National criteria (death of a child/neonate; death of a patient with a Learning Disability or Serious Mental Illness; death following an elective procedure) or are referred by the ME or members of the Clinical Team.
- M&M meetings confirm Death Classification, Lessons to be Learnt and should oversee the taking forward of agreed Actions to improve the care for all patients

- **Clinical Teams** – responsible for reviewing the care of patients where Mortality screening has identified potential learning about the end of life care or other patient experience issues

- **Bereavement Support Nurses (BSSNs**)– 'follow up contact' for bereaved families of adult patients, liaises with both the MEs and Clinical Teams where families have unanswered questions or their feedback to the Medical Examiner has led to a request for further review of care.
- The BSSNs also sign post the bereaved to appropriate support agencies where unmet bereavement needs identified.

- **Patient Safety Team (PST)** – if a death considered to be due to problems in care, will review against the Serious Incident reporting framework and take forward as an investigation where applicable.
- **Mortality Review Committee (MRC)** – oversee the above and support cross specialty/trust-wide learning and action

UHL's "Learning from Deaths" Framework – External Partners

- **The Coroner's Service** – investigate and record the causes and circumstances of all sudden deaths where the cause is not known, violent or unnatural deaths and any death which occurred whilst the deceased was in lawful custody. UHL's mortality reviews will be shared with the Coroner if the death is taken for Coronial investigation (eg deaths due to complications of surgery)
- Learning identified through the Coroner's Inquests or 'Preventing Future Deaths Letters' will be fed into the UHL LfD Programme
- **Child Death Overview Panel (CDOP)**– national programme supported by Local CDOPs. CDOPs oversee multiagency reviews of deaths of children up to 18 years of age. UHL's mortality reviews of children and neonates are shared with the LLR CDOP.
- Learning identified through the CDOP multi-agency reviews will be fed into the UHL LfD Programme
- **Learning Disabilities Mortality Review Programme (LeDeR)** – national programme supported by Local LeDeRs. LeDeR reviews look at all aspects of care across both health and social care. UHL's mortality reviews of patients with a Learning Disability will be shared with the LLR LeDeR
- Learning identified through both the National and LLR LeDeRs will be fed into UHL's LfD Programme
- **MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)** – national programme overseeing the reviews of deaths of babies (stillbirths, perinatal and neonatal). All perinatal and neonatal deaths in UHL are reviewed using the national Perinatal Mortality Review Tool (PMRT) and are submitted to MBRRACE-UK
- Learning identified through MBRRACE-UK's collation of reviews will be fed into the UHL LfD Programme
- **Health and Social Care Organisations** – the UHL Learning from Deaths team liaise with Mortality and Quality Leads at Leicestershire Partnership Trust (LPT) EMAS (Ambulance); CCG (Primary Care and Care Homes) and other Acute NHS Trusts and the Private Sector to share feedback identified through UHL's LfD Programme

'Deaths covered by UHL's "Learning from the Death" process 19/20 and 20/21 Q1 by Hospital Site and Place of Death

Hospital Site	Q1	Q2	Q3	Q4	19/20		Apr	May	Jun	20/21 Q1
LRI	541	545	619	687	2392		320	243	168	731
GH	173	152	199	183	707		98	51	48	197
LGH	54	51	62	66	233		38	29	28	95
All Sites	**768**	**748**	**880**	**936**	**3332**		**456**	**323**	**244**	**1023**

What is the data telling us?

- **The above table includes adult, child and neonatal deaths and both ED and Inpatient deaths as well as those in the Community where deceased brought back to UHL for death certification purposes.**
- Whilst the number of deaths in Quarters 1 and 2 is always lower than for Quarters 3 and 4 this year we are seeing a different picture due to Coronavirus

Place of Death	Q1	Q2	Q3	Q4	19/20		Apr	May	Jun	20/21 Q1
Community	37	26	48	34	145		3	6	4	13
ED	**62**	46	89	83	**280**		28	16	12	**56**
In-Patient	669	676	743	819	2907		425	301	228	954
All Deaths	**768**	**748**	**880**	**936**	**3332**		**456**	**323**	**244**	**1023**

The lower number of 'community deaths' may be linked to the Emergency Coronavirus Legislation allowing GPs to certify even if not seen the patient alive so fewer have been brought back to UHL for Death Certification purposes. The increased number of overall deaths is primary related to In-Patient deaths

19/20 and 20/21 Q1 – Adult, Child, Neonate

	Q1	Q2	Q3	Q4	19/20		Apr	May	Jun	20/21 Q1
ADULT	739	720	850	900	3209		444	313	238	995
CHILD	7	12	10	6	35		3	5	1	9
NEONATES/ PERINATAL	22	16	20	39	88		9	5	5	19
All	**768**	**748**	**880**	**936**	**3332**		**456**	**323**	**244**	**1023**

What is the data telling us?

For the purposes of our Learning from Deaths framework Neonates are babies who are born in UHL or in another hospital and transferred to our Neonatal Unit (can also be referred to as Perinatal Mortality but this is 'age specific') and who subsequently die either in the Maternity Unit or Neonatal Unit.

Children includes all children between 0 and 16 years (where not considered to be 'Neonates)

As might be expected the increased number of deaths in Quarter 1 were all adults.

The increased number of neonatal/perinatal deaths in Q4 for 19/20 have been previously reported to MRC and an update was presented to the August meeting.

19/20 and 20/21 Q1 – Cause of Death Discussion with the ME

	Q1	Q2	Q3	Q4	19/20		Apr	May	Jun	20/21 Q1
ADULT	**739**	**720**	**850**	**900**	**3209**		**444**	**313**	**238**	**995**
ME discussed CoD	689	696	824	883	3092		442	310	234	986
CHILD	**7**	**12**	**10**	**6**	**35**		**3**	**5**	**1**	**9**
ME discussed CoD	0	2	4	1	7		1	1	0	2
NEONATES	**22**	**16**	**20**	**39**	**88**		**9**	**5**	**5**	**19**
ME discussed CoD	0	1	4	2	7		1	1	0	2
All Deaths	**668**	**748**	**880**	**945**	**3332**		**456**	**323**	**244**	**1023**
ME Disc CoD	689	699	832	886	3106		444	312	234	990
% Discussed	**90%**	**93%**	**95%**	**94%**	**93%**		**97%**	**97%**	**96%**	**97%**

What is the data telling us?

Part of the Medical Examiner role is to discuss why a patient has died with one of the doctors involved in the patient's care in order to issue a Medical Certificate of the Cause of Death (MCCD) or confirm referral to the Coroner is required.

Cause of Death Discussion with the ME - 19/20 and 20/21 Q1

- 811 adult deaths were referred to the Coroner in 19/20 and 148 in Q1 of 20/21
- In 46% of cases the Coroner agreed for MCCD to be issued (55% in Q1 of 20/21) – these are usually cases where there is a legal requirement to refer to the Coroner (ie patient died following a fall which led to a fracture which contributed to death)
- 19% of referrals in 19/20 were taken to Inquest (21% in Q1 of 20/21)
- 33% were taken for Post Mortem (with or without and Inquest) – 19% in Q1 of 20/21
- Medical Examiners referred 44 cases to the Coroner in 19/20 (ED deaths usually where there was an Out of Hospital Cardiac arrest) and 12 in Q1 of 20/21
- With the Emergency Coronavirus Legislation, the MEs have been supporting the clinical teams, particularly for deaths on the ITUs, with completing MCCDs following discussion with one of the doctors who is unable to visit the ME Office due to clinical priorities or off sick / isolating.
- 56 MCCDs have been completed by MEs between March and the end of July (plus the Cremation Form where applicable)
- The Medical Examiner team also supported the COVID Tactical Group by ensuring relatives were aware of the need to report data to NHSIE and drafting the COVID Death Notification Forms for submission to NHSIE.
- We have also established a Medical Examiner 'out of hours' service for discussing deaths where 'out of hours Urgent Release' is requested.
- In 19/20 there were 22 deaths discussed out of hours and 9 deaths in Q1 of 20/21.
- Following discussions during Quarter 1, we have also agreed to support LOROS with Medical Examiners being available for discussing causes of death LOROS doctors

Medical Examiner Screening - 19/20 and 20/21 Q1

Hospital Site	Q1	Q2	Q3	Q4	19/20		Apr	May	Jun	20/21 Q1
ADULT	739	720	850	900	3209		444	313	238	995
Screened	739	720	841	870	3166		444	312	236	992
% Screened	100%	100%	99%	97%	99%		100%	99.9%	99.9%	99.9%

What is the data telling us?

In addition to the 3166 deaths screened by one of the Medical Examiners, 43 deaths were screened by the Head of Outcomes & Effectiveness – Learning from Deaths (using information in electronic records)

We have achieved 99% of deaths being screened overall for19/20, although performance had dropped slightly in Q4 due to the increased winter activity and the challenges of dealing with the variable flow plus weekend backlogs.

It is to the credit of the Medical Examiners that we have almost achieved 100% of cases being screened for Quarter 1 despite the increased activity (due to COVID 19). This has been possible due to extra capacity being created by the ceasing of Part 2 Cremation Forms (funding of which will be covered by the National Medical Examiner). Another factor has been the paper Case Notes for LGH / Glenfield deaths being transferred over to the LRI ME office much more quickly as Clinical Coding is being done using electronic records.

As well as increasing throughput, we have also reduced the time taken for screening. 70% of deaths were screened within a week in 19/20 and this has improved to 75% in Q1 of 20/21. We have also reduced the % of cases taking over a month to screen from 12% in 19/20 to 5% in Q1 20/21.

Currently only Adult Deaths are routinely screened by Medical Examiners as all child and neonatal deaths are automatically referred for a full Structured Judgement Review

We are currently in discussion with the Regional/National Medical Examiner Office to confirm 'proportionate scrutiny' required for child deaths, taking into consideration that all are discussed at the Child Death Overview Panel (CDOP) Joint Agency Response meetings within 2 working days and all then are subject to full internal and external review.

Speaking to the Bereaved - 19/20 and 20/21 Q1

	Q1	Q2	Q3	Q4	19/20		Apr	May	Jun	20/21 Q1
ADULT DEATHS	739	720	850	900	3209		444	313	238	995
ME spoke to the Bereaved	452	464	527	544	1987		370	262	195	827
Bereaved not spoken to	204	145	186	205	740		48	24	22	94
% ME spoke to Bereaved	69%	76%	74%	73%	73%		89%	92%	90%	90%
N/A (Referred to Coroner)	83	111	137	151	482		26	27	20	72

What is the data telling us?

In 19/20 73% of bereaved relatives were spoken to by the ME, and as previously reported, there was a significant difference between the LRI and other two sites (95% of bereaved relatives at the LRI spoken to but only 25% at the LGH and 13% at Glenfield)

Due to the improved turn around of case notes going to the LRI, the % of bereaved relatives at the Glenfield spoken to by the ME has increased from 13% to 80% and at the LGH it is now 60% compared with 25%. There has also been a further improvement at the LRI with 97% of relatives being spoken to – half of those not spoken to had not been contactable.

During Q1, all contact has been via the phone as relatives no longer collecting the MCCD. Previously between 25-30% of relatives at the LRI were spoken to in 'face to face' in the Bereavement Services Office. We've been advised by the Registrars that this scanning of MCCDs directly to the Town Hall is likely to be the approach for the foreseeable future.

We have recently sought advice from the Regional ME Office about speaking to bereaved families when the Next of Kin is not available. Historically Bereavement Services have dealt with a representative of the family who is dealing with the funeral and so limited information is shared with them about the cause of death.

What happens where Medical Examiners (ME) think further review required?

- **MEs refer cases for:**
  - Structured Judgement Review through Specialty M&M**)**
  - Clinical Review by Consultant responsible for patient care or Matron/Ward Sister
  - Follow up by Bereavement Support Nurse
  - Feeding back to Non UHL organisations
- **Structured Judgement Reviews are requested where the Medical Examiner thinks there is potential for learning in respect of:**
  - Clinical management
  - Delays or omissions in care
  - Meets the national criteria for SJR (death post elective surgery, patient had a Learning Disability, Severe Mental Illness)
- **Clinical Reviews are requested where concerns are raised by the bereaved about:**
  - Pain management; end of life care, ReSPECT, DNACPR documentation
  - Nursing care, such as help with feeding; responding to buzzers
  - Communication with patient/relatives about patient's prognosis, deterioration
  - Previous discharge arrangements
- **Bereavement Support Nurse follow up will be requested where**
  - The relatives appear to be particularly distressed - to signpost to 'bereavement counselling services'
  - Say they have questions or concerns about the care provided but do not feel ready to talk about them
- **Feeding back to Non UHL Organisations**
  - Process established with the EMAS, LPT and CCG Quality & Safety Leads for feeding back where relatives raise concerns about care provided outside UHL, or MEs think there may be learning for other organisations,

Adult Deaths - Further Reviews - 19/20 and 20/21 Q1

Adult Deaths	Q1	Q2	Q3	Q4	19/20		Apr	May	Jun	20/21 Q1
Yes	**206**	**208**	**261**	**342**	**1017**		75	89	73	237
No	533	512	589	558	2192		369	224	163	756
All Adult Deaths	**739**	**720**	**850**	**900**	**3209**		**444**	**313**	**238***	**995***
% Yes	**28%**	**29%**	**31%**	**38%**	**32%**		**17%**	**28%**	**31%**	**24%**

* 2 cases to be confirmed if further review required

What is the data telling us?

- The higher number/% of cases referred for further review in Quarter 4 of 19/20 relates to the MEs feeding back to clinical teams to support implementation of ReSPECT (from January 2020)
- The lower number/% of cases referred for further review in Quarter 1 of 20/21 is mainly due to the low number of further reviews requested in April (compared with the higher number of deaths).
- Where possible, during the COVID period, the LfD team tried to answer any questions identified either from speaking to the relatives or the ME's scrutiny of the case notes, rather than refer to the clinical teams in order to reduce their workload.
- There were only 4 SJRs requested in Q1 following an elective procedure due to elective activity being 'taken down'.
- Due to the extreme clinical pressures, we put 'on hold' requesting SJRs for the deaths of patients with a Serious Mental Illness (where there were no other reasons for requesting further review)
- We also found that there were very few concerns or requests for further reviews raised by relatives during April.
- There were 15 relatives who did not have any questions or concerns about care but the ME referred to the Bereavement Support Nurses for urgent 'follow up contact' because they were very distressed

All Deaths - Types of Reviews - 19/20 and 20/21 Q1

	Q1	Q2	Q3	Q4	19/20	% of all deaths	Apr	May	Jun	20/21 Q1	% of all deaths
SJR (Adults)	70	73	85	88	316	10%	31	28	16	75	8%
Clinical Review	72	60	93	98	323	10%	13	26	15	54	5%
Investigation*			1	1	2	0.1%	1			1	0.1%
PST F/up	6	2	6	11	25	1%	1	1	1	3	0.3%
Feedback to Team	33	57	51	77	219	7%	19	23	24	66	7%
BSS Review	22	16	15	37	90	3%	5	6	14	25	3%
Theme Review	3		10	28	41	1%	5	5	3	13	1%
All Adult Deaths	206	208	261	342	1017		75	89	73	237	
SJR - Child	7	12	9	6	34		2	2	1	5	
Investigation - Child			1				1	3		4	
SJR - Neonates	22	16	19	30	87		9	5	5		
All Child/Neonate	29	28	29	36	122	100%	12	10	6	28	100%

***Investigation – i.e. Serious Incident Investigation by Patient Safety Team or Safeguarding Serious Case Review**

What is the data telling us?

- The % of adult SJRs requested in Quarter 1 of 19/20 is slightly lower than in 19/20 overall but as explained in the previous slide there has been a reduction in elective procedures and we also put on hold routinely requesting SJRs for deaths of patients with a serious mental illness.
- The lower number/% of cases referred for further review in Quarter 1 of 20/21 is mainly due to the low number of further reviews requested in April (compared with the higher number of deaths).

Current position on Adult Deaths
Where Structured Judgement Review required

	Q1	Q2	Q3	Q4	19/20		Apr	May	Jun	20/21 Q1
SJR (Adults)	70	73	85	88	316		31	28	16	75
Completed	65	67	70	52	254		16	11	7	34
In Progress	5	6	15	36	62		15	17	9	41
% Completed	93%	92%	82%	59%	80%		52%	39%	44%	45%

- UHL's standard is that 75% of SJRs should be completed within 4 months of the death and 100% within 6 months.

- Almost all of 19/20 Q1 and Q2 SJRs have been completed and good progress has been made with Q3's albeit these should all have been competed by now but the cessation of M&M Meetings during the COVID period has contributed to some of the delay.

- This will also have impacted on completion of SJRs during Quarter 1 in 20/21 but meetings are now taking place using Microsoft Teams and feedback has been received from most M&M Leads that they expect to be able to address the backlog during this Quarter.

Current position on SJRs for Child Deaths

	Q1	Q2	Q3	Q4	19/20		Apr	May	Jun	20/21 Q1
SJR	7	12	9	6	34		2	2	1	5
Completed	7	8	2	2	18		1			
In Progress	0	4	7	5	16		1	2	1	4
% Completed	100%	67%	22%	17%	80%		50%	0%	0%	20%

For 2019/20

- 3 deaths were 'Community Deaths' but have been agreed for review by the Children's Hospital M&M (1 out of 3 reviews completed to date)
- 5 deaths were in the Paediatric Emergency Department (2 out of 5 reviews completed to date) – most Paediatric ED deaths are 'sudden unexpected deaths' and usually require police/safeguarding investigations and all will be referred to the Coroner.
- 12 deaths were in the Glenfield Intensive Care Unit/EMCHC and 14 children died in the LRI Children's Intensive Care Unit or Children's Hospital Wards (7 out of 12 GH and 8 out of 14 LRI reviews completed to date)

Child Death Overview Panel (CDOP)

All child deaths are reviewed by the relevant multi agency Child Death Overview Panel (includes representatives from acute, community and primary health care, police, education and social care)

From 1st June there has been an 'immediate Joint Agency Response' meeting held within 2 working days of a death (for LLR children) where the type of review/investigation is confirmed.

The Corporate M&M Team are currently working with the Children's Hospital M&M Leads and CDOP Leads to look at how to incorporate the national Child Death Review requirements within the M&M process in order to avoid duplication of effort and support effective dissemination of learning

Current position on SJRs for Neonatal Deaths

	Q1	Q2	Q3	Q4	19/20		Apr	May	Jun	20/21 Q1
SJR	22	16	19	30	87		9	5	5	19
Completed	21	13	17	12	63					
In Progress	1	3	2	18	24		9	5	5	19
% Completed	95%	81%	89%	40%	72%					

For 2019/20

- 2 of the uncompleted deaths for Quarter 2 are subject to an HSIB investigation

Perinatal Mortality Review Group

All neonatal deaths are reviewed using the national Perinatal Mortality Review Tool (PMRT) which is now completed online and data is submitted to MBRACCE-UK

There were some difficulties with 'real time' data –in-putting when the PMRT was first implemented which caused a back log with reviews.

Death Classification

Death thought to be more likely than not due to a problem in care?	Q1	Q2	Q3	Q4	19/20
No	88	88	92	64	332
Yes	4	2	3	2	11
Review in Progress	7	11	19	57	94
All SJRs/Investigations	99	101	114	123	437

All but one of the deaths thought to be due to problems in care have been previously reviewed by MRC.

The SJR for the 11th case was discussed at the MRC SubGroup meeting where it was noted that problems in care related to chemotherapy complications.

Members supported the Death Classification and noted that the death has been reported as a Serious Incident

EXTRACT OF PAPER D: PATIENT SAFETY REPORT PRESENTED TO QOC 27 AUGUST 2020

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **EXECUTIVE QUALITY BOARD**

DATE: **11th AUGUST 2020**

REPORT BY: **DIRECTOR OF SAFETY AND RISK**

SUBJECT: **REPORT FROM THE DIRECTOR OF SAFETY AND RISK**

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1. INTRODUCTION

1.1 The purpose of this report is to highlight to the Executive Quality Board important safety information which requires further consideration and action. The monthly patient safety data and the monthly complaints reports are now provided separately for information because these reports are also provided monthly to each CMG Quality and Safety Board.

1.2 This month I have provided a deep dive analysis into Medical Care complaints, an annual harms review for 2019/20 and a brief summary of two national PHSO consultations in relation to their Complaints Standards Framework and draft strategy 2012-24.

2. ANNUAL HARMS REVIEW FOR 2019/20

2.1 From 1st April 2019 to 31st March 2020 we have had 139 reported incidents that have been graded moderate harm or above. For the whole of 2018/19 we had 265 moderate and above harm reported incidents. This review into these harm events will analyse where we are seeing the main trends and themes, summary of key findings are:

2.2 With regard to Serious Incidents reported in 2019/20 we saw a reduction in the number that we escalated in the financial year compared to 2018/19. This was the lowest number of Serious Incidents escalated in a financial year for the last 8 years.

2.3 Overall in 2018/19 a total of 139 (0.5%) of the 24,018 Patient Safety Incidents were noted to have caused harm to patients.

2.4 The number of reported Moderate and Major Harm incidents appears to be lowering in 2019/20 compared to 2018/19, this was mainly due to the high reported numbers in 2018/19.

2.5 The data shows that the top two most common themes this year are slightly different from the previous financial year, inpatient falls remains the most common and post-partum haemorrhages (PPHs) has been replaced by Injury/Poor outcome for the mother incidents. In 2018/19 inpatient falls accounted for 16% of the total number of harm incidents whereas for this year this is 28%. In 2018/19 PPHs accounted for 14% of the total number of harm incidents whereas for this year this is 2%. During 2019/20 the Quality and Safety Team in W&C team worked with the Corporate Patient Safety team and have developed a PPH validation tool within Datix which improves identification of where there are any gaps in care that have caused harm.

2.6 Total of 3 incidents reported as causing Death to a patient compared to 3 reported in 2018/19

2.7 In 2019/20 Emergency caesarean section increased by 18% and Injury/Poor outcome for the mother incidents decreased by 14% compared to 2018/19.

2.8 For 2019/20 the top five specialities for harm incidents are Maternity, General Surgery, Geriatric Services, Respiratory Medicine and Emergency Department. Combined the top 5 specialties account for 62 (45%) of the 139 Moderate and Major harm incidents reported in 2019/20.

2.9 The LRI Site reports the majority of Harms incidents and the Labour wards (LRI & LGH) are clear leaders in locations where Harm incidents are reported.

