University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 1 August 2019

Trust Board paper I

Report Title:	**Quality and Outcomes Committee – Committee Chair's Report** (formal Minutes will be presented to the next Trust Board meeting)
Author:	Helen Stokes – Corporate and Committee Services Manager

Reporting Committee:	**Quality and Outcomes Committee**
Chaired by:	Col (Ret'd) Ian Crowe – Non-Executive Director
Lead Executive Director(s):	Andrew Furlong – Medical Director Carolyn Fox – Chief Nurse Darryn Kerr – Director of Estates and Facilities
Date of meeting:	25 July 2019

Summary of key public matters considered by the Committee and any related decisions made:

This report provides a summary of the key issues considered at the Quality and Outcomes Committee on 25 July 2019:

- **CNST maternity incentive scheme year 2** – the Clinical Director Women's and Children's attended to present the evidence being submitted that UHL's maternity service had achieved all of the 10 safety standards described in the CNST requirement for year 2. All of the embedded evidence documents in the main covering report had been circulated to QOC members ahead of this meeting, and had also been reviewed in depth by the Trust's Maternity Champions (Ms V Bailey Non-Executive Director and the Chief Nurse), both of whom were also QOC members. The main covering report had also been discussed at UHL's 23 July 2019 Executive Quality and Performance Board.

  Upon receipt of the safety standards earlier in 2019, Maternity had adopted a robust approach for providing assurance of compliance with those standards, informed by a detailed review of the CNST technical guidance on each one. In presenting the covering report and the accompanying evidence for the CNST maternity incentive scheme year 2, the Clinical Director Women's and Children's particularly drew QOC's attention to:

  - safety action 1 (use of the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard), confirming that this tool was now being used to review all UHL perinatal mortality cases. Further discussion was planned outside the meeting on the most appropriate Committee to receive the detail of those individual reviews;
  - safety action 4 (demonstration of an effective system of workforce planning to the required standard). QOC received assurance that the requirements of the CNST technical guidance were met, and noted the existence of a plan for the LGH site as required. In response to Non-Executive Director queries on whether the existence of an LGH elective pathway plan was sufficient, the Medical Director expressed his view that UHL was compliant with this standard – this was endorsed by QOC, and
  - safety action 8 (90% of each maternity unit staff have attended an in-house multi-professional maternity emergencies training session within the last training year). This was the standard which UHL had not achieved in the previous year's submission; following very significant efforts within maternity services the Clinical Director Women's and Children's confirmed that the service was now compliant with this requirement.

  In further detailed discussion on the standards, Ms V Bailey Non-Executive Director and Maternity Champion noted that some of the evidence comprised minutes of meetings held some months previously. In finalising the evidence upload, she suggested exploring whether more recent information was available or supplementing those notes with an update on the action progress made since that time. QOC also noted the scale of the CNST premium discount associated with full compliance (circa £1.2m).

  QOC was assured by its consideration of the report and the individual evidence documents, and agreed to endorse the declaration of compliance with all 10 safety standards and recommend that declaration for approval by the Trust Board. QOC also thanked the Head of Midwifery for her work on this key project.
  The main covering report on the CNST maternity incentive scheme year 2 is appended to this summary.

- **Freedom to Speak Up annual report 2018/19 and annual workplan** – the report detailed the Freedom to Speak Up (F2SU) activity for 2018/19, the work plan for 2019/20, and the outcome of the self-review tool. With regard to 2018/19 activity, 232 staff concerns had been raised via either the 3636 staff reporting line (39), the UHL Freedom to Speak Up Guardian (93), or the Junior Doctor Gripe Tool (100). An updated version of the F2SU annual report 2018/19 would be presented to the Trust Board on 1 August 2019 via this QOC summary, particularly providing more detail on how the Trust had responded to the concerns raised. This reflected feedback from the 23 July 2019 Executive Quality and Performance Board, which had also queried how to provide feedback to anonymously-raised concerns. The QOC Patient Partner welcomed the report, and considered that UHL's F2SU Guardian was clearly having a beneficial impact – he also received assurance that the expanded section on responses to concerns would include staff attitude (as a key theme in the concerns raised). In further discussion, Mr B Patel Non-Executive Director sought (and received) assurance that the Trust was appropriately resourced to respond to the number of concerns being raised, and it was confirmed that resolution of issues was appropriately escalated by the UHL F2SU Guardian where needed. Ms V Bailey Non-Executive Director suggested it would be helpful to include any relevant benchmarking in future reports, and she also emphasised the need for appropriate internal triangulation of the F2SU concerns with other sources of intelligence about services. The QOC Non-Executive Director Chair noted the shared work elements planned for 2019/20 with the LPT NHS Trust's F2SU Guardian. QOC was assured by the report, commended the work of the UHL F2SU Guardian, and recommended the F2SU annual report 2018/19 for approval by the Trust Board.
  The updated Freedom to Speak Up annual report 2018/19 and the annual work plan for 2019/20 are appended to this summary.

- **Oral and maxillo-facial surgery (OMFS) services: final report** – further to discussions at the January 2019 public Trust Board and the May 2019 QOC, the Medical Director presented a final update on this issue, confirming that all of the Royal College of Surgeons recommendations had now been implemented (with the exception of training as the department did not have any trainees. However, in a positive development, Health Education England – East Midlands now planned to reintroduce OMFS higher surgical trainees back into Leicester in September 2019, due to its confidence in the progress made). The report also set out the patient contact exercises undertaken by the Trust – of the 101 patients involved, 56 had had face to face meetings with either the Trust or the review team. There were a small number of patients who had not responded to the contact offers made, and the Trust had now closed the face to face external review process. As a result of the 2 patient contact exercises undertaken, harm had been identified in 24 patients. The Trust had made a full apology to those patients. QOC was further advised of the position re: recruitment of a 3rd Consultant, noting that peripheral units continued to support UHL and that discussions were now underway re: a potential network approach.

  The Medical Director provided assurance to QOC that significant improvements had been made to the OMFS service quality and outcomes, which was welcomed by the Committee. In response to queries from the QOC Non-Executive Director Chair, the Medical Director advised that the patient contact efforts were kept on a detailed separate database rather than in patients' notes, and he also provided assurance that the MDT was working appropriately and that UHL was in a position to offer the September 2019 trainees a good training experience. QOC was also advised that the Director of Corporate and Legal Affairs was reviewing how the Trust could learn appropriate transferable lessons from its response to the OMFS service issues.
  The OMFS final report is appended to this summary for the Trust Board's information.

- **Neurology service update** – the Head of Operations, Emergency and Specialist Medicine (ESM) attended to update QOC on the challenges facing UHL's neurology service, and on the mitigating actions being taken in response (service action plan appended to the QOC report). Despite continued efforts to recruit to Consultant posts, medical staffing shortages remained a key factor, in addition to rising demand for neurology services. This was impacting adversely on referral to treatment performance and on patient waiting times, leading to a related rise in complaints, and QOC noted the continuing risks within the service even with the current mitigating actions. In response to a query, the Head of Operations ESM agreed to confirm outside the meeting whether any patient harms as a result of delays in being seen were still being recorded on Datix – the Director of Safety and Risk commented that she was not aware of any significant related patient safety or complaints issues. QOC noted that delays could have an adverse impact on patients even if there was no physical harm involved. QOC was further briefed on the various discussions in place with primary care, including demand management and involvement of GPs with a special interest in neurology in reviewing and appropriately filtering referrals. In response to a QOC Patient Partner query, the Head of Operations ESM advised that neurology services were challenged regionally. QOC also queried what work was underway to assess the discharge information provided to GPs in cases where UHL follow-up was not proposed – this was linked to the need for UHL clinicians to validate their follow-up lists. QOC requested a further update on the neurology service at its September 2019 meeting, to cover PRISM work, harms, complaints and validation of follow-up requirements.

- **TIA clinic service update –** further to the November 2018 QOC report, the Head of Operations ESM attended to

update members on the significant progress made in the TIA clinic service over the last 3 months, including a reduction in patient waiting times. The target waiting times for low risk and high risk patients had both been achieved in May and June 2019, and the service was confident of July 2019 delivery. The Chief Executive welcomed this good recovery, and queried what transferable lessons could be learned. In response, the Head of Operations ESM emphasised the positive impact of dedicated, passionate clinical leads working closely both with other related internal specialties and GP colleagues. QOC welcomed the progress made on this service and thanked the staff involved, noting that this example of recovery would also be highlighted in the next Chief Executive's briefing.

- **Deteriorating Adult Patient Board update (including EWS and sepsis)** – the Deputy Medical Director attended to provide the quarterly update on the work of the Deteriorating Adult Patient Board, including performance against the sepsis metrics and EWS guidelines. The paper also contained a separate report on insulin safety performance. QOC was advised that although sepsis performance was being broadly maintained on the wards, performance in ED (antibiotics within 1 hour of arrival) had deteriorated. Detailed work was underway to understand the reasons for this disappointing deterioration (eg rise in the number and acuity of ED attendances), and the steps which could be taken to address it, including the impact of introducing National EWS2 ('new confusion' scoring), strengthening of the UHL DART team and future introduction of sepsis rules in ED. QOC Non-Executive Directors emphasised the need for clarity on the reasons for the deterioration. QOC received assurance, however, from the Deputy Medical Director and the Chief Nurse that the deterioration related to process outcomes rather than quality outcomes, and the Medical Director confirmed that UHL monitored every patient. QOC Non-Executive Directors requested that the next quarterly update include an appropriate trend analysis and an assessment of what actions had/had not been beneficial, and it was noted that 'human factors' issues were being looked at as part of the Quality Strategy work. In discussion on the wider report, the QOC Non-Executive Director Chair queried what steps were being taken to address the red indicator re: insulin safety training for medical staff – in response, the Medical Director emphasised the Trust's focus on this issue and also noted that the metric was being refined so that it appropriately captured only those medical staff who were required to do that training, rather than being measured as 95% of all medical staff. Training numbers were increasing, although issues remained with junior doctors on rotation.

- **Patient Safety Report** – the Director of Safety and Risk updated QOC on the following topics: (i) the 2018/19 year-end review of harms – despite a slight increase in harms, 2018/19 had seen a reduction in the number of Serious Incidents, which was welcomed; (ii) UHL's invitation to participate in an early dispute resolution pilot run by the Parliamentary and Health Service Ombudsman; (iii) the review of notable themes from claims – these included consent issues [learning on this would be routed through UHL's Consent Committee], and ED; (iv) progress on the 'Stop Before you Block' safety initiative, and (v) further work to understand the worsened 2018 staff survey result about staff feeling fairly treated if they were involved in an error, near miss or incident – this was a complex issue and would be reviewed through the new Safety Strategy, but the Medical Director noted his view that UHL was not a Trust with a punitive approach. In further discussion on the report, the Medical Director outlined how learning would be gathered and shared from GP concerns, and the Chief Nurse also agreed to discuss falls issues further outside the meeting. QOC Patient Partners voiced concern at the rise in ED attendances, and noted that this issue had been discussed in detail at the People Process and Performance Committee held earlier on 25 July 2019. QOC also noted that a report on the new national patient safety strategy would be brought to the Executive Quality and Performance Board and then QOC in August 2019.

- **Patient Experience annual report 2018/19** – the Chief Nurse outlined work to strengthen governance processes, learn from excellence, and enhance Patient and Public Involvement. UHL performed very well in terms of both the level of patient experience feedback gathered, and the positive nature of a significant majority of that feedback. QOC welcomed the report. In response to comments from the QOC Patient Partners, Mr B Patel Non-Executive Director requested that QOC receive a report on the Carers Strategy at a future meeting. ***The Patient Experience annual report 2018/19 is appended to this summary for the Trust Board's information.***

- **Infection Prevention annual report 2018/19 –** the report summarised the activity of the Trust's Infection Prevention team, and provided an overview of the mandatory microbiological data UHL was required to collect in order to be compliant with the Health and Social Care Act 2014. The report had been discussed in detail at the 23 July 2019 Executive Quality and Performance Board with the Trust's Lead Infection Prevention Doctor present. QOC noted that UHL had reported 3 MRSA bacteraemias in 2018/19, all of which were deemed to have been unavoidable. UHL's year-end position re: Clostridium difficile was 57 cases against the trajectory of 60, which was welcomed. UHL's Infection Prevention team worked closely with Facilities colleagues and with Public Health England. QOC Non-Executive Directors welcomed the Trust's infection prevention performance, and requested that future reports also include appropriate benchmarking (where available). The QOC Non-Executive Director Chair requested that the Trust Board receive an indepth briefing on infection prevention issues, at a future Trust Board thinking day, and the Chief Nurse suggested that this take place after further progress on workstreams re:

CRO screening requirements in UHL.
The Infection Prevention annual report 2018/19 is appended to this summary for the Trust Board's information.

- **Dementia strategy end of year report 2018/20** – QOC was assured that all of the UHL dementia strategy priorities (7) were being progressed, and particularly welcomed the Trust's partnership with Dementia UK to introduce the nationally-recognised specialist 'Admiral Nursing' role within UHL. This was seen as an exemplar, and the nurses were in place for a 2-year period. QOC Patient Partners voiced concern at the outlying issues mentioned in the report – although recognising this point, the Chief Nurse advised that outlying decisions were taken on a clinical need basis, and the Chief Executive commented on the constraints posed by the medical beds capacity gap.
  The UHL Dementia Strategy 2018/20 end of year report is appended to this summary for the Trust Board's information.

- **Safeguarding children and adults annual report 2018/19 –** QOC was assured re: the significant improvements in level 3 PREVENT training, and welcomed the integrated approach to Child Protection information sharing now in place within ED. The number of referrals to the UHL Safeguarding team had increased, and the learning disability agenda was now integrated into the safeguarding agenda.
  The Safeguarding Children and Adults annual report 2018/19 is appended to this summary for the Trust Board's information.

- **Learning disability annual report 2018 –** QOC Non-Executive Directors particularly welcomed the learning disability annual report, noting that the new Learning Disability Steering Group now fed into the Trust's Safeguarding Assurance Committee. Although recognising that the incidents had taken place some years previously, in discussion Ms V Bailey Non-Executive Director suggested that the next learning disability annual report could also include the learning from and service improvements made as a result of 2 previous Serious Incidents involving young children with Down's Syndrome (as reported separately to the Trust Board).
  The Learning Disability annual report January – December 2018 is appended to this summary for the Trust Board's information.

- **CQC –** the Chief Nurse advised that UHL's Provider Information Request return had been submitted to the CQC on 10 July 2019, with no significant concerns arising from the subsequent data queries.

Items for noting

- **Schedule of external visits, and**
- **Health and Safety 2018/19 quarter 4 update.**

Matters requiring Trust Board consideration and/or approval:

Recommendations for approval:-

- CNST maternity incentive scheme assessment, and
- Freedom to Speak Up annual report 2018/19.

Items highlighted to the Trust Board from this meeting:-

- Oral and maxillo-facial surgery services final report, and
- Annual reports 2018/19 in respect of Patient Experience; Infection Prevention; Dementia; Safeguarding, and Learning Disability.

Matters referred to other Committees:

- None.

Date of next meeting:	29 August 2019

CNST Incentive Scheme Year

Author: Elaine Broughton Head of Midwifery Sponsor: Ian Scudamore Clinical Director

Paper C

Executive Summary

Context

This paper is to provide the board with the evidence and assurance that the maternity has achieved all 10 safety standards described in the CNST requirement for Year 2

Questions

1. What are the 10 safety standards
2. What is the validation process and what are the conditions before the declaration form is uploaded
3. What assurance can the maternity service provide to the Board that the standards have been met

Conclusion

1. The safety standards are as follows

   Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
   Safety action 2: Are you submitting data to the Maternity Services Data Set to the required standard?
   Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?
   Safety action 4: Can you demonstrate an effective system of medical workforce planning to the required standard?
   Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?
   Safety action 6: Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?
   Safety action 7: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?
   Safety action 8: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
   Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?
   Safety action 10: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

2. Trusts must achieve all ten maternity safety actions The Board declaration form must be signed and dated by the trust chief executive to confirm that:

- The Board are satisfied that the evidence provided to demonstrate achievement of the ten

maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
- The content of the Board declaration form has been discussed with the commissioner(s) of the trust's maternity services.
- The Board must give their permission to the chief executive to sign the Board declaration form prior to submission to NHS Resolution.

3. The assurance to the board is in the attached Board report document, three of the standards will be subject to a range of external verification points, cross checking with MBRRACE-UK (Safety Action 1), NHS Digital regarding submission to Maternity Services Data Set (Safety Action 2) and the National Neonatal Research database (NNRD) (Safety Action 10). There is extensive evidence in the report to support each safety action, however some standards such as the training figures hold lists of staff names and therefore remain on the education database, included instead the education report and percentages.
   In the board report the requirement of each standard is set out and the minimum evidential requirement and the evidence embedded in the document.
   The maternity service feel we meet all ten safety standards, there is a further report to add in relation to Standard 1, this is due for are internal processes in August but will be added as evidence. Feedback sessions to staff regarding safety issues are ongoing, the delivery suite leads and safety champions deliver these through the tea trolley teaching and private social media pages.

To review the evidence it would be beneficial to have the NHS Resolution, Maternity Incentive Scheme-year two document (Appendix 1).
Also attached is the Board declaration form (Appendix 2)

Input Sought

We would welcome the boards input into any further evidence they feel may be required

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Not applicable
Consistently meeting national access standards	Not applicable
Integrated care in partnership with others	Not applicable
Enhanced delivery in research, innovation & ed'	Not applicable
A caring, professional, engaged workforce	Yes
Clinically sustainable services with excellent facilities	Yes
Financially sustainable NHS organisation	Yes
Enabled by excellent IM&T	Not applicable

2. This matter relates to the following **governance** initiatives:

Organisational Risk Register	Not applicable
Board Assurance Framework	Yes

3. Related **Patient and Public Involvement** actions taken

4. Results of any **Equality Impact Assessment**, n/a
5. Scheduled date for the **next paper** on this topic: TBC

6. Executive Summaries should not exceed **1 page**. My paper does
7. Papers should not exceed **7 pages.** Does not comply

Board report on UHL NHS Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Date: 3rd July 2019

SECTION A: Evidence of Trust's progress against 10 safety actions:

UHL NHS Trust

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths to the required standard a. A review of 95% of all deaths of babies suitable for review using the PMRT occurring from Wednesday 12th December 2018 have been started within 4 months of each death	**Validation**-NHS Resolution will use MBRRACE-UK data to cross reference against Trust self-certification the number of eligible deaths from 12.12.18 to15.08.19. **EVIDENCE-** Internal monitoring spreadsheet to capture the minimal requirement a-c below	**YES**

b. At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death. c. In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.	**EVIDENCE -** Internal monitoring spreadsheet to capture the minimal requirement a-c  Database.xlsx **EVIDENCE -** Internal monitoring spreadsheet to capture the minimal requirement a-c  PMRT dashboard.xlsx **EVIDENCE – Action Logs**  Action log 15 02 2019.doc  Action log 17 05 2019.doc . **Evidence-** Trust Board Report	

d. Quarterly reports have been submitted to the Trust board that include details of all deaths reviewed and consequent action plans.	QOC report to TB with LFD report - Jun	
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? a. NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria have been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria (please see table below for details).	**Validation**-NHS Resolution will review the National Maternity Data set for compliance by cross reference self-certification against NHS Digital **Evidence-**Email of confirmation that submission has been received FW MSDSv2 update - 2 7 19.msg	**YES**

3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	**Validation-** the coding element can be check nationally	**YES**
a. Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies into transitional care	Complete by 03.02.19, The pathways of care for babies receiving phototherapy, at risk of hypoglycaemia and receiving antibiotics for possible or diagnosed infections are all embedded into the individual guidelines related to that condition. **Evidence-**SOP  SOP for NTC.doc	
b. A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource	**Evidence-**Pathway from Neonates re transitional care babies on the wards  TCU recording action plan July 2019.pdf	

Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2. c. An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews. d. Progress with the agreed action plans has been shared with your Board and your LMS & ODN	The ATAIN action plan has been in place for over a year, discussed at CMG Quality and Performance, themes from reviews relate closely to the national picture **Evidence-**Copy of action plan and LMS Board and email to Linda Hunn (ODN) Paper A - ATAIN action Plan (safety in .Int LMS Meeting Agenda 2nd April 201 Agenda Womens Board 25.03.19.docx Reviewed at Attain meeting and CMG Board and LMS as above	
4). Can you demonstrate an effective system of medical workforce planning?	**Evidence**-Copy of GMC Survey 2018	**Yes**

a. Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: *'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'* In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps	An Action plan to address lost educational opportunities  GMC SURVEY Action Plan.docx  NHSr response.docx  2018 GMC Survey Outcomes summary f The GMC Survey action plan will be sent to GMC following review by Clinical director on 23rd July 2019	
b. An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.	**Evidence**-  Reconfiguration_-_maternity_actions_v1_  FINAL July 2019 CEB slides.ppt **LRI 1.2.4.6, 2.6.5.1 and 2.6.5.6 standards** met for LRI Maternity Unit, a copy of weekly rota of anaesthetic cover and separately staffed elective pathway. There has	

	been a 24 hour epidural service for many years. The duty anaesthetist is present on the delivery suite ward round **LGH 1.2.4.6** this standard currently not met**,** plan in place and agreed at Trust level to separate the elective pathway at LGH see CEO July Briefing notes. LGH meets standards **2.6.5.1** and **2.6.5.6** There has been a 24 hour epidural service for many years. The duty anaesthetist is present on the delivery suite ward round	
5). Can you demonstrate an effective system of midwifery workforce planning? a. A systematic, evidence-based process to calculate midwifery staffing establishment has been done. b. The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable	. **Evidence** Birth rate plus assessment carried out, report received February 2019 UHL Final BR+ Report_25.03.2019.c **Evidence** Identified on Health roster supernumerary status. (The co-ordinator has not had a caseload for many years)	**YES**

oversight of all birth activity in the service c. Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on) d. A bi-annual report that covers staffing/safety issues	**Evidence** Red flag report 6 month period for all red flags patient experience questions  LRI JUNE 19 BR+ Report - Staffing v W  LGH JUNE 19 BR+ Report - Staffing v W  Acuity and Red flag report for LRI and LG  Copy of Red Flag Report March 2019.x  Red Flag Report February 2019.xlsx  Red Flag Report January 2019.xlsx **Evidence** Staffing report  Midwifery Staffing Report for EQB May 2	
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle? a. Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the	**Evidence** Safety Champion meeting minutes, CMG Minutes, Maternity safety Exec Board reports**,** safety walkabout feedback	**YES**

delivery of safer maternity services. b. Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).	Maternity Safety Meeting Notes 28.11. Maternity Safety Meeting Notes 29.05. EQB report on UHL Maternity Service saf **Evidence** Smoking CO monitoring and referral, Fresh eyes compliance, reduced movement policy, Gap/Grow mandatory training slides, training for SF height measurements was completed at the onset of the Grow programme by perinatal institute staff and cascade training. Customised growth charts are used for all women, the evidence is in the hand held records Fresh eyes report Q1 2019.xlsx CO audit July 19.docx	
7). Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?		**Yes**

a. Acting on feedback from, for example a Maternity Voices Partnership. b. User involvement in investigations, local and or Care Quality Commission (CQC) survey results. c. Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women. Time period Jan-July 2019	**Evidence** Minutes of MVP meetings  MVP January 2019 Agenda.pdf  MVP agenda 250319.docx **Evidence**-Parents questions incorporated into the investigation reports; these can be viewed in all serious incident reports as evidence. CQC survey 2018 and action plan  Board Report National Maternity su **Evidence-**Minutes of MVP meetings, Q4 patient feedback triangulation.  Copy of Copy of Message to Matron R  Response to Triangul Q3+4 CMG	

8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year? Training should include fetal monitoring in labour and relevant simulated emergencies	**Evidence**-CNST Training data base with the education team, this has names on therefore not circulated with the papers. See attached education report for June 2019 Training figures as follows Obstetric consultants **100%** All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota **98%** Obstetric anaesthetic consultants **96%** • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota. **92%** • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) **92%** • Maternity theatre and maternity critical care staff (Including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) **100%** • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) **93%** W C Education Practice Board Report Training figures for July 2019.docx	**Yes**
9). Can you demonstrate		**YES**

that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues? a**.** The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the Trust ii. the Local Learning System (LLS) b. The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues c. The Board level safety	**Evidence** Minutes of bi-monthly safety Meetings, Exec sponsor supported maternity safety report at exec board-(report attached).  Maternity Safety Meeting Notes 29.05. **Evidence Minimal Requirement** • **Evidence of executive sponsor engagement in quality improvement activities led by the trust nominated Improvement Leads for the MNHSC as well as other quality improvement activity for trusts in waves one and three** Attendance at National Wave 3 event with Improvement leads, update on MNHSC at Maternity safety meetings-agenda item.	

champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff	• **Evidence that the trust Board have been sighted on the local improvement plan, updated on progress, impact and outcomes with the quality improvement activities being undertaken locally** Improvement leads report sent to exec sponsor to discuss at safety meeting (Latest improvement plan for MNHSC), Plan will be included in next maternity safety Board report due in September. The improvement and progress will be included but this is evident in the fresh eyes results in Safety action 6 evidence. Fresh eyes Project report PDF.pdf • **Evidence of attendance at one or more National Learning Set or the annual national learning event** Exec sponsor attendance at National wave 3 Learning set July 18th 2019, evidence by booking system. **Validation** by National safety collaborative team. • **Evidence of engagement with relevant networks and the collaborative LLS** Board level champions have attended the LLS network events this can be validated at a regional level where there has been good UHL attendance • **Evidence of a safety dashboard or equivalent, visible to staff which reflects action and progress made on identified concerns raised by staff**	

	Safety dashboard monitored through LMS, sent through maternity closed communication page on Facebook, email and news letter  EB- Safety- LMS Highlight report June • **Evidence that safety concerns raised by staff feedback sessions are reflected in the minutes of Board meetings and include updates on progress, impact and outcomes relating to the steps and actions taken to address these concerns** Safety walkabout evidence by exec and non-exec sponsor staff asked about safety concerns the information is fed back to the ward manager to discuss with staff. Tea trolley teaching is well established, board level safety champions take part examples included as evidence  Walkabout Feedback Form Delivery suite LI  Walkabout Feedback Form (clinical).doc  Walkabout Feedback Form MAU JULY 2019  Agenda Safety session 3rd May 2019	
10). Have you reported	**Validation** NHS Resolution will cross reference Trust reporting against the National	**YES**

100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Neonatal Research Database (NNRD) number of qualifying incidents recorded for the Trust. Maternity service sends cases reported to Assistant Director (Head of legal affairs) **Evidence** List of reported 2018/19 cases NHS Resolution referrals April 2018-m	

SECTION D: Appendices

Please list and attach copies of all relevant evidential appendices:

Appendix 1. NHS Resolution:Maternity Incentive Scheme-year 2

Appendix 2. Board Declaration form

NHS Resolution

Maternity incentive scheme – year two

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

Contents

Introduction

NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in year one, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

As in year one, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

This document provides guidance on the safety actions for year two of the maternity incentive scheme.

Maternity incentive scheme year two: conditions

In order to be eligible for payment under the scheme, trusts must submit their completed Board declaration form (see Appendix 1) to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 15 August 2019 and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions
- The Board declaration form must be signed and dated by the trust chief executive to confirm that:
    - The Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
    - The content of the Board declaration form has been discussed with the commissioner(s) of the trust's maternity services.
- The Board must give their permission to the chief executive to sign the Board declaration form prior to submission to NHS Resolution.

Evidence for submission

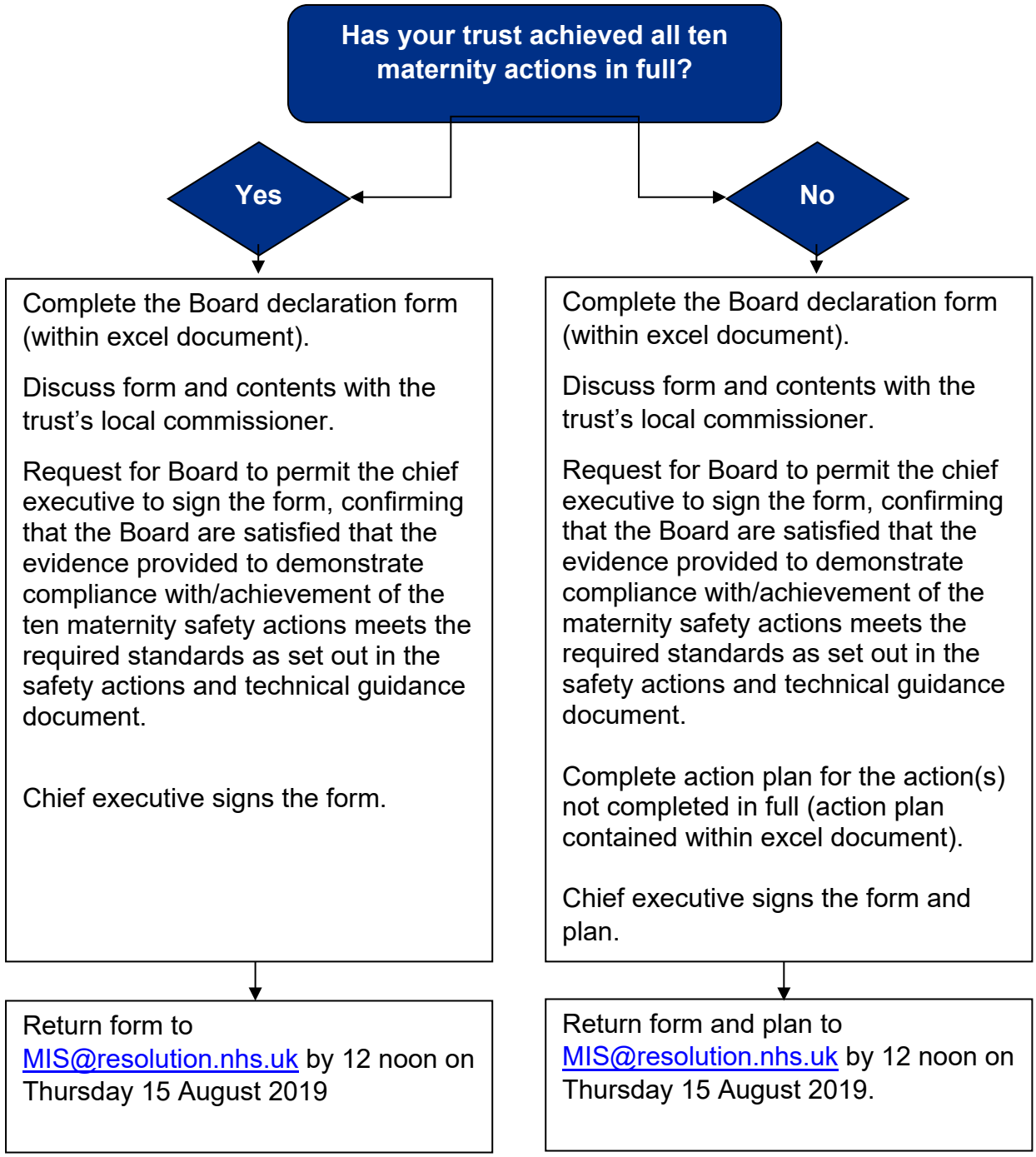
- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the trust Board only, and will not be reviewed by NHS Resolution.
- Trust submissions will be subject to a range of external verification points, these include cross checking with: MBRRACE-UK data (Safety action 1), NHS Digital regarding submission to the Maternity Services Data Set (Safety action 2), and against the National Neonatal Research Database (NNRD) for number of qualifying incidents reportable to the Early Notification scheme (Safety action 10)
- Trust submissions will also be sense checked with the Care Quality Commission (CQC).

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution (MIS@resolution.nhs.uk) prior to the submission date.
- The Board declaration form must be sent to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 15 August 2019. An electronic acknowledgement of trust submissions will be provided within 48 hours.
- Submissions and any comments/corrections received after 12 noon on Thursday 15 August 2019 will not be considered
- Trusts will be notified of results by the end of September 2019.
- Appeals must be submitted in writing by the trust chief executive and sent to NHS Resolution (MIS@resolution.nhs.uk) by Monday 14 October 2019. Further detail on the appeals process will be communicated at a later date. The payments to be made under the maternity incentive scheme will be communicated to trusts by the end of November 2019.

For trusts who have not met all ten maternity actions

Trusts that have not achieved all ten actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such trusts must submit an action plan together with the Board declaration form by 12 noon on Thursday 15 August 2019 to NHS Resolution (MIS@resolution.nhs.uk). The action plan must be specific to the action(s) not achieved by the trust and must take the format of the template (see Appendix 1). Action plans should not be submitted for achieved safety actions.



Send any queries relating to the ten actions to NHS Resolution (MIS@resolution.nhs.uk) prior to the submission date

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Required standard	a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death. b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death. c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.
Minimum evidential requirement for trust Board	A report has been received by the trust Board each quarter from Wednesday 12 December 2018 until Thursday 15 August 2019 that includes details of the deaths reviewed and the consequent actions plans. The report should evidence that the required standards a) to c) above have been met.
Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use MBRRACE-UK data to cross-reference against trust self-certification the number of eligible deaths from Wednesday 12 December until Thursday 15 August 2019.
What is the relevant time period?	**From Wednesday 12 December until Thursday 15 August 2019**
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 1
Are you using the PMRT to review perinatal deaths?

Technical guidance	
What should we do if we do not have any deaths to review within the time period?	If you do not have any babies that have died from Wednesday 12 December to Thursday 15 August 2019 then you should partner up with a trust to which you have a referral relationship to participate in case reviews. NHS Resolution will verify with MBRRACE-UK data the number of deaths occurring in your partner trust in the relevant period.
How does the involvement of the Healthcare Services Investigation Branch (HSIB) in investigations affect meeting this action?	It is recognised that for a small number of cases (intrapartum stillbirths and early neonatal deaths) investigations will be carried out by HSIB that will contribute to the report generated by the PMRT for a baby. Achieving section b) of the standard may therefore be impacted on by timeframes beyond the trust's control. This should be noted in the quarterly report and if this is the case, those babies not included in calculating the 50%.
What does multidisciplinary review mean?	Helpful guidance can be found at the following website: www.npeu.ox.ac.uk/mbrrace-uk
We have contacted parents, but they do not want to be involved - what should we do?	Please document accordingly within the review in the PMRT.
Parents have not responded to our messages, and therefore we are unable to discuss the review - what should we do?	Parents should guide the process and advise how involved they would like to be. The trust should record the attempts made to make contact with the parents within the review in the PMRT.
Is the quarterly review of the Board report based on a financial or calendar year?	This can be either financial or calendar year.