2.10 To conclude in 2019/20 we have seen a sustained decreased level of harm overall compared to 2018/19; this is mainly moderate level harm rather than major or death. This is particularly noticeable in quarter 4 of 2019/20 where the lockdown measures come in to affect. We will continue to monitor the harm rate each quarter and report our validated figures in the Director of Safety and Risk report to EQB.

2.11 Please find full report attached at **Appendix 1.**

2.12 Recommendation

EQB members are invited to consider the findings and themes from the annual harms review 2019/20.

3. DEEP DIVE ANALYSIS INTO MEDICAL CARE COMPLAINTS

3.1 A total of 255 complaints coded as 'medical care' that were received within the period 1st February 2020 – 31st July 2020. These were used for the deep dive analysis.

3.2 Below the table shows breakdown of these complaints by CMG:

Medical Care complaints by CMG	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Total
CMG 1 - Cancer, Haematology, Urology, Gastroenterology & Surgery (CHUGGS)	17	8	5	5	8	12	55
CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)	10	8	0	1	11	3	33
CMG 3 - Emergency & Specialist Medicine (ESM)	14	7	1	1	18	11	52
CMG 4 - Intensive Care, Theatres, Anaesthesia, Pain Management & Sleep (ITAPS)	2	1	0	0	1	2	6
CMG 5 - Musculoskeletal & Specialist Surgery (MSK & SS)	15	14	0	2	9	8	48
CMG 6 - Clinical Support & Imaging (CSI)	2	0	0	0	2	5	9
CMG 7 - Women's and Children's (W&C)	11	9	3	4	4	11	42
CMG 8 - The Alliance	2	2	1	0	2	1	8
Finance & Procurement	1	0	0	0	0	0	1
Operations (Corporate)	0	1	0	0	0	0	1
Total	74	50	10	13	55	53	255

3.3 Below the table shows the top ten specialities that have received the medical care complaints, these account for 61.5% of all the medical care complaints:

Top 10 Specialties receiving Medical Care complaints	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Total
General Surgery	8	4	4	3	4	6	29
Emergency Department	7	0	0	0	9	8	24
Maternity	5	4	1	3	2	5	20
Gynaecology	4	4	0	1	2	5	16
Trauma Orthopaedics	3	4	0	1	3	3	14
Acute Medicine	4	1	0	1	4	2	12
Urology	5	2	1	1	1	1	11
Clinical Decisions Unit (CDU)	3	5	0	0	1	2	11
Elective Orthopaedics	3	3	0	0	4	1	11
Oncology	3	1	0	0	3	2	9
Total	45	28	6	10	33	35	157

3.4 There are 227 complaints in this period that have 'Medical Care' as the primary subject:

Sub-subjects of Complaints that are Primary Subject Medical Care	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Total
Medical Care - Management of Care	51	29	10	7	32	25	154
Delay in Diagnosis	3	4	0	0	2	6	15
Consultation	1	2	0	2	5	3	13
Misdiagnosis	2	1	0	0	0	8	11
Investigations	5	2	0	1	1	2	11
Decision making	0	1	0	1	5	1	8
Medical Care - Pain Management	1	1	0	1	1	1	5
Failed Procedure	1	2	0	0	1	0	4
Medical Care - Documentation	2	0	0	0	0	0	2
Delay in medical review	0	1	0	0	0	1	2
Private Patients	1	0	0	0	0	0	1
Delay attending clinic	1	0	0	0	0	0	1
Total	68	43	10	12	47	47	227

3.5 As the majority (154) of these complaints are listed as 'Medical Care – Management of Care' it is these that have been specifically reviewed as it is these that we need to analyse further for themes.

3.6 The descriptions documented in the complaints Datix module by the PILS team were reviewed manually for all 154 complaints and the following top ten themes were found in order of occurrence:

I. Patient or relative not happy with treatment/care
II. Questions about treatment
III. Poor communication by consultant
IV. Unhappy with outcome of treatment
V. Medical staff attitude and lack of care
VI. Unhappy with consultation
VII. Concerns about management of labour
VIII. Unhappy with correspondence from consultant
IX. Missed diagnosis
X. Error in procedure

3.7 On further scrutiny of the top theme 'patient or relative not happy with treatment/care' complaints, most were noted to be from the following CMGs and specialities;

- CHUGGS – oncology
- RRCV – cardiology and respiratory medicine
- ESM – emergency department
- ITAPS – sleep service
- MSS – trauma orthopaedics, elective orthopaedics and breast
- W&C – maternity and gynaecology
- Alliance – orthopaedics

3.8 Many of these complaints were made about several aspects of care which is why they had been coded as Medical Care - 'management of care'. On review of a sample of the complaints file, the following are examples of what was found as complaints;

Patient unhappy with residual problems left from appendicectomy, not happy with the attitude of the consultant and concerned that he couldn't be bothered to consult the medical notes during appointment.

Patient complained of disjointed care and lack of a clinical diagnosis, being discharged and re-referred several times and still without any diagnosis.

Attitude of consultant and patient felt he was not listened to at all during assessment and consultation.

Failure to diagnose injury to knee in ED despite several attendances, leaving patient in daily pain and unable to have a good quality of life. Now has diagnosis of ruptured ACL and wants to know why this was not diagnosed.

Patient told she was having a hysteroscopy and polypectomy as a day case procedure. She then woke up in recovery and was taken to ward and had to stay in overnight without initial explanation. Then told she has perforated uterus and had to undergo procedure again at later date.

Delay in care and investigations in oncology. Patient's wife claims that this is the cause of cancer spread and terminal diagnosis.

Patient suffered PE post breast reconstructive surgery. She complains of poor communication with link workers and poor communication between the breast and plastic teams. Unhappy about delay in diagnosis of PE in ED.

3.9 Following the analysis of these Medical Care complaints, the Senior Patient Safety Manager will review the current codes and look at best practice from the PHSO to consider if the codes need to be amended to enable improved identification of the issues for services to be able to make improvements from the feedback.

3.10 **Recommendation**

EQB members are requested to note the themes from the deep dive into medical care complaints and the proposed action.

4. CONSULTATION FOR THE PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO) COMPLAINT STANDARDS FRAMEWORK AND DRAFT STRATEGY FOR 2021-24

4.1 The PHSO have developed the new, draft, Complaints Standards Framework in partnership with a wide range of organisations, to create a single, consistent vision for best practice in NHS complaint handling. Their framework is based around an effective complaint handling system; which should;

- ✓ Promote a learning and improvement culture
- ✓ Positively seeks feedback
- ✓ Is thorough and fair
- ✓ Gives a fair and accountable decision

4.2 The COVID-19 pandemic has brought about new and increased challenges for complaint handling. Now more than ever, how public service organisations respond to and learn from people's experiences of public services is critical, as this can help to improve and strengthen future service provision. Senior leaders have a crucial role to play in supporting and embedding learning from complaints. Real and lasting positive change can be made through listening and learning from the voices of those directly affected during the COVID-19 crisis.

4.3 It is important for the NHS to focus on recognising and responding to individual patient experiences in a consistent and clear way.

4.4 As they approach the end of their current strategic period, they would also welcome our views on a new draft Strategy for the Ombudsman service. In April of this year, they decided to delay this consultation due to the COVID-19 pandemic. As they resume their work on health casework and other organisations renew their focus on complaints, they feel the time is now right to seek our views on our priorities for the next three years.

The new Strategy includes three strategic objectives:

- ✓ Improving awareness of our service and access to justice
- ✓ Delivering a transparent and rights-based service that is continually improving to meet people's needs
- ✓ Embedding a culture of learning from mistakes to improve public services

4.5 The PHSO would welcome our views on this consultation to help improve complaints handling across the NHS. If you wish to complete their consultation surveys on the draft Complaints Standards Framework and draft PHSO Strategy, these will be open until 18 September, please visit:

http://vsea.xuhl-tr.nhs.uk:32224/?dmVyPTEuMDAxJiY2ZmFkOTNmYzhlYTU4ZjA0OD01RjE3NENEQ18yNTI2N18yMjExXzEmJmRiY2FhOTIwZjE2M2U2MD0xMjIzJiZ1cmw9d3d3JTJFb21idWRzbWFuJTJFb3JnJTJFdWslMkZjc2Y

4.6 **Recommendation**

EQB members are requested to note the PHSO consultation documents and be assured that the Corporate Patient Safety Team and Director of Safety and Risk have already responded to these consultations and invite you also to feedback as part of the consultation process.

Moira Durbridge,
Director of Safety and Risk
August 2020

Claire Rudkin,
Senior Patient Safety Manager

EXTRACT OF PAPER D: PATIENT SAFETY REPORT PRESENTED TO QOC 27 AUGUST 2020

Appendix 1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **EXECUTIVE QUALITY BOARD**

DATE: **11th AUGUST 2020**

REPORT BY: **DIRECTOR OF SAFETY AND RISK**

SUBJECT: **ANNUAL REVIEW OF MODERATE PLUS HARM INCIDENTS (FOR THE PERIOD 1ST APRIL 2019 – 31ST MARCH 2020)**

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1. INTRODUCTION

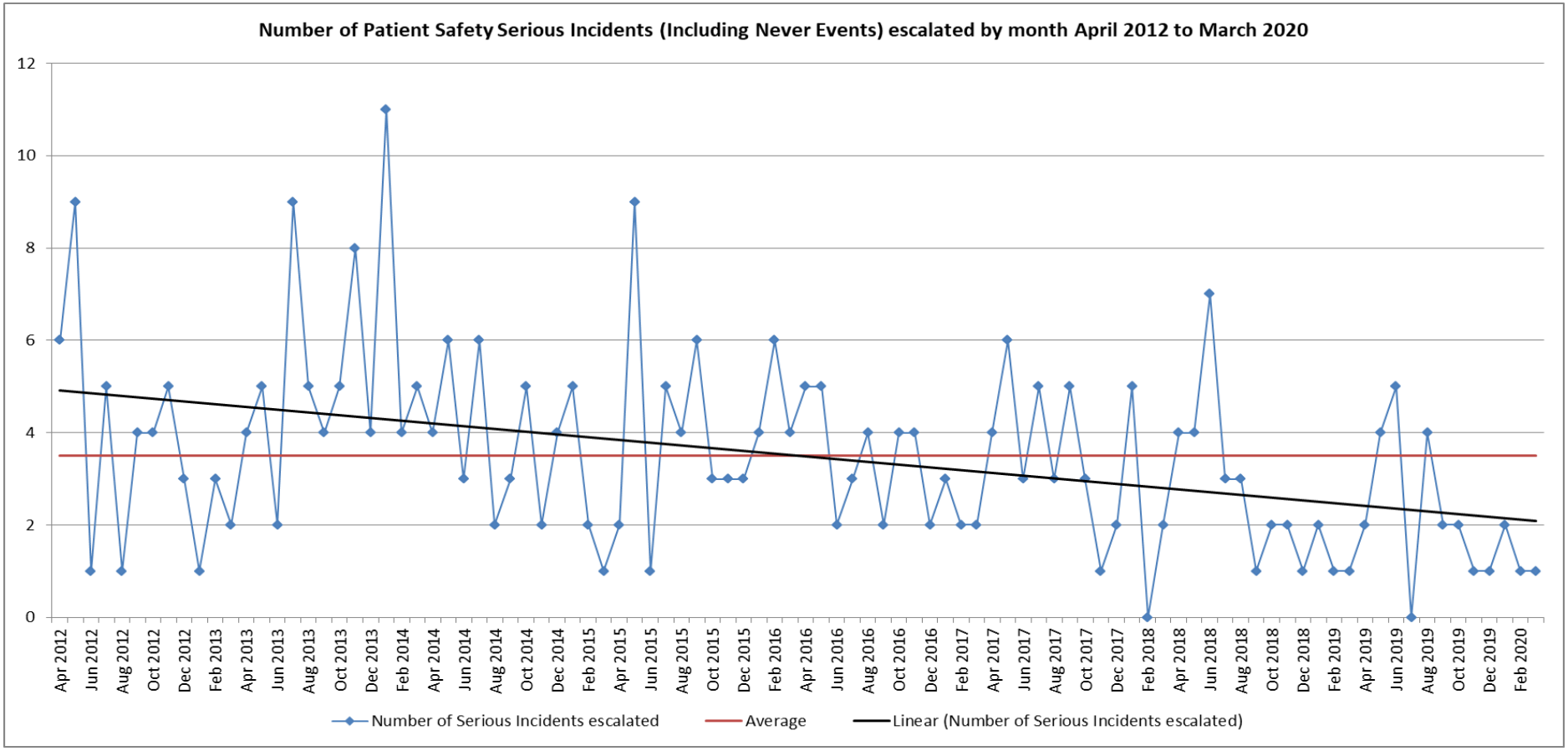
1.1 From 1st April 2019 to 31st March 2020 we have had 139 reported incidents that have been graded moderate harm or above. For the whole of 2018/19 we had 265 moderate and above harm reported incidents. This review into these harm events will analyse where we are seeing the main trends and themes and pose the questions of:-

- Are we becoming less safe?
- What are the types of harm we are seeing, and how do they compare with what we have seen previously?
- Is there any correlation of harms incidents and activity?

2. ARE WE BECOMING LESS SAFE?

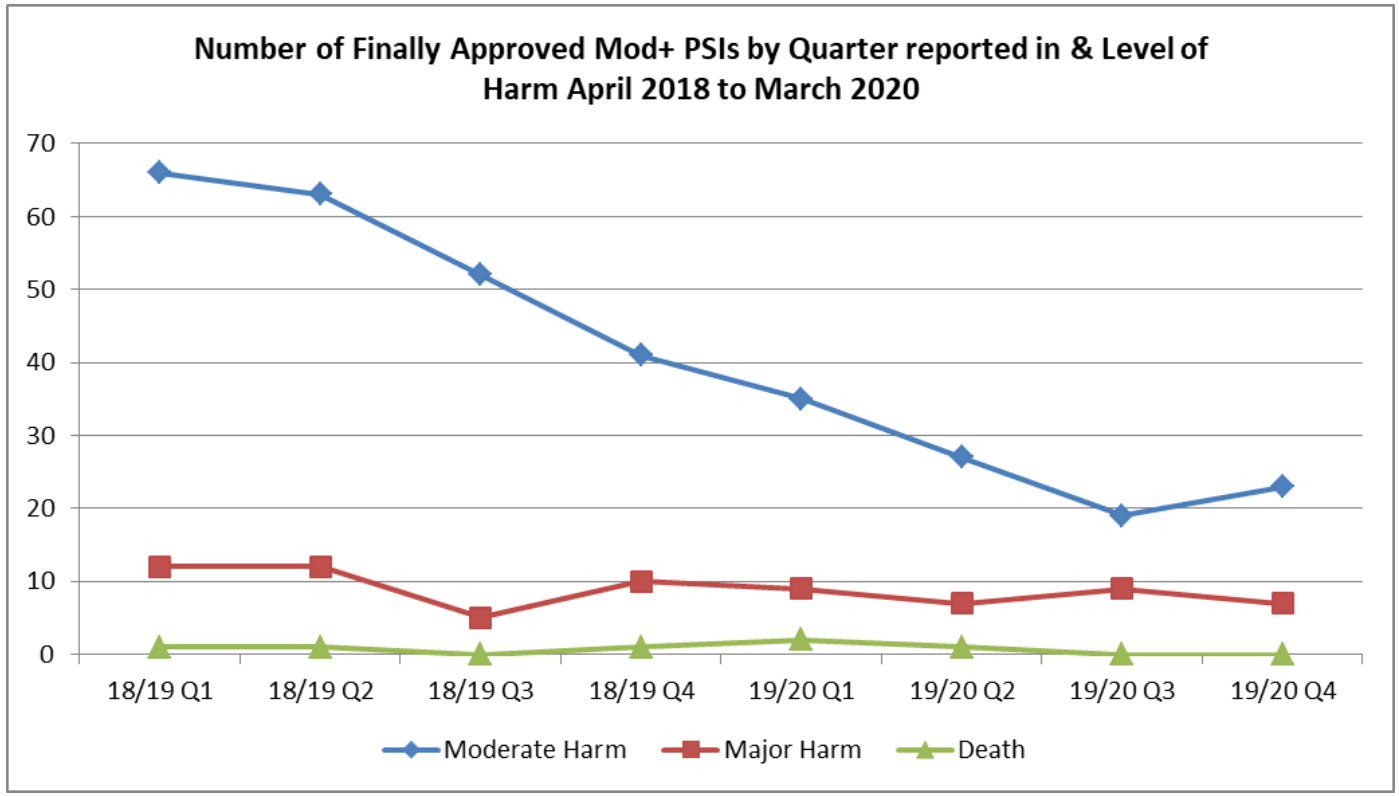
2.1 In 2018/19 UHL escalated 30 Serious Incidents (SIs) which included 8 Never Events and of those 30 there are 7 SIs where there was no harm or minor harm. In comparison during 2019/20 UHL escalated 29 Serious Incidents (SIs) which included 3 Never Events and of those 29 there were 7 SIs where no harm or minor harm was recorded (3 No Harm & 4 Minor Harm). Overall 2019/20 compared to previous years recorded the lowest number of incidents escalated as Serious Incidents over the last 8 years.

Number of Serious Incidents escalated by financial year – April 2012 to March 2019	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Overall Total
Total	45	66	40	50	37	39	30	29	**336**



2.2 The table and graph below display the number of harm incidents reported in each quarter by actual level of harm;

Finally Approved Mod+ PSIs by Quarter reported in & Level of Harm April 2018 to March 2020	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	Total
Moderate Harm	66	63	52	41	35	27	19	23	**326**
Major Harm	12	12	5	10	9	7	9	7	**71**
Death	1	1	0	1	2	1	0	0	**6**
Totals:	**79**	**76**	**58**	**52**	**46**	**35**	**28**	**30**	**403**

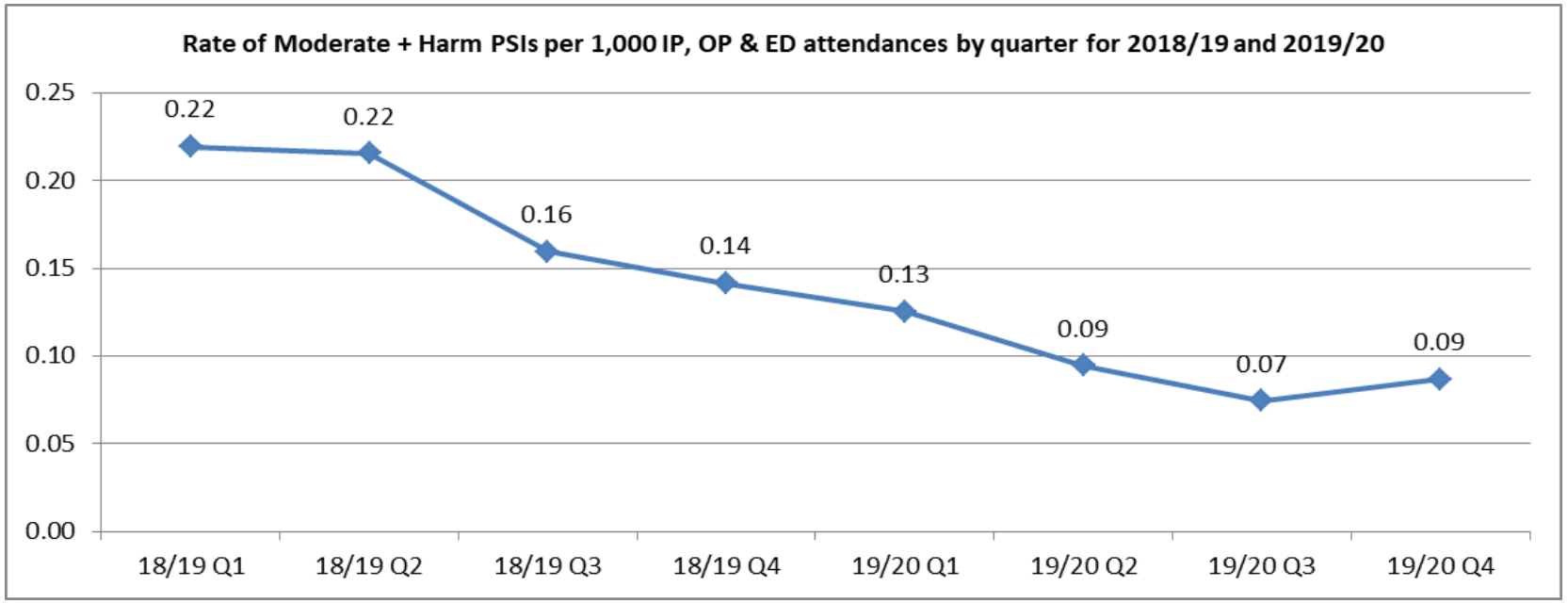


2.3 It can be seen from the table and chart above that the number of Harm incidents reported has decreased in 2019/20 compared to 2018/19. This is also noted that on average for 2018/19 there were 66 Mod+ incidents reported compared to 2019/20 where the average is 35 reported incidents per quarter.

2.4 The decrease in harm incidents in 2019/20 compared to 2018/19 is noted mainly with a decrease in Moderate Harms. Major Harms have only decreased slightly in 2019/20 when compared to 2018/19 with on average 8 being reported per quarter compared to the previous 10, Deaths are consistent with only three being recorded per financial year and the only the distribution of these incidents has changed where 2 Deaths are reported in Q1 of 2019/20 whereas the previous year only ever had 1 Death per quarter at most (Q3 2018/19 had 0 Deaths).

Finally Approved Mod+ PSIs by Year reported in & Level of Harm – April 2018 to March 2020	18/19	19/20	19/20 as a % of 18/19
Moderate Harm	222	104	**47%**
Major Harm	39	32	**82%**
Death	3	3	**100%**
Totals:	**264**	**139**	**53%**

2.5 The reduction seen during 2018/19 across quarters 3 and 4 continues through to 2019/20 quarters 1, 2 and reaching the lowest point in Quarter 3. This shows a 68% reduction from 2018/19 quarter 1 to 2019/20 quarter 3, however there is a slight increase in the rate of moderate and above harm PSIs in 2019/20 quarter 4 which is due to the steep decline in the number of attendances, even then this increase brings it only to the level of 2019/20 quarter 2 and is still far lower than previous years.

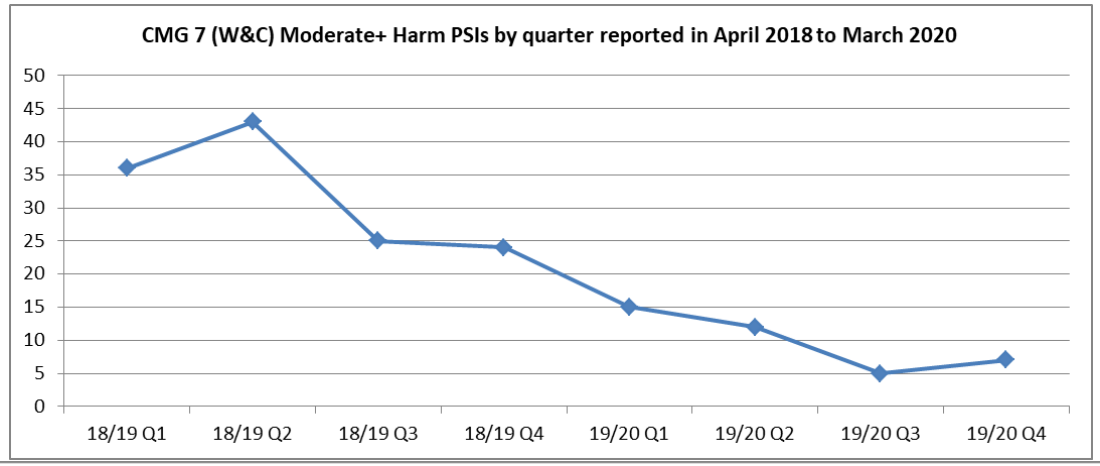


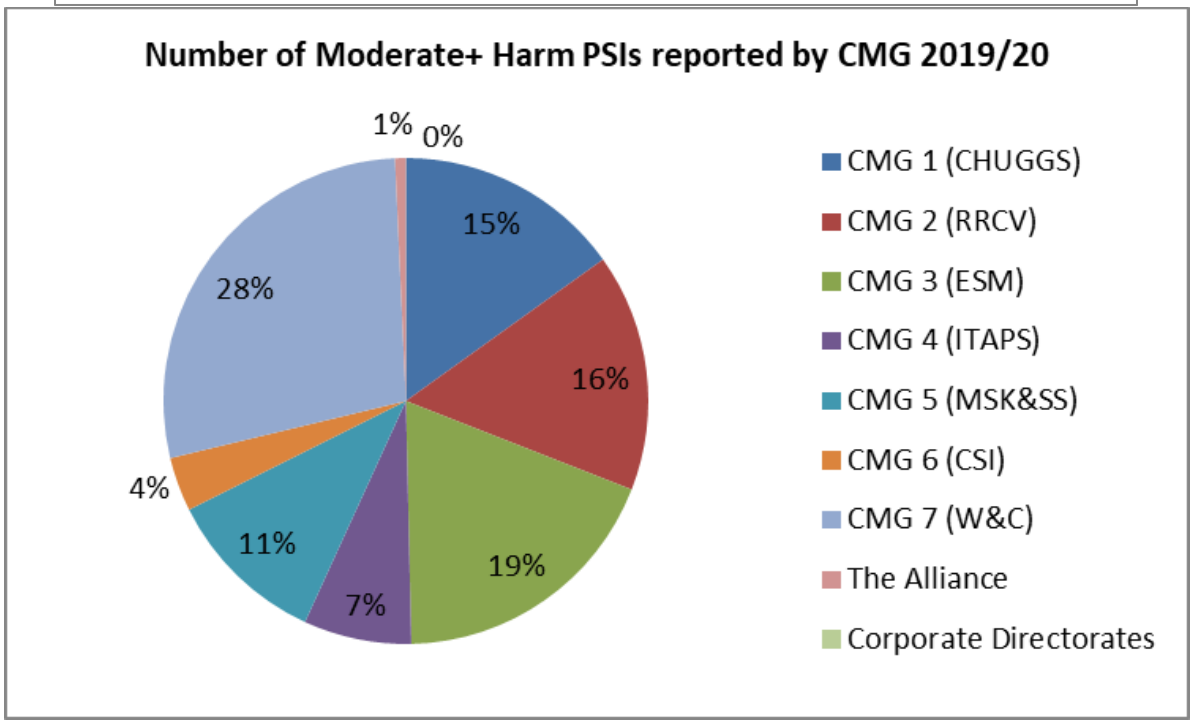
2.6 The number of reported validated finally approved harm incidents can be seen in the tables below, broken down by CMG and Corporate Directorate;

Finally Approved Mod+ PSIs by CMG April 2018 to March 2020	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	Total
CMG 1 (CHUGGS)	8	3	5	1	11	5	2	3	**38**
CMG 2 (RRCV)	9	9	9	7	7	3	3	9	**56**
CMG 3 (ESM)	13	14	5	10	3	7	9	7	**68**
CMG 4 (ITAPS)	6	2	3	4	6	2	1	1	**25**
CMG 5 (MSK&SS)	2	3	7	2	3	5	5	2	**29**
CMG 6 (CSI)	5	2	2	3	1	1	2	1	**17**
CMG 7 (W&C)	36	43	25	24	15	12	5	7	**167**
The Alliance	0	0	1	0	0	0	1	0	**2**
Corporate Medical	0	0	0	1	0	0	0	0	**1**
Totals:	**79**	**76**	**57**	**52**	**46**	**35**	**28**	**30**	**403**

Finally Approved Mod+ PSIs by CMG April 2019 to March 2020	2019/20	CMG as % of Total
CMG 1 (CHUGGS)	21	15%
CMG 2 (RRCV)	22	16%
CMG 3 (ESM)	26	19%
CMG 4 (ITAPS)	10	7%
CMG 5 (MSK&SS)	15	11%
CMG 6 (CSI)	5	4%
CMG 7 (W&C)	39	28%
The Alliance	1	1%
Corporate Directorates	0	0%
Totals:	**139**	

2.7 It is noted that CMG 7 (W&C) saw a significant decrease over the year in the number of reported harm incidents from 18/19 Q2 to 19/20 Q4. In 19/20 Quarters 3 & 4 this decreasing trend was broken by the number of reported harms increasingly slightly in Quarter 4, which is still far below the average and still less than a third of 2018/19's Quarter 4 figures. Despite the reduction in reported numbers over 2019/20, CMG 7 (W&C) continues to be the highest reporter of Moderate and Major Harm incidents accounting for 28% of the total number of Harm incidents reported in 2019/20.





2.8 Of the 39 harm incidents a total of 27 (69%) are recorded as being related to Labour or Delivery, of those 27 a total of 8 (29%) were injury/poor outcome for the mother incidents. During 2019/20 the Quality and Safety Team in W&C team worked with the Corporate Patient Safety team and have developed a PPH validation tool within Datix which improves identification of where there are any gaps in care that have caused harm.

2.9 Slips, Trips and Falls account for 28% of all Mod+ PSIs reported (39) during 2019/20. This is the highest percentage noted for a single incident type behind injury/poor outcome for the mother which accounted for 19%.

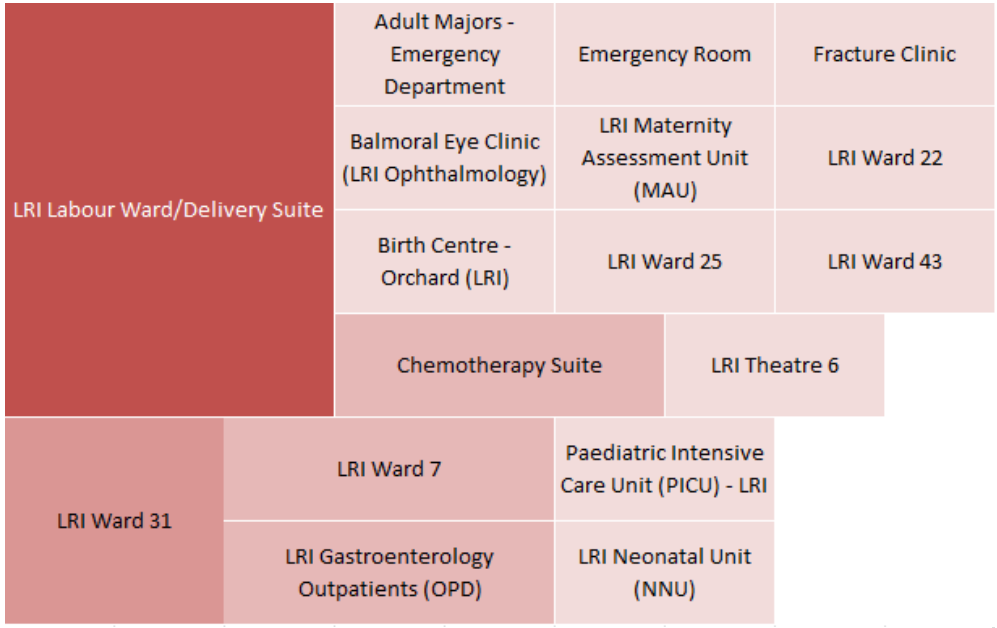
2.10 We note that there are significant drops in harm incidents reported for W&C compared between 2018/19 and 2019/20, similarly ESM also shows lower than usual numbers as does RRCV, only CHUGGS reports slightly higher than before with a very minor increase overall.

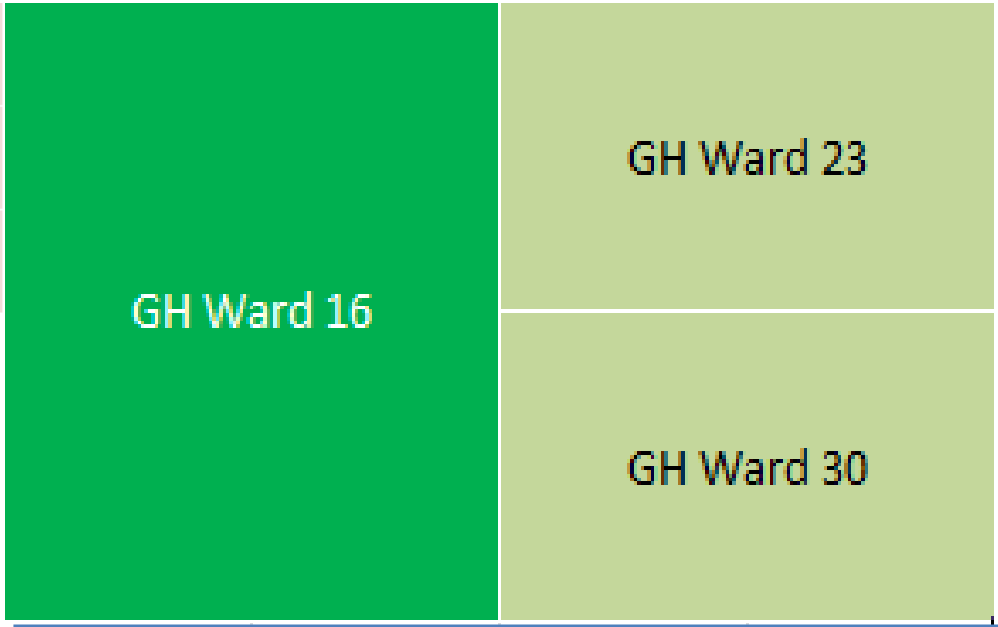
2.11 Over half (58%) of the reported incidents were for the LRI site with the LGH site accounting for 27%, the GH site 13% with the Alliance and Dialysis Unit sites accounting for the remaining 2%.

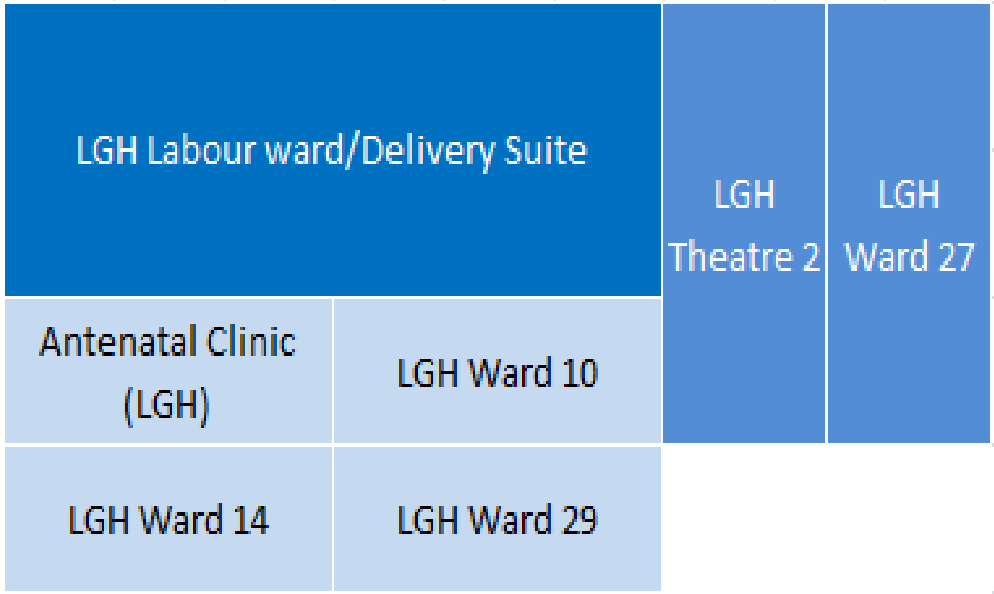
2.12 In 2019/20 the top five specialities for harm incidents are Maternity, General Surgery, Geriatric Services, Respiratory Medicine and Emergency Department. Combined the top 5 specialties account for 62 (45%) of the 139 Moderate and Major harm incidents reported in 2019/20.

Finally Approved Mod+ PSIs Top 5 Specialties - 2018/19 Financial year	**Total**	**Specialty as % of overall total**
Maternity	30	22%
General Surgery	9	6%
Geriatric Services	9	6%
Respiratory Medicine	7	5%
Emergency Department	7	5%
Top 5 Total	**62**	
Overall Totals:	**139**	

2.13 The following 3 charts display the locations with 2 or more reported moderate and major harm incidents on each of the 3 UHL sites during 2019/20







It is clear from these charts which locations reported the highest number of incidents on each site, the larger and darker the box the more incidents were reported.

On the LRI site the highest concentrations of incidents were reported for the Labour ward and Ward 31 which combined accounted for 20% of LRI incidents.

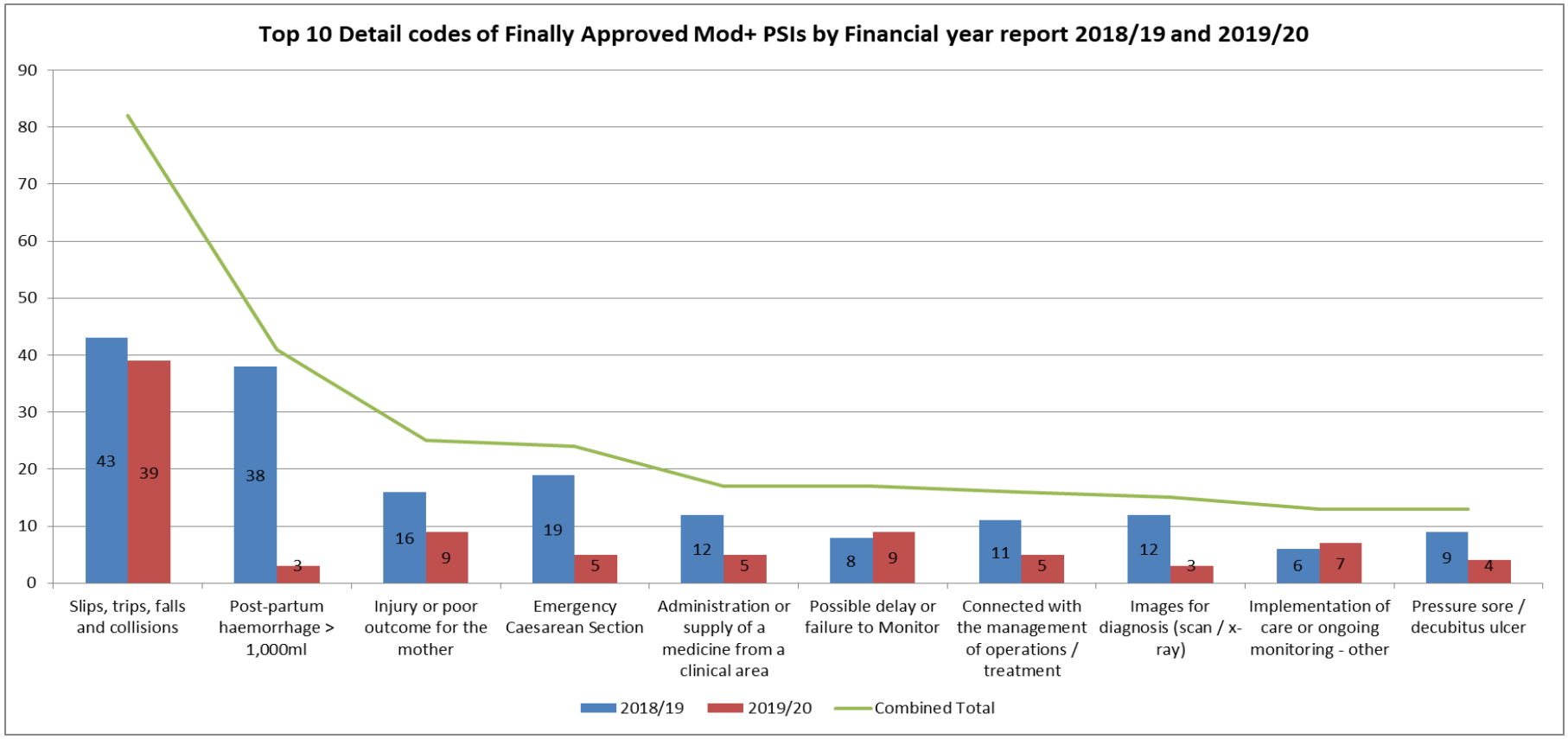
On the GH site the main locations are Wards 16, 23 and 30. These locations all saw similar volumes of incidents reported and combined account for 44% of the reported GH incidents.

On the LGH site 21% of the incidents were reported for the Labour ward with Theatre 2 and Ward 27 having 8% each.

Overall the two Labour wards combined account for 14% of all Moderate and Major Harm incidents reported in 2019/20.

3. WHAT ARE THE TYPES OF HARM WE ARE SEEING, AND HOW DO THEY COMPARE WITH WHAT WE HAVE SEEN PREVIOUSLY?

3.1 The top 10 themes broken down by Datix Detail code are shown in the graph below for both 2018/19 and 2019/20;



3.2 The graph above shows that the top most common theme this year is the same as the previous financial year, that being inpatient falls. In 2018/19 inpatient falls accounted for 16% of the total number of harm incidents whereas for this year this is 28%. In 2018/19 PPHs accounted for 14% of the total number of harm incidents whereas for this year this is 2%.

3.3 In 2019/20 only the possible delay or failure to monitor increased by 12% and implementation of care increased by 16%, everything else decreased.

3.4 It is noted that the number of reported harm incidents relating to images for diagnosis have reduced to a quarter (75% reduction) in 2019/20 compared to 2018/19.

4. IS THERE ANY CORRELATION OF HARMS INCIDENTS AND ACTIVITY?

4.1 It is important that we review activity so that we are able to identify if there is any correlation with activity and harm incidents.

4.2 UHL saw a decrease in both patient attendance activity and overall number of reported Patient Safety Incidents in 2019/20 compared to 2018/19. This activity is reflected in both the overall annual figures and the quarterly breakdowns.

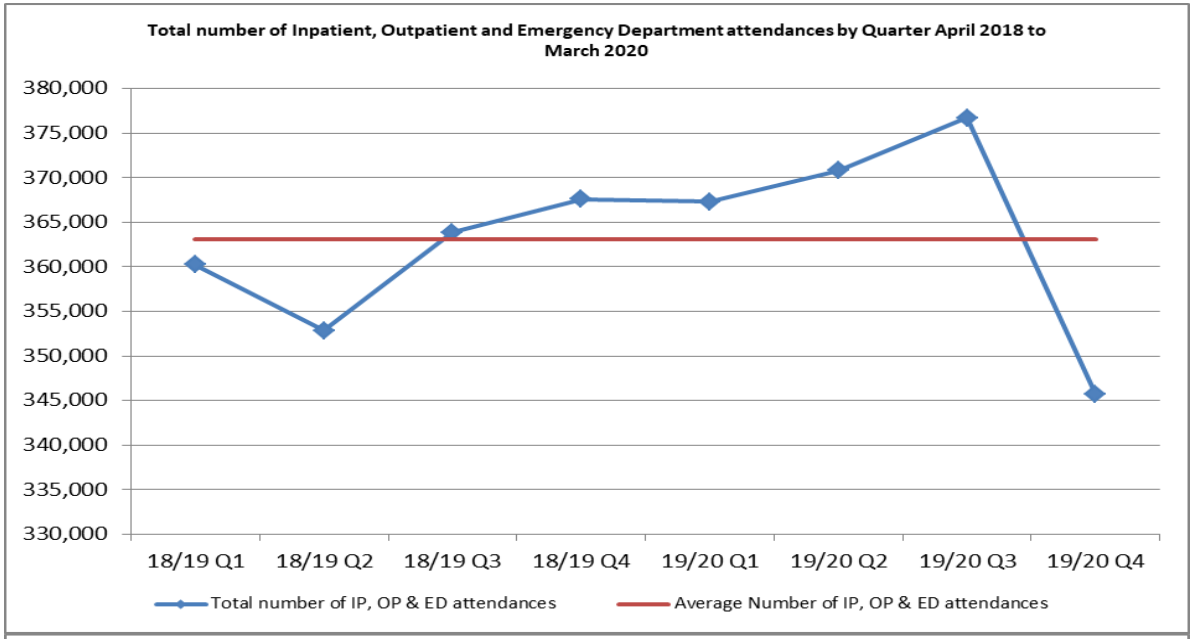
4.3 Due to the decreases in patient attendances in Q4, all PSIs and Harm incidents the rate of Mod+ Harm incidents per 1,000 attendances decreased by 0.10 in 2019/20 compared to 2018/19. This was due to the large decrease in attendances in Q4 which overtook the decrease in harm incidents.

4.4 We saw a similar decrease for the rate of Harm incidents per 1,000 PSIs and this was significantly a decrease of 5.10.