Safety action 2: Are you submitting data to the Maternity Services Data Set to the required standard?

Required standard	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and readiness for implementing the next version of the dataset (MSDSv2).
Minimum evidential requirement for trust Board	NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria (please see table below for details).
Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will cross-reference self-certification against NHS Digital data.
What is the relevant time period?	The assessment will include data from the MSDS from January 2019. This data needs to be submitted to MSDS for the deadline of 31 March 2019. One MSDS criterion relates to data for six months, from October 2018 to March 2019, which needs to be submitted to MSDS for deadlines between 31 December 2018 and 31 May 2019. One criterion relates to the submission of data for the first month of MSDSv2. This data relates to April 2019 and needs to be submitted to the deadline of 30 June 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 2
Are you submitting data to the Maternity Services Data Set to the required standard?

Technical guidance	
What do we do if we are unable to submit data to MSDS for a particular category	If a trust feels that there are exceptional circumstances, they should raise this with NHS Digital at an early stage. This might include evidence of a fall in birth rate, or of services covered in the assessment not being available at the trust.

Assessment to cover January 2019 data submitted for the deadlines of March 2019, one criteria relates to data between October 2018 and March 2019, submitted to deadlines December 2018 - May 2019, and one around MSDSv2 data for April 2019 being submitted to the deadline of June 2019	
	Mandatory categories 1-3 must be met to pass Safety action 2
1	January 2019 data contained at least 90% of HES births expectation, based on number of days in month (unless reason understood)
2	MSDSv2 readiness questionnaire completed and returned to NHS Digital within required timescales
3	Submit MSDSv2 data for April 2019 by the submission deadline of end of June 2019
	14 of the 19 optional categories 4-22 must be met to pass Safety action 2
4	Made a submission in each of the six months October 2018 - March 2019 data, submitted to deadlines December 2018 - May 2019
5	January 2019 data contained valid smoking at booking for at least 80% of bookings
6	January 2019 data contained valid smoking at delivery for at least 80% of births
7	January 2019 data contained all of the tables 501, 502, 404, 409, 401, 406, 408, 602 (unless justifiably blank)
8	January 2019 data contained all of the tables 101, 102, 103, 104, 112, 201, 205, 305, 307, 309, 511 (unless justifiably blank)
9	January 2019 data contained method of delivery for at least 80% of births
10	January 2019 data contained valid baby's first feed for at least 80% of births
11	January 2019 data contained valid in days gestational age for at least 80% of births
12	January 2019 data contained valid presentation at onset for at least 80% of births where onset of labour recorded
13	January 2019 data contained valid labour induction method (including code for no induction) for at least 80% of births where onset of labour recorded
14	January 2019 data contained valid place type actual delivery for at least 80% of births
15	January 2019 data contained valid site code for at least 80% of births
16	January 2019 data contained valid genital tract trauma code for at least 80% of vaginal births
17	January 2019 data contained valid Apgar score at five minutes for at least 80% of births
18	January 2019 data contained valid fetus outcome code for at least 80% of births
19	January 2019 data contained valid birth weight for at least 80% of births
20	January 2019 data contained valid figure for previous live births for at least 80% of bookings
21	MSDSv2 event or webinar attended in late 2018 / early 2019, or had 1:1 call with one of the NHS Digital team in lieu of attendance
22	January 2019 data contained valid (including "Not Stated") ethnic category (Mother) for at least 80% of bookings.

Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

Required standard	a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care. b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2. c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews. d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN
Minimum evidential requirement for trust Board	Local policy available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: 1. There is evidence of neonatal involvement in care planning 2. Admission criteria meets a minimum of HRG XA04 but could extend beyond to BAPM transitional care framework for practice 3. There is an explicit staffing model 4. The policy is signed by maternity/neonatal clinical leads Data is available (electronic or paper based) on transitional care activity which has been recorded as per XA04 2016 NCCMDS. An audit trail providing evidence and a rationale for developing the agreed action plan to address local findings from ATAIN reviews. Evidence of an action plan to address identified and modifiable factors for admission to transitional care. Action plan has been signed off by trust Board, ODN and LMS and progress with action plan is documented within minutes of meetings at Board ODN/LMS.

Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	a) By Sunday 3 February 2019 b) By Sunday 3 February 2019 c) By Sunday10 March 2019 d) By Sunday 19 May 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon.

Technical guidance for Safety action 3
Can you demonstrate that you have transitional care facilities in place and are operational to support the implementation of the ATAIN Programme?

Technical guidance	
Where can we find guidance regarding this safety action?	Helpful guidance can be found at the following websites: www.bapm.org/sites/default/files/files/TC%20Framework-20.10.17.pdf www.bapm.org/sites/default/files/files/NCCMDS.%20Neonatal%20HRGs%20and%20Reference%20Costs%20-%20A%20Guide%20for%20Clinicians%20Dec%202016.pdf
What is the suggested time period for transitional care pathways?	We would expect that all trusts should at least have pathways agreed by 31 January 2019.
What is the definition of transitional care?	Transitional care is not a place but a service and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.

Safety action 4: Can you demonstrate an effective system of medical workforce planning to the required standard?

Required standard	a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: *'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'* In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps. b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.
Minimum evidential requirement for trust Board	a) Proportion of trainees formally recorded in Board minutes and the action plan to address lost educational opportunities should be signed off by the trust Board and a copy submitted to the Royal College of Obstetricians and Gynaecologists (RCOG) at workforce@rcog.org.uk b) Board minutes formally recording the proportion of ACSA standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 that are met. Where trusts did not meet these standards, they must produce an action plan (ratified by the Board) stating how they are working to meet the standards.
Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	a) 2018 GMC National Training Survey (covers the period 20 March to 9 May 2018) b) Six month period between January 2019 and June 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon.

Technical guidance for Safety action 4
Can you demonstrate an effective system of medical workforce planning?

Technical guidance	
What if training opportunities are not being lost due to rota gaps and action plan not deemed necessary?	If training opportunities are not being lost due to rota gaps, then a copy of the trust Board minutes acknowledging and recording this, including the relevant 2018 GMC National Training Survey results, should be submitted to RCOG instead.
Anaesthesia Clinical Services Accreditation (ACSA) standards and action	
1.2.4.6	**Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff**
2.6.5.1	**A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident**
2.6.5.2	**A separate anaesthetist is allocated for elective obstetric work**
2.6.5.3	**Where the duty anaesthetist has other responsibilities, an anaesthetist must be immediately available (within five minutes) to deal with obstetric emergencies**
2.6.5.4	**Medically-led obstetric units have, as a minimum, consultant anaesthetist cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed)**
2.6.5.5	**There is a named consultant anaesthetist or intensivist responsible for all level two maternal critical care patients (where this level of care is provided on the maternity unit)**
2.6.5.6	**The duty anaesthetist for obstetrics should participate in labour ward rounds**
How is an elective caesarean section list defined?	A scheduled list, resourced separately from the general workload of the delivery unit. A separately run list requires a full theatre team and should include a consultant obstetrician and a consultant anaesthetist. The list should be managed in the same way and to the same standards as other elective surgery lists. This may not be cost effective in units with a low elective workload (e.g. one or fewer elective caesareans per weekday or approximately 250 planned operations per year) but for all other units, separate resources should be allocated.

What is level two care or a level two maternal critical care patient?	Since 2007, the obstetric population has been included in the Intensive Care Society (ICS) definitions of levels of care in the adult population. Levels of care as defined by the ICS: **Level 0** Patients whose needs can be met by normal ward care **Level 1** Patients at risk of deterioration, needing a higher level of observation or those recently relocated from higher levels of care **Level 2** Patients requiring invasive monitoring/intervention that includes support for a single failing organ (excluding advanced respiratory support i.e. mechanical ventilation) **Level 3** Patients requiring advanced respiratory support alone or basic respiratory support in addition to support of one or more additional organs
Please access the following for further information on the ACSA standards	https://www.rcoa.ac.uk/system/files/ACSA-STDS2018.pdf

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done. b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on) d) A bi-annual report that covers staffing/safety issues is submitted to the Board
Minimum evidential requirement for trust Board	A bi-annual report that includes evidence to support a-c being met. This should include: •A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. •Details of planned versus actual midwifery staffing levels. •An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls. •The midwife: birth ratio. •The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives. •Evidence from an acuity tool (which may be locally developed) and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any shortfalls

	•Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising (Please note: it is for the trust to define what red flags they monitor. Examples of red flag incidents are provided in the technical guidance).
Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	Any consecutive three month period between January to July 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon.

Technical guidance for Safety action 5
Can you demonstrate an effective system of midwifery workforce planning?

Technical guidance	
What midwifery red flag events could be included (examples only)?	• Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637

Safety action 6: Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?

Required standard	Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services. Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).
Minimum evidential requirement for trust Board	Board minutes demonstrating that the SBL bundle has been considered in a way that supports delivery and implementation of each element of the SBL care bundle or that an alternative intervention put in place to deliver against element(s).
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	The scheme will take into account the position of trusts at end July 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 6
Can you demonstrate compliance with all four elements of the SBL care bundle?

Technical guidance	
Where can we find guidance regarding this safety action?	SBL care bundle and guidance: www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf
Further guidance regarding element 2 of the SBL care bundle	In reference to element 2 of the Saving Babies' Lives care bundle, compliance with the intervention for surveillance of low-risk women does not mandate participation in the Perinatal Institute's Growth Assessment Protocol (GAP) or the use of customised fundal charts. Providers should however ensure that for low risk women, fetal growth is assessed using antenatal symphysis fundal height charts by clinicians trained in their use. All staff must be competent in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated.

Safety action 7: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Required standard	User involvement has an impact on the development and/or improvement of maternity services.
Minimum evidential requirement for trust Board	Evidence should include: Acting on feedback from, for example a Maternity Voices Partnership. User involvement in investigations, local and or Care Quality Commission (CQC) survey results. Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	From January 2019 to July 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Safety action 8: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Required standard	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year.
Minimum evidential requirement for trust Board	Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year through Board sight of a staff training database or similar.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	The scheme will take into account the position of trusts by Thursday 15 August 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 8
Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Technical guidance	
What training should be included?	Training should include fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands-on workshops.
What training syllabus should be used?	Training syllabus should be based on current evidence, national guidelines/recommendations, any relevant local audit findings, risk issues and case review feedback, and include the use of local charts, emergency boxes, algorithms and pro-formas.
Should there be feedback?	There should be feedback on local maternal and neonatal outcomes.
Which maternity staff attendees should be included?	Maternity staff attendees should be 90% of <u>each</u> of the following groups: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Obstetric anaesthetic consultants • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota. • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) • Maternity theatre and maternity critical care staff (Including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) There will be other relevant clinical members of the maternity team that for best practice should be included in maternity emergency training for example neonatal clinical staff however evidence of their attendance is not required to meet the safety action.

What if staff have been booked to attend training after 15 August 2019	Only staff who have attended the training will be counted toward overall percentage. If staff are only booked onto training and/or have not attended training, then they cannot be counted towards the overall percentage.
Will we meet the action if one of our staff group is below the 90% threshold?	No, you will need to evidence to your Board that you have met the threshold of 90% for each of the staff groups before Thursday 15 August 2019.

Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Required standard	a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS) b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff
Minimum evidential requirement for trust Board	• Evidence of executive sponsor engagement in quality improvement activities led by the trust nominated Improvement Leads for the MNHSC as well as other quality improvement activity for trusts in waves one and three • Evidence that the trust Board have been sighted on the local improvement plan, updated on progress, impact and outcomes with the quality improvement activities being undertaken locally • Evidence of attendance at one or more National Learning Set or the annual national learning event • Evidence of engagement with relevant networks and the collaborative LLS • Evidence of a safety dashboard or equivalent, visible to staff which reflects action and progress made on identified concerns raised by staff • Evidence that safety concerns raised by staff feedback sessions are reflected in the minutes of Board meetings and include updates on progress, impact and outcomes relating to the steps and actions taken to address these concerns
Validation process	Self-certification to NHS Resolution using the Board declaration form

What is the relevant time period?	a) All Board level safety champions and exec sponsor for MNHSC must have set up the required mechanisms for supporting quality and safety improvement activity in both the trust and LLS by Sunday 27 January 2019 b) Must be implemented by Wednesday 27 February 2019 c) Must be implemented by Wednesday 27 March 2019 with ongoing feedback to staff on a monthly basis
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 9
Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?

Technical guidance	
Where can we find guidance regarding this safety action?	Helpful guidance can be found at the following websites: • https://improvement.nhs.uk/documents/2440/Maternity_safety_champions_13feb.pdf • https://improvement.nhs.uk/resources/maternal-and-neonatal-safety-collaborative/ • https://improvement.nhs.uk/documents/2956/MatNeo_Collaborative_Driver_Diagram_June_2018.pdf • https://improvement.nhs.uk/resources/patient-safety-collaboratives/

Safety action 10: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

Required standard	Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.
Minimum evidential requirement for trust Board	Trust Board sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team.
Validation process	Self-certification to NHS Resolution using the Board declaration form NHS Resolution will cross reference Trust reporting against the National Neonatal Research Database (NNRD) number of qualifying incidents recorded for the Trust.
What is the relevant time period?	1 April 2018 to 31 March 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 10
Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

Technical guidance	
Where can I find information on the Early Notification scheme?	Early Notification scheme guidance has been circulated to NHS Resolution maternity contacts. Please contact ENTeam@resolution.nhs.uk to request further copies.
What are qualifying incidents?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) **[OR]** • Was therapeutically cooled (active cooling only) **[OR]** • Had decreased central tone **AND** was comatose **AND** had seizures of any kind.

	The above definition is based on the criteria set by the Each Baby Counts (EBC) programme of the RCOG. As a guide, if any incident of severe brain injury occurs which meets the above criteria and is accepted by EBC, then NHS Resolution will treat it as a qualifying incident. Incidents of intrapartum stillbirth or neonatal death as defined by EBC do not need to be notified.
General Data Protection Regulations points	We strongly recommend that all families be told of NHS Resolution involvement at the outset. NHS staff are bound by the statutory Duty of Candour. This includes an obligation to advise the 'relevant person' (i.e. the patient/their family) what further enquiries into the incident the trust believes are appropriate, one of which will be the Early Notification process. The NHS Constitution states that patients have the right to an open and transparent relationship with the organisation providing their care. This is central to maintaining the relationship of trust between the trust and family and in promoting an open and safe learning culture. NHS Resolution's Early Notification scheme involvement should be communicated soon after the incident, to coincide with notification that an internal investigation will take place. For more information please see *Saying Sorry* leaflet https://resolution.nhs.uk/wp-content/uploads/2017/04/NHS-Resolution-Saying-Sorry-2017.pdf NHS Resolution are able to seek disclosure of medical records without the consent of the patient/family. However it is important that individuals know that their personal data is being shared with NHS Resolution, even if you are not asking for their consent. It may also, in some circumstances, be helpful to have an indication of their authority/agreement to their information being used. However, this should not be conflated with 'consent' as the legitimising condition under GDPR. Footnote: under the General Data Protection Regulation, processing is necessary for (1) the management of healthcare systems and services (under Article 9(2)(h) GDPR/Schedule 1 paragraph 2 of the Data Protection Act 2018); (2) the establishment, exercise or defence of legal rights (under Article 9(2)(f) GDPR); and/or (3) undertaken in the substantial public interest (that is, the discharge of functions conferred on NHS Resolution further to s. 71 of the NHS Act 2006 – further to Article 9(2)(h) GDPR).

What if we are unsure whether a case qualifies for the Early Notification scheme?	If the case meets the above criteria and has been accepted by Each Baby Counts, it will be treated as a Qualifying Incident. Should you have any queries, please contact a member of the Early Notification team to discuss further. (ENTeam@resolution.nhs.uk)
We are unsure about how to grade an incident, what should we do	The risk assessment wording has recently been amended to bring it in line with assessments used regularly by front-line staff. It is hoped that this makes the process of grading risk more straightforward. However, should you have any queries, please contact a member of the Early Notification team to discuss further. (ENTeam@resolution.nhs.uk)
We have reported all qualifying incidents, but have not reported within the required 30 day timescale. Will we be penalised for this?	Trusts are strongly encouraged to report all incidents within the 30 day timescale set out in the reporting guidelines however there will be no penalty for reporting incidents from 2018/19 outside of the 30 day timescale. Trusts will meet the required standard if they can evidence to the trust Board that they have reported all qualifying 2018/19 incidents to NHS Resolution and this is corroborated with data held by NNRD.

FAQs for year two of the CNST maternity incentive scheme

Does 'Board' refer to the trust Board or would the Maternity Services Clinical Board suffice?	We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. It is recommended that all executive members e.g. finance directors are included in these discussions If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we may escalate to the appropriate arm's length body/NHS system leader.
Where can I find the trust reporting template which needs to be signed off by the Board?	Please follow the link to the Board declaration form **(see link below).**
What documents do we need to send to you?	Send the Board declaration form to NHS Resolution. Ensure the Board declaration form has been approved by the trust Board, signed by the chief executive and, where relevant, an **action** plan is completed **(see link below)** for each action the trust has not met. **Please do not send your evidence or any narrative related to your submission to us.** Any other documents you are collating should be used to inform your discussions with the trust Board.
Do we need to discuss this with our commissioners?	Yes, your submission should be discussed with commissioners prior to submission to NHS Resolution.
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on Thursday 15 August 2019**. If a completed Board declaration form is not returned to NHS Resolution by **12 noon on Thursday 15 August 2019**, NHS Resolution will treat that as a nil response.

Will NHS Resolution be cross checking our results with external data sources?	Yes, we will cross reference results with external data sets from MBRRACE-UK, NHS Digital and the NNRD for the following actions: Safety action 1, Safety action 2 and Safety action 10 respectively. Your overall submission may also be sense checked with CQC maternity data.
What happens if we do not meet the ten actions?	Only trusts that meet **all ten** maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet **all ten** safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.
Our trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via MIS@resolution.nhs.uk
Please can you confirm who outcome letters will be sent to?	CNST maternity incentive scheme outcome letters will be sent to chief executive officers, finance directors and your nominated leads.
What if my trust has multiple sites providing maternity services	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole trust
Will there be a process for appeals this year?	Yes, there will be an appeals process and trusts will be allowed 14 days to appeal the decision following the communication of results.

Q&A regarding Maternity Safety Strategy and CNST maternity incentive scheme

Q1) What are the aims of the CNST incentive scheme and why maternity?

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

Using CNST to incentivise safer care received strong support from respondents to our *2016 CNST consultation* where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our *Five year strategy: Delivering fair resolution and learning from harm.*

Maternity safety is an important issue for all CNST members as obstetric claims represent the scheme's biggest area of spend (c£500m in 2016/17). Of the clinical negligence claims notified to us in 2017/18, obstetric claims represented 10% of the volume and 48% of the value of new claims reported. These figures do not take into account the recent change to the Personal Injury Discount Rate.

Q2) Why have these Safety actions been chosen?

The ten actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with NHS Digital, NHS England, NHS Improvement, the Care Quality Commission (CQC), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE), Obstetric Anaesthetists Association, Royal College of Anaesthetists, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives. The Collaborative Advisory Group (CAG) previously established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme has also advised NHS Resolution on the safety actions.

Q3) Who has been involved in designing the scheme?

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England
- NHS Improvement
- NHS Digital
- MBRRACE-UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Anaesthetists
- Care Quality Commission

- Department of Health and Social Care
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff

Q4) Who does the scheme apply to?

The scheme will only apply to acute trusts in 2018/19. However, given the schemes aim to incentivise the improvement of maternity services in all settings, we will consider extending it in future years.

Q5) How will trusts be assessed against the safety actions and by when?

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.

Completed Board declaration forms must be discussed with the commissioner(s) of the trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at MIS@resolution.nhs.uk **by 12 noon on Thursday 15 August 2019.**

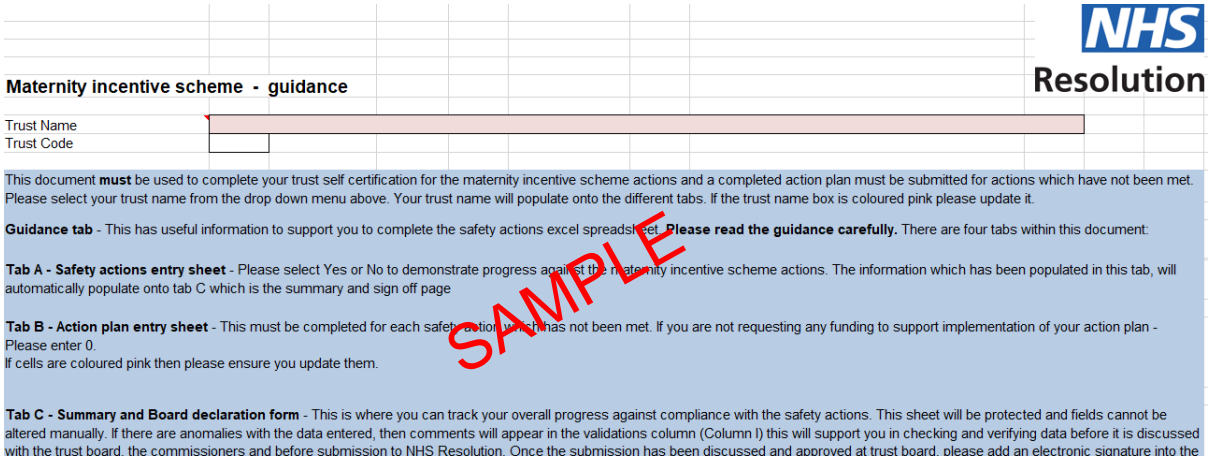
Please note that:

- Board declaration forms will be reviewed by NHS Resolution and discussed with Collaborative Advisory Group.
- NHS Resolution will use external data sources to validate some of the trust's responses, as detailed in the technical guidance above.
- **If a completed *Board declaration form* is not returned to NHS Resolution by 12 noon on Thursday 15 August 2019, NHS Resolution will treat that as a nil response.**

Appendix 1: Board declaration form and action plan template

To access the combined *Board declaration form and action plan template* visit:

https://resolution.nhs.uk/resources/board-declaration-form-and-action-plan-template



Maternity incentive scheme - guidance

NHS Resolution

Trust Name

Trust Code

This document **must** be used to complete your trust self certification for the maternity incentive scheme actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. Your trust name will populate onto the different tabs. If the trust name box is coloured pink please update it.

Guidance tab - This has useful information to support you to complete the safety actions excel spreadsheet. **Please read the guidance carefully.** There are four tabs within this document:

Tab A - Safety actions entry sheet - Please select Yes or No to demonstrate progress against the maternity incentive scheme actions. The information which has been populated in this tab, will automatically populate onto tab C which is the summary and sign off page

Tab B - Action plan entry sheet - This must be completed for each safety action which has not been met. If you are not requesting any funding to support implementation of your action plan - Please enter 0.
If cells are coloured pink then please ensure you update them.

Tab C - Summary and Board declaration form - This is where you can track your overall progress against compliance with the safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (Column I) this will support you in checking and verifying data before it is discussed with the trust board, the commissioners and before submission to NHS Resolution. Once the submission has been discussed and approved at trust board, please add an electronic signature into the

SAMPLE

NHS Resolution

Section B : Please choose your trust in the Guidance tab

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**		**When?**	
Monitoring					

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the*		
Lead executive director	*Does the action plan have executive*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**		**When?**	
Monitoring					

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Maternity incentive scheme - Board declaration Form

Trust name Please choose your trust in the Guidance tab
Trust code

An electronic signature must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT			-	
Q2 MSDS			-	
Q3 Transitional care			-	
Q4 Medical workforce planning			-	
Q5 Midwifery workforce planning			-	
Q6 SBL care bundle			-	
Q7 Patient feedback			-	
Q8 In-house training			-	
Q9 Safety Champions			-	
Q10 EN scheme			-	
Total safety actions	-	-		
Total sum requested			-	

Sign-off process:

Electronic signature

For and on behalf of the board of Please choose your trust in the Guidance tab

Confirming that:

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

The content of this form has been discussed with the commissioner(s) of the trust's maternity services

If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)

We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Name:
Position:
Date:

Trust Board– Paper I

Report from the Director of People and Organisational Development

Author: Director of Safety and Risk & Freedom to Speak up Guardian Date: 1st August 2019

1. Context

The Trust produces a Freedom to Speak up annual report which outlines the activities undertaken in the past year to support staff in our organisation to raise concerns and the numbers and themes from the concerns raised.

Included in these reports are the following;

- Freedom to Speak Up annual report 2018/19
- Freedom to Speak Up annual work plan
- Freedom to Speak Up self review tool

2. Questions

1. What has been achieved in 2018/19
2. What are the numbers and themes of staff concerns and comparison to previous year
3. What are the priorities for the year ahead

3. Conclusion

1. The report highlights that this year the F2SU guardian has developed the 5 Steps approach to responding to staff concerns, the Junior Doctors Gripe tool was shortlisted in the Patient Safety HSJ awards in the Changing Culture category, here for you "Drop in sessions'' for staff have continued into 2019/2020 and there has been an increase in the number of staff raising concerns with the Freedom to Speak up Guardian.

2. The reports highlights the numbers and themes from the staff concerns; F2SU 93 concerns, 3636 concerns line 39 concerns and Junior Doctor Gripe Tool 100 gripes. There has been no real change in the overall number of concerns being raised but specifically there has been an increase in the use of the F2SU guardian and a decrease in the use of the 3636 staff concerns reporting line. This suggests that the staff are now using the guardian instead of the 3636 staff concerns reporting line. The main themes seen from these concerns are around staff attitude, staffing levels, communication, equipment and environmental factors.

3. The report and annual work plan outline the Freedom to Speak Up Guardian priorities for the year ahead. Notably continuation of promoting the role and the 5 Steps to responding to staff concerns.

4. Input Sought

Trust Board Members are invited to note the content of this report and are:-

- Acknowledge the work undertaken by the F2SU Guardian.
- Requested to approve the annual report and work plan and support the priorities for the year ahead.

Freedom to Speak up

Annual Headlines 2018/19

Taking every opportunity to listen to staff views and concerns is extremely important to us, as we know that this improves patient safety and staff engagement. In line with the National recommendation we appointed the Trust Freedom to Speak Up Guardian in February 2017 and since then have built on mechanisms whereby staff can speak up and share their concerns.

WHAT HAS BEEN ACHIEVED THIS YEAR?

- **Development of the 5 Steps approach to responding to staff concerns**
- **Junior Doctors Gripe tool was shortlisted in the Patient Safety HSJ awards in the Changing Culture category**
- **Here for you "Drop in sessions" for staff have continued into 2019/2020**
- **An increase in the number of staff raising concerns with the Freedom to Speak up**

The Freedom to Speak up Guardian role

The role of the Freedom to Speak Up Guardian is one of the many recommendations following the Freedom to Speak Review by Sir Robert Francis in 2015 due to the failings in Mid Staffordshire.

A quote from the Review which is important to reflect on is:-

"**The NHS is blessed with staff who want to do the best for their patients. They want to be able to raise their concerns about things they are worried may be going wrong, free of fear that they may be badly treated when they do so, and confident that effective action will be taken**."

The role of the Freedom to Speak Up Guardian is to offer impartial and confidential advice, supporting all staff to Speak Up about concerns that impact on patient safety, culture and behaviours, training and many more. The Freedom to Speak up Guardian can not be part of any formal investigations as it is important to ensure Trust is acting staff concerns effectively and to ensure there are no repercussions for staff to speak up.

Mechanisms available to help staff to raise concerns

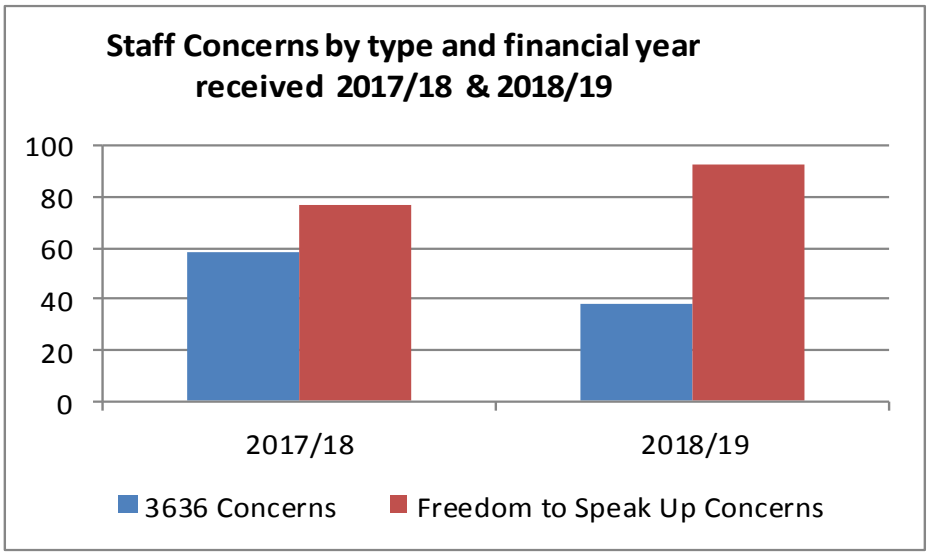
3636 staff concerns reporting line is a Internal telephone line and online form, which is for confidential staff This allows staff to report issues that

Junior Doctor Gripe tool is a dedicated mechanism for Junior Doctors only. This is to encourage Junior Doctors to raise a Gripe around, Lack of staffing resources, IT issues , Equipment and ward environment , Teamwork and communication, Training / supervision , Quality and safety of care

Number of all staff concerns received in 2018/19

Freedom to Speak Up	3636 Staff reporting line	Junior Doctor Gripe tool
93	39	100

Number of staff concerns in 2018/19

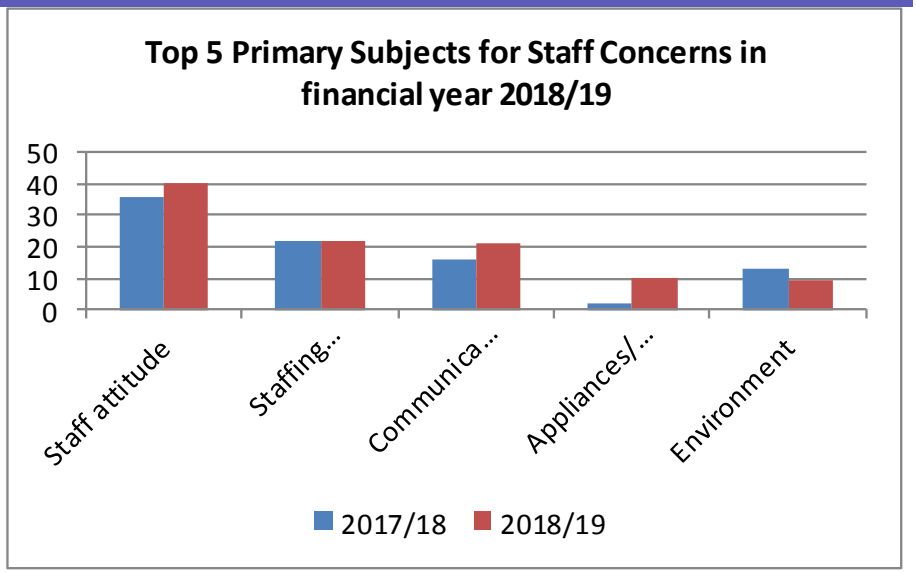


There has been a comparable number of staff raising concerns this year against 2017/18. Highlights observed when comparing the 2018/19 staff concerns to 2017/18 are:

3636 Concerns – Down by 34% F2SU Concerns – Up by 21%

This would suggest that staff are now using the Guardian to raise concerns rather than the 3636 concerns line.

Themes of staff concerns in 2018/19



We have seen increases in all top 5 themes compared to 2017/18 except environmental concerns which have had a 31% decrease. Overall we have seen a 15% increase in the top 5 themes for 2018/19 when compared to 2017/18.

Number of concerns by CMG in 2018/19

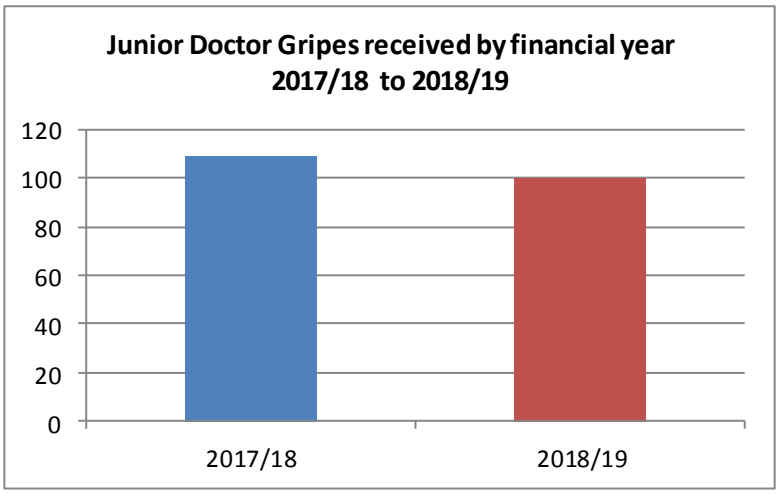
Clinical Management Groups (CMGs) and Corporate Directorates
CMG 1 (CHUGGS): Cancer, Haematology, Urology, Gastroenterology & Surgery
CMG 2 (RRCV): Renal, Respiratory, Cardiac & Vascular
CMG 3 (ESM): Emergency & Specialist Medicine
CMG 4 (ITAPS): Intensive Care, Theatres, Anaesthesia, Pain Management & Sleep
CMG 5 (MSK&SS): Musculoskeletal & Specialist Surgery
CMG 6 (CSI): Clinical Support & Imaging
CMG 7 (W&C): Women's and Children's
The Alliance: Community Hospitals
Corporate Directorates

ESM saw the highest number of staff concerns raised in 2018/19.

The largest increase in staff concerns this year compared to last year is in the Alliance and CSI.

Estates and Facilities have seen a reduction of almost 50% in the number of concerns received.

Number and themes of Junior Doctor Gripes in 2018/19



There has been a small decrease in the number of Junior Doctor Gripes in 2018/19 . We will continue to promote the Junior Doctor Gripe tool at junior doctor induction and during ward visits.

The top themes of Junior Doctor Gripes this year have been around car parking at the LRI site, the environment and necessary equipment in doctors offices and delays in receiving duty rotas and annual leave approval.

Promoting the role across UHL

" I found the Freedom to Speak Up Guardian supportive and approachable"

Being visible is vital in the Guardian role. This year the Guardian has undertaken:-

- Monthly "Here for you drop in sessions" across all UHL sites, these are in partnership with the LPT Guardian and the Head of Chaplaincy.
- Attended wards and departments promoting the role
- Participated in speaking up month in October
- Attended team meetings and training sessions to promote the role including junior doctor and nursing induction.
- Safety walkabouts and participated in annual patient safety kitchen table event
- Six monthly survey circulated to gather staff opinion, ideas and thoughts on the role
- Drop in's held in department's to gathers staff's thoughts, theming the information and working with Organisational Development and the Listening into Action team.