Rate of Mod+ PSIs per 1,000 IP, OP & ED attendances by year reported in April 2018 to March 2020	**18/19**	**19/20**	**Total**
Number of Mod+ Harm PSIs reported	265	139	**404**
Number of IP, OP & ED attendances	1,444,464	1,460,472	**2,904,936**
Rate of Mod+ PSIs per 1,000 IP, OP & ED attendances	0.18	0.10	**0.14**
Number of PSIs reported	24,337	24,018	**48,355**
Rate of Mod+ PSIs per 1,000 Patient Safety Incidents	10.89	5.79	**8.35**

Rate of Mod+ PSIs per 1,000 IP, OP & ED attendances by Quarter reported April 2018 to March 2020	**18/19 Q1**	**18/19 Q2**	**18/19 Q3**	**18/19 Q4**	**19/20 Q1**	**19/20 Q2**	**19/20 Q3**	**19/20 Q4**	**Total**
Number of Mod+ Harm PSIs reported	**79**	**76**	**58**	**52**	**46**	**35**	**28**	**30**	**404**
Number of IP, OP & ED attendances	**360,223**	**352,850**	**363,833**	**367,558**	**367,294**	**370,820**	**376,684**	**345,674**	**2,904,936**
Rate of Mod+ PSIs per 1,000 IP, OP & ED attendances	**0.22**	**0.22**	**0.16**	**0.14**	**0.13**	**0.09**	**0.07**	**0.09**	**0.14**
Number of PSIs reported	6,014	6,106	6,309	5,908	5,800	6,403	6,143	5,672	**48,355**
Rate of Mod+ PSIs per 1,000 Patient Safety Incidents	**13.14**	**12.45**	**9.19**	**8.80**	**7.93**	**5.47**	**4.56**	**5.29**	**8.35**

4.5 The two graphs below show the attendance activity and rate of harm incidents per 1000 IP,OP and ED attendances;

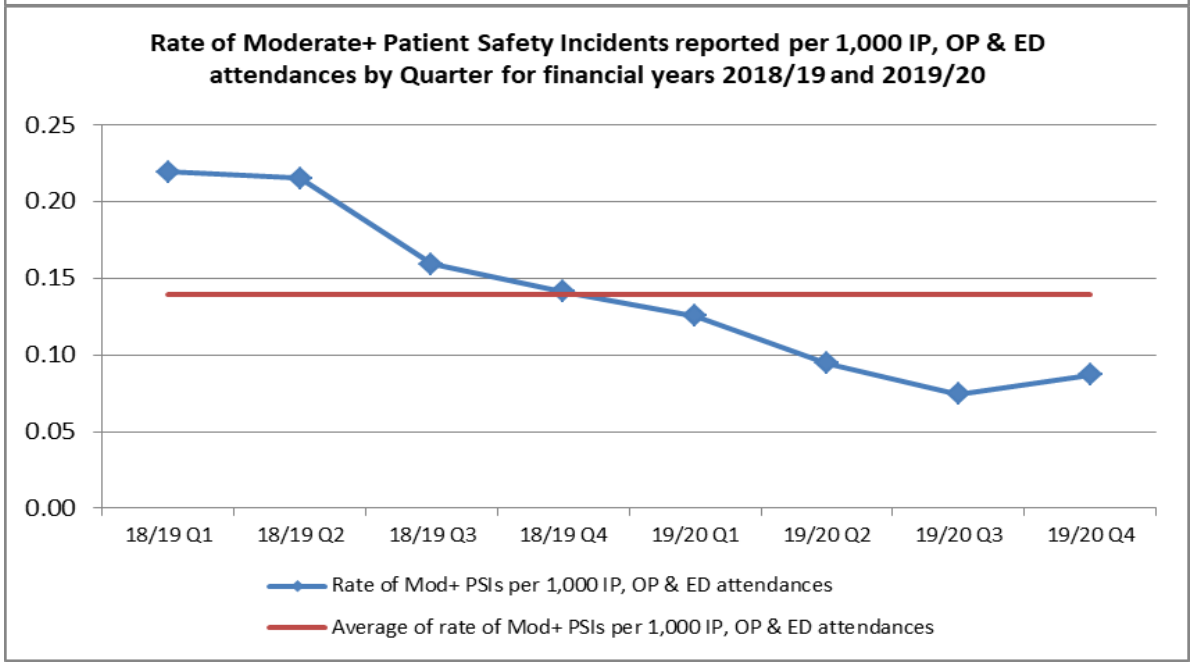


The number of patient attendances overall has continued to rise until Quarter 4 2019/20 when it sharply declined.

The inpatient activity shows minor variation, staying close to the average until March 2020 where it drops by over 20%.

Outpatient activity saw a quarter on quarter increase through 2018/19 which remains fairly consistent in 2019/20.

Emergency activity has seen a quarter by quarter minor increase until Q4 where there's a 14% reduction. It is noted that there is a 1% increase in Emergency attendance activity in 2019/20 compared to 2018/19 as a whole.

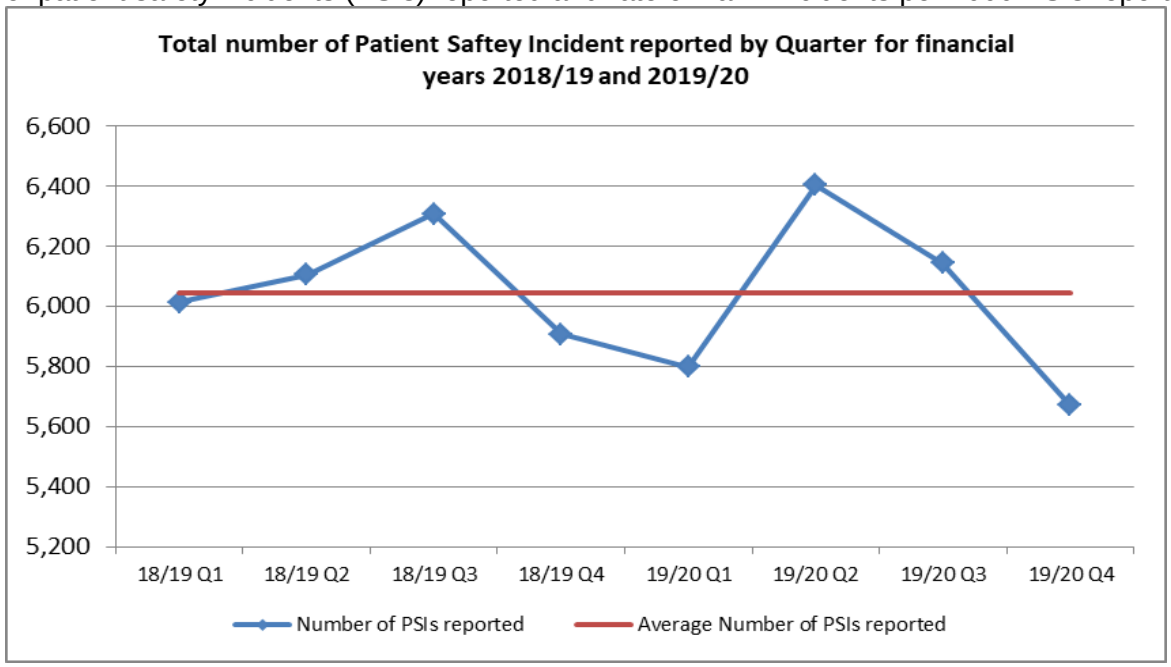


Despite the attendance activity showing a continued increase until Q4 2019/20, this is not reflected in the rate of harm incidents per 1,000 attendances.

The rate of harm incidents continues to remain below its mean (0.14) since Q1 2019/20. The rate appears stabilise between Q3 and Q4 2019/20.

It is worth pointing out that despite the increase in patient attendances the rate of harm has not followed a similar trend and so provides assurance that safe care is being provided even if activity is increasing, until Q4 2019/20 where attendances dropped which caused the rate to increase.

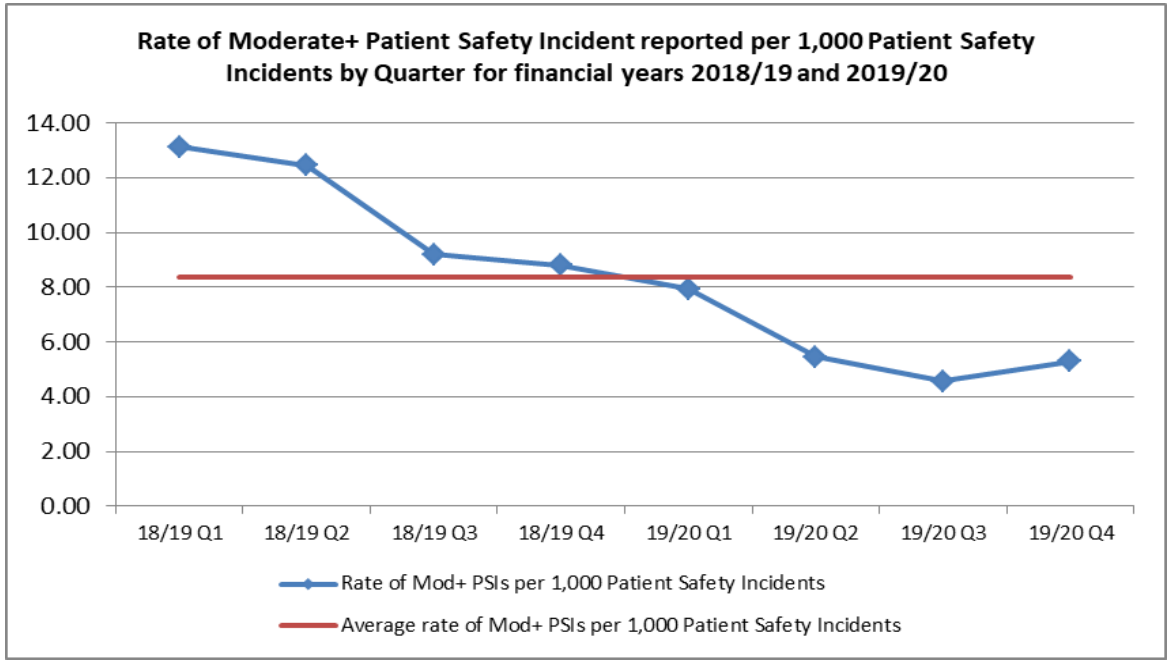
4.6 The other way we can review harm incidents is by correlating with the number of reported patient safety incidents. The two graphs below show the number of patient safety incidents (PSIs) reported and rate of harm incidents per 1000 PSIs reported;



The number of patient safety incidents being reported on a quarterly basis has varied significantly over the two financial years. This could be reflecting certain seasonal trends and the pandemic is involved in 2019/20 Q4.

2019/20 saw a 1% decrease on the number of PSIs reported in 2018/19.

Overall in 2019/20 a total of 139 (0.5%) of the 24,018 Patient Safety Incidents were noted to have caused harm to patients.



Despite the number of patient safety incidents being reported showing a minor decrease this is not reflected in the rate of harm incidents per 1,000 PSIs.

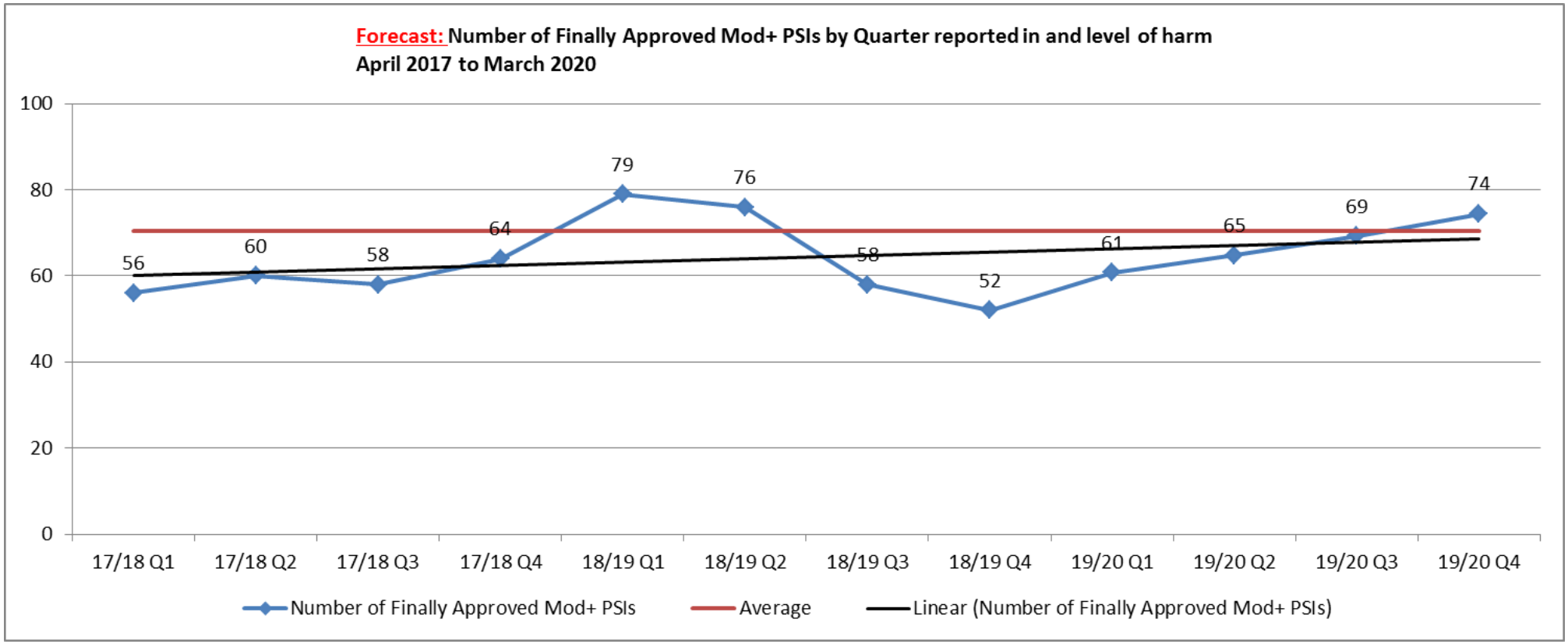
The rate of harm incidents continues to drop below its mean (8) with a reduction below the mean for 2019/20. The rate appears stable and consistent with no significant themes or trends to note.

It is worth pointing out that even with the very minor decrease in reported patient safety incidents the rate of harm has not followed a similar trend and so provides assurance that safe care is being provided as over 99% of PSIs do not cause Moderate/Major harm.

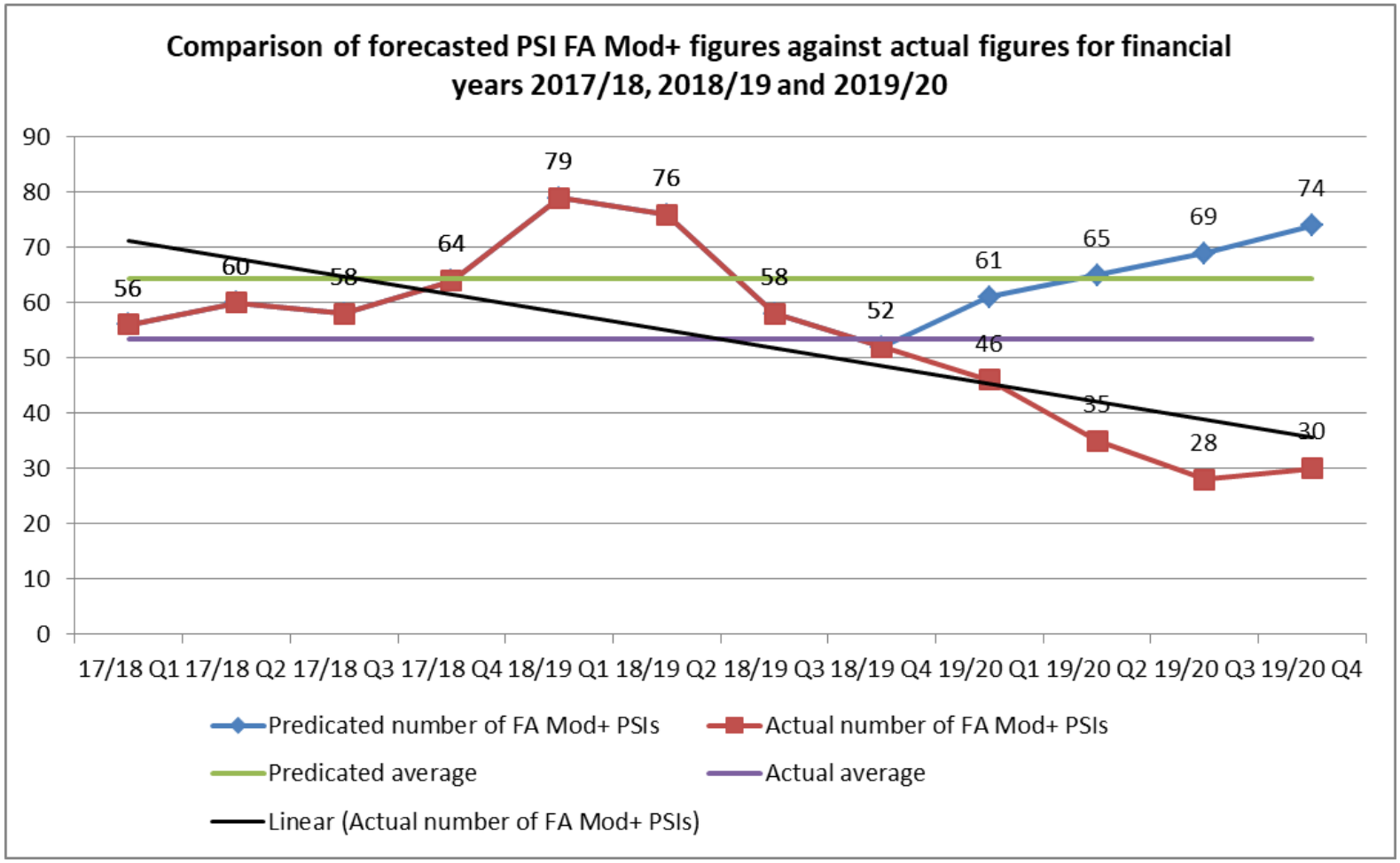
5. Forecast – then and now

5.1 A new element was introduced to the harms review report last year to forecast the future quarter's data and so to try and identify points of focus for the coming year.

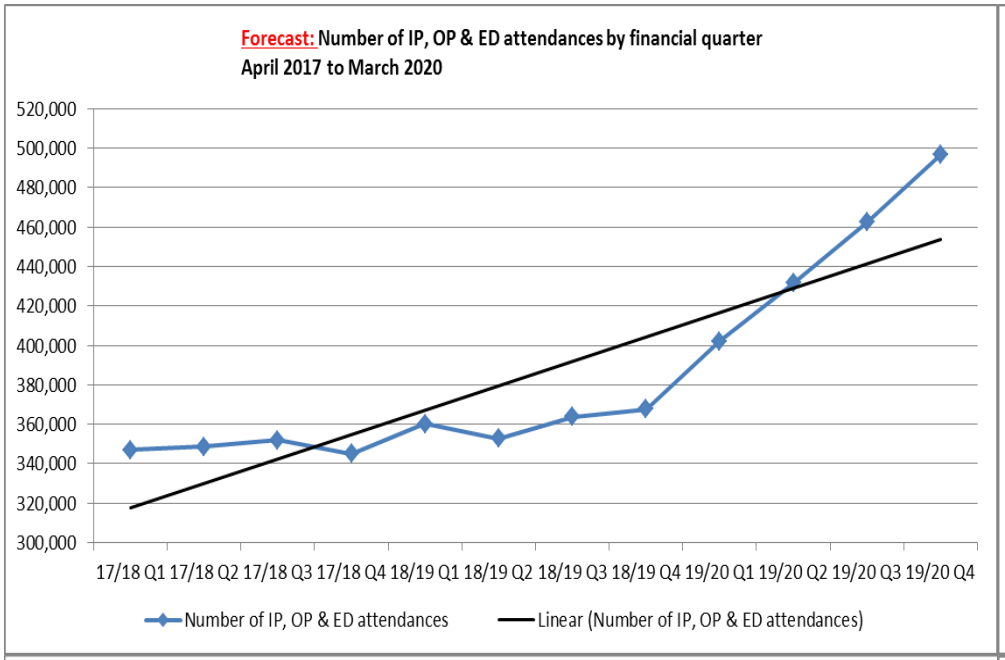
5.2 The forecast at that time was the number of reported Moderate and Major harm incidents will increase steadily over the next 4 quarters reaching highs of approximately 74 incidents reported in a single quarter during 2019/20.