Governance

- The Freedom to Speak up Guardian meets bimonthly with the Chief Executive, and the Chief Nurse and monthly with the Director of Safety and Risk
- Reports are submitted quarterly to Executive Quality and Performance Board, Quality Outcomes Committee, Clinical Quality Review Group and annually to Trust Board.
- Data is submitted to he National Guardian's office and published on their website
- Regular feedback from staff is collated and reviewed by the Guardian

5 steps approach in responding to staff concerns

Watch the 5 Steps initiative in action ***https://tinyurl.com/5StepsInitiative***

This video has been created for all staff at UHL, to explain each step when responding to staff concerns and provides examples of how not to respond to staff concerns. This 'Gold Standard' approach has been promoted and encouraged throughout the trust.

Since the promotion of this the video, it has been viewed **292** times and has received positive feedback from managers who have used this simple method to respond to staff concerns.

What actions have been taken as a result of concerns raised

You said:

- *There were delays in clinic and poor patient and staff experience due to lack of equipment in out-patient departments*

We did:

- ***Replaced equipment to improve the quality of the outpatients clinics and the patient and staff experience***

You said:

- *Ward X: There are inadequate nurse staffing levels*

We did:

- ***Senior Management present on the wards and staffing issues escalated through the Trust operational command.***

You said:

- *Patients moved to non-specialised wards due to operational pressures*

We did:

- ***Safety Doctor; allocated to see patients moved to non-specialised wards***

You said:

- *Concerns raised with regards faulty IT systems*

We did:

- ***Terminated the contract of the identified problematic IT system***

You said:

- *Junior Doctor Gripe received around behaviours from colleagues on ward X*

We did:

- ***This was raised with the Head of Nursing and the Ward Manager. Both are aware of the pressures on Ward X and advise the junior doctors to raise any concerns directly with the Ward Manager so behaviours can be tackled immediately.***

You said:

- *There were no on call rooms or comfortable places for Junior Doctors to sleep/relax; when there is a lull for half an hour when all clinical interventions have been carried out.*

We did:

- ***From the Junior Doctor Morale Listening into Action Working Group, in recognition of the impact that fatigue can have on Junior Doctors safety 'Post On-Call Rest Rooms' are available and have been promoted across the Trust.***

Plans for 2019/20

The plans for 2019/20 are:

- Continue to be visible across the trust
- Promote and communicate the themes Trust wide to promote the role and continually promote the importance of speaking up within the Trust
- Undertake further shadowing shifts to see first hand the challenges staff face on a daily basis
- Here for you Drop in sessions to continue to be rolled out across University Hospitals of Leicester and Leicestershire Partnership Trust.
- Promote the 5 Steps approach in responding to staff concerns
- The Guardian will participate in the Trust's Becoming the Best strategy as an Improvement Agent and the work that results from the NHSI Culture and Leadership Programme
- Support embedding the use of Schwartz Rounds here at University Hospitals of Leicester

Freedom to Speak up Guardian contact details:

Ms Jo Dawson

University Hospitals of Leicester NHS Trust

The Firs, Glenfield Hospital

Jo.dawson@uhl-tr.nhs.uk

Mobile: 07950839130

Tel: 0116 2502740

Freedom to Speak up Guardian – Annual Work Plan 2019-2020

Item	Item last presented	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
Safe													
Freedom to Speak up Guardian engage with staff across UHL	• Promote the role by having a visual presence across the Trust. • Encourage staff to utilise the tools in place and the Freedom to Speak up role to promote an open culture • Provide support and guidance to staff that access the role to raise concerns in a confidential and supportive manner • Create internal and external partnerships • Attend Junior Doctors Induction	X X X	X X 	X X 	X X X	X X X	X X 	X X 	X X 	X X 	X X 	X X 	X X
Engagement with Professional Groups	Link with Medical staff: • DiTc • Meet with Director of Education and dedicated team to discuss themes within Gripes Link with Nursing Workforce • Attend NET	 X X	 X 	 X 	 	 X 	 X	 	 	 X	 	 	 X
Review themes and emerging issues	• Present Data and analysis to EQB • Present Data and analysis to QOC • Present data to CQRG • Meet with Director of Safety and Risk to review and analysis data • Monthly meetings with the CEO	 X	X X X	 X X	 X	X X X X	 X	 X	X X X X	 X	 X	X X X X	 X
Represent UHL both regionally and National as part of the National Guardian office initiative	• Attend National and Regional Meetings in line with the National Guardian Office. • To share good practice and learn from colleagues at a regional and national level • Cascade this information and learning's gained across the trust, through quarterly updates to QOC and EQB.				X			X		X			X
'Here for you' (Drop in sessions across UHL and LPT	• Partnership working with LPT F2SUG, and head of			X	X	X	X	X	X	X	X	X	X

Key: ~~X~~ = deferred X = new date X = changed from monthly to quarterly

Item	Item last presented	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
sites)	chaplaincy service. Providing monthly Drop In sessions across UHL and LPT sites. • These sessions provide an opportunity to promote the freedom to speak up role whilst also more importantly providing easy accessibility for staff.												
Promote the 5 Steps approach in responding to staff concerns	• Share the 5 steps approach with other organisations • Promote the 5 steps approach across UHL with the support from the Executive and Communication team • Create a webpage on insite/ patient safety portal, as a vehicle to share good news stories • Embed the 5 steps approach as part of UHL management programme	X X X	X	X		X X	X X						

Key: ~~X~~ = deferred X = new date X = changed from monthly to quarterly

UHL ORAL AND MAXILLO-FACIAL SURGERY SERVICES

Author: Andrew Furlong, Medical Director **QOC paper E**

In July 2016, Health Education England - East Midlands (HEE-EM) undertook a Quality visit of the Oral & Maxillo-Facial Surgery (OFMS) service. This visit was triggered because HEE-EM had become aware of potential issues with the delivery of postgraduate education and training within the OMFS department at the Leicester Royal Infirmary (LRI) affecting both Dental Core Trainees (DCTs) and Higher Specialty Trainees (HSTs). The outcome of the Quality visit was that HEE-EM took the decision to withdraw the Dental Core Trainees. Their report also raised concerns that potentially affected clinical outcomes and so UHL took the decision to commission an external review of the OFMS service by the Royal College of Surgeons (RCS).

The RCS review team initially visited the Trust for two days in November 2016 and provided verbal feedback at the time on their preliminary findings which led to a decision to immediately suspend all resective cancer surgery of the oral cavity and oropharynx pending a further in-depth clinical records review by the RCS (as reported to the public Trust Board meeting of 1 December 2016 – Minute 292/16/3 refers). This review took place at the end of December 2016 and then further patient records were reviewed at our request in March 2017 – ultimately 73 sets of patient notes extending over a 3-year period were reviewed.

The RCS produced their report in April 2017 and concluded that ablative and reconstructive cancer surgery of the oral cavity and oropharynx should continue to be suspended until such point as it could be demonstrated that robust action has been taken to improve the standard of care the OMFS service was able to provide. In summary, the RCS report raised concerns as to whether patients had been appropriately consented, whether they were offered the best procedure to give them the best possible outcome and that Free Flap and Pedicle Flap failure rates were higher than should be expected.

The findings of RCS report and their 23 recommendations were shared with the Trust Board and our external regulators and commissioners at the time. A multi-agency OMFS Oversight Group was established chaired by the Chief Executive, with representatives from NHS Improvement, NHS England, Leicester City Clinical Commissioning Group, Healthwatch and a UHL Non-Executive Director.

Interim updates on the work of the Oversight Group have been reported to the Quality and Outcomes Committee and an update report last went to the Trust Board in January 2019 (Public session). This paper provides a final update on the areas covered in the report to the Trust Board in January 2019 and the Quality Outcomes Committee in May 2019.

RCS Recommendations

All RCS recommendations have been implemented (implementation overseen by the OMFS Oversight Group) with the exception of those relating to training and the re-introduction of trainees into the department. This is because the department does not have any trainees but we have subsequently been advised that HEE-EM now plans to re-introduce OMFS higher surgical trainees

(HSTs) back into Leicester in September 2019 as they are assured by the changes to practice and personnel that have been made in the intervening period since their withdrawal.

Patient Contact Exercises

All patients (and their GPs) whose medical records were reviewed by the RCS team were contacted to explain what had occurred and offered an opportunity to meet with an OMFS surgeon to discuss any questions/issues they had. This review was initially undertaken by an UHL OMFS consultant with considerable experience in Head and Neck Cancer, who joined the department at the beginning of 2017. 17 patients were initially reviewed by this surgeon and on the basis of the findings, it was agreed that a further look back exercise to include all living patients over a 7 year period prior to suspension of the service was needed (101 patients).

In order to do this, UHL contacted the British Association of Oral & Maxillofacial Surgery (BAOMS) and subsequently commissioned two experienced independent OMFS surgeons through BAOMS to undertake this review.

We wrote to all living patients and their GPs to invite them to a review and the external reviewers subsequently met with 38 patients. We received their report in August 2018 and their findings concurred with those of the RCS in that the reviewers found significant failings in relation to patient consent processes; surgical decision making; type of reconstruction technique offered; and flap failure rates.

As part of this review, the review team were asked to identify patients where they had concerns and where they felt there was substandard care. The reviewers identified 5 cases where care was felt to be *'very substandard'* leading to harm as a direct result of treatment and 4 cases of *'significant concern'* (treatment assessed to be substandard but due to multiple other factors not possible to attribute whether harm was caused to the patient directly as a result of substandard treatment).

However, an appendix to their report providing patient-level details of the reviewers' findings led the OMFS Oversight Group to conclude that notifiable harm as defined under Regulation 20: Duty of Candour (Health and Social Care Act 2008 (regulated Activities) Regulations 2014) may have been caused to other patients seen as part of this review; and so the Oversight Group subsequently sought to identify those patients where 'harm' may have occurred based on the appendix and a further review of the patient medical records.

Of the 38 patients, 13 patients were felt to have definitely suffered physical harm, 2 patients possibly suffered physical harm and 1 patient had indicators to suggest psychological harm. The patients identified included the 9 cases identified by the external reviewers.

All 38 patients were contacted to inform them of and discuss the review findings. Those patients where harm was felt to have occurred were contacted by telephone to explain the findings and offered a further face-to-face meeting and then followed up with a letter to both them and their GP.

There were an additional 63 living patients who either indicated they did not wish to attend for a review with the external reviewers (7 patients) or simply did not respond (56 patients).

In light of the first patient contact exercise findings, we wrote to these 63 patients and their GPs again to advise them of the findings of the first patient contact exercise and to offer them a further opportunity to be seen and assessed by the same external reviewers for any evidence of potential harm.

This was the position as reported to the public Trust Board in January 2019.

18 patients subsequently attended for review in March 2019. The reviewers identified similar themes as in the first patient contact exercise, namely: lack of informed consent and information provided to patients and their families; and poor surgical decision making resulting in limited and/or suboptimal reconstruction choices offered to patients.

Harm was felt to have occurred in 8 of the 18 patients and we followed an identical process to that undertaken following the first patient contact exercise in order to inform and meet with those patients affected. All such patients have either been met with or have a date agreed for the meeting.

We have also met with a number of patients where harm wasn't identified by the external reviewers where a patient had specifically asked for a meeting.

As a result of the two patient contact exercises, 56/101 patients have been seen by the external reviewers and harm identified in 24 patients. A full apology has been made to these patients.

During the course of this process, patients and their GPs were written to on at least two occasions (and three times in some cases) and a small number of patients contacted us to indicate they did not wish to attend for a review. We have now closed the face to face external review process.

Maintaining High Professional Standards in the Modern NHS

This process has concluded and all of the findings arising from the various external reviews and MHPS investigations have been shared with the General Medical Council.

Restoration of OMFS Services

Two OMFS consultants with fellowship training is cancer ablative & reconstructive surgery have been appointed since 2017 and a third post is out to advert. Local OMFS units continue to provide support to cover leave etc. until such time as the third consultant is in post.

Following development of new Standard Operating Procedures, patient information leaflets and a period of gradual restoration of ablative and reconstructive cancer surgery to the oral cavity and oropharynx with external surgeon support, OMFS reconstructive cancer surgery recommenced in UHL in the latter half of 2018. A database and scorecard of patient outcomes are now in use and is being closely monitored – to date we have had no flap failures.

More recently, work is taking place across the region in conjunction with NHS England Specialised Commissioning to develop an East Midlands Head & Neck Cancer Network and it is anticipated that UHL & Northampton Hospital will form one of three surgical clusters.

Input Sought

QOC is asked to note:

- the external review findings in relation to patient harm and the actions that have been taken to meet with those patients where harm has been identified
- that the external review process has now closed
- the position in relation to restoration of OMFS ablative cancer and reconstruction services and the regional work taking place
- the restoration of HST training places within the OMFS service from September 2019

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For Reference

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Not applicable]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Not applicable]
Enhanced delivery in research, innovation & ed'	[Not applicable]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Not applicable]
Financially sustainable NHS organisation	[Not applicable]
Enabled by excellent IM&T	[Not applicable]

2. This matter relates to the following **governance** initiatives:

Organisational Risk Register	[No]
Board Assurance Framework	[No]

3. Related **Patient and Public Involvement** actions taken, or to be taken: [Affected patients have been informed]

4. Results of any **Equality Impact Assessment**, relating to this matter: [N/A]

5. Scheduled date for the **next paper** on this topic: [N/A]

6. Executive Summaries should not exceed **1page**. [N/A]

7. Papers should not exceed **7 pages.** [N/A]

Patient Experience Annual Report 2018-19

Author: Heather Leatham, Assistant Chief Nurse
Sponsor: Carolyn Fox, Chief Nurse

QOC paper J

Executive Summary

Patient Experience facilitates the collection of patient feedback using various methods and reflects the feedback to clinical teams supporting celebration of successes and encouraging learning from suggestions for improvement.

This report provides analysis and triangulation of feedback from patients and families and identifies any trends to drive future improvements over the last 12 months during 2018-19.

This year has seen a great deal of positive progress in response to feedback from patients and families, some of which has been recognised nationally and has resulted in being awarded finalist in the Patient Experience Network National Awards (PENNA) 2018.

Questions

1. Does the Trust have effective governance and processes for the collection of patient feedback?
2. What are patients telling the Trust with their feedback and what are the trends in this feedback?
3. How does the Trust use patient feedback to improve and shape services?

Conclusion

Patient Experience has an annual work plan that is formulated in response to national requirements, local patient and staff feedback and supports the Trust overall strategic quality priorities. This plan is monitored through the Trust's Patient Involvement, Patient Experience Assurance Committee (PIPEAC) which is chair by the Chief Nurse.

This report includes patient feedback at Trust level for:

- The Friends and Family Test scores and free text comments
- The Trusts Friends and Family Test scores for inpatients, outpatients, emergency services and maternity services compared with national data
- Message to Matron Card feedback and triangulation of all the feedback mechanisms
- National Patient Surveys and examines the themes.

To conclude the paper very briefly and at Trust level identifies how during 2018-19 feedback has been used to further improve and shape services in line with feedback from patients.

Input Sought

The Quality and Outcomes Committee is asked to:

- Receive and note this paper.

For Reference

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Not applicable
Consistently meeting national access standards	Not applicable

Integrated care in partnership with others	Yes
Enhanced delivery in research, innovation & ed'	Not applicable
A caring, professional, engaged workforce	Yes
Clinically sustainable services with excellent facilities	Yes
Financially sustainable NHS organisation	Yes
Enabled by excellent IM&T	Yes

2. This matter relates to the following **governance** initiatives:

Organisational Risk Register	Not applicable
Board Assurance Framework	Yes

3. Related **Patient and Public Involvement** actions taken, or to be taken: This report is focused upon patient and public feedback.

4. Results of any **Equality Impact Assessment**, relating to this matter: N/A

5. Scheduled date for the **next paper** on this topic: August 2019 (quarterly update)

6. Executive Summaries should not exceed **1 page**. My paper does comply

7. Papers should not exceed **7 pages.** My paper does not comply

University Hospitals of Leicester NHS Trust

Report to: Patient Involvement and Patient Experience Assurance Committee / Executive Quality Board

By: Heather Leatham, Assistant Chief Nurse

Date: 20th May 2019 / 4th June 2019

Subject: Patient Experience Annual Report 2018-19

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1. INTRODUCTION

1.1 Patient Experience facilitate the collection of patient feedback using various methods and reflect the feedback to clinical teams supporting celebration of successes and encouraging learning from suggestions for improvement.

1.2 This report provides analysis and triangulation of feedback from patients and families and identifies any trends to drive future improvements.

1.3 This year has seen a great deal of positive progress in response to feedback from patients and families, some of which has been recognised nationally and has resulted in being awarded finalist in the Patient Experience Network National Awards (PENNA) 2018.

2. GOVERNANCE

2.1 Patient Experience has an annual work plan or improvement plan that is formulated in response to national requirements and local patient and staff feedback and to support the trusts overall strategic quality priorities. This plan is monitored through the Trust's Patient Involvement, Patient Experience Assurance Committee (PIPEAC).

2.2 PIPEAC has always been chaired by the Deputy Chief Nurse but from January 2019 the Chief Nurse will chair this meeting and therefore the Terms of Reference and forward plan have been refreshed. The Patient Experience Plan for 2019-21 has been agreed and ratified by PIPEAC in March 2019.

3. FRIENDS AND FAMILY TEST FREE TEXT COMMENTS

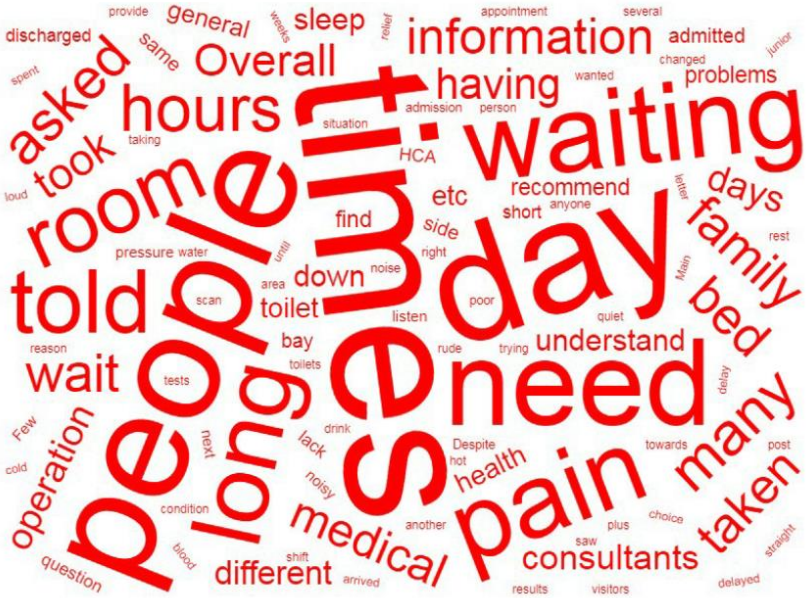
3.1 In 2018-19 the Trust received circa 144,000 Friends and Family Test feedback forms, which are offered to patients who are cared for in Leicester's Hospitals. Approximately 114,000 of these forms contained additional free text comments of which approximately 109,000 were positive, 2,000 were negative and 3,000 were neither positive nor negative.

3.2 Figure 1 shows the main positive comments received from inpatients and daycase wards during January to March 2019 with the main themes being care, staff being kind and caring, and saying thank you.

Figure 1: Positive Word Cloud

3.3 Figure 2 shows the comments where the experience received was below the Trust expected standard, the main themes being waiting, discharge and lack of information. These are reflected in the overall triangulation of patient feedback themes which are collated every six months.

Figure 2: Negative Word Cloud



4. FRIENDS AND FAMILY TEST SCORES

<u>National Comparisons of Friends and Family test Scores</u>

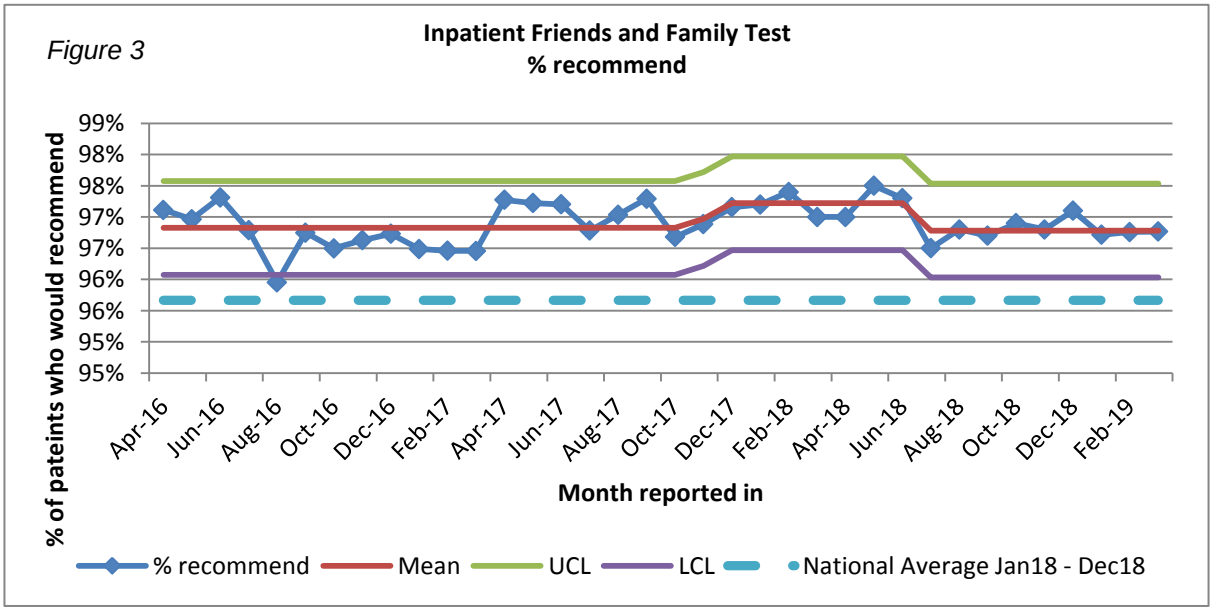
4.1 When comparing patient and family satisfaction levels using the Friends and Family Test scores with others Trusts Leicester's Hospitals is above the national average in satisfaction levels for inpatients, outpatients and the Emergency Department. Maternity services however show lower levels of satisfaction when compared with the national average. These comparisons can be seen in fig. 3, 4, 5 and 6.

Inpatient and Daycase

4.2 Statistical process control charts have been used to analyse the Friends and Family Test performance in the different reporting areas using the last three years results. The initial twenty time points (months) are used to calculate an average percentage recommend score. When a run of five or more points above or below the average is observed this is considered a significant variation.

4.3 Figures 3-6 show how the average and upper and lower control limits have changed over the last three years for each Friends and Family Test area, as performance significantly improves or declines.

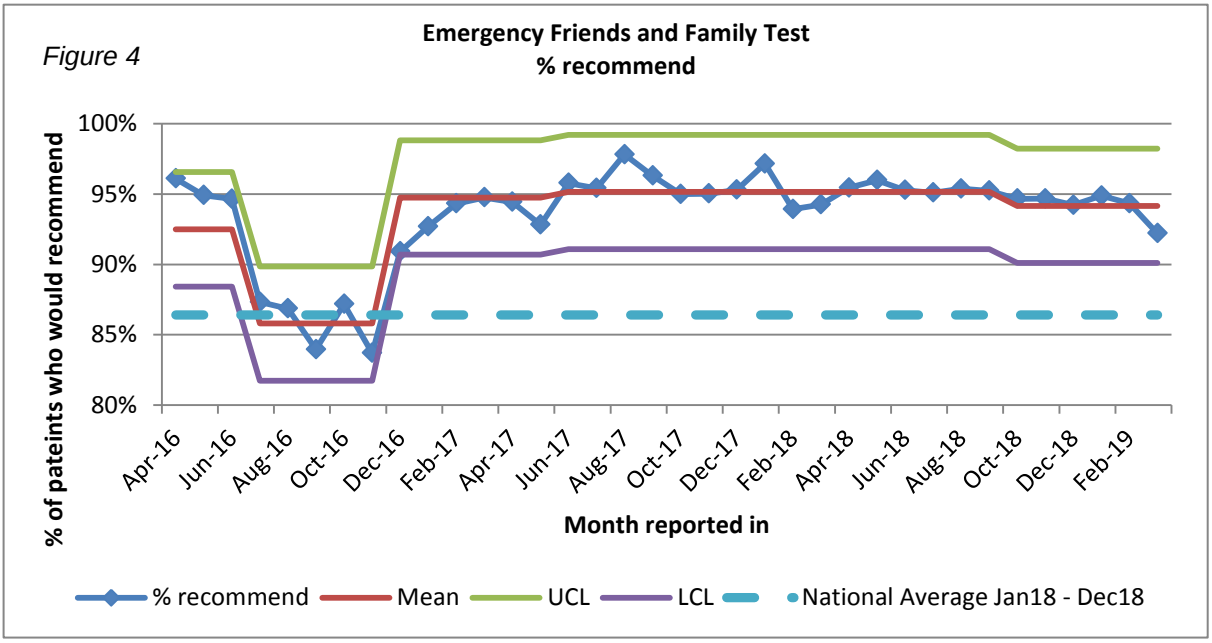
Figure 3



4.4 There has been a significant variation since July 2018 showing a decline in the inpatients Friends and Family Test from average 97.2% to 96.8% onwards. Leicester's Hospitals still remains above the national average.

Emergency Department

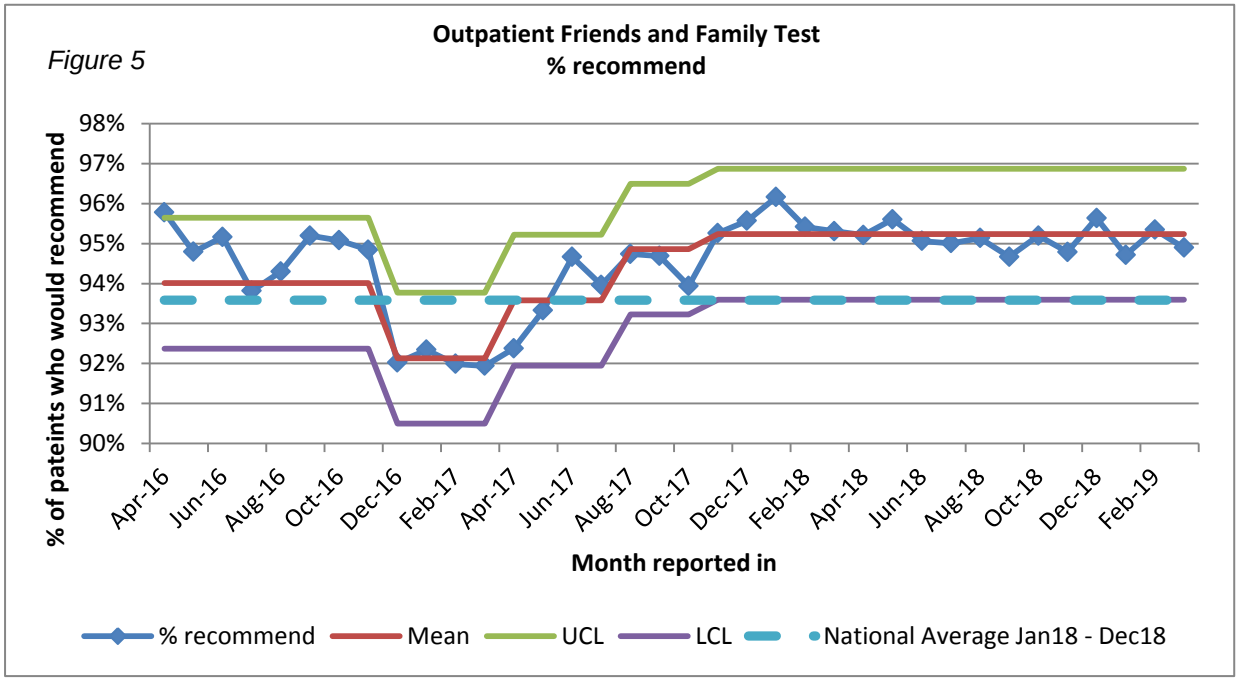
Figure 4



4.5 There has been a significant variation since December 2016 showing an improvement from average 92.5% to 95.1% onwards. Indicating the department is successfully maintaining levels of satisfaction for patients and their families. However Leicester's Hospitals still remains above the national average.

Outpatients

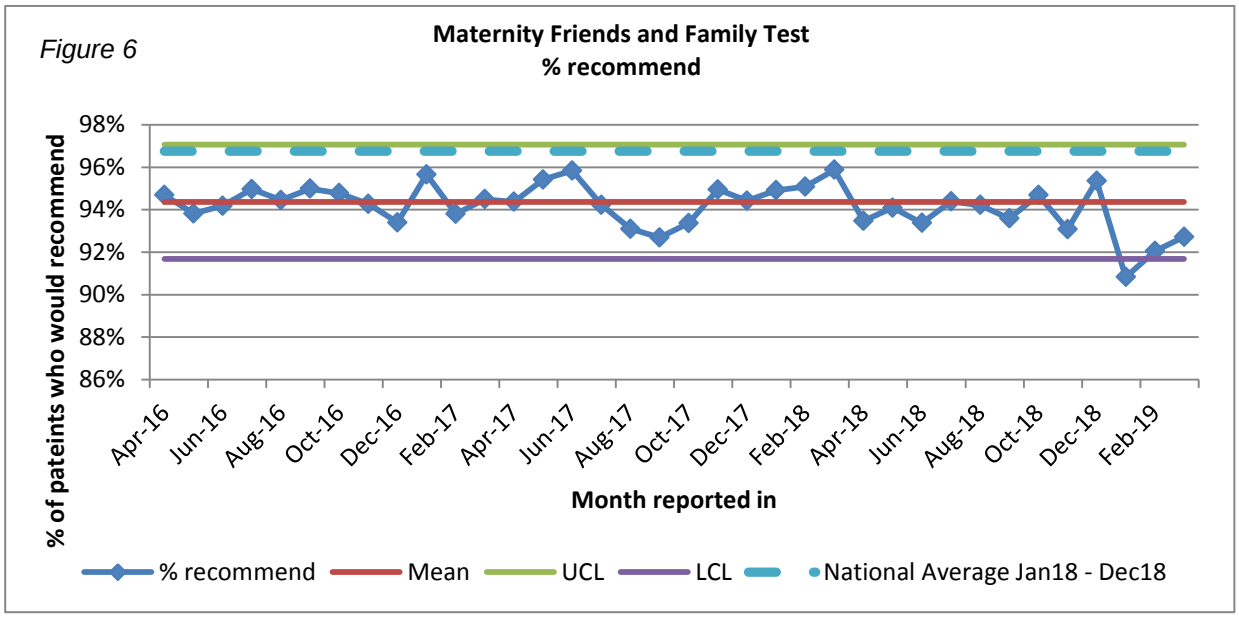
Figure 5



4.6 There has been a significant variation since December 2016 showing an improvement from 92.16% to 95.2% in November 2017 onwards. This improvement occurred when SMS texting was introduced to outpatients resulting in a significant improvement in coverage. Since 2017 there has not been any significant improvement in satisfaction levels across outpatients at trust level. However Leicester's Hospitals still remains above the national average.

Maternity

Figure 6



4.7 The initial average of 94.4% has been maintained over the last three years with no significant improvements. Maternity Services is below the national average.

5. STAFF FRIENDS AND FAMILY TEST COMPARISON

5.1 Based on the hypothesis that a motivated and happy workforce deliver better care for patients, a comparative analysis of Staff and Patient Friends and Family Test results was undertaken.

5.2 On a quarterly basis staff are asked two questions; one relates to whether they would recommend the hospital as a place to work, and the other to whether they would recommend it as a place to receive care.

5.3 Both questions results trends over the last two years were compared to each of the Friends and Family Test areas (maternity, emergency, wards and outpatients). No correlation was found.

6. MESSAGE TO MATRON CARDS

6.1 All clinical areas offer Message to Matron Cards. In 2018-19 approximately 26,000 were completed by patients and their families. These cards are collated by Matrons and are included in the triangulation of patient feedback.

6.2 Figure 7 shows the percentage of positive comments and the number of suggestions for improvement for each Clinical Management Group (each card may contain a number of comments).

Figure 7:

		Total		
		Positive	**Negative**	**Total No of comments**
Alliance	**No. of Comments**	11,682	0	11,682 (902 cards did not include comments)
	%	100%	0%	
Childrens	**No. of Comments**	1,103	103	1,206
	%	91%	9%	
CHUGGS	**No. of Comments**	8,526	876	9,402
	%	91%	9%	
CSI	**No. of Comments**	3,609	361	3,970
	%	91%	9%	
EM	**No. of Comments**	525	111	636
	%	83%	17%	
ITAPS	**No. of Comments**	172	35	207
	%	83%	17%	
MSS	**No. of Comments**	4,634	1435	6,069

	%	76%	24%	
RRCV	**No. of Comments**	1,564	439	2,003
	%	78%	22%	
SM	**No. of Comments**	419	221	640
	%	65%	35%	
Womens	**No. of Comments**	605	151	756
	%	80%	20%	
TOTAL	**No. of Comments**	32,839	3,732	36,571
	%	90%	10%	

6.3 Only 3,732 or 10% of the comments on Message to Matron in 2018-19 were a suggestion for improvement. Remarkably 32,839 comments or 90% of the overall number of comments were patients providing written positive feedback and citing specific examples of 'Caring at its Best'.