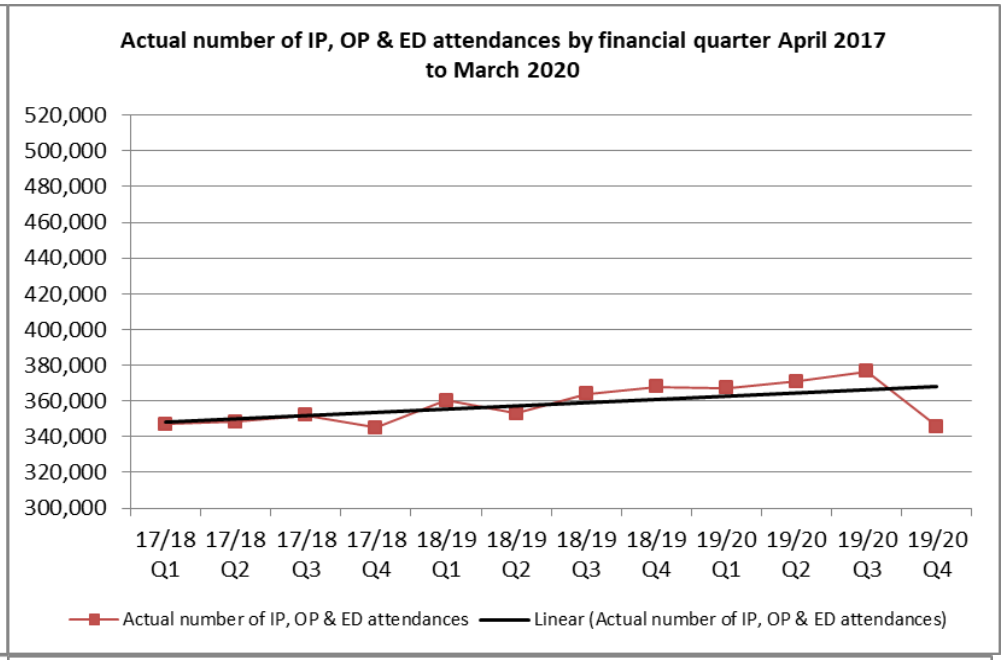

Forecast: Number of Finally Approved Mod+ PSIs by Quarter reported in and level of harm
April 2017 to March 2020
100
80
60
40
20
0
56
60
58
64
79
76
58
52
61
65
69
74
17/18 Q1
17/18 Q2
17/18 Q3
17/18 Q4
18/19 Q1
18/19 Q2
18/19 Q3
18/19 Q4
19/20 Q1
19/20 Q2
19/20 Q3
19/20 Q4
Number of Finally Approved Mod+ PSIs
Average
Linear (Number of Finally Approved Mod+ PSIs)

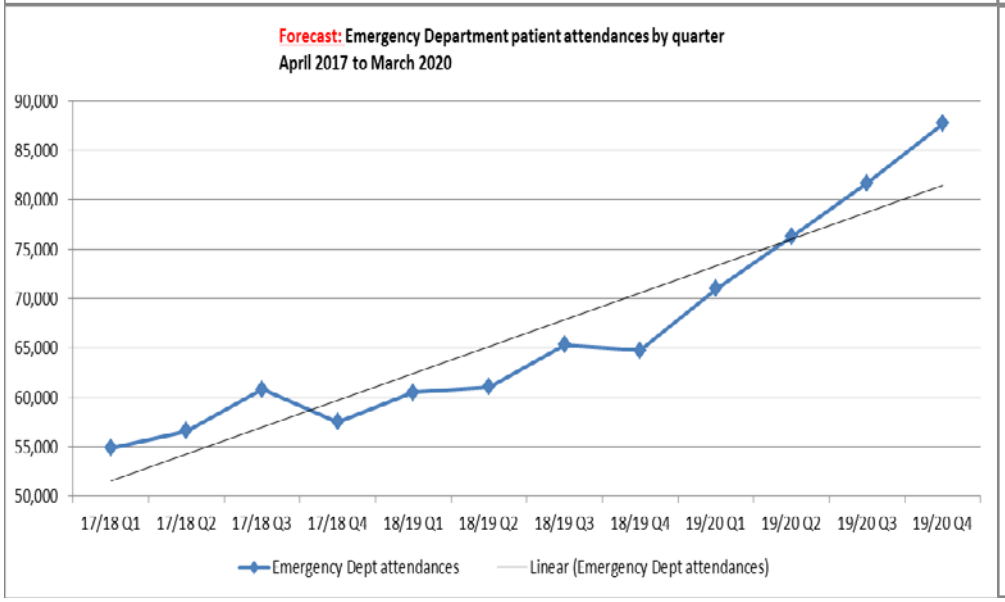
5.3 This forecast could not take in to account what has actually happened, as the comparison below shows the actual figures are far below the predictions, even from before the pandemic.

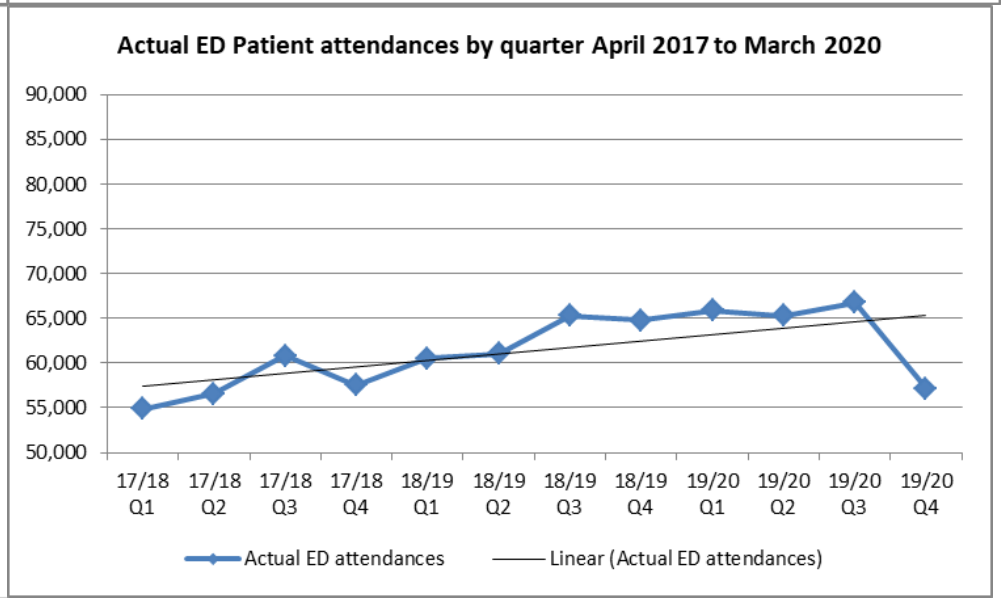


5.4 It was forecast that in regard to patient attendances that there would be a continued increase in activity with record high levels. This forecast was also very inaccurate and could not take in to account circumstances even from before the pandemic.

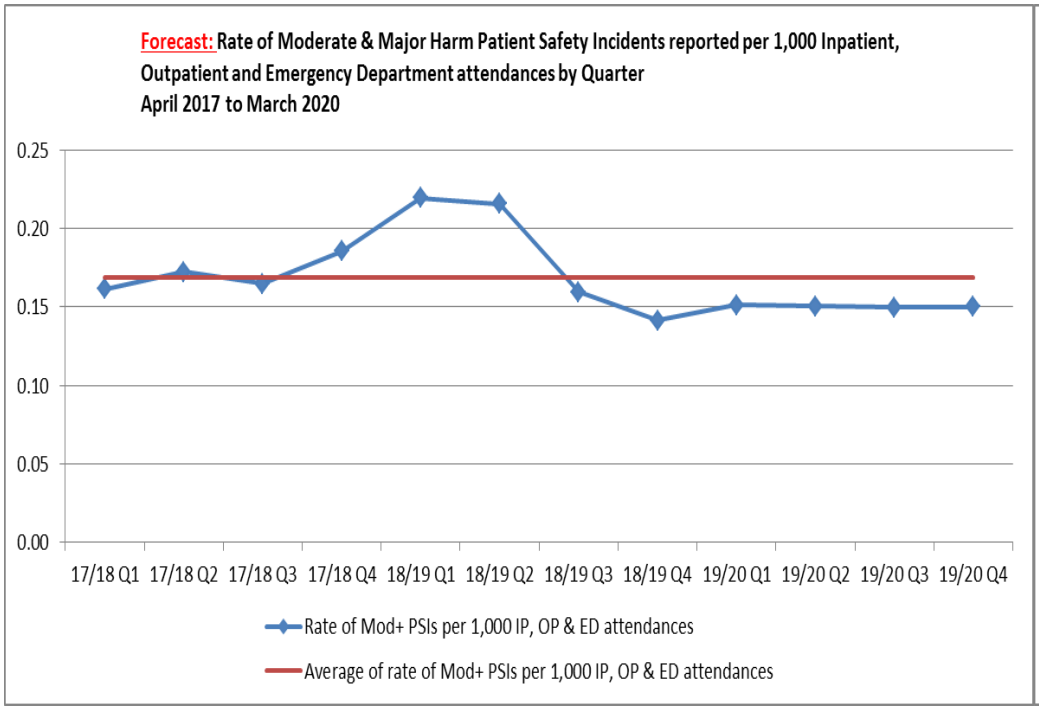


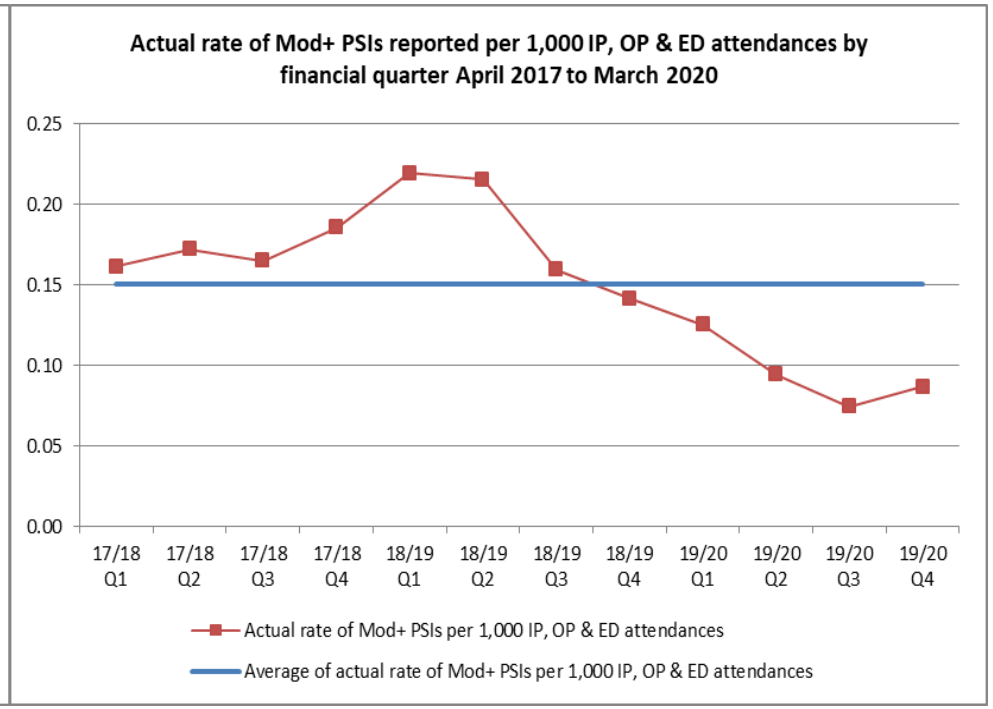






5.5 The forecasted increases in the number of incidents and attendances when plotted as a rate we were expecting to see the rate to be varied but close to the mean with the majority of points being below the mean. These forecasted attendance figures outweighing the forecasted increases in reported harm incidents was also inaccurate as what actually happened is a decrease in reported harm incidents combined with an increase in attendance figures (until Q4 2019/20 at least).





6. FINDINGS

6.1 With regard to Serious Incidents reported in 2019/20 we saw a reduction in the number that we escalated in the financial year compared to 2018/19. This was the lowest number of Serious Incidents escalated in a financial year for the last 8 years.

6.2 Overall in 2018/19 a total of 139 (0.5%) of the 24,018 Patient Safety Incidents were noted to have caused harm to patients.

6.3 The number of reported Moderate and Major Harm incidents appears to be lowering in 2019/20 compared to 2018/19, this was mainly due to the high reported numbers in 2018/19.

6.4 The data shows that the top two most common themes this year are slightly different from the previous financial year, inpatient falls remains the most common and post-partum haemorrhages (PPHs) has been replaced by Injury/Poor outcome for the mother incidents. In 2018/19 inpatient falls accounted for 16% of the total number of harm incidents whereas for this year this is 28%. In 2018/19 PPHs accounted for 14% of the total number of harm incidents whereas for this year this is 2%. During 2019/20 the Quality and Safety Team in W&C team worked with the Corporate Patient Safety team and have developed a PPH validation tool within Datix which improves identification of where there are any gaps in care that have caused harm.

6.5 Total of 3 incidents reported as causing Death to a patient compared to 3 reported in 2018/19

6.6 In 2019/20 Emergency caesarean section increased by 18% and Injury/Poor outcome for the mother incidents decreased by 14% compared to 2018/19.

6.7 For 2019/20 the top five specialities for harm incidents are Maternity, General Surgery, Geriatric Services, Respiratory Medicine and Emergency Department. Combined the top 5 specialties account for 62 (45%) of the 139 Moderate and Major harm incidents reported in 2019/20.

6.8 The LRI Site reports the majority of Harms incidents and the Labour wards (LRI & LGH) are clear leaders in locations where Harm incidents are reported.

6.9 To conclude in 2019/20 we have seen a sustained decreased level of harm overall compared to 2018/19, this is mainly moderate level harm rather than major or death. This is particularly noticeable in quarter 4 of 2019/20 where the lockdown measures come in to affect. We will continue to monitor the harm rate each quarter and report our validated figures in the Director of Safety and Risk report to EQB.

Claire Rudkin
Senior Patient Safety Manager
August 2020

Infection Prevention Annual Report 2019-2020

Author: [Elizabeth Collins] Sponsor: [Carolyn Fox]

QOC paper L

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	29.07.20	Infection Prevention Trust Assurance Committee
Trust Board		

Executive Summary

Context

The Annual Infection Prevention Report for the year 2019 to 2020 is attached.

This report has been written to provide information about Infection Prevention and Antimicrobial Stewardship at the University Hospitals of Leicester in 2019/20.

Questions

The Lead Infection Prevention Doctor and Nurse would welcome the opportunity for the report to be presented to the Board for assurance

Conclusion

The Infection Prevention Team, working with all colleagues across the organisation ensure that there is on-going emphasis given to the prevention of healthcare associated infection, highlight emphasis on the appropriate use of antibiotics to support the reduction of antibiotic resistance and the improvement of cleanliness in our hospitals.

Input Sought

QOC is asked to note this report and continue to support the key priorities for 2020/21 to maintain Clostridium difficile within trajectory, objective to have zero MRSA blood

stream infections. To further develop Gram Negative Bacteraemia Reduction Programme, Development of Leicestershire Continence and Catheter Committee (LCCC) Continue to support the UHL Endoscopy Project Group to deliver a centralised Endoscope Decontamination Unit. Enhanced Carbapenem Resistant Organism Screening and contribution to an LLR Strategy for identification and management.

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

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

1. Quality priorities

Safe, surgery and procedures	[Yes /No /Not applicable]
Safely and timely discharge	[Yes /No /Not applicable]
Improved Cancer pathways	[Yes /No /Not applicable]
Streamlined emergency care	[Yes /No /Not applicable]
Better care pathways	[Yes /No /Not applicable]
Ward accreditation	[Yes /No /Not applicable]

2. Supporting priorities:

People strategy implementation	[Yes /No /Not applicable]
Estate investment and reconfiguration	[Yes /No /Not applicable]
e-Hospital	[Yes /No /Not applicable]
More embedded research	[Yes /No /Not applicable]
Better corporate services	[Yes /No /Not applicable]
Quality strategy development	[Yes /No /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?

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: [date] or [TBC]
6. Executive Summaries should not exceed **5 sides** [My paper does/does not comply]

University Hospitals of Leicester NHS
NHS Trust

Infection Prevention Annual Report

2019/20

Infection Prevention Annual Report

April 2019 - March 2020

Contents

1. INTRODUCTION

Within University Hospitals of Leicester (UHL) the avoidance of healthcare associated infection (HCAI) has remained a top priority for the public, our patients and staff over many years.

Colleagues have worked harder than ever during 2019/20 in the latter quarter of the year with the emergence of a novel virus emanating from China. This virus, SARS-CoV-2 (COVID-19) which can cause a fatal pneumonia in some patients, has been responsible for the declaration of a global Pandemic by the World Health Organisation on the 12 March 2020 after being initially declared a Public Health Emergency of International concern on the 30 January 2020. Within UHL we continue to manage the cessation of a third party provider contract for the delivery of our Estates and Facilities services which whilst over three years ago, coupled with a nationally well recognised shortage of nursing and medical staff has led to a period of unprecedented challenge, not previously seen in living memory.

This report has been written to provide information about Infection Prevention and Antimicrobial Stewardship at the University Hospitals of Leicester in 2019/20. This information will be of interest to patients, their carer's and staff and may also be of interest to members of the public in general. The Infection Prevention Team, working with all colleagues across the organisation ensure that there is on-going emphasis given to the prevention of healthcare associated infection, highlight emphasis on the appropriate use of antibiotics to support the reduction of antibiotic resistance and the improvement of cleanliness in our hospitals.

HCAIs are not only potentially devastating for patients and healthcare staff, but consume valuable healthcare resources. Continued and increased investment in Infection Prevention is therefore both necessary and cost effective.
The report aims to assure the public that the minimisation and control of infection is given the highest priority by the Trust.

Staff within UHL have worked tirelessly in their commitment to patient safety. It has been a privilege to be part of the extraordinary efforts that have taken place across the Trust.

Elizabeth Collins, Lead Nurse Infection Prevention,
University Hospitals of Leicester

2. EXECUTIVE SUMMARY

This Report reviews the 2019/20 Infection Prevention successes and challenges for UHL.

The Trust continues to be licenced to practise healthcare with the Care Quality Commission (CQC).

- SARS-CoV-2 (COVID-19) which can cause a fatal pneumonia in some patients has been responsible for the declaration of a global Pandemic by the World Health Organisation on the 12 March 2020 after being initially declared a Public Health Emergency of International concern on the 30 January 2020.
- In 19/20 there were 5 Meticillin Resistant *Staphylococcus aureus* (MRSA) blood stream infections reported, against a trajectory of zero avoidable cases. 3 cases were deemed un-avoidable. For all cases a Post- Infection Review (PIR) on all patients who have a Trust or non-Trust apportioned MRSA identified was 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
- As part of the Public Health England (PHE) action plan to reduce the number of cases of *Clostridioides difficile* infections (CDI) all hospitals are allocated a 12-month trajectory. UHL has been allotted 108 cases from 1 April 2019 to 31 March 2020. The significant increase, rather than the usual yearly incremental decrease, in allotted cases is a result of the changes that were made to the CDI reporting algorithm (discussed within the CDI section).
- All NHS Trusts are required, by the Department of Health, to report cases of patients with Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia, and as of April 2011 Trusts were also required to report cases of *Escherichia coli* (E coli) bacteraemia and UHL complies with this directive
- We continue to undertake admission screening for MRSA and focus our elective screening on an agreed sub sets of patients where there may be a clinical benefit to screening in terms of reducing risk of serious infection for that individual. Admission screening is also implemented where applicable for Carbapenemase Resistant Organisms (CRO).

3. SARS-CoV-2 (COVID-19) 2020

Coronaviruses are a family of viruses common across the world in animals and humans. Certain types cause illnesses in people. For example, some coronaviruses cause the common cold; others cause diseases which are much more severe such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS), both of which often lead to pneumonia.

COVID-19 is the illness seen in people infected with a new strain of coronavirus not previously seen in humans. On 31 December 2019, Chinese authorities notified the World Health Organization (WHO) of an outbreak of pneumonia in Wuhan City, which was later classified as a new disease: COVID-19. On 30 January 2020, WHO declared the outbreak of COVID-19 a "Public Health Emergency of International Concern" (PHEIC).

The main symptoms of COVID-19 are a cough, a high temperature and, in severe cases, shortness of breath. As it is a new virus, the lack of immunity in the population (and the absence as yet of an effective vaccine) means that COVID-19 has the potential to spread extensively.
Among those who become infected, some will exhibit no symptoms. Early data suggested that of those who develop an illness, the great majority will have mild-to-moderate, but self-limiting illness – similar to seasonal flu. It is, however, also clear that some people who acquire COVID-19 will develop complications severe enough to require hospital care, most often with pneumonia. In a small proportion of these, the illness may be severe enough to lead to death

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak or a major transport accident or a terrorist act. This is underpinned by legislation contained in the CCA 2004 and the NHS Act 2006 (as amended). This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR).

For the NHS, incidents are classed as either:

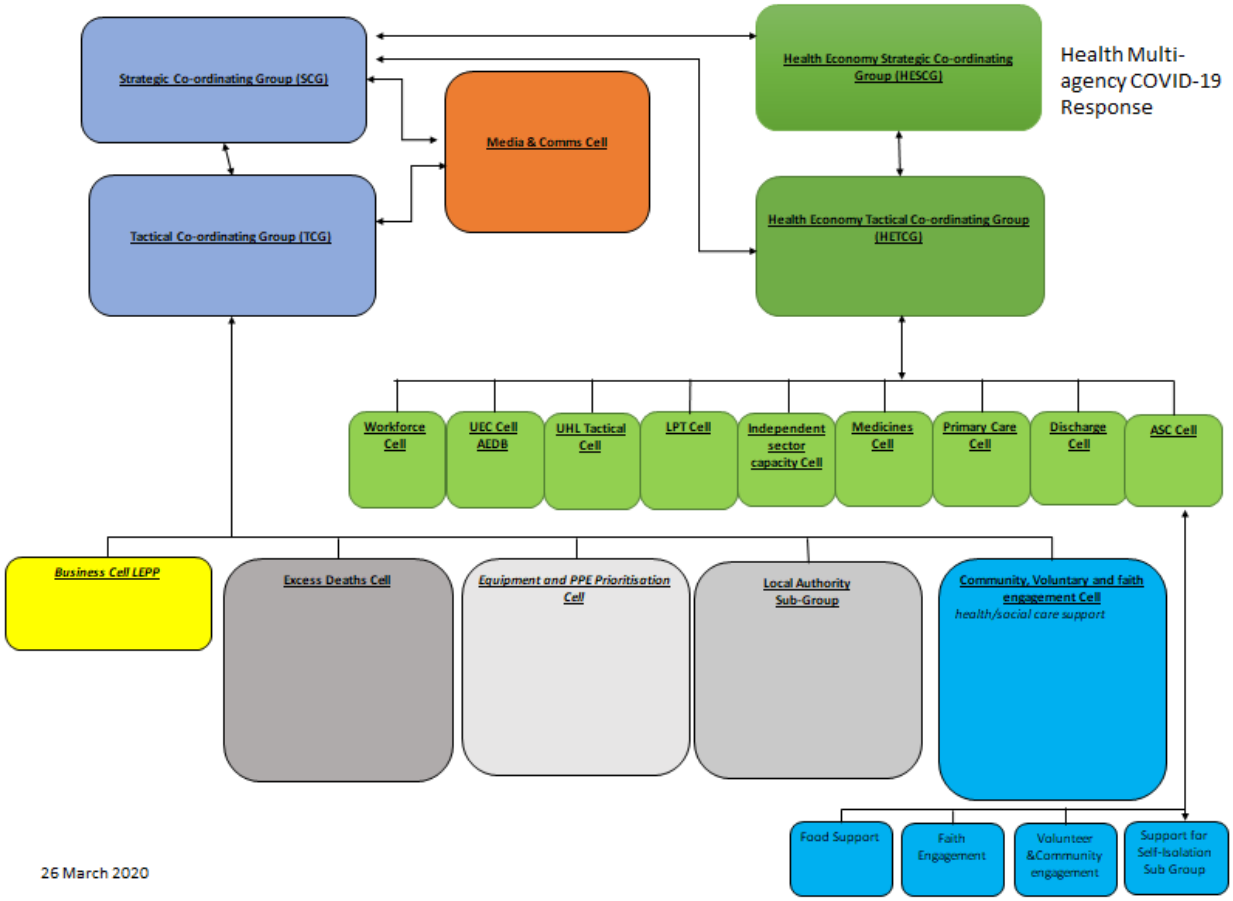
- Business Continuity Incident
- Critical Incident
- Major Incident

Each will impact upon service delivery within the NHS,

A level 4 Major Incident was declared on 4 March 2020 whereby the management of emergency response and recovery is undertaken at one or more of three ascending levels: Operational, Tactical and Strategic. This is based around the concepts of command, control and coordination. https://www.england.nhs.uk/wp-content/uploads/2015/11/eprr-framework.pdf

Responses at Alert Level 4 will require national NHS England command, control and coordination of the NHS across England. Tactical command will remain with local responding organisations, as appropriate.