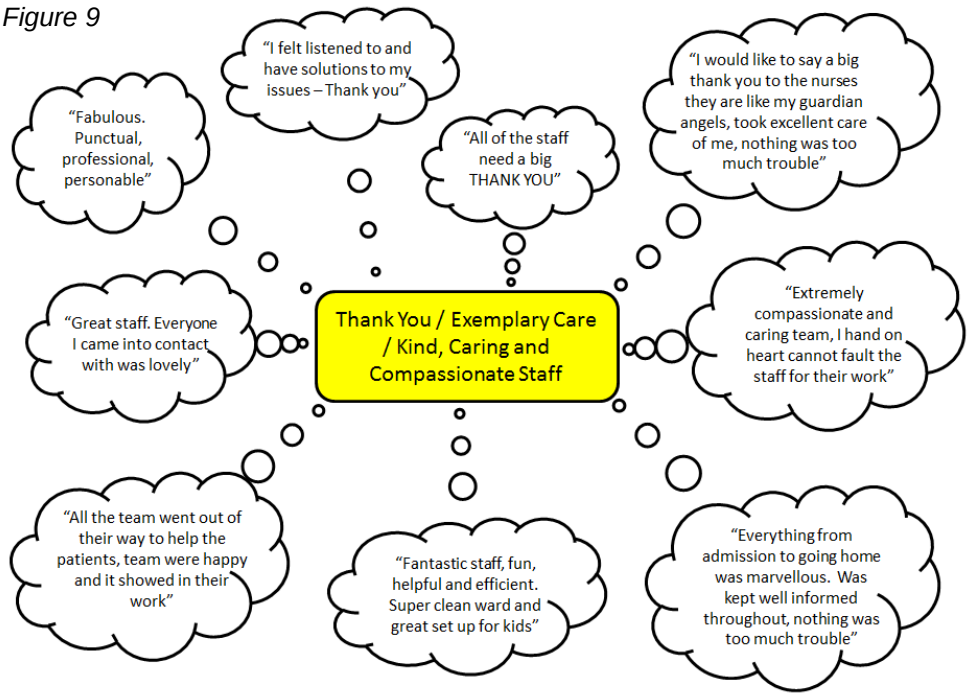
6.4 Figure 8 illustrates what patients and the public comment about Leicester's Hospitals:

Figure 8

	Theme	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
1	Thank you	3,114	2,870	2,528	2,206	10,718
2	Exemplary care	1,095	1,109	676	435	3,315
3	Kind, caring and compassionate staff	924	802	710	566	3,002
4	Service in Outpatients Clinic	901	690	489	452	2,532
5	Other Nurse/Midwife Staff attitude	409	81	408	514	1,412
6	Positive team work	376	470	269	229	1,344

6.5 The overwhelming comments from patients and the public identified that they found the care and services they experienced **exemplary, staff professional while being kind, caring and compassionate and they wished to say thank you.** Figure 9 contain examples of exactly what patients have included as their comments.

Figure 9



7. TRIANGULATION OF PATIENT FEEDBACK

7.1 The Trust brings together a variety of patient feedback via formal complaints, verbal complaints, GP concerns, NHS Choices, Patient Opinion, Friends and Family Test surveys (electronic and paper formats) and Message to Matron. All "suggestions for improvement/complaints/areas that were lacking from the patients perception", are triangulated allowing overall themes at Trust and Clinical Management Groups level to be derived. This analysis is undertaken by the clinical audit team.

7.2 The most recent results relate in quarters three and four 2018/19 and show that there was a total number of Suggestions for Improvement (SfI) of 6,034 from patients and their families. The 'SfI' rate, as a proportion of patients seen/treated during the six month period and for the last two years is shown below. The rate equates to approximately one patient in every 200 treated leaves a suggestion for improvement via the various feedback options available to patients. The SfI rate for 2018-19 has risen since 2017-18 by 0.08%.

Quarter	No. of patients treated	No. of Suggestions for Improvement (SfI)	SFI rate
Q1&2 2017/18	858,911	5,197	0.61%
Q3&4 2017/18	862,083	5,203	0.60%
Q1&2 2018/19	871,779	6,073	0.70%
Q3&4 2018/19	894,644	6,034	0.67%

7.3 The SFI rate in relation to activity in the Trust and for each main theme has been calculated and is shown in figure 10 for quarters three and four 2018-19. A more detailed report is presented and discussed at PIPEAC.

Figure 10

				CMG								
Rank	Main theme	Sub Theme	UHL Total	CHUGGS	CSI	EM	SpMed	ITAPS	MSS	RRCV	Womens	Children
			6034	1152	331	479	776	101	1636	822	412	188
1	Waiting Times	In Clinic	702	59	0	4	123	6	345	159	6	0
2	Medical Care	General Management of Care	449	91	8	37	48	12	92	49	52	20
3	Waiting Times	For Appointment	332	44	9	3	35	9	112	81	24	3
4	Staff Attitude	Consultant Medical Staff attitude	247	25	0	6	32	9	54	86	22	1
5	Delays And Cancellations	Cancellation - Appointments	214	13	12	0	66	8	72	19	8	8
6	Waiting Times	In Ward/Department	207	50	0	74	12	0	37	18	7	3

7.4 To further enhance this the top five subthemes for each of the top five main themes is shown in figure 11 for quarters three and four which gives the Clinical Management Groups detailed evidence to action.

Figure 11

			CMG								
Main theme	**Sub Theme**	**UHL Total**	**CHUGGS**	**CSI**	**EM**	**SpMed**	**ITAPS**	**MSS**	**RRCV**	**Womens**	**Children**
Waiting Times	In Clinic	702	59	0	4	123	6	345	159	6	0
	For Appointment	332	44	9	3	35	9	112	81	24	3
	In Ward/Department	207	50	0	74	12	0	37	18	7	3
	For Surgery/Admission	116	25	0	4	1	0	60	4	10	12
	Results	68	4	17	3	22	1	6	7	4	3
Medical Care	General Management of Care	449	91	8	37	48	12	92	49	52	20
	Failed Procedure	55	15	1	9	4	1	13	5	6	1
	Investigations	42	10	4	6	4	0	6	6	3	3
	Pain Management	36	8	0	6	3	2	9	2	6	0
	Delay in Diagnosis	33	12	0	7	8	0	5	0	1	0
Communication	Communication - Inadequate	131	27	16	10	13	3	26	18	6	3
	Communication - Medical Staff	103	30	1	9	29	1	11	9	8	5
	Communication - Nursing Staff	59	16	0	3	8	0	16	7	4	5
	Communication - Written	48	8	3	1	2	3	12	11	5	3
	Communication - Verbal	43	8	3	2	4	0	15	10	1	0
Staff Attitude	Consultant Medical Staff attitude	247	25	0	6	32	9	54	86	22	1
	Other Nurse/Midwife Staff attitude	82	18	0	15	18	0	9	6	10	2
	Other Staff attitude/non-clinical	63	3	7	9	5	1	17	6	10	0
	Other Staff attitude/clinical	53	11	13	4	3	1	9	3	3	2
	Other Medical Staff attitude	37	3	1	9	2	0	13	3	3	0
Integrated Care / Discharge	Discharge - Inappropriate/Unsafe	56	9	0	12	21	1	3	5	4	0
	GP - To Refer	54	7	4	9	16	0	9	6	3	0
	Discharge - Inadequate discharge comm	42	9	0	6	15	0	3	8	0	1
	Discharge - Drugs	41	15	0	0	3	0	11	8	2	1
	Discharge - Delays, inc transport delays	33	5	0	4	6	1	5	11	1	0

Bi annually the Clinical Management Groups provide a report evidencing their response to the themed feedback above and this is reviewed at PIPEAC.

8. FEEDBACK INCLUSIVITY

8.1 The community that Leicester's Hospitals serve is diverse therefore it is essential to ensure that all members of the community who use our services are given the opportunity to give feedback. Feedback paper and electronic surveys are available in the top three languages in the community; Gujarati, Punjabi and Polish. There are also easy read forms for people who have literacy problems or visual impairment. Figure 12 shows the number of surveys collected compared to the number of patients who have been admitted within the hard to reach groups in our population.

8.2 Figures 12 and 13 illustrate how effective surveying at Leicester's Hospitals is as reaching a representative population by age and ethnicity respectively. Red bars represent the proportion of patients admitted, and blue the proportion of patients surveyed. The balanced shape of these equity pyramids suggests our survey feedback is indeed representative of our population diversity.

Figure 12

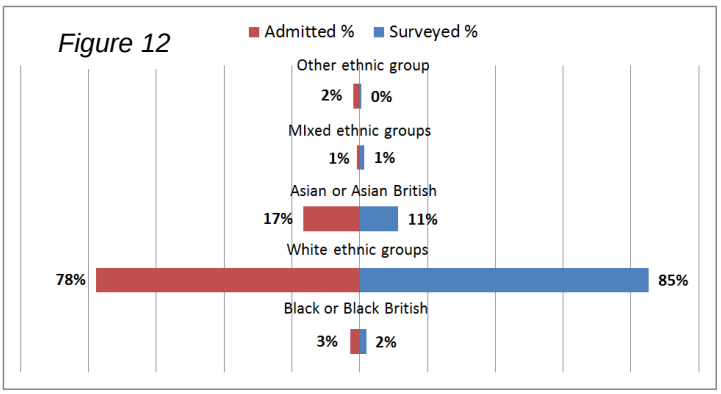
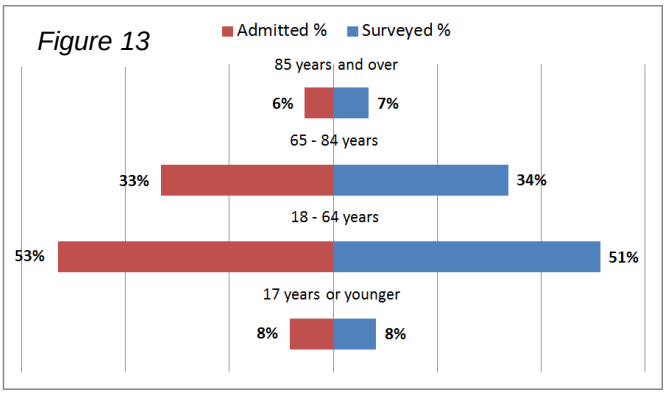


Figure 13



9. NATIONAL PATIENT SURVEYS

9.1 To assist the Trust Quality Priorities, as part of 'Becoming the Best', National Patient Survey results have been summarised to identify areas where the Trust has scored better or worse than others. This new analysis (appendix 1) highlights areas for improvement that are common across the different surveys.

9.2 The two highest areas for improvement are how well we explain things to patients and how well we successfully minimise delays. There are plans for an increased focus during 2019-20 to involve the results from National Patient Surveys to drive improvements within the Trust.

10. PATIENT FEEDBACK DRIVING EXCELLENCE

Patient Experience Driving Excellence Newsletter

10.1 In April 2018 the Quality Commitment bulletin was launched to highlight outpatient areas that had listened and responded to patient, family and carer feedback resulting in a better experience of care. It features teams from all disciplines and all specialities and shares excellent work across the Trust to facilitate shared learning.

10.2 In November 2018 the first edition of the Patient Feedback Driving Excellence newsletter was published to further enhance this and include both outpatient and inpatient teams who have made positive changes in their clinical area following patient feedback. Teams have actively put forward their work to improve the experience of patients to appear in future newsletters. See appendix 2 for an example of this monthly newsletter.

10.3 This was nominated for a PENNA 2018 and was a finalist in two categories.

Patient Recognition Award

10.4 Patient feedback is gathered in a variety of ways across the Trust and is extremely helpful in assisting to shape future services. Some patients are so impressed with their experience that they mention staff members by name in their feedback.

10.5 The Patient Recognition Award has been developed to congratulate and recognise staff that have been named positively within patient feedback five or more times within a three month period. These awards were launched during Experience of Care Week 2018 and are presented once a quarter.

10.6 There have been nine winners so far. Their success has been shared using the newsletter and social media, as it is important for staff to be aware when they are getting it right.

10.7 This was nominated for a PENNA 2018 and was a finalist in one category.

Lift Door Posters

10.8 In February 2019 a number of lift door posters were installed to highlight the importance of patient feedback.

10.9 These can be found in the following locations; Windsor ground floor and level 1, Balmoral ground floor, Kensington level four and the multi-story car park ground floor.

10.10 The lift posters aim to encourage patients and their families to give their feedback about the care received, to assist in improving and shaping future services.

You Said, We Did Boards

10.11 Clinical areas display their responses to feedback on 'You Said, We Did' boards which are updated quarterly. This can be responses to positive feedback or when there was room for improvement. Completed 'You Said, We Did' boards are returned to Patient Experience to review and share great ideas throughout the organisation.

10.12 During 2018-19 these were reviewed following engagement with the public and staff the new Patient Feedback Driving Excellence display will be launched on 1st April 2019. The new display will be updated every six months to allow teams the opportunity to act on their patient feedback, these boards should be displayed in all inpatient, day case and outpatient areas.

10.13 Displaying the response to feedback allows patients and their family to see that the feedback that is given is acted upon and is used to make positive changes within the hospital.

11. PATIENT STORIES

11.1 Patient stories are used across the Trust in a variety of ways, including team meetings, time out days, training sessions, etc. These stories highlight both examples of excellence and areas where improvements need to be made.

11.2 A shared drive 'Sharing Patient Stories' is available to senior members of staff which hosts a range of patient stories for use at appropriate forums.

11.3 Patient Stories are also included at Trust Board on a quarterly basis and involve inviting patients and their families to attend the Board and describe their experience of care in Leicester's Hospital and then hear how the Trust has responded to this feedback.

11.4 During 2019-20 further work is planned to further promote the use of patient stories at team meetings, during training sessions and any other opportunity to enhance learning.

12. CARERS CHARTER

12.1 During 2018-19 there was a period of extensive engagement with community organisations, patients and staff to review the Trusts Carers Charter. This was particularly as feedback was highlighting that not all family members with a caring responsibility wish to be labelled as a carer, but when they come into the hospital setting with their family member, they should be offered the same support.

12.2 Following the engagement an expert panel, was convened to look at all the feedback that had been received. The expert panel included representatives from local carers groups, such as the Carers Centre and Ansaar, Action Deafness and Patient Partners.

12.3 This group designed and agreed the new revised charter, which is presented in two formats:

- Do You Look after someone? For public areas to ensure that family members with a caring responsibility are informed that they will be welcomed and supported while their loved one is in hospital

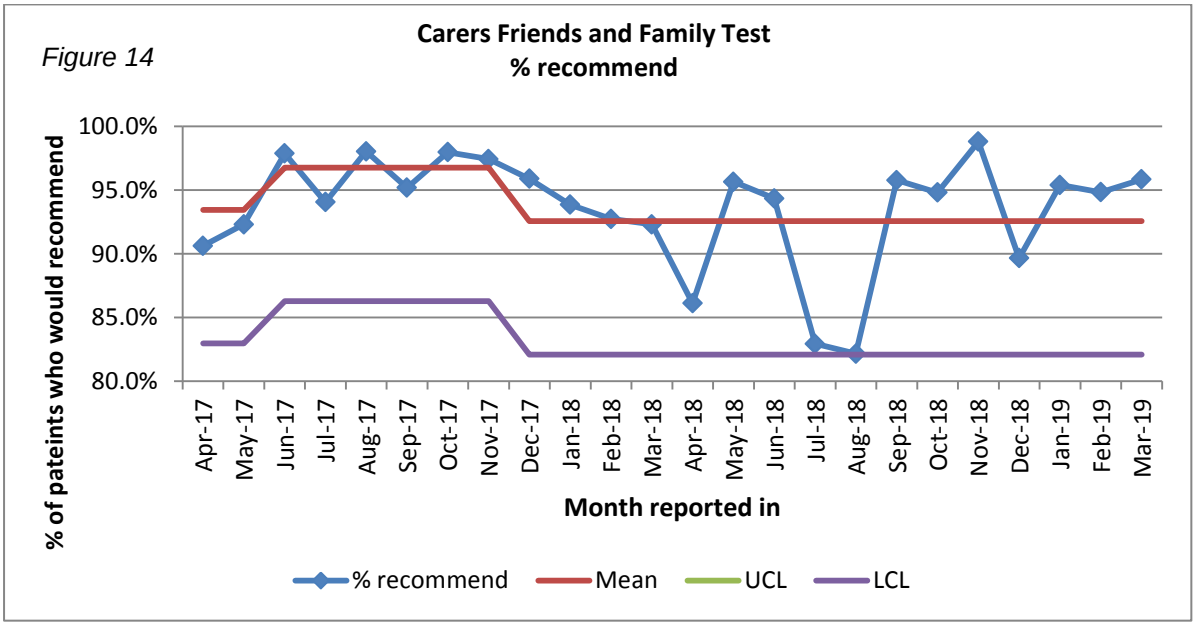
- The "Family, Carers and Friends Charter". For staff guidance regarding how they can offer support for the family member while the patient is in hospital

12.4 Both documents will be available in the clinical areas from April 2019.

12.5 These new documents have been launched across the Trust and has included staff training and the development of improved information provision.

12.6 Figure 14 highlights what carers are saying.

Figure 14



Responses from persons who identified themselves as being 'carers' or 'family members' who support the patient have contributed to the scores shown

13. PRIVACY AND DIGNITY

13.1 A quarterly walkabout, throughout inpatient, day case, endoscopy and critical care, is undertaken by Patient Experience, Facilities and a representative from the Clinical Management Group, to review the same-sex estates provision in line with the Quality Schedule.

13.2 Bathroom facilities, signage and privacy and dignity for patients are assessed in clinical areas and findings are forwarded to the Ward Sister/Charge Nurse and Matron for any necessary actions.

14. RECOMMENDATIONS

14.1 The Patient Involvement and Patient Experience Assurance Committee / Executive Quality Board is asked to:

- Receive and note this paper.

APPENDIX 1

Date of last update: April 2019

Produced by Patient Experience

APPENDIX 2

Edition 5 - March 2019

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Patient Feedback

Driving Excellence

Welcome to the new edition of the Patient Feedback Driving Excellence newsletter!

Experience of Care Week 2019 is Coming!

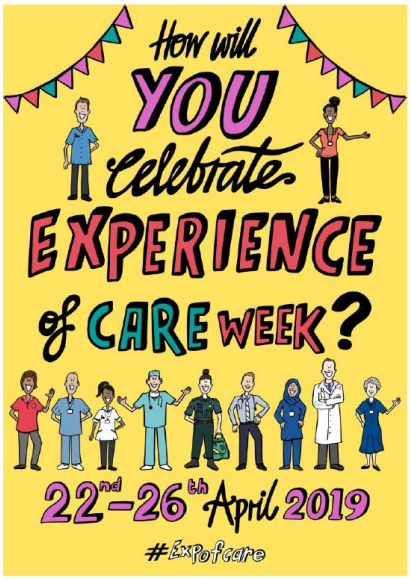
Experience of Care Week 2019 is 22nd – 26th April 2019.

To celebrate this at Leicester's Hospitals we would like to hear what you have done to improve the experience for your patients! Nothing is too big or small... let us have your ideas, if you have a photo even better. We will showcase this as part of Experience of Care Week 2019 by social media, INSite, presentations, etc.

To let us know what you are doing and also to see what else is happening during this week please visit the web page below:

>> Experience of Care Week 2019

We look forward to hearing from you!



See inside to learn more about:

- OUTPATIENT FOCUS - Gynaecology Oncology, Leicester Royal Infirmary and Leicester General Hospital
- INPATIENT FOCUS - Intensive Care Units, all sites

>> Patient Feedback Driving Excellence

OUTPATIENT FOCUS Gynaecology Oncology

Service driving improvements for their patients

Gynaecology Oncology cares for patients with suspected and confirmed ovarian, endometrial, vulval and cervical cancers at Leicester Royal Infirmary and Leicester General Hospital.

Here are some of the things we have been doing to improve the patient experience:

- Clinical Nurse Specialists completed the HOPE lifestyle training course to help guide patients to overcome daily challenges
- With "Patient Initiated Follow Up" the patient has less visits to hospital and is not discharged. So if there is a concern we can get them back into a clinic
- Research into patient satisfaction after surgery: Miss Moss (robotic surgery for gynaecology cancer) and Miss Shesha (colposcopy patients)

Louise Boulter & Nafisa Patel, Clinical Specialist Nurses

RESULTS IN 2018-19	QUARTER THREE	QUARTER FOUR
% RECOMMEND	93%	97%
% NOT RECOMMEND	3%	1%

COMMENTS FROM OUR PATIENTS

I was made to feel very relaxed and comfortable, nurse was amazing as well

The staff were lovely. Kind and professional. What a brilliant service our NHS is. We should be very proud and grateful

Very prompt appointment with a doctor who was very professional and kind

I was made to feel very comfortable and relaxed and everything was explained to me so I understood, a lovely team

Definitely a reassuring appointment. All staff were kind, curtious, professional and reassuring

The clinic was a relaxing place and the doctors and nurses were friendly and with me very calming

Everyone was kind, friendly and efficient. And on time

Pleasant doctor very respectful and I felt comfortable to discuss the issues I had

INPATIENT FOCUS Adult Intensive Care Units

driving improvements for their patients

Critically ill patients come to us as planned surgery and as emergencies following sudden illness, emergency surgery or a deterioration on one of our inpatient wards.

Here are some of the things we do to improve the patient experience:

Patient Diaries Most intensive care patients have little recollection of their stay so we keep a diary of daily events to help them fill in the gaps

Patient Follow Up Clinics Patients are invited back to a follow up clinic to discuss any potential problems and referred for ongoing support as required

Memorial Afternoon A year on, families suffering a bereavement are invited to a memorial service with afternoon tea and a balloon release.

Patient User Days Recent patients and family members are invited to an evening to give feedback on their experience, facilitated by our patient partners and the multidisciplinary team and help us improve patient services.

Sharon Williams, Matron and the nurses from LRI, LGH and GH Intensive Care units

	% recommend	% not recommend
2018-19	98.1%	0.6%

COMMENTS FROM OUR PATIENTS

Thank you all for a pleasant stay- everyone was perfect

Nothing was too much trouble. Everyone was so friendly, excellent, lovely, thoughtful, nurses and doctors. A difficult experience made easier because of the compassion on this ward

Because the staff were amazing - very caring and kind

Everybody has shown dedication and dignity during my stay - always on hand for anything and everything and always have a friendly smile

I cannot thank you all enough for your genuine care and high level of support in all areas

I had an excellent experience in ITU. The nurses are great -the doctors are fantastic. What can I say? Thank you

Thank you to everyone : paramedics, ambulance crew all on ITU ward - you're a credit to your profession and the NHS

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Patient Feedback

Driving Excellence

Please contact Patient Experience if you would like to highlight how your area has used patient feedback to drive excellence

Email:

PatientFeedbackMailbox@uhl-tr.nhs.uk

Tel:

(0116) 258 5384

Annual Infection Prevention Report 2018/19

Author: Elizabeth Collins, Infection Prevention Lead Nurse Sponsor: Carolyn Fox Chief Nurse **QOC paper K**

Executive Summary

Context

The Annual Infection Prevention Report for the year 2018 to 2019 is attached

This summarises the activity of the Infection Prevention Team and provides an overview of the mandatory Microbiological data the Trust is required to collect in order to be compliant with the Health and Social Care Act 2014

Questions

The Lead Infection Prevention Dr and Nurse would welcome the opportunity to present this report and current actions with regard to Carbapenemase Organisms to the Trust Board. Would the Board consider this helpful?

Conclusion

Whilst there continues to be challenges in the provision of healthcare with regard to financial constraints and staff shortages that are well documented both within UHL and nationally, the Infection Prevention Team has worked hard to support colleagues in the maintenance of a safe environment for our patients and it has been pleasing to see the delivery of the Clostridium difficile trajectory.
The challenge of Carbapenemase Resistant Organisms however is a real and present threat and requires consistent and robust action to ensure these organisms are contained and eliminated from our environments when identified.

Input Sought

The Executive Quality Board is asked to note this report and continue to support the robust actions required to tackle Carbapenemase Resistant Organisms

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare [Yes /No /Not applicable]
Effective, integrated emergency care [Yes /No /Not applicable]
Consistently meeting national access standards [Yes /No /Not applicable]
Integrated care in partnership with others [Yes /No /Not applicable]
Enhanced delivery in research, innovation & ed' [Yes /No /Not applicable]
A caring, professional, engaged workforce [Yes /No /Not applicable]
Clinically sustainable services with excellent facilities [Yes /No /Not applicable]
Financially sustainable NHS organisation [Yes /No /Not applicable]
Enabled by excellent IM&T [Yes /No /Not applicable]

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Yes /No /Not applicable]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
XXXX	There is a risk …			XX

If NO, why not? Eg. Current Risk Rating is LOW

b. Board Assurance Framework [Yes /No /Not applicable]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken: [Insert here]
4. Results of any **Equality Impact Assessment**, relating to this matter: [Insert here]
5. Scheduled date for the **next paper** on this topic: [XX/XX/XX] or [TBC]
6. Executive Summaries should not exceed **1 page**. [My paper does / does not comply]
7. Papers should not exceed **7 pages.** [My paper does / does not comply]

University Hospitals of Leicester NHS
NHS Trust

Infection Prevention Annual Report

2018/19

Infection Prevention and Antimicrobial Annual Reports

Infection Prevention Annual Report

April 2018 - March 2019

Contents

1. INTRODUCTION

Avoidance of healthcare associated infection (HCAI) remains a top priority for the public, our patients and staff. HCAIs are not only potentially devastating for patients and healthcare staff, but consume valuable healthcare resources. Investment in Infection Prevention is therefore both necessary and cost effective. The Infection Prevention Team ensure that there is on-going emphasis given to the prevention of healthcare associated infection, the reduction of antibiotic resistance and the improvement of cleanliness in our hospitals.

This report has been written to provide information about infection prevention and antimicrobial stewardship at the University Hospitals of Leicester in 2018/19. 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 report aims to assure the public that the minimisation and control of infection is given the highest priority by the Trust.

Colleagues have worked hard during 2018/19 against increasing financial constraints for the organisation. Cessation of the third party provider contract for the delivery of our Estates and Facilities services whilst over two years ago now has left a significant financial shortfall for this service provision within UHL and a nationally well recognised shortage of nursing and medical staff continues to provide the organisation with significant challenges.

It makes this an excellent opportunity to thank our staff for their effort and the commitment to patient safety and patients and visitors for their cooperation.

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

2. EXECUTIVE SUMMARY

This Report reviews the 2018/19 infection prevention and antimicrobial stewardship successes and challenges for UHL.

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

- In 18/19 there were 3 Meticillin Resistant *Staphylococcus aureus* (MRSA) blood stream infections reported, against a trajectory of zero avoidable cases. All 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

- UHL *Clostridium difficile* numbers were 57 against a trajectory for 18/19 of 60.

- 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.

- Decontamination leadership and practices have been reviewed and significant progress has been made with regard to being able to provide assurance against recommended national guidelines

- UHL identified an outbreak of Carbapenem Resistant Organisms (CRO), the first for the organisation. The Trust and IPT were commended on the management of this incident.

3. 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 18/19 and the schedule has been revised to meet on a bi-monthly basis and receives reports and updates from the Infection Prevention Team and wider allied groups within UHL.

he 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 monitor 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 18/19

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 report are provided to the Executive Quality Board.

4. 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

5. 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 2018/19 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.

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

6. 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.

6.1 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 x 1

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

6.2 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).

An hourly feed of results allows 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.

6.3 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

6.4 Alert Conditions

- Scabies
- Chickenpox and shingles

[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.

- 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.

6.5 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 2018/19 was 0 avoidable cases. The Trust recorded 3 cases for 2018/19 of which all were deemed unavoidable due to the patient co-morbidities.

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.

6.6 MRSA Bloodstream Infections

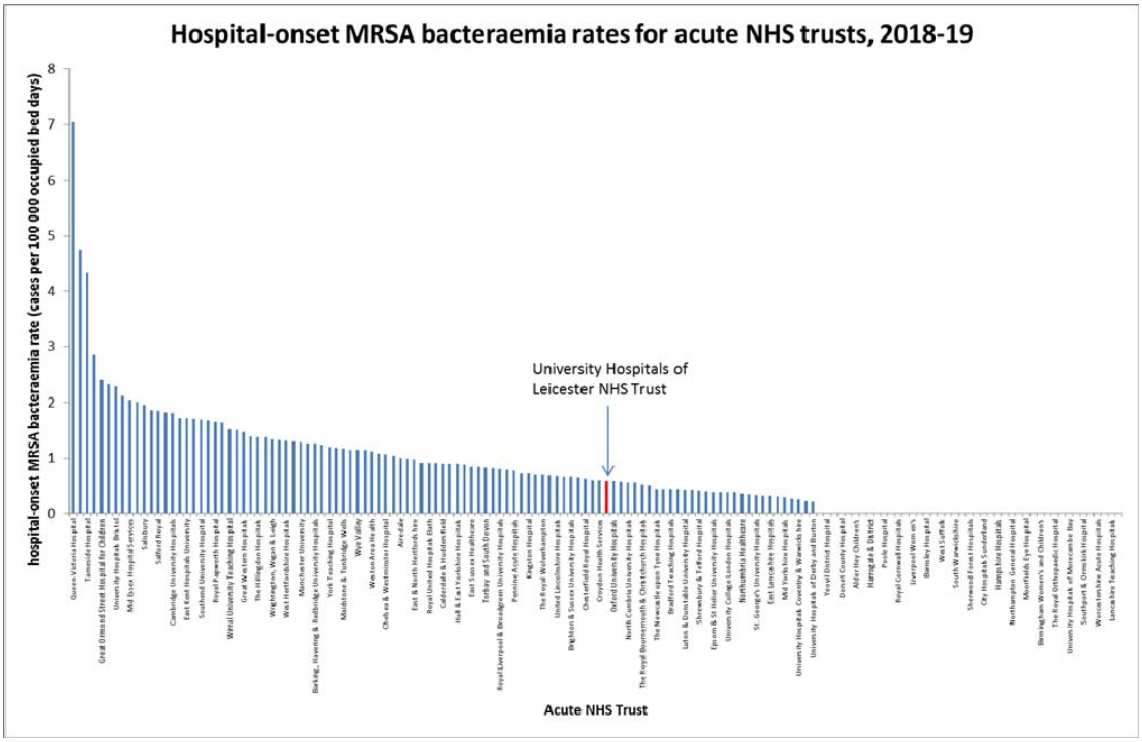


Fig 1: Trust assigned MRSA blood stream infections, 2018/19, cases per 100 000 bed days

6.7 Clostridium Difficile Prevention and Reduction Strategies

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. An episode consists of one or more *C. difficile* toxin positive stools during a 28 day period. Cases that occur more than 72 hours after admission are attributed to the acute Trust with those identified within the first 72 hours likely to have been community acquired.

The agreed trajectory for this infection in 2018/19 was 60 cases of *C.difficile* in patients aged 65 and over. The year-end position for UHL was 57.

Table 1: The monthly number of Clostridium difficile reportable infections

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Actual Infections 18/19	12	4	5	4	7	2	6	4	6	2	0	5

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

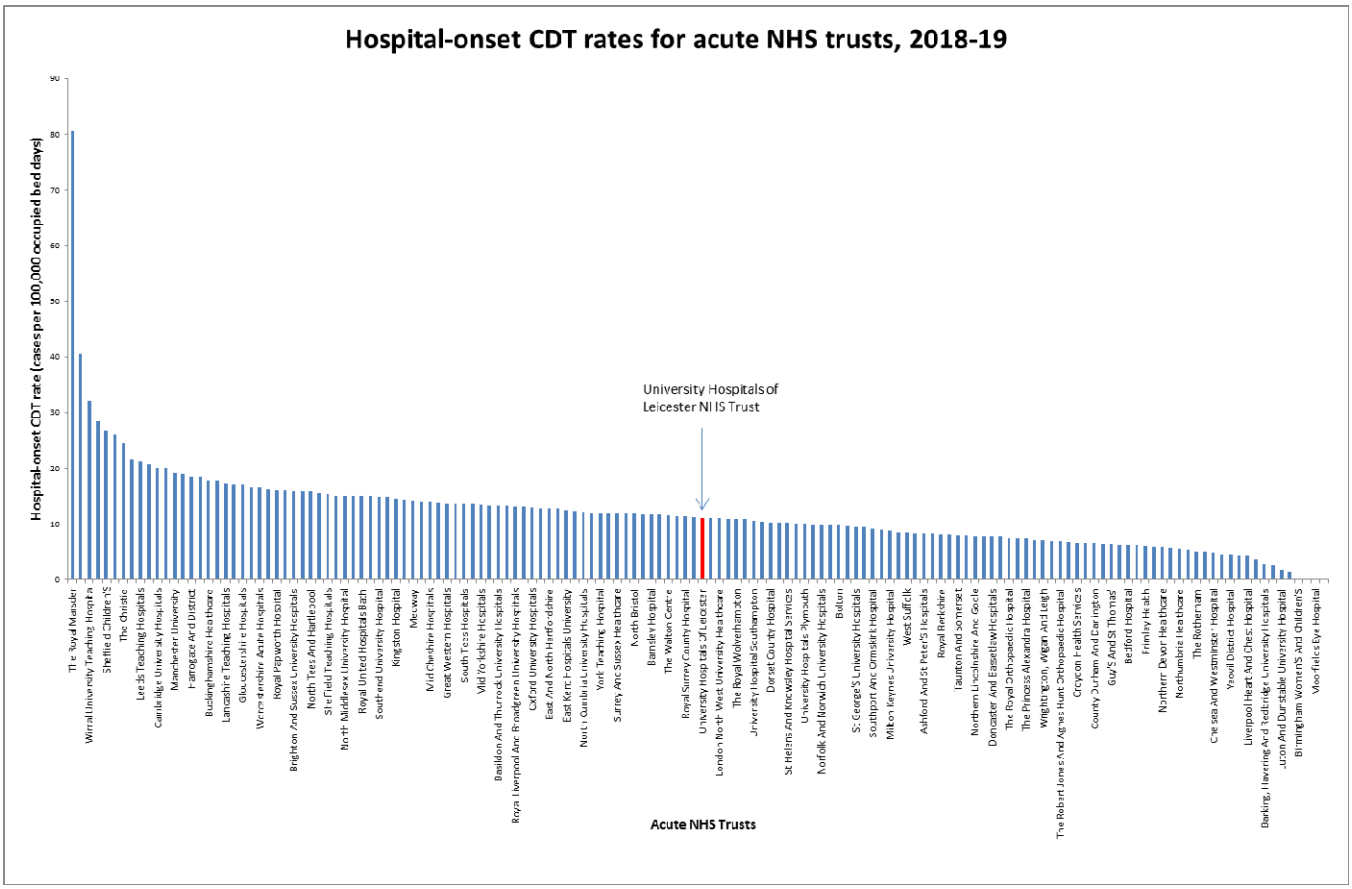


Fig 2. Trust apportioned Clostridium difficile infections by financial year per occupied overnight beds (per 100,000).

7. 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.

7.1 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.