The chart below describes the Leicester, Leicestershire and Rutland (LLR) EPRR response.



Business as usual within UHL ceased and it was recognised that under the Command and Control structure and while the NHS declared a level 4 incident, the Annual Infection Prevention Programmes for both the Trust and the IPT would be temporarily suspended. Mandatory data gathering and reporting of alert organisms to Public Health England continued.

During the majority of the last quarter of 19/20 the UHL IPT embarked on an education and training programme designed to assist all UHL CMG in the preparation of our hospitals to receive patients suffering from COVID-19. This included but was by no means limited to Mask Fit testing, donning and doffing of and the correct use of PPE, walkthrough of clinical areas to redesign pathways for safe patient flow.

Evidence from other countries around the world described a virus which had the potential to infect large numbers of people and overwhelm clinical services, leading to a shortage of beds and equipment for patients who required care. The NHS across the whole of the UK developed plans of healthcare environments to deal with this.

4. UHL GOVERNANCE AND ASSURANCE FRAMEWORK

The Board of Directors has collective responsibility for keeping to a minimum the risk of infection and recognises its responsibility for overseeing Infection Prevention arrangements in the Trust.

The Trust Infection Prevention Assurance Committee (TIPAC) continued during 19/20 and receives reports and updates from the Infection Prevention Team and wider allied groups within UHL.

The TIPAC is chaired by the Chief Nurse, who is also the Director of Infection Prevention and Control (DIPC). UHL TIPAC receives assurance of the Clinical Management Group (CMG) Infection Prevention Programme implementation and monitors compliance with Trust policies.

The Trust CMG's are comprised of different clinical specialities – their management structures are bespoke around these and the IP management arrangements may vary between them. They continue the process of establishing assurance and monitoring processes into their committees and structures for the reporting and monitoring of infection prevention related activities.

A comprehensive assurance reporting framework has been developed by the IP Data Analyst and this has been commended by colleagues from the National Health Service Improvement Service

The Infection Prevention arrangements within the CMGs are reported and confirmed at the CMG Quality and Performance Management Committees and ultimately by exception to the Trust Infection Prevention Assurance Committee and Executive Quality Board.

An annual programme (Toolkit) is prepared by the Infection Prevention Team, which is agreed, each year, by TIPAC and approved by the Executive Team and Trust Board. The annual programme runs from April to March. Progress against the Annual Programme is monitored by TIPAC.

The programme of work is mapped to the duties of The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance (2014) and incorporates elements of the Trust Commissioning Quality Schedule, UHL Quality Commitment, NHS Safety Thermometer and any relevant recently produced national guidance documents.

The IPT did not have any elements within the Commissioning for Quality and Innovation Initiatives (CQUIN) schedule for 19/20

The Trust Board receives monthly reports on HCAI performance (including MRSA and *C.difficile* rates), and quarterly infection prevention and hygiene reports from all CMGs.

The DIPC and the Lead Infection Prevention Doctor provide the direct link to the Executive Quality Board (EQB) with issues, by exception, and quarterly reports are provided to the Executive Quality Board.

5. LEICESTER, LEICESTERSHIRE AND RUTLAND (LLR) MONITORING FRAMEWORK

NHS Commissioning of services for LLR is divided into three separate commissioning groups. Leicester City, East Leicestershire and Rutland (ELR) and West Leicestershire respectively. Infection Prevention advice to all 3 CCGs is provided by 2 IPN who are hosted by the ELR CCG.

The CCG IPN participates in the post infection reviews for all patients who develop MRSA bacteraemia in line with the NHS England guidelines for the management of cases. They also oversee the cases of CDI, reviewing all cases and attributing any lapses in care.

Infection Prevention across LLR has recently been strengthened by the development of an IP and Antimicrobial Multi-Agency Group. The remit of this group is to harmonise the approach to Infection Prevention, working together to ensure the delivery of standardised patient care across the county

6. CARE QUALITY COMMISSION REGULATION

The Code of Practice: *The Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections and related guidance* applies to NHS bodies and providers of independent healthcare and adult social care in England, including primary dental care, independent sector ambulance providers and primary medical care providers.

The code has been revised to reflect the structural changes that took effect in the NHS from 1st April 2013 and the role of infection prevention (including cleanliness) in optimising antimicrobial use and reducing antimicrobial resistance.

The law states that the Code must be taken into account by the CQC when it makes decisions about registration against the infection prevention requirements. The regulations also say that providers must have regard to the Code when deciding how they will comply with registration requirements. So, by following the Code, registered providers will be able to show that they meet the requirement set out in the regulations.

The Code of Practice sets out criteria for the prevention and control of infections associated with healthcare delivery.

Compliance criterion	**What the registered provider will need to demonstrate**
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce

	the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

In 2019/20 the Trust declared full compliance with the Care Quality Commission, Section 20 regulation of the Health and Social Care Act (2008) Outcome 8 Cleanliness and Infection Control.

This declaration was made with due regard to regulation 12 of the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

As discussed in the previous section the UHL IP Toolkit provides assurance against the code. We have been asked to share our Toolkit with other organisations as an example of good practice in this regard.

The latest CQC inspection pf Leicester's Hospitals was between 10 Sep to 06 Nov 2019. Overall the Trust received a 'Good 'rating. Of particular note from the CQC was the comment

"The trust had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services. They had a comprehensive knowledge of current priorities and challenges and took action to address them.

We believe this is particularly relevant to the Infection Prevention Team within the Trust.

A copy of the CQC compliance reports for Leicester Hospitals is available on the UHL public and CQC websites.

7. INFECTION PREVENTION WITHIN UHL

University Hospitals of Leicester has a specialised Infection Prevention Team (IPT) that work across the three main acute hospital city sites and also across the UHL Alliance (Community hospitals and Day Surgical units) 7 Renal Dialysis sites across the East of England and the St Marys Birthing Centre at Melton Mowbray.

7.1 Infection Prevention Team

Lead Infection Prevention Nurse (LIPN).
Senior IPNs x 2 WTE
Specialist IPNs x 6.2 WTE
IPN x 1
Audit and Surveillance Nurse x 1
Senior Information Analyst x1
Team Administrator x1

The Chief Nurse holds the role of Director of Infection Prevention and Control (DIPC) and a Consultant Microbiologist is the Lead Infection Prevention Doctor.

IPN qualifications range from Diploma, BSc to MA level and the team work to a set of core competencies developed by the Infection Prevention Society.

One of the Senior IPN works specifically within the Estates and Facilities Team providing specialist IP advice and support. We feel this is particularly important as the Trust embarks on an ambitious reconfiguration and transformation programme.

National standards and guidance with regard to Water Management, Ventilation system provision, aspects of Decontamination, New Build and refurbishment of existing estate both exist and continue to be developed. Providing guidance and working with both estate colleagues and external contractors ensures UHL works towards meeting these important standards designed to provide a safe environment for our patients.

The IPT coordinates and contributes to the Trust's priority to minimise the risk of infection to our patients, visitors and staff by:

- Providing advice on all aspects of Infection Prevention ensuring that UHL meets the requirements of The Health and Social Care Act (2008) Code of Practice for the Prevention of Healthcare Associated Infections
- Closely monitoring Microbiology results via the electronic reporting system to enable robust and timely patient management
- Managing outbreaks of infection
- Managing incidents that relate to Infection Prevention
- Improving Infection Prevention capability and capacity within Clinical Management Groups
- Developing and facilitating programmes of education and training
- Undertaking audit and developing a targeted surveillance programme where possible
- Formulating policies and procedures
- Interpreting and implementing national guidance at a local level
- Involvement with new building and equipment projects

I am delighted that have been able to recruit to the role of Team Administrator this year. Previous secretarial and administrative support was lost as part of a Cost Improvement Programme demanded within the organisation and this had led to inefficiencies of working,

whereby clinical IPN were undertaking secretarial and administrative roles. Money was made available as one of the IPN opted for the 'Retire and Return' scheme.

It is important for us to recognise that austerity measures implemented over 11 years within the NHS has led to a significant shortage of qualified IPN. There is an ever diminishing national pool of staff from which all organisations now competes. The Retire and Return scheme allows us to retain the skill and expertise of our most experienced staff for a little longer as this gives them an option of a greater 'work life' balance. Succession planning however whilst discussed in previous reports now requires us to act if UHL is to maintain this statutory requirement

7.2 Healthcare Associated Infection Surveillance

The Infection Prevention Team (IPT) undertakes continuous surveillance of alert organisms and alert conditions using the ICNet electronic system. This system links to the laboratory reporting system iLab and the Admission, Discharge and Transfer system (Patient Centre).

In 2009 the UHL Infection Prevention Team were awarded £150,000 from what was then called the Strategic Health Authority in recognition of the success of the Trust in reducing MRSA bacteraemia in particular. This money was used to buy a software system called ICNet that linked the Patientcentre systems to the laboratory reporting system and enabled an hourly feed of results allowing for an almost real time response by the IPT to identified organisms. Staff within wards and Departments can be given management advice in relation to these patient results. Notifications are also received from ward staff where patients are admitted with a pre-existing alert and the IPCT advises on the appropriate use of infection prevention precautions for each case and monitors overall trends.

This system also enabled the creation and management of patient records and since 2011 the UHL IPT has operated a paperless system. I do believe the implementation of ICNet has been one of the most significant Infection Prevention interventions we have taken in recent years. Enabling the efficient direction of IPN and Microbiological clinical staff time to ward and dept areas, to work with and support clinical colleagues with the management of patients as soon as these potential infections have been identified cannot be underestimated.

We were given notice from the company that the version of ICNet that we were using would no longer be supported from September 2020 and if we were to continue to use this system the upgraded, considerably more expensive version would have to be purchased. With all software systems there is also a yearly significant service charge applied as well as the initial outlay for system purchase and installation.
I am delighted to report that we embarked on collaboration with Nervecentre to develop a unique Infection Prevention Software System which has all of the capabilities of ICNet and provides the platform on which to build further IP and antimicrobial data collection systems. All of these are designed to ensure that data crucial for patient safety and management within UHL not only continues but is further developed.

I do not believe the development of this project would have been possible without the knowledge and expertise of Dawn Westmoreland one of our Senior Infection Prevention Nurses or Alice Morris our Senior Data Analyst. Both brought skill sets to this work stream that in collaboration with Trust IT colleagues and Nervecentre architects has resulted in a bespoke product which will go 'live' in 2020. I am very proud of the skills and expertise we have developed within the Infection Prevention Team and want to recognise their work here.

7.3 Alert Organisms[1]

- MRSA
- Clostridium difficile
- Group A Streptococcus
- Salmonella spp.
- Campylobacter spp.
- Mycobacterium tuberculosis
- Glycopeptide resistant Enterococci
- Multi - resistant Gram-negative bacilli e.g. extended spectrum beta-lactamase (ESBL) producers
- Carbapenemase-producing Enterobacteriaceae (CPE)
- Influenza
- Neisseria meningitidis
- Aspergillus
- Hepatitis A
- Hepatitis B
- Hepatitis C
- HIV

7.4 Alert Conditions

- Scabies
- Chickenpox and shingles
- Two or more possibly related cases of acute infection e.g. gastroenteritis
- Surgical site infections

Since 2001 reporting of the numbers of significant organisms related to Healthcare Associated Infection (HCAI) has been mandatory. These are reported to the Public Health England data capture system.

This began with Staphylococcus blood stream infection including resistant strains (MRSA), later extending to Clostridium difficile in 2004 and E coli blood stream infections.

During the past year we have continued to implement a root cause analysis process for MRSA, MSSA bacteraemia, *C.difficile* deaths and increased incidence of cases of *C.difficile*. This ensures we comply with the required external reporting arrangements, and provides us with a way of learning lessons from each case, enabling us to develop and change practice, all with the aim of leading to further reduction in infections and bacteraemias within UHL. MRSA bacteraemia and *C.difficile* are two of the performance management indicators used by the DH.

[1] Alert organisms are organisms identified as important due to the potential seriousness of the infection they cause, antibiotic resistance or other public health concerns. This is a nationally recognised term; these organisms may be part of mandatory or voluntary surveillance systems and are used as indicators of general infection prevention and control performance.

7.5 MRSA and MSSA Prevention and Reduction Strategies

Staphylococcus aureus is a bacterium commonly found colonising humans. Although most people carry this organism harmlessly, it is capable of causing a wide range of infections from minor boils to serious wound infections and from food poisoning to toxic shock syndrome. In hospitals it can cause surgical wound infections and bloodstream infections. When *Staphylococcus aureus* is found in the bloodstream it is referred to as a *Staphylococcus aureus* bacteraemia.

Staphylococcus aureus bacteraemias have been reported to the Department of Health since April 2001, with data being submitted monthly since October 2005.

Reports consist of all *Staphylococcus aureus* isolated from blood cultures processed by the UHL Microbiology Department. These are expressed by the HPA as total episodes of *Staphylococcus aureus* bacteraemia and Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia and include all isolates, whether true infections or contaminated blood cultures; hospital acquired or community acquired infections.

In October 2005, an enhanced data set was introduced which allows the distinction to be made between MRSA bacteraemia occurring before admission or within 48 hours of admission and those that occur more than 48 hours after admission and the graphs presented in the following section provide data relating to infections seen at the Trust.

The implementation of measures, in recent years, has been designed to further reduce the numbers of cases of MRSA bacteraemia within UHL and these have continued during 2018/19.

Examples of some of the on-going initiatives include:

- All adult patients being washed in Stellisept (an antiseptic body wash) and the use of nasal mupirocin (also called Bactroban, an antibiotic nasal ointment) where appropriate.
- Continued monitoring of patients with either known infections or patients that are colonised with an organism with the potential to go on to develop infections, by the IP team. This is particularly related to MRSA.

Compliance with MRSA and MSSA prevention using daily antiseptic skin washes continue to be monitored monthly using the ward metrics to maintain its high profile in patients care.

The UHL trajectory for MRSA bloodstream infections for 2019/20 was 0 avoidable cases. The Trust recorded 5 cases for 2019/20 of which 3 were deemed unavoidable due to the pre-existing patient co-morbidities. In 2 of the cases whilst the exact cause was not able to be identified further education and training of staff was recommended from the post infection review which was undertaken.

The Trust investigates every MRSA bacteraemia as an incident and undertakes a post infection review (PIR). These investigations are fed back to a multi-disciplinary group including the DIPC and members of the Clinical Commissioning Group (CCG) and are accompanied by an action plan and these are monitored through the CMG IP Groups.

We recognise that there is absolutely no room for complacency with regard to our drive to prevent acquisition of infection within the hospitals. As these numbers become smaller, there will inevitably be a threshold beyond which we will no longer be able to deliver a continued reduction. We must recognise that sustained management of systems and processes that we have instigated in previous years will be crucial to our continued success and our teams work hard to maintain these low infection numbers.

The graphs below demonstrate UHL performance against other Trusts of comparable size outside London. The data is taken from the PHE HCAI data capture system.

7.6 MRSA Bloodstream Infections

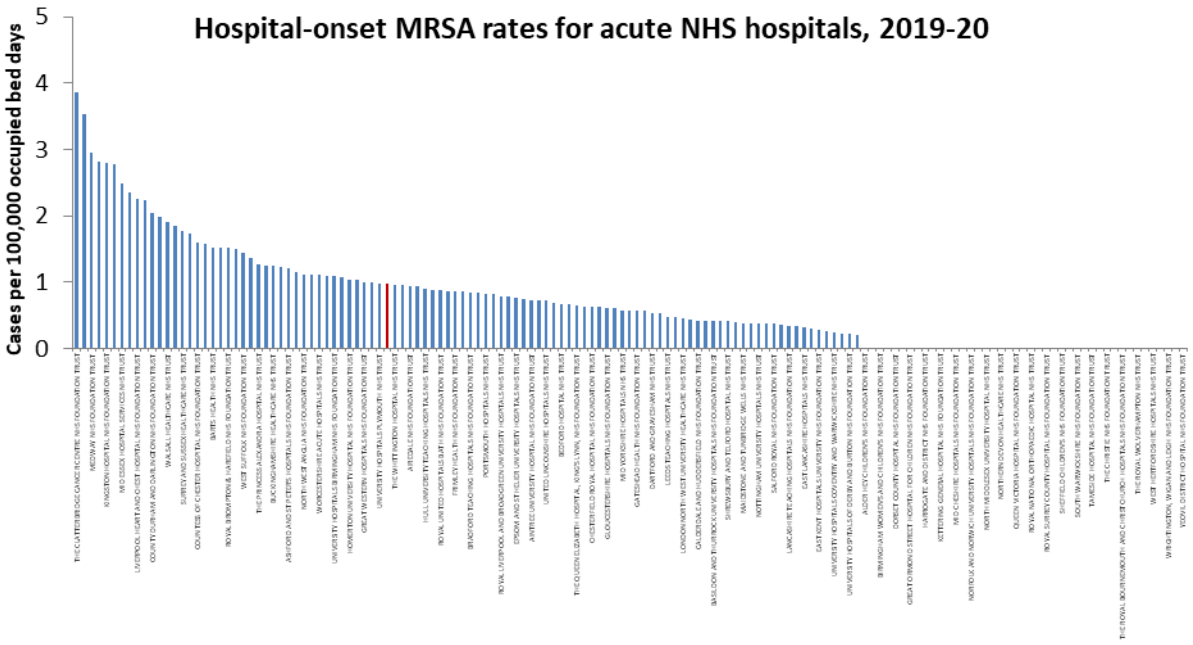


Fig 1: Trust assigned MRSA blood stream infections, 2019/20, cases per 100 000 bed days. (please note this data is always retrospective by one calendar year)

7.7 Clostridium Difficile Prevention and Reduction Strategies

Colleagues should note the nomenclature change of *Clostridium difficile* to *Clostridioides difficile*, based on adoption by the Clinical Laboratories and Standard Institute, (CLSI) and the following publication: Lawson P. A., Citron D. M., Tyrrell K. L., Finegold S. M. (2016). Reclassification of *Clostridium difficile* as *Clostridioides difficile* (Hall and O'Toole 1935) Prevot 1938. Anaerobe 40, 95–99.

We will therefore see this change in subsequent papers and readers should note you may/will see this terminology used going forward

Those dated before January 1, 2019 will retain the former organism name; those dated on or after January 1, 2019 may/will incorporate the new name

Please note that the abbreviations CDI, CDIFF, and *C. difficile* will remain appropriate abbreviations after the change and will not be modified within UHL.

Clostridium difficile is a bacterium that can cause colitis (inflammation of the colon), and symptoms range from mild diarrhoea to life threatening disease. Infection is often associated with healthcare, particularly the use of antibiotics which can upset the bacterial balance in the bowel that normally protects against *C. difficile* infection (CDI). Infection may be acquired in the community or hospital, but symptomatic patients in hospital may be a source of infection for others.

Mandatory surveillance for CDI in over 65 year olds has been undertaken since 2004. Since 2007 episodes of CDI in patients between the ages of 2 and 65 have also been reported.

For mandatory reporting purposes, all diarrhoeal stools submitted to the microbiology laboratory are examined for the presence of *C.difficile* toxin (it is the toxin released by the *C.difficile* bacterium that causes damage to the bowel).

Episodes are reported via the HPA mandatory enhanced surveillance system.

Prior to April 2019

Hospital attributed – cases that were detected after 3 days of admission

Community attributed – cases that were detected within 3 days of admission

Changes to the CDI reporting algorithm (since April 2019)

The changes to the CDI reporting algorithm for financial year 2019/20 are:

• adding a prior healthcare exposure element for community onset cases
• reducing the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

For 2019/20 cases reported to the healthcare associated infection data capture system will be assigned as follows:

• **Hospital onset healthcare associated (HOHA):** cases that are detected in the hospital two or more days after admission
• **Community onset healthcare associated (COHA):** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks
• **Community onset indeterminate association (COIA):** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks
• **Community onset community associated (COCA):** cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

Acute provider objectives for 2019/20 will be set using these two categories:

• Hospital onset healthcare associated: cases that are detected in the hospital two or more days after admission
• Community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

Reference: Clostridium difficile infection objectives for NHS organisations in 2019/20 and guidance on the intention to review financial sanctions and sampling rates from 2020/21. February 2019

The agreed trajectory for this infection in 2019/20 applying the new trajectory was 108 cases of *C.difficile* in patients aged 65 and over. The year-end position for UHL was 105.

Table 1: The monthly number of Clostridium difficile reportable infections

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total
Hospital Associated Infections	5	7	8	14	6	14	7	5	11	11	6	10	104

Isolating each patient with *C.difficile* diarrhoea continues to be a priority, to prevent cross contamination. Patients with *C.difficile* are cared for in single rooms. Where patients were not isolated it was for over-riding clinical reasons in the vast majority of cases (e.g. on an Intensive Care Unit).
It is recognised that it is important to continually monitor and reinforce the messages to staff with regard to HCAI's. The Department of Health published guidance entitled '*Clostridium difficile* - How to deal with the problem' in early 2009. UHL has implemented this guidance

across the Trust and a dedicated CD Liaison Nurse works across the three sites and continues to work with the Infection Prevention Team to ensure appropriate management of these patients and to provide specialist support to nursing and medical colleagues.

A weekly Multi-Disciplinary Team meeting takes place where there is a review of patients within UHL that are both positive and symptomatic with this infection.

Any Periods of Increased Incidence (two or more cases of Clostridium difficile infection within 28 days in the same clinical setting) automatically triggers a multi-disciplinary review of the patients and their environment to ensure that there are rigorous processes in place and policy is being adhered to, to prevent cross infection with this organism.

The Infection Prevention Team and the Antimicrobial Pharmacist continued to support trust colleagues with:

- Increasing hand hygiene awareness among staff, patients and visitors: using soap and water where *C.difficile* is present (as alcohol rub used on its own is ineffective against *C.difficile*). The roll out of the World Health Organisation '5 moments of Hand Hygiene'
- Continuing to improve antimicrobial prescribing, notably more regular recording of the reasons for antibiotics and stopping them as soon as the patient has completed the required course
- UHL has an aspirational deep cleaning programme and the use of hydrogen peroxide decontamination to clean isolation rooms and other clinical areas continued where possible.
- Weekly data reporting to identify problem areas
- Attendance at the Period of Increased Incidence meetings with colleagues supporting these areas with audit, inspections and helping staff to problems solve where necessary.
- Reinforcement of the use of the Care Pathway for *Clostridium difficile*
- Reinforcement of the message of the importance of a clean clutter free environment for patients in order to facilitate effective cleaning.
- Reinforcement of the use of Source Isolation precautions when caring for patients with infections

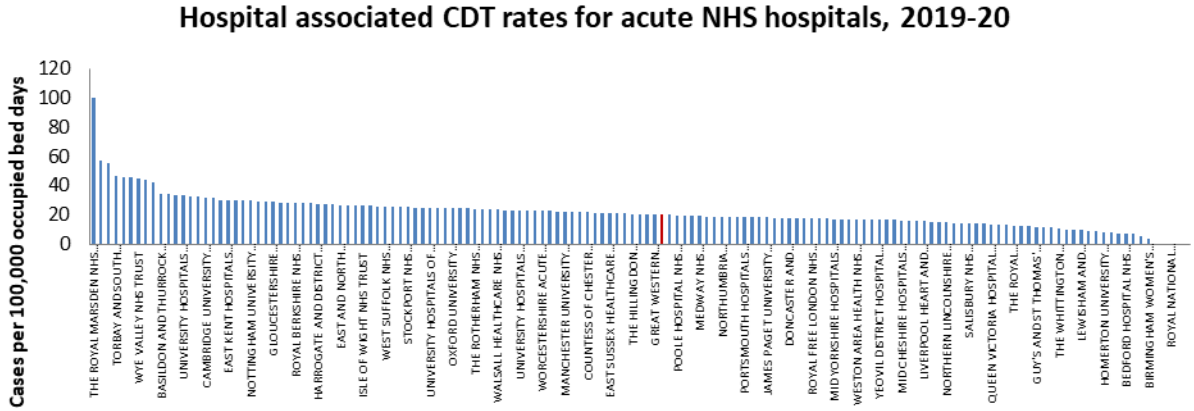


Fig 2. Trust apportioned Clostridium difficile infections by financial year per occupied overnight beds (per 100,000). (please note this data is always retrospective by one calendar year)

8. GRAM NEGATIVE BLOOD STREAM INFECTIONS

There is a national ambition to reduce healthcare associated Gram-negative blood stream infections (healthcare associated GNBSIs) by 50% by March 2021.

These are devastating infections and often result in admission to critical care and in some cases mortality. We know GNBSI cases can occur in hospitals however, half of all community onset cases have had some healthcare interventions either from acute, primary or community care. Therefore, we can only achieve the reductions by working together across the whole health and social care sector. The establishment of the Multi-Agency LLR IP group and the work streams from this group are designed to support this national ambition.

8.1 E coli (*Escherichia coli*) Bacteraemia

E coli is the leading cause of Gram Negative Blood Stream Infections (GNBSIs) and in accordance with the Department of Health Guidelines the IPCT commenced mandatory reporting of *E. coli* bacteraemia in June 2011.

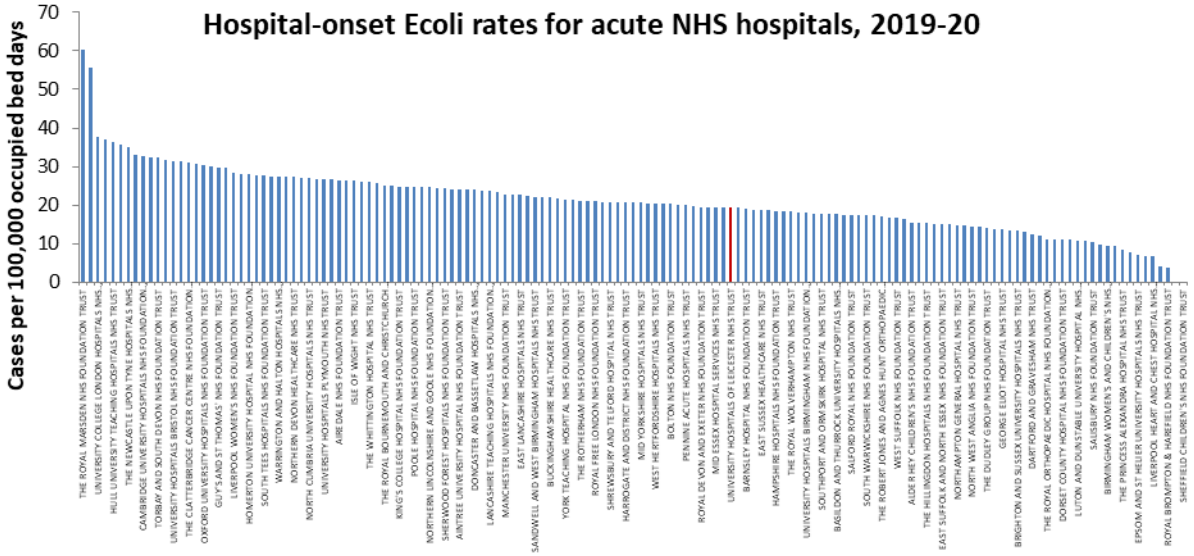


Fig 3. Trust apportioned E coli infections by financial year per occupied overnight beds (per 100,000). (please note this data is always retrospective by one calendar year)

All *E. coli* post 48-hour positive blood cultures within UHL have a limited data set collected and returned to the Public Health England data capture system. In 2016, The Secretary of State for Health set an ambition to reduce all E coli bloodstream infections by 10% and all healthcare associated Gram negative blood stream infections by 50% by April 2021. For 2019/2020 the IPCT will continue to work with the Whole Health Economy and combine efforts to protect our patients from Gram –negative bacteraemia.

These are significant numbers and the UHL IP Team anticipated that the DH would at some point introduce reductions targets. To this end we introduced a surveillance programme to try to identify significant risk factors or interventions which could be potentially reduced the risk. A significant proportion of E coli BSI are secondary to urinary tract infections, and it was assumed nationally that many of these would be related to the use of urinary catheters. Our data however

showed the most significant risk was in fact diabetes, information not widely recognised previously.

8.2 Carbapenem Resistant Enterobacteriaceae/Extensive Drug Resistance

Over the last 10 years, there has been a global increase in the percentage of infections caused by bacteria resistant to the carbapenem class of antibiotics. Carbapenems, including meropenem, are widely regarded as the last line of defence against bacteria such as *Escherichia coli*, *Klebsiella pneumoniae* and *Pseudomonas aeruginosa*, all common causes of community or hospital infection, including severe sepsis, and all increasingly resistant to a wide range of first and second line antibiotics.

The growth in carbapenem resistance has been through the emergence and spread of bacterial genes that encode enzymes, called carbapenemases, that break down and inactivate carbapenems. There are a variety of carbapenemase genes and they differ in the way they work. They are virtually always accompanied by other resistance genes that confer resistance to a wide range of other, unrelated antibiotics, making their host bacteria multi-, extensively- or even pan-resistant to antibiotics.

The emergence of bacteria resistant to many or all antibiotics is an increasing threat worldwide. Understanding of these organisms and the longer term impacts is increasing through surveillance programmes. Whilst resistant mechanisms are understood, the longer term impact on patients who are found to be colonised or infected, requires longer term surveillance.

During 2018 the first OXA-48 outbreak within UHL was identified and experience from other centres, notably Manchester, demonstrated the potential for rapid spread and the involvement of thousands of patients. While intestinal carriage of OXA 48 carbapenemase-producing bacteria does not have an immediate clinical impact, asymptomatic carriage has an implication for patients undergoing surgery or other clinical procedures with a high risk of infection, since infection caused by these bacteria can be very difficult and costly to treat. Consequently, in settings such as Leicester where these bacteria are not yet endemic, it is important that determined and thorough infection prevention actions are pursued in order to regain control of the microbiological environment. This includes actions such as restricting patient movements, screening and scrupulous environmental and personal hygiene measures.

In 2014/15 Public Health England issued guidance in the form of a toolkit and this predominantly concentrated on prevention: isolation of high-risk individuals and screening being of particular importance. The UHL focus is to identify, isolate, investigate, inform and initiate (the i5's of Infection Prevention) management of these patients and all patients that fit specific screening criteria are screened for these organisms. This enables identification and management of these patients to prevent further transmission.

Since the introduction of screening for CRO across the organisation there have been no further outbreaks of infection.

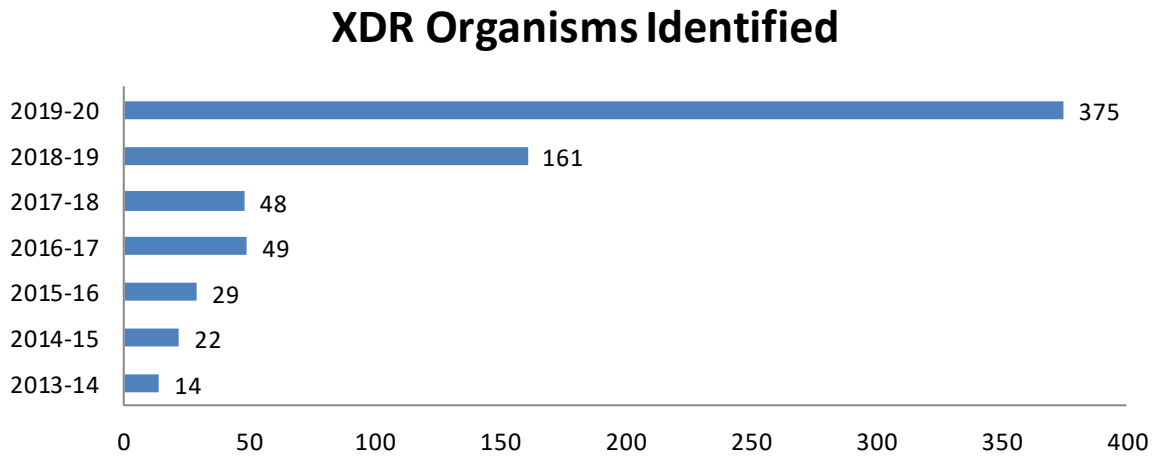


Fig 5. XDR Organisms Identified in Leicester since 2013/14

9. MANDATORY SURVEILLANCE OF SURGICAL SITE INFECTIONS (SSI)

UHL participates in the PHE mandatory hip and knee surveillance programme. Orthopaedic data is submitted by hospitals following the mandatory surveillance requirement introduced by the Department of Health in April 2004 [1]. This requires all NHS trusts undertaking orthopaedic surgical procedures to carry out a minimum of 3 months' surveillance in each financial year in at least one of four categories (hip prosthesis, knee prosthesis, repair of neck of femur or reduction of long bone fracture). The Orthopaedic Team manage and submit data with support and advice from IPT, when required.

In 2019-20, UHL submitted data for knee replacement surgery for quarters 1, 2, 3 and 4. The annual percentage of SSI in this category was 0.925% which is within the threshold limits set by PHE

10. OUTBREAKS OF INFECTION AND INCIDENT REPORTS

Outbreaks occur when there are two or more linked infections which may or may not be preventable. These events are recognised through surveillance, reporting or routine IP activities and are by definition unpredictable.
Infection Prevention incidents may not always relate directly to infection but be the consequence of further investigation required. If this has an operational impact then this in itself can be enough to trigger an incident response requiring a multi-disciplinary focus.

Every year the Infection Prevention Team recognises and responds to many incidents and potential outbreaks. Some are of significance. However others turn out to be chance clusters not caused by cross infection. The Infection Prevention Team has to be alert to all potential outbreaks.

Outbreaks and Incidents may be recorded in several different ways. UHL use a DATIX incident reporting mechanism and a monthly report is produced from this system to enable the Infection Prevention Nurses to feedback to the Clinical Management Teams at their Infection Prevention Group meetings.

Where an outbreak is considered to be particularly significant because of its size or the lessons learnt, this is managed as a Serious Incident (SI) and reported in line with the NHS Midlands and East Policy for the Reporting and Management of Serious Incidents in the East Midlands.

During an outbreak, the IPT provides a higher than usual level of support, information and training to the area affected, and works in close partnership with the clinical staff to try to prevent further spread of the infection, and to minimise service disruption.

After an outbreak, the IPT support the development of a report which is presented to the CMG IP groups and TIPAC. During 18/19 a revised outbreak pack was developed which included 'action cards' to support staff with time efficient working within the ward environments.
The table below identifies the incidents/outbreaks which were reported between April 2018 and March 2019.

Serious Incident and Increased Incident Investigations during 2019/20
5x MRSA Bacteraemia
3x CDT deaths reported on Part 1a of patient death certificate

10.1 Norovirus

Management of Norovirus within UHL follows the national guidance within the 'Guidelines for the Management of Norovirus outbreaks in Acute and Community Health and Social Care settings'

The winter season of 2019/20 saw significantly fewer cases of Norovirus than has been seen in previous years.

The CMG IP groups, relevant UHL CMG Boards, NHS Midlands and East are all part of the reporting mechanism to ensure due process with regard to the management of Governance and Assurance.

UHL Commissioners were copied into a daily increased incidence/outbreak e-mail that is widely circulated across UHL and also sent to external partners to ensure that they were fully sighted to what was happening within the Trust. This e-mail identifies restricted areas and details actions required.

10.2 Influenza

The management of patients with suspected and confirmed Influenza provided further challenge for the organisation during 18/19 although less so than in previous years
In early January 2019, a developing trend was observed in UHL: the strain of influenza responsible for the growing number of inpatient admissions was identified as predominantly the A strain H1N1

Comprehensive guidance and information was produced for staff across the trust which was and is readily available on the internal computer system 'insite'

To support UHL with timely transportation of specimens our colleagues in the charitable organisation 'The Blood Bikes' provided an increased courier service to the Glenfield Hospital transporting samples to the laboratory at the Leicester Royal Infirmary. We are extremely grateful to them for this support during times of increased winter pressures.

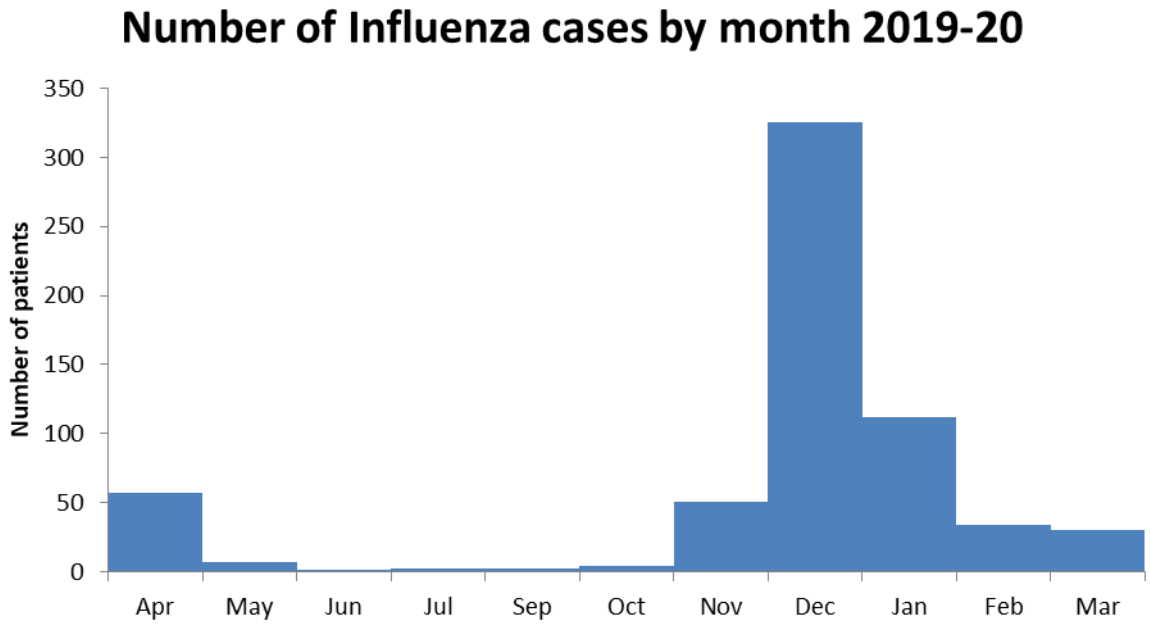
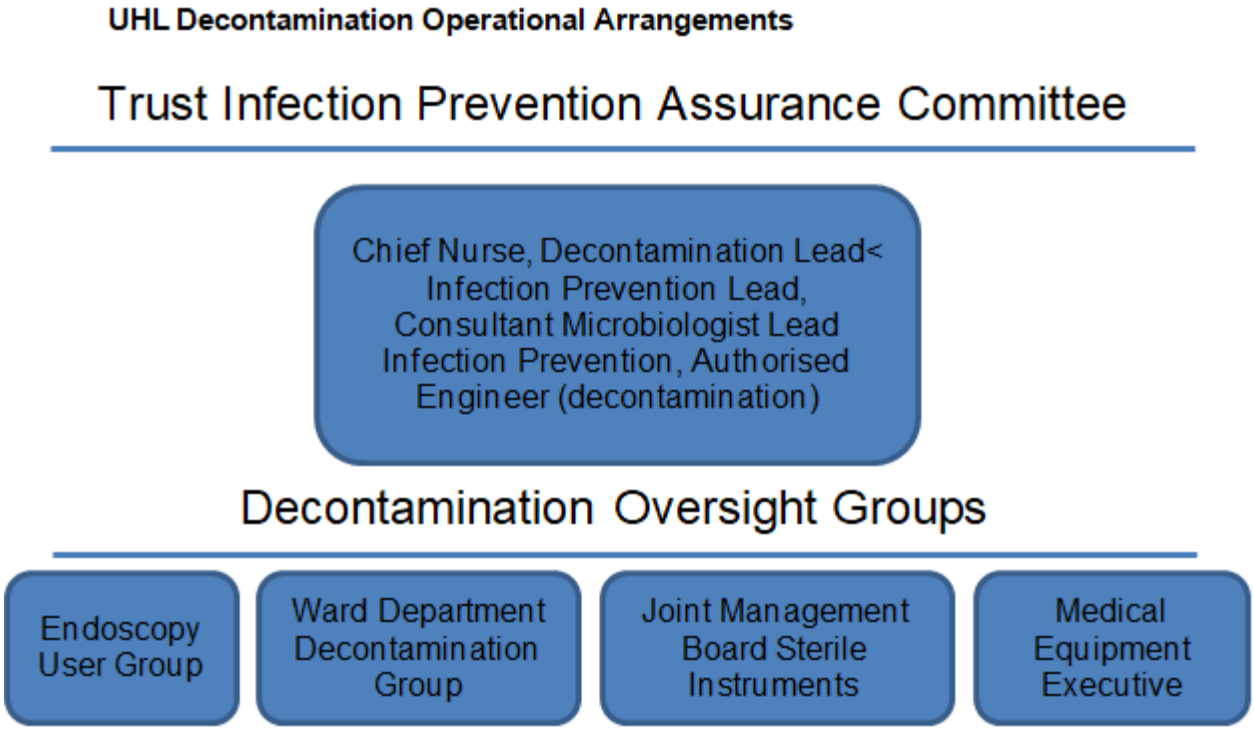


Fig 6: Number of patients confirmed with influenza via positive sample.

11. DECONTAMINATION

Sterile Services for surgical instrumentation is provided off site by Steris PLC (Formerly Synergy Health PLC). This move confirms UHL NHS Trust is able to provide a fully compliant service according to national Decontamination Standards HTM 01-01.



11.1 Endoscopy Services

The national benchmark for dedicated Endoscopy areas within organisations is the Joint Advisory Group on GI Endoscopy (JAG) accreditation. This group ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practised with adherence to HTM01-06. During 19/20 the units at the Leicester Royal and Glenfield sites were inspected and deemed that further remedial work was required to enable accreditation to be given. This has led to temporary mitigation being put into place in the form of a mobile decontamination unit.

11.2 Endoscopy provision

In 2019 Endoscopy Decontamination was conducted over 7 sites within the organization in differing locations. 92% of the equipment used was over 7 years old and does not meet the recommendations within the HTM 01-06 guidelines as the technology uses multi usage decontamination solution (Peracetic acid). This should now be a 'single shot' solution. The estate is no longer fit for purpose and would have required significant environmental estate reconfiguration to the following areas to ensure compliance with guidance and Health and Safety regulations for staff

- Ventilation
- Space
- Building work to ensure pass through technology can be integrated

In February 2019 the trust board accepted a Business Case to centralise the decontamination services for Endoscopy to a purpose built unit. In August 2019 the trust commissioned a temporary solution of a mobile decontamination unit to meet the required JAG and HTM01-06 standards before the centralised unit is commissioned in June 2021.

11.3 Endoscopy audits

These are conducted on a 6 monthly basis and due to ageing, non-compliant estate; compliance with these audits is difficult to achieve.
The audit used is the nationally recognized IHEEM audit and is conducted by the Infection Prevention Nurse with special interest in Endoscopy Services. These audits are made available to the Authorizing Engineer for Decontamination (AED) and also the Decontamination Lead. Any identified issues will be reported by exception to the responsible Clinical Management Groups and Trust Infection Prevention Assurance Committee

11.4 Endoscopy AED

The Decontamination Lead has worked closely with the Authorized Engineer for Decontamination who has produced an annual report around the Endoscopy services within the organisation. This highlighted the ageing estate infrastructure non-compliance in particular.

11.5 User / Operators

The staff involved in the process of Decontamination of Endoscopes have all had appropriate training and work within the guidelines set out in HTM 01-06. They meet on a bi monthly basis.

11.6 Endoscopy Review

In February 2019 the trust board accepted a Business case to centralise the decontamination services for Endoscopy to a purpose built unit. This is due to open June 2021.