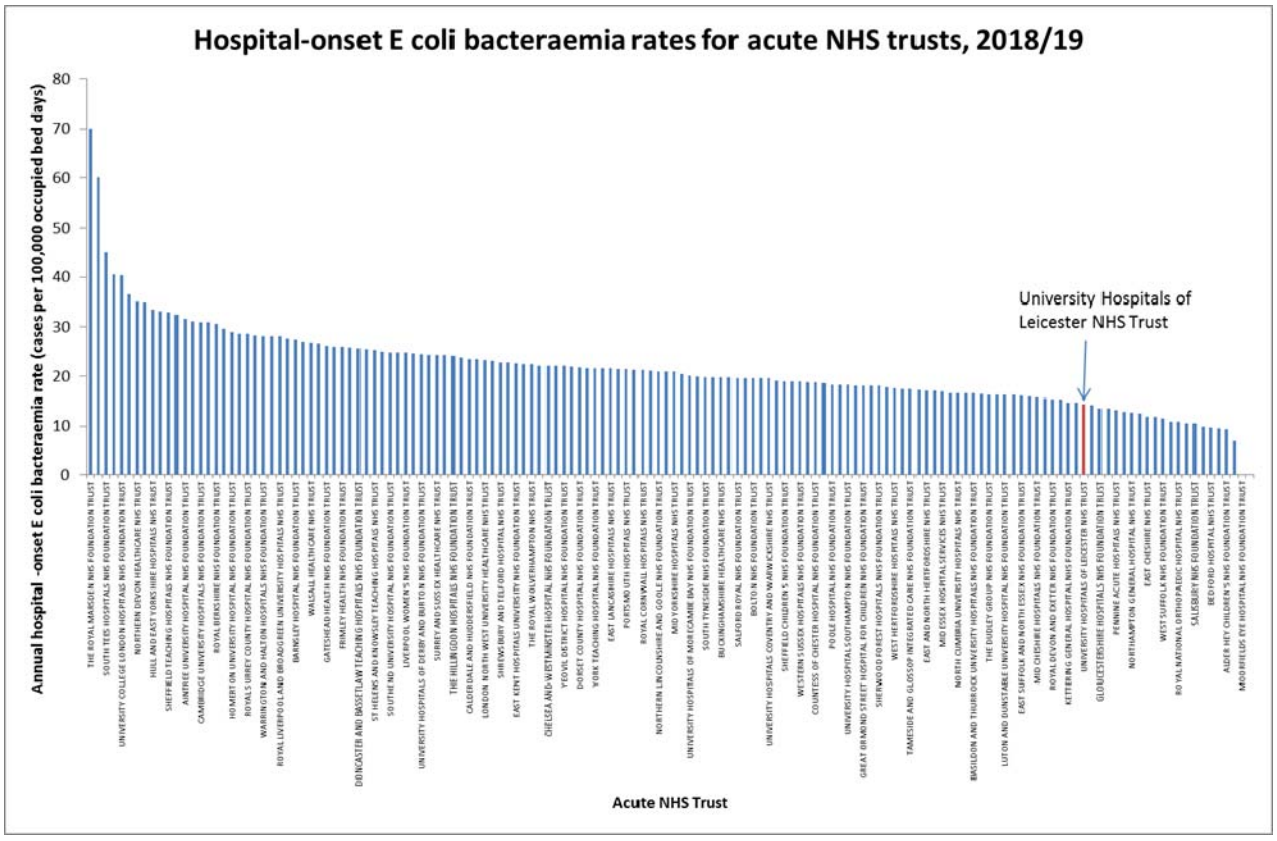


Fig 3. Trust apportioned E coli infections by financial year per occupied overnight beds (per 100,000).

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.

7.2 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.

OXA-48 is a carbapenemase gene that was initially identified in Turkey in 2004 and has subsequently spread across southern Europe and the Middle East.

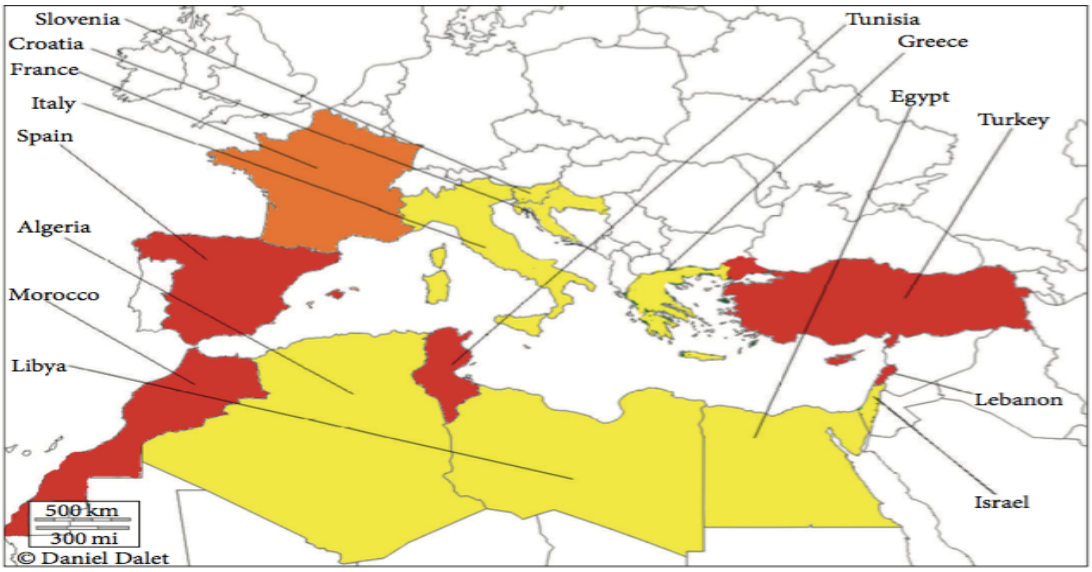


Fig 4: Distribution of OXA-48 producing bacteria in 2014.

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. UHL has been carrying out surveillance on these organisms since 2012 to develop management strategies for and support future capital planning by identifying the increasing need for isolation facilities.

During July, a case of Carbapenemase-producing Klebsiella OXA 48 (Kp OXA 48) was identified at Leicester Royal Infirmary. All patients on the ward were subsequently screened and a further six colonised patients were identified Due to the increased incidence of known or suspected infection occurring when a number of people affected by the same organism, linked by time or place, an outbreak was declared on the 31 July 2018.

This incident is the first OXA-48 outbreak within UHL. Experience from other centres, notably Manchester, has 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. A review of IPC policies does not show any deficit in the management approach within the Trust. Adherence to established Trust IPC protocols, including the identification of high risk patients, isolation, investigation, informing and imitation of appropriate treatment (the I-5s) is key, to prevention.

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.

Part of the IP risk assessment applied to all patients on admission is the question that relates to in-patient admission abroad in the past 12 months or in another hospital outside of Leicestershire. A positive response requires staff to initiate isolation of the patient and screening for these organisms.

The IPT and Outbreak Control Group were commended on their management of the outbreak. Ongoing actions continue to be taken and further initiatives designed to identify and protect UHL patients will form part of the action plan for UHL during 19/20.

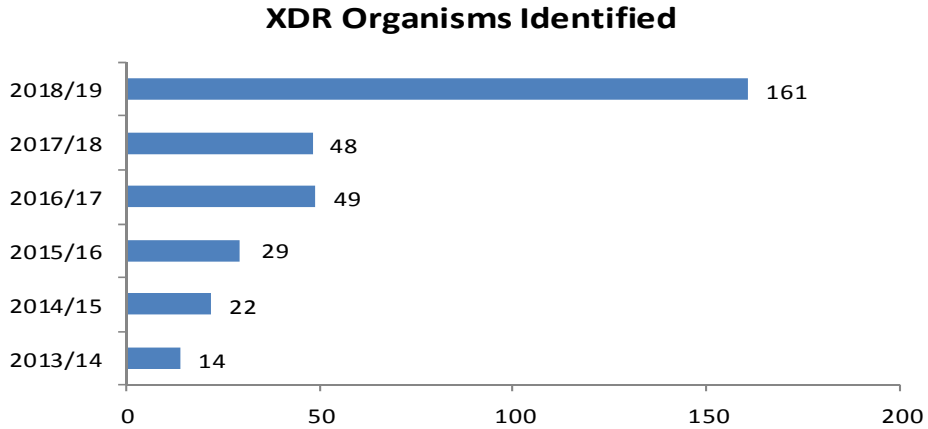


Fig 5. XDR Organisms Identified in Leicester since 2013/14

8. MANDATORY SURVEILLANCE OF SURGICAL SITE INFECTIONS

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 2018-19, they submitted data for knee replacement surgery for quarters 1, 2, 3 and 4. Public Health England (PHE), who process the data and compare infection rates against Trusts carrying out the same surveillance, sent UHL an outlier letter (higher than the national average infection rate) which required the Team to review cases, practice with a responses from the Trust.

A multidisciplinary group was convened to review the data and any circumstances that might have led to a higher than expected SSI risk. The group included a Consultant Orthopaedic Surgeon, Orthopaedic Surveillance Assistant, Senior Infection Prevention Nurse, Consultant Microbiologist and Nursing colleagues within Orthopaedics and Estates.

Following review of all the cases, it has become apparent that the process for collection of the SSI data and how this is processed has changed recently. A new person has started collecting the data and normally this is checked through with a Consultant Orthopaedic Surgeon. For this set of data this did not happen. Had the process continued as previously only 2 patients would have been identified as truly having an infection according to accepted SSI definitions.

9. 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 2018/19
1x CRO outbreak reported as an SI
1x CRO Period of Increased Incidence (PII)
3x MRSA Bacteraemia
2x CDT deaths reported on Part 1a of patient death certificate

9.1 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 2018/19 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.

Beds days Lost	Patients Affected	Staff Affected	Relatives known to be affected
96	**56**	**16**	**0**

Table 2: Norovirus summary showing the impact on the patients, staff, relatives and hospital beds.

9.2 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.

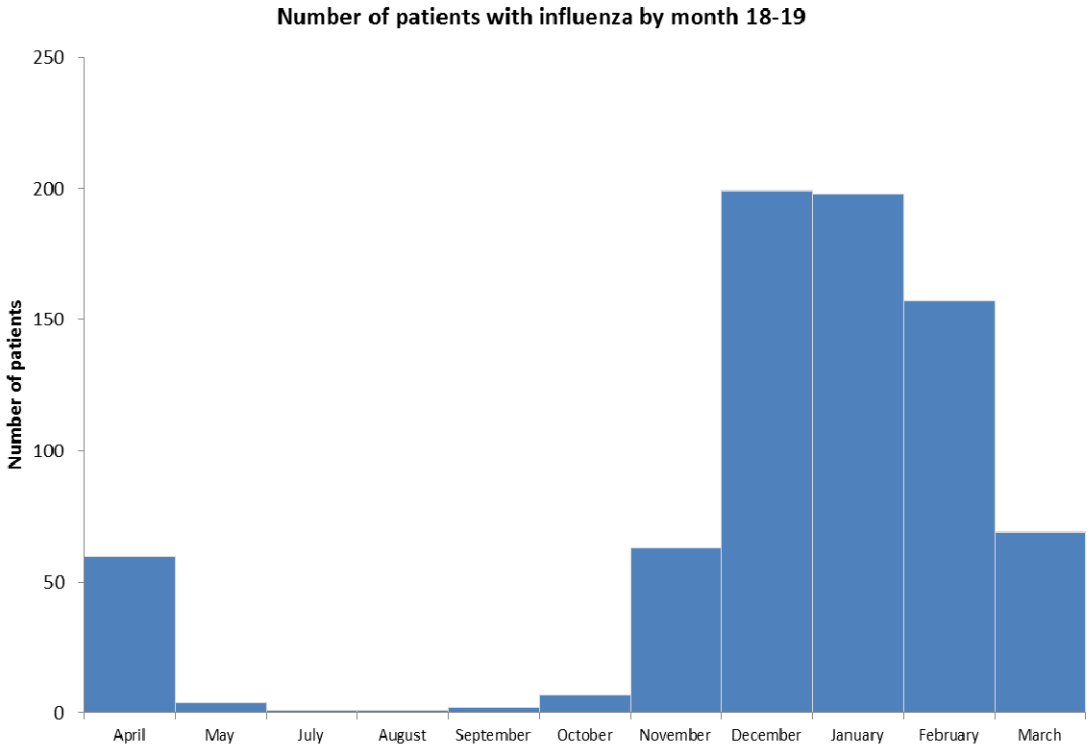
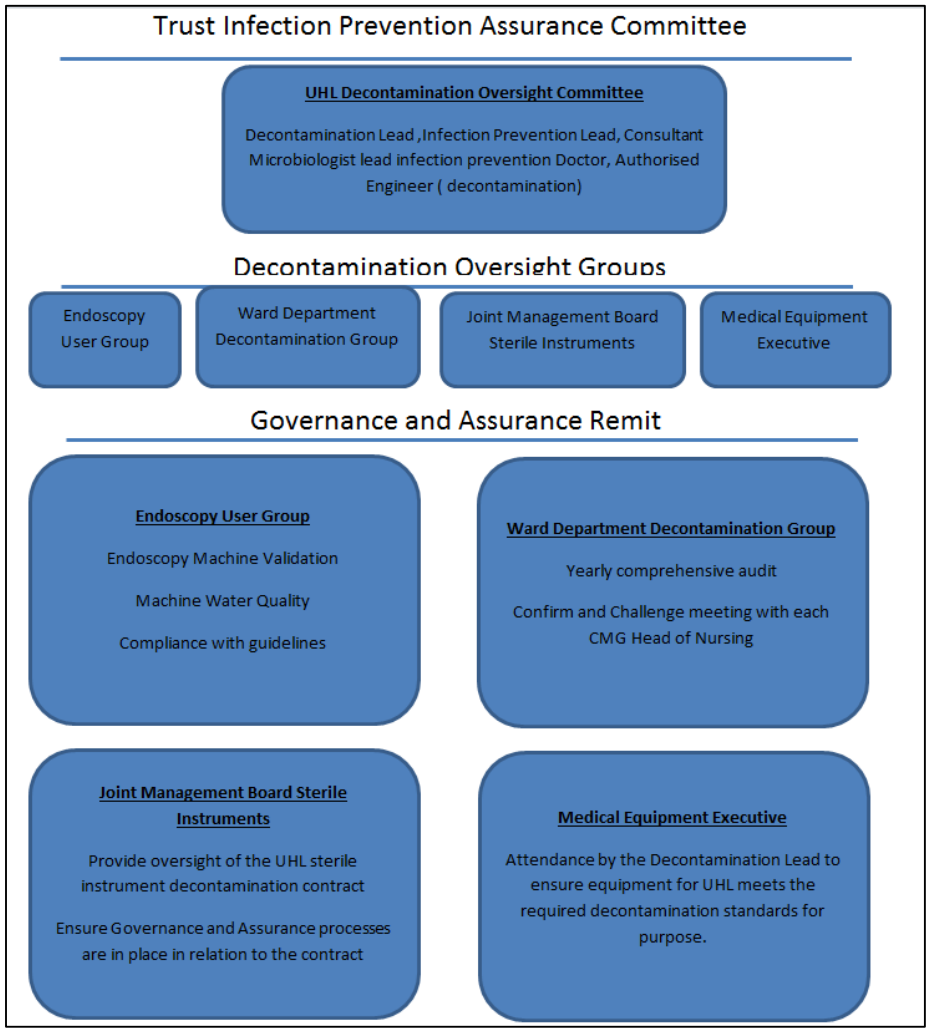


Fig 6: Number of patients confirmed with influenza via positive sample.

10. 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.

UHL Decontamination Operational Arrangements



10.1 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. During 18/19 the units at the Leicester Royal and Glenfield sites were accredited. The General Hospital Unit had work identified to the physical environment that is required to be carried out and it was indicated that further accreditation would not be approved at the next inspection if this was not completed.

10.2 Endoscopy provision

Endoscopy is conducted currently over 7 sites within the organization in differing locations.
92 % of the equipment used is 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 single shot solution.The estate is not fit for purpose and would require 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. This is due to open January 2020

10.3 Endoscopy audits

These are conducted on a 6 monthly basis and due to ageing, non-compliant estate, compliance with these audits is becoming a concern.
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

10.4 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 now in particular.

10.5 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.

10.6 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 January 2020.

10.7 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

10.8 Decontamination Policy

This has been reviewed and has been renamed the Decontamination of medical devices

10.9 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

10.10 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 2019 and accredited in line with HTM 01-01.
Since 2017 the following auditable data has been collected and distributed within the link meetings in 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

10.11 Trans Vaginal probes

The Decontamination Lead has provided assurance to the Trust Infection Prevention Assurance Committee (TIPAC) that all Trans vaginal 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 been asked to present the toolkit at the national Decontamination conference in November 2019.

In 2018 the Decontamination Lead become the facilitator for the National Performance Advisory Group (NPAG) this enables us to benchmark performance with the rest of the country.

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

Recruitment continues to be more difficult at the Leicester Royal Infirmary in comparison to the other two sites whom normally have around one or two WTE vacancies at any one time.

Financial resource continues to be the most significant pressure to this 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 and other forms of absence. In addition to the pressure on the workforce, other areas of pressure where identified and reduced accordingly, such the amount of office cleaning and work conducted at premium rates mostly between the hours of 22:00 and 06:00.

Equipment continues to cause concern with both insufficient amounts as well as very old equipment still being used which again is leading to inefficiencies. Trials of suitable replacement equipment have taken place to identify the ideal solution 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 near identical across the three sites, and additionally create one point of contact to enable more fluid communications between Domestic services and nursing colleagues, etc.

Auditing has experienced difficulties due to the amounts of technical audits completed by the Supervisory teams and the quality of reports produced. Following a review of service providers an alternative has been identified which fulfils the requirements of facilities as well as giving a better quality of report for our medical colleagues.

Increased communication has been implemented to ensure that an active conduit of information is passed between Domestic services and Infection Prevention (IP) and nursing colleagues, etc.

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

11.1 Patient Led Assessments of the Care Environment (PLACE)

The PLACE process is reviewed annually with updates and amendments made to the criteria and questions. For 2018 there have been minor changes within the criteria for each element scored.

The 2018 assessments were carried out with a minimum 50% representation of Patient Assessors as required and the results submitted to the Health & Social Care Information Centre (HSCIC) within the required timescale.

The Patient Assessors have contributed fully to the assessments and have ensured that their views were made known to staff at all levels both during the assessments and by way of their comments all of which have been submitted to the HSCIC as part of the process.

There are 5 domains against which our hospitals are assessed, however looking at Cleanliness, Condition, appearance and maintenance as follows:

- Cleanliness – This includes all ward, outpatient, communal and public areas. Criteria assessed are broadly based on the National Specification for Cleanliness standards which include nursing responsibilities for patient equipment and domestic services for the environment.
- Condition, Appearance and Maintenance – These questions include the décor, flooring, furnishings and furniture in all areas visited. Car parking facilities and payment mechanism, overnight accommodation for relatives or carers, safety, temperature of areas etc. are also assessed.

Summary of Results - The results achieved for 2018, are encouraging and demonstrated significant improvements related to the cleanliness for all three hospitals and have improved marginally compared to 2017 results. Condition and Appearance as shown minor improvement but this is in the main due to areas the Patient Assessors choosing to visit areas which are better than others.

Whilst acknowledging reasonable results it should be noted that there continues be an urgent requirement for a program of significant investment to upgrade many of our patient areas in both wards/OPD. Public Toilets are sadly lacking in terms of suitable environments and this is a continual theme in environmental audits. Whilst we are slowly improving ward kitchen environments it is essential that this program continues to be funded as these are matters which the Local Authority EHO is keen to see our continued investment.

Leicester Royal Infirmary - Cleanliness - The result for the LRI demonstrates a marginal improvement to 98.82%.
Condition, maintenance and appearance - The result for these criteria shows a minor improvement to 90.72%. Patient Assessors note some areas visited had benefited by some investment in redecoration and new flooring etc however significant investment is required to many of the Trust wards and departments at the LRI.

Leicester General Hospital
Cleanliness - The result for cleanliness demonstrates a marginal improvement in standards achieving 98.84% compared to 98.2% last year just above the national average.

Condition, maintenance and appearance - The results for condition maintenance and appearance also improved to 88.69% marginally. Floors particularly barrier matting at entrances are damaged and tired and are in need of replacement. Public toilets are particularly poor in terms of the environment. The external fabric of the building requires some considerable maintenance as noted in previous assessments.

Glenfield Hospital

Cleanliness - The result achieved, 99.36%, was in excess of the national average at 98.47%. The cleanliness standards throughout the wards and departments, including patient equipment, observed on the days of the assessments were very good and Patient Assessors noted an improvement.

Condition, maintenance and appearance - The main issues raised were related to some décor being tired and scuffed and damaged paintwork.

12. 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

13. 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 2018/19 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.

14. 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).

14.1 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 2018/19.

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.

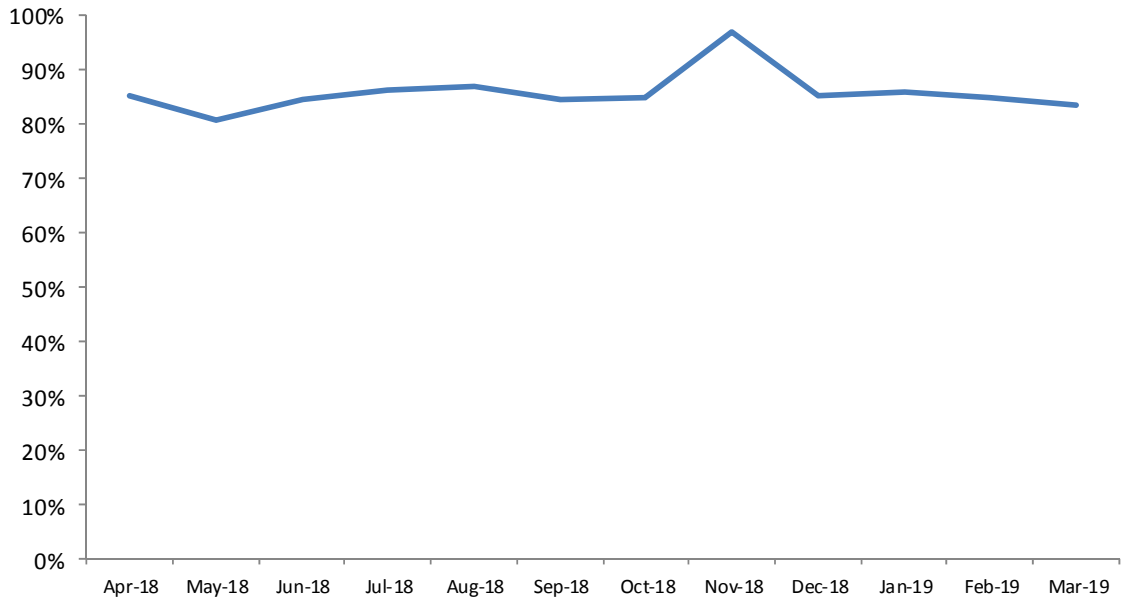


Fig 7. Hand hygiene compliance across the trust during 18/19 collected by ward staff audits.

14.2 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.

15. 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.

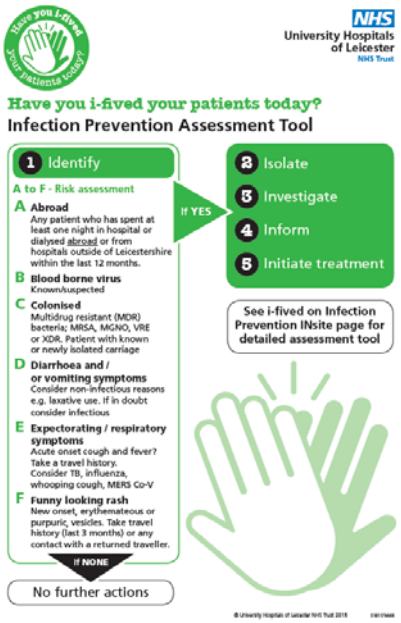
The team delivered over 95 face to face training sessions to approx. 3,000 staff members. These figures do not include locally delivered education by individual IP nurses within their CMG

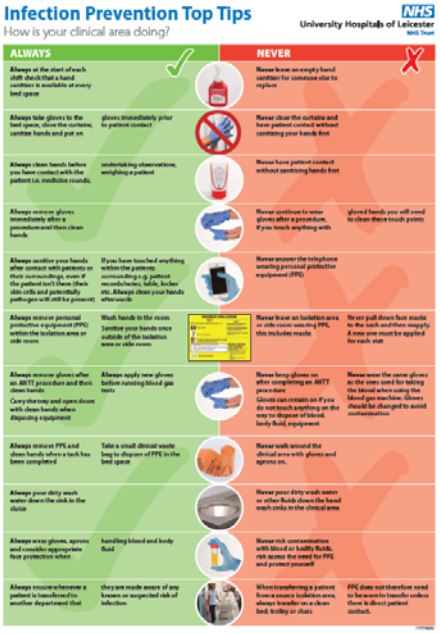
In addition to education within UHL the IP Team liaise closely with Leicester and DeMontfort Universities to ensure training delivered to medical and nursing students is in line with current guidance and UHL policies.

The posters below illustrate two of the initiatives that were developed during 17/18 for use across UHL. These have continued to be further embedded into UHL culture during 18/19. The i5's is a mnemonic that has been developed to provide staff with a quick tool for use when assessing patients for the risk of Infection. Importantly it is not a check list but has been designed so that staff can apply this to any suspected or confirmed case of infection. By using the hand as the visual prompt for this, it continues to follow the overarching theme of all best practices with Infection Prevention namely hand hygiene.

The Top Tips for Infection Prevention were developed from a thematic review of Trust wide Hand Hygiene audits during 17/18 and continued to be rolled out during 18/19. We believe it is important for our colleagues to see the output from the data they collect. We want to ensure that through this we are supporting clinical practise for our patients.

Infection Prevention Pathways are the single page sheets that will accompany all IP policies during 18/19 and into 19/20 as policies are revised. These are designed to provide colleagues with a single sheet that can be printed and used as a care pathway to accompany the patient IP risk assessment. These can be placed in the patient notes or can be used to guide practise at any given time. Further detail and information can be found in the full version of IP policies.





16. 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 and 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.

17. 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 has been reviewed during 18/19 and this role is now being undertaken by one of the Deputy Medical Directors with the Committee being supported by the IP Team. During 2017/18 work streams included a product review and change of needle free devices, policy review, and introduction of QR codes as an educational tool for vascular access devices.

18. 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 2018-19, the total number of occupational immunisations (not including influenza) provided to UHL NHS workforce of c. 16000 was in excess of 1417 (832 last year) which represents an increase of 70%.

This year was our most successful staff influenza vaccination campaign to date, and overall 9796/15998 staff were vaccinated, including 8861/11095 (78.1%) 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.

Measles and whooping cough continue to circulate in the wider community and, as in previous years, a number of such situations have again arisen in UHL, as despite all best efforts to identify patients with infectious conditions, the presence of an infectious illness is not always readily apparent. It is important in such cases to trace all staff members that have been in potential contact with the source of the infection, to ensure they are immune and provide further treatment/vaccination as well as any necessary advice and reassurance. In the past 12 months, six separate major contact tracing exercises have taken place, resulting in the recall, screening and/or treatment of at least 200 staff in a variety of clinical areas.

19. NEXT STEPS

We have identified some key priorities for 2019/20

- 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) Urology Consultant Chair
- 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

Antimicrobial Stewardship Annual Report

April 2018 - March 2019

Contents **Page**

1. INTRODUCTION

Antimicrobial Stewardship is a top priority for the World Health Organisation, the Department of Health and to our patients and staff.

In 2011 the Chief Medical Officer's (CMO) annual report called for 'better antimicrobial stewardship to preserve the effectiveness of antibiotics' (Infections and the rise of antimicrobial resistance).

Antimicrobial stewardship 'embodies an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to reserve their future effectiveness'.

The three major goals for antimicrobial stewardship identified were:

- optimise therapy for individual patients
- prevent overuse, misuse and abuse
- minimise development of resistance at patient and community levels.

In 2013, the Department of Health published the UK five year antimicrobial resistance strategy 2013-2018. The report describes 3 strategic aims:

- improve the knowledge and understanding of antimicrobial resistance
- conserve and steward the effectiveness of existing treatment
- stimulate the development of new antibiotics, diagnostics and novel therapies

The Antimicrobial Stewardship and Resistance CQUIN 2018-2019 focused on reducing the consumption of antibiotics and ensuring antibiotic prescriptions are reviewed within 72 hours of initiation. The Antimicrobial Resistance CQUIN merged with the Sepsis CQUIN in April 2017 and will continue until 2019.

Prescribing of antimicrobials at UHL aims to follow the Start Smart then Focus approach. The Start Smart then Focus guideline sets out standards for AMS programmes and provides recommendations on a co-ordinated approach to tackle AMS from the Trust Board down to ward level.

2. EXECUTIVE SUMMARY

This Report gives an overview of the Antimicrobial Pharmacy Team, Antimicrobial Working Party and a summary of the 2018/19 Antimicrobial Stewardship Work.

The Antimicrobial Pharmacist Team has worked hard during 2018/19 to ensure clinical staff deliver, and patients receive a high standard of antimicrobial stewardship at University Hospitals of Leicester despite significant and unavoidable external pressures. However we cannot achieve these standards without the support of senior colleagues across the Trust.

The Antimicrobial Pharmacy (AMP) Team facilitates the Antimicrobial Working Party to ensure that there are robust antimicrobial guidelines and policies in place, as well as providing on-going antimicrobials prescribing monitoring and feedback to promote and ensure judicious antimicrobial prescribing.

Based on provisional figures UHL partially achieved met indicator 2c and partially met indicator 2d of the Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) CQUIN 2018/2019[2].

- 2c – 72 hour antibiotic review - met
- 2d Antibiotic consumption
    - Reduction in total use – not met
    - Reduction in carbapenem use – not met
    - Increase in proportion of AWaRe category use by 3% - met

The overall consumption of antibiotics was as antibiotic use did not fall to it's usual baseline over summer. This likely to be caused by the significantly warm summer leading to increased dehydration and urinary tract infections.

While the CQUIN target relating to carbapenem use was not met, this should be considered in the context of a 30% reduction in use of carbapenems against year 17/18.

The Trustwide antimicrobial prescribing audit showed compliance with antibiotic guidelines at 93% for 18/19. This is an improvement on previous years and shows that education and training measures put in place by the AMP have had an impact however there is still work to be done at a CMG level to improve prescribing.

Documentation of indication and duration has improved in the year 18/19 (99% and 85% respectively). This is largely due to the introduction of eMeds at Glenfield Hospital.

3. THE ANTIMICROBIAL PHARMACY TEAM (AMPT)

University Hospitals of Leicester has a dedicated Antimicrobial Pharmacy (AMP) Team. The team collaboratively supports and works with the Lead Infection Prevention Doctor, the Infection Prevention team, Pharmacy and the Medical Microbiologists.

At the start of 2018/19 the AMP team substantive establishment included:

- Lead Antimicrobial Pharmacist 1 WTE
- Advanced Specialist antimicrobial pharmacist 1 WTE
- Senior AMP 0.5 WTE

[2] Figures provisional based on available data at date of writing 16/5/19.

In addition to this 0.2 WTE Specialist Pharmacist was funded through CQUIN in this year to lead a stewardship project.

During 2018/19 the AMP establishment has been significantly impacted by secondment of the Advanced Specialist Antimicrobial Pharmacist to NHS England (0.4wte until August 18) and through changes in personnel.

The AMP team works to drive forward and deliver a high standard of antimicrobial stewardship.

3.1. Activities

The antimicrobial pharmacy team provide antimicrobial clinical and pharmaceutical advice across the organisation. A pilot of antimicrobial stewardship rounds in 17/18 on acute medical admissions that showed improved stewardship and a reduction in length of stay has been extended and continues to provide significant opportunities for stewardship interventions.

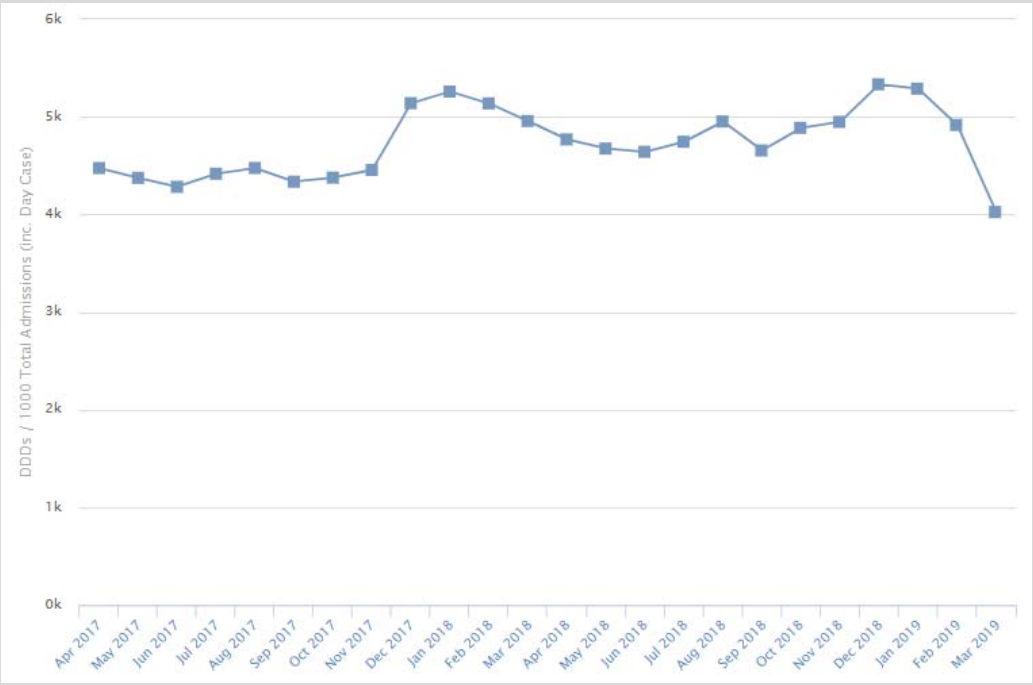
The team continues to populate the antimicrobial prescribing app with UHL guidelines with the intention of retiring the antimicrobial website in 2019 as the software this was built on is no longer supported by Microsoft.

The AMP team coordinates and contributes to the Trust activities to ensure the optimal delivery of Antimicrobial Stewardship for our patients by interpreting and implementing national guidance at a local level.

Monthly **monitoring of total inpatient antimicrobial consumption**, at Trust and CMG level, ensures trends in use are identified and addressed if necessary.

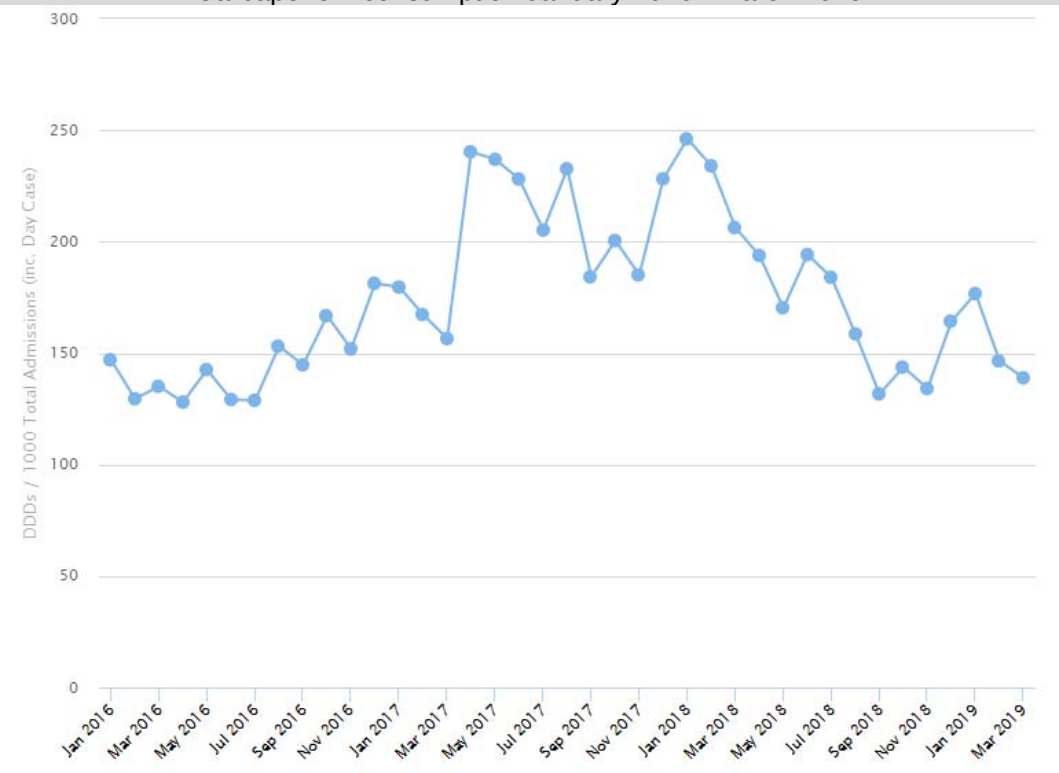
The total antibiotic use in 2018/2019 (measured in defined daily does (DDDs) per 1000 admissions) increased.

Total Antibiotic Consumption for 2017/2018 (DDDs/1000 admissions)



Consumption of carbapenems (mainly) meropenem increased during fell significantly during 2018-19. While the CQUIN was not met as expected, a reduction of 30% in use was achieved in comparison to 2017/18

Carbapenem consumption January 2016 - March 2019



Monitoring of outpatient consumption has been added to the antimicrobial stewardship programme which has identified a need for outpatient antimicrobial stewardship to be developed.

There has been continued development of the Alliance antimicrobial stewardship and audit programme; this is a novel projection nationally.

Education strategy work streams are in place to improve antimicrobial stewardship education for clinical staff and include promotion of World Antibiotic Awareness Week.

The team are involved in managing risks and incidents that relate to antimicrobial prescribing. In 18/19 the team identified a significant risk relating to the use of a new antibiotic product, ceftazidime and avibactam which is used infections caused by some carbapenem resistant organism, and have implemented measures trust-wide to mitigate this risk.

The team provides support to the Out-Patient Parenteral Antimicrobial Therapy (OPAT) service through clinical advice and prescription review and attendance at virtual ward rounds. In 2018/19 the team supported 246 episodes of OPAT.

4. THE ANTIMICROBIAL WORKING PARTY (AWP)

The AWP is chaired by David Jenkins, Lead Infection Prevention Doctor. The group is coordinated and organised by the AMP team.

The AWP oversees the Trust's delivery of Antimicrobial Stewardship for our patients by:

- Ensuring the provision of up to date evidenced local antimicrobial guidance, which are reviewed regularly, and are readily available on the hospital intranet, and printed summary cards.
- Receiving and reviewing assurance reports, of compliance with the Trust's antimicrobial prescribing policy, based on national guidance, which clearly states the responsibilities of the healthcare staff involved in the prescribing, administration and monitoring/reviewing of antimicrobials. It also includes a restricted policy, limiting the use of certain antimicrobials.
- Further development of antimicrobial stewardship within primary care

- Making recommendations to Therapeutic Advisory Service (TAS) for the formulary approval of antimicrobials.
- Making recommendations to Pharmacy Clinical Trials team on clinical trials involving antimicrobials.
- Reviewing and ratifying UHL and LLR wide Patient Group Directions (PGD's) authorising the administration of an antimicrobial.

Dementia Strategy 2018-20 – End of Year Report

Author: Heather Leatham, Assistant Chief Nurse
Sponsor: Carolyn Fox, Chief Nurse

QOC paper L

Executive Summary
The Dementia Strategy Action Group oversees the delivery of the Trust Dementia Strategy and reviews detailed reports on activity against the strategic objectives. This end of year report summarises a number of the key achievements and areas of note over the last 12 months but does not contain detail against each objective.

Questions
1. Does the Trust have a Dementia Strategy aligned to national and local expectations and best practise in dementia care?
2. How is the Trust progressing on the delivery of the key performance indicators related to the Dementia Strategy?

Conclusion
Work has progressed against all of the Strategic Priorities within the Trust Dementia Strategy and the outcome measures were achieved. The Trust Dementia Strategy 2018-20 provides a comprehensive platform to support staff to deliver high quality person centred dementia care and improve care and services for people living with dementia in Leicester's Hospitals.

This paper provides a high level summary of progress against the seven strategic priorities and identifies a number of areas that have proved highly successful in 2018-19, such as:

1. The completion of all the data sets for the fourth round of the National Audit of Dementia.

2. The Forget ME Not Scheme has been implemented across the adult in patient wards and the numbers of patients this is supporting continues to grow and highlight the additional care and support needs of people living with dementia and their families. This data provides an opportunity to explore further how people with dementia experience care and treatment in our hospitals.

3. Improving nutrition for patients with dementia was prioritised following the poor results in this domain in the third round of the National Audit of Dementia and working collaboratively with Facilities, Dietetics, Speech and Language Therapists and ward teams has enabled real improvements to be put in place to encourage nutritional intake for patients.

4. The Meaningful Activities Team provides an innovative service that supports patients with dementia across the Trust by engaging them in activities. In 2018-19, the service has expanded across the Emergency Floor providing seven day meaningful activity facilitation for patients with dementia, their family and carers. More details on the work of the service are included in this paper.

5. In partnership with Dementia UK work has progressed through the year to bring a new service to the Trust. This is the nationally recognised specialist 'Admiral Nursing' role. In acute Trusts Admiral Nurses are clinically facing specialists, supporting best practise relationship centred care and assessment, staff training and development, admission avoidance, early discharge and advanced care planning.

Input Sought
The Quality and Outcomes Committee is asked to:

- Receive and note this report
- Continue to support the implementation of the Dementia Strategy 2018-20

For Reference

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Not applicable
Consistently meeting national access standards	Not applicable
Integrated care in partnership with others	Yes
Enhanced delivery in research, innovation & ed'	Yes
A caring, professional, engaged workforce	Yes
Clinically sustainable services with excellent facilities	Yes
Financially sustainable NHS organisation	Yes
Enabled by excellent IM&T	Yes

2. This matter relates to the following **governance** initiatives:

Organisational Risk Register	Not applicable
Board Assurance Framework	Not applicable

3. Related **Patient and Public Involvement** actions taken, or to be taken: There is Patient Partner representation on the Dementia Strategy Action Group.

4. Results of any **Equality Impact Assessment**, relating to this matter: N/A

5. Scheduled date for the **next paper** on this topic: November 2019 (biannual)

6. Executive Summaries should not exceed **1 page**. My paper does comply

7. Papers should not exceed **7 pages.** My paper does not comply

University Hospitals of Leicester NHS Trust

Report to: Dementia Strategy Action Group / Patient Involvement and Patient Experience Assurance Committee / Quality and Outcomes Committee

By: Heather Leatham, Assistant Chief Nurse
Sarah Stoneley, Lead Consultant
Jenny Kay, Senior Nurse
Justine Allen, Older People and Dementia Sister

Date: QOC 25 July 2019

Subject: Dementia Strategy 2018-20 – End of Year Report

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1. INTRODUCTION

1.1 The Trust Dementia Strategy is based on national guidance, best practise and feedback from clinical staff, patients and families. The strategy is reviewed annually during quarter four to ensure it remains current and in line with national and local expectations for dementia services.

1.2 The Leicester, Leicestershire and Rutland (LLR) Dementia Strategy 2019-22 became operational in January 2019 and as part of the annual review the Trust strategic priorities were linked with the key elements of the LLR Strategy.

1.3 The Trust Dementia Strategy 2018-20 has seven strategic priorities supported by actions and outcome measures to ensure the ambitions of the strategy are delivered (see appendix 1). The strategy is aligned with all other relevant plans supporting older people's care and the Trust Quality Priorities.

1.4 The Dementia Strategy Action Group oversees the delivery of the Trust Dementia Strategy and reviews detailed reports on activity against the strategic objectives. This end of year report summarises a number of the key achievements and areas of note over the last 12 months but does not contain detail against each objective.

2. STRATEGIC PRIORITY 1: GOVERNANCE

National Audit of Dementia

2.1 During quarter one and two 2018-19, the Trust participated in the fourth round of the Royal College of Psychiatrists National Audit of Dementia Care in General Hospitals. Patients with a diagnosis of dementia, who were an inpatient for over 72 hours and discharged in April 2018, were included in the audit.

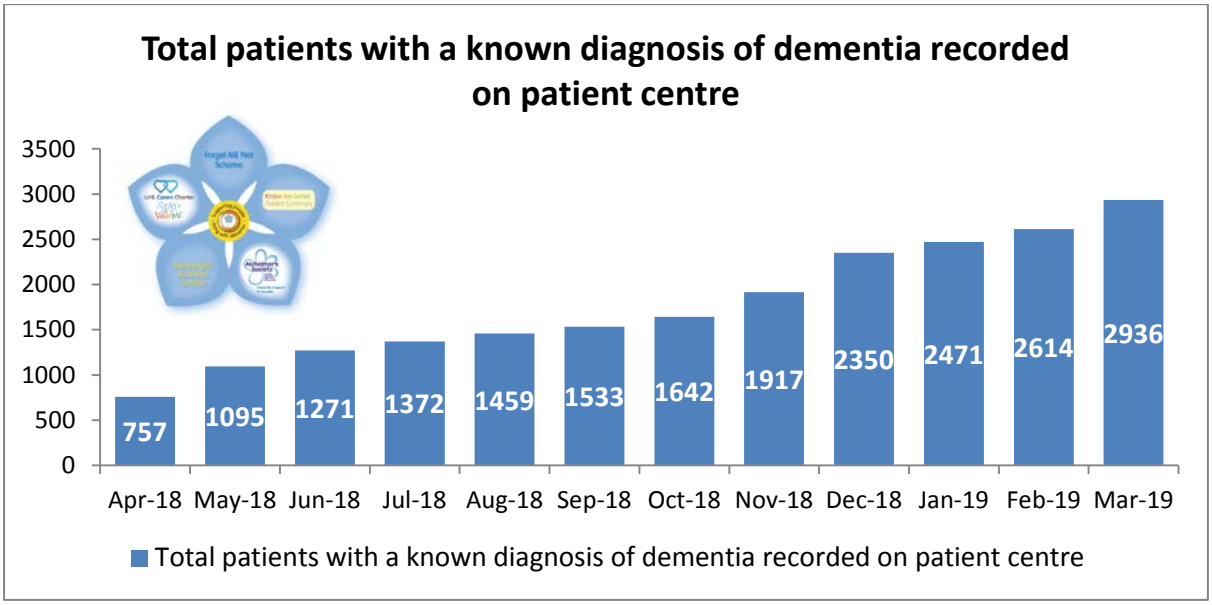
2.2 The audit included a large number of patients, with 263 identified as having dementia; therefore the full data set of 100 case notes was audited.

2.3 Due to the time required by the Royal College of Psychiatrists to analyse the national results it is anticipated that the formal results will not be published until August 2019. However the Trust has used local data collected during the audit to identify areas requiring improvement so interventions and improvements can be planned and implemented prior to national benchmarking (see appendix 2).

Forget ME Not Scheme

2.4 The implementation of the Forget ME Not Scheme across the Trust has been a huge achievement and assists in ensuring all staff respond to people living with dementia in a meaningful way. The roll out of the scheme across all adult inpatient wards was completed in June 2018.

2.5 At the end of 2018-19 there were 2936 patients with a known diagnosis of dementia enrolled in the Forget ME Not Scheme. Feedback from patients, families and staff remains positive. An abstract detailing the Forget Me Not Scheme was submitted and accepted for the Alzheimer's Society Annual Conference in March 2019.



Patient Safety

2.6 It is widely recognised that patients with dementia are vulnerable to 'harms' whilst in hospital. To have a clear understanding of how these impact patients with dementia; this was monitored for two hospital harms: Falls and Hospitals Acquired Pressure Ulcers (HAPU).

2.7 Patients with a diagnosis of dementia were identified using information from discharge letters. This information was cross referenced against validated incidents reported through Datix to determine the number of patients with dementia who had an inpatient fall or developed a HAPU.

- 7.8% of patients over 65 with dementia had an inpatient fall compared to 2.5% of the over 65 without dementia
- 1.0% of patients over 65 with dementia developed a HAPU compared to 0.4% of the over 65 without dementia

2.8 These results recognise that this group of patients are at higher risk of sustaining harm in hospital. The development of enhanced falls reduction measures in 2019-20 and the 'Get up, Get Moving, Get home!' ethos that will be supported through Activity Champions are measures being introduced to help teams provide additional support to adult patients identified at risk of harm in hospital, especially those with cognitive impairment.

2.9 These initiatives will be supported by the Dementia Strategy Action Group and the Falls Management Steering Group; progress will be reported back through these groups.

3. STRATEGIC PRIORITY 2: COMPREHENSIVE ASSESSMENTS AND REVIEWS FOR PATIENTS

Meaningful Activity Service

3.1 The Meaningful Activities Service supports patients with dementia across the Trust by engaging them in activities. In 2018-19, the service has expanded across the Emergency Floor providing seven day meaningful activity facilitation for patients with dementia, their family and carers. More details on the work of the service are included in Meaningful Activity Service end of year report (appendix 3).

Dementia Nurse Specialists

3.2 This year Dementia UK approached the Trust with a proposal to work in partnership with them to establish an Admiral Nursing service. Leicester, Leicestershire and Rutland (LLR) were identified for funding support by Dementia UK to develop an Admiral Nursing service across LLR. At the start of 2018-19 there was one Admiral Nurse in post in Rutland, supported by the Rutland County Council.

3.3 In partnership with Dementia UK work has progressed through the year to bring nationally recognised specialists nurses into the Trust and establish Admiral Nursing roles. In acute trusts Admiral Nurses are clinically facing specialists, supporting best practise relationship centred care and assessment, staff training and development, admission avoidance, early discharge and advanced care planning.

3.4 Dementia UK offered funding support for an Admiral Nursing post in the Trust for three years. A Band 7 Admiral Nurse was recruited in January 2019 and will commence at the start of 2019-20.

3.5 The Admiral Nurse will support the delivery of six of the seven strategic priorities within the Dementia Strategy 2018-20, improve patient and carer experience and provide evidence for the National Audit of Dementia and would support the LLR Dementia Strategy 2019-22.

3.6 With funding support from Dementia UK, Rutland has recruited a second Admiral Nurse and LOROS have recruited an Admiral Nurse.

4. STRATEGIC PRIORITY 3: NUTRITION AND HYDRATION

4.1 Improving nutrition for patients with dementia was highlighted as a key area for improvement within the third round of the National Audit of Dementia in 2016 and progress has been made throughout 2018-19 to make improvements to support patients with nutrition and hydration.

Energy Dense Menu (Smaller Portion Size)

4.2 A range of five smaller energy dense meals were successfully piloted in quarter two and have since been incorporated into the main autumn/ winter standard menu. These meals particularly benefit older people and those living with dementia who can feel overwhelmed when presented with a larger standard portion and therefore do not eat. The energy dense meals whilst smaller have a high calorie count so patients continue to have full nutritional support. Since November 2018 when the smaller

energy dense meals were included on the main menu, 13,279 have been served Trust wide.

Finger Foods

4.3 In quarter three a finger foods pilot was completed on wards 23 and 36 at the Leicester Royal Infirmary. This was positively evaluated by both patients and staff who had highlighted the need for additional snack finger foods to be available for patients with dementia.

4.4 Following on from this, a new Forget Me Not snack finger food menu was launched on April 1st. This has been introduced onto the older peoples wards and ward 32 at the Leicester Royal Infirmary initially. Work will continue to promote the snack finger foods on all wards. An evaluation will take place in two months to assess uptake and satisfaction.

Fixing the Fundamentals in the Emergency Department

4.5 Fixing the Fundamentals enhances and improves older peoples care by listening to older people, visitors and staff.

4.6 Fixing the Fundamentals has been implemented on some adult inpatient wards at the LRI and GH. In July a Market Place was held at Glenfield Site to celebrate the achievements of the wards taking part and certificates were presented by the Lord Mayor of Leicester to each team. This work was shortlisted as a finalist at the Patient Experience Network National Awards 2019

4.7 During quarter three Fixing the Fundamentals was introduced into The Emergency Department in Majors; ensuring fundamentals of care begin at the front door for older patients and those with dementia. Common themes from observation and patient feedback are helping patients meet their nutrition and hydration needs, promoting continence and comfort and care.

5. STRATEGIC PRIORITY 5: FAMILY AND CARER FEEDBACK ON CARE AND EXPERIENCE

Carer Feedback

5.1 Gathering feedback from carers of patients with dementia in the Trust is a challenge as many are not present when the person is discharged home. As such the number of carers providing feedback for this group of patients is relatively small and this mirrors national trends for carer feedback. This was impacted further in 2018 as collecting carer feedback for the National Audit of Dementia (NAD) was prioritised in quarters one and two.

5.2 Responses from Family, Carers and Friends supporting people with dementia, are positive. Themes include ‘excellence in care and compassion’ from staff. Constructive comments focused on ‘poor communication’ from all staff groups.

5.3 Promoting carer feedback will be supported through the introduction of the Admiral Nurse role, the revised Family, Carers and Friends Charter and CMG leads for Dementia and will be a focus for 2019/20.

6. STRATEGIC PRIORITY 6: INFORMATION, COMMUNICATION AND TRAINING FOR STAFF

Celebrating Achievements to Improve Dementia Care

6.1 This year was a successful for year for the Dementia Champion Network, and 135 new champions have been trained to promote the needs of people living with dementia and act as advocates for patients, families and carers.

6.2 Champions provide an additional source of information and support throughout the Trust. They are actively involved in various events and it is their commitment which supports the successful delivery of the work of the Dementia Strategy Action Group at ward level, ensuring all people with dementia receive individualised person centred care. The Forget ME Not scheme and Stay With Me implementation are examples of how effective the Dementia Champions are across the Trust.

6.3 The Champion Network actively promoted events throughout Dementia Action Week in May, celebrating what the Trust is doing to support people living with dementia in the Trust and at a local shopping centre. This enabled the public to see first-hand all the excellent work the Trust is leading on.

6.4 The opening of the new Emergency Floor provided a bespoke dementia space and café area within the build and this was previewed to stakeholders during Dementia Action Week. This space has been a fundamental development to support patients and families at the point of admission to hospital, providing a quiet area to engage in activity, walk and socialise to help reduce distress. The Café area provides additional support for nutrition and hydration.

6.5 The annual Champions Celebration was held on 12th September and provided a unique opportunity for staff to engage and share inspiring ideas. The event was well attended and delegates had the opportunity to learn more, some of the highlights of the day included frailty, diabetes, therapy, volunteers and spiritual wellbeing. The event concluded by recognising the Champion of Champions for their outstanding achievements to support older people and people with dementia.

6.6 The Older Peoples Portal is a new initiative available on INSite, and has been developed to allow staff easy access to relevant information to help improve care for patients with dementia in one easy to use space. The portal includes simple to follow actions to implement successful elements of Fixing the Fundamentals.

7. STRATEGIC PRIORITY SEVEN: HOSPITAL TRANSFERS, DISCHARGE AND READMISSIONS

Outlying – Inappropriate Transfers

7.1 Outlying is when there is a non-clinical need for an adult patient to transfer to another clinical environment outside of their speciality or base ward.

7.2 An inappropriate outlier is a patient who should not have been moved, as detailed in the Outlying Adult Patients Policy. This includes:

- Patients with a known or suspected dementia / delirium
- Patients with a Clinical Frailty score 7-9
- Outlying of patients after 21:00

7.3 The policy also states that:

- A Datix should be completed when a patient is outlied inappropriately

- If the patient lacked capacity, their family should be informed / invited in to support the patient during the move.

7.4 Outlying was monitored for three months, during the winter period 2018-19. This snap shot identified 439 people as outliers over the three months. 125 of the patients were outlied outside the scope of the policy, of these:

- 53 had a diagnosis of dementia or suspected dementia
- 43 had a diagnosis of delirium or suspected delirium
- 65 patients had a frailty score between 7- 9
- 89 patients were moved between 21:00–06:00

7.5 Contrary to Trust policy there was also no documentation that family or carers had been contacted to offer support to patients with dementia who were outlied.

7.6 Outlying continues to be under reported across the Trust, and the resource required to complete the ongoing monitoring is not available within Patient Experience. This data has been fedback to the CMG's for actions. This audit will be completed annually in quarter three.

8. CONCLUSION

8.1 Work has progressed against all of the Strategic Priorities within the Trust Dementia Strategy and the outcome measures were achieved. The Trust Dementia Strategy 2018-20 provides a comprehensive platform to support staff to deliver high quality person centred dementia care and improve care and services for people living with dementia in Leicester's Hospitals.

8.2 The successful delivery of the strategy throughout the year has helped to improve care for people living with dementia and their families. The champions have been pivotal in driving the ongoing uptake of the Forget ME Not Scheme, ensuring that patients receive the support they need in hospital. The collection and submission of data for the National Audit of Dementia has allowed for common themes to be identified and early intervention to be in place prior to the publication of results in 2019.

8.3 The launch of the LLR Dementia Strategy 2019-22 supports the work across the whole health and social care community

8.4 The introduction of Dementia Nurse Specialists, the expansion of Meaningful Activity Service and the growth of the Dementia Champion Network will ensure best practice and the continued delivery of excellence person centred dementia care.

9. RECOMMENDATIONS

9.1 The Dementia Strategy Action Group / Patient Involvement and Patient Experience Assurance Committee / Quality and Outcomes Commitee are asked to:

- Receive and note this report
- Continue to support the implementation of the Dementia Strategy 2018-20

University Hospitals of Leicester NHS Trust
Dementia Strategy 2018-2020

1.0 INTRODUCTION

"We want to ensure that people with dementia and their carers receive high quality, compassionate care whether they are at home, in hospital or in a care home. We want the person with dementia and their family and carer, to be at the heart of everything we do. We also want their wellbeing and quality of life to be first and foremost in the minds of those commissioning and providing services for them"

(Prime Ministers Challenge on Dementia, 2016)

Dementia is a global challenge. It is one of the most important healthcare issues the world faces, as the population ages. It is as big a challenge as the fights against cancer, heart disease and HIV. Globally there is a new case of dementia every four seconds and by 2020 seventy million people worldwide will be living with the condition. More than a million of those people will be living in the United Kingdom (UK).

Dementia is a progressive and currently incurable long term condition. The impact of the disease is felt far and wide. People with dementia are more likely to be admitted to hospital than people of a similar age with the same medical condition. Often if it were not for the presence of dementia, they would not need admitting. People with dementia are particularly vulnerable to harm and poor outcomes during admission to hospital, particularly from hospital acquired infections, delirium, agitation and falls, all of which impact adversely on length of stay.

There are approximately 550,000 carers of people with dementia. It is estimated that one in three people will care for a person with dementia in their lifetime. It touches those who are affected personally, with symptoms including memory loss, loss of concentration and problems with reasoning and communicating. People living with dementia, their families and carers need to be involved and informed in care, treatment and discharge decisions

For people with dementia who are admitted to hospital and their families and carers, there is a clear need to achieve a balance between prioritising task-centred acute care treatment for the cause of an admission, and the acknowledged need to provide person-centred dementia care.

The Dementia Strategy 2018-2020 focusses on improving dementia care for people living with dementia, their families and carers and ensuring the staff caring for them are informed, trained and supported to deliver Caring at its Best.

This document has resulted from an extensive review of current best practice and engagement with clinical staff within this specialist field and also across the Trust.

2.0 FORMULATING THE STRATEGY

The Dementia Strategy 2018-20 is reviewed annually to ensure it reflects the needs of people living with dementia, the expectations of the Trust and national recommendations and best practice.

The 2018 review encompassed the results of the third round of the National Audit of Dementia in General Hospitals which were published in 2017. This highlighted areas not addressed within the existing Dementia Strategy, therefore a more comprehensive review was undertaken and the timeframe of the strategy extended to 2020 to meet the needs of people living with dementia.

Aligning the strategy to the themes of the National Audit of Dementia in General Hospitals enables tangible measurement and monitoring of the successful delivery of improvements in dementia care and services for people living with dementia. The audit's focus is to measure performance against criteria that is known to impact upon people with dementia whilst in hospital.

The 2019 review has integrated those elements relevant to acute health care within the newly published Leicester, Leicestershire and Rutland's (LLR) Living Well with Dementia Strategy 2019-2022. The LLR Strategy has been developed in partnership between local health, social care and voluntary sector organisations through the Dementia Programme Board. The LLR Strategy is guided by principles developed by NHS England in their transformation framework 'Well Pathway for Dementia'

- Preventing Well
- Diagnosing Well
- Supporting Well
- Living Well
- Dying Well

Within the UHL Dementia Strategy 2018-20, the Strategic Priorities clearly connect with the 'Supporting Well' and 'Living Well' and 'Dying Well' pathways of the LLR Strategy for Health and Social Care Providers.

Public and service user engagement will continue to be embedded into the annual review of the document to keep it current and in line with national and local expectations for dementia services.

3.0 LOCAL EXPECTATIONS

University Hospitals of Leicester has a record of innovation and improvement in care for people living with dementia. The achievements within the UHL Dementia Implementation Plan and the UHL Dementia Strategy 2016-2019 demonstrates the commitment of the Trust to improving care and services for people living with dementia and recognises the pivotal role families and carers have in supporting wellbeing and care.

The Dementia Strategy 2018-2020 builds on those previous achievements and sets the agenda as we move towards 2020 to meet the governments vision of 'a society where every person with dementia and their families will receive high quality compassionate care from diagnosis to end of life care'.

The Dementia Strategy 2018-2020 reflects the on-going commitment of the Trust to ensure excellence in dementia care and support.

4.0 CURRENT POSITION

Outstanding progress has been made in caring for inpatients with dementia since the launch of the UHL Dementia Strategy in 2016

- Updated Dementia Care Pathway and Think Delirium Support Tool
- New policy and documentation to support patients with and help staff manage Altered Behaviour
- 'Stay with Me' incorporated into the Trust Carers Charter to welcome families, carers and of people with dementia to support their person whilst in hospital
- Trust staff recognised by John's campaign for the implementation of 'Stay with Me' and invited to be an advocate for the campaign
- Music therapy for patients supported by Leicester Hospitals Charity
- Mandatory dementia category A training maintaining the national 90 per cent threshold
- Continued development of Meaningful Activity Service and presenting the work of the service at national conferences
- Increasing the number of Dementia Champions
- Recognising patients with dementia and implementing the Forget ME Not scheme across the Trust
- Revision of Know Me Better to improve uptake and support person centred care
- Revision of the dementia patient information leaflets
- Introduced a seven day meal planner to allow people with dementia to choose meals in their own time with their families support
- Participation in the National Audit of Dementia Care in General Hospitals 2016

The Dementia Strategy 2018-2020 will continue to focus on transforming the lives of people with dementia, their families and carers across the Trust.

The UHL Dementia Strategy 2018-2020 has used the national and local results from the National Audit of Dementia Care in General Hospitals 2016, Dementia Action Alliance, Dementia Friendly Hospital Charter (2014) and Alzheimer's Society Fix Dementia Care Hospital (January 2016) to inform future improvements and will evolve as new audit data and national reports and recommendations become available.

The implementation of the strategy will be led through the Dementia Strategy Action Group, and the Older People and Dementia Sisters within Patient Experience. Through multi-professional and Clinical Management Group representation there will be clear structure and expectations for each service and department area to action and achieve within the agreed timeframes of the Dementia Strategy 2018-2020 action plan.

The Dementia Strategy 2018-2020 will continue to direct initiatives within the Trust and facilitate community wide communication and engagement ensuring those patients, families, friends and carers' experiences are positively affected throughout their healthcare journey.

This strategy is congruent with all other relevant plans/strategies supporting older peoples care and the Trust Quality Commitment. The strategy will be reviewed annually ensuring it continues to meet the needs of people living with dementia and the Trust.

5.0 SEVEN KEY STRATEGIC PRIORITIES

The Dementia Strategy 2018-2020 aims to deliver across seven identified key strategic priorities. This strategy will address areas the National Audit of Dementia in General Hospitals 2016 highlighted as areas for improvement with particular emphasis on:

- Supporting the nutritional needs of patients with dementia
- Early recognition and management of delirium
- Involving patients, families and carers in care, treatment and discharge decisions

No.	Strategic Priority Titles
1	Governance
2	Comprehensive assessment and reviews to include dementia and delirium
3	Nutrition
4	Information and communication for families and carers
5	Carer feedback on care and experience
6	Information, communication and training for staff
7	Hospital transfers, discharge and readmissions

An action plan with agreed outcome measures will be developed annually to deliver the work of the Dementia Strategy 2018-2020. Each of the strategic priorities will have an identified lead to ensure the agreed actions are achieved and reported to the Dementia Strategy Action Group and

Strategic Priority 1: Governance

Aims:

- To monitor the implementation and delivery of the Dementia Strategy 2018-2020 through the Dementia Strategy Action Group
- To keep the Trust informed of progression in the delivery of the Dementia Strategy 2018-2020 and associated outcome measures by reporting biannually to the Executive Quality Board
- Ensure patient and carer feedback and outcomes of complaints are reflected in future plans and improvements
- To monitor and report the number of patients with dementia in the Trust through the Forget ME Not scheme

Strategic Priority 2: Comprehensive Assessment and Reviews For Patients

LLR Strategy- Supporting Well

Aims:

- Ensure that patients with dementia receive a comprehensive assessment of their needs, care and treatment plan, including tests for cognition and delirium screening
- Use the Dementia Care Pathway and Think Delirium Support Tool
- Early identification and treatment planning for delirium
- Ensure assessments are multi-professional and meet the needs of the patient
- Ensure onward communication of assessments, treatment and screening are conveyed at discharge

Strategic Priority 3:
Nutrition and Hydration

Aims:

- Ensure the nutritional and hydration needs of people with dementia are met
- Menus will reflect the needs of people with dementia
- Ensure people with dementia can eat their meal without interruption
- Ensure provision of meals and drinks outside of set times
- For appropriate help and support to be available to assist people with dementia at meal times from staff, family members and carers

Strategic Priority 4:
Information and Communication for Families and Carers

LLR Strategy- Living Well
Supporting Well
Dying well

- For families and carers to be involved and informed and kept updated about care, treatment
- and discharge decisions
- Ensure Families and carers are given the appropriate support through the Trust Carers Charter and 'Stay with Me'
- Make personal information documents available for families and carers to share their knowledge of the person with dementia and support person centred care.
- Provide signposting to resources, services and support that are available inside and external to the Trust

Strategic Priority 5:
Family and Carer Feedback on Care and Experience

LLR Strategy- Living Well
Supporting Well

Aims:

- Provide family and carers opportunities to provide feedback
- Ensure patient, family and carer feedback is considered in developing care and service for people with dementia
- For families and carers to have a positive experience of care in the Trust

Strategic Priority 6:
Information, communication and Training for Staff

LLR Strategy- Supporting Well

Aims:

- All staff will be aware that a patient has dementia and respond to their needs
- Staff will be dementia aware
- Staff will be informed and involved in new developments and initiatives
- Staff will be trained and confident to recognise delirium and support patients, families and carers
- The Dementia Champions network will continue to grow

Strategic Priority 7:
Discharge and Transfers from Hospital

LLR Strategy- Living Well
Supporting Well
Dying well

Aims:

- To minimise inpatient hospital transfers for patients with known or suspected dementia/delirium unless pertaining to their care and treatment
- For patients with dementia to be discharged or transferred in the day time
- Patients, families and carers will be involved and informed in discharge planning and decisions
- For patients with dementia and delirium to have cognitive screening reassessed and recorded at discharge
- Symptoms of delirium and changes in behaviour experienced during admission will be recorded at discharge

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Our vision for the UHL Dementia Strategy is to consistently deliver excellent patient centred dementia care for patients, families and carers.

The Dementia Strategy 2018-2020 provides the opportunity to creatively explore how to develop care and services for people living with dementia and those caring for them in Leicester's Hospitals. The strategy provides the framework to support and work with staff, people living with dementia, their families and carers and organisations that support people with dementia to improve quality and define a best practice model for dementia and delivery of Caring at its Best.

University Hospitals of Leicester NHS Trust

Report to: Dementia Strategy Action Group / Nursing and Midwifery Board

By: Heather Leatham, Assistant Chief Nurse
Sarah Stoneley, Lead Consultant
Jenny Kay, Senior Nurse

Date: 3rd April 2019 / 14th May 2019

Subject: National Audit of Dementia Care in General Hospital – Areas Requiring Improvement Prior to Formal Report

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1. INTRODUCTION

1.1 During quarter one and two 2018-19, the Trust participated in the fourth round of the Royal College of Psychiatrists National Audit of Dementia Care in General Hospitals. Patients with a diagnosis of dementia, who were an inpatient for over 72 hours and discharged in April 2018 were included in the audit.

1.2 The audit focused only on patients, staff and carers at the Leicester Royal Infirmary as the Glenfield Hospital and Leicester General Hospital did not meet the inclusion criteria of over 50 patients with dementia discharged in April 2018.

1.3 The audit included a large number of patients, with 263 identified as having dementia; therefore the full data set of 100 case notes was audited. The improvements made following the last national audit in 2016 resulted in a 189% increase in the number of patients meeting the audit inclusion criteria. This was a direct result of the Forget Me Not scheme introduced in December 2017.

1.4 Due to the time required by the Royal College of Psychiatrists to analyse the national results it is anticipated that the formal results will not be published until August 2019. Therefore this paper uses local data collected to anticipate areas requiring improvement so interventions and improvements can be discussed and planned prior to national benchmarking.

2. NATIONAL AUDIT OF DEMENTIA STRUCTURE

2.1 The National Audit of Dementia was made up of four sections; an organisational checklist, a case note review of patients, a staff survey available electronically and in paper format, a carers/family postal survey.