11.7 Decontamination Audit

A yearly trust wide decontamination audit is undertaken of re-usable equipment that does not require sterile service decontamination nor is part of the Endoscopy process.
The annual decontamination audit was completed within the University Hospital of Leicester and the Alliance in February 2019 and compliance with completion of the audit has increased to 126 areas compared to 119 in 2018. This was an audit to ensure that all medical devices in clinical areas are audited. The audit was separated into the three separate following areas

- Wards and clinics
- Theatre
- ITU

The Decontamination audit was written in line with the following cleaning regimens

- Single use
- Sterilization
- Trophon automatic disinfection system (Hydrogen Peroxide) for non – lumened flexible scopes
- Tristel 3 step
- Ammonium chloride solution
- Ammonium chloride wipes
- Soap and water

Where areas of exception may be identified these are being addressed through a Confirm and Challenge meeting with the Heads of Nursing for each Clinical Management group and The Decontamination Lead and the UHL Infection Prevention Lead Nurse
All data is available upon request and will be reported to the Trust Infection Prevention Assurance Committee (TIPAC) within the dashboard

11.8 Decontamination Policy

This has been reviewed and has been renamed the Decontamination of Medical Devices Policy

11.9 Further Committee representation

The Decontamination Lead has input into the following committees / departments to be able to oversee the purchasing of medical equipment and ensure it complies with the ability to be cleaned as per the Decontamination policy

- Medical Equipment Executive
- Charity
- Managed Equipment services
- Procurement
- Medical Physics
- Sterile services

11.10 Sterile services audit

Within the role of the Decontamination Lead an audit at the third Party Sterilization Unit (Steris Instrument Management Service) is completed yearly. This provides evidence of compliance to HTM 01-01 and gives assurance that the sterile instruments provided to the organization are fit for purpose and sterility assured.
Steris were further externally audited in February 2020 and accredited in line with HTM 01-01.
Since 2017 the following auditable data has been collected and distributed within the organization. All performance criteria is displayed monthly within the Resource,

Equipment and Decontamination service (REDS) sterile service distribution points within the organization.

- Repairs of instruments
- Loans requested
- Acquisition of new instruments are only processed in line with manufacturer's instructions
- All defects are reported, and serious concerns are reported as a Datix

11.11 Trans Vaginal probes

The Decontamination Lead has provided assurance to the Trust Infection Prevention Assurance Committee (TIPAC) that all Transvaginal probes used within the Imaging service at the organization are processed within an automated validated process.
Currently Woman's and Children's are using a manual system that, whilst being compliant, is time consuming and the Decontamination Lead will be focusing on extending the use of the Trophon system across the organisation and also to ultrasound probes used in the Intensive Care Units and within the Theatre Depts.

UHL are instrumental in implementing an IP toolkit for Ultrasound probes and as such the Decontamination lead has presented the toolkit at the national and regional Decontamination Conference.

The Decontamination Lead continues to be the facilitator for the National Performance Advisory Group (NPAG) this enables us to benchmark performance with the rest of the country

12. ESTATES AND FACILITIES MANAGEMENT

The year 2018/19 has been a productive year with the emphasis being on delving into the activity and resources to fully understand how the service can deliver the standard of cleanliness that is required both locally as well as by the Care Quality Commission, Patient Led Assessment of the Care Environment (PLACE).

Changes to the senior management team have led to a review of working arrangements, with the services actively benchmarked against peer Trusts and identification of best practice being put in place to enable a better service at UHL.

Recruitment continues to be more challenging within the domestic service at the Leicester Royal Infirmary in comparison to the other two sites who normally have one or two WTE vacancies at any time.

Financial resource continues to be the most significant pressure to the domestic service particularly in relation to sufficient funding to cover all elements of the service whilst simultaneously providing sufficient funding for staff to cover annual leave, statutory and mandatory training and other forms of absence. In addition to the pressure on the workforce, other areas of pressure were identified and reduced accordingly, such the amount of office and department cleaning undertaken at enhanced rates mostly between the hours of 22:00 and 06:00.

Mechanical cleaning equipment continues to cause concern with both insufficient amounts in addition to aged equipment still being used – this leads to inefficiencies. Trials of innovative replacement equipment have taken place to identify the appropriate solutions for the needs of the service. This has already seen visible improvements in the main corridor areas at the LRI.

Managerially we have reviewed and are changing the way that we manage domestic services moving from managers responsible for individual sites to one manager that oversees the entire domestic function across the Trust. This will ensure that all of our systems and procedures are

standardised across the three sites, and additionally create one point of contact to enable more fluid communications between domestic services, Infection Prevention and Nursing Leads.

The auditing function of the domestic services has experienced difficulties primarily due to the volume of technical audits expected to be undertaken by the supervisory teams. In addition, the quality of reports produced has not provided the required assurance. Following a review of service providers an alternative process has been initiated which fulfils the requirements of facilities and provides improved quality of reporting for the Trust.

Improved communication has been implemented to ensure that an active conduit of information is passed between Domestic Services and Infection Prevention (IP) and Nursing Leads.

Specific MDT meetings have commenced to enable change and communication, with membership including Estates and Facilities, Infection Prevention, Nursing, Domestics and Senior Facilities Management. Additionally 1:1 regular meetings between the Head of Facilities and Head of Infection Prevention have been introduced to further improvements in our services.

12.1 Patient Led Assessments of the Care Environment (PLACE)

Place assessment are an annual appraisal on the non-clinical aspects of NHS and other healthcare settings, undertaken by teams made up of UHL facilities managers and members of the public (known as patient assessors).

The PLACE collection underwent a national review, which concluded in summer 2019. The question set was significantly refined, and guidance documents have been updated.

Assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environments cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs with dementia or disability.

Our hospitals are assessed against six domains:

Cleanliness -

All areas that can be used by patients or visitors can be assessed, including wards, outpatient areas, and public areas. The criteria for these are broadly based on the National specification for cleanliness standards and include both the cleanliness of the environment in addition to patient treatment and care items

Food -

The score is further broken down:

Food includes food service compliance with various guidelines, nutritional screening, food safety, portion size, dietary needs, and food service specifics.
Organisational food, relates to choice of food, 24-hr availability, meal times, and access to menus
Ward Food, This being an assessment of the Mealtime food delivery with evaluation of Service, presentation and tasting of patient meals included.

Privacy, Dignity and Wellbeing -

The criteria includes infrastructural and organisational aspects such as the provision of provision of outdoor recreational areas, changing and waiting facilities access to television, radio, internet and telephones. It also includes the practicality of male and female services e.g. sleeping, bathroom and toilet facilities, security of patient notes, and that patients are appropriately dressed to protect their dignity.

Condition, Appearance and Maintenance –

Includes various aspects if the general environment including Décor, condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light) linen, access to car parking, waste management and external appearance of the buildings and maintenance of the grounds.

Dementia -

Focuses on flooring, décor and signage, and other aspects such as availability of handrails, appropriate seating, bathroom and toilet fittings and to a lesser extent food.

Disability -

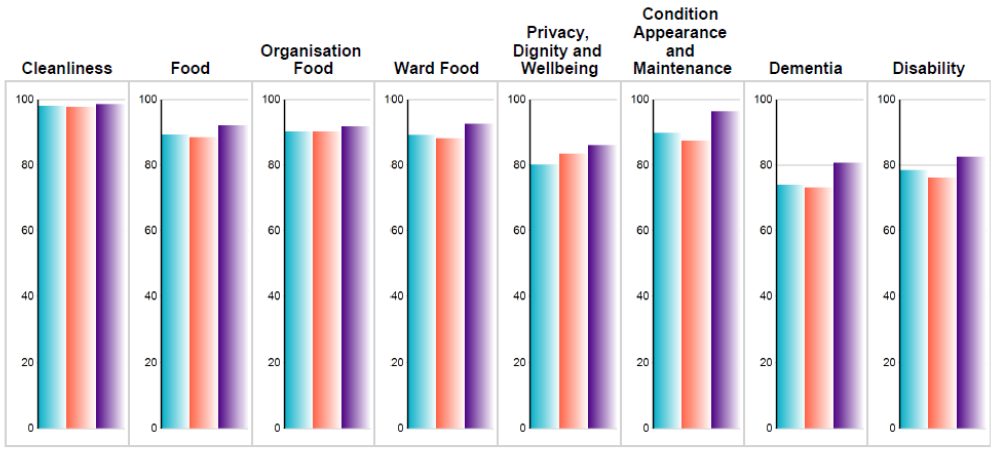
Includes issues of access including wheelchair, mobility (e.g. handrails), signage, hearing loops, and some aspects relating to food and food service

Summary of Results –

The PLACE collection undertook a national review in 2019 including the revision and refinement of the scoring and assessment criteria. Due to this revision, no comparison has been made to previous year's audit results.

<u>Leicester Royal Hospital</u>

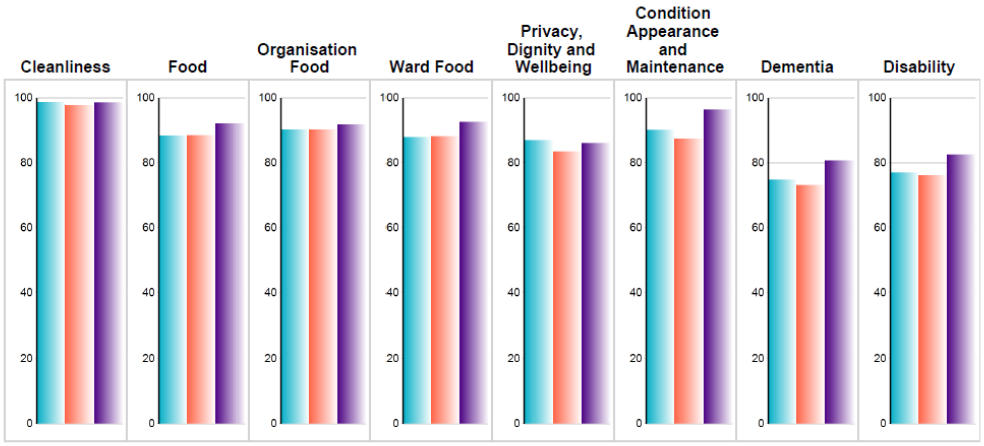
LEICESTER ROYAL INFIRMARY- Collection: 2019



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2509.0000	479.3333	81.3333	398.0000	460.0000	953.0000	588.0000	474.0000
Available Score (Actual)	2556.0000	536.0000	90.0000	446.0000	574.0000	1060.0000	794.0000	604.0000
Site Score	98.16%	89.43%	90.37%	89.24%	80.14%	89.91%	74.06%	78.48%
Organisation Average	97.76%	88.56%	90.37%	88.16%	83.56%	87.48%	73.18%	76.16%
National Average	98.60%	92.19%	91.92%	92.62%	86.09%	96.44%	80.70%	82.52%

Glenfield Hospital

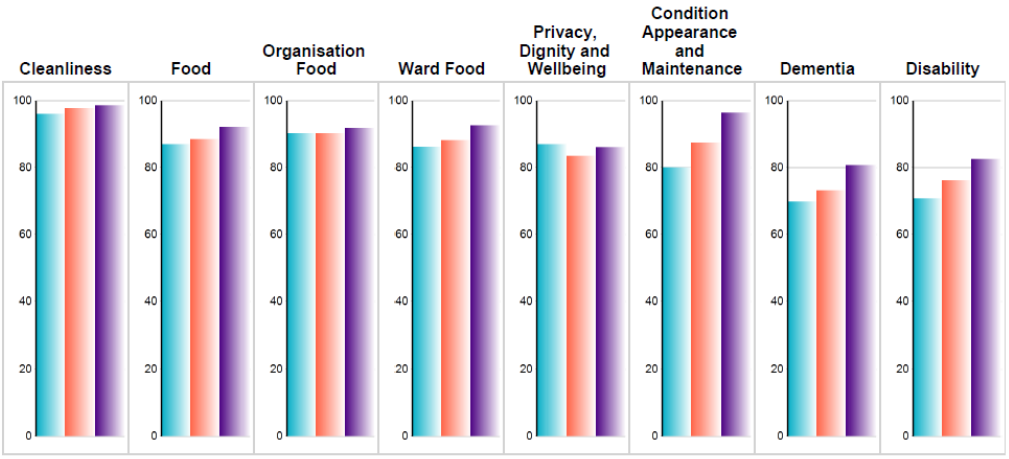
GLENFIELD HOSPITAL- Collection: 2019



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2053.0000	415.3333	81.3333	334.0000	447.3333	695.0000	560.0000	388.0000
Available Score (Actual)	2080.0000	470.0000	90.0000	380.0000	514.0000	770.0000	748.0000	504.0000
Site Score	98.70%	88.37%	90.37%	87.89%	87.03%	90.26%	74.87%	76.98%
Organisation Average	97.76%	88.56%	90.37%	88.16%	83.56%	87.48%	73.18%	76.16%
National Average	98.60%	92.19%	91.92%	92.62%	86.09%	96.44%	80.70%	82.52%

Leicester General Hospital

LEICESTER GENERAL HOSPITAL- Collection: 2019



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	1933.0000	433.3333	81.3333	352.0000	440.0000	608.0000	500.0000	354.0000
Available Score (Actual)	2012.0000	498.0000	90.0000	408.0000	506.0000	760.0000	716.0000	500.0000
Site Score	96.07%	87.01%	90.37%	86.27%	86.96%	80.00%	69.83%	70.80%
Organisation Average	97.76%	88.56%	90.37%	88.16%	83.56%	87.48%	73.18%	76.16%
National Average	98.60%	92.19%	91.92%	92.62%	86.09%	96.44%	80.70%	82.52%

13. WATER MICROBIOLOGICAL SAFETY COMMITTEE

The Trust's Water Safety Group (WSG) provides strategic leadership and monitors and reviews the Trust's arrangements for managing water safety. It was reconfigured following the repatriation of Facilities Management services back to the Trust. The WSG is chaired by the Head of Estates and Property and membership includes representation from Health and Safety, Infection Prevention, Microbiology and Estates and Facilities. Expert external advice is provided

by an Authorised Engineer (Water). The WSG meets quarterly and reports to the Trust Infection Prevention Assurance Committee.

Under the outsourced Estates & Facilities model, the Trust utilised a Water Advisory Group on a weekly basis as a forum to review water safety issues and water testing results. However post repatriation of services, water test results are reviewed via email and a Task and Finish sub-group is formed to address any adverse results, or urgent water safety issues

Water microbiological testing programs for Legionella and Pseudomonas (in augmented care areas) are implemented on an annual basis. Where the 2018/19 water testing program identified areas of elevated microbiological activity, actions were taken to identify if these were a local or a system-wide issue. All of the adverse results from the 2018/19 testing program were found to be locally contained issues and addressed accordingly. The Trust Water Safety policy and the water safety plan are now in place

14. POLICIES, PROCEDURES AND GUIDELINES

UHL recognises the importance for staff to have ready access to a full range of infection prevention and control policies, procedures and guidelines. Through 2019/20 we have continued to revise the Trust these policies and guidelines and have included the Infection Prevention Pathways to help staff quickly and safely manage patients with infections. These are available on the Trust's Intranet site.

15. INFECTION PREVENTION CLINICAL AUDIT PROGRAMME

The IP audit programme is compliant with The Health and Social Care Act: Code of Practice on the prevention and control of infections and related guidance. The audits include evidence based interventions to reduce the risk of infection to provide education and feedback to clinical staff.

The audit programme is part of the Annual Infection Prevention Toolkit with results included within the IP scorecard. The scorecard is reviewed as part of the CMG IP groups and within the Trust Infection Prevention Assurance Committee (TIPAC).

15.1 Hand Hygiene Audits

The importance of hand hygiene in preventing cross-infection is well recognised and we continue to promote best practice with this procedure. Compliance reported by colleagues from ward and clinic areas has not met the required percentage in some areas throughout 2019/20.
The National Patient Safety Campaign and World Health Organisation – 'The Five Moments in Hand Hygiene' continues to be the focus for hand hygiene education and training and is incorporated into the UHL Infection Prevention mandatory training.

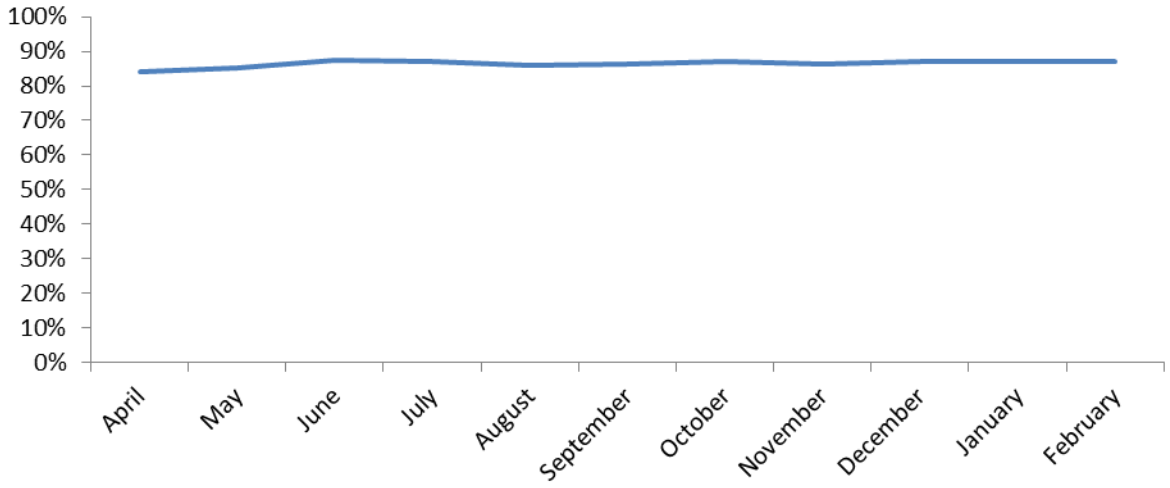


Fig 7. Hand hygiene compliance across the trust during 19/20 collected by ward staff audits.

15.2 Sharps Audit

An audit of sharps containers was conducted by Daniels Healthcare, the provider of our sharps bins. Compliance is monitored against national and local standards. Overall there was a high level of compliance. Relatively minor areas of weakness prompted targeted additional education and support from the IPT and Daniels Healthcare.

16. EDUCATION

The IPT provide an extensive multi-modal programme of Infection Prevention education across the trust to support compliance with mandatory training and national guidance
In addition to this IP education is provided in response to data collection, identified need or upon request.

The team delivered over 95 face to face training sessions. These figures do not include locally delivered education by individual IP nurses within their CMG

In addition to education within UHL the IP Team liaise closely with Leicester and De Montfort Universities to ensure training delivered to medical and nursing students is in line with current guidance and UHL policies.

Hand held fans in the pictures below were distributed to staff and patients during the summer heatwave. The fans contained important messages with regard to hydration and hand hygiene. This was a very well received initiative.

Artwork for the design of a mural for the entrance into the Balmoral building has been completed and this will be installed during 19/20 in support of reinforcing patient and staff hand hygiene.

Dispenser signage and covers has been replace across the wards again to reinforce the hand hygiene message

Signage for the isolation of patients has been re-designed and is illustrated below. This will be rolled out during 2019/20

17. INFECTION PREVENTION LINK STAFF (IPLS)

Each clinical area is required to identify a member of staff to act as their IP link. There is a robust IPLS training programme delivered by the IPT, which includes quarterly training days as well as individual support and workplace advice.
Link staff training days have been revised to ensure they have a focused content with recommended actions for the following 3 months.

These training days have been revised to support/enable colleagues to 'take away' and concentrate on specific elements of the IP Toolkit where it is identified more attention would support clinical best practice.

In this way we are able to provide assurance that the data we collect is being used to support clinical improvement.
One of the link staff study days saw the release of the 'outbreak pack containing action cards' previously discussed.

18. VASCULAR ACCESS COMMITTEE

The Vascular Access Committee reports to the Trust Infection Prevention Committee.
Within UHL the Vascular Access Committee will have lead responsibility for directing clinical activities or interventions which require the introduction of a device into a peripheral or central vein.

The Chair of this committee is undertaken by one of the Deputy Medical Directors with the Committee being supported by the IP Team. During 19/20 a review of the management of Vascular Access was planned however due to the emergence of COVID-19 this has been temporarily suspended

19. OCCUPATIONAL HEALTH

The UHL OH Service continues to play an important role in protecting the health of the workforce through vaccination against common infectious diseases, as well as those which may be specifically encountered in UHL as a workplace. This encompasses a wide variety of staff groups, from laboratory workers handling specific infectious agents, clinical staff who may be exposed to measles, chickenpox and tuberculosis for example, and staff in all areas of the hospital who may be exposed to influenza. The most well-known occupational vaccination programme continues to be for Hepatitis B, and demonstrating non-infectivity for Hepatitis B is mandatory for some occupational groups. We also undertake screening for other blood borne virus infections in clinical staff who undertake specific procedures e.g. surgery, midwifery.

All new staff members are offered vaccinations appropriate to their job role when starting in post, and some require appropriate clearance to start work following testing. Existing staff members are recalled where necessary.

In 2019-20, the total number of occupational immunisations (not including influenza) provided to UHL NHS workforce of c. 16500 was in excess of 1566 (1415 last year) which represents an increase of 11%.

This year was again our most successful staff influenza vaccination campaign to date, and overall 10,692/ 16583 staff were vaccinated, including 9517/ 11539 (82.5%) front-line staff. This is a significant achievement in a Trust the size of UHL, as Trust size and geography are two major factors which can affect uptake.

In addition, the OH Service works collaboratively with the Infection Prevention Team, and specialists in Microbiology, Virology, Infectious Diseases, Public Health and the TB Service, as well as clinical area managers, to respond to situations where staff members have, in the line of their duty, been potentially exposed to an infectious disease.

With the advent of COVID-19, two additional key work streams have emerged; a programme of staff testing for current infection (swabbing) and also antibody testing (as a marker of prior infection and possible immunity). To date, the OH Service has tested over 1800 staff and family members for infection, and is currently involved in the antibody testing programme which has sampled over 6000 staff within UHL. This has been an extremely demanding time and the ongoing impact of COVID-19 on the OH Service in terms of testing both symptomatic and asymptomatic staff and performing antibody tests will become clearer over forthcoming weeks.

20. NEXT STEPS

We have identified some key priorities for 2020/21

- Maintain CDT within trajectory
- Objective = zero MRSA. Post Infection Review (PIR) robustly implemented should any occur.
- We want to further develop our Gram Negative Bacteraemia Reduction Programme key elements of this are
- Development of Leicestershire Continence and Catheter Committee (LCCC)
- Continue to support the UHL Endoscopy Project Group to deliver a centralised Endoscope Decontamination Unit.
- Enhanced Carbapenam Resistant Organism Screening and contribution to an LLR Strategy for identification and management