2.2 The audit concluded on 21st September 2018; an organisational checklist, data from 100 case notes, 92 family and carers surveys and 132 staff surveys were submitted.

2.3 This was a highly successful audit process with excellent staff and family/carer involvement.

3. AREAS IDENTIFIED REQUIRING IMPROVEMENT

3.1 There were two main sections of the audit that appeared to require improvement; Assessment and Discharge.

Assessment

3.2 This area was broken down further into three subsections; multidisciplinary, cognitive and information about the patient. Areas for improvement were identified in two of the subsections.

Multidisciplinary

3.3 The nursing assessment booklet (SND003) was not completed therefore there was no evidence to provide a baseline for activities of living at admission for patients. On a more positive note the nursing core care plans, the risk assessments and the nursing evaluations were completed.

3.4 Continence and elimination baselines for patients were not recorded.

3.5 The multidisciplinary assessment booklets for admissions units were not consistently completed by all disciplines. This was even if an admission unit had been the only clinical area during the inpatient stay which would have been for at least 72 hours to meet the audit criteria.

3.6 There was deterioration from the previous audit in 2016, when assessment documentation was more widely completed.

Cognitive

3.7 Cognitive assessments for dementia and delirium are included in most of the admission proformas across the emergency floor. The cognitive assessments are not being completed therefore no cognitive baseline is recorded. The AMT4 and AMT10 are the assessments used for dementia and the Cognitive Assessment Method (CAM) or 4AT for delirium. There appears to be a lack of staff understanding that patients need, as a minimum, an assessment on admission as the baseline and then again on discharge for the patient's on going care. The audit team found that staff often had written 'dementia' across the assessment tools indicating that they did not appreciate that cognition fluctuates.

3.8 The national audit team notified the Trust in February 2019 that the Leicester Royal Infirmary has been identified as an outlier and is significantly below the national average for the assessment of delirium. The case notes have been reviewed to clarify this data and following submission of this new information the Trust has been informed that we are no longer an outlier in this area. However this notification indicates that our data must be at the lower end of the national benchmark even if we are no longer an outlier.

3.9 The altered behaviour booklet that support patients with changes in behaviour due to cognitive impairment were very poorly completed with only the behaviour chart being used. The care plans and other assessments in the booklets to support mental capacity, 1:1 care, changes in behaviour and cognitive impairment are not completed; as such altered behaviour is not being assessed holistically for patients. This is particularly of note due to the large number of 1:1 Healthcare Assistants that are risk assessed as being needed for individual patients who then have limited further documented assessments and care.

3.10 Again this showed a deteriorating picture from the previous audit in 2016, when staff documented cognitive assessment and changes in behaviour more widely.

Discharge

3.11 This area was broken down further into three subsections; assessments before discharge, discharge coordination/multidisciplinary team input and support for families and carers. Areas for improvements were identified in all three subsections

Assessments Before Discharge

3.12 This information was audited from the notes and the ICE discharge letters. As in the previous audit results in 2016 summarising the level of cognitive impairment, recording symptoms of delirium and summarising behavioural and psychiatric changes/symptoms is not being recorded on discharge to support ongoing care in the community.

Discharge Coordination and Multidisciplinary Team Input

3.13 The national audit team notified the Trust in February 2019 that the Leicester Royal Infirmary has been identified as an outlier and is significantly below the national average for this field.

3.14 During data collection this information was audited in the case notes. As an outlier this data was reviewed to include Nerve Centre and the board round discussions. The data was resubmitted to the audit team. We have since been notified that UHL remains an outlier for this area. This will need to be a focussed area for improvement.

3.15 If a patient has a diagnosis of dementia there needs to be clear documentation of discharge interventions and plans either in the case notes or Nerve Centre and this needs to illustrate multidisciplinary input.

Support for Families and Carers

3.16 Assessing family and carers' current needs prior to discharge is an area where improvement is required, as it was not evident in the case notes that carers' needs are being assessed. Documentation was very limited to illustrate that families had been involved in planning care and discharge.

4. CONCLUSION

4.1 Through the Dementia Strategy Action Group improvement initiatives for people living with dementia and their families in Leicester's Hospitals is ongoing.

4.2 From the previous audit in 2016, which highlighted nutrition and communication with families as improvements areas, progress has been made, with the introduction of the weekly meal planner, energy dense meals, information leaflets and finger foods.

4.3 Disappointingly we have deteriorated in a number of key areas:

- Nursing assessments
- Cognitive assessments
- Discharge Planning

4.4 The case note audit did not support that the areas identified were being completed; as such it was not possible to determine if these elements of care were being undertaken by medical, nursing and multidisciplinary team staff.

4.5 There is currently no confirmed date for the publication of the national and local results for the National Audit of Dementia 2018, they are expected in quarter two 2019-20. However this report provides a clear steer for Clinical Management Groups to focus improvement activities prior to the national publication of the audit results.

UNIVERSITY HOSPITALS OF LEICESTER

Progress Log: Interim National Audit of Dementia Action Plan

DATE COMMENCED: March 2019	DATE OF LATEST REVIEW:	DATE OF NEXT REVIEW: 01.05.19	MONITORING COMMITTEE: DSAG
EXECUTIVE LEAD: Heather Leatham Assistant Chief Nurse Clinical Lead: Dr Sarah Stoneley		OPERATIONAL LEAD: Jenny Kay Senior Nurse	

Ref.	Outcome	Action to be taken	Lead for Action	Action Completion Deadline	Progress RAG	Progress Update/Comments
This action Plan has been developed to support the early implementation of improvements identified through the case note audit. Progress on this action plan will be reported through The UHL Dementia Strategy Action Group.						
1.0	**Assessment**					
1.1	Patients with dementia and or cognitive impairment will have baseline cognitive and delirium assessments completed as part of their medical admission	Cognitive assessments to be completed on admission units	Clinical Lead	Dec 2019	**1**	Liaise with team redesigning admission documents
		Cognitive assessments to be documented in the medical notes	Clinical Lead	Dec 2019	**1**	
		The SQID to be included in all admission performas and outcome documented	Clinical Lead	Dec 2019	**1**	To discuss with Rachel Marsh
		Where Delirium is suspected a 4AT or CAM should be undertaken and results documented	Clinical Lead	Dec 2019	**1**	
1.2	Baseline assessments of continence and Elimination needs will be completed for all patients with dementia/cognitive impairment	Develop continence and elimination assessment with Nerve centre team	Continence Nurse Specialist	March 2019	**5**	Assessment now live on nerve centre
		Ensure all patients with dementia/cognitive impairment have their continence /elimination needs assessed	Ward Sisters Matron	Sept 2019	**1**	
		Refer any identified patients to the Continence Nurse Specialists via ICE	Ward Sisters / Matron	Sept 2019	**1**	

		Audit use of the continence assessments and feedback progress to clinical areas and DSAG	Continence Nurse Specialist	Sept 2019 March 2020	**1**	
1.3	Nursing admission assessments for ADL's will be completed for patients with dementia to ensure person centred care planning	Ward sisters to ensure that all nursing admission assessment on Nerve Centre is completed and care is planned based on the assessment of the patients individual needs	Ward Sisters Matron	June 2019	**1**	Nursing assessments now live on nerve centre
1.4	Patients with altered behaviour will have their care needs assessed and supported to maintain their safety	Raise awareness of the alter behaviour documentation and how the documents support care to maintain safety and supports patients	Older People and Dementia Nurses	April 2019	**1**	
		Bi annual audit of utilisation of the documentation and feedback to ward teams when not fully utilised to support the needs of the Patients	Older People and Dementia Nurses	May 2019 November 2019	**1**	
2.0	**Discharge**					
2.1	Patients with dementia and or cognitive impairment will have a cognitive assessment completed on the day of discharge and documented within the ICE letter	Complete cognitive assessment within 36 hours of discharge to provide a discharge baseline to support transition back to community	Clinical Lead	Dec 2019	**1**	
		Record assessment noting any deterioration form admission baseline on ICE letter	Clinical Lead	Dec 2019	**1**	
		Ensure all adult ICE templates supports recording of admission and discharge cognitive baseline assessments	Clinical Lead	Dec 2019	**1**	
2.2	Symptoms of delirium including any changes in	Record assessment noting any deterioration form admission	Clinical Lead	Dec 2019	**1**	

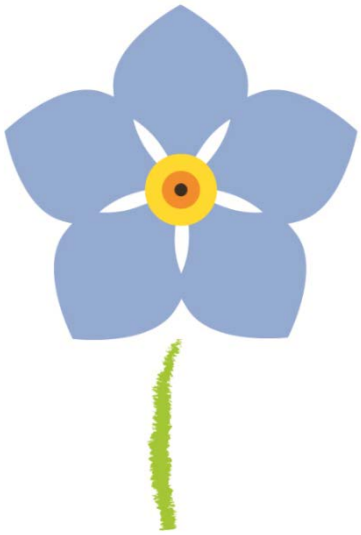
	behaviour will be documented within the ICE letter	baseline on ICE letter				
2.3	Nerve centre will be updated follow at board round to reflect discharge planning discussions	Designate at board round a member of staff to update the board round discharge discussions on Nerve centre to support communication, continuity of care and future audit	Nurse in Charge	April 2019	**1**	

University Hospitals of Leicester NHS Trust

Caring at its best

Meaningful Activities Service

Annual Report 2018-19



Background

The Meaningful Activities Service was established in 2013 and supports people with dementia in Leicester's Hospitals to maintain their skills, routine, and identity and promotes their general wellbeing.

Additionally the service supports the families, carers and friends, encouraging them to be involved in activities with their loved one whilst they are in hospital and signposting them to services in the community, such as the Alzheimer's Society.

Service Summary

The Meaningful Activities Service has seen significant positive changes in 2018-19.

Currently, cover is provided Monday-Friday on wards 23, 29, 30, 32 and 36 at Leicester Royal Infirmary and on a Monday-Tuesday for adult inpatient areas at Glenfield Hospital. There is an Outreach Service at the Leicester Royal Infirmary each Wednesday, Thursday and Friday. The Acute Admissions Units opened in June 2018, and the Emergency Medicine Clinical Management Group funded the recruitment of 5.2 WTE Meaningful Activities Facilitators to provide a seven day service across the Emergency Floor. This expansion of the service has supported more patients with dementia and their family, carers and friends due to greater flow of patients through these clinical areas in comparison with the base wards where the service continues to see patients during their hospital stay.

Between June-and September 2018 the service gradually increased Meaningful Activity Facilitation in the Emergency Floor; a seven day service was fully established in October 2018 with up to three facilitators working in this area every day.

This change in service delivery has enabled the transformation of the Outreach Service. Previously there was a reliance on ward staff to make referrals due to

availability of Meaningful Activities Facilitators. Now, the Outreach facilitator follows up patients who were initially seen by the service on the Emergency Floor. This improvement has supported continuity of care, enhancing overall the quality of the care provided in these areas.

Leicester Hospitals Charity provided funding support for ten Reminiscence Interactive Therapy and Assessment (RITA) systems. The RITA systems are computer based, containing a wide variety of music, TV, films, games, and relaxation resources, which have helped to enhance the level of care we are able to provide. Funding also transformed the former fracture clinic corridor and adjoining room into 'Memory Lane and the Happy Times Café'.

Memory Lane and the Happy Times Café are bespoke specialist spaces for patient with dementia, and are for the exclusive use of the Emergency Floor. The decoration, from the wall art to the blue sky lighting, is designed to help improve a patient's wellbeing, by being calm and relaxing spaces within the busy hospital environment. The spaces opened in quarter three.

Facts and Figures for 2018-19

Summary
Overall, 3,717 patients were seen by the service in 2018-19

- The number of patients seen increased by **70%** compared to 2017-18
- Type of activities included arts, crafts, games, puzzles, reminiscence, sensory across **9,851** contacts with patients
- Contacts with patients include providing support with nutrition and hydration / therapeutic / personal

- Wards with a dedicated facilitator Monday-Friday are 23, 29, 30, 32, 36 Leicester Royal Infirmary
- **1760** were referred directly to the ward facilitator.
- **298** patients were seen after having been initially referred in the ED/Acute Admissions Unit.

Family, carers & friends took part in activities on 2183 occasions

- Family, friends and carers are invited to take part in ward based events, where appropriate. Examples included tea parties, such as in the Happy Times Café in the Acute Admissions Unit, and celebrating the NHS' 70th Birthday on Ward

- Of the **464** patients seen in the Emergency Department, **231 (50%)** were discharged home.
- **233** were followed up by the service during their stay: **60** in the Emergency Department; **158** on the Acute Admissions Unit; **16** on base wards; **16** on Outreach wards; and **1** at Glenfield.
- Number of patients seen in this area per quarter: Q1 - **74**; Q2 - **532**; Q3 – **859**; Q4 – **709**

- The RITA systems were enjoyed by patients on **644** occasions
- The Memory Lane and Happy Times Café areas were used on **381** occasions
- Family, carers or friends present with patients in Memory Lane and the Happy Times Café on **71** occasions

1198 of patients were seen before 12.00 in the Emergency Floor

Outreach Service
378 of patients were supported through the Outreach Service

- Majority of patients were seen at the Leicester Royal Infirmary, with **two** seen at Leicester General Hospital
- **231 (61%)** patients were followed up by the service after being initially support in the ED or Acute Admissions Unit
- This represents an increase of **256%** compared to 2017-18

Glenfield Service
291 patients were supported through the Bleep Service at GH

- The allocated facilitator is able to be visible on the wards, encouraging staff to continue referring appropriate patients
- The number of patients supported increased by **4%** compared to 2017-18
- The Glenfield Service operates two days per week

Family, Carers and Friends Feedback

100% Positive Feedback about the service

116 Family, Carers, Friends and Patients were surveyed and all would recommend the service.

Comments about the service include:

- "What a wonderful service"
- "So kind and helped with feeding, comforting and communication."
- "I saw dad how he used to be"
- "I thought the cafe was very personal and relaxing … I was able to visit my dad in a lovely environment. Not like hospital …took time to get to know … patients in the cafe and I was incredibly impressed with the atmosphere and

Staff Feedback

Comments from staff about the service:

- “Patients with delirium and dementia respond well to meaningful activities”
- “Able to give patients extra time, help communicate and relax”
- “…very supportive in helping staff with tasks”

The service have continued to work closely with Chaplaincy, hosting ‘Songs of Praise’ sessions for patients on Ward 29, and supporting patients in the Emergency Floor to attend the chapel on Sundays and Christmas Day

100% of staff felt the service improves the experience of patients with dementia

Staffing

In quarter one, the service was fully established, with 5.6 WTE Meaningful Activities Facilitators in post. By December 2018 a further 6.2 WTE Meaningful Activities Facilitators were recruited, inducted, and trained. Emergency Medicine funded 5.2WTE of these posts to provide their new seven day service. Currently 10.8 WTE Meaningful Activities Facilitators are in post, and vacant posts are being recruited into.

The Service is currently supported by seven Forget Me Not volunteers for 28 hours per week.

Fundraising

The service continued to raise money for the Forget Me Not fund within Leicester Hospitals Charity to provide resources for activities.

Fundraising events this year have included selling cakes, Winter arts, crafts and gifts, and a raffle during Dementia Action Week. The service supported Patient Experience in their Summer Raffle, including its launch at the Trust Summer Fun Day.

A big thank you to everyone who supported the raffle, the companies that donated prizes, and the staff who bought and sold tickets.

Overall, the service helped to raise over £3,000 to support activities and staff training.

Dementia Action Week

In May 2018, Dementia Action Week was the focus, and the service used the opportunity to promote the Hobbies and Interests section of 'Know Me Better' Patient Summary, with one patient reconstructing the tower from the former Wolsey building.

The launch of Memory Lane and the Happy Times Café was a great success, giving staff and external agencies the opportunity to preview the space.

The service was featured in the Trust's 'Together Magazine' in December 2018, which has coincided with a rebranding of the service in all clinical areas.

A dayroom tea party was held 70 days ahead of the NHS' 70th birthday with the help of Leicester Hospitals Charity. This was well attended by patients, relative, and staff.

The profile of the service has been raised externally to the Trust, and has been visited by other Trusts interested in implementing a similar service.

And finally…

The Meaningful Activities Team Leader promoted the service, the Trust, and the Alzheimer's Society at the UK Dementia Congress. A poster entitled "Multi-Agency InterProfessional Learning for Student in the Acute Setting" and was a joint collaboration with the Alzheimer's Society.

QUALITY AND OUTCOMES COMMITTEE 25 JULY 2019

Safeguarding and Learning Disability Annual Reports

Author: Michael Clayton Head of Safeguarding Sponsor: Carolyn Fox Chief Nurse

Executive Summary

QOC paper M

Context

The Trust produces an annual Safeguarding and Learning Disability report which outlines the activities undertaken in the past year to support and protect vulnerable people cared for in the organisation.

The reports highlight the increased focus on supporting vulnerable people including service activity, new initiatives and future priorities

Questions

1. What improvements have been made in provision of services to protect patients
2. What is the demand for services to protect people from harm
3. What are our plans for the year ahead

Conclusion

1. The two reports outline the changes made to the governance arrangements for the Safeguarding and Learning Disability Services, and how these link to the Trusts Dementia and Mental Health plans. During 2018 some key developments were made which are described in the report, these have strengthened oversight of the care of vulnerable people as well as improving the patient experience.
2. The reports highlight the increasing number of patients that are being referred to the Trusts Safeguarding and Learning Disability Services. There have been significant increases in the number of Child and Adult Safeguarding referrals which is placing greater demand on the Trust Specialist Teams
3. The reports outline the service priorities for the year ahead. Notably staff training and meeting new mandatory requirements

Input Sought

We would welcome the board's input regarding:-
Approving the two annual reports
To note the contents of the reports and acknowledge the work undertaken in the past yea
To support the proposed service priorities for the year ahead

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes / No / Not applicable]
Effective, integrated emergency care	[Yes / No / Not applicable]
Consistently meeting national access standards	[Yes / No / Not applicable]
Integrated care in partnership with others	[Yes / No / Not applicable]
Enhanced delivery in research, innovation & ed'	[Yes / No / Not applicable]
A caring, professional, engaged workforce	[Yes / No / Not applicable]
Clinically sustainable services with excellent facilities	[Yes / No / Not applicable]
Financially sustainable NHS organisation	[Yes / No / Not applicable]
Enabled by excellent IM&T	[Yes / No / Not applicable]

2. This matter relates to the following **governance** initiatives:

Organisational Risk Register	[Yes / No / Not applicable]
Board Assurance Framework	[Yes / No / Not applicable]

3. Related **Patient and Public Involvement** actions taken, or to be taken: [Insert here]

4. Results of any **Equality Impact Assessment**, relating to this matter: [Insert here]

5. Scheduled date for the **next paper** on this topic: [XX/XX/XX] or [TBC]

6. Executive Summaries should not exceed **1 page**. [My paper does / does not comply]

7. Papers should not exceed **7 pages.** [My paper does / does not comply]

University Hospitals of Leicester NHS

NHS Trust

Caring at its best

ANNUAL REPORT

SAFEGUARDING CHILDREN AND ADULTS

January 2018 – December 2018

Neglect / Self Neglect	County Lines	PREVENT
Child Sexual Exploitation	Female Genital Mutilation	Mental Capacity Act
Sexual Abuse	Mental Health	Deprivation of Liberty Safeguards
Physical Abuse	Domestic Abuse	Modern Slavery
Safeguarding Reviews	Organisational Abuse	Learning Disability
C-PIS	Emotional Abuse	FGM-IS

SAFEGUARDING CHILDREN AND ADULTS ANNUAL REPORT

January 2018- December 2018

Contents **Page**

1 INTRODUCTION

Welcome to the 2018 UHL Annual Safeguarding Report. This report seeks to inform the Board and wider stakeholders of the work undertaken to protect people from harm and abuse who access services provided by the Trust. In particular this report will share with the reader some of our key work and successes in protecting people from harm and abuse.

1.1 Safeguarding People in the Reformed NHS:

The Accountability and Assurance Framework (NHS England 2015) sets out the safeguarding roles, duties and responsibilities for all NHS organisations and this report describes the role of UHL within this.

As part of these requirements, NHS Trust Boards must produce an annual report which provides assurance about the systems in place to protect individuals, treat them with dignity and respect and safeguard them from abuse.

The Trust is committed to these principles and recognises that many people who access or work within our services will have experienced, or be at risk of experiencing, abuse, neglect or harm. We are particularly proud of the work we have undertaken in the past year to introduce new systems to protect people from abuse.

The report describes recent service improvements within the Trust which aim to strengthen our safeguarding processes and ensure that safeguarding remains integral to the Trust's core business.

1.2 What People Are Telling Us:

One of the most important aspects of safeguarding practice is to listen to the views of people, and their representatives, where work has been undertaken in order to safeguard them.

During a recent safeguarding enquiry we received positive feedback from a deceased patient's family who felt that the safeguarding nurses had really listened to them. They reported that until then, no-one else had taken the time to understand the issues that were most important to them and their relative. They were particularly pleased that we had taken into account their views of the concerns raised, and that we had specifically directed our enquiries to address those concerns. They also appreciated having opportunities during the enquiry, to receive updates and information about the findings. They were so reassured by the outcomes of the safeguarding enquiry that they asked HM Coroner if the inquest could be avoided.

A key focus of all safeguarding work is to listen to the views of the people affected by abuse. It is now part of the core business of the Trust's Safeguarding Assurance Committee to take into account the views of people, through a professional debate. This involves discussing a scenario / dilemma which is based on a real safeguarding incident or situation, and provides committee members with an opportunity for learning and reflection. The introduction of the professional debate has been well

received. Patient stories have also been used to ensure the voice of service users is heard, and to promote ethical and moral debate.

2 KEY ACHIEVEMENTS

2.1 During 2018

- By June 2018 we had trained around 7000 staff in Level 3 PREVENT training and by the end of 2018 this figure had increased to 8900 staff, giving a compliance rate above 99%. This means the Trust is one of the best performing Trusts in the country for PREVENT training
- We developed an integrated approach (through Nerve Centre – IT application) to ensure staff in our Emergency Department can view national records containing vital child safeguarding information. The Trust is one of the first in the country to achieve this
- We implemented the Child Protection information sharing system in Maternity services via the summary care record.
- We developed a system to record all detentions under the mental health act and developed a service level agreement with Leicestershire Partnership Trust to ensure that the legal requirements associated with mental health act detentions were met.
- We reviewed the governance arrangements for safeguarding, and we now have more robust structures in place. We have revised the Committee's terms of reference to reflect this, and we have a work plan in place which includes a schedule of safeguarding audits.
- We have refined our internal systems for recording and monitoring child safeguarding training, particularly Level 3. Following the launch of the intercollegiate guidance for safeguarding adult training (August 2018) we have a plan in place to implement the required new levels of training for health are staff. We have also used this an as opportunity to revise the Trust's safeguarding induction session, in line with both intercollegiate documents (adult and child) and a new, integrated session will be launched in 2019.
- A review of the processes and procedures for the management of Deprivation of Liberty Safeguards authorisations/applications was completed in autumn 2018, in association with internal and external lawyers. This was completed to reflect the work undertaken by the Trust following the last Care Quality Commission's Well Led inspection of services. The Trust now has revised policy and procedures in place to address the actions required following the CQC visit.
- We extended the membership and remit of the Trust's safeguarding activity to include oversight of Learning Disability, Dementia and Mental Health provision for patients.
- We updated our safeguarding webpages, to include information for members of the public on how to raise safeguarding concerns, and access information on safeguarding. This has resulted in direct contact by members of the public with the Trust's safeguarding team which has enabled the team to promptly direct people to sources of support in their community.

3 SAFEGUARDING PERFORMANCE INDICATORS

As part of the multi-agency partnership, we have been assisting in developing a comprehensive tool for collating and scrutinising meaningful safeguarding data in order to create indicators of safeguarding practice. Much work has taken place to ensure that the data collected provides a true reflection of safeguarding work and quality of the service we provide, which in turn will be used to monitor safeguarding performance.

The following data shows key safeguarding activity:

Number of DoLS applications

The data shows a slight increase in the number of applications that the Trust has made to the supervisory body. Applications are made to the supervisory body where restrictions are place on an individual in hospital who lacks capacity.

Year	No of applications
2015	548
2016	635
2017	753
2018	777

Number of Safeguarding Adult Referrals to the UHL Safeguarding Team

There has been a significant increase in the number of referrals to the Adult Safeguarding team, which reflects both an increasing awareness of safeguarding. It also highlights the increasing complexity of some hospital admissions and the requirement to work with other agencies prior to discharge.

Year	No of Enquiries
2015	1274
2016	1359
2017	1618
2018	2308

Number of Safeguarding Children Enquiries to the UHL Safeguarding Team
As above, the service has seen a significant increase in the number of safeguarding enquiries. Following the integration of the Children's Admission Unit into the Children's Emergency Department there has been a significant increase in the number of safeguarding enquiries.

Year	No of Enquiries
2015	11,686
2016	11,924
2017	9,302
2018	13,375

Number of Safeguarding Maternity Enquiries to the UHL Safeguarding Team

Again the number of safeguarding enquiries have increased.

Year	No of Enquiries
2015	863
2016	1019
2017	1150
2018	1323

Number of Serious Case Reviews for Adults/Children/Domestic Homicide Reviews

Year	No of Enquiries
2015	13
2016	16
2017	15
2018	13

It should be noted that the numbers of referrals are, by themselves, only part of the story. Thresholds and reasons for referrals vary considerably across the three service areas, in line with local policies. The complexity of cases is also variable and sometimes this makes it difficult to define the full activity for the services.

3.1 Training Compliance Data

Throughout the year a significant amount of work has been undertaken to review and improve the systems for the provision of safeguarding training across the Trust. This

included the recording of Levels of Safeguarding Childrens training to reflect national guidance. Reviewing the content and updating of e learning training for safeguarding and associated subject matters.

In August 2018 the first national guidance for Adult Safeguarding was published and following this work began to scope existing training provision again the new guidance. Following on from this through the Trusts Safeguarding Assurance Committee work was completed to map existing safeguarding training against the new training requirements and to consider the impact of this on Child Safeguarding training.

Throughout the year the performance has been monitored and demonstrating improvement, further work will continue into the new year to ensure that compliance adheres to the Trusts own training target of 95%.

4 GOVERNANCE ARRANGEMENTS

The Trust has a monthly Safeguarding Assurance Committee (SAC) which is chaired by the Chief Nurse and is attended by UHL Safeguarding Leads, representatives from CMG's, a Patient Partner, a Deputy Medical Director and a Designated Safeguarding Nurse representing the local CCG's. A monthly safeguarding report is provided for this Committee from the Head of Safeguarding and a quarterly update report from this Committee is provided to the Trust's Quality Assurance Committee.

In late 2018 a review was completed of the structure and function of the committee, this included expanding its remit to oversee the work for Learning Disability, Dementia and Mental Health. In addition a detailed audit schedule, safeguarding work plan and revised terms of reference were developed. The committee has representation from all Clinical Management Groups, Clinical Commissioning Group and a Patient Partner.

The Safeguarding Assurance Committee act as the forum where all safeguarding activity is reviewed considered and approved and includes ratification of policies and procedures and submissions to outside agencies.

The Care Quality Commission (CQC) reviews the effectiveness of safeguarding as part of their inspection process. Following the publication of the UHL CQC Well Led report work took place to review policy and procedures for the management of Deprivation of Liberty applications. In November the Trust was part of a CQC review of Safeguarding and Looked After Children Services in Leicestershire, and the report relating to the outcome of this was due to be published in February 2019.

The Leicester City Clinical Commissioning Group oversees UHL Safeguarding arrangements on behalf of the three local CCG's. The Trust is required to provide assurance as part of the quality review process. The CCG also undertake quality visits to Trust sites to review the effectiveness of safeguarding practice.

Safeguarding is a multi-agency process where agencies work together to have an oversight of local arrangements to protect people from harm and abuse. UHL is a member of four safeguarding boards:

- Leicester City Children's Safeguarding Board
- Leicester City Adults Safeguarding Board
- Leicestershire & Rutland Safeguarding Children's Board
- Leicestershire & Rutland Safeguarding Adults Board

The Trust is represented at these boards by the Director of Clinical Quality to support the work of the safeguarding boards. There are number of sub-groups where the Trust is represented by the Head of Safeguarding and the Named Safeguarding Professionals.

The Trust is required to provide assurance to all the safeguarding boards that it has robust systems in place for safeguarding adults and children. To support this, the Trust has completed three safeguarding assurance returns to the safeguarding boards. In addition the Children's Safeguarding Boards undertook a peer review process, and as a result the Trust was commended for the robustness of its safeguarding systems.

Within UHL the Chief Nurse is the Executive Lead for safeguarding and is supported by the Director of Clinical Quality, Head of Safeguarding and Named Safeguarding professionals. The Trust has dedicated safeguarding teams for children, adults and maternity who act as the point of contact for Trust staff and outside agencies to address safeguarding concerns and enquiries. The portfolio of the safeguarding teams also covers PREVENT, the Mental Capacity Act and Deprivation of Liberty Safeguards (Dolls), Liaison services and child death process. The Trusts learning disability team is managed by the Trust's Head of Safeguarding

5 QUALITY ASSURANCE

NHS England and the Care Quality Commission set out standards that all NHS Trusts are required to meet. As part of the Trust's internal assurance processes, oversight of these standards is through the Trust's Safeguarding Assurance Committee.

During 2018 a number of developments have taken place to enhance the quality and to provide assurance about safeguarding practice as outlined below:

5.1 NHS Improvement – Review of Actions Taken in Response to the Lampard Reviews (Savile Enquiry)

The Trust has confirmed that during 2018 it remains compliant with the recommendations made in the Lampard Review, and will audit aspects of these through an internal audit process in January 2019. There are no outstanding areas for action

5.2 Leicester City CCG Safeguarding Assurance Framework

In 2018 a revised Safeguarding Assurance Tool was developed by Leicester City CCG. The Self-Assessment and subsequent CCG review identified the following developmental areas:

- To improve training compliance for Safeguarding training
- To revise the Trust Female Genital Mutilation Policy (FGM)

In response to this the following work has taken place –

Revisions have been made to HELM to enable the recording of different levels of safeguarding training. Work has also taken place to revise the Adult Safeguarding training which will commence in April 2019.

The Named Midwife has also undertaken work to develop a Trust wide FGM policy with a completion date of March 2019 to include guidance on the implementation of FGM information sharing

5.3 Safeguarding Board Submissions

<u>Leicester City/Leicestershire & Rutland Safeguarding Board Self-Assessment</u>

- During 2018 the Trust has submitted an Adult Self-Assessment audit
- Participated in five multi-agency case file audits
- Participated in two multiagency audits of adult safeguarding practice. One relating to strategy meetings in safeguarding enquiries, and one relating to self-neglect in high risk cases (VARM process).

The purpose of these has been to inform the future work of the safeguarding Boards. The audits identified that the systems in UHL are consistent with best, local practice. The Trust was noted for their good practice in both adult safeguarding audits. In particular, the Trust was commended for developing SMART objectives following the audit of Vulnerable Adult Risk Management (VARM) cases.

5.4 NHS England PREVENT

The Trust met it's PREVENT training trajectory in May 2018, and has continued to improve training compliance to achieve 99% compliance against Level 3 PREVENT training in December 2018.

5.5 Care Quality Commission

There were two CQC inspections during 2018. The 2018 UHL Well Led inspection resulted in a 'Must Do' requirement to

'Review the Trust's Deprivation of Liberty Safeguards Policy'

"The trust must ensure formal processes are in place to handle administration systems relating to Mental Health Act administration functions"

These were completed in June 2018, by revising the Trusts Deprivation of Liberty Policy and developing a service level agreement with Leicestershire Partnership Trust for the administration of Mental Health Act detentions. In addition the number of Mental Health Act detentions across the Trust is reported monthly through the Safeguarding Assurance Committee. The CQC is satisfied that this requirement was met

In November 2018 the CQC undertook a review of Safeguarding Health Services provided to children living in Leicestershire. The finding of will be published in February 2019, and an interim action plan has been developed and discussed through the Trust Safeguarding Assurance Committee.

5.6 Mental Health Act

In 2018 there have been 5 reported Mental Health Act detentions. These have been quality assured by the Mental Health Act Office Leicestershire Partnership Trust, as part of a service level agreement.

There have been no appeals made to the Trust and all were deemed to be lawful and compliant with regulation.

6 POLICY DEVELOPMENT

As safeguarding practice develops and changes it is important that policies and procedures reflect the most current guidance. The Trust's safeguarding policies for child and adult safeguarding remain up to date. During 2018 the following policy was updated:

- Deprivation of Liberty Safeguards Policy
- The Emergency Department's Domestic Abuse Standard Operating Procedure
- Participated in the review of development of Safeguarding Board Policy and Procedures

7 LOCAL AND NATIONAL DRIVERS

Over the past year the focus of safeguarding practice has been the provision of services for people at risk. In addition following revised government proposals the structure of Local Safeguarding Boards was debated. Information below provides a summary of the current local and national safeguarding policy drivers.

7.1 Changes to Working Together to Safeguard Children 2018

Working Together to Safeguard Children 2018 was published in the summer. This outlines a number of significant changes to how Safeguarding Children's Boards will work in the future. The document outlines a requirement for Safeguarding Partners Police, Social Care and Health (CCG) to review their existing multiagency working arrangements and have new arrangements in place by September 2019

Work has begun with the partners to consider the work required to meet the September 2019 deadline.

7.2 Child Protection Information Sharing Project (C-PIS)

It is a National initiative to enable all health urgent care settings to check whether a child is subject to a child protection plan or is looked after. It also identifies women whose baby will be subject to a Child Protection Plan at birth. Within UHL work is progressing to integrate the system into the Trust's Emergency Department and Maternity Services by January 2019.

7.3 Learning Disability

In 2018 NHS Improvement published new guidance and standards for the care of learning disability patients using health services. The Trust has reviewed these and developed an action plan. Throughout 2019 there will be a greater focus on the needs of learning disability patients cared for by the Trust. A copy of the Trusts Annual Learning Disability report is added as an appendix to this report for reference.

7.4 Domestic Abuse

Across Leicester, Leicestershire and Rutland work is progressing to strengthen the existing services that are available to support people at risk of domestic abuse. In August 2017 the Trust appointed a hospital Independent Domestic Violence Advisor (IDVA). Their role is to provide support to victims of domestic abuse. The role has been developed as part of collaboration between Leicester Women's Aid and the Trust using charitable funds. To date 104 victims have benefitted from this service.

Locally it is recognised that the current services available to support victims of domestic abuse require greater capacity and focus. A strategic multi-agency executive group has now been established for domestic abuse and will develop a local multi-agency strategic plan for domestic abuse and sexual violence.

8 LISTENING TO THE VOICE OF VICTIMS OF ABUSE

The effectiveness of safeguarding is assessed by ensuring that the individual views of people are listened to. During 2018 a number of new approaches were introduced to strengthen the voice of people who have reason to access the safeguarding service.

Making Safeguarding Personal (MSP) is a framework used in adult safeguarding to ensure that the views and wishes of patients are always sought during safeguarding enquiries. This approach was extended in 2018 to be included in serious incident investigations, which involve adults with care and support needs. A previous multiagency audit of MSP practice was undertaken and the Trust was fully compliant with all aspects of MSP. MSP is incorporated into all Section 42 adult safeguarding enquiries and is included in the Trust's safeguarding reports.

Children's safeguarding prompts are included in all standard assessments to ensure that the child's views and understanding of the reason for admission to hospital is captured. Work is also underway to develop standards to ensure that there is oversight by Paediatric staff of all Children cared for in the Trust regardless of location.

10 SERIOUS INCIDENTS/CASE REVIEWS

It is a statutory duty for the Trust to co-operate and participate in multi-agency serious case and domestic homicide reviews. These take place following the death or serious harm to an individual as a result of abuse, neglect or domestic abuse.

Tragically there were four murders in 2018 as a result of domestic abuse which are now subject to domestic homicide reviews. Three adult safeguarding reviews and six child serious case reviews commenced in 2018. In September 2018, following a change in national guidance a new process was introduced for the review of serious child protection incidents, called rapid reviews. This requires organisations to produce an initial fact find report within 14 days of the incident, for submission to a national panel; in 2018 the Trust completed 10 of these.

In addition a number of multi-agency reviews have taken place; these are cases which do not meet the threshold for a statutory review, but where agencies consider there could be learning from the incident that should be shared.

The learning from each of these reviews is shared with the workforce through the Trust's Safeguarding Assurance Committee.

The Trust Board is provided with an update of the progress on case reviews and media plans are put in place prior to publication of any report.

10.1 Mental Capacity Act and Deprivation of Liberty Safeguards

The application of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) is an area of practice which continues to present us with challenges. There have been a number of developments which have evolved following case law over the past few years and this has changed practice locally. DoLS policy has been amended to reflect the changes and the Trust is implementing new MCA and DoLS training from 1 April 2019. . Additionally, the local authorities are unable to meet the statutory requirement to authorise DoLS applications within the required timeframes. The Trust's Safeguarding Adult Team maintain data relating to the Trust's DoLS applications and they support the clinical teams in identifying and managing patients detained under DoLS .

In addition, new MCA DoLS legislation (Liberty Protection Safeguards) is expected to be passed by Parliament in around May 2019, with an expected implementation date of April 2020. The LPS will represent significant changes in practice and further resources will be required to implement the new legislation in NHS Trusts.

11 KEY PRIORITIES FOR 2019

The Annual Report has outlined the work of safeguarding within University Hospitals of Leicester NHS Trust. In the next year work will continue to strengthen and protect the needs of individuals and to protect them from harm.

In the next year the following areas will be priority areas for the UHL Safeguarding Services:

11.1 Improving service provision for vulnerable people

Through the work undertaken in 2018, it is recognised that there is further opportunity to improve the experience of people with Learning Disability, Autism, and Dementia and Mental Health issues. This will be overseen by the Safeguarding Assurance Committee by monitoring progress against workplans for each of these areas.

11.2 Impact of Intercollegiate Training Guidance

The first intercollegiate training guidance for adult safeguarding was published in August 2018 and it is expected that the revised Children's guidance will be published in early 2019. Work has already taken place through a gap analysis to establish the new training requirements for safeguarding adults. Through the safeguarding committee this work will be monitored to consider the impact from a resource perspective.

11.3 Revision to the Mental Capacity Act

It is expected that during 2019 amendments will be made to the Mental Capacity Act, which will reform the current approach to Deprivation of Liberty Safeguards. The full

detail of these reforms is likely to lead to greater responsibility for hospitals to manage deprivations of liberty. As a consequence work will need to be undertaken to ensure compliance with any amendments to the law.

11.4 Implementation of revised statutory Safeguarding Children arrangements

By September 2019 there will be new arrangements in place to oversee the multiagency approach to safeguard children. Safeguarding Boards will be replaced by Safeguarding partnership arrangements between the Police , Social Care and Health Clinical Commissioning Group Leads. These reforms have to be in place by September 2019 and work during the early half of 2019 will focus on the plans to implement these new arrangements. This could lead to different approaches to partnership working for the Trust, and how it works within these new arrangements to safeguard children.

12 CONCLUSION

This report shares the Trust's key safeguarding achievements, developments and challenges over the past year. It highlights the significant amount of safeguarding activity that has taken place during 2018.

The Annual Report also provides an insight into the broad spectrum of safeguarding work undertaken within the Trust. In doing so the report provides assurance to the Trust's Board that we remain fully committed to meeting our statutory safeguarding duties and that we work hard to exceed these, in order to minimise the risk of abuse, neglect and harm to children, young people and adults.

Michael Clayton and the UHL Safeguarding Team
February 2019

University Hospitals of Leicester NHS Trust

QOC paper N

Care of patients with a Learning Disability at University Hospitals of Leicester

Annual Report 2018

January 2018 – December 2018

Contents

Executive Summary

The University Hospitals of Leicester NHS Trust (UHL) encompasses three hospital sites. The Leicester Royal Infirmary, The Leicester General and The Glenfield Hospital. Altogether there are approximately 1900 inpatient beds. UHL continues to strive to ensure that patients with a learning disability (LD) are afforded equality of access to appropriate levels of care and treatment as any other member of the population. The Trust is committed to making reasonable adjustments to enable those with additional needs to be supported holistically to achieve the best possible outcome and to have a good patient experience.

The Trust works in partnership with commissioners at Leicester City, East Leicestershire and Rutland and West Leicestershire Clinical Commissioning Groups (CCG's) including the commissioining of an LD liaison serivce within the hospitals. The LD acute liaison nurses (LDALN) maintain links with City, County and Rutland Councils through the Learning Disabilities Partnership Boards. The LDALN team work closely with colleagues from the Community Learning Disabilities Health Teams (LPT) as well as community providers of Learning Disability Services to actively promote good quality care for all patients with a learning disability.

1. Introduction

This annual report provides UHL and the Commissioning CCG's with information regarding the care and treatment of patients with LD using the hospitals in 2018, providing assurance that LD patients are supported by staff, who are empathetic to their specific needs, at every stage of their hospital journey whilst also identifying areas of concern and the actions and learning required to remedy any shortfall.

The UHL LD agenda is monitored by the newly established Learning Disability Steering Group which reports directly into the UHL safeguarding assurance committee, chaired by UHL's Chief Nurse.

2. Strategic Direction

The quality and effectiveness of health and social care afforded to people with learning disabilities has been recorded in various publications and reports. *Death by Indifference* (2007)*, Healthcare For All* (2008)*,Six Lives* (2009), *74 Deaths & Counting* (2012*) Improving Health & Lives* (2013) and CIPOLD (2013). More recently huge emphasis has been placed on the Transforming Care agenda (2012) and the Bradley Report (2014) following the treatment of people with LD at the

‘Winterbourne View’ care home. As a result of this people with LD with very complex needs are being brought back into Leicester and Leicestershire from acute mental health inpatient units to community settings, accessing local services including UHL.

The LeDeR programme (2017) has become a key component in measuring and evaluating the care provided to LD patients as it requires Trusts to review all learning disability patient deaths. Most recently (June 2018) LD Improvement Standards have been introduced by NHSi.
The work that UHL has done with regard to both LeDeR and the NHSi standards will be covered later in this report.

3. Governance Arrangements

3.1 UHL Learning Disability Steering Group

Formed in December 2018, this newly established steering group will oversee the learning disability work plan across UHL. Initially it will be chaired by the Trust Director of Quality & Assurance and will be held 4 times a year. The membership of this group includes lead practitioners from across the Clinical Management Groups (CMG’s) as well as representatives from LPT and patient carer/patient partners with experience in LD. In order to ensure strength in governance arrangements, the steering group will report directly into the UHL Safeguarding Assurance Committee which is chaired by the Chief Nurse. (Terms of Reference ; Appendix 1)

3.2 Hospital Learning Disability Acute Liaison Team

The LDALN team is commissioned by Leicester City CCG to provide skilled and experienced LD registered nurses to support UHL in meeting the complex health needs of patients with LD.
The team consists of a full time Band 7 Lead Specialist Nurse plus one full time and one part time (15hrs/week term time only) Band 6 Acute Liaison Nurses. The team work across all 3 hospital sites with the office base being in Glenfield Hospital.

The acute liaison team sits within Corporate Nursing under the management of the Trust Head of Safeguarding.

4. Learning Disability Awareness - Training for staff

The acute liaison team provide training to staff as part of regular programmes as well as responding to requests for bespoke training.

In 2018 the team provided face to face training to over 500 staff across the following groups:-

Care Cert Induction (HCA's) = 253 participants

Preceptorship Nurses (Newly qualified) = 141 participants

Maternity Services = 26 participants

IPL pre-reg. students = 21 Students

Nursing Associates = 107 Participants

13 staff attended additional sessions provided to two of the Trust Alliance sites (Hinckley and Loughborough)

All UHL staff, including Doctors are able to access an e-learning LD training package on HELM called 'Freddie's Story'

5. Learning Disability Patient Activity

The following information, provided by the hospital informatics team, is based on those patients who have been recorded as having a learning disability on a HISS specialist register key or in the case of ED attendances a Nerve Centre alert.

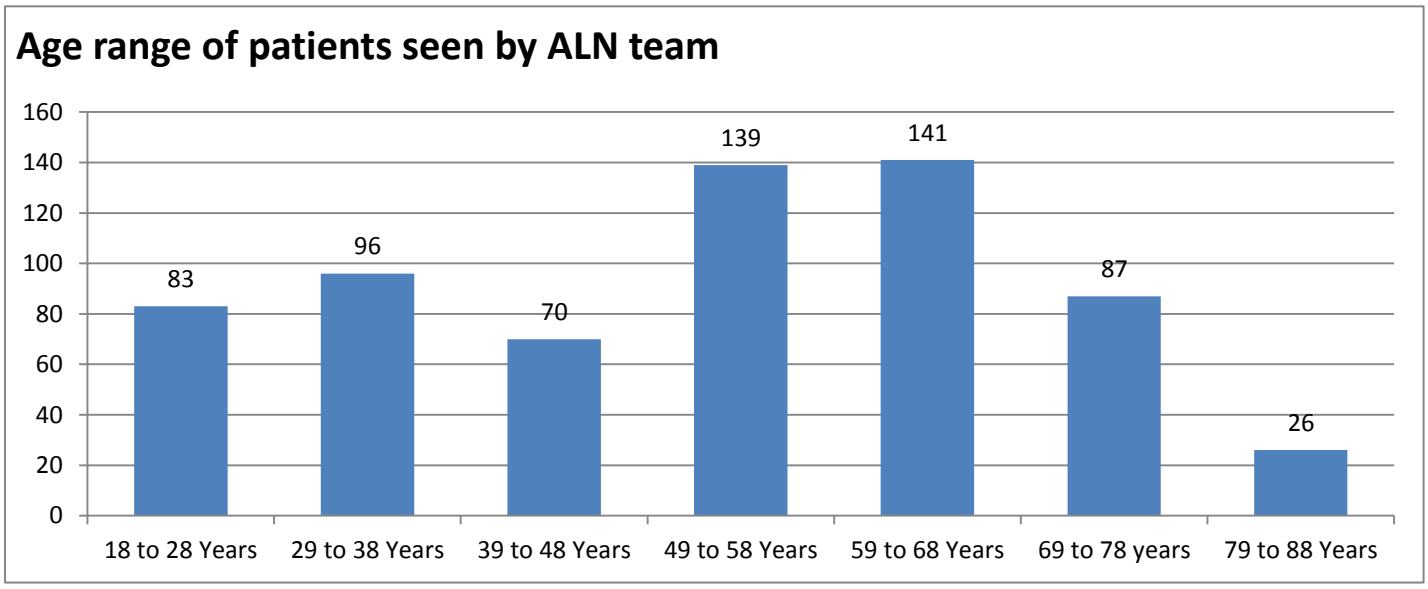
Further work will be undertaken in 2019/2020 to review the information contained within the two systems to ensure that systems and processes for identifying LD patients are robust.

Number of patients with a learning disability Alert who have received Acute Inpatient Secondary Care (Based on HISS Specialist register key)	857
Number of people with a learning disability Alert who attended ED (Based on an LD alert on Nerve Centre)	612
Number of outpatient appointments attended by patients with learning disabilities	762
Number of DNA outpatients appointments for patients with a learning disability	40

6. Learning Disability Acute Liaison Team Activity

The following information is gathered from the LD liaison team database, which holds an accurate record based on patients referred to the LD liaison team either from the daily generated IT email (based on the special register alert on Patient Centre) or by direct referral from the wards, community LD teams or LD patients and their families & carers.

	Leicester City	East Leics. & Rutland	West Leics.	Out of County	Total
Number of patients referred to LD team	378	186	139	18	**721**
Number of patients where team have contributed to care (either by visit / advice or care planning)	322	164	124	17	**627**
Number of patients referred who do not meet criteria for LD services (e.g. MH patients or those with Autism but no LD)	70	33	20	5	**128**
Number of missed patients (those who have been admitted & discharged over weekends/ BH etc. and therefore not seen by ALN Team.)	56	22	15	1	**94**



As shown on the chart, the largest numbers of patients seen by the Acute Liaison Nurse Team are between the ages of 49 and 68. It is well documented that people with learning disabilities are not living as long as those without an LD (CIPOLD 2013) and therefore our figures mirror the national findings regarding numbers of older people with a learning disability.

7. Reason for inpatient admission

The top 5 reasons for admission of LD patients to UHL , ascertained by cross referencing LD alert on HISS against the disease classification codes are as follows:-

1. Respiratory conditions including pneumonia and aspiration pneumonia
2. Gastro-intestinal disorders including reflux and constipation
3. Urological conditions including retention and urinary tract infections
4. Cardiology including congenital heart disorders
5. Epileptic seizures

These findings are in line with national data regarding disease prevalence within the LD population and further work is being done at a national level looking at the issue of constipation following the well-publicised death of a 33 year old man with a learning disability and further deaths from constipation identified in the LeDeR progress report published in 2018.

8. Review of LD Patient Deaths

8.1 UHL mortality reviews

Since late 2017 as part of the National 'Learning from Deaths' initiative, the LD liaison team have been supporting the UHL Mortality team to identify and review the deaths of patients with LD occurring in the hospitals. In September 2018 The Specialist LD Lead Nurse and the Trust Mortality Lead developed a new LD specific template to sit within the existing standard judgement review tool (SJR) requiring the Medical Examiner to answer specific questions related to the episode of care leading up to the death of a patient with LD. Thus identifying any missed opportunities or delays in decision making and treatment which could have had an impact on the way care was delivered.

Medical examiners assigned to complete the SJR for a patient who has been identified as having an LD are asked to liaise with the LD acute liaison team in order that the LD section of the template can ideally be completed together. Any issues identified are discussed at the relevant CMG mortality review group with follow up learning and actions raised with relevant Specialty M&M Leads. The resulting report and any learning is then presented to the the wider UHL Mortality Review Group and the Learning Disability Steering Group, thus providing assurance that actions and learning points are imbedded into practice.

In 2018 the LD team's database recorded the deaths of 17 patients with a learning disability who died in hospital

In over half of the deaths (n.10) the patient died due to pneumonia, this replicates national mortality studies which identify respiratory conditions as the principal cause of death in people with learning disabilities. A more detailed breakdown of causes of deaths is as follows:-

Cause of death	Number of patients
Pneumonia/Bronchopneumonia	6
Aspiration Pneumonia	4
Cardiac failure/arrest	2
Acute on Chronic Kidney injury	1
Multi Organ dysfunction Syndrome	1
Frailty of Old Age	1
Emphysematous gastritis	1
Sepsis	1

8.2 The LeDeR Programme

In 2015 in response to the recommendations in the Confidential Inquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD 2013) the Learning Disability Mortality Review (LeDeR) programme was introduced. The programme specifies an expectation that all deaths of people with a learning disability are subject to a full review.

LeDeR is a national programme, commissioned by NHS England which aims to improve the quality of health and social care for people with learning disabilities. It is doing this by supporting local areas to carry out reviews of the deaths of all people with learning disabilities. The process will draw attention both to good practice and to any potentially avoidable aspects of care that may have contributed to the person's death and to develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.

Across LLR reviewers have been identified and trained in order to carry out the holistic reviews which are then reported back via a local area contact to the review board at Bristol University. They in turn disseminate recommendations and learning back to the local contact for roll out to the

relevant service areas. A strategic Steering Group exists to oversee the work locally. Currently the LD Specialist Lead Nurse from UHL represents the Trust on this group.

Within the local LeDeR plan there is an expectation that the hospital will identify reviewers who will carry out an agreed number of LeDeR reviews over the year. Presently the LD Liaison Nurse team and two members of UHL Palliative Care Team are trained to carry out these reviews.

The reports produced using the new SJR LD templates will be available to reviewers from outside of the Trust who are reviewing the death of a patient who died in hospital. This will hopefully replace the need for a reviewer to spend a lot of time going through hospital notes to formulate the timeline required within the LeDeR review.

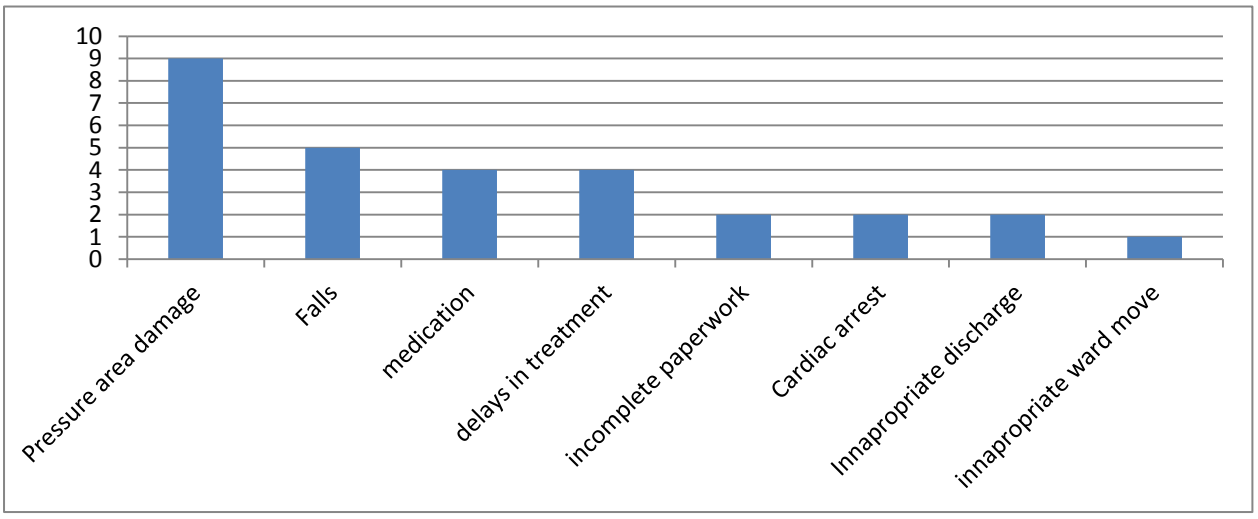
It is hoped that in 2019 at least 5 reviews will be carried out by UHL staff to support the countywide strategy.

Learning from LeDeR reviews will be fed back from the Countywide Steering Group to the UHL LD Steering Group, overseen by the Safeguarding Assurance Committee.

9. Incident reporting for patients with Learning Disability

From September 2018 the LD Specialist Lead Nurse has sight of any recorded incidents where the reporter has indicated that the patient has a learning disability.

The table below shows a breakdown of the nature of the incidents.



The table shows that the predominant reason for reporting incidents was in regard to tissue viability, a common theme within the LD population due to a higher level of contributory factors

such as lack of continence and immobility resulting in moisture legions and pressure area damage. 5 reports related to patient falls, 4 for issues regarding medication and 4 regarding to delays in treatment mainly as a result in the failure to follow protocol and guidance.
Incidents recorded through the Datix system are investigated and actioned at a local level in order to share learning within the immediate team. The themes of incidents are not dissimilar to those of the non LD population with pressure area care being the most frequently reported followed by falls and medication issues.
The incident reports are also discussed and recorded at the LD liaison team weekly meeting and a summary of incidents and learning is presented at the UHL LD Steering Group.

10. Complaints involving Learning Disability Patients

Information provided by the Trust Patient Safety team, and verified by the Lead Specialist Nurse to confirm the patients LD status, reported four complaints made to UHL in 2018. Two complaints related to clinical care whilst the other two related to waiting times. Further work is planned in 2019/2020 to review both the surgical the waiting list and outpatients waiting lists for patients with learning disability to identify and address any significant delays.

11. The Learning Disability Improvement Standards for NHS Trusts

In June 2018 NHSi produced new standards for NHS Trusts regarding the care they provide to people with a learning disability or autism or both.
The standards have been developed with a number of outcomes created by people with LD and families which clearly state what they expect from the NHS. By taking this approach to quality improvement, it places patient and carer experience as the primary objective, as well as recognising the importance of how the NHS listens, learns and responds in order to improve care.
There are four standards, which include:

- respecting and protecting rights
- inclusion and engagement
- workforce
- learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both)

In response to the publication of the new standards NHS Trusts were asked to carry out a benchmarking exercise.

A gap analysis was undertaken which identified positive findings in relation to the work carried out by the LD acute liaison team and also identified areas for improvement in the strategic planning and oversight in relation to the care of patients with learning disabilities.
An improvement plan was developed along with a more immediate action plan (appendix 2)
A Learning Disabilities Steering Group was developed and an inaugural meeting held in December 2018
A 2019/2020 work plan, reportable via the LD steering group, was developed to provide the governance and oversight of the improvement plan.

Also as part of the NHSi benchmarking exercise questionnaires were sent out to 80 patients who had recently used hospital services and a separate survey was sent to 20 members of staff. The responses were made electronically directly back to NHSi.

12. Achievements

In addition to the substantial piece of work completed in the last four months of 2018 in relation to mapping and planning the current and future provision of care for LD patients in line with the new NHSi standards there have been some notable achievements as outlined below :-

Mencap – Treat Me Well Campaign.
In June 2018, the LD acute liaison nurse team in conjunction with local LD self-advocacy group Mosaic took part in the national Mencap campaign –Treat Me Well. The campaign was launched during Learning Disabilities Week to raise awareness of the need to make reasonable adjustments and to encourage NHS staff to sign up to be LD Champions. During the week stalls were set up at all 3 hospitals and the response was tremendous with over 100 hospital staff agreeing to sign up to champion the rights of LD patients. Amongst other things the campaign is lobbying the Government to make awareness training in learning disability and autism mandatory for all health service staff.

Maxillofacial Learning Disability Pathway
A pathway has been developed to improve the journey of patients with a learning disability who are booked for surgical interventions by the maxillofacial department. In the past there had been difficulties due to the specific needs of the patient not being identified prior to their arrival at their pre-op assessment giving little time for consideration of issues regarding physical access and mental capacity and consent. To overcome this, staff within the maxillofacial outpatients department are asked to write on the ‘pink slip’ proforma if the patient has a learning disability or

another additional need at the point of referral to a waiting list. Staff operating the waiting list then adds a comment to ORMIS which will alert the pre-op team that the patient has additional needs and enable them to contact the patient prior to their arrival to discuss and plan for their individual needs and if necessary contact the LD acute liaison team for advice or support.
The system appears to be working well at present and it is hoped that a similar adjustment can be explored and rolled out across the Trust from other outpatient departments in the future.

Autism Support within Children's services.

Whilst the LD acute liaison team work only with adults over the age of 18, with a global learning disability (Valuing People 2001 definition), it has been agreed that work currently being carried out to improve services for children with autism should have oversight from the Learning Disability Steering Group in order to ensure that information regarding adjustments and resources are recorded and cascaded amongst the CMG's.

In 2018 UHL appointed a Project Lead for Autism who has supported the CMG to improve the experience of children and young people when they visit Leicester Children's Hospital
The following developments have been or are in the process of being implemented:-

- the 'All About Me' Patient Passport
- 21 Autism Champions trained to raise awareness of autism and make positive changes
- 57 staff have been trained in Basic Autism Awareness
- Engagement of multidisciplinary staff across the hospital with autism awareness and on- going improvements
- Developing resources to help communicate what happens when visiting the hospital in advance and during the visit
- Developing webpage on Leicester Hospitals site to share helpful information on the Leicester Children's Hospital and hospital procedures to help families prepare, information on autism for parents/carers and children/young people, and local groups
- Facilitating multidisciplinary meetings to identify improvements that can be made along the patient journey

13. Conclusion

The Annual Report seeks to provide assurance of UHL's commitment to facilitate equality of access and improve the experience for patients with a learning disability.

It recognises the need for staff across the Trust at all levels to understand their own responsibility for ensuring that the specific needs of this very vulnerable patient group are acknowledged and that reasonable adjustments are made to support patients whenever they access hospital services.

It acknowledges that there is still work to be done and recognises that there is a robust plan in place to enable this work to be implemented.

It recognises areas of good practice and achievements in the care of patients with a learning disability.

References

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Department of Health (2012) *Transforming care: A national response to Winterbourne View Hospital: Department of Health Review Final Report*

G. Durcan, A. Saunders, B. Gadsby & A. Hazard, (2014) *The Bradley Report years on: an independent review of progress to date and priorities for further development*

Heslop et al (2013). *Confidential Inquiry into premature deaths of people with learning disabilities* (CIPOLD). Learning Disability Observatory.

Michael (2008) *Healthcare for All: Report of the independent inquiry into access to healthcare for people with learning disabilities*

Mencap (2007). *Death by Indifference. Following up the* Treat me right! *report.*

Mencap (2012). *Death by Indifference: 74 deaths and counting. A progress report 5 years on.*

Parliamentary and Health Service Ombudsman and Local Government Ombudsman (2009). *Six Lives: The provision of public services to people with learning disabilities.*

University of Bristol (2015). *Learning Disabilities Mortality Review Programme (LeDeR).* http://www.bristol.ac.uk/sps/leder/

Appendix 1

UHL Learning Disabilities Steering Group

Terms of Reference

Membership	• Director of Clinical Quality (Chair)
	• Head of Safeguarding (Deputy Chair)
	• Learning Disability Lead Specialist Nurse
	• Learning Disability Liaison Nurses (UHL)
	• LD Patient/carer representation
	• Adult Safeguarding Nurse Specialist
	• Children Safeguarding Nurse Specialist
	• Safeguarding Midwife
	• Palliative Care Nurse Specialist
	• Representatives from:
	  ○ Acute Medicine/ED Specialist Medicine
	  ○ CHUGGS
	  ○ ITAPS
	  ○ Musculoskeletal and Specialist Surgery
	  ○ Clinical Support & Imaging
	  ○ Renal, Respiratory and Cardiovascular
	  ○ Women & Children's
	• Primary Care LD Liaison Nurses – LPT (City & County)
	• Representatives from Community Team for People with a Learning Disability – LPT (City & County)

Quorum	• 9 Members – 50% of membership • The forum may co-opt members dependent on work plan/national drivers/key emerging themes.
In Attendance	• Key divisional and corporate personnel as required.
Frequency of Meetings	• Quarterly
Accountability and Reporting	• Accountable to UHL Safeguarding Assurance Committee • Provide a summary report to Safeguarding Assurance Committee after each LD steering group meeting • Annual report will be provided to the Safeguarding Assurance Committee and through to the Executive Quality Board.
Date of Approval	• December 2018

1. Constitution

The LD Steering Group is accountable to the Trust Safeguarding Assurance Committee (SAC)

2. Purpose of the Steering Group

The Learning Disability Steering Group aims to;

- Provide assurance to the SAC and ultimately the UHL Trust Board that effective structures and systems are in place to embed the LD work into practice across the Trust. Ensuring that high quality and equitable care is delivered to people with LD accessing the acute Trust.
- To seek assurance from the Clinical Management Groups regarding arrangements for managing, safeguarding and improving safety of patient centred healthcare for patients with a learning disability in line with relevant legislation, related standards and guidance.
- To support the review, analysis and identification of learning from national reports/guidance relating to Learning Disability issues e.g. confidential inquiry into premature deaths of people with a Learning Disability (C.I.P.O.L.D) and Learning Disability Death Review (LeDeR)
- To highlight any actual or potential risks that may affect care of people with a Learning Disability.
- To share and celebrate examples of best practice in relation to care of patients with a Learning Disability.
- To develop and monitor the Learning Disability forward work plan.
- To approve any policies or care pathways specifically for people with a learning disability.
- To have oversight for operational delivery of the requirements of the UHL LD forward work plan together with cascading of information and best practice care delivery for patients with a Learning Disability within the Trust.
- Improve patient experience, working with partners to improve care.

3. Membership

- Director of Clinical Quality (Chair)
- Head of Safeguarding (Deputy Chair)
- Learning Disability Lead Specialist Nurse
- Learning Disability Liaison Nurses (UHL)
- LD Patient/carer representation
- Adult Safeguarding Nurse Specialist
- Children Safeguarding Nurse Specialist
- Safeguarding Midwife
- Palliative Care Nurse Specialist
- Representatives from:
    - Acute Medicine/ED Specialist Medicine
    - CHUGGS
    - ITAPS
    - Musculoskeletal and Specialist Surgery
    - Clinical Support & Imaging
    - Renal, Respiratory and Cardiovascular
    - Women & Children's
- Primary Care LD Liaison Nurses – LPT (City & County)
- Representatives from Community Team for People with a Learning Disability – LPT (City & County)

4. Quorum, Frequency of Meetings and Required Frequency of Attendance

No business shall be transacted unless 9 members (50% of the membership) of the group are present. This must include the Chair or Vice Chair.

The group will meet quarterly. Members of the group are required to attend a minimum of 75% of the meetings held each financial year and not be absent for two consecutive meetings without the permission of the Chair of the group.

5. In Attendance

- Secretary to Head of Safeguarding

- Other officers of the Trust and external partners may be asked to attend at the request of the Chair.

6. Accountability and Reporting Arrangements

The agenda and papers will be circulated for reading 7 days prior to the meeting date, with draft minutes being circulated for accuracy within ten working days of the meeting being held

The minutes of the group meetings shall be formally recorded by the PA to the Head of Safeguarding. The Head of Safeguarding will ensure appropriate administrative support is afforded the Learning Disability Steering Group.

Accessible versions of the agenda and minutes will be produced if these are required by the LD patient representatives on the steering group.

7. Administration

The group shall be supported administratively by the PA to the Head of Safeguarding whose duties in this respect will include:

- Agreement of the agenda for group meetings with the Chair/Vice Chair
- Collation of reports and papers for group meetings
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward
- Seeking support from the LD Liaison team in the production of accessible minutes if these are required.
- Advising the group on pertinent matters
- Recording attendance of the forum

8. Requirement for Review

These terms of reference will be formally reviewed by the group at least annually.

9. FOI Reminder

These minutes may be subject to disclosure under the Freedom of Information Act 2000, subject to the specified exemptions, including GDPR 2018 and Caldicott Guardian principles.

Appendix 2

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

UHL LEARNING DISABILITY 2019 ACTION PLAN

REF	INTENTED OUTCOME	ACTION	LEAD	COMPLETION DATE	PROGRESS UPDATE	RAG STATUS
1	To ensure the Trust has representation at local partnerships that are responsible for the development of learning disability and autism services.	To confirm with the Trust strategy department, the local arrangements to ensure representation at the Better Care Together LD work stream	Director of Clinical Quality / Head of Safeguarding	December 2018		**4**
2	All patients with an LD will be flagged on the Trust IT system.	To review the current systems and databases with the Trust informatics team to ensure there is an effective system in place to flag all patients with a learning disability Undertake an audit to test the reliability of the system in June 2019 To report back to the June LD Steering Group	Specialist Nurse Team Lead Learning Disability	March 2019 June 2019		**1**
3	Ensure there are clear commissioning arrangements between UHL and the local CCG's for LD and autism services.	To review the current funding and demand/capacity arrangements for the specialist learning disability service. Agree a service specification with CCG for the provision of LD and autism services.	Director of Clinical Quality / Head of Safeguarding	March 2019		**1**

REF	INTENTED OUTCOME	ACTION	LEAD	COMPLETION DATE	PROGRESS UPDATE	RAG STATUS
4	To ensure there is a system in place to identify patients with LD on hospital. waiting lists.	To review waiting list prioritisation systems with hospital informatics team. To develop a Trust policy for the management of LD patients on hospital waiting lists.	Specialist Nurse Team Lead Learning Disability/ Head of Information Specialist Nurse Team Lead LD/ Head of Safeguarding	March 2019 July 2019		**4**
5	An adapted SJR template will be used to review the deaths of all patients with LD.	To develop an adjusted SJR template. To formalise the arrangements to ensure that there is specialist learning disability input into the completion of the adapted SJR. To confirm with the chair of the local LeDeR steering group a ervice level agreement to be developed between UHL and the CCG outlining the Trust commitment to LeDeR reviews.	Director of Clinical Quality	February 2019 July 2019		**1**
6	There will be a systematic approach to the provision of LD training within the Trust.	The development of an LD training strategy	Specialist Nurse Team Lead Learning Disability	July 2019		**1**

REF	INTENTED OUTCOME	ACTION	LEAD	COMPLETION DATE	PROGRESS UPDATE	RAG STATUS
7	Trust will demonstrate access to resources regarding the care and treatment of patients with learning disabilities for both staff and patients/carers.	The LD page of the UHL website will be updated to provide relevant links to LD resources for staff to enhance the care of patients with LD To establish a page on the external UHL website to provide information in an easy read format for patients with LD and/or carers.	Specialist Nurse Team Lead Learning Disability / Communications department	October 2019 December 2019		**1**
8	To equip the UHL Patient Partners with the necessary skills to represent the views of patients with an LD and their carers	To organise an awareness raising session with the Patient Partners.	Specialist Nurse Team Lead Learning Disability / Patient engagement officer	May 2019		**1**
9	For UHL staff to have a tool to enable them to appropriately identify and plan for the specific care needs of patients with an LD	To develop a care planning checklist for patients with learning disability	Specialist Nurse Team Lead Learning Disability	July 2019		**1**
10	Secure funding for the employment of a dedicated LD project worker	To complete a charitable funds application, job description and role outline for an LD project worker.	Specialist Nurse Team Lead Learning Disability / Head of Safeguarding.	February 2019		**1**